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(Re)making a Frontier: The Ethos of Motherhood, Midwifery, and Public Health in 1920s Southeastern Kentucky

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(Re)making a Frontier: The Ethos of Motherhood, Midwifery, and Public Health
in 1920s Southeastern Kentucky

by

Elizabeth Topping

Under the Direction of Lynée Gaillet, PhD

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

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ABSTRACT

In the early twentieth century, American female reformers engaged in various programs to enhance public health, including maternal and infant health. In this spirit, Mary Breckinridge founded the Frontier Nursing Service in southeastern Kentucky, providing low-cost midwifery and public health medical care. Adopting a microhistorical and feminist archival approach, this project explores multiple facets of Breckinridge's life and work. Rhetorically, she asserted her ethos as a bereaved mother with medical expertise. She aligned her work with emerging science-based practices in medicine and record-keeping, intending replicability of her model. Along the way, she transformed herself from a traditional True Woman to a dedicated professional, mirroring concomitant changes in rhetorics of motherhood. However, her reliance on racialized arguments and the frontier nature of Appalachia, while effective in the short term, limited the reach and memory of her Service. By reclaiming and revision Breckinridge's life story, this project offers an analysis at the nexus of rhetorics of medicine, race, class, and gender.

INDEX WORDS: Rhetorics of motherhood, Public health, Midwifery, Anglo-Saxon ideology, Appalachia, Eugenics, Scientific motherhood, Scientific medicine, Feminist and Archival Methods

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2022

(Re)making a Frontier: Motherhood, Public Health, and Race in 1920s Southeastern Kentucky

by

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DEDICATION

In some ways, this project began when I was a little girl, hearing stories about my great-aunt Helen's life adventures. When I entered this PhD program, I wanted to find out more. As I followed the trails of what I did know, I found out that those stories were embellished, as family stories so often are, but the real story of her 1930 Kentucky summer led me to so much more. Aunt Helen, you have been gone for thirty years now, but thank you for living life on your own terms and leaving behind such amazing stories for us.

I also want to dedicate this to my parents – for teaching me that what we think we know is not always what is, and to look behind the curtain. Thank you for not answering my questions and making me look up the answers to figure it out for myself. And for the constant love and reassurance that you believe in me, for asking me to articulate why I wanted to do something to make sure I was pursuing my own dreams, and for sharing the journey through all the difficulties.

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LIST OF KEY TERMS

Certified Nurse-Midwives/Midwifery: According to the American College of Nurse-Midwives, “Midwifery as practiced by certified nurse-midwives and certified midwives encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care.” These midwives complete graduate-level accredited midwifery programs and must pass a national certification exam. They normally work with or for physicians (Lay 7, Rooks 1).

Lay Midwives/Midwifery: According to Judith Rooks *Midwifery and Childbirth in America*, lay midwives are those who become midwives through experiential or informal means (6). In the early 1900s, the term ‘granny midwives’ distinguished traditional birth attendants from their counterparts in obstetrics or midwifery schools, but the term implied superstitious, dangerous practices often cloaked in racism. Alternatively, the term referred to those who responded to a need for birth attendants in their community and often learned informally (Rooks 7). More recently, practitioners use the term *direct-entry midwives* to distinguish their experiential or apprenticeship training, typically foregoing nursing degrees (Lay 4). More well-known contemporary organizations include the Midwives Alliance North America (MANA) and The Farm Midwifery Center in Tennessee. I use the term lay, community, or traditional midwives to emphasize the highly localized, experientially-based nature of their training and practice as distinct from the school-centered education of certified nurse-midwives.

Maternalism: Because maternalism as a sociopolitical movement has been written about by so many scholars, a range of definitions exist. Some scholars distinguish maternalists from feminists, though their perspectives, exigences, activism, and goals often overlapped in the late

nineteenth and early twentieth centuries. Therefore, these women reformers can be understood as existing on a continuum. They worked to improve social and environmental conditions for subordinated and marginalized demographics throughout the United States, though individual attitudes, biases, and relationship to state institutions mediated their impacts. The height and arguably greatest successes of their activism roughly correspond to the Progressive Era of the 1890s to the 1920s, though many reformers were active outside these years. I follow maternalist historian Molly Ladd-Taylor's definition for this project: maternalism as a specific ideology that promoted a "uniquely feminine value system based on care and nurturance. This system claimed "that motherhood was a service to the state, that motherhood united women across their differences, and men should earn enough to allow their wives and children not to work" (*Mother-Work*, 3). In this period, most maternalists believed in separate spheres for women and men, which typically serves as the primary distinction between the two categories of female reformers.

Scientific Motherhood: Scientific motherhood built upon the Cult of True Womanhood with the addition of science-based knowledge and instruction in child rearing, behavior, and health (Ladd-Taylor, *Mother-Work*, 4). Motherhood became defined as "a skill that mothers must study and perfect" (Goan 40), rather than a natural outgrowth of gender. Experts delineated normal and abnormal child development, from pregnancy onward; an entire industry built around educating women in modern parenting knowledge developed in the Progressive Era (Goan 42; Isenberg 193). This conception of motherhood devalued the knowledge of mothers and midwives (Lay 57), thereby also justifying medical knowledge as expert and authoritative over experiential knowledge (Lay 22; Siegel 7).

Scientific Medicine: I use this term to distinguish it from traditional medicine (often labeled heroic medicine). Scientific medicine refers to medical care provided by physicians and

doctors who received extensive higher education and experiential practice based in scientific studies over the period of years. This extensive training process culminates in state licensing.

These are the kinds of doctors we tend to assume as the default in the twenty-first century.

Historian of medicine Lewis Grossman notes that by the 1890s, as scientific research advanced and germ theory increasingly formed the basis of treatments, “research science” that advanced both medical knowledge and therapeutics “was arguably the most important source of regular medicine’s professional authority” (48). The increasing legislative push toward requiring medical licenses in the early twentieth century allowed license-holders to label non-licensed providers as incompetent and therefore assert control over medicine as a profession (Harper 88).

In the 1920s, providers of both traditional and scientifically-based care practiced throughout the country, with the former often more affordable and accessible.

1 INTRODUCTION

As scholars of American society have long noted, the United States has a vested interest in managing its population's fertility. Scholars in a range of fields have documented and analyzed the ways in which policy has controlled, restricted, or even eliminated the fertility of marginalized and BIPOC women in the United States (e.g., Kimberly Harper; Dorothy Roberts; Loretta J. Ross and Rickie Solinger). Our tragic historical policies grounded in racism have resulted in significant harm to women of color across the nation and still impact reproductive care and outcomes. These policies continue to be scrutinized closely, as they should. In tandem with this crucial work, however, we should also examine the other side of the coin, as it were—historical choices and policies that have also encouraged, coerced, and even forced women to have larger families than they desired. In other words, while keeping attention on the ways in which “past abuses of women’s reproductive bodies live on in contemporary harms and coercions” (Ross and Solinger 12), we also should be mindful of the myriad ways in which white supremacy has shaped, and continues to shape, all women’s reproductive choices while acknowledging disparate impacts grounded in intersections of identity. It is in this spirit that I examine attitudes toward reproduction as they shaped rhetorical and policy choices in eastern Kentucky’s Frontier Nursing Service (occasionally also labeled as FNS) in the interwar period of the twentieth century.

The Frontier Nursing Service officially opened its doors in southeastern Kentucky in 1925 in a period of considerable social and political change. Beginning in Reconstruction through at least the early Progressive period, women’s rhetorical contributions were steadily erased from oratorical records as they were pushed into a version of womanhood that silenced them within the home (Johnson, *Gender and Rhetorical Space*, 2). In these same decades,

reinscribing of race relations, rapid industrialization, large-scale immigration, and significant economic and territorial changes reshaped the country (Gere 3; Ladd-Taylor, *Mother-Work*, 5). Many Americans did not see these changes as social improvements. Clubwomen, feminists, and maternalist activists targeted social ills associated with rapid industrialization. These women often argued their public reform efforts fell under their purview as women, wives, and mothers (Gere 12; Wood 11 – 12). As historians of maternalist reform have noted, their efforts resulted in a long-lasting change in the relationship between the state and its citizens, changes that presaged the beginnings of the American welfare state (Koven and Michel 2). Through their club and organizational memberships, women “carried out cultural work that aided a refashioning of the nation” (Wood 5). Particularly through their literacy practices, clubwomen’s activities “put these women in dialogue with the larger culture, helping them understand and negotiate conflicting ideologies of womanhood” (Wood 5). Thus, they contributed to and helped shape “new concepts—of nationhood, economy, gender, culture, and professionalism” (Wood 5). A considerable number of these reformers sought to improve public health, including infant and maternal mortality rates. In this project, I focus on how a subset of these public-minded women worked with and reshaped ideas of gender—in particular, experiences and expectations of reproduction and motherhood in white America.

According to the CDC, in the early twentieth century maternal and infant mortality rates were extremely high. For every one thousand live births, between six and nine women died of complications from pregnancy and childbirth, while one hundred children died before their first birthday. Approximately forty percent of these mothers passed away due to care providers inappropriately intervening in the birthing process and failing to ensure proper sterility. Many children passed due to environmental issues, such as unclean water, milk substitutes, injuries and

infections, and endemic viral illnesses. Significant numbers of women who survived their reproductive experiences experienced long-lasting harm. These tragedies impacted nearly every woman and family in the country, with rural, poor, and non-white communities experiencing the highest rates of loss. This nearly universal experience galvanized women to use their growing political power to enact federal and state reforms. Many reformers joined forces “out of [their] agony and grief” (Mendenhall, cited in Ladd-Taylor, “My Work’,” 325) to advocate for public attention and intervention to improve maternal and infant health. The efforts of grass-roots women’s activists, club women, and federal officials culminated in the 1921 Sheppard-Towner Act, the first federally funded social welfare program. This Act provided regulatory and financial support to states to reduce maternal and infant mortality rates (Ladd-Taylor, “My Work’,” 321). In this period, arguments often recast motherhood as a national service, no less worthy than soldiers’ ultimate sacrifices during war (Michel 298).

By the late 1920s, social and political antipathy to women’s activism led to society and the state treating childrearing as more of “an individual, not a social concern” (Ladd-Taylor, *Mother-Work*, 7). Even so, reform efforts of the Progressive Era improved obstetric care, reproductive experiences, and maternal health resources and initiated a long, substantial decline of maternal and infant mortality rates. However, racial ideologies of the period limited the benefits of those reforms. In fact, racism and the widespread appeal of the pseudoscience of eugenics justified not only excluding women of color from the majority of these initiatives, but also controlling their fertility (Harper 30). Thus, reform efforts led to a bifurcated approach to reproduction in the United States: elimination of “inferior” genetics through restricting fertility and promotion of “superior” genetics by increasing the number of children born with the “right” heritage. In either case, women’s reproductive autonomy became “subordinated to the rights of

an abstract organic collectivity” (Dikötter 467) and thus women became defined by their reproductive potential. Marika Siegel’s analysis of prior research and pregnancy manuals of the period in *The Rhetoric of Pregnancy* revealed how these materials furthered women’s subordination to the larger social collective. She reviewed the work of feminist scholars who “have described how medical, scientific, cultural, philosophical, and technological discourses and developments work to highlight [the function of pregnancy as a service] and to downplay women’s humanity” (7). These discourses “have made the fetus a public figure, disconnected from the maternal environment” (Siegel 7). “System errors,” Siegel writes, “originate with the maternal body” (10), and the need for women to conform to behavior that supports the healthy fetus justifies surveillance and control. In this ecosystem, the mother’s body exists to create the goal of a normal, healthy fetus; she must work in tandem with the technological and medical apparatuses that operate to produce the same (Siegel 13). Her independence and autonomy are secondary, even threatening, to medicine’s goal. To gain access to the support and resources she needs, she must acquiesce to the technological system that surveils and controls her. This same system intervenes when the mother is judged unable to obey its dictates. A woman’s identity therefore becomes one of a reproductive vessel.

In a time when so many women and children died from preventable causes during pregnancy and childbirth, however, a partnership with the medical system to save lives and improve physical health makes sense. More broadly, the reformers of the Progressive Era improved living conditions for many Americans. However, these changes occurred unevenly, often stratified by race and class. Furthermore, reforms predicated on racialized and cultural assumptions often led to attempts to mandate middle-class Anglo-America values or even train individuals to serve those same reformers (i.e., Enoch 116, 118). The often-antagonistic

relationships between states and communities of color also forced Black Progressive reformers to pursue reform “through institutions of their own making” (Boris 215). Eventually many of the reforms pursued by white activist women became subsumed into new state agencies, while many communities of color continued to find themselves ignored or harmed by the emerging social welfare state.

In the end, physicians and the state came to dominate reproductive medical care. The legacy of racial ideologies and eugenics led to widespread sterilization of Indigenous, African American, and Hispanic women across the country until recently. White women, too, often still find it difficult to receive adequate medical care, especially if they are poor, rural, or both. Then and now, white women benefit from the racial hierarchy in that they often receive more support and resources and are not as often subject to compulsory sterilization. However, access and support are not always sufficient, and they sometimes find themselves expected to have large families to counteract the supposed negative genetic and social consequences of children of other demographics. Through the lens of Progressive Era racial beliefs, both the inaccessibility of contraception and coerced sterilization served the goals of eugenics – desirable genetics should be reproduced frequently (through large families and frequent pregnancies), while undesirable traits should be eliminated (through sterilization). In neither case would contraceptives or elective pregnancy termination be sufficient to guarantee desired societal outcomes. Furthermore, women’s autonomy would counteract those end goals.

In this project, I explore the ways in which Breckinridge fit into the social, historical, and rhetorical context of her time. I examine the ways in which she mirrored the major rhetorical narratives of motherhood circulating in the postbellum and Progressive eras. This personal transition from a traditional True Woman to committed career woman, always operating within

the ideals of service, traditional gender norms, and valuing motherhood above all, serves as the backdrop for how she developed the Frontier Nursing Service. Aligning herself with scientific motherhood and expertise gained from her own medical training, she interrupted the credibility claimed by an emerging professional obstetrics discipline and advocated for the ability and expertise of her own medical staff of certified nurse-midwives at the expense of traditional health providers. Arguing that the women of the mountains of southeastern Kentucky merited modern scientific medicine, she used new scientific analytical methods to prove her results, though not always as rigorously as modern readers might expect. She relied heavily on beliefs of Anglo-Saxon superiority to promote her organization and its work, arguing that ‘old blood’ of the mountaineers of the Appalachians was one of the best hopes to stem the tide of America’s growing racial and ethnic diversity.

For quite a long time, Breckinridge and her organization were nationally known and well supported. However, after the end of World War II, her racial and romantic appeals came up against a modernizing (and increasingly less impoverished) Appalachia. Changes in medical care and funding in conjunction with falling birth rates led Frontier Nursing Service nurse-midwives to cease their trips to patients’ homes and to eventually close the maternity ward of their hospital in Hyden. Outside southeastern Kentucky and the midwifery profession, few remember the Frontier Nursing Service or the decades of demanding work in which Breckinridge engaged in the face of significant personal tragedy and injuries. Her energy and motivation, borne out of the tragic loss of her two young children and desire to protect other women from that same grief, led to improved pregnancy outcomes for their patients. However, the very same arguments that allowed her to provide that care relegated her work to an ever-receding frontier.

In the review that follows, I discuss the historical and rhetorical scholarship that shapes my interpretation of the archival and published evidence I analyze throughout this project. I first provide a brief history of Breckinridge and the Frontier Nursing Service. Then I review rhetorics of motherhood relevant to Breckinridge's life and the first two decades of the Service, and then their relationship to maternalist reform. Next, I examine the changing state of medicine and reproductive health care in this era, focusing on the changing relationships between mothers and the state. I also briefly review the emerging public health movement of the era and how reproductive healthcare fit into the movement's goals. Then, I discuss the racial ideology dominating national conversations and policies in this period, focusing on how and why Appalachia became a focal point in the mission to 'save America.' From this historical backdrop, I move into a more theoretical discussion explaining the framework through which I interpret the actions of Breckinridge and her Service, and their relationship to public memory and forgetting. Finally, I provide a brief chapter outline. Key terms are defined in detail in the front matter.

1.1 History: Mary Breckinridge and the Frontier Nursing Service to 1939

Mary Breckinridge was the second of four children, born February 17, 1881, in Memphis, Tennessee. Her father's appointment as Russian ambassador and post-government work led to frequent moves, and Breckinridge received education from various private tutors and governesses as well as attended schools in Lausanne, Switzerland, and Stamford, Connecticut, before beginning her adult life. In 1925, Mary Breckenridge officially opened the Frontier Nursing Service in southeastern Kentucky's Leslie County. Until her death in 1965, she dedicated herself to this first rural nurse-midwifery service in the United States. She created this organization out of her lasting grief at losing her children and her desire to prevent this too-

frequent tragedy in the United States. Her resolve resonated with multitudes of women who suffered similarly.

1.1.1 Life of Mary Breckinridge: Before the Frontier Nursing Service

In the late nineteenth century, the Breckinridges of Kentucky occupied a notable social and political niche in the United States. Publicly visible as political leaders, military officers, educators, and medical professionals, the Breckinridges exhibited a seemingly universal dedication to excelling and national service. During the Civil War, the Breckinridges joined the Confederate cause; the Confederate loss diminished their political influence and wealth. Mary Breckinridge's parents remained loyal to the Confederacy and raised their children to honor the values espoused in Lost Cause mythology (Goan 20). Thus, Breckinridge grew to believe her duty was to be a mother and devoted wife under male authority. She also viewed white supremacy as natural and necessary (Breckinridge 162, 344; Goan 22).

Yet, as historians and her own publications reveal, Breckinridge's restlessness, her desire to serve the nation as her male relatives had, and her personal tragedies made it difficult for her to abide by the gendered duty laid out by her parents. Her first marriage ended after a year when her husband died from untreated appendicitis. Following his death, she worked at an Appalachian settlement school. While there, she witnessed a young girl die of typhoid. Upset by this preventable death and still wrestling with her grief, Breckinridge enrolled at St. Luke Hospital School of Nursing in New York City in 1906. Thus began Breckinridge's lifelong commitment to scientific medicine and her choice of service: to improve the health of the country's most vulnerable (Breckinridge 52; Goan 33; Klotter 253).

Eventually, Breckinridge remarried a professor who later became the president of Crescent College, a two-year women's college, in Eureka Springs, Arkansas. During their

marriage, though her responsibilities to her family continued to come first, Breckinridge participated in the movement to professionalize nursing. She also supported the merging of scientific medicine with traditional ideologies of motherhood for healthier children and families (Goan 39; Thompson, *Breckie*, 98). However, her primary focus and greatest joy came from the birth of her son, Breckinridge Thompson (known as Breckie). To parent him, she relied on her considerable knowledge and the expertise available through published texts. She also carefully taught him about the service integral to her own family identity. In *Breckie: His Four Years*, the text that recounts the life of her young son, she wrote “Where I could only have helped a little here and there he, in his manhood a leader of men, would strike at the roots of poverty, ignorance, and vice and rescue childhood” (Thompson, *Breckie*, 93).

Soon thereafter, Breckinridge became pregnant again with a daughter. However, Polly, born prematurely, only lived a few hours. Soon, the unthinkable happened again – her son developed fatal peritonitis before his fourth birthday (Thompson, *Breckie*, 182), a bacterial infection of the abdominal wall untreatable without antibiotics (Thompson, *Breckie*, 187). After his loss, she divorced and sought a new path. She never fully overcame her grief, but her losses also opened a path that allowed her to reconcile her grief, her duty, and her desire to “do something useful” (Breckinridge 45).

Following the dissolution of her marriage, Breckinridge turned more fully to public life. She gave speeches on children’s welfare, for the Child Welfare Department of the Council of National Defense across the Midwest (Breckinridge 75; Klotter 255). Soon after, she joined CARD (the American Committee for Devastated France), founded by Anne Morgan and Anne Murray Dike, to help the rebuild the regions of France most damaged by World War I (Goan 53). In doing so, Breckinridge gained extensive experience in managing a large, complex charitably

funded organization with minimal state oversight and assistance. From staffing to structure, health initiatives and even staff uniforms, her time in France proved foundational to the work she would do in Kentucky (Goan 55). Specifically, she credited CARD's scientific data and record-keeping practices in proving the practicality and benefits of such an organization (Breckinridge 112).

1.1.2 A Brief Timeline of the Frontier Nursing Service

After her time with CARD ended, Breckinridge studied public health and later earned her midwifery degree at the British Hospital for Mothers and Babies. She also traveled to the Orkney region of Scotland to learn how to manage a district nursing service in isolated areas (Goan 57; Klotter 257). Upon returning to the United States, she secured the approval of appropriate state officials in Kentucky to open the Frontier Nursing Service. While organizing the Service, she conducted demographic surveys of Leslie County. In 1925, she incorporated a Board of Directors for the Kentucky Committee for Mothers and Babies, the original name of her organization (Breckinridge 158, Goan 83 - 85). Because Breckinridge chose to staff her organization with certified nurse-midwives and demanded independence from state oversight, she eschewed money available through the Sheppard-Towner Act and related supporting organizations and agencies both state and federal (Goan 75). Her decision also placed her at odds with state institutions and the emerging medical establishment.

The Service grew slowly in the beginning, with the first clinic in Hyden, Kentucky. Soon, she opened a hospital in Hyden and opened clinics in nearby locations. The first outpost, the Jessie Draper Memorial Nursing Center, welcomed its first patients in 1926; by 1930, five more opened (Breckinridge 228). The beginning of World War II meant she could no longer hire midwifery graduates from Britain, so she opened Frontier Nursing University in 1939. By her

death in 1965, Breckinridge had raised over six million dollars and invited professionals from sixty countries to study the Service (Patterson, “Foreword,” xv). Much of the organization’s growth relied on charitable donations and small patient fees. At the same time, the organization also treated health problems historically endemic in poor rural areas, including trachoma, diphtheria, and typhoid epidemics as well as parasitic worm infections. Of the infants and mothers who were patients, only a small number were ever lost (Breckinridge 257 – 261).

Yet, despite its success, her district nurse-midwifery model of care has never been widely adopted in the United States outside Kentucky, and her achievements have folded into and mostly disappeared from an overarching narrative of physicians and scientists improving childbirth outcomes. In part, the loss of her contributions and diminishing of public memory of her and her work can be attributed to how localized her achievements were, at least in the United States. However, the attribution of improved medical care to the efforts of (predominantly male) modern medical providers and systems reflects how gender complicates the memory of women’s achievements. In the next section, I explore the relationship of gender to women’s roles, expectations, and achievements.

1.2 Rhetorics and Ideologies of Motherhood and Womanhood

In constructing a usable past, rhetoricians who study women’s rhetorical achievements and practices pay close attention to how gender, race, and class intersect to circumscribe and provide opportunities to the rhetors they analyze. Beginning with Karlyn Kohrs Campbell’s *Men Cannot Speak for Her*, rhetoricians have sought to reconstruct the rhetorical landscape, reclaiming women’s rhetoric as worthy of study and remembrance. They also seek to answer questions of why women rhetors continue to be erased in the first place. As Nan Johnson points out in her foundational work *Gender and Rhetorical Space in American Life, 1860 – 1930*, “The

boundaries around rhetorical space have been actively patrolled for as long as it has been undeniably clear that to speak well and write convincingly were the surest routes to political, economic, and cultural stature” (2). In defining who can and cannot have rhetorical power, justifying narratives emerge. Those narratives situate individuals within existing power dynamics, dictating what rhetorical power they may have as well as the avenues to rhetorical power that they may claim. However, those very same avenues that allow an opportunity to access public rhetorical power also hold constraints that often limit that power.

1.2.1 Defining Motherhood

From the very beginning of the United States, national narratives have sought to define the relationship between women and the state. With the important caveat that many only ever applied to a small, privileged segment of the women in the country, the definitions of woman- and motherhood that correspond to the historical era of and immediately prior to this dissertation can be summed generally as Republican Motherhood, True Womanhood, New Womanhood, and Real Womanhood. Each of these ideals roughly correspond to periods of women’s public activity and backlash that together form an ecology of women’s rhetorical and public work.

The concept of Republican Motherhood emerged from the ideals of the Revolutionary War. While men occupied public life and directed the country, their wives and daughters, custodians of civic virtue, transmitted the values of the Republic over generations (Kerber 11). While Republican mothers had some indirect political influence through their husbands and sons, they remained on the political periphery, confined to the domestic sphere (Kerber 12). One manifestation of women’s influence was the growing imperative to manage literacy in the home and immediate community. As Sarah Robbins’ study of domestic literacy narratives finds, by “directing [primarily her son’s] reading, writing, and oral language acquisition, [the mothers]

also shaped their public behavior and thus, eventually, their influence on the nation” (3). This management of literacy learning became a middle-class enterprise, in which “motherly administrators depend[ed] on the physical labor of other classes” (3). Literacy became a tool by which middle class white women gained social status and claimed the right to education while excluding others “from full participation in national civic life” (9).

Of course, women did not confine themselves solely to domestic responsibilities. Feminists and abolitionists of the antebellum period challenged republicanism’s exclusion of so many citizens and the institution of slavery, in the process affirming an American tradition of women’s public speaking and political activity. Important scholarship like Campbell’s *Men Cannot Speak for Her*, Jacqueline Jones Royster’s *Traces of Stream*, Shirley Wilson Logan’s *Liberating Language: Sites of Rhetorical Education in Nineteenth-Century America*, and Lindahl Buchanan’s *Regendering Delivery: The Fifth Canon and Antebellum Women Rhetors* analyze myriad ways that women rhetors engaged in and shaped public discourses.

In response to the chaos of the Civil War and its aftermath, the Cult of Domesticity and the concept of the True Woman emerged. An ideal drawn from Republican Motherhood, the True Woman was queen of the private sphere, a force of stability and virtue holding back the breakdown of social order. Reams of conduct literature, religious teaching, and women’s magazines in the late nineteenth century opined these women upheld the core of the republic. Women had successfully left the home to publicly persuade even as the very definition of the Republic was being argued in speeches and on battlefields. When the question was seemingly settled, backlash against women’s public rhetorical activities illustrates that “cultural contestation about rhetorical practices often marks a historical moment when foundational values are in flux and a cultural problem is being renegotiated” (Johnson, *Gender and Rhetorical Space*,

2). True Women were not public speakers and rhetors, but submissive, quiet women. However, these women subverted “parlor rhetoric (or outright lack of training) designed to keep women in their places” (George et al. 7).

Within the Cult of Domesticity that Mary Breckinridge grew to adulthood, and it is this narrative by which she attempted to abide. Though often dissatisfied with the values and norms of separation of spheres, she did her best to live as she had been taught. When personal tragedies ended her ability to be a True Woman, she sought a new path that aligned with those ideals. The changes in her own life coincided with the rise of feminist and maternalist reform of the Progressive Era, in which new ideas of woman and motherhood began to circulate. These new kinds of women, the Real and New Women, demanded increased agency and control over their lives (Wood 11). No longer content to wait at home, peacefully by the hearth, these women demanded, received, and then later acted upon their right to public lives, expecting those around them to respect and judge them by their choices and actions (George et al. 7).

One subset of reformers, maternalists, advocated a separate spheres approach to social reform (Koven and Michel 6), offering Mary Breckinridge an opportunity to reconcile her gendered beliefs with her desire for public service according to the Breckinridge creed. The politicization of women’s all-too-frequent tragedies of childbirth-related loss also allowed her a public path to channel her grief. Maternalism legitimated women’s activism, justifying their public work as a kind of “municipal housekeeping” and as fulfilling the public service requirement of women’s groups (Gere 11). In fact, as rhetorician Anne Ruggles Gere points out in her text *Intimate Practices*, clubwomen developed power from their literacy practices that they used “in their cultural work on behalf of the nation and themselves,” functioning as “one of the *competing* publics at the turn of the century...[which] calls into question the category of ‘separate

spheres' common in academic feminism, urging instead more complex interpenetrations of women's clubs and other social formations" (13, emphasis in original). At the very least, for maternalist reformers, rhetorics of motherhood allowed them rhetorical credibility to act in public spaces.

1.2.2 Expanding Women's Spheres: Feminist and Maternalist Reform

Through the late nineteenth and early twentieth century, maternalist and feminist reformers combatted the social ills of a rapidly industrializing America. Initiatives ranged from working with immigrant families in the Hull House in Chicago, to improving the living conditions of immigrant families in New York City and addressing the burdens of motherhood among rural families. While women of all demographics participated in this drive for change, the most visible were middle-class white women. In attempting to change society, often while professionalizing women's work, these women positioned their values as superior. As Jessica Enoch concluded in her chapter on domestic scientists, they "drew lines between an 'us' and 'them'—those who had the expertise and knowledge, and those who needed to change their ways" (116). Even so, reformers dedicated to improving burdens of motherhood shifted it "from women's primary *private* responsibility into *public* policy" (Koven and Michel 2, emphasis in original). Specifically, these reformers envisaged "a state which not only had the qualities of mothering we associate with welfare, but in which women played active roles as electors, policy makers, bureaucrats, and workers, within and outside the home" (Koven and Michel 3). In this vision, the state bore significant responsibility to ensure the public's health. However, the state resisted. In part to force the state to act, women expanded definitions of the domestic sphere, claiming public spaces as within their purview as women and mothers. As they spoke and acted, they claimed the authority to change society.

Thus, through the very language that had attempted to circumscribe women's roles and abilities, women claimed rhetorical and actual power, seeking to change their worlds for the better. While they spurred considerable changes, they were also bound by racial, gender, and class ideologies of their time. Thus, the legacy of their work continues to impact our lives in uneven and not always beneficial ways. While their reliance on rhetorics of motherhood gave them authority to push for change, the same language also constrained the memories of their stories. Despite their sustained public activism and successes, they did not “dislodge larger cultural beliefs about what women *should* do” (George et al. 11, emphasis in original). As had many women abolitionists, Progressive Era reformers found their memories erased from our texts and our cultural memories (George et al. 2).

1.3 Scientific Medicine and Motherhood: Emerging Professional Medical Identities

In this section, I review the transitional period of medicine from the late nineteenth century to the 1920s. As historians of medicine have noted, medicine before the late nineteenth century was more of an art than a science. Scholars often call it ‘heroic’ medicine for its treatments intended to resolve a perceived imbalance of the body's humors through aggressive bloodletting, sweating, and medicines. These treatments were rarely based on scientific testing as we would recognize today (Grossman 10). By the 1870s, medical experts and practitioners increasingly favored more scientifically-based approaches. Additionally, through legislative, educational, and professional organizational approaches, physicians sought to redefine and control medical practice.

1.3.1 The Rise of Obstetrics

While not the first professional medical organization, the American Medical Association (AMA) has exerted considerable control of the discipline since its 1847 creation. Though their

actions did not result in immediate change, their control marginalized what we would now consider alternative or traditional healers (Grossman 8). Furthermore, the AMA's creation and push for changes in medical education had the effect of creating barriers for women physicians, who constituted about five percent of physicians from the end of the nineteenth century until the 1970s (Wells 8).

The AMA recognized obstetrics as a medical specialty in 1859; the American Association of Obstetricians and Gynecologists formed in 1888 (Rooks 21). Male physicians had begun making inroads into childbirth and reproductive treatment since the development of the forceps in the seventeenth century (Rooks 15). However, until the highly problematic medical experiments of J. Marion Sims, considered the father of American gynecology, obstetricians seemed to have little to offer women that family and midwives could not (MacGregor 48). As medicine became more science-based and less of an 'art,' states embraced licensing, education became more stringent (Grossman 47), and middle- and upper-class patients and reformers often helped to expand scientific medicine's reach (Barney 9). Among these perceived benefits were medically supervised and assisted pregnancies and births.

Regarding pregnancy, physicians understand pregnancy pathologically, as a kind of rupture in an otherwise healthy body (Siegel 10). Childbirth ends this rupture and must be managed to protect the fetus; this attitude has been extended to prenatal care, positioned as managing risky bodies and practices to create a healthy child (Siegel 6). Because "pregnant bodies can become the sites through which social, political, and environmental risks are managed," a system of enforcement is necessary to ensure a healthy and normal fetus (Siegel 13). Through educational interventions and regular assertion of obstetric authority, including eliminating most alternatives, most white women gave birth in hospitals by the 1950s (Devitt

47). Women of color did not join these numbers until 1962, when the Supreme Court case *Simkins v Cone* mandated desegregation of hospitals receiving federal funding (Harper 90).

1.3.2 The Midwife Question

During the 1920s, obstetricians primarily practiced in the homes of affluent women and hospitals for the indigent. Most women, if they sought any care at all, tended to rely on community networks and lay midwives (or, in many immigrant communities, midwives formally trained in European midwifery schools). However, physicians increasingly labeled midwives as dangerous, incompetent, ignorant, and superstitious, positioning themselves as expert saviors for women suffering from tragedies of pregnancy and childbirth (Rooks 11). Answers to this “midwife question” ranged from abolition, to increased regulatory control and training, or allowing midwives to be legally licensed as separate, recognized medical profession (Rooks 13). Affluent women who preferred obstetricians believed that poor women could benefit from physician care. However, most women could not afford or access obstetric care. Thus, women reformers developed, funded, and promoted services and organizations that improved access. Especially in remote or isolated areas of America, physicians teamed with these women-led public health organizations as well as corporations. Such alliances allowing physicians to ultimately exert professional autonomy and delineate the parameters of medical care (Barney 9).

As new scientific understandings about health and medicine emerged, concern grew that traditional providers caused most problems in childbirth due to their lack of formal education. The Sheppard-Towner Act provided federal funding to institute lay midwifery training programs. Eventually all states created programs that monitored and trained community midwives (Goan 75). These compulsory training sessions undoubtedly aided in teaching lay midwives the basics of care and sanitation that improved mothers’ health, or at least reduced the possibility of

infections and puerperal (childbirth) fever. However, these programs also positioned midwives in a kind of ‘stopgap’ position. Until (male) obstetricians could claim their rightful place, traditional caregivers were allowed to continue, but only temporarily and under supervision. Rhetorically and in practice, midwives’ authority was increasingly eroded.

In regards to the medical staff of the Frontier Nursing Service, the organization hired both nurses and nurses who had obtained graduate certificates or degrees from midwifery schools. These degrees first typically came from schools in England, but the outbreak of World War II led to Mary Breckinridge founding Frontier Nursing University. Breckinridge wrote in her 1951 memoir that she and her medical staff founded the American Association for Nurse-Midwives in 1928 and worked with the Maternity Center Association of New York City to establish a more permanent legal and educational place for nurses who also wanted to be midwives (Breckinridge 304-305, 323). Modern publications generally follow Breckinridge’s lead in calling her staff nurse-midwives, though it does not seem full recognition using that term came until after World War II. It is also worth noting that not all nurses on Fronter Nursing Service staff were midwives, though all medical providers (except doctors) did have at least a nursing degree from accredited schools.

1.3.3 Disseminating Scientific Motherhood

I noted above those women who increasingly relied on physicians for their reproductive healthcare worked to extend those benefits to women who traditionally had not had access to doctors. These efforts increased as modern scientific medicine became the dominant medical model. Concerns over the competence of traditional models of care correlated with growing faith in the power and validity of science. At the end of the nineteenth century, scientific theories began to be applied to childcare, “ushering in the birth of the child-study movement and the rise

of ‘educated motherhood’” (Goan 40). Parenting became seen as “a skill that mothers must study and perfect” and experts “became the arbiters of what was considered ‘normal’ and ‘abnormal’” (Goan 40). Steadily, women lost their autonomy as arbiters of their reproductive decisions. In other words, women become positioned as objects rather than fully autonomous humans, with a focus on their reproductive functionality and subject to discipline and intervention (Siegel 7).

Even so, new scientific theories and principles of motherhood and scientific medicine promised an alternative to the mysteries that had taken so many women and children in childbirth for so long. In addition, as industrialization attenuated the social networks that had historically supported new mothers, scientific knowledge and education helped to fill that gap (Ladd-Taylor, *Mother-Work* 18). However, scientific motherhood strengthened the division between public and private spheres. Principles of scientific motherhood included that parenting demanded women’s full attention and time, even as changing family size and decreasing domestic labor allowed them more time. This idea of motherhood positioned women’s lives as a trajectory akin to a career that required careful attention and care throughout a woman’s life. From healthy choices in young girlhood to when her children left the home, women’s lives should fulfill the obligations of motherhood.

By the late 1920s, states integrated the work of maternalist reformers into state agencies recognizable today, and women’s political force was blunted. But the idea that motherhood was a social institution to be monitored and regulated by state actors and physicians (Siegel 13) had firmly entered the sociopolitical and cultural landscape, positioning women as nonexperts regarding their own bodies. Devaluing women’s experiential expertise justifies intervention and disallows women the agency to make their own reproductive choices.

1.3.4 Public Health in the Early Twentieth Century

While I have focused specifically on scientific medicine regarding reproduction and its impacts on women's autonomy, in the Progressive Era maternal and infant health fell under the purview of public health more broadly. Public health emerged in the modern industrial era as nation-states began to invest in their populace's physical well-being. Concerns included addressing the environmental ills of urbanization, ensuring a healthy populace for military and economic reasons, and a sense of moral duty or even fear of the illnesses of poverty. The focus of public health shifted as social attitudes and beliefs, medical epistemologies, and economies changed. In this section, I provide a brief history to contextualize public health after World War I in the United States to set the stage for my later discussion of the Frontier Nursing Service as a public health organization. The information in this section comes primarily from Virginia Berridge's *Public Health: A Very Short Introduction*, with relevant information from additional sources about Progressive Era reforms that embraced and promoted public health.

As the profession of public health arose, individuals and institutions worked to improve environmental and social conditions and address individual behaviors. According to Winderman et al. in their *Rhetoric of Health and Medicine* article, public health practices developed as "a constant epistemological negotiation between experts and lay publics" (117). Older understandings of illness as arising from 'bad smells,' or a miasmatic disease framework, allow the lay public to more easily understand disease and disease prevention. Though this framework can function at odds with the germ theory of disease, which locates illness in an invisible source, the two perspectives often function together (121), thus encouraging a partnership between experts and individuals to improve a society's health.

The miasmatic perspective informed early public health initiatives, such as the famous cholera outbreak in London. Military and economic needs, the association between health and morality, and the emergence of scientific inquiry (especially statistics) characterized early public health initiatives through the eighteenth and nineteenth centuries (Berridge 30). These trends set in motion the language and concepts that helped to inform public health approaches in the post-Civil War and Progressive Eras in the United States. Places and people that smelled bad and looked sick received attention. Charitable organizations and state institutions shifted focus to the health of non-elites as urban areas grew (Berridge 35) as well as to address “fears of social disorder” brought about by the “moral corruption which could result from disease” (Berridge 37). Such language encouraged punitive measures to control disease.

In the early twentieth century, scientists and physicians made considerable progress in preventing and curing seemingly intractable diseases, particularly illnesses such as syphilis, tuberculosis, viral outbreaks, and parasitic worm infections. Other initiatives included programs that have helped a great many people, such as school lunches, health insurance, and old age pensions (Berridge 58). However, these advances should be understood in the larger context of racial and hereditary fears that led to what Berridge and other scholars name “negative eugenics,” which included sterilization and state-sponsored deaths of the ‘unfit’ (58). On the other hand, programs to improve maternal health and parenting became widespread as organizations and women sought out and disseminated resources that lessened the likelihood of tragic outcomes. In part, the interest in such initiatives were responses to “[a]nxieties over population quantity and quality” (Berridge 59). “[C]hanging habits of domestic hygiene, and reinforcing public education” (Berridge 59) helped to address those anxieties. After World War II, negative eugenics and its language fell out of favor, though its legacy lives on (Berridge 66).

Public health shifted its focus to individual health, with primarily prevention and curative approaches (Berridge 67), a focus on “diseases of behavior or ‘lifestyle,’ on chronic disease, and on the role of quantitative techniques to investigate those behaviors (Berridge 71).

The fading of maternalism, with the ideological privatization of motherhood and its burdens, in the late 1920s (Ladd-Taylor, *Mother-Work*, 7) mirrored the public health shift—that public health and motherhood is an individual responsibility of women. That shift is reflected in the expiration of the Sheppard-Towner Act of 1921. This Act passed with a compromise that limited funding and enforcement. Like other state-sponsored public health initiatives, the legislation had considerable potential to substantively improve maternal health. Opposition to its proponents and its reforms led to it quietly expiring in 1929 (Ladd-Taylor, *Mother-Work*, 175). However, certain elements of the legislation lived on, particularly the lay midwife education program and state agencies dedicated to maternal and child health. The concern behind the original introduction of the Act continued to matter, as a range of individuals worked to improve maternal and infant mortality rates. While the Frontier Nursing Service relied on modern science – a germ theory-based approach to addressing public health of the communities they served – in practice, the framework mattered less than their results, a tendency that seemed characteristic of maternalist reformers. Reformers of this period as well as public health professionals often promoted a holistic approach to addressing community, environmental, and individual behaviors and risks to achieve their goals of healthier individuals and communities. In this sense, the Frontier Nursing Service functioned as a public health organization rather than a nursing service that only provided midwifery care.

