PART I

Early Labor Pains,
1925–1940
Born in 1899 in Oxfordshire, England, Betty Lester worked as a nurse and then completed her midwifery training at the York Road General Lying-In Hospital in London. One of her classmates at York Road was Alice Logan, an American nurse who told stories about an idyllic place back in the United States where she planned to return to practice midwifery. According to Logan, this place offered midwives a wonderful life, with horses, dogs, beautiful mountains, and frontier living. Lured by her classmate’s tales, Lester applied to work at Frontier Nursing Service (FNS). Her parents were dead, she was single, she had no particular ties to England, and she loved the idea of riding a horse through the mountains to attend births (especially as she had ridden horses throughout her girlhood). “I want[ed] to go so badly,” she remembered thinking. “All I thought about was having a horse and a dog.”

But her British instructors told her that she could not go unless she did a six-month postgraduate course in midwifery so that she could be of more use to her new employer. Finally, after completing her postgraduate work, Lester made the eight-day voyage to America, arriving on the Fourth of July, 1928. She landed in New York City, took an overnight train to Lexington, Kentucky, and then another overnight train to Krypton in the Appalachian Mountains. Next, she rode a horse for seventeen miles to the tiny town of
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Hyden, home to FNS. Shortly after her exhausting trip, Lester was given midwifery license number thirteen, becoming the thirteenth nurse-midwife in the United States. Except for a brief return to Britain to serve her country as a nurse during World War II, she lived the rest of her life in Hyden. She served FNS in many capacities: as a district nurse-midwife, field supervisor, superintendent of the hospital, director of social services, and even as the star of the 1927 silent film about FNS, *The Forgotten Frontier*. Lester officially retired from FNS in 1971 at age seventy. However, she continued to work for the service as a speaker, tour guide, and member of the Mary Breckinridge Hospital Auxiliary until her death in 1988.

Betty Lester and her FNS colleagues were the first practitioners of nurse-midwifery at the first nurse-midwifery service in the United States. Mary Breckinridge (1881–1965), an American public-health nurse with British training in midwifery, established FNS in 1925 in the Appalachian Mountains of eastern Kentucky, a region with one of the highest maternal and infant mortality rates in the nation. The stated purpose of FNS was to protect the lives and health of mothers and children by providing trained nurse-midwives in a geographically isolated area without access to health professionals. FNS nurse-midwives denounced the work of the local “granny” midwives as a way to promote their own professional status. They then gradually replaced “grannies” as the region’s birth attendants. Breckinridge and her staff offered their Kentucky patients midwifery service, general medical care of families, and preventive medicine at low cost, and dramatically improved their health. Although some local people initially resisted the service’s efforts, most eventually took advantage of at least some of its services. In 1939, FNS also opened the Frontier Graduate School of Midwifery to train registered nurses to work as nurse-midwives in remote rural regions. FNS still exists today, and its school, renamed the Frontier School of Midwifery and Family Nursing, continues to have a significant impact, training almost one-quarter of the nurse-midwives in the United States through a special community-based distance-education program.

Breckinridge faced financial, professional, and image problems as she created and built up FNS. Her Appalachian patients could not afford to pay for health care, and her attempts to secure government funding failed. Because nurse-midwifery was new and different, it was believed to represent a potential threat to the medical establishment’s ideas about birth and to their incomes. Finally, health professionals and the lay public often associated nurse-midwives with “granny” midwives, whom they saw as dirty, ignorant, and unprofessional. The names were similar, and many feared their approaches to maternity care might be similar too.
In response to both the constraints Breckinridge faced and her own biases, she carefully constructed FNS nurse-midwifery. She limited her work to rural Appalachia, a region off the beaten path of other health professionals. She raised money for FNS by tapping into contemporary racist views, claiming that her patients were the “finest old American stock”—that is, white, Anglo-Saxon Protestants—people with the “right” genes who needed some help in order to thrive. She also portrayed her horseback-riding, mountain-mother-serving nurse-midwives as mythical figures, rather than serious professionals who might threaten physicians or the American health-care status quo.

Given Breckinridge’s tactics, myths about FNS were and remain persuasive. While FNS, unlike the other aspects of this book, has received some attention from historians, it has been the subject of even more attention in the popular and nursing press both because of the extensive public relations efforts by Breckinridge and her friends and because of its appeal from the beginning as an organization functioning in a place that seemed to be from another era. Building on the scholarship of Nancy Schrom Dye, Carol Crowe-Carraco, and others, my work analyzes in depth the service’s unique approach to birth and health, offers a new focus on the reactions of eastern Kentuckians to the service that received so much attention from outsiders, and, most important, contributes a new interpretation of Breckinridge’s cleverly crafted use of eugenics, nativist beliefs, and racism to gain support for FNS.

Mary Breckinridge’s Mission

Mary Breckinridge was FNS. Although FNS could not have succeeded without the support of physicians, nurses, and donors, Breckinridge was both its sole creator and guiding light until her death in 1965. Thus, it is impossible to separate FNS ideology and history from Breckinridge. In many ways a typical Progressive (a supporter of a variety of reforms popular after the turn of the twentieth century), Breckinridge believed that the terrible health problems of rural mothers and babies could be solved. Using the latest social scientific techniques, she studied these problems (with the help of others), publicized them, and came up with a solution: use professionally trained nurse-midwives to provide health care and education for rural families. Tough, energetic, and single-minded in her focus, Breckinridge devoted half of her long life to FNS, inspiring others, especially
women, to join her crusade against maternal and infant mortality and morbidity. Although part of a generation of single Progressive women who focused their energies on social reform causes, Breckinridge was also a nonconformist.

Despite her blue blood, she disdained many of the trappings of her class. Ignoring the fashions of the day, she always kept her straight hair

FIGURE 1. Frontier Nursing Service founder Mary Breckinridge on horseback. Courtesy of the Audio-Visual Archives, Special Collections and Archives, University of Kentucky Libraries.
short and plain, and she defied social convention by refusing to wear a hat. A short woman who was somewhat hunch-backed as a result of a horseback riding accident at age fifty, Breckinridge undoubtedly raised more than a few well-shaped eyebrows when she gave talks to the upper crust in New York, Cincinnati, and Detroit to raise support for her beloved FNS.  

But if the upper crust found Breckinridge unconventional at fifty, they would have been shocked to have met her earlier in her career. When Breckinridge first came to eastern Kentucky, she openly and frequently swore, but she changed after her father repeatedly told her in his summer visits to Hyden that ladies did not use that kind of language.

According to her staff, Breckinridge was a force to be reckoned with. Betty Lester described her as “commander-in-chief” and said that when Breckinridge came into the room, you felt like you had to stand. She was the “five-star” general of FNS.

Breckinridge’s background gave her the financial backing, connections, and motivation to head FNS. Born in 1881, she came from a distinguished southern family. Her father was a congressman and ambassador to Russia, and her grandfather was vice president of the United States under James Buchanan. Breckinridge married twice. Her first husband died young and her second marriage ended in divorce. She had two children with her second husband; her son “Breckie” died at age four and her daughter Polly died just six hours after birth. According to Breckinridge, the deaths of her children and her experiences in World War I prompted her lifelong commitment to improving the health of mothers and babies.

Prior to developing FNS, Breckinridge, a registered nurse, worked for the U.S. Children’s Bureau and in a post–World War I massive relief program for France. As director of Child Hygiene and District Nursing for the American Committee for Devastated France from 1919 to 1921, she coordinated food and medical relief for approximately seventy villages, and organized a visiting nursing service to provide general and maternity nursing. Her experiences first in France and then in London with British nurse-midwives prompted her to write in her autobiography: “After I had met British nurse-midwives . . . , it grew upon me that nurse-midwifery was the logical response to the needs of the young child in rural America.”

Breckinridge’s experience in World War I also influenced her to compare motherhood with war, arguing that “maternity is the young woman’s battlefield. It is more dangerous, more painful, more mutilating than war, and as inexorable as all the laws of God. . . . But for her there will be no drums beating or trumpets blaring.” In fact, she argued: “We have lost more women in childbirth in our history as a nation than men in battle.”
Breckinridge used the military comparison to justify her nurse-midwifery service to potential donors. Americans' lack of concern for maternal mortality as compared with wartime deaths also troubled Breckinridge on a personal level. In her private correspondence during World War II, she suggested that Americans seem to pay more attention to the suffering of war than the suffering of peace, including death in childbirth.  

On returning to the United States, Breckinridge took refresher courses in public-health nursing at Teachers College, Columbia University, from 1922 to 1923. She then began to make plans for a demonstration site in nurse-midwifery in eastern Kentucky. She chose this region because of her family connections in the area, her belief that rural mothers and children were in greater danger than those in urban areas, and her conviction that success in a region so remote and poor would prove nurse-midwifery could succeed anywhere. Her first step was to ride through the eastern Kentucky mountains to survey local midwives. She found these midwives providing inadequate care to their rural patients; most had no formal training and did not offer prenatal or postnatal care. A minority of midwives received instruction from nurses working under the State Board of Child Hygiene in conjunction with county health officers. Yet, even these midwives continued “unhygienic practices” unless they received instruction from physicians who made extra efforts to teach them. Despite Breckinridge's perception of them, the midwives Breckinridge interviewed often proudly proclaimed they “never had to call a doctor yit,” citing their own abilities and geographic distance as the main reasons for not involving physicians.

For Breckinridge, the local midwives served as both an inspiration and a marketing tool. Her 1923 survey, “Midwifery in the Kentucky Mountains: An Investigation,” supported her argument that Leslie County desperately needed modern medical care. Breckinridge eventually used the survey to denounce the midwives in her publications and speeches, and to show outsiders why they should support nurse-midwives in eastern Kentucky. She always contrasted the old, “bad” ways of the “granny” midwives with the modern, “good” ways of trained nurse-midwives.

Breckinridge visited fifty-three local midwives from three counties in the Appalachian Mountains of Kentucky in summer 1923. She visited the midwives in their homes, and typed up notes after each interview. Her reports on Susan Stiddum and Nancy Brock were typical. Born in Leslie County, forty-five-year-old Susan Stiddum had practiced midwifery for sixteen years. Breckinridge found numerous problems with her. Stiddum's home and husband were not up to standard: “Dirty untidy rough plank house, with [her] children working, bringing up wood, and mother not at
home. Found her several miles off, working in the field for Uncle Clavis Lewis, while her preacher husband sat in the shade nearby.” According to Breckinridge, Stiddum had used bad judgment in raising her own children: “Raised 5 [and gave birth to eight] but oldest is now only 15 and has stopped school when only in 2d reader, to work, although mother says she has ‘fainting fits’ since her ‘health come on her.’” Stiddum could not read or write, and she had become a midwife for “economic reasons.” To Breckinridge, her obstetrical practices were abysmal: she “rubs her hands with castor oil or other grease for examination, and makes no other preparation [such as cleaning her hands]. In answer to all questions as to what she would do if the baby did not breathe, if mother had convulsions, etc., she made the one reply, ‘aint never had none yit.’ And she had not thought what she would do should any of these complications arise.” Breckinridge concluded that Stiddum was a “dirty, untidy, poor drudge of a woman”—and obviously not fit to deliver babies.

Breckinridge thought much more highly of another local midwife, Nancy Brock. Also born in Leslie County, fifty-year-old Brock had practiced midwifery for eight years because she was “called on by neighbors.” According to Breckinridge, Brock had a “clean, neat” appearance, as well as a “clean and tidy,” “extraordinarily picturesque old double log house, with big white oak tree behind it, and apple trees in front.” With her farmer husband, she had had nine children, eight of whom lived. Breckinridge approved of Brock’s connections to the formal health-care system in Leslie County. She had registered as a midwife six years prior to the interview on the advice of the registrar, and she carried a clean washable bag with birth records and drops of silver nitrate for her babies’ eyes to prevent blindness in case the mothers had gonorrhea. Brock called a doctor when a mother in labor went into convulsions, showing her willingness to get help at least in some situations. She also “attended state conference at Beach Fork [instruction for midwives given by nurses from the State Bureau of Child Hygiene in conjunction with the county health officers] last year and appears to have profited by it to some extent.” However, even this midwife had her problems. Despite Brock’s contact with the health-care system, she admitted using some folk remedies, such as “pepper tea for chilling” the mother. Although she scrubbed her hands, Brock used no disinfectant on them. She also admitted that she had had some infant deaths due to prematurity, and her neighbors noted that she had had three stillbirths recently.

After gathering information on Brock, Stiddum, and fifty-one other midwives, Breckinridge wrote her report. She found that the midwives did
have a few good qualities; some had “native intelligence,” even if they could not read or write. At least fifteen midwives and their homes were “exceptionally neat and clean,” according to Breckinridge, although she described ten midwives and their homes as “filthy,” with the rest in-between. As expected, Breckinridge found more bad than good. None had formal midwifery training; the little instruction they received had come from watching other midwives. Their obstetrical practices were poor. For example, very few carried equipment bags, and none provided postnatal care. When a mother started to hemorrhage, the midwives used “superstitious practices,” such as giving teas or spices, “cording the leg,” putting an ax under the bed, or reading a passage from the Bible. Worse, most midwives failed to recognize when they needed to call for medical assistance, and if they did, they called “pseudo-doctors,” rather than licensed physicians. They also were generally unprepared for and unconcerned about complications. Breckinridge cited one example after another to show the disastrous results of their approach to birth. Although she claimed that she did not want to “point the moral’ of the data collected,” ultimately she insisted that the story of these fifty-three midwives would continue to be a “problem” until a solution had been found and applied.

While conducting her 1923 survey of local Kentucky midwives, Breckinridge asked her friend Dr. Ella Woodyard, from the Institute of Educational Research of Teachers College, Columbia University, to perform random intelligence testing of Appalachian children. Woodyard found the median intelligence quotient to be 99.5, somewhat higher than the national median. She concluded that while most Appalachian children possessed good native intelligence, very few lived in an environment conducive to stimulating these abilities. Breckinridge would later use this data to show potential donors and supporters of FNS that eastern Kentuckians were worth helping, and would improve in the right atmosphere.

Roadblocks, Racial Myths, and Romantic Imagery

Despite Breckinridge’s efforts to establish her potential patients’ native abilities and their great need for improved maternal and infant care, her initial attempts to set up a nurse-midwifery demonstration site failed. The major roadblock she faced came in the form of the director of Kentucky’s Bureau of Maternal and Child Health, Dr. Annie S. Veech, whom Breckinridge derisively called “Mr. Ready-to-Halt” in her private correspon-
Veech refused to support Breckinridge’s proposal for a nurse-midwifery service, thus preventing her from getting funds from the American Child Health Association (ACHA), which required state support, or from state agencies. In fall 1923, just after completing her midwifery survey, Breckinridge applied for money from the ACHA for what she titled the Children’s Public Health Service, a five-year demonstration site in nurse-midwifery in eastern Kentucky. Her plan was to create a free health-care program, offered by public-health nurses with advanced education in midwifery, for children from the prenatal period through school age. In her proposal, Breckinridge promised the support of the few physicians from this remote region. She also argued that because the people of eastern Kentucky could not afford to pay for the majority of the program, it needed to be funded by government money, specifically through the recently passed Sheppard-Towner Act, which had allocated funding to improve maternal and child health. Although members of the ACHA liked Breckinridge’s project, the organization, which was funded by the Commonwealth Fund (a private philanthropic organization dedicated to improving health care) needed state approval for the project before granting its support.

But approval was not forthcoming from the project’s state evaluator, Veech, who rejected the plan on several counts. First, she felt that Breckinridge was too independent, unwilling to take the advice that Veech and her staff offered. As Veech chided Breckinridge in personal correspondence regarding the matter, others were “willing to take absolutely our outlined policy for [child health] work in the state” whereas Breckinridge was not. Similarly, while others “have not come to us suggesting how we should do things, but knowing our experience here have come asking how they could help to do the things as we thought best,” Breckinridge thought that she knew best. Second, Veech believed the plan for a nurse-midwifery demonstration site was impractical. She disagreed with the idea of nurse-midwives: “After all, a nurse-midwife is only a midwife. There appears to be a tendency among certain groups of nurses towards practicing medicine for which they are in no way prepared without graduating in medicine.” Furthermore, Veech argued, a less costly solution to maternal and child health-care problems was to train “granny” midwives, rather than hiring nurse-midwives. Her comments suggested that she viewed “granny” midwives as more willing than nurse-midwives to submit to state control. Finally, she found Breckinridge’s report of her midwifery survey to be very disturbing. In fact, Veech refused to publish the report, telling Breckinridge that she was exploiting the people of Appalachia:
Your suggestion that the report of your observations of the midwife condition in our mountains be published by us was very unexpected. I told you I would have it printed before I realized it was your intention to broadcast this report. It seems to me our distressing midwife problem is our own, and does not concern the great public. Our mountain people are hypersensitive—already they have been greatly exploited. . . . Broadcasting such a report as yours is like making public family skeletons or shouting one’s sorrows on the housetops. I fear in your enthusiasm to be of service, you failed to get this viewpoint.26

Stopped in her tracks by Veech, Breckinridge was unable to pursue further the possibility of financial support from the ACHA or the state of Kentucky. A few years later, looking back at her run-in with Veech, Breckinridge maintained she was glad that FNS did not get Sheppard-Towner money:

we would have been hampered with red tape at every turn, with no compensating financial assistance, and a position less strong as regards the nursing association, and the bureau of nursing. . . . and the medical profession, than we have at present with our direct contact with [Dr. Arthur] MacCormack [State health officer] independently of any bureau. . . . I am thoroughly in favor of Sheppard-Towner as a principle; but in our American tradition nothing ever yet began in a governmental way in new movements in health and education. Private initiative and voluntary aid is our tradition for the creation of all such work.27

In part, Breckinridge likely was rationalizing her rejection by Veech, but she also genuinely believed she was better off not having to deal with the bureaucratic roadblocks associated with government funding.28

Despite Veech’s rejection of her plan, Breckinridge remained convinced that she should establish her program in eastern Kentucky. Before doing so, she went to Britain to learn more about its system of nurse-midwifery. She attended the British Hospital for Mothers and Babies in the Woolwich section of London from 1923 to 1924 to become a midwife, and was certified by the Central Midwives Board, a regulatory body established by parliament in 1902. Breckinridge took a four-month midwifery course, typical for British trained nurses who wanted certification. She and her fellow students served rotations at prenatal clinics, labor wards, mothers’ wards, nurseries, and in the districts, and delivered, with supervision, a minimum of twenty normal childbirths. Breckinridge also benefited from
delivery room and bedside teaching by physicians and nurses, as well as classroom lectures. She then spent several months in Scotland studying the Highlands and Islands Medical and Nursing Service, an organization staffed by nurse-midwives to provide skilled health care to a poor rural population. As Breckinridge stated, “the system used by the Frontier Nursing Service is an adaptation of the methods used in the Highlands and Islands work.” Located in an area similar geographically to eastern Kentucky, the Scottish service was decentralized, administered by local volunteer committees, and financed by private donations with the help of government grants. Nearly prepared to begin her Kentucky project, Breckinridge returned to England, where she enrolled in postgraduate courses in midwifery at the Post Certificate School of the York Road General Lying-In Hospital in London in 1924.

Back from Britain, Breckinridge applied what she learned from her experiences there. Given her failed attempts to secure public funding, she created a private philanthropic organization, the Kentucky Committee for Mothers and Babies (renamed Frontier Nursing Service in 1928), to serve mothers and families in a 700-mile area extending into four southeastern Kentucky counties. Modeled after Highlands and Islands, FNS had three parts: 1) the hospital and nursing center in Hyden; 2) the administrative headquarters, nursing center, and Breckinridge’s home five miles away in Wendover; and 3) by 1930, six outpost centers. Breckinridge believed strongly in a decentralized organization because of the difficulties of traveling through the rough Appalachian terrain. Additional benefits accrued to local families who were able to develop relationships with their district nurse-midwives and comment on center operations through a center citizens’ committee. Local citizens also donated labor and money to help build the centers. Each outpost center, the gift of a wealthy benefactor from outside the mountains, housed two nurses responsible for the general health of all the families within their district. Districts covered an approximately five-mile radius around the outpost, meaning that nurse-midwives would never be farther than an hour’s horseback ride to families in the area. First by horseback and later by jeep, FNS nurse-midwives traveled through the mountains offering prenatal, labor-and-delivery, and postnatal services for women, as well as general nursing care and public-health programs for men, women, and children.