1.4 Anglo-Saxon Ideology and the Forgotten Frontier

As I have mentioned previously, the reforms of the Progressive Era cannot be understood apart from the racial fears and ideologies of the period. Rapid demographic changes “left middle- and upper-class Americans increasingly aware of the diverse racial and ethnic makeup of the United States” (Ladd-Taylor, *Mother-Work*, 5). In many cases, these Americans looked for ways to rebalance society in terms of prior racial hierarchies and proportions. Local and national policies included immigration restriction, fertility control and sterilization, and policies to influence family sizes. In this section, I focus on constructions of whiteness in the late nineteenth and early twentieth centuries. White supremacy creates a hierarchy based on race, gender, and class, labeling demographic categories in subjective terms that construct some as ‘better’ or ‘best.’ By definition, those who fit into lesser-valued categories are less deserving of respect.

I draw on Kimberly Harper’s discussion of ideology as ethos of a nation-state (drawn in turn from Lynette Hunter’s “Ideology as the Ethos of the Nation State”) to shape my framing of how Breckinridge shaped the ethos of the Frontier Nursing Service. In an ideology that constructs white, Anglo-Saxon men at the top, other demographics’ ethos operates to sustain that hierarchy and are in large part defined by and in opposition to those with the most privilege. I do not wish to dismiss the importance of racism’s impact. The hierarchy in which whiteness was constructed in this period functioned as justification of withholding resources from and harming Indigenous, Black, and other communities of color. At the same time, this hierarchy also justified pouring resources into Appalachia. Lastly, though the throughline from the 1920s to the 2020s is beyond the scope of this project, to understand “the ways that the history of white supremacy operating in a capitalist system penetrates and misshapes the present” (Ross and Solinger 11) requires attention to how white supremacy impacts all women. Thus, while acknowledging that

white supremacy directly harms non-white women the most, I focus my attention on the ways in which ideas of whiteness positioned the women of Appalachia.

1.4.1 Anglo-Saxon Ideology

Sir Francis Galton, a cousin of Charles Darwin, argued for “further[ing] the ends of evolution more rapidly” through “supplanting inefficient human stock by better strains” (1). In other words, he viewed human reproduction through the lens of animal livestock breeding, in the sense that preferable inheritable characteristics could be selected for by promoting or restricting who should have children with whom. His ideas formed the basis of eugenics and genetic justifications for white supremacy, an approach favored in Britain, Germany, and the United States (Dikötter 474). The “more suitable races” were, according to the first president of Stanford, “Greek, Roman, Frank, Saxon, Norman, Dane, Celt, Scot, Goth or Samurai” (Jordan 6). In other words, ethnic identities associated with warrior races, primarily of Scandinavian and Germanic origin, were portrayed as physically and mentally superior. This idea that war created the strongest and best formed a foundation for Anglo-Saxon ideology, a race-based system that assigns power and privilege according to the degree to which individuals fit the image of male warriors of the Roman and medieval European periods.

While ideologies are not always confined to a dominant social power, in this case, Anglo-Saxon ideology served to define an American sociopolitical hierarchy that stratified individuals according to their racial identities. In this way, proponents worked to “*unify* a social formation in ways convenient for its rulers” (Eagleton 30, emphasis in original), which solidified the power of the upper classes. This unity also ensured, as Eagleton phrased it, “complicity of subordinated classes and groups, and so on” (30). Eagleton also noted that ideology “signifies ideas and beliefs which help to legitimate the interests of a ruling group or class specifically by distortion or

dissimulation" (30). Not all ideas of the ruling group or class are ideological, and not all members hold the exact same ideology. However, by creating a shared vision of the ethos of various demographics within the state, the government can “control institutional structural systems, which are where power struggles are enacted” (Harper 54).

The linkage between ethos and ideology requires viewing ethos as more than a defining characteristic of an individual. Instead, if we consider ethos as “a complex set of characteristics constructed by a group, sanctioned by that group, and more readily recognizable to others who belong or share similar values or experiences” (Reynolds 327), ethos encompasses the social context the rhetor inhabits. When the rhetor inhabits a socially powerful community, then the collective ethos of their community can function as an ideology that encompasses “a specific set of political practices dealing with how nation states represent themselves to the people they represent, through economic, legal, educational, and health institutions” (Hunter 198). Beyond specific practices alone, dominant ideologies unify and legitimate formation of societies in ways that reproduce social power (Eagleton 29-30). However, by creating a shared vision circulated in society of the ethos of various demographics within the state, the government can “control institutional structural systems, which are where power struggles are enacted” (Harper 54). Thus, by defining the country ideologically based on ethos built on race, institutional systems benefit or harm communities based on that race. In this sense, then, withholding resources from communities of color in favor of supporting communities such as Appalachia upheld the racial ideology that defined the country.

1.4.2 Construction of Appalachia: The Last Bastion of White Purity

The belief that Appalachia merited considerable resources to improve residents’ lives emerged following the Civil War and existed simultaneously with beliefs about the intellectual

and physical degeneracy of individuals from poor communities. Through the early colonial and Early Republic periods, landed gentry with breeding depicted themselves as opposites to poor, often landless whites who had few chances to obtain property, except along frontiers claimed by Indigenous peoples. In the post-Civil War period, poor whites were derided as living off government handouts (Isenberg 178). In some cases, the only way to ‘cure’ the degeneracy of poor whites was to institutionalize and sterilize them (Isenberg 181). This attitude is most clear in the Supreme Court case of *Buck vs Bell*, in which Justice Oliver Wendell Holmes proclaimed, “Three generations of imbeciles is enough” (Hartman 56) and upheld states’ right to sterilize its citizens. By the late nineteenth century, poor whites often served as a metaphor for all that was wrong with white America: uneducated, unintelligent, unmotivated.

Yet poor mountain whites had enormous potential. Members of the Boone and Crockett Club, an organization originally dedicated to hunting and conservation, believed the best Americans were descended from the original English (Anglo-Saxon) settlers, and those with such heritage were endangered. So few remained that “Imperiled Anglo-Saxon pioneers...required preservation and restoration” (quoted in Hartman 2). William Goodell Frost, president of Berea College in Kentucky, claimed “[The mountain white] is not a degraded being, although, to tell the truth, he has not yet been graded up! The ‘poor whites’ were degraded by competition with slave labor” (Frost 316). Frost, and others looking for evidence of pioneer English ancestry, found it through preservation of rural English traditions, dialect, and last names (315). In this construction, the Anglo-Saxons of the mountains had the hereditary legacy that merited the socioeconomic power urban elites held. They simply did not have the proper education or opportunities to rise above their poverty. Once provided them, they would serve as the greatest contribution to American democracy and strength. In a nation that seemed

increasingly less white, preserving Anglo-Saxon whiteness would preserve the fundamental ethos of the country, and the largest reservoir of that identity existed in Appalachia.

It was not until 1873 that Americans outside the region began to perceive Appalachia as a distinct place preserving a frontier way of life, when a travel publication described the mountains of Kentucky and its people as “a strange land and a peculiar people” (Harney, quoted in Shapiro 3). The many writers who followed created a cultural notion of Appalachia as an isolated region untouched by progress, maintaining “a style of life and a mode of social organization once common to all areas of the country” (Shapiro 5). This view of Appalachia served proponents of the Anglo-Saxon ideology. Theodore Roosevelt, in his multi-volume work *Winning the West*, claimed western pioneers descended from Kentuckians (cited in Hartman 23), linking the greatness of Westward expansion to the heart of the mountains. Historian Frederick Johnson Turner expanded on this idea in 1893. His frontier hypothesis argues that American democracy was birthed by its frontier: “American social development has been continually beginning over again on the frontier. This perennial rebirth...furnish[es] the forces dominating American character” (1). A particular kind of whiteness – descent from mountain residents of eastern Kentucky and Tennessee – had forged the great, democratic nature of America through continual conflict on the frontier. As white birthrates fell and increased numbers of non-whites became citizens, America’s fundamental racial character was seen as threatened. Fortunately, the people of the Appalachian Mountains and elite white women still preserved the genetic core of America. As the superiority of whiteness came under threat, the right, white women had the duty to combat their race’s falling numbers. In this paradigm, to prevent ‘race suicide,’ Anglo-Saxon women had to bear four to six children, “enough so that the race shall increase and not decrease” (Hochman; Roosevelt, cited in Isenberg 192). This view, often explained through animal

husbandry metaphors coupled with fears about reproductive extinction of whites, populated eugenic texts throughout the era (i.e., Jordan 6).

1.4.3 The Intersections of Race, Class, Region, and Reproductive Policies

Given the pervasive poverty of southeastern Kentucky in the 1920s and 1930s, class narratives were potentially a hindrance in gaining support for the Frontier Nursing Service. In fact, justifications for institutionalizing and sterilizing individuals to ostensibly protect “the nation’s gene supply” (Bishop, quoted in Powell, “Rhetorics of Displacement,” 310) often entirely ignored the impacts of poverty even as policies punished people for being poor. In fact, concerns over economic costs of aiding poor and institutionalized individuals as well as a desire to prevent suffering led to greater support for negative eugenics across the world (Dikötter 469). In terms of class, Appalachia’s poverty would seem to deter investment and aid.

In fact, those who left Appalachia in search of economic opportunity often found assistance denied to them. In response to the overwhelming numbers of economic migrants from the mountains, Indiana enacted the nation’s first sterilization law in an attempt to address generational poverty (Hartman 49). Attitudes toward those who left the Appalachian Mountains reflected the tendency to blame individuals for systemic problems. In sharp contrast, regional promoters such as the president of Kentucky’s Berea College, William Goodell Frost, claimed Kentuckians as “contemporary ancestors” (quoted in McNeil 19) or a repository of pure Elizabethan culture and stock (McNeil 19), thus worthy of respect, admiration, and even celebration. In contrast, problems faced by those who remained in the mountains were often seen as structural, not individual. Few differences existed between the two groups, but their decision to stay or leave marked them very differently.

The relentless boosterism of Appalachia as a land that preserved Anglo-Saxon pioneer blood, culture, and ways of life attracted considerable charitable resources. Missionaries and others concerned with ‘uplift’ began to enter the area in the 1880s (Shapiro 32). In fact, the American Missionary Association, which originally focused on aiding formerly enslaved individuals, shifted the bulk of its resources to the area. One member argued doing so was necessary because “[the whites] have little hope, for [Appalachia] is black through illiteracy” (Fairchild, quoted in Hartmann 30). Thus, the families of Appalachia became a prime target for those supporting what scholars call *positive eugenics*: promoting large families and providing resources to those who were needed to preserve the racial makeup of the nation (Roberts 60, 62). Women’s loss of autonomy and control over their own reproductive decisions seemed a small price to pay to save a nation in peril.

1.5 Methods and Methodology

In this section, I explain the theoretical framing of my analysis in the chapters that follow. After, I discuss the materials and the processes by which I analyzed their messages and intent within the larger national conversations and concerns of the early twentieth century. I begin with a discussion of ethos, its relation to the ideologies of a nation-state, and ethos as a resource and characteristic of traditionally marginalized communities. This foundation allows me to relate Breckinridge’s rhetorical work through a microhistorical approach to understand how the appeal of her organization resonated, but ultimately faded.

Ethos has historically been understood as primarily a matter of character, often through either an actual honorable character or appearance of such. However, as scholars studying the rhetoric of marginalized groups have often pointed out, such definitions presume that rhetors are in complete control of their ethos or the nuances that influence that ethos. Kimberly Harper

points out that “character and forms of virtue are indeed important [and] are embedded in the social expectation of a community” (52). For members of marginalized groups, often with limited social agency and voice, ethos functions on a continuum that allow these rhetors to “reimagine how they enter into a rhetorical space—situating the location based on the subjectivity they created which reflects their world, politics, and existence” (53). Ethos assigned to these marginalized groups provides avenues for them to exercise rhetorical agency and power, but also constrain their impact. In defining these demographics, the state can produce and justify oppressive power structures that deny agency, voice, and privilege. In this way, the “boundaries around rhetorical space” are patrolled, as Johnson notes (*Gender and Rhetorical Space*, 2), and the ethos of the impacted individuals and groups is viewed through the state’s ideological filter. Thus, women (as do all who experience marginalization according to the intersections of their identities) must position themselves in relation to dominant ideologies that impact their credibility. As Lindahl Buchanan’s work *Regendering Delivery* points out, choices of rhetorical delivery are constrained by the “complex interplay among a speaker, audience, and a plethora of social and ideological factors” (5). Understanding the socially situated nature of rhetoric and the choices involved in creating and delivering messages means understanding how a rhetor’s ethos is also socially situated – a multilayered conception that allows shifts as society changes.

Ryan et al., in *Rethinking Ethos: A Feminist Ecological Approach to Rhetoric*, identify the ways in which women connect “the relations, locations, and dynamism that compose their ethos” as an “imaginary”: an interconnected but dynamic and open system “of images, metaphors, tacit assumptions, ways of thinking” (Code, quoted in Ryan et al. viiii). To do so, women engage in at least three rhetorical maneuvers, or rhetorical acts in the “space between the subject position and the subject form” (Phillips, “Rhetorical Maneuvers,” 325): interruption,

advocacy, and relating (Ryan et al. x). Interrupting allows women rhetors to disrupt current assumptions and the ethos assigned to them in ways that foster change (Ryan et al. 24).

Advocacy entails “rhetors advocating for their own right to speak authoritatively and negotiating the complexities of speaking for others” – a process that requires “continuous ethical consideration to power, relationships, experiences, and imagined versus real needs” (Ryan et al. 111). Unfortunately, the process of advocacy often falls short of its potential, thus limiting the actual change that can be achieved. Finally, relating “draws attention to the ways in which women’s *ethé* are socially constructed...in relation to others and their environments” (Ryan et al. 195). Mary Breckinridge’s rhetorical activities mirror these rhetorical strategies. She *related* to the nearly universal experience of losing a child or mother, racial ideologies and fears, and science while *advocating* for the professional expertise of her staff. Therefore, she was able to *interrupt* the rhetorical (and actual) marginalization of midwifery to serve public health.

However, her advocacy had limits. Her choices positioned white women of the Appalachian Mountains as vessels to bear children who deserved intervention and charitable support. When the need faded, so did her original Service, but she contributed to the rhetorically positioning of white women as morally responsible for bearing large healthy families (with monitoring and support of medical experts). The end goal became healthy white children. Women continued to be denied the agency and voice to advocate for their own reproductive justice and autonomy.

Breckinridge’s choice to rely on ideologies of motherhood provided her rhetorical power, but also repeated and reinforced cultural narratives around women’s roles and responsibilities. Doing so “train[s] through repetition [a belief of] a specific version of a history or of a life” (Guglielmo 3). Through these repetitions, culture (and in this case, ideologies of motherhood) is recreated over again (Phillips, “The Failure of Memory,” 218) and exceptions are forgotten.

Erasure is so effective “that each generation of women appears to be charting completely new territory as they infiltrate the barriers and navigate the checkpoints at the borders of rhetoric” (George et al. 4). In fact, her reliance on already-existing avenues of credibility and ethos as well as appealing to fears and beliefs of her period resonated with her national audience, who donated substantial resources to fund the Frontier Nursing Service helped build Breckinridge’s name as a public servant dedicated to eliminating the tragedies of pregnancy and childbirth. However, those same appeals in part eventually undermined her power as their currency faded.

Understanding the ecology of women’s rhetoric as existing within a milieu that contains the opportunities, exigences, and constraints allows me to view Breckinridge’s own transformations through a microhistorical approach. By looking at the exceptional normal, or normal exceptional, in a single analysis means “all levels of knowledge are revealed” (McComiskey 19). Thus, the historian can interpret the relationship between normal and exceptional. When a person is the focus of analysis, that person has *contextualized agency*. McComiskey cites Levi to explain that social actions are the result of a myriad of available choices within a “normative reality” (20). To unveil levels of knowledge more fully, to explore what influences are exerted on and by individuals through a microhistory lens, sources are understood as rhetorical. The ‘normative reality’ is not shaped solely by local contexts, nor do they exist solely within national narratives. Rather, individuals have knowledge of both perspectives, and seeing a rhetor as drawing on both to enact her life allows a richer understanding of both perspectives.

It is this understanding of a microhistorical approach to Mary Breckinridge and her life that informed my selection of materials for this project. Thus, I focused my analysis predominantly on published material and Service records available in digital archives as well as

in copious materials donated to the University of Kentucky. I had originally hoped to include the voices and experiences of the women of eastern Kentucky. However, the wealth and depth of material illuminating Breckinridge's rhetorical and personal evolution led me to focus primarily on her life; the stories of the women of Leslie County will hopefully become the focus of later research. I analyzed a subset of the following resources for themes regarding motherhood, scientific medicine, and race:

- The *Frontier Nursing Service Quarterly Bulletins*
- Mary Breckinridge's own published texts
- Organization and clinic reports
- Newspaper, magazine stories, and images about Breckinridge and the Service (saved in scrapbooks)
- Letters and photos related to Breckinridge and the Service
- Contemporaneous publications regarding midwives, obstetrics, and eugenics

A sizable portion of the material included in this project are of photos that primarily come from newspaper publicity pieces and *Bulletins*; I included several from her text *Breckie: His Four Years* and her fundraising film *The Forgotten Frontier*. Because the *Bulletins* and the film seemed to be the primary means of soliciting donations, this choice allowed me to better understand how Breckinridge situated her organization and its work within a national context. Breckinridge relied heavily on visual evidence to demonstrate her organization's needs and successes. Furthermore, written materials from her life before 1923 are limited, so analyzing photos of that period help to illuminate Breckinridge and her life beyond the carefully curated texts available after her death.

In analyzing the photographs, I relied on Helena Zinkham's "Finding and Research Photographs" as a heuristic for interpreting their meaning and messages. I examined articles and chapters focusing on image analysis to determine "common visual-presentation conventions" (Zinkham 127). Kristie Fleckenstein's article "Professional Proof: Arguing for Women Photographers in the Fin de Siècle" provided substantial insight regarding photographic conventions of women and children in the Progressive Era (90). Zinkham's questions about the purpose of gathering and analyzing photos (126) helped me to determine that they would triangulate Breckinridge's written words with national contemporary trends and conversations and visually manifest her activism and rhetorical choices. That triangulation also helped me to challenge the tendency to "see through the filter of modern perspectives" that may limit the ability to understand "all what is going on in the photographs" (Zinkham 129). In particular, the collection of images related to the Frontier Nursing Service held by the University of Kentucky Archives (for much of which the institution does not hold copyright) allowed me to cross-reference Breckinridge's photographs against those taken by others. The next section summarizes the body chapters of this project.

1.6 Chapter Outline

Chapter Two focuses on rhetorics of motherhood and Breckinridge's relationship with and manifestation of those ideals. I examine the ways in which Breckinridge shifted her own positioning as a mother in response to the tragedies she experienced in her life in the context of rhetorics and ideologies of motherhood. I trace her evolution from a True Woman to her eventual embracing of the identity of a New Women that the Progressive Era engendered. Her lifetime commitment to motherhood allowed her to merge traditional gendered values with her tragedies

in ways that made substantial impacts on the lives of thousands of women while remaining true to her own beliefs.

Chapter Three examines the ways in which Breckinridge navigated a changing medical landscape to claim authority for certified nurse-midwives. I trace the ways the American Medical Association rhetorically and legally wrested control of pregnancy and childbirth from traditional birthing attendants. I then explore how Breckinridge interrupted the growing consensus over who had the authority to medically manage reproductive healthcare and advocated for her own staff.

Chapter Four analyzes Breckinridge's reliance on principles of scientific and medical discourse to advance her organization's credibility. By relating to growing trust in statistical analyses to verify anecdotes, she did prove that her organization provided safe, effective care, though her tendency to rely on generalizations limit applicability of her claims of success. Even so, she established the Frontier Nursing Service as medically and professionally credible. This basis for her credibility probably gave her organization staying power when non-professional public health reformers throughout Appalachia found themselves sidelined by physicians and state agencies.

In Chapter Five, I move from the successes of Breckinridge and her organization to the racial ideological appeals she relied on so heavily: the racial makeup and frontier nature of the Appalachian Mountains. I explore how she reflected ideas of Appalachian mountaineers as the last bastion of whiteness and how her target audience of donors responded, even in the Great Depression. Then I explore ways in which she continued to rely on those appeals, even as Appalachia left behind its frontier image, explicit eugenics policies, language, and beliefs fell out of favor, and the nation grew concerned with other issues after World War II.

Finally, in Chapter Six I situate my conclusions within a reproductive justice framework. I explore how Breckinridge became, in many ways, a victim of her own success: public memories of her are fading, but Breckinridge – and maternalist reformers like her – continue to influence us even today. A focus on the racial context of the period in conjunction with the emergence of science as a credible arbiter of legal, political, and social decisions will also, hopefully, allow us to wrestle with the harmful legacies of our past in ways that allow us to create a more just future.

1.7 Conclusions

Through the life and work of Mary Breckinridge, we can follow the significant cultural changes and reform movements of the early twentieth century. From the social chaos following the Civil War, to the enthusiasm and energy to redress endemic and emerging social ills, women operated within paradigms that defined them first as mothers and wives. Despite these constraints, reform-minded women found ways to adapt gendered assumptions and expectations to resist cultural narratives and redefine womanhood and themselves. However, embedded within the opportunities that allowed women to make their rhetorical mark existed the same constraints that marked their efforts outside motherhood as exceptional, or as not worth remembering. Breckinridge falls in both camps: an exceptional individual with significant career and rhetorical accomplishments who is also poorly remembered.

By taking a microhistorical approach, I hope to redress the tendencies to see Mary Breckinridge as an exceptional hero, as a woman motivated by a unique grief that tackled social ills through her natural abilities as a mother while armed with the latest scientific knowledge. Books like Nancy Dammann's 1989 *A Social History of the Frontier Nursing Service* and even more recent academic publications like Anne Cockerham's chapter "Mary Breckinridge and the

Frontier Nursing Service: Saddlebags and Swinging Bridges” or Donna Parker’s “Made to Fit a Woman: Riding Uniforms of the Frontier Nursing Service” tend to lionize her achievements while neglecting complexities and often ignoring the residents of Leslie County outright. In some cases, they uncritically repeat Breckinridge’s own claims. Texts intended for lay audiences, such as Amy Pennington Brudnicki’s nostalgic collection of anecdotes, *Remembering the Frontier: Our Horseback Heritage*, also tend to provide a romantic, rosy view.

The tendency to believe Breckinridge’s telling of her life also obscures the ways in which she participated in a much larger reform and activist movement. Progressive Era reforms and the men and women who participated are taught as isolated instances of changes that benefited all equally, and furthermore as activism that occurred in only a specific time and place. The complexities of those reforms and the ways in which class, race, and modernization ideas intersected to differently impacts individuals and segments of society must be interrogated and resisted. We can recognize the power and draw of narratives of activism, change, and impactful public lives, but we must also interrogate our attachments to particular versions of these people and events. In the case of Breckinridge’s life and work, doing so allows us to unpack a century’s worth of retelling of Progressive reforms and ideologies of motherhood for a fuller, richer understanding of those individuals their actions, and their impact on our lives today. Only then can we begin the challenging work of wrestling with our past to move forward to imagining and enacting a more just future

Furthermore, reliance on her loss as her primary exigence also erases nuances and complexities of her life and work. While I do not want to imply that she used her own losses in a mercenary way to achieve her goals – archival and published material make it clear how deeply her children’s deaths impacted her the rest of her life – the wedding of her work to motherhood

and simplifying the considerable achievements (as well as problems) of the Frontier Nursing Service to this one reason helps to reduce her memory to a local effort that ultimately had little implication for the rest of the nation. In fact, the social milieus she navigated as well as the nexus of race, motherhood, and reproductive medicine evident in her own organization reveal myriad legacies. Beyond the complexities inherent in any human life, her life reveals how the very choices women make to be rhetorically and substantively effective in their social context often also minimize and erase their memories and legacies even when they effect significant change. In this erasure, at least in Breckinridge's case, we also risk losing how the history of reproductive policies and care continue to shape the lives of women and their communities today.

2 MOTHERHOOD: TRANSFORMATION

Across seven issues of *Southern Woman's Magazine* published in 1916 and 1917, Mary Breckinridge Thompson (the name she used during her second marriage) published an article titled, "Motherhood—A Career: A Series of Lessons Learned by the Writer from Her Own Life." This article was intended to educate young women how to properly prepare for and conduct motherhood. In the first part, published in November 1916, she wrote:

Motherhood is a business. A modern writer has well said, "It is a good business to bear normal children." Motherhood is a career—the only one open exclusively to women, and the one among them all for which modern science and advanced thought have done most. The difference between rearing a child well (and not just keeping it alive, but giving it the fullest possible chance that should be every child's birthright) and merely raising it is the difference between being a musician and banging on the piano, a great painter and daubing signboards. (14)

Breckinridge's claims about modern motherhood echoed the sentiments of maternalists and proponents of scientific motherhood. These individuals believed in a new version of motherhood that would create a nation of citizens living healthy and to their potential. That promise was predicated upon women fully embracing their supposed natural roles as nurturers and caregivers. At the same time, mothers could no longer rely on scientifically inadequate collective wisdom to properly raise their children.

According to anthropologists and historians of midwifery (e.g., Brodksy 48), the centrality of motherhood to community and social continuity has always required codified traditions. Scholars of feminist rhetoric have also examined how those traditions and

understandings function to define women and their possibilities. Those understandings form an ideology that “*unify* a social formation in ways convenient for its rulers” and “legitimate the interests of a ruling group or class” (Eagleton 30). In this case, the ideology organizes a hierarchy in which women are rhetorically, civically, and professionally constrained in ways that center their potential and actual capacities in relation to their children and husbands. Thus, narratives of motherhood function ideologically by defining “our lived relations to reality” (Eagleton 30).

Reformers in the Progressive Era often used available rhetorical resources of motherhood to argue that their status as women and mothers provided them unique perspectives, understanding, and therefore the power to effect “material change[s]” (Eagleton 30) in reality. They worked to transform the living and working conditions of urban poor. They transformed the state’s responsibility to the health and well-being of its citizens, especially to mothers and children. They gained the power to vote and effect political change. They pursued professional careers of their own. This wave of reform did make fundamental social changes, laying the foundation of the modern welfare state. However, their reliance on motherhood as exigence in a patriarchal society (George et al. 11) limited the reach and memory of their achievements. Political backlash to women’s activism as well as racism and classism also limited the degree of these women’s ability to effect change.

The legacies of many reformers and professionally and politically active women of this period have been simplified, silenced, or erased. For instance, feature articles portrayed Marie Curie’s scientific achievements as a natural outgrowth of her “feminine sympathies and moral concerns” (Jack 226). In another example, Maria Martin, the background and foliage painter for John James Audubon, was footnoted only twice, and mentioned obliquely in only a few letters

(Shirk 109). In another typical example, inventor and metallurgist Carrie Jane Billings Everson developed a groundbreaking process for mining ore for precious metals that was ignored until well after her death (Hallenbeck 69). Connected and influential women in Appalachia helped to create the region's modern medical infrastructure, in the sense that they introduced the people living there to scientific medicine and helped licensed doctors become the preferred resource for medical treatment (Barney 12). Yet, once physicians had established hegemony over medicine in Appalachia, these women found themselves on the periphery and their contributions in transforming medicine mostly forgotten.

Mary Breckinridge's life and contributions do not absolutely follow these general tendencies described above; she and her organization were well-known for decades. However, public memory of her work seems to have mostly faded from the public eye outside eastern Kentucky, and neither does she seem to be remembered in the sense of exceptional professional women like Marie Curie. Rather, her life and her rhetorical and medical contributions seem to have been folded into a larger narrative: a brief burst of women's activism that solved pressing problems of that time. A closer examination of her life, however, provides insight into the ways that ideologies of motherhood impacted her choices, as well as how she navigated the tragedies in her life. In doing so, she found a path that allowed her to remain true to her lifelong values of motherhood and service.

First, I review rhetorical scholarship examining ideologies of motherhood and their function in society, focusing on postbellum and early twentieth century periods. Then I examine maternalism in the context of Progressive Era activism. Following these reviews, I will analyze the archival and published works of Breckinridge and the Frontier Nursing Service to trace her evolution from a postbellum 'angel of the hearth' to an accomplished, influential professional.

2.1 Ideologies of Motherhood

Lindhahl Buchanan's *Rhetorics of Motherhood* explores how motherhood functions as a persuasive code that "reinforce gender stereotypes and diminish women's complexity, dimensions, and opportunities" (xvii). These rhetorical resources allow women credibility and authority but can also work to their detriment. Defining women through motherhood positions them as mothers first, with their other contributions seen as often either an extension of or in opposition to their central role. Doing so often reinforces the already existing gendered system that subordinates women's accomplishments in favor of men's. Yet, strategic use of motherhood ideology allows women to advance their own agendas. Rhetorical resources defined through and by women's gender can be deployed to claim the right to speak in public, act for social change, and redefine rhetorical strategies, even as motherhood continues to be seen as women's natural and primary aspiration. The repetition of motherhood as women's primary duty and role trains public memory to view other contributions as secondary and therefore less meaningful.

A cultural code of motherhood "communicates but cloaks prevailing power relations; through constant repetition, it makes those relations seem normal, eternal, objective, self-evident expressions of 'the way things are'" (Barthes, cited in Buchanan 5). Thus, repeating messages can train public memory "to believe a specific version of a history or of a life" (3) as well as a group of individuals. The process helps people, places, and events to be remembered in the same way with each act of remembrance, "craft[ing] the same culture over and over again" (Phillips, "Failure of Memory," 218). Jenny Edkins, a political scientist, notes that because a social order is not natural, it must be continually produced through "day-to-day production and reproduction of the social and symbolic order" (12). In telling these same stories about the same people, places, and events, we create a shared understanding of what those things mean, understandings

that can be remarkably resistant to change and function to maintain continuity and stability. Therefore, ‘returning’ women to the home and confining them to the domestic sphere then operated as a short-hand way to recover lost stability after periods of social disruption.

Nan Johnson documents how “efforts to regulate women’s rhetorical behavior intensified rather than abated” following the Civil War (“Reigning in the Court of Silence,” 275). In particular, conduct literature created the ideological trope of a wise, thoughtful, and silent woman as opposite the intellectually vapid talkative woman (274). In offering an emerging middle class an education in when and how to speak, conduct literature and the parlor rhetoric movement promised both happiness and success (275). However, this promise was deeply gendered, built on the emerging ideology of True Womanhood. Historian Barbara Welter defined the ideal of True Womanhood as a pious, pure, submissive, and domestic woman who ensured a happy home and a stable society amidst national chaos (152). With these qualities, she would be happy, and she would have rhetorical power within the home. Nan Johnson finds this message dominant through the end of the nineteenth century across a wide range of rhetorical materials (*Gender and Rhetorical Space*, 6). The parlor rhetoric movement coupled with other pedagogical dialogues “sponsored a conservative view of the domestic rhetorical domain of women, gendered theories of rhetorical performance exert[ing] an ideological influence on public view of rhetorical roles well into the late nineteenth and early twentieth centuries” (Johnson, *Gender and Rhetorical Space*, 15). So effective was this agenda that important women rhetors, once present in oratorical texts, had almost entirely disappeared by 1910. Of course, women of color had an additional racial element to overcome to be considered as accomplished in the first place, so the few canons that did include women speakers or women writers tended to exclusively focus on

white, affluent women. In any case, oratory had become the domain of the statesmen by 1910 (Johnson, *Gender and Rhetorical Space*, 159).

Welter notes that the core True Womanhood value of piety afforded many women the opportunity to expand their influence outside the home (153). Letter-writing manuals of the period recognized the importance of church activities, providing templates for various social and personal affairs (e.g., Dick, *Dick's Society Letter-Writer for Ladies*, 136). By the turn of the century, many women were active not only in church activities, but in women's clubs with shared beliefs and goals. Mother also had a responsibility to society through their children, particularly their sons. By raising their sons to be of sound moral character, they were promised influence on the course of the nation. Domestic literacy narratives of the nineteenth century help to paint this ideal, depicting reading as a way to allow women to be better wives and mothers and the teaching of reading to their 'lessers' to inculcate morality and stabilize society (Robbins 25). Even so, education for women was regarded suspiciously, as educated women did tend to compromise their virtue by speaking publicly (Johnson, "Reigning in the Court," 277). Yet, the role of the 'domestic queen' was in no doubt. As Johnson quotes from an 1888 text, "she consciously or unconsciously organizes...a set of influences...that do more to mold the destiny of the nation than any man, uncrowned by the power of eloquence, can possibly effect. There can be no substitute for this" (Bates, quoted in Johnson, "Reigning in the Court," 278). Symbolically, (white) women were mothers of the nation, and their morality (or turpitude) would make the nation great (or sinful). With such weight on the shoulders of women, regulating their behavior was essential to preserving the essential positive character of the nation.

However, women's status as arbiters of morality afforded them opportunities to engage in social reform. They may have been viewed as quiet and submissive around their menfolk,

knitting at the hearth, but these women also took to the avenues that society opened for them and engaged in their world to understand it, change it, and open further opportunities. Through a range of activities, club women of all sectors of American society examined their social reality, shaping and shaped by “the way the nation thought of itself” (Gere 5). In particular, times of social disruption allowed opportunities to challenge and reshape cultural codes of motherhood. For example, Jessica Enoch’s *Domestic Occupations* analyzed how during World War II government-funded daycare centers and corresponding rhetoric equating those centers with the home allowed a workforce of women to be marshalled to support the war effort. When the war ended, those childcare centers closed, and mothers were expected to return home (Enoch 175). Rhetorically, redefining the workplace as an extension of the home made work a place that women could enter. The work daycare did not simply substitute for home but functioned as an additional domestic space where children would receive the same care as they would in their actual home. However, when men returned home from war, changes that offered a reshaping of motherhood in relation to society were reversed. In particular, the closing of government-funded daycares in the mid-1940s sent the message that there was only one actual home, and that women belonged there rather than in wage-earning jobs.

This reinforcing of the status quo mirrored arguments made regarding motherhood following the Civil War, when conduct literature rhetorically moved women back into the home. In the 1820s and 1830s, women increasingly “emerged as civic rhetors” (Buchanan, *Regendering*, 8). Some developed a feminine delivery style that “disguised the fact that women were engaged in public discourse,” (80). Their indirect, nonthreatening delivery allowed them to “defy dominant gender norms dictating their public silence but also to maintain the appearance of femininity” (80). Other women rhetors chose a more direct, masculine style that has been

remembered and celebrated. However, those relying on feminine delivery style began to disappear from public memory first (8), and even those relying on a more masculine delivery found themselves written out of canonical texts by the early twentieth century (Johnson, *Gender and Rhetorical Space*, 17).

At the same time, women pushed back against the codes of motherhood following the Civil War. They claimed rhetorical, educational, professional, and motherhood goals as their own, arguing for their right to speak, make their own choices, and act as they saw fit. In the liminal spaces between cultural codes and women's choices, the terrain shifts as choices are redefined and backlashes occur. However, women are rhetorically resituated in the home repeatedly, regardless of how they redefine their beings in relation to their domestic roles. Thus, as George et al. note in their introduction to *Women and Rhetoric Between the Wars*, the largescale movement of women into the public arena in the 1990s seemed like something completely new, yet women did the same in the 1920s after achieving suffrage (2) and in response to cultural tensions around slavery (Buchanan, *Regendering Delivery*, 77).

As the nineteenth century grew to a close, competing narratives of womanhood began to circulate. The Real Woman of the postbellum period was fit, educated, and self-reliant. She did marry, but it was not a rushed choice, and she carefully chose who she would wed (Wood 11). The New Woman of the 1890s saw education and public activities as her right, sought paid work, and would delay or forgo marriage and motherhood (Wood 11). Even as white women achieved greater professional status, however, responsibilities to morality tended to carry over into their professional work. For instance, female physicians' seeming ease in conversation with their patients allowed those physicians to exert moral authority with individual patients (Wells 28). The periodical *The Independent Woman* employed embodied epideictic rhetoric to, among other

goals, expand “adherence to values associated with traditional femininity among professional women during a period of cultural upheaval” (Applegarth 135). Even as women expanded their professional and rhetorical boundaries, social responsibility remained to behave morally in a gendered manner.

2.2 ‘Mother-Labor’: Maternalism in the Progressive Era

In a 1978 oral history interview with Marvin Breckinridge Patterson, Mary Breckinridge’s cousin and Frontier Nursing Service Board member, the interviewer asked Patterson her perspective on the purported feminism of the women of the Frontier Nursing Service. In response, she answered:

They were not self-conscious about women. They were not antagonistic to men. That’s a feeling today that reminds me very much I like men. But they were able to do things on their own without making, waving a flag and making a great big thing of it. They just went out and did it. They always got along...with men.... but (the Frontier Nursing Service) was a demonstration of what women could do and women did it.

Though tempered by the passage of a half-century and her own considerable accomplishments as a board member of the Service and a war-time CBS news reporter, Patterson’s commentary suggests a key difference between how she and her cousin saw themselves and feminists. They believed women had natural abilities imparted to them by their gender (“*what women could do*”), and rather than push against gender stereotypes, they simply answered a need (“*women did it*”).

This understanding of women’s abilities and achievements align with what historians have named *maternalism*. Many women activists of the late nineteenth and early twentieth

centuries worked to reform stubborn and newly emerging social ills while managing gendered expectations of their behavior. In fact, like the women who spoke out against slavery in the antebellum period, Progressive Era reformers' public presence required they break with conceptions of feminine behavior in some form. However, these early twentieth century women do not neatly fit into the conventional feminist waves model. In their collection *Women and Rhetoric between the Wars*, editors George et al. note that the notion of feminist waves acts as a terministic screen that deflects our attention away from the women who lived and worked between those waves. This "shorthand version of women's activism" (3) also means that attention is directed away from how women's contributions are often rewritten and "systematically erased from public memory" (3). In other words, women between the traditional waves of feminism are effectively made invisible. They became a mass of women who chose to acquiesce to the way things were, faceless, nameless, and less deserving of attention and memory. Furthermore, we are blinded to how those women did work to change their worlds. We also lose sight of the nuance and complexity of reformers such as maternalists, who wanted to change society for the better while maintaining traditional gendered ideals and values.

Historians of maternalism define the label in various ways, but, in this project, I rely on Molly Ladd-Taylor's explanation of maternalist beliefs:

(1) that there is a uniquely feminine value system based on care and nurturance; (2) that mothers perform a service to the state by raising citizen-workers; (3) that women are united across class, race, and nation by their common capacity for motherhood and therefore share a responsibility for all the world's children; and (4) that ideally men should earn a family wage to support their 'dependent' wives and children at home. (*Mother-Work*, 3)

This definition separates maternalists from feminists primarily due to the idea of separate spheres of responsibility and influence: women as mothers whose work was mostly in the home, and men as earners whose primary responsibilities resided in public spaces. However, feminists and maternalists were not at ideological odds with each other in the Progressive Era. Considerable overlap existed in their beliefs, organizational memberships, and activism (Ladd-Taylor, *Mother-Work*, 3). Conservative maternalists supported objectives now understood as feminist, such as suffrage, because those objectives accrued political power to achieve maternalist goals. Feminists might wish to improve living conditions for working women through public health initiatives that maternalists viewed as beneficial to the goal of motherhood. Because no strict binary exists, categorizing individuals can become difficult.

Racial and class prejudices further complicated the reform efforts of the period. Assumptions about racial superiority led to excluding women of color from organizations and initiatives. Women of socioeconomic, religious, cultural, and racial backgrounds different from affluent white activists tended to view reform efforts as attempts to change their culture and traditions or impose racial stratification. Enoch's analysis of domestic scientists illuminates how they positioned themselves as experts against their audience, who "needed to change their ways" (116). Furthermore, Enoch points out that African Americans resisted domestic science education as one that would "serve white families and publics" (118). Indigenous Americans often experienced these reform efforts through residential boarding schools with assimilationist agendas, intended to erase indigenous cultural identities (Wood 58) and impose white middle-class ideals of motherhood (Wood 65). While those subjected to these efforts resisted, even attempting to shift the discourse (Wood 63), prevailing prejudices continued to dominate perceptions.