Financing this new organization proved very difficult. Fees for FNS services were low compared with typical health-care providers. Until the late 1940s, FNS charged five dollars for complete midwifery care, including prenatal care, care during childbirth, and nursing visits for ten days...
after the baby was born. The service charged each family one dollar a year for general nursing care, and never denied care based on lack of ability to pay. Because patients often lacked cash, they sometimes paid with animal fodder, eggs, butter, corn, potatoes, chestnuts, apples, rhubarb, or honey. Sometimes, women paid by making quilts, and men by making chairs. At other times, fathers or sons worked at FNS, mending fences, chopping wood, and whitewashing barns to pay their families’ bills. These payments, whether in cash, work, or produce, covered only a fraction of the cost of the services. Yet the poverty of the patients meant they could not possibly meet these costs. In 1932, the average family income for residents of Leslie County, where FNS was located, was $416.50 per year, with only $183.53 of that in cash, or $36.70 in cash annually for each person in an average family of five. In 2006 dollars, that translates into an average
family income of $5,947.86 per year, with only $2,620.92 of that in cash. Because FNS lacked money from both patients’ fees and government funding, it needed private contributions and marketing. To provide FNS with both, Breckinridge, who was extraordinarily savvy in marketing and public relations, created a system of mixed-gender volunteer committees in the Northeast and Midwest to form the backbone of FNS financial support. FNS committee members were among the most prominent and wealthy in their cities (in other words, the opposite of FNS patients), and they came from a wide range of political and social perspectives. At various times, the committees included Eleanor Roosevelt; Sophonisba P. Breckinridge, Mary’s cousin and professor and founder of the University of Chicago’s School of Social Service Administration; Joseph B. DeLee, a leading obstetrician; and Clara Ford, wife of conservative automobile magnate Henry Ford. Committee members donated money to open FNS outpost centers, and, in return, FNS named the centers after benefactors’ relatives. Committee funds also financed FNS operations. In addition, Breckinridge set up a program for “couriers,” young horse-riding debutantes who came to the Kentucky mountains for several months, or sometimes several years, to care for the nurse-midwives’ horses and otherwise assist them. She used these couriers to advertise FNS to the blue bloods back home, whom she hoped would donate money to the service. Many, if not most, couriers became members of FNS committees after their service in Appalachia, and maintained lifelong connections to FNS.

Anticipating criticism about nurse-midwives and knowing from experience that physicians such as Veech could injure her nurse-midwifery service, Breckinridge carefully designed both her service and its publicity. FNS deviated from increasingly popular views of childbirth as a medical process, yet these deviations did not turn away potential donors or alarm physicians, mostly because of the patients FNS served. Media materials created by FNS staff and volunteers helped the public see nurse-midwifery as anomalous—employed only by people on the margins. They emphasized not the unusual approach FNS took to birth and health, but the needs of its poor, white, Appalachian patients, thus shielding FNS from potential opposition and hostility from the medical establishment. However, the media coverage also prevented the public from taking the FNS approach or nurse-midwives seriously as potential birth attendants for the middle class or even for other poor people with some access to physicians. Although this careful crafting worked at the outset to garner support for and deflect negative reactions to the service, it would ultimately circumscribe the authority given to the nurse-midwives who worked for FNS.
From the beginning, Breckinridge and her staff, as well as FNS volunteers and friends, published articles touting their experiences with FNS, took hundreds of photographs, and produced several films of nurse-midwives in homes, on horseback, and in jeeps in Appalachian Kentucky. Breckinridge spent at least twelve to fifteen weeks a year outside the mountains, speaking to FNS committees and using films, books, and magazine articles created by her staff, couriers, and friends to add to the FNS coffers.

The words and images FNS supplied to journalists emphasized the class, culture, and race of FNS patients and the difficult circumstances in which nurse-midwives worked. These portraits perpetuated and extended myths about Appalachia in an attempt to prompt potential donors to give money, and to encourage volunteers, students, and nurse-midwives to join the FNS. Starting after the Civil War, novelists, missionaries, and journalists created a series of positive and negative images of Appalachian people and Appalachia, the place. They described the region as natural, undeveloped, and beautiful, separate from civilization and industrialization. They described the mountaineers as hillbillies, moonshiners, feuders, bushwhackers, and inbreeders—as quaint, primitive, and, yet of pure stock, as descendants of Anglo-Saxons. As William Goodell Frost, long-time president of eastern Kentucky’s Berea College at the turn of the twentieth century, explained, Appalachia was a remnant of eighteenth-century civilization, “a contemporary survival of that pioneer life which has been such a striking feature of American history,” while the mountaineers were “our contemporary ancestors,” descended from Revolutionary War heroes.

Two forces in the 1920s made Americans receptive to the romanticization of Appalachia. First, the 1920s saw a resurgence of nativism and racism, resulting in large part from the influx of a “new” kind of immigrant between 1880 and 1920 (many of whom were Southern and Eastern European), as well as from the nationalism accompanying the United States’ entry into World War I and the Red Scare following the Bolshevik Revolution. Nativism and xenophobia helped create the severe immigration restrictions of the early to mid-1920s, Americanization campaigns, the founding of numerous nativist organizations, such as the National Patriotic Council, and the revival of the Ku Klux Klan. For the upper-class women and men Breckinridge tried to reach, Appalachians were true Americans; saving Appalachians provided an opportunity to save the “old stock,” even if they came from the wrong class (and even as that stock was under threat). Second, in the 1920s, timber buyers and coal speculators

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continued a tradition from the late nineteenth century of depleting Appalachia’s natural resources, using mountaineers to do the logging and mining and then leaving Appalachian people with ruined land susceptible to the ravages of floods. As upper-class outsiders exploited Appalachian land and people, they glorified the culture they were also helping displace. Like many other Appalachian social-service programs, schools, and institutes, FNS reflected its founder’s upper- and middle-class “outsider” values, as well as a desire to preserve Appalachian culture.

Articles and films produced by FNS romanticized its patients as mountaineers of this so-called true American heritage. In a typical article, a student of the Frontier Graduate School of Midwifery argued that her patients reminded her of a glorious past: “There was something excitingly different about these mountain people who seemed to have resisted the standardizing influence of modern communications systems, and clung to the customs and habits which were brought over and handed down to them by their British ancestors. One senses a curiously whole-hearted friendliness in their attitudes. Their mountain twang sounded delightfully strange to the ear of an ‘outsider.’” According to a former courier, Breckinridge did “a lot of research” to trace the Anglo-Saxon roots of eastern Kentuckians. She, her staff, and friends sought to convince their audience that eastern Kentucky patients were the “worthy poor”—people whose lives could be improved, and who deserved the improvements. In a 1928 article penned by Breckinridge, the caption under a photograph of an elderly woman with a child read: “A fine old grandmother. The people of this lonely mountain region are pure English stock.” FNS committee pamphlets explained that Appalachians were “people of old American stock,” and that “nowhere is the stock truer to type.”

In fact, FNS public-relations materials made a point of explaining that unlike the immigrants and African Americans who seemed to be taking over urban areas, its clients were “just like you and me,” only poor. Elizabeth Perkins made this point clearly when explaining the purpose of *The Trail of the Pioneer*, a film on FNS she codirected and which Breckinridge used in her lectures around the country:

The one great thing for us all to remember is that we pure blooded Americans must stand solidly together, whether we come from the South or the North, for we Americans are the inheritors of this wonderful country, and we are very distinct from the foreign born element which is overpowering us in the great cities.
It is with every desire to preserve the coming generation of Americans that we want to acquaint all America through the medium of pictures—with the knowledge of the uncontaminated race to be found in our mountain regions. It is with the hope that those whose lives lie in the maelstrom of cities may appreciate the quietness of the mountains, and send their own people such assistance as may help to continue for generations the best examples of sturdy, upright, God fearing Anglo-Saxon race.\textsuperscript{48}

Nativism prompted Perkins to make her film, and she hoped that “pure blooded Americans” would respond to her nativist appeal by giving money to FNS. FNS simultaneously portrayed the mountaineers as backward and excellent raw material; as different, but in a good way; and as “good old American stock handicapped only by geographical conditions.”\textsuperscript{49}

Even as they tried to appeal to eugenic beliefs, Breckinridge, Perkins, and other supporters of FNS were wrong about the heritage of FNS patients. Appalachian people predominantly were not Anglo-Saxon, but “Scotch-Irish,” people whose ancestors originally came from Northern Ireland, the lowlands of Scotland, and northern England. In other words, the ancestors of FNS patients had lived in the British borderlands, just as they did in Appalachia. As residents of these marginalized regions, the “Scotch-Irish” had been considered suspect by the “true” English; this view persisted in America where English Americans regarded them as barbarian and non-English. Tellingly, at the time of the Revolutionary War, this “heroic stock” was viewed as marginal, and certainly not of “good” stock, as FNS claimed fewer than two hundred years later.\textsuperscript{50}

FNS media materials also played on existing gender roles to romanticize Appalachians. Breckinridge and other writers on FNS viewed Appalachia as a remnant of a better past, when men were men and women were women. As Breckinridge explained, eastern Kentucky men feuded to keep their honor—just as “men of the intellectual ability of Hamilton, Jackson, and Clay” had done in a previous century—and practiced “the utmost chivalry for women.”\textsuperscript{51} In another article, Breckinridge argued that “in the country, the mother is the heart of the household in a way that has come to be old-fashioned in city life.” While the man handled the timbering, plowing, and raising of crops, the woman tended the garden, dried the beans, turned raw produce into food, milked cows, fed chickens, and quilted covers for beds in an eighteenth-century–style household economy. Breckinridge claimed: “In all of this, she has the help of her children whose lives revolve around hers. In a country home, the mother is irreplaceable.”\textsuperscript{52}
The media produced by FNS seemed to long for a past when men and women held roles different from the ones found in the early to mid-twentieth century—a past they claimed to find in eastern Kentucky. However, other sources show Appalachian gender roles to be less distinct than FNS portrayed. According to recent scholars, both contemporaries and academics have portrayed Appalachian women in simplistic, romantic ways, ignoring the nuanced realities of women’s lives and relations between men and women.