African American women who wished to participate in white reform spaces often found themselves excluded on spurious grounds. Wendy Sharer recounts how racial assumptions at the U.S. Women's Bureau resulted in policies that while "Black women could be the subjects of white researchers...they were not allowed a powerful voice in the composition of Bureau bulletins" (25). Sharer includes a quote from an assessment of Mary Church Terrell's application to the Bureau that makes clear she was rejected through a racial lens, explained as based on lack of qualifications and representation of "colored women in industry" (Anderson, cited in Sharer 25). Terrell's experience with the Women's Bureau was typical of African American women reformers more generally. Their work had to consider their legal and social realities and that the state rarely acted to benefit African American communities or families (Boris 215)

In time, backlash against women's civic activism helped to turn the tide against their attempts to change society. White reformers were often able to leverage their connections to achieve legal and political reform, with many eventually obtaining professional identities as the experts administering the nascent welfare state their reform efforts helped to create (Boris 215). Many reformers left public activism altogether. Even so, their rhetorical strategies and achievements did successfully reframe relationships between the state and its citizens, particularly in terms of motherhood. Though unable to create a society where the state had the responsibility to support all women through their reproductive cycle, they did successfully shift responsibility for the biologic and social acts of motherhood from one that solely fell on the woman to one that involved the state.

The complex legacies of reformers who tackled social and medical aspects of motherhood have also fallen victim to the tendency to simplify and revise women's legacies. In Mary Breckinridge's case, her life story as the founder of the Frontier Nursing Service and

tireless advocate for improved maternal health was quite well-known for the first half of the twentieth century. Her memory now is confined primarily to those involved in her organization as patients, care providers, and fundraisers (and their families) as well as medical professionals and scholars familiar with the history of midwifery. Even among those who do remember, her story is shaped around her own desire to save women from the tragedies she experienced; nuances and complexities are often forgotten or glossed over.

2.3 The Life of Mary Breckinridge: Redefining Motherhood

Again and again in oral history interviews and texts that romanticize the Frontier Nursing Service, Breckinridge is painted as a woman dedicated to the health of children and their mothers. The loss of her own children spurred her to create a system that would save other women from the deep, unending grief that Breckinridge herself endured – grief preventable through proper application of modern scientific medicine and obstetrics. Unable to mother her own children, Breckinridge became a kind of mother for all the children of Kentucky.

Breckinridge's romanticization of her life attributed her move toward the Frontier Nursing Service as directed by an unseen hand. From her first meeting of a midwife with her younger brother's birth in Russia, to her yearning to be useful, Breckinridge remembers herself in her memoir as a young woman who did not understand what life held for her or what she was meant to be. Yet, throughout her life, signs indicated she would eventually fulfill her duty and goal to be a mother, a goal finally achieved by facilitating access to modern medicine to women who had suffered as she had without it.

She married not long after finishing high school, as her family encouraged. However, her first husband died a little less than a year after they married due to untreated appendicitis (Goan 33). Breckinridge faced a crossroads – what direction should she go next? Marriage or career?

Her family urged her to spend a summer volunteering at a settlement school in North Carolina until she was ready to remarry. While there, a young girl died of typhoid (Goan 34). Her grief, caused in part by inaccessibility to medical care, led her to enroll in nursing school in New York. While working on hospital wards, she found herself drawn to infants, even attempting to adopt an abandoned child (Breckinridge 58; Goan 36).

Her duty to her family pulled her away from active nursing, and she married a language professor at Crescent College and Conservatory, an exclusive two-year school for women in Eureka Springs, Arkansas. He became vice-president in 1910, shortly before he and Breckinridge married, and served as president from 1914 to 1923 (Goan 38). Breckinridge embraced her new domestic responsibilities, often hosting young women at the college for social events, for instance.

She did not completely abandon her desire to effect social change in this period. She promoted various social issues such as literacy, child welfare, and suffrage. She frequently published, including the series of articles quoted at the beginning of this chapter. She also worked to help professionalize nursing, promoting licensure laws to elevate the field's status. However, more relevant to her eventual role as director of the Frontier Nursing Service, she also volunteered with various organizations to promote the growing public health movement of the period (Goan 39). Her memoir of her son's short life includes anecdotes and references that illustrate her efforts: giving speeches about nursing, considerable correspondence regarding public health and nursing initiatives, and classes at the College so the students would be armed with the scientific knowledge to become better mothers (Thompson, *Breckie*, 158). However, she minimizes her reform efforts of this period in later writings about her life, focusing instead on the lives and loss of her two children.

Tragedy struck again in 1916. She lost her second child, born prematurely, only a few hours after her birth; her son died of a bacterial infection barely two years later. She and her second husband soon separated, and she began the portion of her life that would lead to the Frontier Nursing Service. She moved to Europe in 1918 to help citizens to recover from the ravages of war (Goan 54). As she honed her organizational and fund-raising skills, her focus on children's welfare led her to attempt to help France reform its nursing standards, and later she traveled to England for training as a certified nurse-midwife (Goan 62). She spent time in northern Scotland, observing how healthcare might be provided in an inaccessible, sparsely populated region. Finally, in 1923, she returned to Kentucky and formalized the organization that would become the Frontier Nursing Service (Goan 82). By the time her fundraising memoir *Wide Neighborhoods* was published in 1952, she had successfully refashioned herself as a reformer and medical expert who repurposed her own grief to improve the experience of motherhood for other women.

This version of her life has considerable traction, but rhetorical analysis of her earlier publications and writings, as well as the Services' *Quarterly Bulletins* and other fundraising material, reveal a less certain path. In this respect, Breckinridge's life reminds us of the importance of resisting hero-narratives and examining the vicissitudes and complexities of life. Rather than rely on the power of public memory, (re)telling life stories that subsume the rhetor to the same ideologies that gave her power, a more thorough analysis can allow us to wrestle with the past and how it has created the present more fully.

With Breckinridge's basic biography established, I now turn to a selection of texts to analyze how she curated public perception of herself and her organization, as well as how that changed over time. As I mentioned earlier, Breckinridge wished to control her

legacy, and one way in which she did so was to ensure that not all texts from her life were available for archival storage. Goan notes that, as Breckinridge wrote *Wide Neighborhoods*, she asked friends to return letters for destruction; she also destroyed journals after she published the books *Breckie, His First Four Years, 1914 – 1918* and *Wide Neighborhoods*. Without these materials, it is difficult to fully pierce the veil of the legacy she curated. Even so, a chronological examination of her publications as well as how she presented motherhood in fundraising material reveal indirectly how she changed in response to her personal tragedies and the world in which she lived. The materials I focus on include the oral histories of 1978, particularly of those who knew her in her youth or in the beginning of the Frontier Nursing Service; the books she published, recognizing that she wrote them with specific goals delineated in the books themselves; the Service's *Quarterly Bulletins*; and the many photographs preserved in these various texts and archival collections at University of Kentucky.

2.4 Embodied Rhetoric: Women's Visual Representation of Themselves

One of the most common images of Mary Breckinridge comes from the early years of the Frontier Nursing Service (see Figure 1, left). Seated on a horse on the edges of a river, she wears the Service's nurses' uniform. She is alone in this image but for her horse, surrounded by tree branches and rocks. Looking directly at the camera, she sits with a straight back, astride her horse. She appears certain, confident, and professional in a wild countryside.



Figure 1: Mary Breckinridge in Kentucky (left: circa 1920s; right: circa 1950s) (*Frontier Nursing Service Collection*)

Variations of these images appear in multiple places, including advertising for Frontier Nursing University in the Lexington, Kentucky, airport. One taken near the end of her life, probably in the late 1950s (see Figure 1, right) shows her on a horse of similar color as the older photograph. She fords the river (probably the same one) with her saddlebags holding the necessary medical supplies to safely deliver newborns. The images help to sustain the story of a driven, capable professional dedicated to help the most vulnerable infants in the remotest region of the country. Whether young or elderly, she appears to be someone ready to answer the need to deliver healthy babies in an environment that too often precludes such.



Figure 2: Newspaper Clipping, March 4, 1932, Pennsylvania Times (*Frontier Nursing Service Collection*)

Other photographs during her years with the Frontier Nursing Service portray her in clothes more suitable for offices or charity meetings or highlight her face (see Figure 2). In each, she wore dark, simple clothing and kept her hair cut short with minimal styling. I looked through several scrapbooks containing clippings from major newspapers in most medium to large cities in the East and Midwest organized by year. Many of these clippings contained images of Breckinridge, sometimes on her horse, but often positioning her face so she gazed to the side toward the news story or directly at the camera, appearing to look at the reader. She typically wore a dark blouse and simple jewelry. I realized that she or her organization likely provided the information and images published in these clippings, and that only a select few images were ever widely circulated. Even in the society pages in New York newspapers covering social lives and events of young women who volunteered for summers at the Frontier Nursing Service relied on those images, if they published images of Breckinridge at all. The film *Forgotten Frontier*, frequently shown at fundraising events, shows Breckinridge only briefly visible in the background and only then at the filmmaker's urging, dressed plainly.

Her careful attention to her visibility and clothing helped to visually strengthen the appearance of her commitment to her cause.

Carol Mattingly's *Appropriate(ing) Dress: Women's Rhetorical Style in Nineteenth Century America* analyzes the ways in which women's dress in that period became a focus of not only those who reported on women rhetors, but also how those same rhetors managed their appearance to gain credibility as they spoke publicly. Mattingly notes that gender "was constructed largely in the visual impact created by their clothing and appearance" (1). Gendered expectations, often assessed through clothing, circumscribed and constrained women's credibility, but careful attention to their dress also allowed those same women to leverage social expectations to their benefit. Lindahl Buchanan's *Regendering Delivery* also examines the ways in which women adapted to gendered social expectations to speak out on social issues, noting that rhetors such as Emma Willard "employed indirect methods of delivery in order to mask her unconventional gender and discursive performances" (81). By speaking and acting in ways expected of women and employing "correspondence, conversation, and reading," the three "cornerstones of the feminine delivery style" (83), Willard was able influence those who might not otherwise have listened to her arguments for women's education. Her use of cultural codes of gender and citizenship allowed her to cast a revolutionary argument as a natural course of events and necessary for the good of the nation.

Following the Civil War into the early twentieth century, women tended to shape public opinion through organizations "that enabled networking and built solidarity," continuing to claim their expertise through their moral and domestic spheres, drawing on the emerging power of science, especially statistics, and circulating otherwise ignored

views through their own networks (George et al. 4). As women entered professions and workplaces in large numbers in the 1920s and 1930s, women's bodies and dress disrupted spaces previously inhabited by men (Applegarth 130).

To help women navigate and negotiate changing professional norms, one long-running publication, the *Independent Woman*, offered substantial advice to wage-earning women. The periodical advised women to pay close attention to their appearance in all respects, their clothing, hairstyle, behavior, and the impression of their overall appearance. This attention helped to reinforce traditional gender norms in the workplace. Such attention helped to make their entry into paid work less disruptive but made disruption of dominant gender ideologies less likely. The way in which women dressed in public workplaces enacted gendered values; emerging conventions of professional dress helped to reinforce those values (Applegarth 133).

Scholars who study fashion and clothing also recognize the interplay of choice of dress and identity as well as how that identity is formed in relation with cultural values of gender. In her introduction in the companion book (published in 1989) to the Smithsonian's exhibit on historical clothing, home economist Barbara Schreier wrote:

...we wanted to explore the historical relationship between our outward appearance and our definitions of masculinity and femininity. In the process we discovered a dialogue anchored in polarities—between males and females, public life and private life, ideals and reality. It is a dialogue encompassing voices that resonate with cultural differences, class variations, and ethnic diversity. It is a dialogue that adjusts its vocabulary to accommodate the values and images endorsed by tradition as well as the promise of new gender arrangements. (1)

In other words, Breckinridge's careful attention to her appearance helped to minimize her own presence in favor of her work. Her choice of clothing, whether suitable to the rugged environment of southeastern Kentucky or plain and dark dresses for social or fundraising events, adhered to the advice that clothing should not draw attention to her, reinforcing gendered norms that demanded quiet from women. At the same time, doing so allowed more complete focus on her mission.

While certain jobs had long been associated with wearing specialized clothing, the association between work and uniform developed as various fields professionalized. Valerie Steele's contribution to the Smithsonian volume on historical clothing styles explored the ways in which gender expectations were incorporated as uniforms became professionally symbolic in the late nineteenth and early twentieth century. In medicine, the physician's white coat, originally from scientific laboratories, symbolized the scientific authority of the medical expert in the hospital (Steele 74). Nurses, on the other hand, did not universally wear white-only uniforms until the 1930s. Their caps also became symbolic of the nursing profession (Steele 76); in turn, the domination of the profession by women also tended to imbue nursing, a previously male profession, with feminine ideals.

Like Emma Willard and other women rhetors, and professional women who 'dressed the part,' careful attention to one's dress is an essential element of the rhetorical power that these women possessed. A keen awareness of gendered dress expectations helped shape impressions and understandings of the woman speaking. Breckinridge leveraged this rhetorical skill to enhance her own credibility and rhetorical power.

2.4.1 *The True Woman Becomes an Activist*

I was unable to view images from Breckinridge's youth. However, her memoir, *Wide Neighborhoods*, as well as historian Goan's descriptions of her family's history and gender values, suggest indirectly that Breckinridge was taught to dress appropriately to public expectations of her station. Goan writes that Breckinridge "received clear lessons to behave" like most young women and adolescent girls in the postbellum South (23).

Through private nurses, specialized girls' schools, and family lessons, Breckinridge was taught to "speak and read and write with social grace" (22), to be ready to marry anyone (presumably of a similar class) and follow him anywhere. Her husband would in turn financially support her fully throughout her life. In her memoir she wrote, "Marriage...meant that [a woman] gave up her own ambitions, which she might cherish otherwise...Marriage called upon a woman for renunciation, entire and complete" (48).

Breckinridge remembered herself as willing to be that kind of wife with her first husband, but her second marriage made clear she wished to take on a larger service role outside the home while she maintained fidelity to the ideals of True Womanhood. Her book *Breckie, his Four Years, 1914 – 1918¹* provides greater insight into how she navigated this phase of her life, as well as how she presented herself rhetorically.

Almost immediately after the title page, the reader encounters a photo of Breckinridge's son, Breckie, aged two years and nine months. He sits on what appears to be a bench, smiling and looking away from the camera. He wears sturdy shoes and short pants. This photo reinforces the title, that this book is a record of her son's life. However, the text is more than that. While all

¹ The text I used for this portion of the analysis is a scanned reproduction of the original from Scholar Select. The text is in the public domain. Thus, content may be missing or illegible in this version.

her writing circles back around to her son, we read about her vision of his future as a Breckinridge, her beliefs and attitudes about raising a healthy, intelligent child, and her values. Her son's photograph focuses the readers' attention on his life, but his life is not possible without her actions as a mother. Her son is constructed as the center of her married life, but he also functions as an extension of her motherhood. The symbiotic relationship between mother and child is evident in her preface:

I reared him as carefully as I could by those scientific laws of child development whose discovery in recent years has revolutionized the care of little children in body and mind, and this partly explains his wholesomeness and the growing reasonableness of his third and fourth years. But Breckie was a creature of higher endowments than my own...He was not my little child only but my master as well, and the best friend I ever had. (v)

Breckinridge also attributed her success as mother, visible through his "wholesomeness" and "reasonableness," to partnering with new scientific theories of child development in line with scientific motherhood. This emerging concept situated motherhood as women's primary duty, but a duty that required instruction from experts for the best results. Breckinridge did have domestic workers in the home who performed many daily household responsibilities, but she followed experts' recommendations in caring for her son. According to these parenting texts, such parenting allowed Breckie to begin his life ready to live up to his own natural potential, or the 'higher endowments' that his mother should guide him to reach.

The book continues in chronological order, with the next image of Breckinridge's mother holding the infant. Katherine Breckinridge focuses her gaze on the infant, who is dressed in a long white gown. Breckinridge tells us she gave birth at her parents' home; presumably, her

father or a sibling was available to take pictures of Mary and Breckie together. However, she chose to publish the photograph of grandmother and child, de-emphasizing her role in the early days of his life. Almost immediately, Breckinridge's retelling of her son's life focused on his potential, learning of nature around him, his love of reading (6), and later, a nebulous vision of the public service denied her by her gender (28). Her son comes first in her day-to-day life; she "tucks in the odds and ends of the rest of my life about [his schedule]" (11). Her work, now that she is an actual mother, was to serve her child, even to the near-total neglect of other responsibilities or hobbies, and she herself faded into the background in the only picture included of her holding her son.

In her chapter on studio portraiture at the turn of the century, rhetoric scholar Fleckenstein notes how prominent photographer Frances Benjamin Johnston fulfilled presentation of gendered expectations through photos celebrating the Victorian ideal of purity, piety, and commitment to the home. Johnston's photographs evoked this in several ways: downcast eyes, simple clothing, and womanly beauty and grace (90). In the image of Breckinridge holding her son reproduced in Figure 3, we see similar values on display (note this photo is a reproduction of the original out-of-print text, which affects quality).



Figure 3; Mary Breckenridge, her son, and her dog (Thompson, *Breckie*)

Breckenridge sits in what appears to be her parlor or living room, with a lamp and an open window behind her. Wearing a simple white dress with her hair done up in a manner typical for married women prior to the 1920s, she holds her five-month-old son in her lap. Her son and her small dog gaze directly at the camera, but she herself looks downward at her son. Her son's central location is symbolic of his importance to the family. By extension, his mother becomes relatively unimportant except as a mechanism of support. Physically, emotionally, and mentally, she holds him until he can hold himself. That this is the only photo of Breckenridge in the book helps to reinforce her duty to serve her family.

The open window reminds a reader familiar with her son's raising that he often slept on the porch in the outside air, with his mother on a mattress on the floor next to him (Thompson, *Breckie*, 6). His importance is thus reinforced, as his mother sacrifices her comfort for her son's desires and health. Though the quality of the photograph scan makes it difficult to be sure, this seems to be a common room in their home where guests may have been entertained, further reinforcing Breckenridge's commitment to domestic affairs. Her white dress also suggests purity,

in keeping with the ideals of motherhood current in the post-Civil War era. The remaining photos in the book reinforce her secondary importance. One photo places her son and husband in the center of the page. Other photos show her son playing alone or in care of a nurse. It certainly is common for a mother to take many photos of her children, and it is possible there were few photos of her with her son. However, that she chose only one of herself, and that one of holding her son, reflected her belief in the importance of motherhood as an act and an ideal.

As the book traced her son's growth, her responsibility to guide her son to a public life of service appeared more frequently. She wrote:

Ever since I had become a trained nurse the question of neglected children had troubled my heart, and after motherhood came to me the sight of undernourished or misunderstood children was oftentimes intolerable. I did what I could, of course, in my own environment, but the thought was ever present with me that in rearing Breckinridge I was doing far more than my puny services could ever accomplish had I devoted them to nothing by Child Welfare. (Thompson, *Breckie*, 93)

Of course, she would eventually devote herself to the welfare of children with the Frontier Nursing Service, but it does not seem at this time that she was considering such a goal. Rather, “Where I could have only helped a little here and there he, in his manhood a leader of men, would strike at the roots of poverty, ignorance, and vice and rescue childhood—sacrificed from countless ages to these three evil gods” (*Breckie*, 93). This sentence makes clear that she, a mother, could only make minor changes through her own charitable work, influencing a limited number of people. On the other hand, her son could change the country, even the world, by eliminating ‘these three evil gods’ in service of children everywhere. As a man, he could “learn

how to help the little children and [he] won't let them be hungry and cold" (*Breckie*, 83). She copied from a journal written when her son was two "...if I am living in a backwater now I am rearing a man child who will emerge some day to lead the crisis of his age" (*Breckie*, 29). While she could achieve some good in her community, the world was to be changed by men such as her son. In this way, she abided by the ideals of True Womanhood. Her influence extended only to her family, but through that influence she could play a small part in making profound change.

Yet the pull to serve more than just her family seemed to remain, and she was not blindly obedient to all she had been taught about being a woman. While living in Eureka Springs, she engaged in activities that served to advance her causes of maternal and infant health, promoted the nursing profession in Arkansas, and urged other young women to prepare themselves for motherhood through education and clean living. The opening quote of this chapter comes from one of these publications, *Southern Woman's Magazine*, for which she wrote a series titled "Motherhood—A Career." She argued in the first part that "it is [women's] duty and their right to know something about babies before babies are born" (Thompson, "Motherhood," November, 41). She also reinforced a central tenet of scientific motherhood in this first article, that no woman is born knowing how to be a mother and that is why Breckinridge's article was necessary. Failing to avail oneself of this education to fulfill each child's potential means "bring[ing] her children into the world...with no lofty purpose for bearing them...then even the joy of their coming is nullified through her ignorance" (Thompson, "Motherhood," November, 41). In keeping with her family's teachings, she advocated for the centrality of motherhood to a woman's life, but she centers scientific knowledge regarding reproduction and child-rearing as a crucial element of fulfilling that responsibility. Her argument that motherhood was not an inborn

talent repeats a central element of scientific motherhood, in that all women needed expert instruction to be successful in parenting.

To alleviate the presumed general lack of knowledge most women possessed regarding their bodies, pregnancy, and mothering young children, Breckinridge provided extensive, specific instructions. Calling out an education that prioritized Latin and math over biology, she argued that a woman ignorant of her own body and the biology of motherhood violated the right of every child “to be well-born” (Thompson, “Motherhood,” November, 41). From ensuring one does not marry a “rake” who can cause a child’s blindness (probably due to a sexually transmitted disease), to moderating one’s energy spent on the wedding, young women are cautioned to make choices that benefit their children. Once pregnant, these women are instructed to follow a careful diet and engage medical support staff. No aspect of young motherhood is neglected, as Breckinridge even provided an exact list of necessary baby clothes and advice on when to buy a crib.

The regular advice to consult and defer to medical experts reflects the changing authority of physicians in conjunction with emergence of scientific medicine from the late nineteenth century. Breckinridge’s care to position herself between her readers and the experts they engaged for their specific pregnancies also mirrors the rhetorical strategies and impact of women physicians’ engagement with health advice. Carolyn Skinner found that women sought information about their bodies but were reluctant to ask questions of men in their lives. Women’s physicians disseminated books and lectures to provide that advice to lay audiences. The existing genre of advice books allowed women physicians to “develop rhetorical characters as professional, authoritative, expert, and consequently due a significant degree of respect” (77). Women physicians of the late nineteenth century had to teach their readers to view them as

authoritative. However, by second decade of the twentieth century, Breckinridge would have been able to utilize that existing ethos to instruct her own readers. She also was able to capitalize on a growing tradition of sex education led by women across the country, not all of whom were medical practitioners (Jensen xv). As a nurse, Breckinridge did not have the same authority as physicians. Hence, despite her own expert knowledge, she adopts the intermediary position of directing her readers to defer to and trust in their own medical team. In other words, her article served a necessary and useful purpose, but it is not the endpoint of successful mothering. Even so, with the foundation laid by this article and the individual woman's acquiescence to physician direction, a reader should expect the one image included within the series: a healthy infant wrapped in a blanket on a scale, registering the proper weight for his age (January, 35).

Publications, talks, and correspondence allowed Breckinridge to speak to regional and perhaps national audiences. However, as the wife of the president of Crescent College, she had certain social responsibilities to the students. Like many college presidents' wives, Breckinridge used her status to further her activist goals for healthier mothers and children. For instance, she organized a public celebration of Child Welfare Week in 1917, including exhibits, baby improvement contests, speeches given by experts, and a well-attended parade in which even the Boy Scouts participated (Thompson, *Breckie*, 98). Beyond her speeches, parades, and articles, Breckinridge taught classes on Child Welfare and Hygiene to promote the scientifically-based education she believed central to twentieth-century parenting. Affluent young women, like the students of Crescent College, were targets of maternalist and eugenic educational initiatives to produce larger, healthier families to counteract the growing presence of non-whites in the country. Child Welfare Week, and to an extent her class, was part of a larger trend of concern for the mental, physical, and genetic fitness of the citizens of the United States. While *Breckie* does

not explicitly discuss eugenic thinking, historian Nancy Isenberg notes that eugenics thinking translated into various government incentives (including expansion of the child tax credit) as well as community events that promoted healthier children (193). While these initiatives often built on racist assumptions and fears, these events were often popular because motherhood was so dangerous (Ladd-Taylor, *Mother-Work*, 6). Additional support such as ‘better baby’ initiatives, regardless of racial animus, promised better outcomes. The widespread need for such knowledge and support helped to explain their broad appeal, including activists such as Margaret Sanger, who relied on Anglo-Saxon imagery to promote family planning and contraception (Buchanan 49), and black maternalist activists such as Anna Julia Cooper and Mary Church Terrell Hope adopting maternalist ideals in working to better maternal health outcomes for Black families (Boris 216).

It is difficult to tease out how much of Breckinridge’s work was based on the racism of the early twentieth century, though hints, such as discouraging ethnic intermarriage, do appear in *Wide Neighborhoods* (351). The book about her son included a passage in which she disapproves of his speech mimicking his first nurse, calling it “a mixture of baby talk and darkey talk” (Thompson, *Breckie*, 47). Furthermore, the modern midwifery profession acknowledges Breckinridge’s racism and refusal to treat patients of color (Hassan-Sheffield, personal communication). Breckinridge’s own arguments in her earlier writing followed eugenics lines: “that only women of good blood who married men of good blood should reproduce” (Thompson, *Breckie*, 45). However, the materials analyzed here do not explicitly link Breckinridge with the worst of eugenics-justified abuses.

Breckinridge's time as a mother ended abruptly, however, and she no longer had the indirect influence that her son would have made possible. Her grief at her children's death profoundly impacted her, as this passage about her daughter indicates:

From a distance comes the voice of my little son at play—but close by me, closer than any but the dead can reach, is that other voice of my baby girl. I hear it in the lapping of the lake upon the shore, in the wind sighing softly in the cedar and hemlock trees, I feel it in the brave sunlight and the wide stretches of water and sky, and in the spicy odors of the forest...But I still waken at night and imagine she is a live baby and I am nursing her, and Breckinridge (to whom I talk of his little sister who has gone to live beyond the stars) has asked me for 'anuder 'ittle sister' that won't go so far away. Beyond the stars! As if one knew! She is closer yet. (Thompson, *Breckie*, 64)

When her son became ill two years later, she tended him closely for days. The last night he lived, she soothed him to sleep in “the last hours before hope left us altogether” (Thompson, *Breckie*, 186). He passed “at five minutes after three in the afternoon” (Thompson, *Breckie*, 187).

Interestingly, the scientific thinking that had informed her parenting and her own social work appeared at the end of her son's life, as she recorded the exact minute he drew his last breath.

With the loss of her children and the dissolution of her marriage, she turned to her social activism. One of her first events was a summer speaking tour sponsored by the U.S. Children's Bureau and the Council for National Defense. Though the latter nominally existed to encourage the home front during World War I, the Council also participated in initiatives that promoted citizen's public health and child welfare (Connolly and Golden 902). Through these events, motherhood becomes a citizen's duty no different from the duty required of soldiers.

Breckinridge's theme remained consistent: healthy children. In one newspaper clipping, title "Aid Infants, Save Nation," the writer summarized the speech with key quotes outlining how Breckinridge put the issues of child welfare before her audience: Not only mothers should be concerned about a child, but the nation as a whole must be involved. Because children are the future of the nation, they must be saved. The article distinguishes Breckinridge as a "woman as citizen" who argued that World War I is for the future of the nation—the children—and if their needs are not met, then "they will not benefit as much as they should by the immense sacrifices on the battlefields of France." Another talk in Brainerd, Minnesota, advertised the event as part of the "program of the Children's Year as endorsed by President Wilson" hosted by the Council for National Defense. A talk in St. Paul, Minnesota, was advertised as hosted by the state women's committee and the Council for National Defense. The language and sponsoring organizations make clear the linkage between child welfare, women's duty as citizens, women's clubs, patriotism, and soldiers fighting to preserve the nation (see Figure 4).

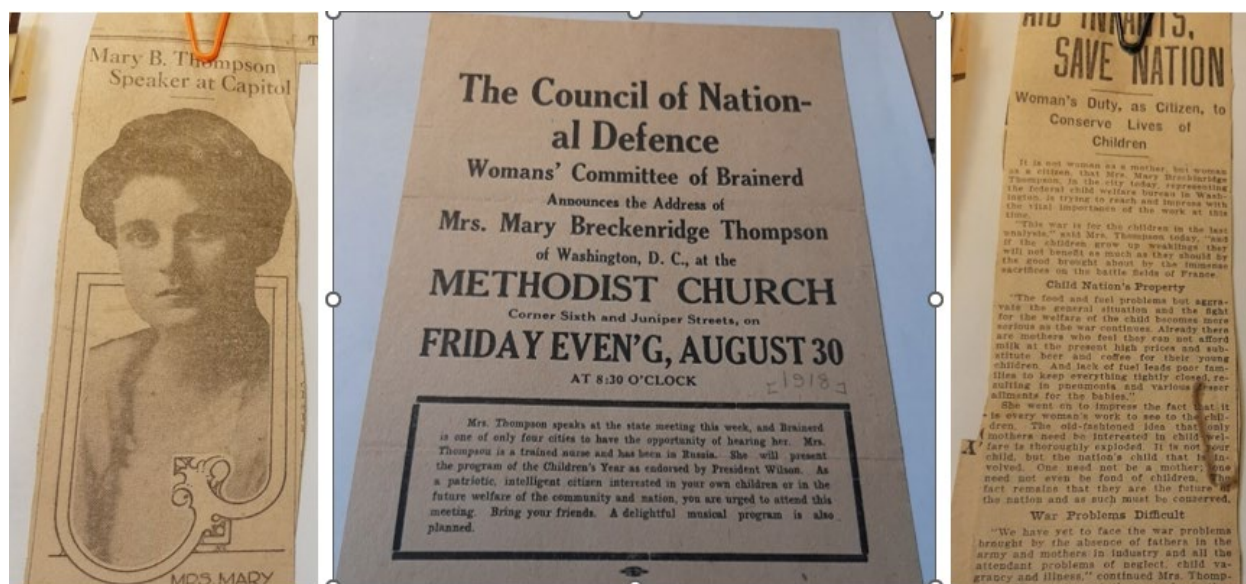


Figure 4: Newspaper Clippings and Speech Flyer (*Frontier Nursing Service Collection*)

The newspaper story followed a common line of maternalism reasoning: the children are the future of the nation. If the children are not cared for, then the nation's future is in jeopardy. What the nation will be can be seen in the present, in the bodies of the children themselves. Drawing on patriotic language indicative of support for World War I, the article argued that for soldiers' deaths to be meaningful, those who remained behind must do their part to ensure there will be a future. The participation of the Council of National Defense strengthens the association of motherhood and patriotic duty. Their sponsorship of Breckinridge's tour, while within their organization's scope, equated child welfare with defense of the American way of life.

The relatively larger space dedicated to the summary of the talk itself makes the cause more prominent than any individual. Because this cause is something everyone can be involved in, child welfare became a collaborative, patriotic effort. While this language suggests that everyone has a responsibility to ensuring child welfare, the linkage with war implies another unfortunate consequence. If the soldier does not survive the war, his sacrifice still makes possible preservation of the country and its ideals. Similarly, the present is responsible for the future at home, in that women must be willing to sacrifice themselves to ensure healthy children. Of course, activists also worked toward better medical and social supports for mothers so they could bear and raise their children without dying. However, this line of reasoning positions the mother as secondary, important primarily, or even only, for her reproductive capacity. Thus, her own autonomy is sacrificed to the patriotic goal of having more healthy children. Child Welfare becomes a goal as worthy as victory in Europe. In fact, Breckinridge employed the same metaphors in describing the mission of the Frontier Nursing Service.

2.4.2 *A Career of Service to Motherhood*

Breckinridge's work with CARD (Committee for Devastated France) receives rather less attention in terms of publicity in the archival material, though she discussed her experiences in some detail in her book *Wide Neighborhoods*. She painted her time in France as preparation for being director of the Frontier Nursing Service. While helping run the organization, she attempted to abate the privation wrought by the destruction of the war and leveraged charitable networks to donate material resources. After CARD, she worked with individuals wishing to professionalize nursing in France, completed midwifery training in London, and observed district nursing practices of the British National Health Service in far northern Scotland. In this time, her goals seemed coalesce around what would become the Frontier Nursing Service. As she continued her professional and personal shift, available images also changed.

The government of France defined the Devastated Region of France, or Zone Rouge/Red Zone, as a roughly 460 square mile region of northeastern France destroyed and nearly uninhabitable due to human and animal remains, property damage, and unexploded ordnance. To this day, some villages in the area have never been rebuilt, chemicals still poison the land and water, and farmers still frequently find artillery shells and mines (Flynn; Thornton). Following the World War I armistice, however, non-relocated villagers in the Red Zone had to cope with the near-total destruction of their homes and farms. Activist Anne Morgan, known also for her support for union activity among female garment workers in New York, and her physician friend Anne Dike organized CARD, or the American Committee for Devastated France (The Morgan Library & Museum).

The image in Figure 5 was taken of a small number of the over 350 volunteers working with CARD. The women are arranged in two rows, some leaning against the building while

others are seated on the ground. These women's work demanded long hours and often considerable labor, so their choice not to stand in regimented rows may reflect a certain level of casualness or even tiredness. Each woman looks confidently at the camera. The women wear clothing appropriate to the time as well as the work context – long skirts, but serviceable shoes and coats. Except for their shirts, the clothing itself is dark. Given the devastation of the area and the labor involved in distributing and delivering supplies, working with villagers, and assisting in farm recovery, dark clothing ensures the women do not appear as dirty as they would with white clothing. The business-like nature of their work is even reflected in the ties they wear. These women clearly came to work, not for leisure or pleasure.



Figure 5: Mary Breckinridge and Volunteers of CARD (*Frontier Nursing Service Collection*)

Unlike prior images of Breckinridge, this photo removes her from a domestic setting surrounded by her home and family, and places her outside the home in a region known to be destroyed (Anne Morgan widely disseminated photographs of the region to raise awareness and funds). The volunteers' clothing appears similar to that of nurses and female support personnel of World War I: A military-style jacket with white blouse and tie, and ankle-length skirt. The lighter clothing is the horizon blue of the French army (Parker 2). The style and color of clothing

linked their organization and services to military authority. This image does not celebrate the domestic, feminine virtues of an “Angel of the House” (Fleckenstein 90). These women are now professional, practical, and public: they have a mission to achieve in the service of ameliorating war devastation.

Mary Breckinridge’s practical uniform disappeared from images of her upon her return to the United States and early newspaper publicity efforts. She was not in all Frontier Nursing Service photos. As the Service expanded, photos of the people of Leslie County, especially babies and young children, increasingly appeared in news stories and *Bulletin* issues along with images of the nurse-midwives of the Frontier Nursing Service. However, when Breckinridge was depicted, she appeared to wear dresses that a woman of her age and class might be expected to wear. She often looked directly at the camera, by extension at the readers, or gazed at the newspaper story. She returned home, abandoning, at least temporarily, the functional clothing necessary in war-torn France for expected feminine clothing. Even so, her dresses are not as ruffled or fancy as in images of other society women of the period, a difference particularly evident in New York City society pages highlighting debutante community service. Furthermore, Breckinridge’s hair was short, in a page-style haircut cut, rather than the bound-up long hair of pictures from her marriage. She acquiesced to social expectations to a degree but abandoned affectations that might signal vanity. Combined with her frequent gaze at the stories themselves, readers could still see the practical working woman even as she did not explicitly contradict expected feminine values. Readers could recognize the mission as most important to Mary Breckinridge.

By the early 1930s, pictures of Breckinridge changed once again. Often a head shot only, the images showed her with short hair and a dark shirt, with her looking straight at the camera

more frequently. Most clippings saved from this period that include her image use the same photograph. This may be because she did not have or wish to have so many photographs that she could choose a variety, but more importantly, in seeing the same image repeatedly (when an image of her is available), we get a sense that though she is the person in charge, she is not the most important person here. Her plain clothes and hair suggest she was little concerned with a glamorous appearance as one might expect from a woman of privileged status. While she recognized that certain appearances were expected of her because of her status and gender, her work was more important than her appearance. Figure 6 provides examples of images typical of newspaper publicity articles from the late 1920s through the mid-1930s.



Figure 6: Breckinridge newspaper photos (New York Times 1927; Rhode Island 1933; Minneapolis 1935) (*Frontier Nursing Service Collection*)

In the 1930s, publicity images focused more on young children and the nurse-midwives of Leslie County. Post-World War II images highlighted the medical personnel as well as the traditional

ways of life associated with Appalachia, as well as the region's modernization. However, the image of Breckinridge in the distinctive riding uniform of the Frontier Nursing Service endured. Until her death in 1965, she was pictured as garbed against the elements and the geography, confidently astride her horse. She was no longer the mother of her early years, or a newly divorced woman finding her way. She maintained fidelity to the ideals of motherhood of her upbringing and early adult life, as she adopted the cause of infant and maternal health as her *raison d'être*. Her visual transition reflected her personal transition.

2.5 Conclusion

Like the rhetors that Lindahl Buchanan analyzed in *Rhetorics of Motherhood* and to a degree the women idealized in the conduct manuals in Nan Johnson's *Gender and Rhetorical Space in American Life, 1866 – 1910*, Breckinridge embodied the domestic 'queen of the hearth' – devoted to her children and her family, active in public service when her family duties allowed. The loss of her family spurred her to a new version of herself, but one that still honored the gender hierarchy that called for women to serve the nation through motherhood. Because motherhood "pervades American discourse" (Buchanan, *Rhetorics of Motherhood*, 5), doing so allowed Breckinridge considerable authority, but also kept her within the bounds of public life deemed acceptable for women who wished to enact reform in the Progressive Era.

3 INTERRUPTION AND ADVOCACY: DEVELOPING PROFESSIONAL ETHOS

In early 1928, physician Dr. Keith of Hyden, Kentucky, accused Mary Breckinridge and her organization (then known as the Kentucky Committee for Mothers and Babies) of illegal and unethical conduct. Those allegations included the charge that Breckinridge allowed her nurses to act as doctors. In response, Breckinridge wrote in part:

Third, I would advise you that the nurses here have at no time ever, under any circumstances, given medical advice. The household remedies, which are the only ones they administer without individual prescription, are done under the authorization of two physicians whose names you see on this letterhead. Any regular medical drug is given under the special orders of a physician only.

(Frontier Nursing Service Collection)

The letter from Dr. Keith is not preserved in the Frontier Nursing Service records. However, extrapolating from Breckinridge's response, Dr. Keith apparently charged that the organization breached medical territory physicians had only recently begun to control. In fact, by 1900, nearly every state required that physicians, who diagnosed and prescribed medical treatments, attend 'reputable' medical schools and pass a licensing exam to practice medicine (Grossman 50). Those who had not received education or permission in accordance with these regulations were deemed as illegally practicing medicine. Control of education and professional practice allowed physicians to limit competition from alternative practitioners and promoted identification of medicine "as an exclusive and learned profession" at a time when professional and business Americans increasingly preferred scientific experts (Grossman 51). While physicians and medical organizations increasingly narrowed the legal boundaries of who could practice medicine in general, obstetricians who sought to obtain control over reproductive care targeted

midwives as incompetent, dangerous, non-scientific, and generally incapable of properly caring for pregnant women who wished a successful birth. In allying themselves with state officials regarding issues of health, physicians “create[d] a shared authoritative knowledge regarding management of health care for mothers and babies” (Craven 197). These attacks created lasting distrust of midwives and their abilities, so that to this day midwives and birth attendants (such as doulas) must fight an uphill battle to gain legal recognition and the right to practice (Craven 210). However, in the 1920s, the “midwife question” – what to do with these decidedly non-medical but highly trusted community members – was not yet settled. Most women, particularly those in communities of color, in poor rural or urban areas, or recent still relied on traditional means of support during childbirth. Furthermore, the professionalization of nursing offered another avenue for reproductive care, particularly in areas with few physicians. Exactly who would occupy the role of expert, obstetric medical provider was not yet fully decided; Breckinridge took advantage of the unsettled nature of the debate in staffing the Frontier Nursing Service. Negotiating a shifting a rhetorical and legal landscape that privileged the authority and knowledge of physicians, she engaged in the rhetorical strategies of interruption and advocacy (Ryan et al. ix-x) to claim professional credibility and expertise of the organization’s certified nurse-midwives.