To gain support for the FNS cause, Breckinridge, her staff, and her friends emphasized the high birthrate of Appalachian women. They used racial stereotyping to perpetuate myths about eastern Kentucky in an era of great concern about high fertility rates among immigrants and African Americans and low fertility among native-born whites. One of the more exaggerated examples of this emphasis on eastern Kentuckians’ fertility can be found in a letter from actor, author, and humorist Will Rogers. Breckinridge encouraged Rogers to write to several New England newspapers supporting an FNS cruise to the West Indies. This was just one of many newspaper advertisements for local and national fundraisers and benefits for FNS. Rogers began his letter with the salutation, “Well if it aint Mary Breckinridge.” He explained that as an actor he did not have the time to take a cruise. He continued: “The trip I want to make is right out in that virgin baby country of yours. I can talk to those people that are breeding these babies, but I never could understand a black Negro in Jamaica that spoke English better than Lady Astor [one of the cruise stops was Jamaica]... So when I get some time off I am heading for this incubator country of yours. You can’t beat old Kentucky for a breeding ground. It’s the limestone in the soil, and the corn in the jug that does it.” Rogers clearly intended the letter to be funny, but his humor shows how Breckinridge and her supporters used racial arguments to solicit money for FNS.

Breckinridge and FNS used the mass media to romanticize not only the Kentucky mountaineers but also the mountains themselves and rural life in general. The media images FNS generated and supplied to the press had a sort of tension; on one hand, the place and people were wild and different; on the other hand, they were simple and reminiscent of a better time. By the 1920s, the majority of Americans lived in urban areas. Yet, Ernest Poole, an author who worked closely with Mary Breckinridge for an article about FNS in Good Housekeeping, quoted Breckinridge as saying, “fully eighty percent, I am told, of the men who direct our great corporations came from rural regions.” She argued that “the vigor and youth of a nation are born again in its children, and most of all in the country districts,” and
therefore we must “help mothers to have their children well born.” Poole himself suggested that “nobody hurries in the hills. Life is quiet down there. You hear only soft halloos.” FNS created articles and supplied information to journalists portraying eastern Kentucky as a simple place that deserved attention because it produced so many fine citizens—and as a kind of exotic, foreign–seeming region, a place with “Swollen Rivers and Rocky Mountain Trails”—“The Last Frontier.” FNS writers figured the more exotic FNS seemed, the more likely it would attract potential donors. They also appealed to a long–standing and persistent American myth—that the “real” America was in small towns and rural areas, where people continued to have good values.

Media shaped by FNS also glorified nurse–midwives as “Heroines on Horseback,” emphasizing their role in saving mothers and babies in a region with few resources. Just as the Model T was becoming more widely available in the United States, Breckinridge emphasized the horses nurse–midwives rode. As she explained, Appalachia had “no railway, no highway, no automobiles, no physicians”:

All of our work is carried forward on horseback. . . . Each nurse saddles and feeds and grooms her own animal. . . . The riding is always difficult and dangerous. During the winter, when the cold spells come and the streams freeze over, the horses, shod with ice nails, slip and stumble and often crash through with bleeding hocks. Sometimes a way must be made for them out to the rapids, where one commonly finds the fords, by a chivalrous mountaineer with his axe. When the “tides” come the fords of the unbridged river are unpassable.

Breckinridge praised the nurse–midwives—and the horses—who worked against the odds for “all–American” mothers and children. Her cousin, Mary Marvin Breckinridge (known as “Marvin”), who came to FNS as a courier in summer 1927 after graduating from Vassar College, made a silent film, The Forgotten Frontier, portraying the difficulties nurse–midwives and their patients faced. She opened with the question: “Do you know that America is still a frontier country for about fifteen million people with almost no medical, nursing, or dental care?” The film, with local actors portraying real events connected with FNS, showed nurse–midwives crossing swollen rivers, a woman giving birth with the assistance of an FNS nurse–midwife, one man shooting another and nurse–midwives dealing with the aftermath, and nurse–midwives inoculating a group of children.
In addition to the lack of motorized transportation, the difficult topography, and a dearth of professional medical care, ignorant “granny” midwives were another difficulty that eastern Kentuckians faced, according to Breckinridge, her staff, and friends. Repeatedly, Breckinridge told potential donors that FNS brought modern health care to poor, deprived Appalachians, who suffered at the hands of these backward women. She used the information from her 1923 midwifery survey to gain support for FNS. Breckinridge’s condemnation of local midwives was part of a strategy to contrast traditional midwives and the new nurse-midwives to foster the perception of nurse-midwives as modern professionals. This tactic helped Breckinridge to establish her service but created some problems for nurse-midwifery in the long term. No matter how hard nurse-midwives tried to portray themselves as modern, many people—both potential patients and health professionals—associated them with the traditional midwives whom Breckinridge and other nurse-midwives criticized.

Breckinridge, her staff, couriers, and friends then used a variety of strategies to help FNS get off the ground and survive. They glorified and romanticized the people of eastern Kentucky, rural life, and nurse-midwives while condemning “grannies.” They argued that FNS could uplift Appalachians, who deserved such efforts because of their presumed Anglo-Saxon heritage. But in the process, they indicated that the nurse-midwife only served people on the margins, and that the nurse-midwife did not engage in a modern profession, but in an exotic, romantic pastime. FNS certainly promoted the good works its own nurse-midwives performed, but did not attempt to encourage the general expansion of nurse-midwifery around the nation.

Despite the myths, FNS was a perfect solution to the health problems of Appalachians, providing excellent care and avoiding condemnation from physicians. Certainly, FNS could not have succeeded without medical support, both backing up the nurse-midwives and lending authority to the organization. Breckinridge formed a national medical advisory board, composed of some of the country’s leading obstetricians, including George Kosmak, editor of the American Journal of Obstetrics and Gynecology, but the board did not have a regular influence on FNS work. Physicians who supported FNS realized that very few doctors worked in Leslie County, and no hospitals existed there until FNS opened one in 1928. As physicians knew from both a study by Johns Hopkins statistician Raymond Pearl and their own experiences, poor, rural areas lacked good medical care for two reasons: physicians could not make money in such places
and they disliked being isolated from modern, technological medicine. Thus, FNS medical advisors saw nurse-midwives as the best alternative to physician or hospital care and even suggested that nurse-midwives’ presence encouraged a few qualified physicians to locate in Leslie County. Some physicians may have lent support to the “nurses on horseback” because they believed nurse-midwives received proper obstetrical training and up-to-date medical supervision, while local general practitioners and midwives had little to no training in obstetrics. Supporting FNS may have assuaged the guilt of some physicians, who were dedicated to improving maternal and infant care yet unwilling themselves to practice in poor, rural areas—or to encourage their students to do so. Finally, they also may have promoted the program because they endorsed the racial myths and romantic imagery surrounding FNS and its patients.

The Local Perspective

What did eastern Kentuckians think of the way that Breckinridge and her colleagues portrayed them—and their land—in the media? The available evidence suggests that some people did not like it. Interestingly, these people were middle or upper class, and not FNS patients. They understood that Breckinridge and FNS staff needed to appeal to rich outsiders to raise money, but believed that the appeal could be made in a different way—one that depicted Appalachians more accurately. Mary Brewer, who came to Leslie County in 1939 as a social worker with the Works Progress Administration, wrote a book to correct erroneous images of her adopted home and its people:

Mary Breckinridge . . . was the first one, I guess, that put the people in this area on the map by going out and soliciting aid, and naturally most of their material was slanted toward the poorer class of people. They didn't tell anything about the fine homes that were here. It was always the little shacks on the hillsides and people going without clothing and half-starved and barefoot. So that most people . . . outside of Kentucky, they got the wrong idea, and I . . . thought that ought to be corrected.

An erudite Leslie County resident, M. C. Roark, wrote an angry letter to the editor of the county’s newspaper in 1927 after it reprinted a *New York*
We welcome, and will be glad to support any organized work in Leslie county, and hope to say nothing to lower their efforts and goal, and especially honor Mrs. Breckinridge for her work in our behalf.

But we feel that we pay in the sacrifice of our honor when the support is agitated and purchased by the Miss Smith and Perkins plan. We don’t like to see the worst possible conditions that can be described and exaggerated peddled upon as the fruits and products of Leslie county. It seems to me that any organization would find a higher plane upon which to raise funds than to come down to the wornout plan of exaggerating conditions.70

Clearly, some local people resented the picture FNS painted of them, but what did they think of FNS itself? Their feelings were mixed and varied. Some actively welcomed FNS, others actively disliked and rejected FNS, while many responses were in-between those two extremes. However, after some initial resistance and even hostility toward the service, most people came over time to like or at least accept FNS.

Breckinridge and her staff members’ official writings proclaimed widespread acceptance of and cooperation with FNS. In her autobiography, Breckinridge wrote that as she rode through Leslie County trying to gain support for the new FNS, she found a crowd of mothers “begging for a nurse for their part of the county.”71 Nurse-midwife Betty Lester explained how wonderfully the local people came together to make “the clinic the neighbors built.” All of the local men with whom she met agreed to donate timber to build a new outpost center. In fact, most donated more than the 200 feet for which she asked. Once the men built the clinic, local women cleaned the building, wallpapered the walls, and decorated two rooms for the grand opening.72

The statements of some Leslie County residents who were interviewed in the 1970s and 1980s support the notion that local people liked FNS. These interview subjects pointed to local respect and admiration for Breckinridge and her desire to improve area health care. Born in 1901, Frank Bowling was working for the Fordson Coal Company (a subsidiary of the Ford Motor Company) at the time he met Breckinridge in 1928. But he had heard wonderful things about her long before that meeting:
Well, everything that I’d heard about her was . . . good. . . . Miss Breckinridge was well respected in this section of country. Everybody looked up to her. She come in here . . . and helped people when they couldn’t help theirselves back yonder. . . . Everybody owed an awful lot to Miss Breckinridge.

Hallie Maggard, a Hyden native who was interviewed in 1978 at age ninety, retained a clear picture of Breckinridge from when the FNS founder first arrived in the area. Maggard said that the local people “honored her. I mean they helped in every way they could. People was glad to have her. And they tried to help her in what she’d come here . . . to do. . . . She took care of mothers and babies. That was a great relief to people.”

However, there clearly was some resistance to FNS, at least during its first few years. Rumors of terrible things FNS nurse-midwives did to mothers and babies were common. FNS nurse-midwife Grace Reeder mentioned that early on the locals believed that nurse-midwives took their female patients’ rectal temperatures because “they were fixing the little girls so that they could never have babies.” Other local people refused to use the service, or to help FNS in any way. Lester said that “at first people didn’t want their children to have . . . these needles shoved into them. They thought it was cruel. They didn’t see any sense in having a needle shoved into a child.” Some locals wondered about FNS motives. Ruth Huston, who first visited Hyden in 1924, stayed to work with a Presbyterian school, and became a member of the first local FNS committee, explained that the local people “weren’t sure what she [Breckinridge] was there for. They got the idea that they were missionaries at first. They didn’t understand what she was doing, although she had a meeting in the courthouse trying to explain it.”

Resistance seems to have been strongest during the earliest years of the service. Several oral histories indicated that once FNS had established itself and people learned to trust the nurse-midwives, even those who initially resisted FNS accepted at least some of the services it offered. For example, Lester explained that “after a time” the same people who resisted vaccinations “began to tell us when their typhoid shots, and this, that, and the next thing, were due.” And, according to Huston, eventually Leslie County residents understood Breckinridge’s motives and accepted her: “They finally got onto the fact that it [FNS] was medical and that she wasn’t a missionary.” Breckinridge and her staff ultimately gained the trust and support of many local people.
Chapter 2: Eastern Kentucky

The Depression and World War II: Financial Troubles and the Opening of a School

The Depression severely damaged FNS work. Cancellations of FNS subscriptions and a decline in donations caused staff reductions and nonpayment of staff for several years; as late as 1947, FNS owed back payments to its employees. During the early 1930s, the FNS Executive Committee debated closing some outpost centers, but decided to maintain them with reduced services.80

Financial decline during the Depression also hampered Breckinridge’s goal to extend nurse-midwifery to other isolated areas of the United States. In 1930, the FNS St. Louis Committee, one of many volunteer committees designed to provide funding for FNS, requested that FNS survey certain Ozark Mountain counties to determine whether it should bring its services to these remote rural regions. In fall and winter that year, two FNS nurse-midwives and one FNS secretary spent two-and-one-half months surveying seven counties in northern Arkansas and southern Missouri. Despite an interest in expanding their services, FNS officers and trustees decided against going into the Ozarks because of a lack of funding.81 Eastern Kentucky turned out to be the only place where Breckinridge established a demonstration site in nurse-midwifery.

World War II forced FNS to make changes as well. The first occurred when FNS began receiving some government money. After Breckinridge’s 1923 attempt to gain government funding failed, Breckinridge did not try again until World War II, when FNS participated in the Emergency Maternal and Infant Care Program, whereby the government reimbursed FNS for its care of servicemen’s wives. The second change entailed the creation of a nurse-midwifery school. Since nurse-midwives did not exist in the United States prior to FNS, the service had originally employed mostly British public-health nurses, like Betty Lester, who had also trained as midwives. Sometimes FNS sent American nurses to England and Scotland on scholarships to receive midwifery training. However, World War II terminated these options. Once again, Breckinridge created another survival strategy for FNS: the development of an educational program to maintain its staff. FNS probably would have closed if Breckinridge had not opened a new school for nurse-midwives, the Frontier Graduate School of Midwifery, in 1939.

FNS staff had made some earlier attempts at nurse-midwifery training. In 1932, FNS nurse-midwife Mary B. Willeford outlined a plan for a
nurse-midwifery school in her dissertation, “Income and Health in Remote Rural Areas,” at Teachers College, Columbia University. Willeford proposed a school that would train graduate nurses to meet the health-care needs of the rural poor. In 1935, FNS provided midwifery training, as well as instruction in “our frontier technique in bedside nursing and public health,” to two Native American nurses, at the request of the National Society of Colonial Dames of America in Pennsylvania; Colonial Dames in other parts of the country provided financial support for the nurses’ year at FNS. (Colonial Dames were women of Breckinridge’s class and ethnic background who could trace their ancestors back to the colonial era.) Upon completion of their training, the two nurses worked for the Bureau of Indian Affairs on reservations in Wyoming and Nevada.

In the mid-1930s, Breckinridge had wanted to open a nurse-midwifery school affiliated with the University of Kentucky, with the nurses completing most of their fieldwork at FNS. Although the president of the university supported the idea, Breckinridge’s repeated attempts to find financing failed, thwarting the school’s creation. Originally, Breckinridge had thought FNS could obtain money under a clause in the new Social Security Act which sought to appropriate one million dollars for research into and care of maternity cases in rural areas. However, Congress struck out this clause when it passed the legislation, thus eliminating the possibility of federal funds for an FNS school. In addition, the Carnegie Foundation rejected the service’s request for money to conduct studies of schools for midwives in northern Europe, which FNS had hoped would help in the development of plans for its own school.

In 1939, FNS opened the Frontier Graduate School of Midwifery, since by then Breckinridge felt she had no choice but to open her own school. That year, many British nurse-midwives employed by FNS returned home to help Britain fight the war. The war also cut FNS off from British educational opportunities for American nurses who wanted training in midwifery. The Frontier Graduate School of Midwifery offered midwifery training to registered nurses, with the goal of meeting the service’s personnel emergency and then supplying nurse-midwives to other agencies working in “frontier outpost areas.” The school started by training two nurses at a time in a four month course, with each student receiving scholarship money. In 1940, the school expanded to training three students at a time, and extended the course to six months. Early classes were small because FNS lacked the facilities and staff to teach more students. To meet its staffing crisis, FNS sent two graduate nurses to Maternity Center Association’s Lobenstine School in New York City.
Chapter 2: Eastern Kentucky

Once the Frontier Graduate School met the service’s staffing needs, FNS hoped to expand its mission to train nurse-midwives for work in other isolated rural areas, and “at last to respond to the calls so frequently made upon us to provide frontier nurses for American outposts from the Caribbean to Alaska and including the Indian reservations.” In 1941, the U.S. Children’s Bureau asked FNS to expand its school to train more nurse-midwives, who would then return to their home states to work in maternal and infant health care. FNS complied, and later that year beginning with its fourth class in 1941, the school expanded to four students, funded by scholarships from the U.S. Children’s Bureau, private donations, and churches, which helped sponsor missionary nurses. Each student promised to work for FNS for two years after her training, receiving the regular salary paid to first- and second-year nurse-midwives.

Modeled after British midwifery schools, the Frontier Graduate School of Midwifery offered something unique in the United States—instruction in theory combined with practical experience in rural midwifery. Students learned “to work with what they have,” and to develop their judgment in observing problems affecting their patients’ pregnancies and/or births, recognizing the abnormal, and applying necessary emergency measures until a physician arrived. Student nurse-midwives heard thirty lectures in midwifery from the medical director and took thirty classes with the instructor, a nurse-midwife with a master’s degree in public health. Classes involved frequent discussions and tests. The medical director and instructor used a life-size mannequin in demonstrations and for practice as well as forty-seven preserved specimens to demonstrate fetal development and abnormalities. Students had access to a reference library with British and American midwifery textbooks.

Under supervision, FNS students provided prenatal, labor-and-delivery, and postnatal care in a variety of settings. They gave prenatal and postpartum care in patients’ homes, in outpost nursing centers, at clinics held at the FNS hospital in Hyden, and to a lesser extent, at the hospital itself. They learned to conduct detailed prenatal examinations, including abdominal examinations, a test for albuminuria, blood pressure, vaginal smears and blood for the Kahn test to diagnose syphilis, measures for hemoglobin, and measures for blood coagulation time. Carrying out part of Willeford’s original plan of teaching students broad issues in public health, the school instructed student nurse-midwives “how to supervise the diet of the low income rural group,” including methods for eradicating intestinal parasites. Students handled both home and hospital deliveries, attending at least twenty women under the supervision of an instructor. In
addition to their regular twenty deliveries, they had the option of assisting the medical director in abnormal deliveries. During the postpartum period, students provided bedside care to mothers and babies. Upon completing the course and fieldwork, FNS students took a final examination, with written, oral, and practical components, given by the Kentucky State Board of Health. When students passed the examination, they received diplomas from the Frontier Graduate School of Midwifery and certificates to practice midwifery in Kentucky, as well as the right, granted by the Kentucky State Board of Health, to use the letters C.M. (Certified Midwife) after their names.90

Grace Reeder was a member of one of the Frontier Graduate School's first classes and a typical student in those early years. Originally from Ohio, Reeder had graduated from the Columbia University School of Nursing, and then worked as a private duty nurse. After hearing Breckinridge speak about FNS in Cincinnati, she became “very intrigued,” so she went first to FNS as a non-midwife nurse volunteer in the hospital, and then two years later worked as a paid staff member, chief of the hospital outpatient department. Approximately six months later, she entered the Frontier Graduate School of Midwifery. While a student, Reeder had the “responsibility of total care for . . . patients,” and remembered getting to know them very well. She had no difficulty logging her twenty required deliveries, all but four of which took place in patients’ homes. At the end of her course, Reeder remained at FNS as a district nurse-midwife for three years, after which she left for New York City to pursue her bachelor’s degree and eventually her master’s degree. Reeder repeatedly returned to FNS to relieve nurses in need of vacation, and she later returned to eastern Kentucky on a full-time basis to take over the outpatient department of the United Mine Workers Hospital in Harlan. Late in her life, she worked as a nurse in hospitals in central Kentucky and Appalachian Virginia. Reeder was so attached to FNS that she returned once again to the area when she retired.91