Breckinridge entered a contentious moment in defining medicine and who were best suited to belong to the profession, but the debate itself had been ongoing since the early years of the United States. In fact, Lewis Grossman, historian of *Choose Your Own Medicine: Freedom of Therapeutic Choice in America*, locates the origins of what he terms *American Health Libertarianism*, the right to choose medical therapies as either patient or physician, to impassioned speeches given by Benjamin Rush before the American Revolution (12). Through

the nineteenth century, attitudes and laws reflecting those perceptions tended to favor therapeutic freedom. Not until the nineteenth century, as heroic medicine (treatments that favored bleeding, purgatives, and the like) fell out of favor and germ theory grew to inform medical perspectives and practice (Grossman 47, 48), did medical professionals begin to define and enforce educational and legal boundaries that we recognize as the default in the twenty-first century. Prior to this period, medicine was often viewed as an art rather than a scientifically-based discipline, and legislation tended to protect patients' rights to choose treatments and practitioners (Grossman 51). Courts tended to support physicians' efforts in sympathy with their own efforts to professionalize and license the practice of law; the Supreme Court upheld the validity of medical licensing in 1889 (Grossman 57). Physicians also made medical education more rigorous (and more difficult to access) after the American Medical Association's 1910 Flexner Report (Rooks 23; Wells 9). However, significant legal and rhetorical space remained open for what became known as alternative therapies (such as spiritual healing and Christian Science) (Grossman 52).

A later analysis of obstetrics education found that medical schools were particularly substandard in their education of obstetricians (Rooks 25). Furthermore, there simply were not enough obstetricians entering practice to meet the demand across the country, especially for women who were poor, immigrant, of color, or rural. Obstetricians preferred to practice where they could charge higher fees. This preference for more affluent, white patients in urban areas did not stop physicians from arguing over the role of midwives, however. Some wanted to eliminate midwives altogether (through legal means), while others more practically argued for supervised midwifery until the number of qualified obstetricians met demand (Taussig 90). Even those who admitted that numbers alone dictated reliance on midwives until the emerging medical

system could care for all pregnant women distrusted community and foreign-trained midwives. Taussig, a prominent Progressive-Era obstetrician, suggested relying on licensed nurses who had taken relevant courses to work under physician supervision (90), a suggestion that amounted to simply replacing existing midwives with nurses who had graduate midwifery training.

Even as philosophical and legal arguments raged, high maternal and infant mortality rates required practical solutions. Out of concern for the high number of women and children dying for preventable reasons the Sheppard-Towner Maternity and Infancy Protection Act of 1921 was passed, the first federally funded social welfare act. Many states, including Kentucky, used part of this federal money to establish a training and sort of licensing framework for lay midwives in largely rural areas (Goan 59), placing their practice under control of the state. Though funding ended in 1926, and the act expired in 1929 (Ladd-Taylor, "My Work," 329), midwifery oversight and training programs continued to exist in a number of states for some years (Campbell, *Folks Do Get Born*, 11), a fact that demonstrates the staying power of alternatives to establishment-educated, trained, and licensed natal care providers. In fact, women began to turn from hospital births in the 1970s (Craven 197), leading to a resurgence in midwifery. However, midwives never completely disappeared. Religious, Indigenous, some immigrant communities (Lay 14), and communities of color (Fraser 210) utilized midwives until at least the 1950s; for many African American women, segregated care and cost often meant that midwives were the only real option (Harper 90). Christa Craven, a medical anthropologist, noted that "underground midwives attended homebirths during the 1980s and 1990s in Virginia with little interference from the state" (198). Since the 1990s, traditional birth attendants and direct-entry midwives (those who do not receive training or licensing through graduate nurse-midwifery programs) have increasingly fought for and gained legal recognition and authority to provide pregnancy-

related care. Even so, maternal healthcare has become increasingly harder to access, with nearly seven million American women living in counties with limited or no maternity care services (Scott).

In the United States, actual and rhetorical space for alternative practices has existed as long as orthodox medicine has. Regarding maternal health care, a gap between available physician-provided services and the need for them has existed for over a century. However, the public health and medical reform movements of the early twentieth century provided hope that women who had not been able to access expert medical care soon could, and preventable harm and deaths caused by unavailable, inaccessible, or poor care could be eliminated. The early years of the Frontier Nursing Service existed in this backdrop, showing how a local organization responded to the national discussion over maternal care and “the Midwife Problem.” In doing so, Mary Breckinridge and her organization created a rhetorical and legal opportunity for certified nurse-midwives to practice, in line with newly emerging professionalization standards. She also addressed classism, demonstrating that poor white communities could benefit from the turn to modern, scientific medicine. However, her racial attitudes represented a lost opportunity in extending that care to women of color who, historically, often have been both ignored and harmed by the medical establishment, contributing to continued racial disparities in maternal outcomes in twenty-first century America.

In this chapter, I rely on Ryan et al.’s ethos framework set out in *Rethinking Ethos: A Feminist Ecological Approach to Rhetoric* to analyze how Breckinridge interrupted arguments over medical authority to advocate for her own, intermediate model. I begin with a discussion of ethos, specifically in a feminist ecology, to provide theoretical backdrop for how marginalized rhetors claim and exercise their own ethos. I focus specifically on gendered perspectives of ethos

to highlight that, while considerable opportunity existed for Breckinridge to build ethos for her organization and its staff, she did so in a landscape often hostile to women's authority and credibility in professional spaces (as explored in Chapter 2). Then, to illuminate the shifting terrain of medical authority in the early twentieth century, I examine how physicians interrupted and claimed expertise over ethos carried by traditional birth attendants and care providers. Next, I turn to Breckinridge's own interruption and advocacy strategies to portray her organization and staff as credible, expert professionals operating within acceptable boundaries of medical care. I rely primarily on published material from the early years of the Service in my analysis. These materials include the *Frontier Nursing Service Quarterly Bulletins*, the fundraising film *The Forgotten Frontier*, and other supporting materials from the Frontier Nursing Archives at the University of Kentucky. The *Bulletins* and the film were primarily directed at a national audience who were or relied on physicians licensed through the emerging orthodox medical framework for their own care, and thus likely not sympathetic to midwives. Therefore, they demonstrate how Mary Breckinridge 'talked back' to those in favor of eliminating midwifery and established an admittedly limited rhetorical (and legal) space for certain midwives.

3.1 Battling over Ethos

Traditionally, ethos has often been understood as based on one's own individual character, a conception that ignores the sociocultural forces that limit and inscribe the ways credibility operates in social interactions. Instead, Ryan et al. propose thinking of ethos ecologically, taking into account "women's public ethos construction relative to time, contexts, and different relationships" (2). An ecological approach to ethos allows for consideration of its social context, particularly when the rhetors are traditionally marginalized. The patterns Ryan et al. observe as women attempt to navigate and establish ethos fall under three broad rhetorical

moves: interrupt dominant representations of women's ethos, advocate in transformative ways, and relate to others (3). In particular, marginalized rhetors experience "socially determined ethē...ascribed to women [that] do not lend themselves readily to public speaking" (Ryan et al. 2). Thus, these rhetors must create and define new ethē to speak, paying close attention to social expectations and beliefs to establish the trust prerequisite to a sympathetic listening, as they appropriate, adapt, and generate ethos.

Relying on certain audience expectations, however, can limit the impact that these rhetors have. For example, Buchanan notes that the reliance on the trope of motherhood often limits women in their reach, and their memory after their time in a public sphere has passed. This is, as Buchanan notes, "slippery rhetorical terrain for women, on the one hand, affording them authority and credibility but, on the other, positioning them disadvantageously within the gendered status quo" (*Rhetorics of Motherhood*, xvii). Buchanan's case study of Dianne Nash, a civil rights leader, demonstrates this tendency: as Nash and her husband battled to keep her out of jail, they relied on her status as mother to achieve the immediate goal of maintaining her freedom. As a result, she rhetorically became the "courageous, committed sidekick" primarily defined through her motherhood rather than remembered as an accomplished Civil Rights activist (Buchanan, *Rhetorics of Motherhood*, 79). Nash escaped a jail sentence, but at the expense of her civil rights role and legacy.

The 'gendered status quo' sees motherhood as the default and pinnacle to which women should aspire. This force is so powerful that Buchanan defines the concept of Mother as operating as a "god term within public discourse" that "connotes a myriad of positive associations." In contrast, its converse, Woman, is the antithesis (*Rhetorics of Motherhood*, 8). Therefore, women who pursue public lives must compensate for the tendencies to be seen, and

judged, against cultural concepts of motherhood. Many do so successfully. Yet, women's contributions and rhetorical work is often remade and eventually erased, so that succeeding generations of women must fight similar rhetorical battles (George et al. 2). In one example, Myatt's essay in Gaillet and Bailey's *Remembering Differently* analyzes the erasure of Rosamund Franklin's legacy, a scientist who researched DNA in the mid-nineteenth century. Her early death combined with what Myatt terms 'distortion of memory' (48) served to erase her significant research contributions. Without spouse or children to promote her scientific legacy, Franklin's reputation was at risk of being rewritten. Watson, the author of *Double Helix*, portrayed her as a difficult woman who did not understand her research results and who was unwilling to share, promoting a distorted version of the scientist and researcher she actually was. Watson went as far as to falsely represent Franklin's knowledge and discoveries, shifting credit for discovery of the helical structure of DNA to himself (Myatt 49). By drawing on cultural assumptions that women should be submissive, decorative, and supportive rather than discoverers, Watson was able to successfully erase Franklin's research from public memory.

Women have worked hard to establish themselves as career professionals in a social space that views those women who choose to do so as suspicious. In the early decades of the twentieth century, as professional opportunities for women expanded, "symbolic associations and material arrangements surrounding women and work underwent considerable renovation" (Applegarth 130). For instance, Fleckenstein in Gold and Enoch's *Women at Work* collection analyzes how Frances Benjamin Johnston, an acclaimed professional photographer at the turn of the twentieth century, advocated for female photographers as professionally, artistically, and commercially successful. A key way Johnston achieved this is through recoding masculine virtues of the career as feminine both verbally and visually (85; 91). In Applegarth's analysis of

Independent Women, a popular early twentieth century periodical intended for working women, she highlighted *embodied epideictic*, defining it as:

textual depictions of behavior that invite or articulate an attitude of praise of blame...[that] “invite women professionals to take up an attitude of attentiveness—even vigilance—toward their dress, hair, demeanor, and overall performance. (Applegarth 130-132)

Domestic science worked to redefine the traditional women’s provinces of home and kitchen as scientific and professional (Enoch 102) in the same period. Capitalizing on both traditional women’s occupations and merging them with new ways of examining the world, in conjunction with rhetorical work done to celebrate those professional gains, women professionals worked rhetorically to position themselves as competent and capable, with knowledge and work worth paying attention to.

The intersectionality of class and race further impact a rhetor’s ability to speak, be heard, and remembered, as Sojourner Truth’s “Ain’t I a Woman?” speech argues so plaintively. But as central as motherhood has historically been to women’s archetypal identity, her experiential authority can be interrupted, redefined, and relocated. Such is what happened to reproductive healthcare in the United States. As the medical profession staked out and asserted their authority in the late nineteenth and early twentieth centuries, the emerging field of obstetrics worked to interrupt the authority of traditional (primarily female) midwives, claiming for themselves the authority, knowledge, and rhetorical control over women’s pregnancies (and pregnant bodies). This occurred in tandem with legislative changes that exerted real consequences for and control over women who did not accede to this shifting authority. Marika Siegel’s book *The Rhetoric of Pregnancy* examines the role of pregnancy manuals in this shift, concluding that “pregnant

bodies can become the sites through which social, political, and environmental risks are managed[;]...the role of doctors, employers, law enforcement officials, fathers, and other ‘enforcers’ of prenatal care practices is to impose such discipline” (13). When such rules are imposed successfully, and the pregnant woman obeys, the result is, first, a healthy, normal fetus, the end goal of her pregnancy. The mother-to-be’s role is to submit to authority, guidance, and surveillance, primarily of medical professionals, who must identify and mitigate abnormality (Seigel 13). What was once the province of women moved to the purview of scientific medicine.

Physicians, legislators, and public figures engaged in the “midwife question” from about 1910 to 1935, pushing to eliminate midwives from modern medical practices altogether. Rooks’ history of midwifery categorizes the debate’s themes into three strands: that midwives were incompetent; pregnancy is dangerous and thus requires trained medical providers; and the reliance of midwives meant that obstetricians could neither practice nor advance their discipline (24). Midwives saw their purview drastically limited by the 1930s, from attending about forty percent of births in 1915 to less than eleven percent in 1935. Statistics by race and region show an even starker divide. In 1935, midwives attended only 4.5% of all white births, in contrast to more than half of births in communities of color (Devitt 48). By the turn of the twentieth century, most middle- and upper-class women preferred obstetricians, whether at home or hospital, and had almost entirely moved to hospitals by the 1950s (Rooks 22). Midwives became strongly associated with communities of color and the poor in general as the ‘midwife debate’ gained steam (Fraser 37). Marginalized by clientele, community, class, and race, midwives did not have the power to successfully resist a sustained transgression of their ethos. Pregnancy ceased to become ‘women’s work’ and instead a social responsibility entrusted to the authority of various enforcers in women’s lives. Though women and midwives have pushed back, distrust of

midwives persists medically, legally, and socially (see Lay's *The Rhetoric of Midwifery*, Fraser's *African American Midwifery in the South*, and Craven's "Claiming Respectable American Motherhood"). More recently, reporting has focused on the extensive lobbying of traditional birth attendants such as doulas (Maxie; Webb-Hahn).

To achieve such a fundamental shift in managing pregnancy and birth, the medical profession had several rhetorical tasks before it. They had to construct themselves as the authority on all things related to pregnancy and birth as well as construct midwives as unfit. In this shifting rhetorical terrain, Mary Breckenridge had to acknowledge prevailing discourses on what defined a professional medical care provider as well as increasing limits on midwifery. Simultaneously, she had to advocate for authority and expertise of her own organization and staff to audiences unfamiliar with professional nurse-midwives and who regarded traditional midwives as dangerous. The ecological ethe strategies laid out by Ryan et al. in *Rethinking Ethos* provide an analytical lens for these rhetorical shifts: interruption, advocacy, and relation (ix). This chapter focuses on the shifting terrain of interruptions and the role of advocacy: as obstetricians interrupted the ethos of midwives, Mary Breckenridge carved out a rhetorical space for nurse-midwives by advocating for her staff's credibility. The third strategy, relating, will be discussed in greater detail in Chapter 5, as the ethos constructed through her choice of relations also served to limit the legacy and impact of her work.

3.2 Claiming Authority: Interrupting Midwives' Expertise

Ryan et al. theorize interruption as a way for women rhetors to break into and "change the status quo of dominant values and practices" (23). Rhetors who do so entail risks of negative reputations, but interruptions can "uncover and disrupt habits that hinder communications across differences" (23). While the concept of interruptions is theorized particular to marginalized

rhetors in *Rethinking Ethos*, it can also be a successful strategy for those in power. For example, obstetricians and legislators also used interruption to rhetorically and legally draw medicalized childbirth into their expert medical purview. As physicians interrupted midwives' ethos, their privileged and powerful status provided their arguments with greater weight. In fact, several emerging fields cast themselves in scientific terms with the aim to change differing traditions and lifestyles to fit dominant, white cultural narratives. Enoch's examination of the emergence of domestic science as a professional discipline illustrates this trend: as primarily women domestic scientists sought professionalize women's work in the home, they "crafted their ethos in contrast to their working-class immigrant clientele" (102). As domestic scientists carved out a rhetorical space to educate others on the most up-to-date knowledge regarding the home and nutrition, those they chose to educate were asked to assimilate to the culture of the domestic scientists while traditional knowledge was attacked as backwards, superstitious, and insufficient to ensure their families' health. In other words, as Enoch quotes, they wished to "make over immigrants and poor into 'real Americans'" (Cravens, cited in Enoch 102). Physicians engaged in a similar strategy, defining approaches that did not fit into the scientifically-informed medicalized model of childbirth as deadly.

Physicians benefitted from alliances with legislators in shifting motherhood from a private to a public concern. By "allying...with state concerns for public health and safety and by assuming the role of arbiters of social standards around mothering and childbirth" (Craven 198), physicians worked together with reformers of the early twentieth century who made motherhood a political and social concern. This work, just like that of domestic scientists wishing to reform the home according to newly developing scientific standards, occurred in a larger context in which cultural and class elites wished to remake the nation in a particular cultural and racial way.

Increased immigration and falling white birthrates seemed to threaten the cultural identity of the United States (Ladd-Taylor, *Mother-Work*, 7). Identifying (and sterilizing) those they saw as unfit to reproduce, encouraging reproduction among those that were, and educating those with potential were all ways to manage the racial and cultural makeup of the nation. Doing so required motherhood be monitored, regulated, and ultimately controlled by a state and medical system. An unattributed 1918 article reporting a talk Breckinridge gave on promoting infant and maternal health justifies this concern:

The old-fashioned idea that only mothers need be interested in child welfare is thoroughly exploded. It is not your child, but the nation's child. One need not be a mother; one need not even be fond of children. The fact remains that they are the future of the nation and as such must be conserved. (*Frontier Nursing Service Collection*)

High rates of maternal and infant mortality meant that women became vested in making healthy pregnancies and births a social rather than a purely private concern, as well. Interrupting the traditional authority of midwives, marginalized by virtue of their race, origin, and class already, allowed greater surveillance and control over the nation's future. Doctors argued that mothers had been trusted to their own devices, and those of midwives, for too long, and they had failed to rise to the task. These rhetorical interruptions did mean better care for many women, and did help to regulate and limit unethical, untrained, or unlicensed physicians, thereby generally improving the state of medical care among those fortunate enough to have access. However, these changes meant overall fewer providers for decades (Devitt 49; Wells 9), a fact recognized by some obstetricians at the time (Taussig 90). And for communities of color, an "underlying ambivalence about how much, if any, financial resources should be directed at African American

communities” (Fraser 27) meant women in those communities relied primarily on midwives for decades and continue to have much higher rates of infant and maternal mortality to this day. As important as it was to support women who were tasked with creating the nation’s future, it mattered far less in communities of color or for poor women.

Progressive Era reformers did attempt to bring better care to communities living on the margins, albeit in problematic ways. Their political effort to make the state more responsible for healthy mothers and children culminated in the 1921 Sheppard-Towner Act, which provided a framework and funding for states to measure the health of their children, to educate care providers who were not graduates of formal medical institutions and address ongoing social and health issues that harmed so many women and their children (Goan 40). Though the Act expired in 1929, institutions created under its purview continue to exist in some form today (Departments of Family and Children Services and other similar names). Community midwife educational programs, for example, existed well after World War II in many states (Fraser 210).

Beginning in the late nineteenth century, but especially after the blistering Flexner Report in 1910, the medical profession organized a systematic way of training, licensing, and practicing. This privileged a body of knowledge attainable only through specific medical schools. Those who passed the educational requirements were able to obtain a license to legally practice; those who did not were liable to prosecution and jail time (Wells 8-9). All other practitioners were legally excluded from treating patients, working in hospitals, and providing medicine (Rooks 23) and faced the threat of criminal charges if they transgressed legal limits. Following the professionalization of medicine, women tended toward nursing education (Wells 9). One outcome was that nurses were expected to be subservient to doctors, simply carrying out his orders (Taussig 91). Such changes improved the standard of care and significantly reduced

medical providers who actively perpetrated harm on their patients, but they also limited access. Such a hierarchy reflected and reinforced gendered assumptions of professional medical knowledge: whether professional or patient, women did as doctors ordered, who knew best by virtue of their gender and training.

As the modern educational and licensing system emerged, the location of authoritative knowledge shifted. Obstetricians and their legislative partners placed greater trust in formal documents and school-based training rather than experiential ethos. Legal authority to practice medicine required formal education, as Kentucky's law indicated: "[the State Board of Health] shall issue a certificate to any reputable physician who desires to practice medicine in this State who has passed a satisfactory examination before it in the branches of medicine taught in reputable medical colleges" ("Judge Kirby's Decision," 151). Shifting the source of authoritative knowledge interrupted traditional ways of knowing. By defining and controlling what was acceptable knowledge, physicians claimed control over pregnancy and childbirth.

Physicians and legislators also needed to interrupt acceptance of mothers' knowledge and experience as authoritative and acceptable. They historically justified their regulations "by highlighting the 'pathological' practices of mothers—particularly mothers who challenge dominant American trends and ideologies around childbirth" (Craven 195). For far too many women of color and poor white women, this led to forced sterilization (Hartman 37; Roberts 70; Ross and Solinger 13). Agencies such as the U. S. Children's Bureau and an entire cottage industry intended to promote "Better Babies and Fitter Families" reached a wide swath of individuals (Isenberg 193). Even though often these campaigns grew out of fears at the changing racial makeup of the United States, many women clamored for information that would make pregnancy and childbirth less dangerous (Ladd-Taylor, "My Work," 325). The merging of

scientific medicine with ideologies of motherhood promised a better, safer birthing and mothering experience (Goan 10). However, the constant repetition of a scientific medical approach to pregnancy and the gradual removal of traditional providers reinforced the ethos of obstetricians. The practical effects of limiting allowable care providers also forced women into the medical system.

Like the unnamed writer of the 1918 article quoted above, doctors explicitly linked civilization to modern scientific medicine; by implication, reliance on traditional birth attendants were remnants of a superstitious past. A 1924 article published in the *Virginia Medical Monthly* argued that women's nonchalance towards childbirth and labor and low value placed on trained professionals meant that "about fifteen or twenty thousand [women] die yearly from [childbirth]," which ranked amongst "tuberculosis and heart disease" as the leading causes of death in the early part of the twentieth century. According to this doctor, the United States ranked nearly last amongst "civilized" countries in maternal mortality rates and the loss of children in the first month of life was nearly as great (Andrews 148 – 149). These concerns were echoed across the country. A 1914 article in the *American Journal of Public Health*, written by a licensed nurse, claims "The blot on our escutcheon is the fact that we give the safekeeping of nearly one-half of our mothers and babies into the hands of women who are ignorant, careless, and dirty because they are neither trained nor supervised." This trust of untrained attendants is of incredible concern, because "This type of midwife knows nothing of hygiene, asepsis, or antisepsis and is often practically responsible for the death and invalidism of mothers as well as the death, blindness, and mental and physical impairments of infants" (van Blarcom 198). In other words, traditional birth attendants, because they received no official training, could know nothing of modern medical standards of care. Therefore, they were too dangerous to allow.

Lay midwives' ignorance could substantially increase the risk of puerperal fever, an often-fatal infection associated with unhygienic medical deliveries. A 1922 editorial in the *Kentucky Medical Journal* blames the state's "so-called midwives," arguing that "most of these women are ignorant, dirty, and are really a greater danger in the lying-in room than would be a totally inexperienced person who would do nothing but sit by the bedside and hold the hands of the suffering woman" ("Midwives" 514). Even though women in the early twentieth century generally experienced worse outcomes when attended by obstetricians in hospitals (van Blarcom 198), the editorial writer directly links lack of knowledge of medicine and cleanliness to the dangers inherent in childbirth. In this scenario, having the wrong kind of knowledge is worse than having none. Presumably, someone with no medical training would passively offer comfort rather than insert themselves into the obstetricians' domain.

The editorial continued to describe the training courses that lay midwives were required to attend in order to continue to provide services: the nurses taught "not only the simple methods of cleanliness necessary for all who are about the lying-in room and how to make and keep clean the beds and linens of their patrons, but especially teach them the signs and indications which should cause them to call for a physician" (514). Lay midwives came away from this workshop with two roles: keeping the room clean and calling for a doctor when needed. Cleanliness is of first concern here, especially of making and keeping a bed properly; actual medical interventions (in this case, including overseeing birth) are to be reserved for the licensed physician, and the midwife is to remain passive and silent except to serve as a bridge between the mother and proper medical care. In fact, if she cannot even be trusted to make a bed properly, then she certainly cannot be trusted to safely deliver a child. These midwives "know nothing of hygiene" (van Blarcom 198) and therefore endangered the mother and child. It seems cleaning, making the

bed, and observing was all she is truly fit to do: the “signs and indications” of needing a physician were apparently “the most important feature of this work” (“Midwives,” 514).

Ultimately, the physicians argued, they had the legal permission and knowledge to manage pregnancy and childbirth. A 1917 *Kentucky Medical Journal* report, “Judge Kirby’s Decision,” of a legal case regarding whether a nurse could administer anesthesia cited a Massachusetts case in which a midwife was convicted of practicing medicine illegally: “when there is the occasional use of obstetrical instruments and a habit of prescribing...such a course of conduct constitutes a practice of medicine *in one of its branches*...obstetrics as a matter of common knowledge has long been treated as a highly important branch of the science of medicine” (154, emphasis in original). In fact, obstetrics had not ‘long been treated’ in this way. However, the language of the court decision indicated that the judge supported and enforced the legal status of the medical model of pregnancy and childbirth.

Mary Breckenridge engaged in this interruption of traditional ways of knowing and caring for pregnant women, as well. In competition with local lay midwives, Mary Breckinridge characterized their care “as medieval as the nursing care ‘of the sick in the public hospitals’ in France” (116). Her first *Bulletin* situates the type of care available to most women in the United States as firmly behind the times:

So that while we could not conceive of eighteenth century care for our young soldiers, we continue to supply eighteenth century obstetrics to our young mothers, and have lost more women in childbirth in our history as a nation than men on the field of battle, and over a hundred thousand of our youngest and most defenseless citizens pass annually from one dark cradle to another with hardly a gap between. (1)

The comparison made clear the scale and significance of reproductive tragedies across the nation. She linked war and soldiers' deaths to childbirth and chided the country for providing modern medicine only to those wounded in battle, in defense of the nation far from home. The far greater tragedy was to provide substandard care for those at home, particularly the most vulnerable. If giving soldiers adequate medical care was vital to protecting the nation, then 'young mothers' deserved the same regard for the same reason.

Breckinridge did qualify her claims regarding community midwives' abilities in her 1952 memoir: many were "intelligent women whose homes were tidy and gay with flowers." Sixteen of the fifty-three were above average; ten were "filthy, as were their homes." She noted she respected them "despite their superstitious practices" because the women in the area had "no one else to stand by" (116 – 117). In this construction, the midwives were simply women, some of better and some of worse character and habits. She avoided characterizing all these women as dangerous, recognizing a range of ability and cleanliness that other writings often did not at the height of the 'midwife debate.' Under the Sheppard-Towner Act, many of these midwives would have attended regular meetings with the county public health nurse to receive medical training, which probably contributed to at least some of them being seen as "better-class midwives." Even so, Breckinridge made clear that ability and minimal training is no stand-in for specialized professionals. She wrote:

Even the most intelligent midwives had no advance knowledge of the possible complications in their maternity cases because, unlike the midwives in France, they had had no training whatsoever. A few of them had attended conferences held by nurses under the State Bureau of Child Hygiene. But the

nurses themselves were not midwives and, therefore, unable to teach them how to look for abnormalities, even if such things could be taught in conferences. (117)

She made it clear that, despite the best intentions of the Sheppard-Towner-funded training and supervision system and the dutiful study of lay midwives themselves, only school-trained specialists in maternity care could provide the full medical support needed for women to have successful pregnancies and healthy children. She aligned instead with obstetricians like prominent Canadian obstetrician Fred Taussig, who had written in 1910: “It is better to train the nurse to do midwifery than to attempt to teach the midwife some of the rudiments of nursing” because “the foundation for the proper care of the woman in confinement lies in the work of the nurse” (89). Women who graduated from nursing school were trained in the standards of care that the field of medicine agreed nurses should adhere to, but, more importantly, these same women would be able to provide basic emergency care and “could be trusted to send for help in any serious case and would naturally send at once for the man specially trained in obstetrics” (90). Nurses would not overstep their bounds, for, Taussig argued, “her higher moral sense” and her field’s threat of censure would keep her in bounds. Apparently, traditional midwives did not have the same sense of responsibility or consequences.

Responding to the rhetorical interruption of traditional reproductive care, Breckinridge placed her service in between lay midwives and obstetricians. She defined her staff as specialized nurse professionals capable of providing the midwifery care that women desperately needed where obstetricians were in short supply. In this way, she drew on the interruption technique as described by Moraga: allowing a rhetor to “interrogate normalizing tendencies...[which] become agentive ways to transform values” (cited in Ryan et al. 25). As obstetricians worked to change the value traditionally placed on midwives, Mary Breckinridge

worked to shift the narrative to allow for space for certified nurse-midwives to practice where obstetricians did not.

3.3 Talking Back: Advocating for Professional Midwives

As midwives fell into further disregard, Mary Breckinridge risked her organization, staffed almost entirely by nurses and nurse-midwives, holding the same status increasingly associated with lay midwives. Like many women, these midwives already “were not recognized as worthy of public participation” (Ryan et al. 7); their statuses as immigrant, rural or urban poor, Indigenous, or Black further cemented their marginalized status. Thus, Mary Breckinridge faced a two-pronged problem to advocate for her staff and organization’s ethos. Having turned down funds from the from the Child Health Association and the Kentucky Bureau of Child and Maternal Health (Goan 75), she needed to solicit substantial funds from affluent donors outside Kentucky, from the very same individuals who preferred obstetricians. She also needed the mothers in Leslie County to realize the benefits of her organizations’ services to expand its reach. She did not have the resources of a national professional organization like the American Medical Association to support her, as none for midwives existed until 1955 (ACNM, “History”; Rooks 42). Though she sought federal funding available through the Sheppard-Towner Act, she refused the state’s conditions. Other options for funding either were denied or required her to sacrifice her organization’s independence, a choice she was unwilling to make. Therefore, advocacy fell to Breckinridge. She advocated for her midwives’ abilities with “continuous ethical consideration and adjustments to power, relationships, experiences, and imagined versus real needs” (Ryan et al. 111), constructing their ethos as professional experts. This section focuses on two ways she advocated for her staff: publications and uniforms.

3.3.1 Publications

From the first year her organization operated, Mary Breckinridge published the quarterly *Frontier Nursing Service Bulletin*, sent to all who donated to her organization. Throughout the *Bulletins*, Breckinridge responded to national conversations to advocate for her organization's ethos while requesting funds. She imbued her organization, its staff, and its mission with considerable gravitas. She portrayed them as working professionally, competently, morally, and firmly within the legal bounds set upon them. The notion that nurses' training provided a moral superiority had been espoused by physicians, such as obstetrician Taussig, who had written that nurses ostensibly had a "higher moral sense" (90). This superior morality is supported by the extensive training and education Breckinridge's nurses were required to obtain. The *Bulletins* demonstrate that the nurse-midwives of the Frontier Nursing Service were indeed well-suited to their task according to the requirements of the modern medical system.

State laws barred all but doctors from the duties "usually performed by physicians," and Kentucky, as well as other states, prosecuted those who infringed upon physicians' territory without the matching license. While exact boundaries between nursing and doctoring were not fully settled, as the dearth of prior precedents indicated, those who overstepped were punished. Thus, Breckinridge had to carefully delineate not only what her staff were trained to do, but also ensure they followed the law; otherwise, she risked losing funding and being shut down. Of course, in a remote area such as Leslie County, restricting her staff too far could result in potentially fatal outcomes, precisely what the establishment of the Service was supposed to prevent. With physician oversight, her donors could be assured that her staff operated well within legal bounds and relied on physicians as legally and medically appropriate. In the first *Quarterly*

Bulletin, published in 1925, a description of the first Committee meeting to establish the organization highlighted accessibility of doctors:

As for the difficult case, which would absolutely require a doctor, for that the midwife, trained to observe signs of the abnormal, just as the nurse is trained to observe them in the nursing of sick people, either would secure medical attention from the nearest possible point, *in time*, or arrange by means of passes generously offered by the Louisville and Nashville railroad...to transport such a case to the nearest city hospital, *in time*. (emphasis in original, 3)

The choice of the word *observe* and the explicit linking of the midwife to standards of nursing care highlight the nature of their work. Painting the midwife as taking an observational role makes clear she did not intervene when doctors should. Instead, the nurse-midwife supported a normal delivery, but was alert for signs of complications beyond her training and purview. She then ensured a mother with labor complications was transported to the nearest qualified professional before such labor turned for the worse. Choosing to italicize *in time* in this document further accentuates how skilled the midwife was in her observations. She became an intermediary for when nature cannot take its course. Mary Breckinridge (who seems to have written most of the early *Bulletins*) threaded the needle of the competing concerns that intertwine goals of modern medical care: appropriate roles of each professional and the needs of the women in labor. Here, she argued that, in most cases, midwives would only assist what is already natural, but when this is not enough, midwives are professional and well-trained enough to call for the true expert. Firmly entrenched in the gendered hierarchy and standards of modern

medicine, they knew when they should *not* intervene. In this way, Breckinridge's certified nurse-midwives were no threat to the authority of physicians.

Later *Bulletins* continued to push back against the perception that all midwives were dangerous, repeatedly referencing nurses' education and often using the terms *nurse* and *midwife* interchangeably. Such focus reinforces the idea that the Frontier Nursing Service medical personnel were *nurses* first, and as such knew, as Taussig wrote in 1917, "through her higher moral sense and better medical education...her limitations" (91). These limitations were based in gender, schooling, and professional standards. The third issue of the 1931 *Bulletin* attributes several entries to nurses: "Nancy's Baby" is written by a staff nurse at the Draper Center; "Transporting Children with Pneumonia" is an excerpt from a nurse's letter. Such repeated reference to the word *nurse* invoked and normalized that these professionals are nurses first. In fact, the vignettes suggested they nurse-midwives spent more time as pediatric nurses than assisting in deliveries. Even so, it was not enough to be only nurses. The third issue of the 1927 *Bulletin* indicated that two nurses "have completed a year's work with us. This is as long as a nurse can remain with us, who has not yet had her mid wifery training" (6). More education was even better: the 1931 winter *Bulletin* noted that two of its staff members were working towards higher degrees: one was earning her degree at a nearby Teacher's College, while another, who had already earned an M. A., was working on her Ph. D. in Public Health Nursing.

The *Bulletin* further highlighted the expertise of their staff by highlighting various vignettes of their patients. The 1931 Winter volume told the story of two children, ages ten and seven, so weak with pneumonia they had to be carried to the hospital, probably the Hyden hospital (12). The Winter 1927 issue documented a premature infant healthy at six weeks and

four pounds as well as a “destitute mother to shelter under [Wendover]’s roof and stay until the arrival of her ten pound boy, Paul Aden Mosley” (4). Annual reports in the summer bulletins highlighted the sheer numbers of patients and variety of care they received the year before. For example, the Summer 1933 *Bulletin* noted that due to ongoing financial impacts of the Depression, they had reduced staff, who responded by working increased hours to care for “8,695 people in 1,891 families. Of these 5,543 were children, including 2,535 babies and toddlers” (3). The numbers are presented in a similar vein in nearly every *Bulletin*, highlighting the scope of care the Service provided. These reports and vignettes hammered home not only how much work the staff did, but also that the work they did was well within the legal purview of their licensing. In fact, these kinds of reports also assured subscribers that hospital doctors in nearby Kentucky cities of Lexington, Louisville, Cincinnati, and Richmond received emergency cases, while the organization’s medical director managed routine medical services. Additional doctors from the area came as requested for not only emergencies but also at the request of individuals. Recipients of the *Bulletins* could rest easy that their donations supported modern, rather than primitive medicine, and thus the children of the women of Leslie County were in the best possible hands, both nurse-midwife and physician.

3.3.2 Visually Professional: Advocating through Dress

Breckinridge did not confine her ethos-building to written newsletters. She also carefully designed uniforms for her staff. Clothing has long been recognized as an important feature of how women are evaluated, especially when they have a public presence. Carol Mattingly’s introduction to *Appropriate[ing] Dress: Women’s Rhetorical Style in Nineteenth-Century America* noted that women in the nineteenth century were “so fully defined according to gender, and because gender was based largely upon dress and appearance, women understood the

importance of clothing in negotiating the rigid power structure that permitted them little access to public attention” (5). As public women of the nineteenth century broke restrictions on their public speaking, they appropriated and capitalized on a rhetoric of dress to achieve success (6). Concessions to the expectations of women’s dress, in conjunction with their domestic personas, allowed these women’s public activities to reach a wider audience.

However, by the 1920s, women, according to George et al., “spent less time demanding a right to speak and more time proving her right to act (and be judged) in accordance with the norms of her chosen field” (7). George et al. link women’s identification with professionalism to the scientific professionalization movement of the late nineteenth century (7). As in earlier public speaking arenas, in the workplace women had to pay attention to their clothing to portray respectability, capability, and trustworthiness. Attentiveness to dress resulted in professional and social rewards (Applegarth 137); women who neglected their work clothing were seen as less capable (Applegarth 138). Aware of the close association between appearance and perceptions of competence, Mary Breckinridge carefully designed summer and winter uniforms of her nurse-midwives so that their clothes visually represented the Service as professional and competent.

The nursing profession emerged earlier than the professional clothing that Applegarth analyzed in her article, but the general pattern follows similar rhetorical trends. As nursing professionalized and the first nursing schools opened in the 1870s, a mostly standardized uniform emerged. The first nursing school to mandate a uniform, at Bellevue Hospital in New York City, concluded that standard uniforms were both economical and psychologically beneficial, but it was not until the 1890s that nurses’ clothes standardized across nursing schools. These uniforms allowed ready recognition of the nurse as a professional (Kalisch and Kalisch 79 – 81). Fashion historian Parker noted that World War I required additional changes for military

nurses so their clothing mirrored soldiers' uniforms, with concessions to gendered clothing expectations. Some differences allowed these women to maintain some distinctiveness—they very clearly were not soldiers while wearing skirts—but, like soldiers, they dressed in military-inspired functional clothing, often in dark colors. Nurses working in field hospitals wore white aprons and caps more recognizable as a post-World War II nurses' uniform. Figure 7 shows a World War I nurse in her outdoor uniform to the left, and a military nurse in her hospital uniform to the right (Library of Congress records indicate that nurses who transitioned from the Red Cross to military status maintained their Red Cross markers).



Figure 7: US Army Nurse in outdoor uniform (*Feder, left*); Nurse in Indoor Uniform (*Bain News Service, right*) (*Library of Congress*)

Parker both recognized the inspiration of nursing and World War I-era uniforms, particularly those of CARD, in the Service's uniforms. Breckinridge's own speeches reinforced this linkage between war and the Service's work, as she characterized the work to save children

as a war as early as 1918, in which a newspaper report of a speech quoted her as saying “This war is for the children in the last analysis, and if the children grow up weaklings they will not benefit as much as they should by the good brought about by the immense sacrifices on the battle fields of France.” Grohowski and Hart’s chapter “Not Simply ‘Freeing the Men to Fight’” note that the Armed Forces’ tendency to employ women temporarily tended to historically reinforce the failure to recognize women as important to war efforts as men (93). Once finished with their work, they went home and got married (94), giving up their uniforms. However, Breckinridge makes clear that such work, at least as far as the health of women and children are concerned, was never ended. Failure to focus on children’s dire need would render soldiers’ sacrifices meaningless. Breckinridge brought this perspective to her staff’s clothing, sending the message that, in military-inspired uniforms and with the seriousness and competence of any well-trained healthcare professional, the nurse-midwives served as soldiers might in the face of great need.

In Figure 8 below, published in 1933 in a Worcester, Massachusetts, newspaper, a Frontier Nursing Service nurse in dark clothing with hat, gloves, and boots crosses a river on her way to a patient’s home. Her white shirt and tie are covered in a vest, with an overcoat to protect her from the elements. Her saddlebag is visible behind her. Once in a patients’ home, the nurse divested herself of her coat and vest, donning a white apron to maintain cleanliness, as seen in this image following from a 1933 Chicago newspaper. A major accusation against lay midwives was their lack of hygiene; the clean, crisp white apron and shirt help to show that, despite the messy business of medicine and birthing, these nurse-midwives not only abided by modern standards of cleanliness but did so uniformly. The caption identifies each person in the image, with the nurse “the woman in the overseas cap.” This was a particular style of hat adopted by the US military for its World War soldiers (“New Cap Ready”). Wearing a military cap while

attending to the young mother showed that the nurse is not just professional, but competent to almost military precision. Well-ordered clothing reflects and produces a ‘well-ordered mind’ and the ability to conform with the needs of the position (Applegarth 138). From *Bulletins* and the newspaper articles, readers across the country already knew the staff was well educated; seeing their distinctive clothing maintained to military precision and medical cleanliness reinforced the association between the nurses and their abilities.