Frontier Nursing Service’s Approach to Birth and Health

Prenatal Care

Grace Reeder, Betty Lester, and the many other women who dedicated themselves to FNS provided unusually comprehensive care to their low-
income patients. From their first year of practice in 1925, FNS nurse-midwives advised their patients to seek prenatal care early and often. They urged prenatal care for all expectant mothers, even those planning to deliver with a “granny” midwife. As founder and director Mary Breckinridge said, “You’ve got to take care of the baby before it’s born,” and frequent antepartal visits allowed nurse-midwives to detect abnormalities immediately.\textsuperscript{92}

FIGURE 3. Shown in a 1937 article in \textit{Life}, the caption above this photo read: “Prenatal visits during which the blood pressure is taken are part of the routine for the busy Kentucky Frontier Nurses. Note the primitive plainness of this Kentucky mountaineer’s well-scrubbed home, the sturdy well-bred features of its hard-working mistress.” (‘Frontier Nursing Service Brings Health to Kentucky Mountaineers,’ \textit{Life} 2, no. 24 (14 June 1937): 35.) Courtesy of the Audio-Visual Archives, Special Collections and Archives, University of Kentucky Libraries.
Lester explained, “That’s what we midwives are for, to take care of the normal and recognize the abnormal.” In the 1920s, Lester and her fellow FNS nurse-midwives went directly to their patients for the most part, often traveling two or more hours by horse to reach the cabin where a patient lived; by the mid-1930s, many prenatal patients visited weekly clinics at one of several FNS nursing centers. Ideally, FNS nurse-midwives saw their prenatal cases every two weeks until the seventh month, and then every week until delivery. In reality, most cases delivered by nurse-midwives had at least one month’s prenatal care; by 1930, only 21.4 percent of the service’s pregnant patients saw a nurse-midwife before the sixth month of gestation. By 1937, FNS saw a rise in its prenatal care record, with 32 percent of patients registering before the sixth month.

On each prenatal visit, Lester took blood pressure, inspected breasts, performed an abdominal examination, checked for edema, examined urine for albumen and sugar, and took external measurements to see that the fetus was properly positioned. She discussed preparation for delivery, baby clothes, rest, and diet. Malnutrition was a serious problem for expectant mothers in eastern Kentucky. FNS staff taught prenatal patients how to use a limited diet to serve their needs, especially since rural mothers generally received the least food in their families. As the delivery date neared, an FNS nurse-midwife gave instructions on what to do once labor began: “have a big fire burning, a kettle or lard bucket full of boiling water, clean gown or dress, clean sheet, newspaper pads, plenty of coal oil in the lamp, and [do] not to wait too long before sending for the nurse.”

FNS nurse-midwives believed that familiarity with the patients and their families allowed them to provide good care. Each FNS nurse-midwife had a district, usually limited to a three- to five-mile radius from the nursing center where she worked. As former FNS district nurse-midwife Reeder explained, “as a practicing nurse-midwife on the district . . . you were so familiar with your patient that if . . . there was any abnormality, you were well aware that there was a problem before it came time for the actual delivery. You really knew your patients very, very well.”

FNS nurse-midwives were not the only ones with this familiarity. Despite the service’s criticism of “granny” midwives, they were the neighbors, friends, or relatives of the birthing women and likely knew much more about their patients’ daily lives, needs, and concerns than did the nurse-midwives, who were outsiders to Appalachia and often foreigners. However, in the 1920s and 1930s, FNS nurse-midwives’ provision of prenatal care was unique. At that time, only obstetricians offered prenatal care to their elite clientele, while traditional midwives and general practitioners,
who attended the majority of births before World War II, for the most part did not.103

Nurse-midwives’ prenatal patients usually saw physicians for an initial exam, and after that only if they had abnormalities. FNS nurse-midwives first tried themselves to deal with the abnormalities, such as a fetus in a breech position, following the medical routines authorized by the service’s Medical Advisory Committee. If unable to deal with the situation or uncertain of what they found, FNS nurse-midwives sought help, first from the midwifery supervisor and then, if necessary, from the service’s medical director.104 Alternatively, nurse-midwives convinced pregnant patients, such as one “expectant mother who seemed to be having more than the customary discomforts,” to attend a physician’s clinic.105 Sometimes the nurse-midwives had difficulty getting prenatal patients who were in need of medical assistance to see a physician. Poor roads and rivers that could not be forded often prevented patients from coming to the hospital; in those situations, the medical director made home visits with a nurse-midwife, and outlined a course of home treatment.106

When providing prenatal care, Lester and her colleagues looked not only at the expectant mothers’ bodies but also at their life circumstances. This approach differed significantly from most physicians (at least those untrained in public health), who tended to be narrower in focus. FNS began providing formal assistance to patients through its social-services program during the Depression. In 1931, the Alpha Omicron Pi national sorority voted to create and support a social service department at FNS as its national philanthropic project. This sorority wanted to help handicapped children; in choosing to assist FNS, one member argued, “Is there anywhere a more environmentally handicapped child than the mountain child?” The social-service director, supported by the Alpha Omicron Pi fund, distributed food, clothing, and books; placed dependent children in homes; provided family casework; and arranged for patients to pay what they could afford for hospital stays outside the mountains and return train rides.107

During the Depression, FNS provided material aid to the people of Leslie County in other ways. The Depression brought many unemployed people who had worked in railroad and coal-mining towns back to Appalachia, just as a terrible drought in 1930 created near-famine conditions.108 Many people survived the drought only because of a $2.50 per person monthly allowance they received from the American Red Cross. FNS pushed the Red Cross to help, by hiring a Leslie County man to survey families in the 700-mile area covered by FNS to determine how much (or
in this case how little) corn each family had for the months ahead. FNS also assisted local people by employing male heads of households, and by giving away milk and cod liver oil to pregnant women and children, as well as clothing and shoes to those in need. FNS staff saw the direct benefits of this kind of assistance. For example, several FNS nurse-midwives, with some assistance from the service's volunteer chairman and social-service department, and free labor from neighbors, helped one young couple create a home with a cooking stove, utensils, food, and a mattress. The service's help meant that the woman did not have to work in the fields for several months; after two previous stillbirths, likely caused by overwork, this woman bore a healthy child.

In addition to extensive prenatal care and aid, FNS nurse-midwives also offered education for mothers and pregnant women. They traveled to local county fairs equipped with model baby beds and cribs; model sanitary toilets to be placed away from water sources (as opposed to the more typical privy where human waste was dumped into the same streams from which people got their drinking water); life-sized demonstration dolls; and posters on infant care. At weekly clinics held in the nursing centers, nurse-midwives advised mothers about child hygiene and urged fathers to build sanitary toilets and baby cribs and to screen their houses to keep out disease-carrying mosquitoes. The nursing centers also sponsored mothers’ clubs, where FNS staff gave speeches. At one club meeting, Mary Breckinridge spoke about “the development of the mind of the little child up to school age, using the simplest language and illustrations.” Thus, while general practitioners and traditional midwives, who attended most births in the 1920s and 1930s, provided little, if any, prenatal care, FNS nurse-midwives pioneered some of the most thorough and accessible prenatal and postpartum care and education in the United States.

**Labor and Delivery**

Betty Lester told her maternity patients to send a man to get her as soon as they felt their first labor pains. Once the man arrived, Lester dressed in her special blue-grey uniform and gave her bags to the man, who saddled her horse. Then the two rode out to the patient, day or night. Sometimes a patient was in false labor, but that did not bother Lester. She maintained that she always stayed long enough to ensure that her patient was doing well. If her patient was indeed in labor, she watched and waited, and then delivered the baby on her own. If the birth became complicated, Lester left

Part I: Early Labor Pains, 1925–1940
the home and called the FNS medical director, who then helped her with
the delivery. Lester’s approach to labor and delivery was typical of Ameri-
can nurse-midwives in the 1920s through 1940s. This approach, combined
with nurse-midwives’ emphasis on prenatal and postpartum care, was very
successful in reversing high rates of maternal and infant mortality and
morbidity.

Lester and her fellow FNS nurse-midwives, in comparison with many
traditional midwives, were well trained in the latest obstetrical and aseptic
procedures and knew when to hand over their patients to obstetricians
with whom they had established relationships (although the obstetricians
could not always get there in time). The nurse-midwives delivered women
at home, with less chance of infection than in the hospital where infection
spread from patient to patient. While they used anesthesia and forceps in
delivery, they did so less frequently than their physician counterparts. The
reasons for this varied and included a lack of qualifications to use the nec-
essary equipment and techniques and lack of access to the equipment.
Unlike obstetricians, who typically spent little time with their laboring
patients, nurse-midwives used a time-intensive approach, which discour-
gaged the automatic use of anesthesia and forceps and focused on the
women’s needs.

However, the FNS approach to childbirth had its limitations. For
example, the nurse-midwives used enemas to promote cleanliness in the
name of germ theory, but such a procedure produced new problems for and
opposition from birthing women. FNS nurse-midwives were simply fol-
lowing nursing protocol of the day. Up until the 1980s and even in some
cases today, medical personnel believed enemas would reduce infection
rates by decreasing the chance of the expulsion of feces during labor. How-
ever, recent evidence has shown that enemas do not accomplish this goal;
rather, they cause significant pain and distress for women, who often dread
receiving them.115

FNS nurse-midwives handled the overwhelming majority of deliveries
without physicians. Between 1925 and 1937, FNS nurse-midwives
obtained physicians’ services during one or more stages of labor only 166
times out of 3000 deliveries, or around five-and-one-half percent of the
time.116 Although the nurse-midwives were supposed to attend normal
deriveries only and to use physicians as backup, the difficulties of traveling
long distances over rough terrain meant that physicians were often
unavailable, even in emergencies.

From the beginning, FNS had a medical advisory committee of Lex-
ington physicians, which included several of Breckinridge’s cousins.117 This
committee wrote the *Medical Routines* manuals for nurse-midwives to follow, as they realized physicians might not be available when nurse-midwives needed them. Committee members also served as consultants for more complicated cases and held special health clinics for FNS patients. Visiting medical specialists from Lexington and Louisville also volunteered to provide clinics in obstetrics, trachoma, hookworm, orthopedics, pediatrics, dentistry, nose and throat, and ear and eye at FNS. In addition, FNS benefited from the services of a visiting surgeon in a mining town twenty-four miles from Hyden. Unlike most surgeons, this one charged his patients based on ability to pay, and performed many free operations. FNS also used the services of other local physicians whenever possible, but often faced problems, especially in the early years, getting these physicians to the patients when nurse-midwives called. An FNS annual report explained:

Medical care was obtained with great difficulty during the winter, owing to the illness or absence of the two nearest physicians. For one abnormal obstetrical case we were over thirty hours in getting assistance and twenty-one hours for another. The doctors were, as always, splendidly cooperative when they came, and answered the call at the earliest moment possible. One physician, from Bell County, who came in from an emergency eclamptic (the one who was twenty-one hours getting to us), had not been in his bed for two nights in succession. His territory covers a thousand square miles.

In 1928, FNS finally established a twelve-bed facility, Hyden Hospital, and hired a resident medical director both to lead it and to attend to emergencies in the districts. Adding a hospital and a medical director meant that FNS could provide more consistent medical care. The hospital treated patients with appendicitis, burns, dysentery, and gunshot wounds, as well as women in childbirth with complications. Even after the founding of Hyden Hospital, outside specialists continued to hold health clinics at FNS, and when the service’s hospital in Hyden did not meet patients’ needs, they were sent to hospitals in Louisville, Lexington, Cincinnati, or Richmond, all of which had ties to FNS. Still, because of the mountain topography and long distances between the hospital and patients’ homes, nurse-midwives continued to handle most home deliveries without additional medical assistance. In an era when increasing numbers of births took place in the hospital with physicians, FNS nurse-midwives successfully attended the majority of births at home without physicians.
Given their isolation, FNS nurse-midwives obviously had to be prepared for whatever occurred during labor and delivery. The contents of their midwifery bags combined with their delivery routines showed a keen concern with cleanliness. Delivery bags held a rubber apron, an operating gown, a cap to cover their hair completely, gloves, soap, and a scrub brush. They also brought a thermometer, an enema tube and funnel, artery clamps, a hypodermic set, scissors, umbilical cord ties, several basins, rubber sheeting, dry sterile gauze and cotton, perineal pads, and towels. In advance, they made sure that the home had pads made of clean rags and newspaper for the delivery bed, as well as baby clothes. Nurse-midwives also carried several drugs and medical supplies, including Lysol as a disinfectant; silver nitrate for babies’ eyes to prevent blindness; ergot, a fungus-derived medication causing the contraction of muscle fibers, to prevent and check postpartum hemorrhage; pituitrin, a hormone causing uterine contractions, which was also used to stop postpartum hemorrhage; and sedatives for the first stage of labor.

FNS nurse-midwives tried to reach their laboring patients as soon as possible. According to Breckinridge, “the support and help given through the long hours of the first stage has a bearing on the outcome.”

Medical Routines instructed FNS nurse-midwives to greet the patient upon arrival and ask about when labor had begun, the strength and time between contractions, and the woman’s overall health. She was also to make sure there was a fire, hot, sterile water, and if possible, cold, sterile water. In the first stage of labor, the nurse-midwife was to wash her hands well with soap in the patient’s basin, and then boil the necessary articles she carried in her midwifery bag, including a pair of gloves and a hypodermic syringe and needles. She was then to conduct an abdominal examination; take the patient’s temperature, pulse, and respiration; and perform a vaginal examination, if necessary, after scrubbing for five minutes with soap and warm water and soaking in a Lysol solution for three minutes. If there was time, the nurse-midwife could give her patient an enema. Except in cases of breech presentation or fatigue, both first-time mothers and others were to be up and walking in the first stage, and taking hot drinks and food, predominantly carbohydrates, at regular intervals. However, the nurse-midwife was to encourage the patient, especially a first-time mother, to rest with sedatives, as circumstances required. If she arrived in time, she was also to give the patient, again especially a first-time mother, an ounce of castor oil, which acted as a laxative, at the beginning of the first stage. Breckinridge explained, “our aim is to get a quiet first stage.”
The nurse-midwife’s goal in the second stage was to protect the perineum and avoid tears “by delivering between pains when the head is fully crowned, and with a minimum of bleeding. We usually deliver on the left side, as we were taught, keeping careful pressure on the fundus [top of the uterus] and following down with the left hand.”126 While physicians commonly used forceps, such deliveries at FNS were rare. FNS staff used forceps in only nine out of the first 1000 midwifery cases, four out of the second 1000, and one out of the third 1000 performed through the service—and most likely physicians, not nurse-midwives, actually delivered the babies in these instances.127 The FNS medical director, upon being called by a nurse-midwife, apparently used forceps only if the patient had been in labor for an unusually long time.128 Other interventions were also uncommon at FNS. Only four of the first 3000 midwifery cases (1925–1937) required Caesarean sections; just two needed episiotomies; one required a Duhrssen’s incision (an incision of the cervix to facilitate delivery) with low forceps; and four needed internal versions with ether.129

As Breckinridge explained, “the third stage [of labor] causes us the deepest anxiety, because upon our judgment alone hangs the life of the patient should the third stage not be normally complete, as medical aid could not possibly reach us until too late.”130 At that stage, the nurse-midwife was directed to “hold [the] fundus firmly without stimulating for twenty minutes after the birth of the baby. If, at the end of that time, the midwife knows by the usual symptoms that the placenta has separated and is in the vagina, and the patient does not expel it, the midwife may express it through the abdominal wall, as she has been taught.” After delivery and examination of the placenta, the nurse-midwife was to give the patient ergot to prevent hemorrhage, leaving the family to give more ergot to the patient in three to four hours. Then, the nurse-midwife was to give the patient perineal care, and again take the temperature, pulse, respiration, and fundus height. She was also to destroy the placenta after examining it, preferably by burning, while remaining at least one hour after the placenta was delivered. As soon as the baby’s head emerged, the nurse-midwife cleansed the eyes with dry, sterile cotton. Once the baby was born, the nurse-midwife clamped and cut the cord, and placed him or her in a blanket in a safe, warm place. After the mother’s needs were met, the nurse-midwife scrubbed up for the baby, dropped silver nitrate in each eye, tied the umbilical cord twice and applied a dry dressing, oiled, weighed, and dressed the baby, and placed the baby at the mother’s breast for five minutes. Finally, the nurse-midwife was to clean both patients and the room before leaving.131
Chapter 2: Eastern Kentucky

The stories FNS nurse-midwives told about births show that they spent extensive time, and often went to great lengths to be with their patients during labor and delivery. In February 1930, two nurse-midwives at an FNS nursing center reported a mini baby boom, with six deliveries in one four-day period, and one labor lasting thirty-one hours with “slow but steady progress.” Usually the two nurse-midwives saw each other frequently, but the large number of deliveries prevented them from working together. The sixth birth occurred a little later than the rest, and thus the nurse-midwives were able to attend the event together, arriving at the home at 7:00 P.M., nine-and-one-half hours before the birth. It was not unusual for FNS nurse-midwives to spend hours with a laboring woman in addition to occasionally spending hours getting to her house. One Saturday night in winter 1932, an FNS office secretary accompanied a nurse-midwife on a call from the husband of a pregnant woman who lived outside the FNS districts. The two FNS staff members rode horseback for two hours, arriving to find the expectant mother frightened about having as long a labor as with her first child. According to the secretary, the nurse-midwife “reassured her, and it almost seemed miraculous to me the way she succeeded in transferring her calmness to the mountain woman.” The patient gave birth to a daughter four hours later, and the nurse-midwife stayed another two hours to make the mother feel comfortable and to clean and dress the infant.

Both the service’s prescriptive literature, such as Medical Routines, and reports of actual deliveries reveal that nurse-midwives typically stayed with their patients through the entire labor and delivery.

Postpartum Care and General Nursing Care

The nurse-midwife/patient relationship did not end with the delivery. Betty Lester stayed with a mother and her newborn for at least one-and-one-half hours after the delivery. She took care of each to ensure that both were healthy, clean, and comfortable. Plus, “you had to stay . . . to make sure that everything was all right because you might be five miles away from home. . . . A woman could hemorrhage, she could do anything. A baby could get asphyxiated, anything can happen.”