Figure 8: Left: FNS Nurse in Riding Uniform; Right: FNS Nurse at a Home Delivery (*Frontier Nursing Service Collection*)

The depiction of Service nurse-midwives remained consistent across media. The fundraising silent film *Forgotten Frontier* also showed footage of nurses in their uniforms riding through the countryside. In the first fifteen minutes, a man arrives in the dead of night in winter weather to summon the midwife, who sent him to saddle her horse while she dressed and packed her saddlebags. She carefully organized her supplies, and then dressed practically for the weather in her winter uniform with a heavy poncho against the snow. A nurse on horseback traveled

faster than the local man on a mule, further highlighting how urgently nurse midwives treated their mission. So, viewers were treated to the sight a woman on a mission: carefully dressed, with forty-two pounds of supplies in her saddlebags (according to the text on screen), astride a horse. When she reached the icy, fast-flowing creek, she crossed carefully, but with no hesitation. Her uniform, her attitude, and her actions mirrored each other: practical, dedicated, and capable.

In the cabin, she removed the coat, making visible her white blouse and distinctive tie. She did not remove her cap or tie, further visibly marking her as a professional midwife on duty. The repetition and consistency reinforce the connection between uniform, competence, and medicine: well-dressed, well-ordered, well-educated. Donors watching the film could be assured Leslie County mothers received the best modern healthcare.

Later in the film, viewers see the nurses on duty at the Hyden hospital. Like nurses in hospitals across the nation, they wore a white dress, white stockings, white shoes, and distinctive white caps. To the donors viewing the film, they would have known instantly that the infants were being turned over to trained professionals. The two nurses have slightly different caps, which signaled the different schools they attended. Because nurses wore their caps in the style of their school long after graduation, other medical professionals were able associate the reputation of the school with the nurses' abilities (Kalisch and Kalisch 82), so any nurses viewing the films would have had additional information regarding the specializations and abilities of the nurses filmed.

Though the film is in black and white, the constant use of white is apparent. In the saddlebags are white layettes and blankets; the nurses wear white shirts or nursing uniforms; even the couriers, who assisted in supply and transport, wore white shirts. The surroundings,

however, are often darker. Some of this is because of the quality of filming; the creator of the film noted that, at times, weather conditions combined with a hand cranked camera meant that some film was over, and other under, exposed (Patterson, Oral History). However, when Marvin Breckinridge Patterson returned to finish filming with an automatic camera, that exposure is more constant. And, of course, the region was not electrified at the time of filming, so the only bright light available would have been the sun. But the contrast does help to associate the nurse-midwives and thus the Service with cleanliness—a trait that lay midwives simply did not have, as anyone following the midwife debate knew. The similarity of their clothing across locations, types of work, and seasons also helps to reinforce that the Service worked together as a unit with almost military precision and efficiency. Far from the lazy, dirty, ignorant midwives of yesteryear, the Service was clean, modern, efficient, competent, and overall, trustworthy.

Breckinridge remained cognizant of the importance of clothing in demonstrating professionalism and enforced this requirement. In one incident, a nurse wore a green shirt rather than white, leading to a memorandum issued to all staff members. Betty Lester, who arrived as one of the first nurse-midwives and worked her entire career there, recalled in her 1978 oral history interview that “We had to be in full uniform...we did not go out in uniform unless it was absolutely perfect.” A June 1930 memorandum detailed only a few new uniform options, which would ensure minimal variability: white shirt, coat, pants, and cap, and gray woolen sweaters to wear over the shirt. Sheepskin coats were forbidden; approved leather topcoats could be bought from the Service or provided by the nurse if their clothing choice fit the image of the Service. Not only were clothing rules strict, but they were also limited so that nurses would not accidentally stray from Breckinridge’s vision of how to visually present the organization.

3.4 Conclusion

For Breckinridge and obstetricians, the central importance of motherhood to the future of the nation and the desperate need to reduce infant and maternal mortality drove their work. Lay midwives could not be trusted to preserve the mothers and children of the nation; the midwife debate had made this very clear. Only the ‘science of medicine’ could do that. Being part of modern medicine meant applying it according to what school training and state guidelines dictated. To distance herself from traditional midwifery, Breckinridge had to advocate for her staff to build an ethos that aligned with modern medicine, separate from traditional ways of knowing. Educational achievements were celebrated, and continued employment was contingent upon completing a midwifery school program. Nurses were seen combatting the elements with determination in their military-inspired uniforms and obeying the laws of medical cleanliness. A lay midwife could not be expected to know, much less so carefully abide by, the rules that dictated the Service’s work, and monthly training sessions were insufficient to achieve that goal. Breckinridge’s advocacy reveals a careful consideration of the larger medical ecology in which her Service operated. Her interruption and advocacy revealed in words and images that her Service did offer the potential of improving experiences of pregnancy and childbirth.

Through the lens of three rhetorical maneuvers implicated in *ethos* (Ryan et al. 7), analysis of the national midwife debate and Mary Breckinridge’s responses illuminate ways in which physicians interrupted traditional medical authority to shift *ethos* to themselves. This analysis also shows how Breckinridge’s advocacy created an alternate space for another pathway. This analysis shows that interruption is not only a tactic employed by marginalized rhetors wishing to draw attention to existing problems in society. In interrupting the *ethos* of lay midwives, obstetricians gained official, legal, and rhetorical control over pregnancy and birth through their

own scientific expertise and gender. Physicians and their allies depicted traditional ways of knowing and caring as uncivilized and inappropriate for modern America.

As traditional midwives found their authority and legal ability to practice increasingly controlled and eroded, Breckinridge employed similar strategies to align her own organization and its staff with scientific medicine. Adopting a similar stance as physicians, she depicted her nurse-midwives in opposition to traditional medicine. In addition, aware of the suspicion attached to professional women in general and to midwives of any ilk specifically, she carefully controlled how her staff presented themselves in their uniforms, images, and in written texts. Thus, she was able to sidestep, at least to a degree, assumptions about the dangers of midwives. However, as Chapter 5 analyzes in depth, rhetorical opportunities to advance ethos can also contain the same constraints that limit potential and memory of social changes. In this case, the third rhetorical maneuver that Ryan et al. identify, *relating*, led to Breckinridge aligning her organization with ideals that increasingly limited its impact and ultimately its memory.

**4 “THE LONGEST RUNNING SCIENTIFIC DEMONSTRATION IN THE WORLD”:
PUBLIC HEALTH AND SCIENCE IN THE FRONTIER NURSING SERVICE**

The Autumn 1985 *Frontier Nursing Service Quarterly Bulletin* opened with an article describing the donation of the organization’s records to the University of Kentucky Archives. The unnamed writer of the article reflects on the history of the Service throughout the article, part of which is reproduced here:

[The archives are] an ongoing record of how FNS came into being and how it has pursued its objectives and developed its resources so that, sixty years later, it remains a major force in the world of health care...It was not enough that FNS should serve the people of Leslie County. It must also become – as [Mary Breckinridge] emphasized many times – a ‘demonstration’ of ways to bring health care to rural areas. What actually resulted was ‘a nursing *model*’ ...in providing formal health-oriented care, decentralized to permit easy access by clients...It was concerned with health promotion and disease prevention, and was offered as ‘out-of-institution’ care in clinics and at home. (2-3, emphasis in original)

Most marketing and fundraising materials, especially in the early years, focused on delivery and care of infants and children in southeastern Kentucky. But the Frontier Nursing Service was never just a midwifery service. In reality, the Service was a public health organization, providing a range of care that included obstetrics. However, because the Service was privately funded, it needed to convince potential donors that their care met modern standards of that time and made a difference in the lives of their patients. Therefore, the organization’s donor material relied heavily on what Carolyn Skinner calls “scientific professionalism” to accrue ethos (2). From the nineteenth century, quantitative social science was a favored avenue to present issues in ways

that appeared objective and grounded in expertise (Sharer 9). Thus, with the ‘hard’ facts in hand, activists were often able to advocate for those about whom they collected data (Sharer 8). Female physicians in the late nineteenth century had relied on the same style of discourse to develop an individual and communal ethos that served to elevate the authority of medicine and themselves as authority figures (Skinner 4). Outside of medicine, activists such as Dorothy Day used scientific language as she personalized the suffering of the poor to garner support (Weiser 117), and even newly emerging fields such as domestic science transformed women’s work to a scientific discipline of study worthy of respect (Enoch 94). The circulation of scientific professionalism as a source of ethos allowed Mary Breckinridge and the Frontier Nursing Service to build their argument of need.

Like many professional activists, Breckinridge possessed personal and expert knowledge on her subject. Armed with formal education and a license, she was able to transform her personal status as a bereaved mother into language that showed her loss was not unique nor unpreventable. She knew that such heartbreak did not have to be so common, and that the knowledge and expertise existed to minimize the chances of that loss happening to other women. In Appalachia, Breckinridge was something of an anomaly, however. Many women medical reformers in Appalachia, as historian Barney chronicles, were themselves not medical professionals. Desiring to bring the benefits of the medicine they enjoyed to their communities, they established strategic alliances with medical professionals to remake healthcare in the mountains; those alliances enabled state institutions and private physicians to establish their medical hegemony (Barney 12). Breckinridge and her organization resisted this transformation, establishing the independent medical and scientific authority of her organization and their expertise while embracing the wider aims of the public health movement of the era to achieve a

long-lasting presence in Kentucky. To do so, Breckinridge relied on the same sources of authority as other women professionals since the nineteenth century, from physicians to Progressive Era activists, to Children's and Women's Bureau agents: scientific discourse, formal knowledge gained through education, and personal experience. These sources of authority represented a shift from individual and collective morality justifying women's public ethos to "respect for professional expertise and authority" (Skinner 43).

However, the Service occupied shaky rhetorical ground. Not physicians but more than nurses, their claims to medical and scientific authority opened the organization to criticisms of overstepping the boundaries of nursing work. Breckinridge also needed to appeal to a lay audience who did not necessarily possess the same medical expertise she and her staff did. Nor did they necessarily have a full understanding of the work or impact of the Frontier Nursing Service. To a large degree, Breckinridge and her medical staff had the freedom to define their own identity as a unique and necessary organization worthy of respect. However, that identity had to be defended against claims that they overstepped professional boundaries. Therefore, Breckinridge situated the Service at the intersections of public health, medicine, and science. In the sections that follow, I provide a brief overview of public health as a discipline. I follow this with a more extensive discussion of the ethos of scientific professionalism. I analyze a subset of medical records and reports available from the University of Kentucky Archives and the *Frontier Nursing Service Quarterly Bulletins* to demonstrate specific ways in which Breckinridge and the Frontier Nursing Service asserted their own professionalism through scientifically-based ethos.

4.1 Public Health

Generally speaking, public health refers to the health of a population and the institutions that support improving a population's physical well-being. However, the field's definition and

scope have been contested over space and time. In 1948, the World Health Organization defined public health very broadly, as “complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity” (Berridge 2). Often, individual responsibility is included as a crucial factor (Berridge 3).

As modern nation-states arose, they began to administer public health institutions. More diseases began to circulate as populations became denser and increasingly globalized, potentially threatening national security and the ability for colonial powers to expand. Eighteenth century Austrian physician Johann Peter Franck argued that people and their bodies belonged to the state, and thus needed to be managed for the benefit of the state (Berridge 41). Variations of this idea continued to circulate in European and American states. Epidemics of the eighteenth century also led to considerable state involvement in addressing environmental issues; the story of the cholera outbreak being sourced to one water well in London is perhaps one of the best-known examples. Simultaneously, fears of the ‘diseased poor’ infecting the elites they served often led to punitive and coercive public health measures (Berridge 47). Public health broadly helped to manage the state’s needs of its citizens as well as control behaviors.

During the early industrial period of western Europe, versions of later eugenics arguments began to circulate. For example, as the Poor Law reforms began to take place, some argued that saving poor children only increased poverty, while others felt that improving the health of those capable of work built the economy (Berridge 51). In fact, these arguments shaped discussions over the nature of British colonization in the Americas, in which shipping the growing numbers of poor, disease-prone individuals to the colonies would cure Britain of its “‘plague’ of poverty” (Isenberg 22). New medical scientific insights, such as the ability to inoculate against smallpox, coincided with a shift at the end of the century to conduct public

health initiatives in the home rather than ameliorate the environment (Berridge 57). By the time Mary Breckinridge opened the doors to her first clinic, the tension between addressing community and individual ills had come to define public health initiatives.

Public health reached its peak of influence between the two World Wars (Berridge 64). Increased collection of data regarding public health as well as the maturing field of statistics allowed public health professionals to make compelling arguments for intervention at a time when public figures and leaders were increasingly concerned with population health. The growing amount of statistical data helped to demonstrate that public health problems, including maternal and infant mortality rates, were not localized or individual, but indicative of public health problems across the country. Whether measuring the intelligence of World War I recruits (Isenberg 198), comparing physician and midwife attended births and associated poor outcomes, such as blindness (van Blarcom 197 – 199), assessing malnourishment of drafted soldiers (Berridge 66), and calculating actual infant mortality rates (Devitt 52), increased data collection allowed scientifically-based arguments for social change. Public health nursing positions skyrocketed in number in this period, as well. However, despite increased enthusiasm for such initiatives, funding remained limited, often at substantially lower levels than funding appropriated for education and first responder services (Kalisch and Kalisch 271).

In the United States, public health has often focused on poor individuals (Berridge 21). However, some important public health initiatives leveraged public sentiment, careful scientific measurement, and low-cost interventions that drastically improved health across the country. The Rockefeller Institute funded two such initiatives. One benefited mothers who purchased milk to feed their infants, while the other dramatically reduced the incidence of hookworm in rural areas, especially across the South. In the case of the former, careful investigation and analysis of

unsanitary conditions demonstrated conclusively that failure to safely store or pasteurize milk endangered the lives of infants. The Rockefeller Foundation initiated educational and lobbying efforts that resulted in a significant public outcry, regular inspections, and fines of unsanitary dairies. The project also formed part of the research and policy efforts of the U.S. Department of Agriculture to introduce the Pure Food and Drug Act of 1906 (Snyder), a significant achievement that bettered the health of countless people in the U.S.

The Foundation's hookworm initiative took advantage of recent scientific discoveries of how hookworm infection damaged individual health to fund and lobby for initiatives to provide for immediate treatment to rid infected individuals of the parasite, build more effective waste and sewage systems, and educate individuals to wear shoes year-round. Initial resistance required a careful public opinion and education campaign. The campaign was a success, and hookworm infection rates declined substantially over the first half of the twentieth century (Shubinski and Iacobelli). However, the parasite itself is still endemic. A recent Guardian report found that in Lowndes County, Alabama, thirty-four percent of residents in communities unconnected to water treatment facilities tested positive for hookworm. Faulty septic systems and lack of funding to install sewage systems (Pilkington) mean that the very conditions the Rockefeller Institute attempted to eradicate over a century ago never truly went away, and marginalized communities continue to suffer the greatest negative impacts. Similar issues of disparity have been uncovered in early sex-education movements (Jensen xv). The activism of the late nineteenth and early twentieth century helped some people, but lack of funding, competing priorities, racism, and classism often limited impacts of public health initiatives.

The Sheppard-Towner Act of 1921 is a prime example of public health initiatives formalized at a federal level. Like so much health reform of the period, considerable potential

existed to support women and children's health, but resistance, classism, racism, and minimal, short-lived funding limited potential benefits. Even so, the law had long-term impacts in how the U.S. approaches maternal care. The earliest state agencies responsible for educating and ensuring the health and welfare of mothers and children opened in this period. Most states engaged public health professionals to train community midwives in sanitary childbirth practices as well as ensuring that silver nitrate² drops were widely available to combat infant blindness. Kentucky engaged more enthusiastically than many southern states with the Sheppard-Towner Act and other initiatives to improve the health of mothers and children in the state. According to historian Melanie Beals Goan, Kentucky began registering births in accordance with the new federal Birth Registration Area in 1911 (68), four years before the U. S. Census Bureau extended this requirement to all states (National Center for Health Statistics). Full-time county health departments opened in 1918, among the earliest in the nation. In 1922, the state created the Bureau of Maternal and Child Health, now the Division of Maternal and Child Health, with funds from the Sheppard-Towner Act. Initiatives to promote child and maternal health included sponsoring four traveling nurses, preschool children's clinics, distribution of nutrition information, weekly columns about infant and child health, community midwife and registration programs, and distribution of supplies such as silver nitrate drops (Goan 68).

² Texts discussing lay and community midwife training often mention the need for silver nitrate drops in newborns' eyes to prevent blindness, but rarely indicate why. Gonorrhoea was quite common at the turn of the century, but no effective treatment existed before antibiotics. Newborns who acquired the infection from their mothers would develop lesions that quickly led to blindness and accounted for 20 to 75 percent of blind children in institutions in the late nineteenth century. Silver nitrate drops in newborn's eyes prevented the lesions from blinding the children (Meheus 22).

4.2 Cultivating Ethos, Inviting Advocacy: Women's Scientific Professionalism

In the late nineteenth century, professional culture shifted, according to Clark and Halloran, from a “collective moral authority” to “the authority of the expert” (3). This shift mirrored social changes in the U. S. As the country transitioned to a more industrial economy, changes in political and economic values translated to a shift “in public discourse, in theory as well as practice” (Clark and Halloran 3). As experts’ knowledge became more valued, commitment to and faith in “science and scientific reform” (Giesberg 18) followed. Statistics had provided ways for reformers to “make a systematic approach to medical morality” from the eighteenth century (Cassedy 25). However, the cholera epidemics of the nineteenth century had revealed weaknesses in collection of quantitative data. Incomplete data made it difficult to accurately ascertain the effectiveness of any specific approach (Cassedy 187). The lack of qualified personnel trained in data collection further hampered data quality. Statistics as a field professionalized in the mid-nineteenth century (Cassedy 193), helping to lay the foundation for “community efforts to eliminate excesses of deaths over acceptable norms” (Cassedy 207). As the power of data became clearer, the authority of those who utilized that data grew.

Carolyn Skinner’s *Women Physicians and Professional Ethos in Nineteenth-Century America* analyzed ways in which women physicians utilized this “evolution in rhetorical values” (43) to develop their own professional ethos in a milieu that esteemed both expertise and male-associated behaviors. Faced with conflicting expectations, women physicians relied heavily on scientific discourse to assert their own ethos. Through scientific discourse in medical research articles, education of lay audiences, editorials, and reform efforts, these women physicians demonstrated that their femininity did not contradict their ability and expertise as physicians. Their considerable volume of published materials allowed them to “translat[e] their professional

status into important contributions to late nineteenth-century social and medical thought” (Skinner 172). These physicians’ success depended on establishing ethos as “culturally situated rhetor[s] who may work in collaboration with others, who may have to choose among competing sets of values held by a heterogenous audience, and who may be believed incapable of some of the most prestigious virtues in her context” (Skinner 173). Of the five elements of this culturally situated ethos, of particular interest for this project is that “*a rhetor’s ethos is shaped by the material resources available to her and the popular beliefs about those of her social position*” (Skinner 174, emphasis in original) and that “*ethos is not crafted in response to a coherent and identifiable set of audience values but is instead composed in a dynamic context that includes multiple competing beliefs about the ‘best’ virtues*” (Skinner 175, emphasis in original). In the case of professional women presenting themselves as knowledgeable and trustworthy experts, scientific discourse often allowed them to overcome negative assumptions about women’s abilities.

The presumed objectivity of facts and data sets allowed the writers of the U.S. Women’s Bureau to advocate for the women they studied and about whom they wrote. The creation of the Bureau, Wendy Sharer wrote, “reflected an increasing desire on the part of the federal government to put the investigation and resolution of societal problems in the hands of trained experts” (9). Trained in social sciences and data analysis, these Bureau agents were able to collect information about those whom they studied to demonstrate that social ills were not individual in nature or impact. With their objective reports, they were then able to draw on their own experiences with labor activism to challenge the bulletin reporting genre in which they wrote to advocate for the subjects of their research (9). Because the Bureau’s writers and researchers were trained experts in quantitative social science, they were able to draw on the

ethos that had accrued to “communities of trained experts” (Sharer 9). These experts “communicated in specialized, rational discourse,” gradually restricting debate over societal concerns to “narrowly circumscribed arenas of expertise” (Sharer 9). Familiar with how to present information to garner audience trust and respect, Bureau writers were then able to challenge the genre of the scientific report to push for more progressive policies. Because they wished to “apply scientific methodology to social amelioration,” women leading the U. S. Women’s Bureau joined pathos with the ethos of their scientific writing to draw responses from their audiences. They “personalized the statistical” by presenting images, highlighting actual individuals who would benefit from new policies, and so forth. Because women did not often have the direct political power to enact changes, changing or manipulating public opinion served to advocate for change. Doing so required “effective literacy” (Hobbs, cited in Sharer 14), joining the “technical skills of reading and writing” with the rhetorical knowledge of using those skills in a community context (Sharer 14).

The combination of expert knowledge, experience, and status allows a rhetor to exert power as a professional (Skinner 9), often shifting attention away from the factors that traditionally prevent the individual from claiming ethos. Women who capitalized on the growing power of scientific professionalism found their own rhetorical authority enhanced. However, many individuals otherwise qualified found themselves excluded. Women physicians minimized the autonomy of patients (Skinner 154), while Women’s Bureau employees excluded expert individuals on racial grounds (Sharer 25). Even so, the strategies of privileging one’s own expertise and experience in objective reports, with a garnish of sympathetic, personalized appeals to invite reaction and support, proved useful beyond medicine and social science. Dorothy Day serves as another example of a rhetor who drew on her own experiences and expertise as a social

reformer and activist as well as her deeply held religious convictions. Therefore, she was able to “carry[y] the pathos of the poor across a social divide to middle- and upper-class donor/volunteers upon whom the success of her work depended” (Weiser 116). She personalized the objective facts of the poor with whom she worked, applying the Burkean theory of “translating one’s personal narrative into abstract ideas...and then translating it back into a new, persuasive narrative now larger than oneself” (Weiser 127). The value placed into objective, scientific discourse and data presentation that developed over the nineteenth century, combined with appeals through personalization of the aggregate numbers and objective reporting, allowed women like Mary Breckinridge to credibly assert professional ethos for their work and causes.

4.3 The Science of Public Health in the Frontier Nursing Service

Goan claimed that, especially in the first three years of operations, the Frontier Nursing Service did more public health work than midwifery work. Her characterization represents a common misconception: that public health initiatives and obstetrics fit into fundamentally different care definitions. The Frontier Nursing Service’s tendency to outwardly focus almost exclusively on midwifery care as their mission also tended to occlude their other services. However, midwifery work – prenatal care, assisting delivery, and family, infant, and pediatric checkups (ACNM, “Definition”) – all fall squarely within the realm of public health as understood in the early twentieth century. A timeline of historical medical developments divides public health into three phases: 1840 to 1890 as the “empirical environmental sanitation” period; 1890 to 1910 for the first applications of bacteriology, emphasizing cleanliness (in other words, the application of germ theory); and 1910 and forward with an emphasis on personal hygiene and health choices, supplemented by physicians assisting in disease prevention (Feldhusen). The Frontier Nursing Service operated at an intersection of these three foci of public health at a time

when hospital births were uncommon except in urbanized areas among affluent (Litoff 8) and indigent classes (Brodsky 132). Particularly in areas where hospitals and licensed medical providers were rare, being able to travel to the homes of those needing attention likely allowed the Service to expand the reach of their medical services. Providing care in patients' homes also allowed nurses to observe and address environmental, epidemiological, and lifestyle impacts on health. Beyond the ability to provide more targeted and holistic care, being present in the homes of families seeking care established trust between the organization and community members. Support from community members and outside donors allowed the Service to grow to include a hospital, eight nursing centers, and a university (Breckinridge 232; Frontier Nursing Service Collection). In this section, I examine selections of the considerable evidence in the archival record about their public health work to not only illustrate the scope of the medical care they provided, but the ways in which Mary Breckinridge and her organization relied on the material resources of scientific professionalism. In the next chapter, I examine personalized emotional appeals.

As scholars of Appalachia have noted, Breckinridge's organization was not exceptionally innovative or novel in its desire to bring the benefits of Progressive Era science, technology, medical care, and education to the region. Appalachian clubwomen, maternalist reformers, charitable organizations, coal companies, and medical and public health professionals worked in tandem to promote scientific medicine in the region's communities and coal camps, portraying access to modern medicine "as a campaign to extend benefits they had already secured to those previously denied them" (Barney 70). However, Leslie County was an extreme version of the isolated, poor, and backwards stereotype of the region. The county apparently lacked paved roads all together and had few railroad lines. Most residents of the county worked in subsistence

agriculture. The industrialization of coal mining and resulting medical, physical, and economic infrastructure had not yet developed in the 1920s. Dana Johnson's master's history thesis noted that in 1920, only thirty-six of the county's 10,000 residents worked in manufacturing, far fewer than in other counties. Most residents did not have ready access to cash and a licensed physician did not serve the county, likely because of its ruggedness and poverty (36).

The isolation of Leslie County provided Breckinridge several opportunities: her organization could operate relatively freely while contributing to expansion of medical care. However, because she chose to operate independently of newly emerging health institutions in Kentucky, she could not rely on their authority to promote her own. Instead, she drew on existing discourses and her own training to prove the impact of her organization's mission.

4.3.1 "It was time to begin": Launching the Frontier Nursing Service

Breckinridge initiated her first steps to open her Service in 1923 after four years abroad. Her organization, the Kentucky Committee for Mothers and Babies, became official in 1925; initial surveys of the area to determine actual needs were planned for 1927. Breckinridge credits Arthur McCormack, Kentucky's chief public health officer, with suggesting the earliest surveys of the population to serve as a baseline against which to measure their achievements. However, data collection began earlier in 1923. She traveled throughout the area to meet with area midwives to determine what kind of medical care residents could access, referring to her notes as "tabulations." Her memoir (which reproduced the following summary from prior *Bulletins* nearly verbatim) described her survey results quantitatively and qualitatively:

From the daily notes I kept, I wrote up my investigation as soon as it was completed, with tabulations on the 53 old midwives that I had interviewed. The total age of the 53 was 3,193 years, and their average age 60.3 years...the care

given women in childbirth and their babies, thousands of them in thousands of square miles, was as medieval as the nursing care of the sick in the public hospitals in France...many of the midwives were intelligent women whose homes were tidy and gay with flowers. At least sixteen of those I visited, even six in windowless log cabins, were women of more than average ability...Most of them had taken up midwifery, after their own families were raised, in order to help neighbor women who had no one else to stand by. (116 – 117)

This paragraph with only minor variations appeared in several *Bulletins* over many years. She made a numerical distinction between midwives who assisted births when no one else was available to help and those who intentionally provided substandard care. Presenting the average age seems to heighten the contrast of traditional midwifery with professional midwifery. In the case of the former, most traditional midwives were women finished bearing children who assisted younger women. In contrast, professional midwives were much younger, probably not long out of school and unmarried. Their difference in marriage status presumably allowed the nurse-midwives to be fully committed to the mission of midwifery, with continuing education, rather than simply filling a gap in care. She also characterized a substantial number as smarter midwives, mirroring the consistent claim she made in various contexts through the years regarding the ‘native intelligence’ of mountain whites. Thus, she cast mountain midwives as rather different from the midwives that physicians attacked as ignorant, superstitious, and dangerous. This choice emphasized that the ‘midwife problem’ in southeastern Kentucky was lack of training, a problem she intended to ameliorate through the formally educated midwives of the Service.

The numbers reinforce the considerable lived experience of these women. More importantly, by making claims about the cleanliness of their homes as well as their intelligence, she painted the women in a sympathetic light. These midwives and their patients were not fundamentally bad people, she argued, but they did what had to be done because there was no other choice. Without options, pregnant women found ways to manage with resources they had. Therefore, mountain community midwives should not have been blamed for state and experts' failures to act upon the problem of maternal healthcare, a tactic reminiscent of maternalist reformers nationwide working to shift responsibility for maternal and infant health to the state. The numbers demonstrated the scale of the problem relative to the low density of population, as well. With several dozen midwives available in a region with few residents per square mile, who had large families, Breckinridge implied these mothers needed rather more help than had been previously realized. The larger number of midwives suggested that low population density masked the scale of need, a tactic likely to draw sympathy from potential donors who likewise had not realized just how badly mountain women needed help. Like the writers of the U.S. Women's Bureau (Sharer 13), Breckinridge invited action through objective, but sympathetic writing.

The midwives she interviewed likely attended mandatory state-sponsored training as required by the Sheppard-Towner Act, and thus were not completely reliant on folk tradition and experiential training. However, accepting such workshops as sufficient to ensure proper reproductive and natal healthcare would have negated the need for the Frontier Nursing Service and its midwives, whose status was precarious. Thus, Breckinridge had to carefully distinguish between traditional midwifery, emerging state management of those same midwives, and her own. Placing value on expertise specific to midwifery schools, she minimized in quality and

quantity the state-sponsored training traditional midwives did receive. She argued that because community midwives had no access to scientific medical training other than a few week-long workshops, they were unable to effectively aid in childbirth. Breckinridge later characterized this limited training as wholly inadequate, writing that these community midwives had, for the most part, “no training whatever.” The public health nurses who provided annual training to traditional midwives apparently had no specialization in maternal care, and so therefore, Breckinridge criticized, little germane expertise could be disseminated. To worsen the situation, she claimed the only doctors in the area were unlicensed physicians she described as illiterate and versed only in herbal remedies, whose care only delayed the call for those who had the knowledge and training (as demonstrated by the license) to save an endangered mother (Breckinridge 117). This claim is belied by the network of licensed physicians she claimed her organization relied on when her nurse-midwives encountered complications beyond their training and purview. However, emphasizing lack of availability of appropriate, scientific medical care would likely have alarmed potential donors who believed that Leslie County residents deserved the same care more affluent women in cities could easily access.

Unlike other publications that ranged from racist and classist attacks to a reliance on gendered ideologies of the role of women in medicine, Breckinridge did not identify these lay midwives as actively dangerous. Instead, she relied on an intimation of helplessness based on the value of expertise. Without training and licensing that specializes in obstetrics, these midwives were helpless to do what they were asked to do. Thus, Leslie County had even greater need than anyone seemed to realize, she suggested. She also emphasized the sad state of medical care in Leslie County through comparisons with Britain. For example, in the very first *Bulletin*, published in June 1925, the introduction explained that “In many parts of rural Kentucky are to

be found pure Anglo-Saxon folk, living under conditions similar to their kins-people in the British Isles, but entirely lacking the trained service [available in Britain]” (1). Britain’s midwives had formally organized and introduced an education and licensing system by 1902. They worked independently and attended nearly three-fourths of all births by the turn of the century (Rooks 16). In comparing the more advanced healthcare system of Britain to the lack of a system in southeastern Kentucky, Breckinridge suggested that the same kind of people in similar conditions deserved similarly advanced healthcare.

Breckinridge also employed social science research to prove the potential benefits of her planned organization. While Breckinridge interviewed community midwives, Dr. Ella Woodyard, a faculty member in the Institute of Educational Research of Teacher’s College, Columbia University, accompanied her. Woodyard administered the Binet-Simon intelligence test to sixty-six randomly selected children (Breckinridge 120; *Bulletin*, June 1925, 2), a revised version of the same test that Breckinridge had regularly given her son (Thompson, *Breckie*, 57). Though psychologists argued over how well this test measured actual innate intelligence even in the early twentieth century, the test was widely used to label innate intelligence (Kuhlmann 59). Originally developed in France to assess school grade placements, the test was translated and deployed by American scientist Henry Goddard in an attempt to quantify eugenic categories of mental ability (Roige). This usage was widely accepted, and thus testing mountain children with this tool served Breckinridge’s purposes of depicting them sympathetically.

Concerns regarding the intelligence of those who lived in the mountains were widespread. By employing a widely accepted measure of intelligence, Breckinridge could prove, in ways that mattered to her audience, that the people of Appalachia were not inherently “feeble-minded” but rather lacking the same educational opportunities that children in other regions had

readily available. Breckinridge later claimed she wished to be able to prove that isolation and lack of opportunity, rather than inherited mental inability, made the mountaineers seem less intelligent than they were (*Bulletin*, Spring 1942, 31). Eugenics thinking equated supposedly innate intelligence with the ability (or inability, depending on the IQ number) to “act morally and to foresee the consequences of one’s actions” (Roige). Quantifying the population of eastern Kentucky as inherently intelligent provided an objective-seeming measure that soothed concerns about their morality and whether they deserved modern scientific care, large families, and healthy lives. In an environment where eugenics thinkers wished to deny social welfare to the poor, on the grounds that “adequate medical care, better working conditions, and minimum wages all harmed society because those measures enabled people with inferior heredity to live longer and produce more children” (Roberts 64), only some people merited aid. In proving innate intelligence, and therefore moral worth, of the people of Appalachia through scientific measurement and reporting, Breckinridge could ease “the characteristically American fear of giving to the poor” (Weiser 123).

Breckinridge’s 1942 summary of the 1923 surveys claimed that, in fact, these children were more intelligent than average and that one “high-grade imbecile, with an Intelligence Quotient of 82” was a statistical outlier. She claimed that the actual intelligence of the remaining children was misrepresented due to poor research design when developing the tool and the supposed prevalence of “many Middle English words in their speech” (31). In other words, the children were as intelligent as comparable children of the rest of the nation. Score differentials occurred because the test did not take into account confounding environmental and social factors. This criticism of the validity of the test is a fair one, as measures of intelligence have often masked classist and racist judgments while failing to adjust for external influences. Her argument

also reminded readers of her argument regarding the natural ability of untrained midwives. In both instances, inferior performance is related directly to the environment and available resources. Without access to proper midwifery training, the midwives, actually quite smart and capable, did the best they could with the knowledge they had. The children are the same; raised in a poor environment, speaking an old dialect that modern tests failed to account for, they did the best they could with the knowledge they had. In both cases, Breckinridge's scientific results, presented rather neutrally, blame the environment rather than individuals. Change the situation, she seemed to be arguing, and the people would change, too. In this way, the people of Leslie County were constructed as worthy of modern scientific medicine.

Skinner noted that scientific arguments employed by women physicians “did not have to be ‘scientific’ in the twenty-first century sense, but instead had to be recognizable according to the multiple and evolving notions of ‘science’ available in the nineteenth century” (45). Thus, scientific arguments made in the late nineteenth and early twentieth century may not meet modern validity criteria but were effective for contemporary audiences. Breckinridge follows the same method: providing survey results and numbers, but not fully contextualizing them as would be expected in the twenty-first century. This lack of contextualization makes it difficult to ascertain exactly how “medieval” midwifery care was, if women in Leslie County did travel out of the county to see doctors, or if the schoolchildren's test results truly were impacted by dialectical or other environmental factors. Furthermore, the numbers themselves do not obviously relate to her larger claims. It is unclear what the total or median ages of the fifty-three midwives represent in terms of providing care, just as it is unclear how representative the sixty-six children are of the county's children. Not enough information is provided in the case of the midwife argument. The demographic information of the children as well as a comparable

measure is not provided to understand how the results compare mathematically or scientifically. It is certainly possible that she did collect information for a fuller comparative argument in her surveys. However, that information seems never to have been published. Nor does she compare her data to the considerable data that other Appalachian reform organizations had collected.

Rather, the presentation of her data is organized to support existing assumptions about mountain whites and midwives. Her arguments read similarly to William Goodell Frost's, who argued in 1899 the virtues of the white mountaineer would "require a scientific spirit and some historic sense to enable us to appreciate their situation and their character" (1). Frost's relentless boosterism made familiar 'the scientific spirit and some historic sense' in interpreting the Appalachian environment as lacking. Situating her discourse in existing arguments, she reflected back to her audiences what they already knew about Appalachia. Her hyperfocus on Leslie County allowed her to extend those existing arguments to rhetorically remake the area an exemplar of Appalachia: a place with the most danger to women and their children, but the most promising. Thus, in providing the 'scientific spirit' for her audience amidst sympathetic portrayals of Leslie County residents, she gave her claims increased authority.

Her argument also fit into larger arguments about generational poverty. Other Progressive reformers supported moderate labor reform, or protection against the worst excesses of capitalism, to strengthen the social and moral makeup of the nation (Hartman 44). In other words, the supposed degeneracy of white families, at least for some reform-minded individuals, was more due to a system that impoverished and took advantage of them rather than a natural result of their own character and heredity. In some cases, of course, individuals could not simply overcome their family legacies and merited sterilization or institutionalization, a practice that initially targeted mostly poor white women (Harper 30). In many cases, policy makers and

physicians viewed their responsibility to society as requiring sterilization of women (and men) who could not adequately contribute (Harper 31). But, if some populations are so undeserving as to require removing them and their genetics from the population, then, conversely, other populations did deserve support. Indeed, the promise to uplift the character and future of the nation almost required the provision of aid to worthy individuals. Breckinridge's arguments created a subset of the 'deserving poor,' which aligns more closely with the latter argument. While the material I have does not provide an explicit connection to other writers or speakers promulgating such ideas, that thinking was certainly accessible through popular publications such as McCullough's *The Tribe of Ishmael: A Study in Social Degradation*. The usefulness of this kind of 'deserving poor' argument meant that Breckinridge could argue to sympathetic audiences that the people for whom she wished to provide care would not squander resources spent on them. They simply needed help in a situation not of their own making.

Later in life, Breckinridge returned to the idea of innate intelligence to argue that her Service had helped Leslie County residents as desired. She commissioned a follow-up IQ study by Woodyard in the 1950s, when socioeconomic circumstances had dramatically improved. This study found "careful testing by [Woodyard] of 810 of our young children, ranging in age from 35 to 40 months, gives a median I.Q. of 108.3, a mean or average of 108.0...compared with a norm of 100. It is no surprise to me, who know them so well, to find that our young mountain children show a higher average of intelligence than the national norm" (Breckinridge 120). Using the same test administered by the same person ostensibly helped to minimize variations in application and interpretation, eliminating statistical noise that could have obscured test gains. By describing the two studies as nearly identical except for the passage of time, she presented the Service as a kind of longitudinal social science experiment. Longitudinal studies allow

researchers to uncover cause-and-effect relationships over a time, which is useful for determining the outcomes of interventions. The first IQ study was latitudinal, or cross-sectional, in nature, which can illuminate relationships but not causes or effects (Caruana et al. 537). With a study demonstrating an outcome over time, she was able to claim that improving health of her patients allowed them to realize their intellectual potential. Her claim is not controversial in general, as healthy individuals being able to fulfill their potential is an intuitive relationship. However, her report ignores the impact of socioeconomic changes that may have also influenced children's test results, or changes in school curricula. In this sense, as she often did, she claimed a larger impact than her data could support. However, by presenting the results over time in the context of health care, she argued that her organization had been successful – that in changing the health environment, the people had positively changed, too, as she had promised. Thus, she demonstrated the value of her scientific approach.

4.3.2 A Scientific Demonstration: Recording Nurses' Work

Breckinridge's commitment to scientific professionalism did not end with her 1927 midwife and IQ surveys. She insisted on meticulous record-keeping, accounting for nearly every minute of her staff's time on duty. With a wealth of data, Breckinridge could prove Frontier Nursing Service achievements quantitatively. Analysis of her records also reveal the broad scope of public health the Service undertook, despite its marketing and fundraising focus on midwifery. This section analyzes examples of clinic records and relevant oral history interviews to explore how the Service documented its work in accordance with scientific principles.

Edna Rockstroh, one of the first nurse-midwives hired by the Frontier Nursing Service, recalled in her 1978 oral history interview that Leslie County resident requested hookworm treatments most often. Other nurses recalling their work in the 1920s mention hookworm,

diphtheria, and typhoid as the most common ailments. Their memories align with the clinic records. Any given clinic day, the nurses would give various vaccinations and treatments, conduct wellness exams, dispense advice, and otherwise attend to the general health of the community. Older clinic records are not as detailed as later ones, as the paperwork changed to reflect the actual work they did. One data point that did not change was how carefully the nurses accounted for their time. At first, Breckinridge may have assumed most nurses would provide midwifery care. She may also have wished to capture more detailed information about midwifery care to bolster her fundraising. In either case, the clinic reports changed format to document the growing scope of non-midwifery services through the late 1920s and 1930s. Each clinic kept careful daily records, with the nurses assigned to duty that day signing off on the form. Those forms were sent to the headquarters in Wendover, where staff tabulated monthly and annual reports. Annually, the *Bulletin* published a comprehensive list of care drawn from those reports. Midwifery statistics were collated from reports every of one thousand births to send to the Metropolitan Life Insurance Company (also frequently referred to as MetLife) for analysis.

The comparisons from MetLife's statistical reports are a bit problematic, however. While there is no doubt that the rate of complications and maternal and infant death were low among the patients of the Frontier Nursing Service, baseline data for comparison was not available in the same level of detail or accuracy. Goan suggests that the rates of mortality were already lower in Leslie County than national averages (126), a supposition supported by research that showed that midwives in general had better outcomes than physician-assisted births (van Blarcom 198). The careful records and analyses did prove the Service's model of care worked, especially in terms of pregnancy complications and related deaths. However, it did not necessarily prove that this care was better than existing care.

The image shows two pages of a clinical summary report from 1928. The left page is a 'DAILY REPORT' with multiple tables for patient counts, midwifery cases, and hours on duty. The right page is a 'GROUP INSTRUCTION, CONFERENCES OR SPECIAL CLINICS' section with attendance records and a 'FUNDS RECEIVED' table.

Place	Character	Attendance
Thousandsticks	Luncheon with Dr. Block and 2 teachers	Men 2, Wo 2, Ch
Hyden	Health Talk at meeting, Parent-Teacher Association (P. M.)	Men 1, Wo 1, Ch 1
Totals		4 of conference (not) 12 at P. M.

Description	Amount	Remarks
Thousandsticks	\$1.00	New family: Brown, John
Hyden	\$5.00	1 Baby: Brown, Charles (John) Born 5-18-28
		2 Adults: Brown, John = 2-25-28
		Brown, Daily Collins = 7-14-10
		Post Office: Hyden, Locality: Mouth of Asher's Cr.
		Olive White (Bob) and Jack Smith (James) transferred from school.
Totals	\$6.00	

Figure 9: Clinical Summary, 1928 (*Frontier Nursing Service Collection*)

Figure 9 provides an example of a daily report from Hyden Hospital. On this date in 1928, 587 patients received care there, most of whom were children. One child was born prematurely, another was present for a neonatal visit (the mother is left unnamed), and two midwifery cases were closed out after post-partum care or transfer. Another eight midwifery cases were still on the books, indicating women who were receiving prenatal care. Three children received health or wellness visits, one child was born (listed by name in the prior section), and one sick child was tended to in their home. A parent brought a sick infant in, while a pregnant woman came in for a checkup. In total, these visits took nearly ten hours of time, including travel time for the in-home visits. Not documented is how long it took to complete reports and patient records. The most detail is reserved for midwifery cases, though more time was spent on other care. Other records reveal similar patterns. Nurses spent the most time addressing non-midwifery needs, such as health education and vaccinations. However, the most detail and space in the reports themselves were devoted to midwifery care.

The extensive data reporting began with daily reports, as shown in the example above. These reports were compiled into monthly reports, and then annual, displaying the raw numbers of each kind of care given at each location. As the Service grew, opening more clinics, offering

more services, and covering a wider geographic area, these reports increased in number and detail. Figure 10 shows the May 1927 monthly report, when only a few clinics were open.

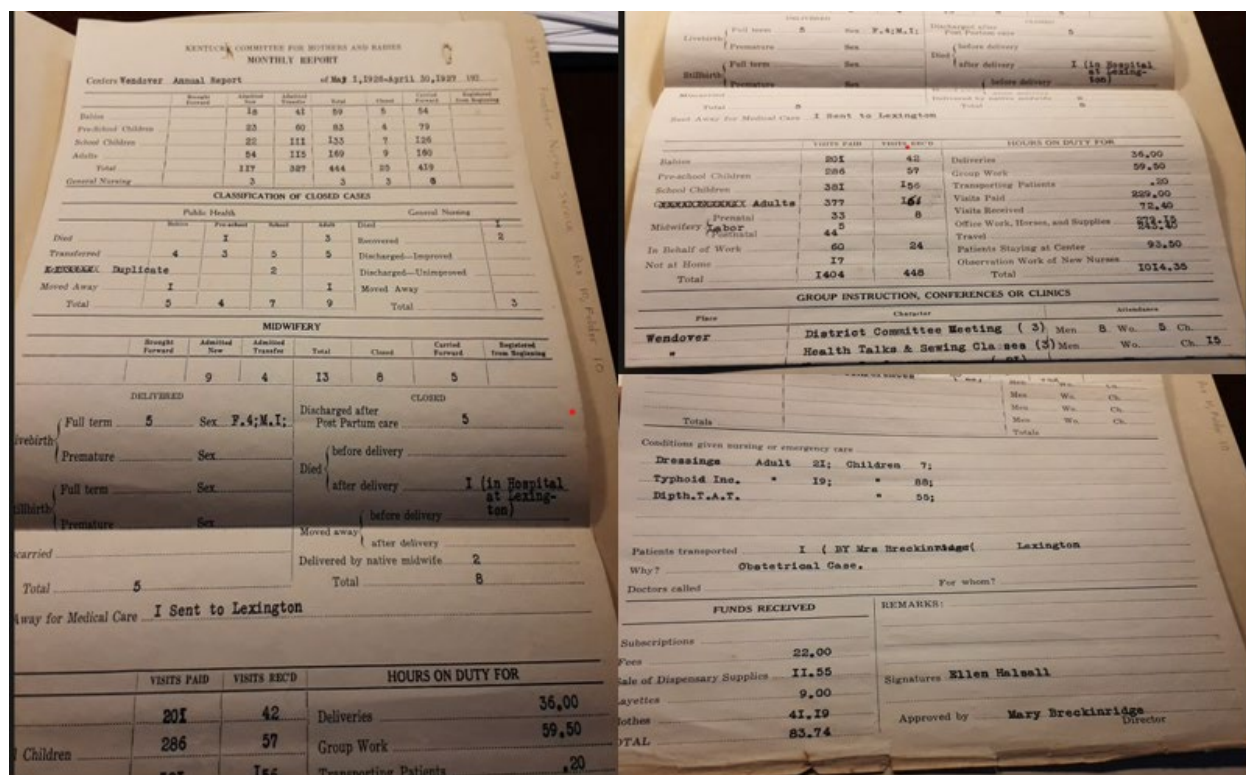


Figure 10: Monthly Report May 1927 (*Frontier Nursing Service Collection*)

The monthly report totals the care and labor-hours expended through the three primary clinic locations, Hyden, Wendover, and the Jessie Draper Center. The first table provides a total count of the age groups of patients, from infants to adults. The categories for younger patients are more precisely divided, reflecting how age impacts medical care, especially in the youngest years. Older children who were not yet of school age would not require such different care as young school-aged children, but that would be different care from children in the preteen or teenage years. Thus, this categorization allowed a general overview of the kinds of care by age provided to the patients of these three clinic locations.

The next two divisions on the chart break out midwifery cases in detail: how many new cases, how many children were born, how many required a doctor’s intervention, how many

children or mothers were lost, and so forth. Following this paragraph is a table breaking down how many visits these patients required over the twelve-month period, as well as how many hours in total nurses spent with those patients or traveling to them. Finally, the last section of the annual report details the kind of public health work engaged in that year: clinics, meetings, conferences, and health education talks (which further indicates the public health scope of the Frontier Nursing Service), labeled by hours and locations. Such detailed recordkeeping, gleaned from the daily reports, allowed Breckinridge to demonstrate in precise detail exactly what her organization was doing. These reports were collected into annual reports every year. These reports allowed her to argue that her organization made a significant positive impact. By extension, she could argue that her medical system would positively benefit all women without easy access to physicians.

Looking through a modern lens, such detailed recordkeeping seems a matter of course, but at the time, such exhaustive recording was not so common. Oral histories with the nurses and the film *Forgotten Frontier* regularly include anecdotes of the late nights spent notating case histories after long days at clinics and in saddles; the 1932 Summer *Bulletin* recorded the Carnegie Corporation grant they received to support their documentation. The tallying of cases, time, and care provided the raw data needed for scientific analysis, reports, journal articles, and even speeches. Thus, Breckinridge was able to successfully argue the volume of their work proved need.

4.3.3 Scientific Proof: Analyzing Nurse's Work

Simply recording Service activities in depth or listing the total number of vaccination clinics or healthy infants born would not have been enough to show that the Frontier Nursing Service provided the best, most cost-effective model for addressing rural health issues.

Therefore, Breckinridge regularly engaged with expert professionals for data analysis. While the resulting reports are often awe-inspiring in terms of the raw numbers, the tendency to compare numbers with broad claims or uncontextualized numbers undercut the strength of her proof. However, as Skinner pointed out, the appearance of scientific discourse in ways that audiences understood and responded to generates ethos (45). This demonstration of scientific methodology should not be judged against twenty-first century standards as wanting or invalid; there is not enough data easily available to determine that. More likely, she engaged in presentation of data in ways that were familiar to her audience to support arguments in which they already at least partly believed. The additional layer of numbers and analyses functioned as an additional layer of persuasion but did so likely because this kind of credibility was already largely accepted by the very audiences from whom she requested money.

Daily reports were compiled into monthly, and then annual reports. From the annual reports, staff would extract midwifery data and develop tables detailing the various facets of childbirth in the mountains, including the age of the mother, how many children she already had, negative outcomes, and so forth. Any incomplete data was tracked down by Gladys Peacock, the primary administrative manager, in collaboration with the nurse-midwives who had attended those cases. Once data was complete, the organization sent the records to the Metropolitan Life Insurance Company for analysis. In fact, this company regularly engaged in public health initiatives and demonstrations throughout the country (Kalisch and Kalisch 276), so employing a company recognized as experts on the impacts of public health initiatives to analyze her data lent her reports additional authority. Since acknowledged leading experts found her results impressive, Breckinridge could bolster her own claims. Breckinridge published MetLife results and written summaries every 1,000 births in the quarterly *Bulletins*. These reports do indicate an

extremely low rate of mortality among their patients, much lower than the national average. However, without a clear comparison to mortality rates before 1925 or a clear indication these comparisons were made with similar populations across the country, these careful records do not make the same argument that Breckinridge claimed they did. In other words, they show that the Service's care did mean low mortality rates, but they do not show their care meant a significant decline in comparison to the many births attended by community midwives in Leslie County or across the country. However, for an audience that had accepted the truism that traditional midwives meant poor outcomes, these tabulations were likely enough.

Age of the Mother	Number of the Birth										
	Total	First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eighth	Ninth	Tenth
Total all Ages	18	1	1	1	1	1	1	1	1	1	1
20 to 24 years	1	1									
25 to 29 years	1										
30 to 34 years	1										
35 to 39 years	1										
40 to 44 years	1										
45 years +	1										
Unknown Age	1										

Figure 11: Internal Midwifery Report (*Frontier Nursing Service Collection*)

Figure 11 illustrates how staff collated data on midwifery cases. The image displays a midwifery case chart comparing the age of the mother in four-to-five-year increments to gestational age of the pregnancy in which the mother experienced hemorrhage. As can be seen in the image, the youngest mother was 20, while the oldest was between 40 and 44. Furthermore, eighteen cases of hemorrhage, which did not necessarily mean death when adequate scientific medical care was available, is not so many in one thousand births at this time, suggesting that the Service was able to ensure these women, regardless of age, usually experienced a healthy pregnancy. At a time when loss of a pregnancy, often for reasons unknown, impacted women

across the nation regardless of race, class, or region, seeing that pregnancy hemorrhages were so few may have been reassuring. The numbers certainly correlate modern, scientific medical care with fewer negative outcomes, helping to justify the Service's work.

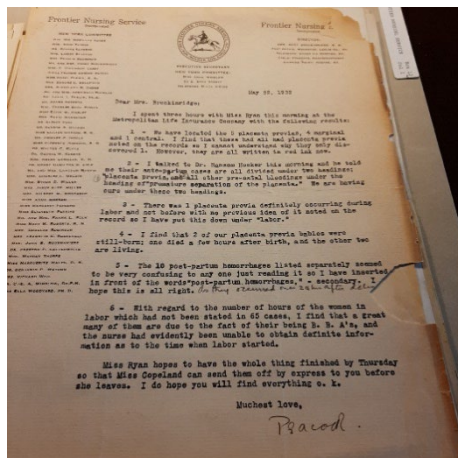


Figure 12: Letter Explaining Missing Data (*Frontier Nursing Service Collection*)

Figure 12 displays a letter from Gladys Peacock explaining how she resolved data anomalies. While the nurses worked long hours to ensure their records were accurate and complete, they did make mistakes. In a hurry or having forgotten details after a long day of nursing, not all daily reports included complete information. To ensure that all data could be considered in analysis, Peacock corrected those oversights. When statistically analyzing small sets of numbers, even just a few outliers or inaccurately labeled data points can alter the results, making resulting claims of statistical significance weaker. Inclusion of incomplete data obscures the actual relationships between the result being tested for and variables that influence that result. In large data sets, this effect is less confounding (Chambers 26). However, Breckinridge's data sets were relatively small, with only one thousand cases in total at a time and very few complications within that set. Ensuring the data was as complete as possible made resulting analyses more accurate and thus more compelling. The extra steps taken before sending data to

Metropolitan Life serve as another example of Breckinridge's commitment to scientific professionalism.

Table I
Distribution by Age of Mothers
Second Thousand Births at The Frontier Nursing Service, 1931

Age Group	Number of Births
Total - All Ages	1,000
Under 20 years	100
20 - 24	210
25 - 29	210
30 - 34	180
35 - 39	110
40 - 44	50
45 and over	5
Age not specified	0
Average Age	26.2 years

Table XII
First and Second Thousand Births Compared
The Frontier Nursing Service, 1931

	First 1000 Births	Second 1000 Births
Total Requisitions	1,000	1,000
Delivered	1,000	1,000
At term		
Before term	400	370
Low birth	80	40
Still births	100	100
Late abortions	20	20
Condition of mother at end of first month	1	6
Fair	40	40
Satisfactory	300	300
Unsatisfactory	-	1
Dead at end of first month		
Mother	1	-
Baby	25	26

Figure 13: MetLife Midwifery Calculations (*Frontier Nursing Service Collection*)

Once internal reports were sent to Metropolitan Life, staff statisticians compiled data into tables for statistical analysis (see Figure 13). As the letter from Third Vice President Durbin details, reproduced in the Summer 1932 *Bulletin* and excerpted in Figure 15, Ms. Steele, a staff member, completed the original analysis, which Durbin then reviewed and approved. That a woman conducted the actual analysis at Metropolitan Life is indicative of the tendency in the 1910s and 1920s for college-educated women to collate, analyze, and report information for the purposes of defining and changing perceived social problems. From the Dillingham Commission in 1907, formed to research growing immigration and employing women for nearly half its staff (Benton-Cohen 4, 11) to the U.S. Children's Bureau (Theerman 1589) and the U.S. Women's Bureau (Sharer 11), it was not unusual to find women engaged in recording and producing

knowledge (Benton-Cohen 11) in scientific ways. Breckinridge's actions and the division of labor at Metropolitan Life reflect these larger trends.

From Ms. Steele's calculations came charts, with a summary report comparing mortality rates of Leslie County against national rates. Durbin concluded that "If such service would be available to the women of the country generally, there would be a saving of 10,000 mothers' lives a year in the United States, there would be 30,000 less stillbirths and 30,000 more children alive at the end of the first month of life" (*Bulletin*, Summer 1932, 16). Breckinridge reproduced his comparative statements in her *Bulletin*, thus indicating not only the immense value of her organization's work, but also the potential value of her model of care (see Figure 14).

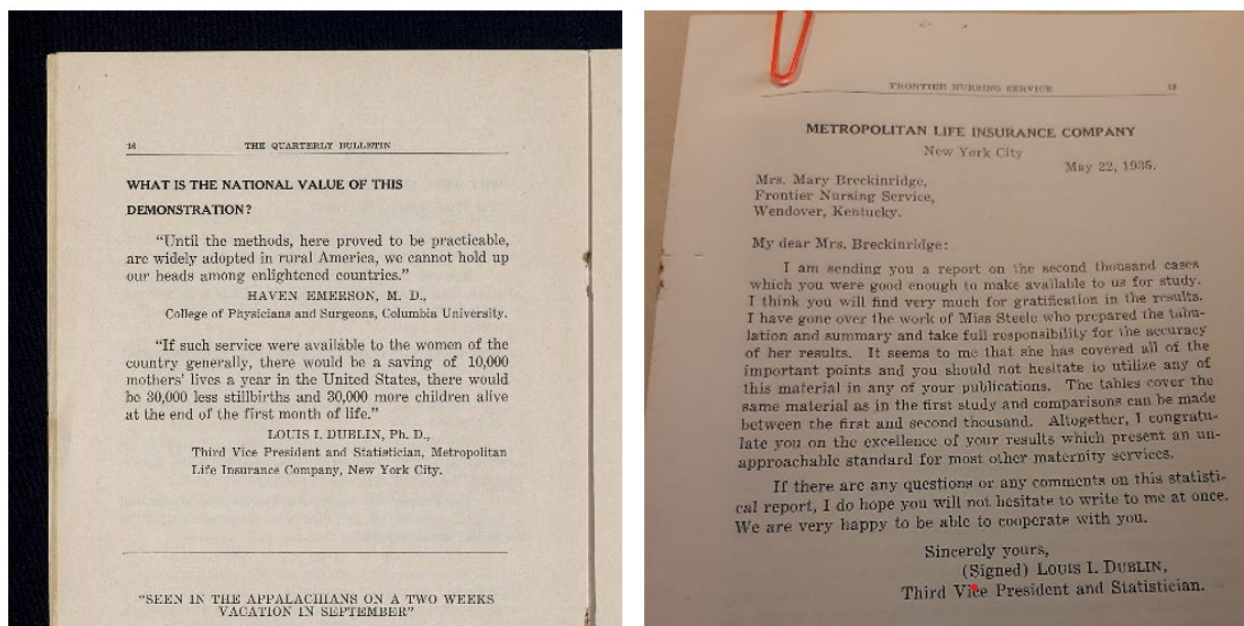


Figure 14: MetLife Quotes and Letter (*Frontier Nursing Service Collection*)

Finally, the MetLife report of the second 1,000 births was partially reproduced in the Summer 1932 *Bulletin*, highlighting improvements in maternal care, starting with the complete absence of maternal deaths in this cohort. As shown in Figure 15, the numbers of vaccines and patients are provided, with a more general list of public health initiatives, from chlorinating

drinking wells, to treating hookworm and trachoma (a leading cause of preventable blindness (WHO, “Trachoma”)), providing dental care, and commentary about the Service’s growth.

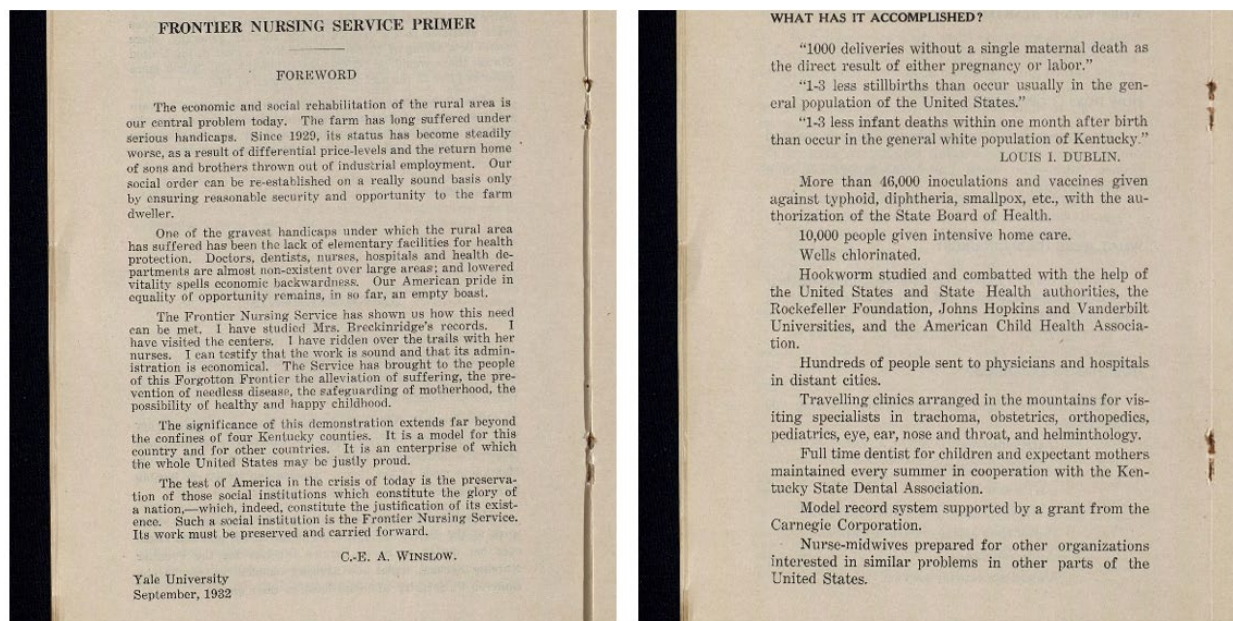


Figure 15: Frontier Nursing Service Introduction and Achievements (*Frontier Nursing Service Collection*)

These achievements are undeniable, and Leslie County’s isolation and extreme poverty compared to the rest of Kentucky do suggest that the Frontier Nursing Service accomplished public health goals that the state had heretofore been unable or unwilling to do. In other areas of the state, coal companies and women’s clubs often sponsored doctors and public health nurses (Barney 12) in addition to the medical practitioners already present. However, coal had not yet penetrated Leslie County (Goan 71), thus limiting the area’s exposure to company-sponsored medicine; it is less clear what clubwomen had already achieved, though Barney’s history of medicine in Appalachia suggests that aside from nearby settlement schools, public health nursing probably was not very accessible either (11). While it is certain that the Service made headway against the dangers and diseases of rural life, the implication that their work had singularly redressed such a significant issue is problematic. Durbin’s comparison did not break down

mortality numbers sufficiently to understand if the population of Leslie County is comparable to other rural, white populations, while the difference between Leslie County's mortality rate (25 stillbirths for 989 births) and Kentucky's as a whole (26 stillbirths per 1015 births) is not actually as drastic as the one-third lower mortality rate he claims in the line before (*Bulletin*, Summer 1932, 10). The difference in mortality rates between patients of the Service compared to patients of traditional birth attendants is also not revealed, though oral histories and Goan (131) indicate that a substantial number of women continued to rely on the providers they always had. Therefore, while the results in the *Bulletin* appear astounding, interpreting their results as such depends on the assumption that the situation was previously dire. However, for audiences that trusted in scientific authority, the numbers Breckinridge provided in conjunction with their analysis by noted statistical experts do reassure that the organization achieved measurable, beneficial results for a region of the country generally accepted as needing aid.

Later material published in the *Bulletins* and available in the Frontier Nursing Service archival collection show that into the 1930s Breckinridge fine-tuned her statistical message, qualifying claims about her outcomes to reflect reality more closely. Even with this qualification, she seemingly never compared her organization's outcomes to mortality rates in populations that chose to engage traditional midwives or doctors in towns outside the counties she served. Even though the Service conducted a local census, giving themselves an accurate population, birth, and death count, Breckinridge did not utilize that information to clearly show an improvement through using her service. In addition, given the numbers of women in the area who did not, or could not, engage Service midwives, a comparison between the two groups would have revealed clearly whether the organization was indeed making a positive difference in the Leslie County population specifically. Instead, comparisons relied on anecdotal data of lost infants and

children. While those anecdotes likely stirred up sympathy among women who had experienced loss themselves, the sympathetic emotion took the place data-driven arguments that were within the realm of possibility. In this respect, rather than personalizing the data for her audience, Breckinridge relies on the universality of loss in childbirth to make the numbers more real to her audience. Therefore, Breckinridge would not have needed to remind her audience of the grief and pain of that experience. Her audience already knew poor maternal care was a problem for everyone, in other words. Her numbers and analyses showed in quantifiable ways that her work made a difference.

Additionally, the non-contextualized numbers of the MetLife letter, reproduced frequently through the first four thousand births attended by the Service, reveal a willingness to elide the impacts of race and class. The national numbers of infants and mothers lost during or near childbirth are not broken down by race, class, age, region, or other demographic data that would have allowed a more like-for-like comparison of the Service's result. Furthermore, determining the actual scale of the problem was hampered by the inconsistency of vital statistics reporting across the nation. Even when such data collection became mandated, births and deaths were not always reported, as individuals may not have engaged with institutions that reported those events to the state. Thus, the clear comparisons that statistical analysis could have yielded were either not possible with the information available or ignored. The Service's records were thorough and complete, but the scope of argument claimed reveals as much about the power of sympathy and emotion amid numbers as it does about the power of data in a climate that relied on expert knowledge for truth. In a sense, like the U. S. Women's Bureau, the Frontier Nursing Service *Bulletins* were "humanly statistical." In the Bureau's case, "the reader cannot distance the aggregate data from the lived experience of working immigrant women" (Sharer 18).

Similarly, the audience of the *Bulletins* cannot separate the numbers from their own lived experience.

4.3.4 *Choosing Medicine*

As Breckinridge's staff surveyed the families of Leslie County to more accurately count the population, she began marshalling resources to treat the endemic illnesses of the region. Dysentery, typhoid, hookworm and roundworm infections, smallpox, diphtheria, and croup were common. Poor nutrition and hygiene were also of concern. Accidents common to rural ways of life, such as splinters, broken bones and sprains, skirts catching fire from open fires and the like, also received attention. Without doubt, addressing these common health concerns could, and did, improve the health of the local population. However, accepting treatment was another matter.

Breckinridge's memoir paints a rosy picture of a population desiring to avail themselves of her expertise. She wrote, "As I rode from place to place I gave such nursing care as I could to the sick people I met, especially the babies. So many of these in their second summer had such terrible dysenteries that I carried two tiny catheters with me in my saddlebags in order to give them colon irrigations" (164). As is common in her publications, she focused her description on the sickliest and most vulnerable, in this case toddlers with gastrointestinal distress. In keeping with her public focus on children's health, she described herself as treating these sick children first and carefully used medical language to describe problems. Then she turned her attention to the mothers, dispensing advice to avoid such issues in the future. She reported telling them, "I explained why [potatoes] had to be baked and not fried, and eggs boiled and not fried. I told them tomato juice was good but not to give them cucumbers...I told them to take the [bread] crusts of the corn bread and bake them" (165). She noted that the mothers listened closely, since she had helped their sick children. In this telling, she reserved her objective, medical language

for her book's readers, but used much more informal language for the women of Leslie County. Using this language reminds her readers of her expertise as a well-educated nurse with the authority to aid families in this way. The mothers themselves, presumably unfamiliar with medical language, were spoken to more plainly, ensuring they clearly understood what they needed to do. They also appeared willing to receive expert knowledge because their children have received care that worked, in this case care they were unable to provide themselves. The mothers, then, were seemingly aware their isolation prevented them from obtaining the necessary knowledge to adequately care for their children. Their lack of knowledge is portrayed as a facet of their environment, not something for which they were inherently responsible. Once that lack is rectified, they behaved appropriately, accepting new expertise not previously available and changing their behavior as directed.

This justification for accepting outside medical care and advice seems logical because if existing care is not allowing a sick infant or toddler to improve, then availing oneself of a new alternative seems a logical choice. However, this description, as is common in her writing, glossed over the organization's slow start and local resistance. It also positioned these mothers as passive and subservient. In this way, Breckinridge depicted her organization as an exemplar of the narratives that informed so much maternalist reform, a perfect world where those with the scientific, medical expertise instructed those needing and willing to be reformed on the experts' terms. Like the female physicians in Skinner's text *Women Physicians and Professional Ethos in Nineteenth-Century America* and the domestic scientists analyzed in Enoch's *Domestic Occupations: Spatial Rhetorics and Women's Work*, Breckinridge rhetorically remade Leslie County as a place lacking the scientific knowledge that only she and her organization possessed.

Through educational interactions, she provided information necessary for women to fulfill their duties of motherhood. Leslie County thus became a utopia of maternalist reform.

In reality, the residents of the areas did not act so passively. Many reform efforts of the era attempted to enforce middle class, white values on populations targeted for reform while ignoring their traditions and customs. Breckinridge expected the women of Leslie County to accept and embrace scientific motherhood and medicine as she brought it to them, on her travels and in their homes. However, as Jessica Enoch points out in her analysis of the emergence of domestic science, *ethos* depends on the audience (99). In this case, her mission depended on her potential patients believing in the credibility of the new information Breckinridge carried with her from New York and London. In the case of domestic science, the new professionals were “crafting their ethos in contrast to their working-class immigrant clientele” (Enoch 102). Domestic scientists were the experts; their working-class audience were those who needed to learn. Similarly, Breckinridge rhetorically positioned her expertise in contrast to the folk knowledge of Leslie County.

Yet, the women and families of Leslie County were not necessarily eagerly awaiting modern knowledge that would magically make their lives better on Breckinridge’s terms. Glossing over this reality also elided the nuances of negotiating credibility with those she sought to serve and the resistance that was offered. In the case of the demonstration kitchens, the targeted women often “refused to surrender their foodways” (Enoch 103). The residents of Leslie County endured a slightly different imposition. Their ways of life and communities were often caricatured and romanticized through the literary and missionary industries that entered Appalachia and helped to create a national sense of Appalachia as a unique region that needed uplift. As Barney noted, multiple medical approaches (from homeopaths to eclectics, to believers

in miasmatic theory and germ theory) presented conflicting information for people to sort through (8). Cost also influenced preference for traditional caregivers, leaving practitioners of scientific medicine often as an option of last resort, even though individuals may have preferred them (Barney 16). While proving that the new medicine was beneficial, or even better than other kinds of medicine, most likely did develop trust between the Service and its patients, the process was probably neither as straightforward nor as immediate as the anecdote suggests.

Breckinridge's constructions of Leslie County residents as intelligent and deserving could not always overcome deeply rooted associations among poverty, backwardness, and lack of intelligence. At least one historian has noted that Breckinridge herself never fully believed in the supposed 'native high intelligence' of her patients (Johnson, *'A Cage,'* 42). One example in a 1929 *Bulletin* demonstrated her own biases. She wrote she used "the simplest language and illustrations" to demonstrate principles of childcare. She likely never fully believed in her patients' abilities to understand medical language or concepts. Negative assumptions about their actual intelligence appear in the oral histories, as well. Edna Rockstroh, one of the first midwives hired by Breckinridge before the Frontier Nursing Service opened, recounted her visceral reactions upon arriving in Leslie County in detail in her 1978 interview as well as how she viewed her patients.

When she first arrived in Krypton, Kentucky, a nearby family provided breakfast consisting of "fried cornbread, fried potatoes, and fried eggs with question mark raisins in them...and then we discovered we'd eaten flies." While her reaction is difficult to produce here, the taped audio reveals that, fifty years after that one meal, she still reacted with strong disgust. She remembered with some consternation that later that evening, after a twenty-two-mile journey on horseback to Wooten, couriers pulled her a bath from the well. The isolation of the region is

pronounced as she talks about engaging in the survey to ascertain the actual numbers of people in the area: “I had to...learn *their* language, and they had to learn *our New York* language” (original audio emphasized). As far as Rockstroh was concerned, not only did they have a poor, unsanitary diet and lack of running water, but their speech was also not understandable.

She also remembered how families often did not express the same kind of devotion to children that so many maternal health activists considered ideal and natural. While on a survey, she met an older woman with a sick infant: “he was so unhappy, and so sick, so we got the granny to sign a release. I asked who the baby was, and she said, ‘Oh, my daughter had him. He’s a bastard. But she went off with another man. So I got the baby and I don’t want him.’” With the grandmother’s permission, Rockstroh took the infant back to Wooten, where she nursed him back to health and arranged for his adoption so that he could receive the love and care he deserved. Bluntly stating the child was unwanted and agreeing to give him up contradicted the utopia of motherly love and devotion that Breckinridge described in her writing.

The primitiveness of Appalachia continued to be a theme in her memories. She remembered the “outdoor toilets” and arranging a kind of yard sale where locals traded garden produce for donated clothes. In the Wooten clinic, she described hanging magazine pictures and posters depicting proper nutrition and eating habits. She recalled the treatment that she gave most often, far more than assisting with childbirth, was for hookworm, an infection firmly associated with poor, rural regions. The published material often promoted preventing infant and maternal natal deaths as the organization’s *raison d’être*, a motivation shared by patients, staff, and donors alike. However, Rockstroh’s memory indicates the truth of Barney’s assertion that Appalachians sought medical care on their terms, rather than the terms dictated by the providers themselves. In Rockstroh’s memories, the locals preferred seeking out treatments that allowed them greater

strength and endurance to farm. Rockstroh also recalled that successfully treating hookworm often established trust for fathers to bring their families in for now-routine vaccinations and preventive care. Creating trust through effectively treating one debilitating condition aligns with the process of trust-building described by Breckinridge and Patterson; the focus on treating hookworm infection and vaccinations in oral histories indicate that for many in Leslie County, the value of the Service lay less in its maternity care and nutritional education than in its ability to ease health burdens of their lived experiences. In fact, such exercise of autonomy often seemed to surprise Rockstroh and her colleagues.

Whether taping magazine pictures of food dishes to teach proper nutrition, or judging individuals for not being completely self-sacrificing mothers, Rockstroh's memories reveal a tendency to conflate the area's poverty with ability and intelligence. From the nurses' perspectives, while the locals needed modern medical care, they seemed to not entirely be capable of living by those standards. The residents' selective use of services also reveals a resistance to an emerging modern medical infrastructure. While some of the new medical treatment was welcome, choosing to utilize it did not automatically signal a whole-hearted embrace of every aspect of scientific medicine. Like the domestic scientists in New England, the nurses of the Service positioned themselves as experts on medicine, public health, and what locals wanted and needed. This choice likely convinced those who already believed in that expertise. However, their assumptions about the people whom they wished to treat minimized their patients' autonomy and devalued their knowledge and lived experiences.

4.4 Conclusion

Breckinridge and her biographers consistently argued over decades that the Frontier Nursing Service successfully demonstrated that professional midwifery care that met individuals

where they were, whether in local clinics or their homes, could substantially reduce the tragedies and burdens of inadequate maternal healthcare on women and their families. The Service's records and reports indicate the truth to these claims. At a time when natal mortality rates were high, their model of care resulted in far fewer deaths of infants and their mothers than was typical across America. Even though the women and families of Leslie County did not always embrace the medical care and scientific knowledge the Service brought as enthusiastically or fully as the nurses wished, Breckinridge did show donors and state officials that her organization's expertise could, and did, make a difference in the lives of their patients. She also showed that this difference was sustained across time. And, in a county where the coal industry and its sponsored doctors had not fully transformed lives, the economy, and medical infrastructure, Breckinridge proved that an organization willing to go its patients could be successful. In this sense, the characterization that opened this chapter, that of the Service being the "longest running scientific demonstration in the United States," has some truth. Her reliance on scientific data collection and analysis and scientific professionalism in presenting her results does prove the value of a traveling nursing service.

Breckinridge occupied a unique position in modern medicine. In a changing medical landscape when public health initiatives had considerable influence, the Frontier Nursing Service both introduced and controlled the medical care that they provided. In contrast, most women reformers wishing to bring modern medicine to Appalachia partnered with public health and medical professionals as well as local industries to do so. Historian Sandra Lee Barney's study of the organizations and reformers who brought scientific medicine to Appalachia revealed a tension between the women who created the mechanisms by which mountaineers encountered and consumed that medical care, the growing coal camps and towns that brought medical doctors

to the region to ensure its workforce was healthy enough to mine, and the growing number of physicians who wished to exert control over the profession. In time, most Appalachian women reformers withdrew from the activism that had brought medical experts and new patients together. Physicians became the arbiters of medical knowledge (152). This, Barney noted, resulted in important lost opportunities: physician's exertion of control over medicine allowed those doctors to dominate preventive medicine and public health programs, while maternalist and feminist reformers' withdrawal from advocating for working-class rights to affordable care stymied the possibility of universal health care (153). Physicians were able to position themselves as the primary arbiters of type and delivery of medical care broadly, not just in obstetrics. Maternalist reformers and activists in Appalachia rarely had expertise of their own to push back and thus eventually retreated. In contrast, Breckinridge's organization lasted far longer than those of other reformers.

A portion of Breckinridge's success came from relying on rhetorical choices that aligned her with the Progressive Era's faith in expertise and the scientific professionalization movement of the late nineteenth century forward. From the beginning, she collected data, assessed her patients and results, and reported her records for analysis according to the rigors of statistical analysis of her time. She displayed her results in sheer numbers and occasionally through percentages, emphasizing the wide-ranging impact of the Service's work as well as the numbers of people she reached. However, the ways she presented information tended to mask the nuances of maternal health outcomes, particularly the influences of race, region, and class. Furthermore, her data does not definitely show that she resolved an actual maternal and infant mortality crisis. Oral histories of locals and of nurses reveal that losing children was common, but the anecdotes never rise to the level of rigorous data collection characteristic of the Service.

However, given that Breckinridge's mission was to address a tragedy not unique to any one demographic or locale, I suspect that, at least for those who donated money to the organization, providing full comparative data was not necessary. Donors knew the problem existed, at least in part because of their own experiences. Institutions like the U.S. Children's Bureau had demonstrated convincingly that losing a child or a mother was not simply a private, individual burden, but one that impacted nearly every family and community in the country. Proving that the Service could reduce the number of those tragedies was likely enough to generate belief in their claims. Furthermore, the constant reminders of achievements coupled with reminders of the general scope of the problem they advertised themselves as resolving worked as a remembering and forgetting in "interwoven dimensions of larger symbolic or discursive processes" (Vivian 10). Repetition trains public memory to believe a specific version of events (Guglielmo 3). In regard to this project, the 'specific version' was that mortality rates related to pregnancy and childbirth were far too high for every community. Strategically forgetting that some areas might not exhibit the same national averages allowed Mary Breckinridge to remake Leslie County rhetorically as an exemplar of the problem and therefore the solution.

The 1978 oral history interview with Breckinridge's cousin, Marvin Breckinridge Patterson, describes a map created as part of the exhibit for the events commemorating the fiftieth anniversary of the Frontier Nursing Service. She described the physical representation of the influence of Mary Breckinridge's dream:

We've graduated something like seven to eight hundred [nurses] from our graduate school of midwifery, which is now Midwifery and Family Nursing. And they're working all over the world. I have a map...showing from Wendover the

red lines that go out all over the world, especially to underdeveloped countries of course.

The Frontier Nursing Service was a 'demonstration area' that Breckinridge built from four hundred square miles of service area to roughly a thousand square miles, in a rugged, isolated part of the country, difficult to get to and to travel around. Through the power of her experience and expertise, she marshalled enthusiasm for the power and promise of science to combat age-old problems. Even with data omissions and the elision of race, class, and region, her numbers do show that her methodical, careful management allowed her to outlast her equally enthusiastic, though ultimately less credible, peers, at least in part due to her commitment to the tenets of scientific practices and discourses.

5 THE LIMITS OF THE FRONTIER



Figure 16: left: Frontier Nursing Service advertisement, right: portion of Wendover painting hanging in University of Kentucky Archives (pictures taken by author)

When I traveled to the University of Kentucky for my archival research trip, from nearly the moment I landed in the Lexington airport I encountered images advertising the region's deep connection to the Frontier Nursing Service and Mary Breckinridge. I saw Frontier Nursing University advertisements in airport hallways, images of Breckinridge in her uniform on horseback, and even a picture of Wendover (Breckinridge's home and organizational headquarters) in the winter in the University of Kentucky Special Collections reading room (See Figure 16). I felt surrounded by and embedded in these memories. The very mountain scenery that so captivated the imagination of generations of readers of Appalachian local color fiction drew me in, and I found myself imagining myself as one of the 'angels on horseback.' Yet, when I left the following weekend, I easily moved back into my regular life, feeling a little bit like I had "commuted between centuries" (Breckinridge 182). Without regular reminders, the romance slipped away.

In some ways, my experience aligns with the story of the Frontier Nursing Service. While the organization and its history are exceptional in some ways, the whole story is not extraordinary in historical and rhetorical context. The maternalist and feminist reformers and professional women who moved into public and professional life made places for themselves that did not revolve solely around their capacities and identities as mothers. Yet, as George et al. explained, these women, as have women before and since, had to contend with the powerful patriarchy that defined their humanity, and most fell victim to it. Some women are remembered as being one-of-a-kind, while many others' stories have been forgotten altogether (11). Maternalist reformers whose public lives revolved around addressing the burdens and dangers of pregnancy faded into the background, their memories lost even as their legacies live on.