Postpartum care did not end there. Once a woman gave birth with Lester’s help, she and her baby both received regular care and assistance. This regular at-home nursing care, along with an emphasis on breastfeeding, which provided many health benefits to baby and mother, made
nurse-midwives’ postpartum care different from that provided by other birth attendants. Traditional midwives also emphasized breastfeeding, but focused more on housekeeping and care of older children than on the mother’s health. During this period, physicians of all types did not especially encourage breastfeeding, and by the mid-twentieth century, artificial infant feeding had become the norm.\textsuperscript{136} General practitioners provided little postpartum care. Obstetricians kept their patients in the hospital for ten to twelve days after delivery; in the hospital, new mothers received attention to their health along with relief from household chores and older children, but they also dealt with alienating, impersonal hospital routines and what they sometimes saw as insensitive obstetric nurses.\textsuperscript{137}

FNS nurse-midwives had close contact with patients after delivery. \textit{Medical Routines} instructed FNS nurse-midwives to visit each mother and new baby for the first ten days, on a daily basis if the patients lived within a three-mile radius of the nursing center, and every other day if they lived within three to five miles of the center. Nurse-midwives’ work with the
mother included bathing, checking temperature, pulse, and respiration, dressing the perineum, helping the family with the mother’s diet, asking about urination and bowel function, and “giv[ing] very careful attention to breasts, especially as the milk comes in, as the baby’s food supply for the year depends largely upon getting lactation well established in the beginning.” The nurse-midwife gave a laxative to the woman on the second day after delivery; had her sit up in bed after the first nursing visit; and had her out of bed on the tenth day. During those first ten days, nurse-midwives also paid careful attention to the newborn, giving sponge baths, dressing the umbilical cord, retracting and cleaning the foreskin if necessary, weighing at birth, the fourth day, and the tenth day, asking about urination and bowels, and assuring that the baby was getting enough milk through nursing. After the first ten days, nurse-midwives visited the mother and baby every week until one month after delivery. The manual also gave instructions on what to do in case of abnormalities.\textsuperscript{138}

Although it is hard to determine to what extent nurse-midwives followed the manual’s instructions, statistical and anecdotal evidence shows they spent a significant percentage of their time on postpartum care. Tabulating the service’s first 1000 midwifery cases (1925–1930), statistician Louis I. Dublin explained that FNS nurse-midwives followed up with all new mothers for one month after delivery, and reported that ninety-six percent of these women were in satisfactory condition.\textsuperscript{139} FNS monthly reports show that in the 1920s and 1930s, postpartum visits for mothers and babies made up a significant percentage of nurse-midwives’ visits. For example, in May 1929, FNS had sixty midwifery cases, with twelve deliveries, 118 visits with prenatal patients, 115 visits with postpartum mothers, and 109 visits to newborn babies. Assuming that visits to postpartum mothers and babies generally occurred simultaneously, postnatal care comprised 39 percent of nurse-midwives’ midwifery work, in terms of number of visits to patients, that month; and took up 103.2 hours, or 38 percent of the time nurse-midwives spent on midwifery care.\textsuperscript{140} In November 1930, FNS had 111 midwifery cases, with twenty-four deliveries, 204 visits with prenatal patients, 241 visits with postpartum mothers, and 341 visits to newborn babies. Postnatal care comprised 60 percent of all midwifery visits, and 189.05 hours, or 42 percent of the time nurse-midwives spent on midwifery care.\textsuperscript{141} The other monthly reports indicate that nurse-midwives spent many hours providing postnatal care.

Stories of nurse-midwives’ work also illustrate the extent to which nurse-midwives attended to the needs of their postpartum patients. On one Saturday morning in 1931, an FNS nurse-midwife made her regular
visits to her patients: “In the next home there is a brand-new baby. The mother too is new, being only seventeen and this her first child. . . . The lusty-lunged infant is bathed, instructions as to regularity of feedings are given. The nurse will return the day after next.” In another case in that same year, a family called in a nurse-midwife after trying a patent medicine to cure their very ill thirteen-month-old, and after failing to understand a doctor’s directions on how to make a special formula. The nurse-midwife demonstrated to the mother how to make the formula and give it to the baby; she then returned the next day to ensure that the mother understood the procedure and that the baby was improving.

Fannie Huff, a patient whose five children were delivered by FNS nurse-midwives, explained that the nurse-midwives “come ten days after the baby was borned, and dress you, and get you cleaned up and . . . take care of your beds. And you didn’t have the things to take care of ’em with, why they’d bring their own things, you know, their sheets and everything they needed.” Huff also said she could buy a layette, including baby clothes, blankets, towels, and soap, from the nurse-midwives for just one dollar.

Betty Lester said that not only did she see her patients every day for the first ten days after delivery, and every week for the first month, but also every month for the first year. In fact, Lester and her colleagues took care of women, children, and even men long after the babies they delivered passed out of the newborn stage. They saw children twice a year while they were in school, and saw adults on an as-needed basis.

Stories from the nurse-midwives confirm not only the amount of time FNS staff spent on postpartum care but also their emphasis on breastfeeding. Lester noted that in the service’s early years all of its mothers breastfed their babies. As Lester explained, breastfeeding was both what she and her fellow nurse-midwives advocated and what mothers wanted. She claimed “all our babies stayed on the breast for nine months to a year.”

FNS nurse-midwives provided more than comprehensive maternity care. They also offered general nursing care, and preventive actions and public-health education for families. They provided patients with this wide range of services in a period when American public-health nurses focused more narrowly on instruction and prevention. Breckinridge explained her rationale for this broader approach:

The nurse who tends the sick only, and teaches nothing and prevents nothing, is abortive in her work. On the other hand the nurse who
attempts instruction and prevention without combining with them an appreciation for the sickbed, and without meeting its appeal, has failed in the one element which differentiates her profession from all others and out of which it was created.¹⁴⁷

FNS district nurse-midwives held weekly clinics not only for prenatal examinations but also for vaccinations and advice on child hygiene and sanitation, and they sometimes held special clinics on the outer bounds of the districts, since the mountainous terrain and lack of roads and transportation often made travel difficult even to the outpost centers.¹⁴⁸ In the first month of its service, FNS staff bandaged the wounds of fifty adults and forty-one children, treated several hundred nonmaternity patients, vaccinated thirty adults and 114 children for typhoid at the request of the Kentucky Board of Health, and worked on persuading people of the need to maintain stores of smallpox vaccine and toxin-antitoxin to prevent diphtheria.¹⁴⁹ By 1932, FNS had given more than 46,000 inoculations and vaccines against such diseases as typhoid, diphtheria, and smallpox.¹⁵⁰ From its earliest days, FNS believed that in areas with few or no physicians, “prevention is more than ever the life-saver.”¹⁵¹ FNS nurse-midwives also held numerous classes for children, especially girls, in general health and hygiene, on topics such as “Germs and How They Are Spread,” and home hygiene and care of the sick.¹⁵² They hoped to prevent disease and ensure that eastern Kentuckians knew how to provide basic care for themselves, especially given the long distances they needed to travel to receive medical or nursing care.

Statistics

An examination of maternal mortality statistics for FNS during the interwar period shows that the service’s emphasis on early and frequent prenatal care, on home deliveries with few interventions, and on close contact with patients and their families in the postpartum period appeared to pay off. As seen in table 2.1, FNS had an astoundingly low maternal mortality rate. This is especially remarkable given that one would expect exactly the opposite simply because the service’s patients were low income and often had poor nutrition and housing—factors that typically contribute to higher rates of maternal mortality.

It was no accident that FNS compiled statistics on its rate of maternity mortality. FNS anticipated criticism, or at least skepticism, about its work,
and knew that it needed to prove that it provided patients with good outcomes. FNS hired Louis I. Dublin, statistician and a vice president at Metropolitan Life Insurance Company, to help gather the data. A well-known, well-respected statistician with a PhD in mathematics from Columbia University, Dublin believed that statistics as applied to public health could benefit humankind. Employed at Met Life from 1909 to 1952, Dublin was president or director of many public-health institutions, including the American Public Health Association, and he had expertise as well as an interest in maternal and child health. Hired by FNS in the late 1920s, Dublin issued his first report on the organization in 1932, after he analyzed data from the first 1,000 deliveries. He continued to compile and analyze the statistics for FNS through its first 10,000 deliveries in 1954. FNS broadcast the statistics in its literature, hoping to promote its good work and to combat assumptions that nurse-midwifery would not improve maternal health.

There were potential shortcomings with this collection and analysis: Dublin was sympathetic to nurse-midwifery and FNS hoped to prove itself to health professionals and the public, in part by using these statistics. However, Dublin was a highly esteemed statistician whose reputation would have been damaged had he lied about the statistics. In addition, he worked for a life insurance company; the job of a life insurer is to assess risk, and thus he or she would tend to err on the side of an increased possibility of morbidity and mortality. Furthermore, to this day, no one has been able to counter or disprove Dublin’s statistics for FNS.

### Table 2.1 Frontier Nursing Service and Comparison Groups:

Maternal Mortality Rate (per 10,000 births), 1925–1937

<table>
<thead>
<tr>
<th>Group</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frontier Nursing Service (3000 deliveries, 2 maternal deaths)</td>
<td>6.6</td>
</tr>
<tr>
<td>Kentucky (white population only)</td>
<td>44–53</td>
</tr>
<tr>
<td>White women delivered in hospitals by physicians in Lexington, Kentucky</td>
<td>80–90</td>
</tr>
<tr>
<td>United States:</td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>48.9–69.5</td>
</tr>
<tr>
<td>White population</td>
<td>43.6–63.1</td>
</tr>
<tr>
<td>Non-white population</td>
<td>85.8–121</td>
</tr>
</tbody>
</table>
Conclusion

FNS provided much-needed, comprehensive maternity and general health care to people in a large area of eastern Kentucky, as well as a school to train nurse-midwives in service to the rural poor. However, the ways in which Breckinridge, her staff, and friends promoted the new service limited the development of nurse-midwifery as a profession. The service’s media messages focused on the exotic and romantic sides of nurse-midwifery in Appalachia and on the “backward” patients of supposed “fine old American stock” rather than on the nurse-midwife as a legitimate professional type. Readers and viewers were left with the notion that nurse-midwives were mainly good for ignorant mountaineers living in rough and rugged Appalachia. No matter how much Breckinridge believed in the ability of nurse-midwives to make a difference in Americans’ health, she had to compromise in order to launch and sustain FNS. Additionally, she had to find ways to appeal to local people, who were not used to seeking out health care from professionals and outsiders. But Breckinridge encountered challenges much greater than recruiting patients. Because the nurse-midwife was new, because outsiders confused her with the much-maligned traditional midwife, and because she represented a potential threat to obstetricians and what was becoming the American way of birth, Breckinridge faced a host of problems. How would she win approval from physicians—necessary for FNS to function (since nurse-midwives required physician backup) and garner cooperation from outsiders? How would she get support from nurses, members of her own profession who sometimes felt threatened by the independence of the new nurse-midwife? How would she raise money? Finally, how would she get support for FNS when the American health-care system generally disregarded poor patients?

To answer these questions and overcome the service’s potential problems, Breckinridge appealed to racist beliefs. She used her passion to help women and children, her incredible network of family and friends, and her excellent public relations skills to paint a picture of the FNS nurse-midwife and her poor, white, and worthy charges that both health professionals and the lay public could support. She simultaneously ensured that FNS would flourish and that nurse-midwifery would be seen as a noble and romantic calling rather than a real profession.