In some cases, the rhetorical choices that help to further women's public and professional lives serve to limit possibilities of envisioning public life for women as normal rather than exceptional. In the case of women scientists in the early twentieth century, epideictic rhetoric that celebrated their success also constructed science as "an elite occupation, meant only for the smartest, bravest, and most persistent of individuals" (Jack 224). In other words, by celebrating exceptional scientists like Marie Curie, news reports and career guides did help women to envision the possibility of becoming scientists, but simultaneously reinforced the message that women scientists were the exception and that only the very best could be as great. Similarly, narratives of motherhood and her scientific expertise as a nurse and midwife allowed Breckinridge to make her mark in public health and demonstrate options for addressing the maternal and infant health crisis of the early twentieth century. Even as motherhood and reproduction as a national concern faded from the national political stage, Breckinridge and the Frontier Nursing Service outlasted maternalist reformers who retreated from public life when

their initiatives were incorporated in or rejected by state institutions. Her own medical expert status likely allowed her to hold her own against the increasing control physicians exerted over medicine into the 1930s and beyond. However, by positioning herself as outside the emerging state-sponsored mother and child welfare system and physician control, Breckinridge found herself almost solely responsible for securing money to fund operations. Over the years, she built a substantial fund-raising network throughout Midwestern and Eastern cities. These local committees were often staffed by former couriers, often affluent young women who volunteered for the Service for a summer and then returned home. As these young women matured, they often engaged in charity work; their experience as couriers often directly translated into fundraising activities for the organization. In fact, Patterson and several former couriers interviewed for the 1978 Frontier Nursing Service oral history project recalled their Kentucky summers fondly, explicitly pointing out that the experience galvanized them to raise money and even encourage their daughters to do the same (Mulhausen).

But this courier and committee system took time to develop, and Breckinridge needed money almost immediately. Though her inheritance helped to fund operations for the first few years, as the organization grew, so did its need for money. In Chapter Four, I discussed how she used scientific discourse and data collection to demonstrate the validity of her work. However, as the writers and researchers of the U.S. Women's Bureau realized, presenting numbers alone did not garner a significant response. They were not personal enough (Sharer 18). Thus, fundraising materials, including the *Bulletins*, the film *Forgotten Frontier*, and speeches, often relied on personal stories and images to make real the raw numbers presented in the text. While this tactic was successful, Breckinridge's choices of stories and images reflect racial ideologies prevalent at the time. In particular, she *related* to her audience by reflecting their racial fears and prejudices.

In other words, through her publications she “invoke[d] a range of relationships: collaboration, connection, and coalitions or alliances” (Ryan et al. 195) to which her audiences responded favorably. Though Breckinridge’s archival and published material examined for this project does not make explicit connections to negative eugenics, her word and image choices demonstrate her alignment with what historians term *Anglo-Saxon ideology* (Hartman 5) and positive eugenics (Roberts 82) – ensuring those of primarily English descent had large families to counterbalance the perceived over-fertility of the wrong people. A key tenet of Anglo-Saxon ideology located a reservoir of purely white heritage in the mountains of eastern Kentucky and Tennessee, where lived the descendants of pioneers like Daniel Boone and Davy Crockett who had never left the ruggedness of their mountain crucible.

Like others who poured or drew significant money into Appalachia in the early twentieth century, Breckinridge capitalized on the symbolic power of those mountains to mobilize financial support. In her earliest *Bulletins* and fundraising film *Forgotten Frontier*, she often made direct reference to the ideas and concepts that quickly came to define Appalachia, from racial terms to references to their customs and traditions as preservations of traditional English life. In the 1930s, she shifted to the romantic appeal of riding on horseback in rugged country, saving individuals from the dangers of disease and childbirth. Even without direct reference to genealogy and heritage, however, her frontier focus still relied on ideas of whiteness and the role of Appalachian mountain people in a changing nation.

By the end of World War II, explicit eugenics arguments faded as the horrors of Hitler’s regime and its utilization of the very arguments that had informed racial policies and ideals in the United States were publicized. To be clear, these arguments and ideas never disappeared; however, their nature shifted (Dikötter 467). Following World War II, Leslie County, in a sense,

caught up with the rest of the country. Roads, jeeps, running water, and electricity became normal, and nurses no longer traveled on horseback to provide care. In fact, by the 1980s, nurses no longer traveled at all except to commute to clinics and hospitals. Even as the country changed, though, and Leslie County with it, Breckinridge remained committed to her vision of district nurse-midwifery. Unfortunately, her participation in the racialized discourse of the 1920s and 1930s, though doing so generated substantial funds, likely also contributed to the organization's fading from the public eye. The symbolic association of white mountaineers did not hold the same power as it once did. In this chapter, I first discuss how public memories are created, reinforced, and forgotten to provide a theoretical framing to the impacts of Breckinridge's rhetorical choices of personalizing her work. Then I explain how the racial ideologies of the 1920s, specifically ideas of whiteness defined through Anglo-Saxon heritage, created a romanticized version of Appalachia. I analyze a sample of materials, written, photographs, and images from the film *Forgotten Frontier* to explore how Breckinridge created a romantic image of her organization saving white lives in the very area that had made the U.S. so great.

5.1 The Future of the Nation

Motherhood was not the only ideology that helped to relegate Breckenridge and her organization to a past on the distant horizon. Her use of cultural narratives and ideologies that had currency in the 1920s helped her organization obtain significant funds, but also helped to paint her organization as a model intended only for the frontiers of civilization. As Mary Breckinridge adopted the maternalist narrative of motherhood for her own reform efforts, she also coupled it with Anglo-Saxon ideology. Racial fears in the late nineteenth century, fueled in part by acquisition of new territories and falling white birthrates, fueled eugenic arguments that supported some women and their children at the expense of non-white children and women

(Ladd-Taylor 5). While it is not evident that Breckinridge actively supported campaigns to sterilize women, she did participate in educational activities during her second marriage that promoted scientific motherhood amongst the women tasked with bearing the ‘right’ children. Though she relied on the authority of scientific and medical expertise to garner ethos, she, like the writers at the U.S. Women’s Bureau (Sharer 20), personalized her work. Through images, film, and written text, she connected the scientific, medical nature of her work to contemporary white supremacist ideologies to relate to her target audience of middle and upper-class white women. The symbolic resources of her surroundings in eastern Kentucky in conjunction with the notion of Appalachia and its position in and potential for white America generated additional ethos for her mission.

In this section, I first summarize Anglo-Saxon ideology (an explanation is also provided in Chapter One), and then analyze key ways in which she promoted her organization in the 1920s as one that helped to fulfill the goals of the Progressive Era’s “Better Baby” campaigns. I primarily rely on the images provided in her *Bulletins* and fundraising film *Forgotten Frontier*, but also briefly analyze the 1925 report of the first meeting of the Board of the Kentucky Committee for Mothers and Babies (the original name of the Frontier Nursing Service).

5.1.1 Creating Appalachia

An 1873 travel publication describing the mountains of Kentucky and its people as “a strange land and a peculiar people” (quoted in Shapiro 3) marked the beginning of the construction of Appalachia as distinct region. The many writers who followed, most of whom were outsiders, defined the region as isolated and untouched by progress, maintaining “a style of life and a mode of social organization once common to all areas of the country” (Shapiro 5). The

association of the frontier with Appalachia was strengthened by travel writers and missionaries in the decades that followed.

The actual Western frontier ceased to officially exist in 1890, when the U.S. Census Bureau declared it closed due to increased white population density. Three years later, historian Frederick Johnson Turner hypothesized that the American frontier, as it moved from east of the Mississippi to California, formed the nation's democracy. He wrote that "American social development has been continually beginning over again on the frontier. This perennial rebirth...furnish[es] the forces dominating American character" (1). With the western frontier no longer in existence, the mountains of Appalachia began to represent what remained of the frontier. Yet the region seemed perpetually poor and backwards. Folklorist Henry Shapiro noted that this construction of Appalachia "served to integrate the perception of reality of Appalachian otherness into dominant conceptions of the nature of American civilization" (31). Some reformers attempted to civilize Appalachia through systematic social work. The conception of Appalachia as 'other' also allowed an understanding of American civilization of the 1920s to emerge as 'natural' (Shapiro 31). Mary Breckinridge capitalized on the national fascination with Appalachia as the last remaining frontier to promote her organization, even renaming it the Frontier Nursing Service in 1928.

5.1.2 Anglo-Saxon Ideology

Terry Eagleton's *Ideology: An Introduction* defines ideology as a discursive field in which "self-promoting social powers conflict and collide over questions central to the reproduction of social power as a whole" (29). Proponents of particular ideologies work to "unify a social formation in ways convenient for its rulers" (30, emphasis in original), which not only solidifies the power of the upper classes but ensures, as Eagleton phrases it, "complicity of

subordinated classes and groups, and so on” (30). He further refines this definition into a system in which ideology “signifies ideas and beliefs which help to legitimate the interests of a ruling group or class specifically by distortion or dissimulation” (30). Anglo-Saxon ideology joins a belief in white racial superiority with civilization and strength.

This ideology had its origins in what historian Hartmann called the “Teutonic origins thesis” (3). Essentially, millennia of warfare had allowed Germanic and Nordic people to spread across the world, leaving less war-like, weaker, and genetically inferior people behind them. In time, the Teutons became the Anglo-Saxons, and those with the purest Anglo-Saxon blood, the British, the Scottish, and their settler descendants that conquered the United States, were defined as those best equipped to lead the world. Theodore Roosevelt claimed British colonization of territories across the globe “the crowning and greatest achievement” (quoted in Hartman 14) of human history.

However, the growing American empire, unrestricted immigration, and fears of inheritable physical, moral, and mental degeneracy threatened to destroy Anglo-Saxon countries through ‘race suicide,’ a term coined by sociologist Edward Ross in 1901. He argued that those with the purest blood were failing to ensure the fittest people were born in enough numbers to hold back the threat of American destruction from non-Anglo-Saxons, poor, Black, or immigrant individuals seen as genetically inferior. Ross believed the higher birth rates among these undesirable groups would lead them to eventually outnumber the superior Anglo-Saxon. This disparity in birthrates would eventually cause the Anglo-Saxon race to die out, leaving the greatest accomplishments of the greatest race to fall (Benton-Cohen 25; Hartman 14). These fears led to dual pressures to socially engineer the racial makeup of the United States, by restricting the numbers of mentally, physically, and racially inferior people as well as supporting

Anglo-Saxon women (generally understood to be middle- and upper-class white women) to have more children (Hartman 13 – 15). Believers in Anglo-Saxon inherited superiority worried that the centuries of evolution that had placed them at the top legally, socially, and economically were in jeopardy, and pushed for social policies that directly controlled women's reproductive life (Isenberg 193).

While restricting reproduction of undesirable or unfit men and women promised to redress their overly high birthrates as well as minimize the chances for 'dilution' of pure white blood, the women who should be having large families simply were not. As the United States industrialized, white birth rates fell. Rapidly growing industries heavily recruited immigrants, who were the main driver of population growth (Benton-Cohen 25). Many poor non-immigrant whites were viewed as 'white trash,' a prime source of irresponsible reproduction and interracial relationships. In fact, even W. E. B. DuBois compared these poor whites unfavorably with the legions of "efficient Negroes" throughout the South (quoted in Isenberg 174). Social policy educating and supporting Anglo-Saxon women was simply not translating into higher birthrates.

However, Appalachia, despite its poverty and backwardness, provided an answer to the racial crisis: high birth rates among pure descendants of the original Anglo-Saxon settlers. These individuals lived in the last frontier of the nation, where isolation in harsh conditions preserved the ways of life that had birthed the nation. In the Appalachian Mountains could be found the salvation of America. Birthrates were still high in the region; logically, if maternal and infant mortality could be eliminated among these women, then the natural racial order could be preserved. Many of those Mary Breckinridge targeted for charitable donations were also likely believers in Anglo-Saxon ideology and responded well to portrayals that constructed Appalachia as the last bastion of pure white blood (Barney 97 – 98). The idea that the future greatness of

America, just like its past, depended entirely on preserving the best of its people had considerable resonance. Early eugenics advocate and first president of Stanford University David Starr Jordan made the connection between directed social policy regarding reproduction and the nation in his 1907 work *The Human Harvest*: “Our Republic shall endure so long as the human harvest is good, so long as the movement of history, the progress of science and industry, leaves for the future the best and not the worst of each generation” (7).

Other regional promoters used similar language to encourage investment in the area. One key figure was William Goodell Frost, the president of Berea College, located not very far from Leslie County. Appointed as president in 1892, Frost’s background at Oberlin College and his abolitionist family seemed like an ideal combination to lead a school committed to interracial education. However, an 1893 tour of the nearby mountain counties and embracing of a version of mountain settler lineage allowed him to aggressively promote the school as uplifting those that history had left behind – the “last educational frontier” (Klotter 843). The Day Law of 1904 segregated all educational institutions in Kentucky, leaving Berea attended primarily by white students from the region. Promotion of Berea as providing uplift to “the sons of those loyal mountaineers” (Barton, quoted in Wilson) proved attractive to philanthropists, who generously supported the College (Wilson). Charitable supporters across the nation already understood the mountaineers of eastern Kentucky as worthy and deserving of support. Breckinridge capitalized on this narrative to remarkable success.

However, with the end of World War II, Appalachia joined the modern world. Roads were built where there had previously been none; jeeps and cars became common. Modern infrastructure brought electricity and running water throughout the region, and old frontier-style log cabins were replaced with more modern buildings. The general post-war boom also lifted the

economy of Appalachia, and the ideological and romantic appeals that had been so crucial to fundraising in the 1920s and 1930s simply no longer worked as well.

5.2 Public Memory: Remembering and Forgetting

In the introduction to Maurice Halbwach's *On Collective Memory*, sociologist Lewis Coser tells us that "it is in society that people normally acquire their memories. It is also in society that they recall, recognize, and localize their memories" (38). When looking backwards to remember, people reconstruct and refigure those memories "on the basis of the present" (40). Thus, memory works in a dynamic fashion: as our present changes, we recast the past in those terms, but we also rely on the perspective and memories of the groups around us to retell those memories. As Coser puts it, "the individual remembers by placing himself in the perspective of the group, but one may also affirm that the memory of the group realizes and manifests itself in individual memories" (40). Attempts to shape collective memories are subject to the responses of individuals and their communities, thus allowing various narratives to reshape public memories. Thus, though an individual such as Mary Breckinridge may attempt to train public memory to remember her as a dedicated servant to the public health of the mothers and children of the world, other memories and ideologies influence the reception of that memory.

The cultural narratives of motherhood often prove too powerful for individuals to fully reshape their memories that celebrate their achievements. As Lindahl Buchanan explains, the god-term Mother masks the patriarchal power relationships that undergird and sustain gender dynamics. Taking advantage of rhetorics of motherhood, as Breckinridge and other maternalist reformers did, provides credibility and authority, but also "always/already position[s] them disadvantageously within the gendered status quo" (Buchanan, *Ideologies*, 5). So, women who position themselves publicly as mothers gain ground with their audiences but simply become

mothers again once they vacate the public stage. For instance, Margaret Sanger eventually softened her message by aligning ideologies of motherhood, in which race was embedded, with family planning. This resulted in uneven gains to contraceptive access. (Buchanan, *Ideologies*, 28). Women of color experience even greater risks. Narratives developed over centuries that justify the brutality of controlling Black women's fertility position them as already bad mothers (Harper 56). In other words, the cultural value placed on motherhood that provides white women credibility and authority is not readily available to all women.

Intersections of class and race in the Progressive Era can help explain why maternalist reformers met with significant success in writing the terms of the emerging welfare state to benefit 'deserving' recipients, generally poor people who, by no genetic or social fault of their own, deserved a helping hand to be productive members of society. These reformers' access to the state and actors within it, in conjunction with their growing political power in the Progressive Era, helped them to dictate the form those agencies took and the primary ways in which they supported those in need (Boris 215). In contrast, Black women activists, largely excluded from direct participation in state efforts, shaped their reform activities around the social and economic realities of their lives, thereby recasting middle-class Anglo-Saxon motherhood ideals in a way that challenged those assumptions (Boris 217). However, the political and institutional successes these reformers found were not sustained. As one historian of maternalism puts it, "the lives of the nation's poor children did not have enough political value to compel an enduring public interest in child health" (Klaus 207). Despite progress made in addressing problems of maternal and child health, the disappearance of the support needed to ensure that health reflect Nan Johnson's observation that "boundaries around rhetorical space have been actively patrolled for as long as it has been undeniably clear that to speak well and write convincingly were the surest

routes to political, economic, and cultural stature” (*Gender and Rhetorical Space*, 2). Women succeeded in making their concerns about motherhood national for a time, but backlash moved that burden to mostly a private concern. Maternalist successes eventually, except for a few exceptional women, became victim to patriarchal notions of what women are – mothers, first, foremost, and always. These women’s attempt to train public memory to recall their lives and achievements in particular ways did not have the power of more deeply lodged patriarchal notions of womanhood.

The embedding of racism and white supremacy in our history and society has had considerable costs for women of color. Kimberly Harper’s recent text *Only White Women Get Pregnant* points out that the racial definition of motherhood in the United States positions Black women as, at best, inadequate mothers and results in care disparities that result in too-frequent deaths of Black mothers and their infants. Motherhood, as an ideology that “is used to ensure patriarchal control” (Harper 51), operates alongside a medicalized understanding of pregnancy and childbirth that dehumanizes mothers in favor of producing babies. In this model, motherhood is something that is *done*, with the child the product of the activity or service (Rothman 6 -7). Rothman noted in her 1989 text *Motherhood in America* that “White babies are a precious commodity” (184), the desired product of a healthy pregnancy and managed childbirth undergone by a white mother.

A nation that defines itself on the basis of race and gender “create[s] ethos for groups of people in society” (Harper 54). Hunter’s article “Ideology as the Ethos of the Nation State” pointed out that “Ideology works by building representations that seem to be naturalised ways of life” (Hunter 218). These representations then define audiences (or members of the nation-state) in ways that maintain existing systems of power and oppression, giving “added status to gender

discrimination, and...naturalis[ing]racism” (Hunter 220). The artificial becomes real as citizens circulate a shared vision in society (Harper 54). Anglo-Saxon ideology reinforces the value placed on white infants while simultaneously devaluing non-white infants in a kind of formula that determines the future success or greatness of the nation. In a nation imperiled by increasing numbers of non-white individuals, the ‘right’ mothers must serve by having larger families. For many who spearheaded reform efforts in Appalachia, the region was populated by the ‘right’ people who were undiluted by interactions with the ‘wrong’ people. Thus, the women of Leslie County become vital to replacing or enlarging the white population. The power of this shared vision can be seen in retrospect. Not only the attention given to Appalachia, but also the amount of money that poured in from charitable organizations such as the American Missionary Association or in response to fundraising pleas from individuals like Frost of Berea College, and even Theodore Roosevelt’s celebration of Boone and Crockett, show the power of calls to ‘uplift’ the region.

By tapping into this system of beliefs, Mary Breckinridge took advantage of the desire to ensure that this genetic bastion of pure white, pioneer greatness continued to produce the children that would ensure the continued greatness and security of a nation in racial and economic flux. Doing so strengthened the idea that some poor people deserved aid, by remaking the people of Leslie County as particularly deserving recipients. However, as times changed and Leslie County modernized, the particular focus of maternalism and Anglo-Saxon ideology faded or adapted. Therefore, these narratives no longer carried the same weight. By the time Leslie County was no longer a frontier, the Breckinridge’s rhetorical power began to fade. The same cultural and ideological dynamic that provided authority to efforts to reform Appalachia in the

end subsumed the women enacting those reforms. When the region successfully changed, they, their stories, and their justifications faded from the national stage of public memory.

5.3 Analysis: Race and Frontier

5.3.1 “It’s Sporting to Begin There”: Appeals to Race

The Frontier Nursing Service published its first *Quarterly Bulletin* in June 1925. The cover features a sketch of Jesus surrounded by children of various ages, while he strokes a young girl’s hair and holds a toddler. Mothers with their children form a line through a door as they wait for his blessing. The picture is captioned, “He shall gather the lambs with his arm and carry them in his bosom, and shall gently lead those that are with young.” While Breckinridge did not seem to belong to a church after moving to Kentucky, she was a deeply spiritual woman. Her image choice reflected that spiritual commitment and reminded her readers that caring for children and their mothers is a religious and moral responsibility.

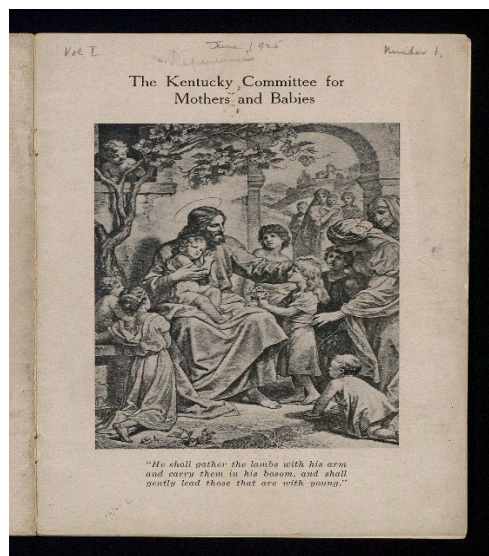


Figure 17: Ordained by God (*Frontier Nursing Service Quarterly Bulletin*)

However, the representation of Jesus, the mothers, and the children reflects an understanding of Jesus and his followers as white. This representation aligns with Christian images circulating for

generations at least in the United States, so perhaps there were few other options available. However, depicting him more accurately would also likely have alienated her donors who visualized him the same way. In reflecting back to her audience the same religious imagery they associated with their churches, she establishes a common religious and racial ground. She also softens her message by constructing both herself and her audience as serving a higher spiritual duty. She does not engage in a direct request but appeals to a shared religious tradition that obligates helping those less fortunate. Fortunately, the less fortunate visible in this image appear to the same race as the donors likely were, therefore assuaging fears that donations would not be used to aid the least deserving.

The shared racial understanding invoked indirectly in the religious image in Figure 17 appeared regularly in material directly and indirectly from the very beginning of the Service. In the first meeting of the Board of the Kentucky Committee for Mothers and Babies, the organization's mission and initial resolutions for the Board were approved. Breckinridge was named as the first speaker, and her words were summarized as a presentation of the problem of infant and maternal mortality and justifications for the choice of location. While she does not specifically refer to notions of 'old stock,' the three justifications quoted here invoke the need for perpetuation of Anglo-Saxon blood:

1. The mountains presented an intensification of the problem and it was more sporting to begin there.
2. The native population in the mountains had a very high average of ability and was of greatest possible value to the nation. She cited figures...to prove this as characteristic of the mountaineer in both [Britain and the United States].

3. The picturesque appeal of the mountains would draw a more ready response in getting the work under way. (2)

The second justification comes the closest to explicitly stating why these ‘mountaineers’ needed well-trained and licensed midwives. Stating that they were of the “greatest possible value to the nation” invokes Ross’s ‘race suicide’ fears of 1901. These words indicate a double meaning, in fact. Maternalist and feminist reformers employed rhetorics of motherhood to advance their often-overlapping agendas (Ladd-Taylor, *Mother-Work*, 7). The politicization of motherhood and childcare helped to publicly cement the value of mothers’ work in service to the nation; fears of the seemingly disappearing Anglo-Saxon family directly translated to fears of the degradation of the nation. Thus, the work in Leslie County would buttress the nation against threats to its greatness by supporting work increasingly valued in society. In addition, the value of scientific medicine to ensure good mothering (Ladd-Taylor, *Mother-Work*, 4) can be read into this statement. Providing modern medical care to these women, who, apparently, had never had any, would also demonstrate the value of providing such care to every deserving woman in the nation. Whether a reader would hear all or part of these meanings, Breckinridge’s phrasing would appeal to the racial and scientific biases of her donor audience.

Other speakers at the first board meeting invoked Anglo-Saxon ideology. Judge O’Rear is paraphrased as calling “the Highland people...the seed corn of the world” (5). The “seed corn” metaphor seems to be a version of the animal husbandry metaphors often employed by eugenicists (see quote from David Starr Jordan earlier). A local activist reformer, Linda Neville, related a story of a motherless teenager imprisoned for theft, asking if ensuring women did not die in childbirth would prevent the moral degradation that resulted in “penal tragedies” (4). The implication is that proper mothering would have allowed the teenager to mature with a strong

moral compass, an invocation of the value of motherhood to society. However, the close association at this time between race, class, morality, and the idea of the Anglo-Saxon pioneer in the mountains suggests that she may have understood his criminality as something he could not help because of his environment, a claim that appears in other Frontier Nursing Service literature (see section 4.3.2). The idea that the region represented an “intensification of the problem” implies that criminals would have grown up with a good character if only the responsibility to mothers were taken seriously. The seemingly simple solution of providing women with subsidized modern medical care promised a great deal in this report: the most basic sustenance to the character of the nation, its white children, to have a healthy start to life; widespread criminality averted; and high chances of success.

The judge’s reference to “Highland” people can be read two ways: the people in the mountains of Appalachia, but also as descendants of Scottish highlanders. Breckinridge mentions her own Scottish ancestry several times in her memoir, at one point writing about her visit to Scotland that she felt “at once that I had come home. Scotland, its soil, its people and its traditions became mine—not by inheritance as before, but actually through the response my spirit made...” (131). Her descriptions of the mountain residents of Kentucky regularly describe their behaviors and beliefs as “not unlike that in the old Scottish clan” (159). My secondary sources on Anglo-Saxon ideology do not explore this element, so it is difficult to ascertain whether claims of Scottish clannishness are part of the definition of the early nineteenth century of whiteness. However, certainly the elite Kentuckians represented in this *Bulletin*, including Breckinridge herself, claimed Scottish descent as part of the Kentucky mountain identity.

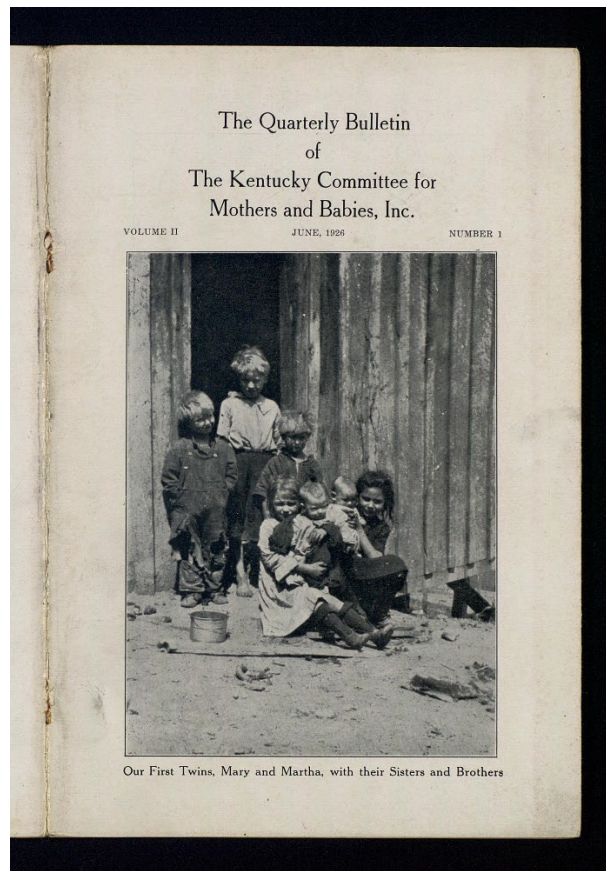


Figure 18: A Mountain Family (*Frontier Nursing Service Quarterly Bulletin*)

Breckinridge continued to explicitly invoke the ideology that placed such high value on her target patient demographic in following *Bulletins*. The first issue of the 1926 *Bulletin* displayed a family of seven children in front of a log-cabin on the cover (Figure 18). The ground is bare dirt, and one child's overalls have large rips at the knees. Though all are wearing shoes, the roughness (compared to donors' more comfortable homes in midwestern and eastern cities) of their living situation emphasizes the frontier nature of the region. In this picture, as in all *Bulletin* pictures in the 1920s and 1930s, the children are white. A reader might not realize this racial choice consciously, but if all the people of Leslie County are supposedly of old Anglo-Saxon heritage, what else would they be? More obviously to a reader concerned about population changes, this family of seven children, with potentially more in the future, is certainly

large enough to counteract the equally large families of undesirables elsewhere. In these early *Bulletins*, regular written and visual reminders of the children's heritage reinforce each other, supporting a larger message: though poor, these children (and by extension their parents) deserve the best that modern medicine can offer. They deserve the best because they have the greatest potential, which is immediately obvious in their racial makeup. Thus, Breckinridge continued to rely on and relate the frequent maternalist message of the “deserving poor” suffering through no fault of their own. Arguing to provide scientific medical care to the those who deserve it despite their class or rurality does expand access, but simultaneously the argument constructs others as non-deserving, reinforcing racial inequities in access to medical care.

In the same *Bulletin*, a short piece titled “America's Own” reinforced the visual message of cover photo:

To make all the following figures come alive to our friends, we offer, with them, pictures of some of the babies brought into the world by our nurse-midwives, and cared for by our service during the months following their birth.

We challenge any section to show finer babies than these wee Leslieans of ours—and here and now we pay a tribute of respect to the intelligent and eager cooperation of their mothers. This is the old stock, with modern care and teaching—America's own.

Hasn't the year been worthwhile? (5)

This passage directly referenced ‘old stock’ to remind readers of the racial heritage of Leslie County and ties into maternalist goals regarding scientific motherhood. Certain mothers are shown as recognizing their duty to their children. Their “intelligent and eager” cooperation paints them in contrast to other women who resisted scientific

motherhood. These descriptors depict motherhood as needing to be controlled and surveilled by experts, and paints 'good' mothers as those who acquiesce to that control. In fact, the mothers of Leslie County were so smart they did not resist at all, a connection reminding reader of the supposed innate intelligence attributable to their genetic inheritance. Furthermore, the picture personalizes the achievements of the Frontier Nursing Service by showing readers happy and healthy infants born under the watchful care of the organization's nurse-midwives. The short piece reminded readers of the value of their donations and the organization's work.

An article in the Summer 1927 issue of the *Bulletin* explicitly referenced key tenets of Anglo-Saxon ideology in its second article, "Waiting to Serve." The article is identified as an editorial published in the November 23, 1927, edition of *The Louisville Courier-Journal*, but beyond this byline, no other authorial information was given. The unnamed writer credited an anonymous Rotarian writer for quoting Woodrow Wilson as saying that "the millions of people living in the mountain regions of Kentucky, Tennessee, the Virginias and the Carolinas had been preserved there to supply a great future need in American life." The writer stated that "these millions of people" were descended "unadulterated" from the "mainly Anglo-Saxon" settlers of three hundred years before. They had been strengthened through constant warfare with "the Indian, the primeval forest and the predatory animal" and later with the land to grow enough food to survive. The writer ends the article with "Their wits have been sharpened on a natural whetstone." The writer did not identify the "great future need," but the descriptions of the people clearly reference the Teutonic thesis of greatness honed through a warlike nature and the ideological understanding of the Appalachian people as one of a very few untainted sources of original settler genetic material. In fact, this reads very similarly to Turner's "The Significance of

the Frontier in American History” of 1893, which made a nearly identical argument about the relationship between American identity and the frontier. Therefore, readers probably understood the ‘great future need’ as racial threats to American civilization and democracy. Next, the writer claimed that all the people in the mountains needed was to be “armed with a little education” to “wrestle with the world” (2). The anonymization of everyone except Woodrow Wilson makes the editorial sound like the ubiquitous ‘everyone says’ argument, in which the information is presented as accepted common knowledge, so obviously true that origins need not be credited. If the statements in the editorial were already believed (at least by most readers), then confirmation bias would allow readers to interpret the article as yet more evidence of the universality of this supposed truth.

5.3.2 *Frontier Romance*

Mary Breckinridge never abandoned her preference to display the infants and young children her organization had helped, with good reason. Her organization did positively impact the public health of Leslie County and surrounding areas in multiple ways and showing the good health of happy children is an easy, sympathetic way to demonstrate the good that her organization did. Whether ensuring that their patients had access to the newest deworming and parasite treatments, tonsillectomies and the like, ensuring treatment for trachoma, engaging the WPA to build more sanitary waste and sewage systems, or even treating individuals for burns and splinters (Breckenridge 257 – 261), the Service addressed far more than just the dangers of pregnancy and childbirth. In fact, her work did go beyond simply ensuring treatment and preventive health, as the archival records contain considerable correspondence and record-keeping between Mary Breckinridge the US Farm Bureau during the Great Depression. During that period, she hired locals to do manual labor on her clinics and outposts, and then sent those

wages to make payments on farm mortgages to prevent foreclosures (despite laborers' clear preference for cash) (*Frontier Nursing Service Collection*). Especially during the first two or three decades her Service operated, Breckinridge displayed an ability to adapt to the circumstances that adversely affected her adopted home and marshalled resources to aid its people, even if not always the way in which they preferred. However, the ways in which she persuaded outsiders to assist relied not only on constructions of whiteness, but also on the conception of Appalachia as a backwards frontier. In this way, she responded to prevailing narratives of Appalachia and contributed to their persistence as well as positioning the Frontier Nursing Service as a perennial frontier organization. Rhetorically, when Appalachia modernized, then the Service's work was complete. Despite changes following World War II, many of which her organization worked toward, she never entirely let go the romantic notion of 'angels on horseback on the frontier.' But when the frontier left the Kentucky mountains, the exigence and urgency that had informed the first few decades of her work left, too. Despite the clear benefits of her Service that she had scientifically demonstrated for so long (see Chapter 3), without a frontier left to work in, the need for her model of care faded.

One of the favorite images that Breckinridge used in her *Bulletins*, postcards, and the movie *The Forgotten Frontier* was of a nurse on horseback in a river. These images constantly reminded viewers that Leslie County had no actual roads or bridges. The images evoked the dedication and passion of the nurse-midwives and couriers who travelled great distances over and through rugged terrain and harsh conditions to serve families in their homes. In a subtle way, these images, along with reminders that Leslie County had no full-time physicians, suggested

that nurse-midwives were far more dedicated to their work than physicians, who would rather live comfortably in wealthier cities than share their knowledge and gifts with all.

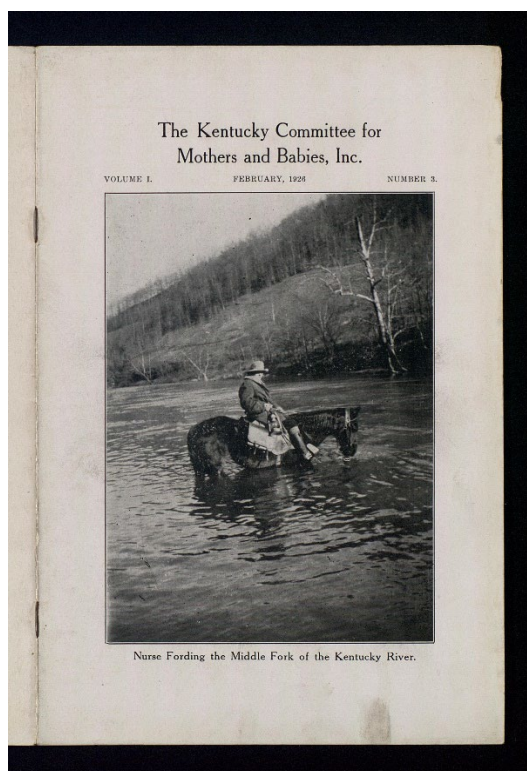


Figure 19: Rivers are Roads (*Frontier Nursing Service Quarterly Bulletin*)

The second *Bulletin* of 1926 emphasized the rugged isolation of Leslie County. The photograph shows a nurse on her horse, crossing the Middle Fork River (see Figure 19). The lack of a bridge in the image probably reminded readers the first pioneers encountered no bridges, either. In reminding readers of when Kentucky first opened to white settlers, Breckinridge invoked the heroism of folk heroes like Daniel Boone, a favorite of proponents of Anglo-Saxon ideology. She also reminded readers that settling wild frontiers required great energy, a willingness to fight, and an adventurous spirit, all hallmarks of the Anglo-Saxon prototype. Finally, she also invoked the idea of America. Folk heroes like Daniel Boone and Davy Crockett, representative of “common people rather than leaders and for a frontier or regional rather than a national community” (Bodnar 26), served as an everyday model of patriotism. With the western

frontier closed since 1890, only the Appalachian Mountains encapsulated the very rugged, not quite conquered land that, according to contemporary historian Frederick Turner, had given birth to American democracy and identity. In fact, the area was so isolated that outsiders could not easily change how the mountaineers lived; thus, many seemed to believe, they had not changed in language, customs, and daily living. Leslie County's supposed extreme isolation reinforced these ideas and resonated with those who sympathized with historian Turner's frontier hypothesis. This hypothesis also implicitly called to mind the greatness of the white pioneers, with their Anglo-Saxon heritage. Their descendants, living in the same conditions with the same issues, are rhetorically constructed as nearly identical.

The images in Figure 20 provide examples of the ways in which the isolation, primitiveness, and ruggedness of the region were emphasized in Frontier Nursing Service material between the 1930s and the 1950s. All images were found in the archival collection, but they were originally clipped from both newspapers and magazines.

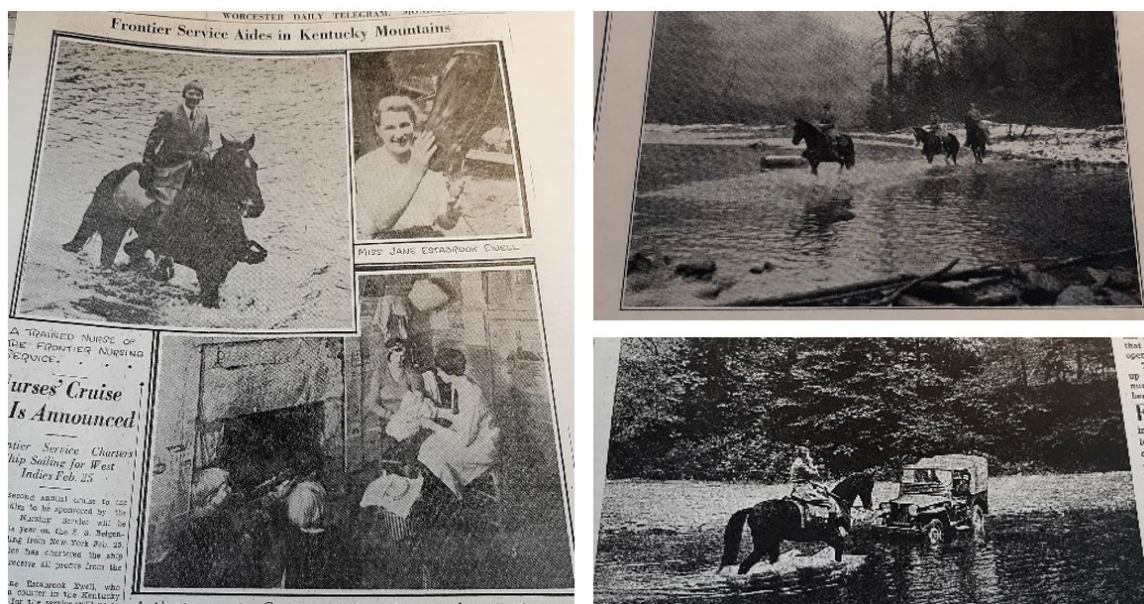


Figure 20: Nurses of the Frontier and Changing Appalachia (*Frontier Nursing Service Collection*)

In the final picture, the caption reminded readers that, even though jeeps were available, the region still lacked road infrastructure. There were still no bridges even when gasoline-powered vehicles became available. In addition, the constant reminder of horses calls to mind the occasional newspaper headline that referred to Service nurse-midwives as ‘angels on horseback,’ a moniker used in the 2021 PBS documentary on the Service and alluded to in Ernest Poole’s *Nurses on Horseback*. The narrative is similar across the years and publications: Resolute nurses, saving babies no matter the conditions, going where they were needed instead of waiting for patients to brave the elements to reach a clinic or hospital. This narrative introduces a sense of awe at the nurses’ dedication to their mission in such a harrowing environment as well as a moral appeal. These nurse-midwives were so dedicated to their mission that they are willing to sacrifice considerable benefits to practicing medicine. They chose to forego practicing in an office, clinic, or hospital. They willingly moved to this isolated county far from their friends and families in the East and in England. Records in the archival collection also show that the nurses accepted reduced pay during the Depression to conserve funds for medical services. The nurses were portrayed as morally superior, braver, and more courageous than physicians working in more comfortable locales. A reader asked to donate what they can spare, even if only a few dollars, to support these brave women might feel guilty for not donating while they lived in comfortable modern homes surrounded by modern infrastructure.

Beyond the nurses daily conquering the ruggedness of the region, the patients themselves were frequently depicted as still living in the prior century. The association between Daniel Boone and David Crockett and the frontier endures in movies and TV shows, such as the 1960s Disney show *Daniel Boone* and many movies about the Alamo. Figure 21 shows several images

from newspaper and magazine articles that emphasize the frontier living conditions of eastern Kentucky.



Figure 21: A Modern Frontier (*Frontier Nursing Service Collection*)

The images on the left were clipped from a newspaper from the late 1930s. Again, the horse for transportation was emphasized. Leslie County's lack of modern road infrastructure and isolation, even between families, was frequently featured. To the left of the family on horseback is a nurse standing with an older woman outside the hand-hewn wooden fence surrounding her property. The woman wears a blouse and skirt reminiscent of frontier life. To the right of the horses was a small log cabin with a family standing on the front porch. The smallness of the home and roughness of the logs emphasizes the frontier by implying they cleaved their home out of the wilderness.

The second set of pictures comes from a magazine story published in 1963. A similar log cabin on stilts, built over a creek, rises on a small bit of flat ground. The next picture shows the ruggedness of the area. The middle pictures provide a close-up of another log cabin home, with

six small children sitting on the porch in the left-hand picture and the father and a couple more children inside the home. The wood stove in the middle indicates the lack of central heating, a luxury in many mountain homes that reminded readers these individuals still lived like America's frontier ancestors. Despite the decades between the two pictures, they tell a similar story. These people, frontiersmen with large families, lived hardscrabble lives with few luxuries. They raised large families without the staples of modern life, building their homes by their own hands wherever the harsh landscape allowed. This kind of frontier promotion capitalized on the idea that, in the mountains, the direct and undiluted descendants of the very people who had given birth to America still lived the same kind of life that had given birth to American democracy and exceptionalism.

These ideas and narratives were repeated throughout interviews and materials gathered from others involved with the Frontier Nursing Service. Breckinridge's much younger cousin, Marvin Breckinridge Patterson, had just completed a degree at Vassar when she spent the summer in eastern Kentucky in the late 1920s. In her 1978 oral history interview, when asked her thoughts on when she first arrived , her answer reflected how Appalachia had been constructed as a frontier and her interpretation of mountain life:

Well, I had read something about Appalachia and mountaineers so I had an idea what it was like. I didn't realize how different in time it was. It was a hundred years before time that they were still living in. And this is why my film *Forgotten Frontier* is appreciated by the Library of Congress and the National Archives, because it showed life in America 1850, 1860 when there were no movie cameras to record it.

The power of the myth of Appalachia as a place lost in time also appears in Breckinridge's 1952 memoir, in which a section of Chapter 19 is titled "Commuting between Centuries." While this chapter did not explain explicitly how she was traveling between 1825 and 1925, other chapters discussed in detail her opinions of the 'mountaineers.' She described two 'old stock Kentuckians' whose "mother had been carried away by Indians!" (169). She insisted all the mountaineers, except for occasional French Huguenot and German (by way of the Pennsylvania Dutch, with incontrovertible Revolutionary War bona fides), were of British descent; they retained the British language and customs without change from colonial times; they celebrated "old Christmas" on January 6th, courtesy of following the old Julian calendar; they retained a pioneer 'code of honor,' behaving in a far more chivalrous manner than modern men and in which stealing is worse than shooting a man; and even Revolutionary War customs around the gentleman's duel still existed (Breckinridge 170 – 171). The enduring power of Appalachia as a frontier region in the eyes of outsiders retained power, even as the overt racial connections faded from written language in the *Bulletins*.

The film *The Forgotten Frontier* explicitly frames the Frontier Nursing Service as a mission of mercy on the frontier. Patterson filmed the movie at Breckinridge's request in the late 1920s. The film is silent, with written words explaining the moving images. At times, the exposure is uneven; Patterson explained in her 1978 interview that the air and wind were so cold that she could not keep a constant speed as she hand-cranked the movie camera. The next several figures are stills captured from the film to show how Patterson and Breckinridge chose to portray the region to reflect the national narrative of the last frontier.



Figure 20: Travel in the Mountains (*Forgotten Frontier*)

From the very beginning of the film, viewers learn that the nurse-midwives are in the Appalachian Mountains, and are treated to images of how rugged, isolated, and desperately difficult the conditions of the region were. Arriving in Leslie County required a night ride on an old-fashioned steam train, a car ride to the literal end of the road, and a twenty-mile ride on horseback to Wendover. The nurse-midwives and their courier assistants are shown on horseback in the river, along mountain paths, and going to one-room schoolhouses and log cabins. Typical log-cabin homes are shown precariously perched on mountainsides, barely hanging on over the river, similarly to later newspaper and magazine photos (see Figure 20). The indoors areas of the ‘mountaineers’ themselves are very frontier-like, with little in the way of amenities, bare wooden walls, and large fireplaces with minimal and rough, handmade furniture. The women wear the long skirts and aprons in which Hollywood Westerns dress pioneer women (see Figure 21). Later parts of the film also show behaviors and customs that the films claimed to be typical of

mountain life. These aspects are the same as those found in newspaper and fictional accounts that helped to construct Appalachia as the last frontier.



Figure 21: Midwifery Care in the Mountains (*Forgotten Frontier*)

Part 3 shows non-midwifery medical care, demonstrating the willingness of individuals and communities to receive vaccinations and standard preventive health interventions. Part 3 also engages in the more general boosterism typical of discourse of Appalachia in the period, turning to traditional customs and crafts. One scene shows court day in town, with everyone coming in on horses or in mule-drawn wagons. The town looks very much like one in any Western movie, with bare wooden boards in porches and a dusty street. While a nurse visits homes to conduct wellness checkups on young children, viewers are shown a ‘mountain craftsman’ showing off the baby crib he handmade and his traditional craft of making of chairs. These scenes reflect the boosterism of Frost and others who ‘discovered’ the old ways still extant in Appalachia in this period. Finally, near the end of the movie, an ‘old-fashioned shootin’ is acted out. Two men

riding along a mountain path encounter each other and argue over whether one shot the others' brother. The conversation mimics the supposed archaic speech patterns that so many have claimed identical to the English of Shakespeare's time (Montgomery 66). The bereaved gentleman pulls out a shotgun and shoots the other man at point-blank range, a portrayal of a duel similar to depictions of the Hatfield and McCoy feud. Though the focus of the movie is on the harsh conditions that make childbirth particularly dangerous for the women of Leslie County, its portrayals of frontier life reinforced the argument that these communities retained the most important features of the pioneers who had created the country.

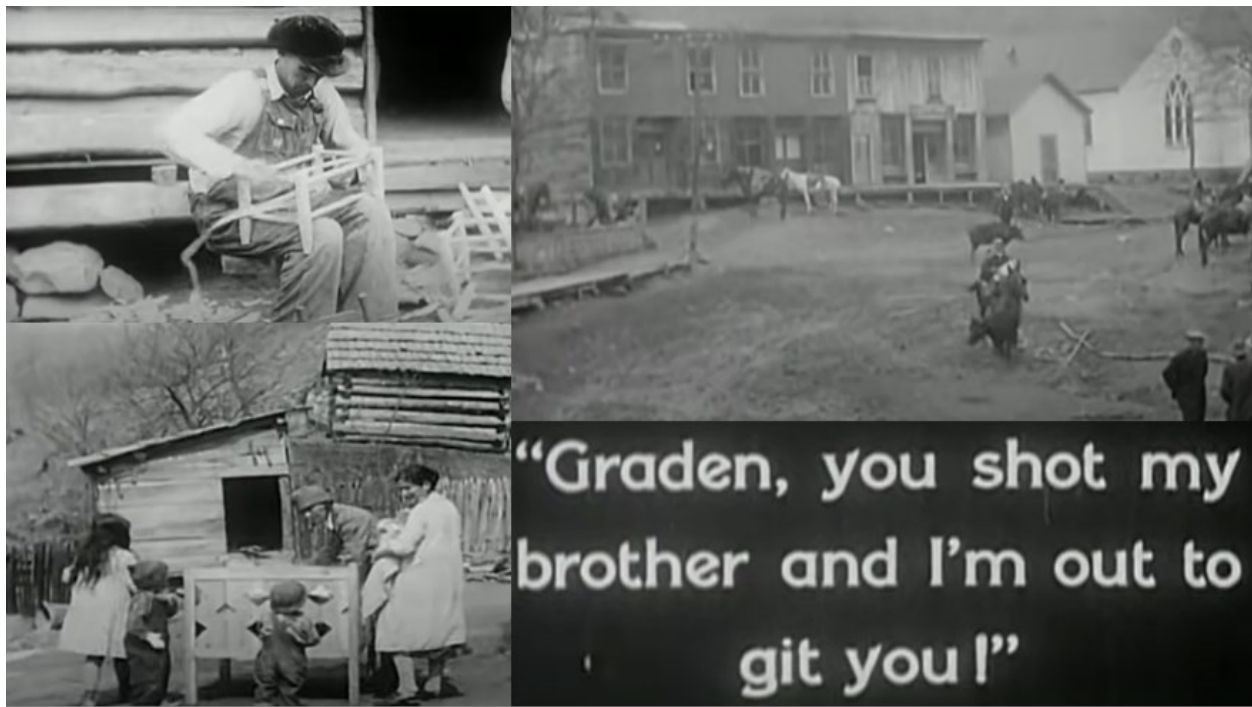


Figure 22: Scenes of Traditional Life (*Forgotten Frontier*)

As would be expected in any movie, much of this film was staged. Patterson and Breckinridge requested the unpaid assistance of all extras who were not Frontier Nursing Service employees and recreated what they considered typical scenes of daily life. The home that served as the setting to demonstrate homebirths as attended by nurse-midwives was chosen because the

owner had recently removed the roof, allowing enough light to film the scenes. The infant in this scene was one born to a patient a few weeks before filming. The buildings, whether farms or town, were actual locations rather than sets, but the interactions were set up in advance (Patterson, Oral History). As the movie progresses, more focus is given to traditional ways of life, with images of handcrafts and handmade homes filling the camera shots. The creation and recreation of scenes that Breckinridge directed for the movie further demonstrated her ability to capture nationally circulating narratives and ideas to reflect back to her donors what they already knew and believed from a robust literary and boosterism tradition of Appalachia. She created her own material, adapting existing rhetorical resources for her own purposes. Her success, however, stamped the Service as an organization of the frontier, limiting its replicability elsewhere.

The association of Appalachia with a particular version of the western frontier combines with ideas about how people lived, dressed, and behaved in those regions. There is nothing particularly surprising that, in an area lacking infrastructure to allow easy movement of inexpensive ready-made goods, that individuals would build their own homes and furniture, or that they would rely on horses in the absence of automobiles or trains. In a sparsely populated area, the few opportunities that allowed social interaction would probably have drawn all who could attend. And all these features of rural mountain life would have made providing medical care more difficult for the nurses, particularly those who were not skilled riders or were used to modern amenities. However, the meaning imbued into these ways of life speak to the sheer power of the romantic idea of Appalachia as the home of our 'contemporary ancestors.' In other words, the myth of American pioneer history that had given birth to the United States and had seen it grow from sea to shining sea was still alive and well in the mountains of Kentucky in these images.

The relative positioning of men and women throughout the film also remind viewers of traditional life, a way of life that many feminists and New Women were rejecting in whole or part. However, New Women were not rejecting their traditional gendered responsibilities altogether. These ‘fotched-on’ women (as the film described them) were engaging in activities suitable for their gendered natural abilities. The women they took care of also follow traditional gender roles, as shown by the placement of ‘mountaineer’ women in the home, with their husbands outside or taking care of public business on court day. Throughout the movie, very few of the local women are ever shown speaking. The men are shown initiating activities and conversations with the nurses, but their wives are even more submissive and passive.



Figure 23: Vaccinations at the School House (*Forgotten Frontier*)

This gender separation can be seen when the children are brought to receive vaccinations at the local one-room school. However, that traditional delineation of authority fades in the face of expertise. Primarily fathers bring the children for care and line them up to receive shots at the local schoolroom. While some mothers are present, they carry infants and seem to follow their

husbands' directions. All these mountain residents are ready to receive the shots until the schoolteacher, another expert, resists. She even asks the children if they want to receive vaccinations since they hurt, but soon afterward the nurse-midwives prevail. The children receive all their shots. Traditional gender authority bends before expert knowledge, and non-medical experts submit to medical professionals, just as domestic scientists expected for their immigrant audiences in test kitchens.

The presence of the schoolteacher shows another facet of missionary and charitable work in which so many Appalachian reformers engaged. Breckinridge's organization was not the first to arrive in Appalachia, or even Leslie County. The American Missionary Association had been sending funds and teachers to the region for schools for some years at this point, and the schoolhouse shown in the video might have been one of those settlement schools. In fact, Breckinridge had volunteered at a North Carolina mountain settlement school before enrolling for her nursing degree (Breckinridge 52). This scene demonstrates conflicting authority between an already-established individual and organization and the new medical organization. The locals are seen as eager to embrace the new knowledge and benefits of modern medicine, coming from miles away to gather at this school building. The scene merges medicine and education in a way reminiscent of public health initiatives. The schoolteacher represents what Barney describes in her history of medicine in Appalachia, in which she explained the native Appalachians did embrace scientific medicine enthusiastically when the benefits were clear. However, resistance to some aspects was often interpreted as not fully understanding modern medicine (10). In this scene, families arrive from a distance to gain the benefit of vaccinations, but the schoolteacher attempts to block the clinic. A non-narrated silent conversation between the nurse and the teacher results in the vaccinations eventually going ahead. Presumably, once she understood the benefits,

the teacher agreed they were necessary. This triumph of scientific medicine would have appealed to the reform-minded and progressive donors that Breckinridge targeted by virtue of repeating back the narrative that was so typical of Appalachia: backwards, behind the times, but the best of America lives here; they just needed access to and education about the new ways of doing things. Once they knew the new ways were better, they would willingly accede to the authority of the expert, and thus eventually modernize.

Ensuring that locals understood medical benefits and respecting their traditions to establish trust appears in a number of the oral histories. Patterson recalls nurses asking fathers, “What time [for the next appointment] would suit you?”, contrasting that with a city clinic that would instead order the patient to “Come here tomorrow, 8 o’clock.” Historian Ladd-Taylor notes that maternalists, especially some in the U.S. Children’s Bureau, experienced resistance rooted in concerns that experts would take away the authority and autonomy fathers and husbands exerted over their homes (“My Work,” 329). The tension between paternal authority and female medical expertise required acknowledgement of both, showing that traditional family values were respected but modern science and medicine carried more weight.

As Enoch described in her analysis of domestic science kitchens and other historians of the era have pointed out, the women who enforced the ways of life they saw as ‘right’ or ‘best’ were in fact often pushing women who did not share the same cultural background to accept a middle-class Anglo-American way of life (131). In this film, acquiescence to the vaccines depicts this perceived need for education, and the belief that if the targeted population simply understand why the reformer women were right, then problems could be solved. In this case, receiving vaccines for typhus, diphtheria, and other common epidemics as well as deworming medicines objectively did improve the health of the community, so the belief of Progressive Era

medical reformers was not off-base. However, the depiction also demonstrates the lack of empathy that many of these women had for the people they were trying to help. To be experts in this scene, the nurses must supersede traditional authority. Like the women physicians of the nineteenth century, they can acknowledge traditional values but minimize patient autonomy and authority (Skinner 154).

Drawing on the imagery and connotations of the frontier helped to personalize the scientific expertise they brought so that donors could see examples of actual positive changes. They also could see the Appalachia they already envisioned in the images and film, helping to reinforce the message of targeted reform that characterized the early introduction of modern medicine to the region. Yet, throughout, the actual people welcoming this new way of taking care of themselves and their families are depicted as passive and subservient, a quality decidedly not typical of the supposed Anglo-Saxons who had colonized and modernized the world.

5.3.3 *Fund-Raising*

Seeing the script of reform played out so successfully on the backdrop of the frontier life of Appalachia demonstrated a keen awareness of the kinds of messages that donors would respond to, and had, ever since the American Missionary Association began funding settlement schools in the region. As Breckinridge deployed these images, adapting existing Appalachian narratives for her own use, donors responded enthusiastically. In the first few years, Breckinridge used her inheritance to fund any monetary shortfalls, but eventually she was able to secure enough funding, largely through donations, to ensure the Service could grow. Even in the 1930s, as the economy suffered under repeated waves of the Great Depression and she had to find creative ways to raise funds, the Service still received substantial donations. The beginning of World War II, the organization's participation in government-funded medical training programs

and the post-war economic boom changed funding models. (Breckinridge 334). By the 1970s, the oral histories recount how the communities were asked to shoulder more of the cost for keeping open their clinics and Hyden hospital. However, funding changes after 1939 are beyond the scope of this project. Instead, I look at the growth of donations over the late 1920s and 1930s in their national historical context.

Figure 24 shows the *Bulletin* page summarizing the 1926 annual report (certified by a local accountant) detailing the total donations received that year. The Service was not fully self-sufficient in 1926, in the sense that Breckinridge's personal fortune still covered any budgetary shortfalls until 1928 (Breckinridge 161). As can be seen in the image from the June 1926 *Bulletin* excerpt shown here, donations totaled \$9,712 between May 1925 and April 1926. Using an online conversion calculator, this amount is roughly equal to \$160,383 in 2022. Donations were listed individually in this *Bulletin*, by name and with the dollar amounts, ranging from \$5 to \$1000 (most donations were between \$5 and \$250) printed over seven pages. After expenses, the Service had about \$750 left over, roughly equivalent to \$12,385 in 2022. Expenses including paying for surveys, operating expenses, transportation, and medical costs, among other various necessary expenditures to ensure that the Frontier Nursing Service could successfully operate. In 1927 the organization was able to raise enough money to fund existing services, but not enough remained for a safeguard against economic downturns or to enable growth.

THE QUARTERLY BULLETIN

EXHIBIT A

THE KENTUCKY COMMITTEE FOR MOTHERS AND
BABIES, Inc.
Statement of Cash Receipts and Disbursements
May 28, 1925 to April 30, 1926

RECEIPTS

Subscriptions and Donations (Schedule A-2)	\$ 9,712.00
Lawns	1,640.00
Sale of Saddle Bag	13.00
Refund	3.40
Total Receipts	\$11,368.40

DISBURSEMENTS

Cost of Survey	\$1,807.79
Wolfe Creek	79.44
Saddle Bags	145.72
Saddles, Bridles, Blankets, Harness	123.66
Horses	670.00
Dispensary Furnishings	550.02
House Furnishings	613.55
Expenses (Schedule A-1)	6,622.92
Total Disbursements	\$10,619.10
Balance on Hand	749.30

Represented by:

Treasurer's Acct., Security Trust Co.	\$706.81
Petty Cash Acct., Security Trust Co.	42.49
Total	\$749.30

Figure 24: Donations and Expenditures (*Frontier Nursing Service Collection*)

With the stock market crash of 1929 and environmental disasters and bank crises in the years after, Americans found themselves less well-off than before. These economic tragedies were memorialized in iconic images of Dust Bowl farmers traveling to California, newly homeless in tent cities, or out-of-work men lined up at soup kitchens. Even in more affluent families, extraneous expenditures needed to be cut. In Kentucky, many subsistence farms operated on already-depleted soils, and the droughts and dust storms of the 1930s hit hard. Families lost livestock and seed corn, subsisted on Red Cross aid and donations, and farms were in danger of being foreclosed (Breckinridge 300; Klotter 98). The wealthy donors of Breckinridge's social circles across the central and eastern parts of the Eastern United States also found themselves less able to donate. Breckinridge's fundraising matured in this period, with frequent trips away from Wendover on speaking tours. Individual committees to raise money were established in most major cities throughout the Midwest and East. However, economic conditions did improve between 1933 and 1937, reflected in the increased donations of those years compared to the depression of 1929 to 1932 (History, "Great Depression History").

COMPARATIVE STATEMENT OF INCOME					
	1933-34	1934-35	1935-36	1936-37	1937-38
Contributions	\$ 69,599.25	\$ 66,232.47	\$ 65,225.26	\$ 79,996.87	\$ 69,425.55
Benefits	6,166.18	1,044.22	3,441.33	8,627.99	4,676.46
Lecture Fees	585.25	831.94	1,002.45	165.68	561.00
Income on Investment	1,029.98	1,638.23	3,242.69	5,574.23	9,034.42
Post Office	1,244.47	1,180.66	1,375.54	1,380.55	1,120.86
Sale of Books	72.41	265.31	57.10	36.30	34.50
Refunds, Miscellaneous	7.27	11.79	75.00	79.83	--
Medical Fees	576.50	725.16	751.49	1,678.82	1,636.28
Hospital Fees	--	--	--	--	1,061.65
Income, Nursing Centers	2,914.65	3,056.72	2,963.92	3,190.75	3,517.29
TOTAL RECEIPTS	\$ 82,195.96	\$ 74,946.50	\$ 78,134.78	\$ 100,731.02	\$ 91,068.01

Mr. Manning paid \$5,000 note in 1933-34, not included in above total.
Mrs. Thorpe paid \$5,000 note in 1933-34, not included in above total.
Mrs. Ballard paid \$10,000 note in 1935-36, not included in above total.

ENDOWMENTS secured in above years:	1932-33	\$ 6,024.53
	1933-34	24,000.00
	1934-35	--
	1935-36	8,000.00
	1936-37	70,000.00
	1937-38	65,000.00
		25,900.00

Figure 25: Donations in the 1930s (*Frontier Nursing Service Collection*)

While the organization had always charged a nominal fee of its patients, for some years, families simply did not have the disposable income to pay in cash. Instead, they often donated labor or goods. Breckinridge's memoir claims that in 1930, Leslie County's per capita income was \$85.70 (approximately \$1531 in 2022), with only five families with incomes of over \$340 (less than \$6,000 in 2022) (202). However, by the late 1930s, as can be seen in the comparative income statement in Figure 25, the national economy had recovered enough that donations increased. Donations ranged from a total of about \$69,000 a year to just under \$80,000, increasing as the economy improved but falling again with the 1937 recession. Frontier Nursing Service income from donations in the year before the 1937 recession was \$79,996.97, which is roughly equivalent \$1,682,280 in 2022. Breckinridge's appeals to potential donors successfully turned them into actual donors.

As the 1930s wore on, Breckinridge developed creative fundraisers to draw volunteers and donations of goods and money. One sustained fundraising plan was to invite young women to volunteer for three months as a courier. Couriers provided most of the non-nursing and non-

record keeping labor. They would meet new nurses and couriers at the train station, ensure that the nurses' horses were fed, stabled, or ready to ride, and even went on calls to provide a set of extra hands. By the fiftieth anniversary event of the Frontier Nursing Service, courier service was multigenerational. Couriers would spend a summer in their early twenties supporting the nurses, transition to a committee to raise funds, and often encourage their daughters to do the same.

In a 1979 interview with former courier Ann Mulhausen, she recalls how, in 1935, her mother and a friend's mother encouraged that she and a friend to write to Wendover, Kentucky, to request a courier position. They arrived in early January 1935 and remained for three months, which Patterson commented was typical in her interview. When the interviewer asked if the experience had forged a lifelong friendship with the other couriers in that quarter, Mulhausen seemed rueful that it had not. However, Patterson noted that other couriers, such as Kate Ireland, became a national chairperson of the Board. The various regional committees had, at the time of Patterson's 1978 interview, "over ninety members that have been couriers...they really know what they're working for. And some of them have daughters that have been couriers...there are a mother and two daughters who all three have been couriers." The experience deeply involved many young women in the philanthropic work of Breckinridge's organization, showing them the benefits of medicine in the face of frontier life. They were then able to translate their short volunteer period to a commitment and authenticity of experience that helped to generate donations over decades.

In addition, volunteers of the upper class matured with the expectation they would be involved in charity work. They often appeared in high society and in city newspapers as debutantes, and newspaper society pages followed their personal lives and community involvements. Taking advantage of the fact that part of these young women's introduction to

society was to meet potential husbands, Breckinridge arranged a cruise for these young women to take, with regular events including eligible young men. Those who participated had to pay a fee, which covered cruise and entertainment costs with the leftover money going to the Frontier Nursing Service. Unfortunately, a bank failure prevented the Service from realizing profit from this event (Breckenridge 274). Even so, the images of the couriers in the mountains, donating freely of their time and energy to the frontier families of eastern Kentucky, helped to publicize the organization and remind donors, potential and actual, of the good their financial commitment to the Service brought.

Perhaps the longest-lasting fundraising focus I found involved the saddlebag. Saddlebags featured prominently in imagery and descriptions of the nurses – they were so central to the idea of the ‘angels on horseback’ that Breckinridge even reprints part of a letter from the accountant who managed the organizations accounting records. (I did not see the original letter; this may have been one of the personal letters she destroyed after writing *Wide Neighborhoods*).

I shall never forget the first audit we made for the Service. [Mary Breckinridge] walked into our office, a total stranger; dumped on the floor an old rusty pair of saddlebags, and calmly announced that she wanted her accounts straightened out...I do not know how familiar you may be with saddlebags, but that was my first introduction to the species, and I am still amazed at the enormous mass of papers that first pair of saddlebags disgorged. They reminded me of nothing else quite so much as an old ragbag my grandmother kept hanging on the inside of her closet door as a receptacle for the most varied assortment of cloth...it has ever been my lot to inventory in any department store. (201)

He continues with this analogy for another two paragraphs, remarking that the annual visit of the Frontier Nursing Service saddlebags of accounts helped him imagine vividly the dedication and bravery of the organization's staff. At least for this accountant, the association of the saddlebag with the past, the past that lived in the present in eastern Kentucky, motivated him to promote the organization and its work.

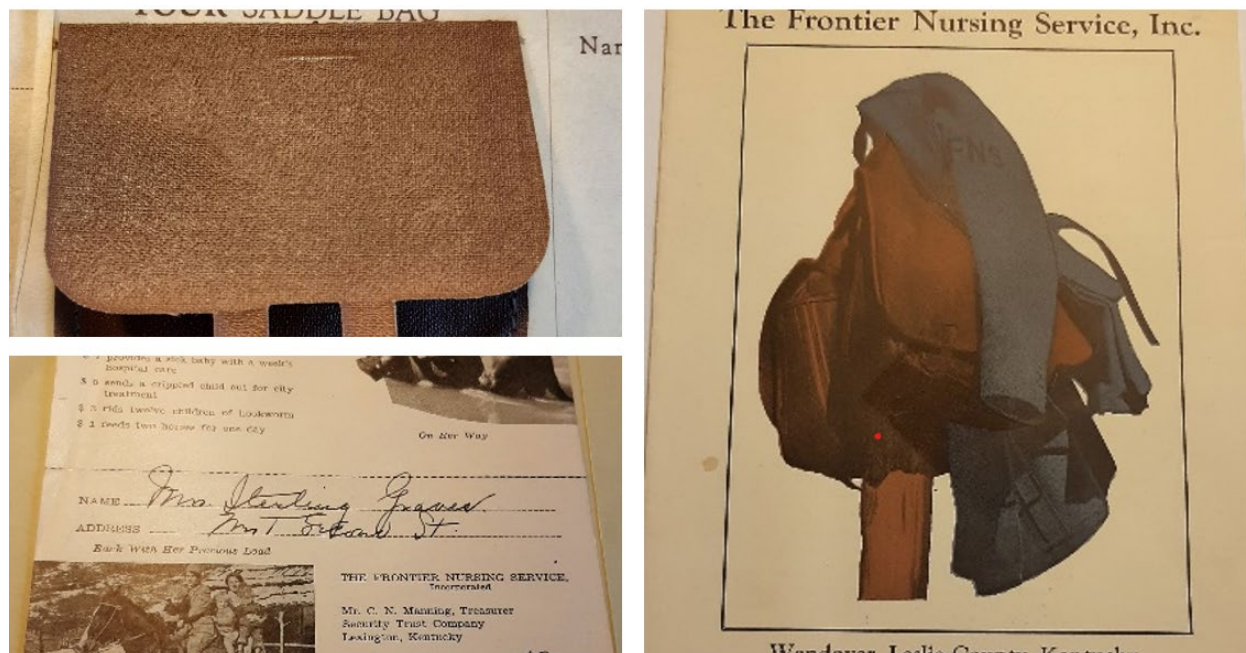


Figure 26: Saddlebag Fundraising Appeals across the Years (*Frontier Nursing Service Collection*)

The saddlebag functioned as an essential carrier of nursing supplies. Without the saddlebag, the medical staff could not do their work. These bags were the only pharmacy and medical supply station available once the midwife had left her clinic. She carried everything she might need, such as medicine, silver nitrate drops, bandages, blankets, even medical instruments, and arranged them according to an internal standard. In 1933, Breckinridge and the Service marketed the saddlebag as representative of the frontier in a Christmas appeal. The fundraising card shows the image of a nurse, again fording a river, with her saddlebags prominently featured.

To her left is a list of suggested donation amounts accompanied with an explanation of what each amount will buy. For instance, \$10 pays for an entire delivery, while \$3 pays for enough hookworm medicine to treat twelve children. Below the amounts is pictured a nurse on her horse with a new mother holding an infant and two older siblings. The juxtaposition of the donation amounts and intended purchase with the happy mother and her children suggests that donations will make true the depicted outcome. A donor then had the option of removing an actual reproduction felt saddlebag as a souvenir of sorts before sending the card in with the donation. This campaign was revised and reused again in 1948. No felt saddlebag was available for a donor to tear off as a keepsake, but the front of the card shows the saddlebag partially covered with the distinctive coat of a Frontier Nursing Service nurse-midwife.

Even though eastern Kentucky changed after World War II, fundraising continued to revolve around the constructed frontier nature of Leslie County. As jeeps and roads replaced horses and trails, images of the frontier populated oral history memories and drove much of the fundraising until changes in law, medicine, and demographics forced the Frontier Nursing Service to restructure its model of care. To this day, frontier imagery defines the organization, and so many sources remember it is one dedicated to saving children. The broad outline of the appeal of the Frontier Nursing Service – save the infants, save the nation – worked on one level because children are any community's future. Carrying out that mission in the face of the seemingly nearly insurmountable odds of such rugged mountains is admirable. However, the power of eastern Kentucky as a mountain frontier cannot be separated from Anglo-Saxon ideology and definitions of American democracy current in the 1920s. Without the frontier, the white pioneers and settlers would not have had the struggle that created a particularly American democracy and identity. By the 1920s, eastern Kentucky and Tennessee, home of Daniel Boone

and Davy Crockett, were symbolically one of the only frontiers remaining. The ‘race panic’ of the 1920s helped to relate and personalize the mission of the Frontier Nursing Service for Breckinridge’s donor audiences, who responded generously for decades.

5.4 Conclusion

The archives of the Frontier Nursing Service are extensive, and letters, photographs, images, certificates, and much more record decades of the organization’s work in eastern Kentucky. Over these decades, their service area and physical infrastructure grew from the headquarters at Wendover and two original clinics in just Leslie County to serve over 1,000 square miles in two counties. She did so through indefatigable fundraising and travel, even when she broke her back after a fall from her horse. She built an extensive network of committees that involved not only her friends, relatives, and peers in the major cities of the Midwest and Eastern coast, but also local communities and the networks of the young women who volunteered. Through the hard years of the Great Depression, even as she spent all but a nominal amount of her own money, the doors stayed open. With the outbreak of World War II in 1939, she could no longer recruit trained nurse-midwives from London’s midwifery school, so she opened Frontier Nursing University. This institution continues to provide training for graduate-level nurses to work with under-resourced and disadvantaged communities across the world. Her continued work to professionalize nursing, and later nurse-midwifery (in collaboration with the midwives of the Maternity Center Association of New York City, which led to the establishment of a professional organization (ACNM) and legal changes) are among her greatest achievements in terms of the number of individuals touched by her dream. Her decision to turn her grief into service has done lasting good, both among individuals in eastern Kentucky and those who have taken what they learned from her legacy to help others.

Master's theses, undergraduate papers, published nursing articles, and the 1978 oral interviews all highlight the ways in which Breckinridge dazzled those around her. By the end of her life, she had truly forged her own path and countless women across the world have benefitted from the tradition of service and medical excellence she established. However, to understand the full complexities of her legacy requires a reckoning with the ways in which racism functioned as she created her organization. Like the institutions built by other reformers working within the racial limits of their beliefs and communities, the Frontier Nursing Service has not been able to fully realize its potential to help all women, all children, and all communities. The continued dominance of the physician-centered medical model also inhibits the potential benefits of independent nurse-midwifery care as conceived by Mary Breckinridge a century ago.

Breckinridge so skillfully crafted her legacy and memory during her lifetime that much early scholarship on the Frontier Nursing Service tended to be blinded to the limits inherent in her own racism and reliance on constructing Appalachian as a frontier, a narrative built upon a racist ideology. She, like other reformers, wanted to better conditions for women, their children, and pregnancy care. However, the organization refused service to women of color until federal regulations required it (Hassan-Sheffield, personal communication), and her own writing in *Wide Neighborhoods* reveals glimpses of her own racism (Breckinridge 315). In this light, Breckinridge's decision to utilize dominant racial narratives of the 1920s were natural in the sense that she probably believed the racial appeals she presented. Choosing to highlight the poorest people in Leslie County did add to a growing demographic of 'deserving poor' who merited charitable support, expanding modern medical care by class. However, the converse, the 'underserving poor,' continue to battle systems that were not built to support them.

The mountaineers of Appalachia, by their very poverty and isolation, were deserving, though often enough, as Katrina Powell's *Anguish of Displacement* and research into eugenics and sterilizations show, that was not always sufficient. Simply being Appalachian was not enough to merit aid; their ethos was built on the location in which they lived. In return, they were required to have large families to deserve the resources given them. Once they left the location that contained the promise of the pioneer struggle, however, they no longer held the same value within American society. To this day, Appalachian counties are among the poorest and most under-resourced communities in rural America, revealing the limits of an ethos that depends on a community living and behaving in ways determined by outsiders to be of value.

6 LOOKING BACK TO LOOK FORWARD

As I finish this project, *Roe v Wade* has been officially overturned, and I cannot help but to read the decision and the conversation around it in the light of the rhetorical history I researched for this project. As I reflect on this decision and my own interactions with this issue, I have realized that the right to reproductive *choice* is not, and never has been, enough to guarantee reproductive freedom and autonomy in the United States. I am struck by Solinger and Ross's introduction to reproductive history in America, which emphasizes three intertwined threads that shape reproductive policies and decisions at individual and state levels:

...first, to achieve its most fundamental goals, *every* government depends on the reproductive capacity of people who can give birth...The second thread shows that laws and policies were quickly fundamental to racializing the colonies and then the nation, establishing (and fortifying) the primacy of whites...Racializing the nation depended on the development of a culture and politics—and a body of law—that declared that white babies had a different, dearer, and nonnegotiable value compared to nonwhite babies and that enforced those different values...[which] constituted a formidable population-control structure...(emphasis in original, 14-15)

The third thread identifies the ways in which racialized laws that “called for policing the sex, reproductive, and maternal experiences of *individuals*, in fact...have had the effect of punishing whole *communities*” (emphasis in original, Ross and Solinger 16). In terms of this third thread, significant research, writing, and conversations across institutions, agencies, and disciplines have explored the ways in which racializing the nation and, by extension, its reproductive capacity, have harmed women of color. This harm has

historically often left individuals without a true choice in reproduction or family makeup. My project recognizes this fact, and I do not wish to take away from the hard work still required to fully wrestle with our history of over four hundred years of racialization and the legacies of slavery.

But it is also important to reckon with the ways in which white supremacist ideals “operating in a capitalist system penetrate[d] and misshape[d] the present” (Ross and Solinger 11). A reproductive justice framework recognizes “that individual choices have only been as capacious and empowering as the resources any woman can turn to in her community” (Ross and Solinger 16). The decision to bring in modern, scientific medicine and scientific motherhood to a community previously lacking access to trained medical professionals (in the modern sense) and knowledge is, on its face, a noble cause. I am not arguing that such access should not have been expanded, nor that modern scientific medicine and public health practices have not improved community health outcomes. However, understanding the racialization that accompanied such efforts helps us to understand why the language and enactment of Progressive Era reforms, such as this one, promised so much but constrained reproductive autonomy.

The women in Leslie County did benefit from having access to more and better evidence-based care and likely experienced lower rates of maternal and infant mortality deaths under Frontier Nursing Service care. However, the promise of better pregnancy outcomes was also predicated on a notion of motherhood and pregnancy/childbirth that assumed these women would, and should, continue to have large families. Their reproductive capacity stood in as a national racial resolution at a time when prominent public figures feared the ‘whiteness’ of America was in danger. On the worst hand,

women of color for decades experienced forced sterilization and were unable to have the families they chose in environments they wished – and attempts to redress the harm of reproductive healthcare policies should take into account the intersections of race, class, and region and the impact on those who have been harmed the most. White women experienced less of the worst of racialized reproductive policy, but still experienced a significant loss in reproductive autonomy. In a society where the nation's very existence centers around the number and quality of children white women bear, these women were unable to fully decide the sizes, kinds, and environments of their families without endangering the existence of the very systems that provide them the necessary support to have healthy families and lives in the first place.

The sheer amount of materials available in the archival collections donated by Breckinridge and the Frontier Nursing Service to the University of Kentucky provide a wealth of stories, facts, and data to unpack. Nor are these collections the only sources available. I have not examined research articles published in nursing and midwifery journals by Breckinridge and her staff, nor have I closely analyzed the ways in which the women and their families of Leslie County accommodated and resisted scientific medicine and motherhood in their lives and traditions. I have not examined in any detail how Frontier Nursing University and Hyden Hospital adapted to the closure of the Service or how they have reckoned with recent changes in healthcare and important sociocultural events. I also relied heavily on existing historical scholarship to contextualize the rhetorical choices that Breckinridge made, as well as focused my research almost entirely on the pre-World War II years. The connections I have made to

modern medicine and its failings are attenuated by the passage of a century, and therefore suggestive only.

However, historians of the Progressive Era seem to be mostly in agreement that changes in that period shaped modern society, its institutions, and modern public health and social safety nets. Therefore, understanding the ways in which the pre-Depression welfare state was constructed becomes vital. These early initiatives and institutions that white maternalist and feminist reformers developed functioned as a model, even archetypes, for the federal response to the damages and needs of the Great Depression. Thus, understanding the rhetorical nature of their initiatives, especially the ways they developed authority and credibility, helps us to understand what those institutions were designed to do and the ways they rhetorically and actually shape our lived realities. Such analysis also helps us understand what they could have been as well as the ways they have failed – and if those failures are by design. I am not arguing for a modern lens of interpreting these initiatives. However, enough time has passed that fundamental building blocks to these institutions have become effectively invisible, so that we do not always understand what to look for when we seek to change them for the better. Looking back to see what is missing, as well as the ways in which policy justifications default to specific versions and expressions of white supremacy, can illuminate paths forward.

6.1 Cultivating and Deploying Ethos

To understand how Breckinridge employed national narratives and ideologies of her time to cultivate support and staying power, I summarize her rhetorical work in relation to ethos here. To understand her ability to do so requires a tracing of her personal evolution from an “angel at the hearth” to an “angel on horseback.” Understanding her

own personal relationship with traditional values of motherhood illuminates her growth into a medical expert, as well as her ability to translate, or rhetorically remake, her mission and its location in ways that reflected existing beliefs about whiteness and the Appalachian frontier to her audiences so that they willingly supported and amplified her mission.

6.1.1 *Interruptions, Interrupting, and Motherhood*

Rhetoricians, particularly Ryan et al., have noted that marginalized rhetors often take advantage of a gap in ethos to interrupt others' ethos (3). Breckinridge recognized that, in her moment in time, actual authority over childbirth was not as settled as obstetricians and AMA-affiliated physicians liked to claim. Thus, she was able to rhetorically move into that liminal space and interrupt the conversation to claim her own authority. She gained greater credibility because she had the advantage of the training (and later the numbers) to prove that she, and the nurse-midwives she hired, provided care that resulted in few infant or maternal deaths. In unsettled rhetorical terrain in which credibility did not yet belong to any one group of care providers, she was able to interrupt the argument and stake out her own identity.

This process was probably not completely unfamiliar or uncomfortable for Breckinridge. Despite her parents' attempt to raise her to be a quintessential elite Southern woman, her family's tradition of national service likely influenced her desire to be something more than simply a mother and wife. According to recent historians, Breckinridge struggled with conflicts between her family's obligation to serve the nation and gendered notions of responsibility and capability. Her two marriages represented her desire to live up to the ideals her parents modeled for her and expected her to live by. However, Breckinridge was also surrounded by women who had not lived by the ideal of mother and helpmate, including her great-aunt, Susanna Lees (who

willed her own fortune to Breckinridge) and her cousins. Though apparently Breckinridge's mother expected her to do her duty as a Southern woman of elite heritage, Breckinridge also desired to do, and be, more. In response to the tragic death of her first husband, she enrolled in nursing school; after her second marriage ended, she pursued graduate education in nursing and midwifery while also aiding France in rebuilding after the devastation of World War I. Her own extended family's experiences, and later her own, illuminated that interrupting traditional behaviors of gender and authority were valid paths forward, as long as motherhood remained sacrosanct. Rhetorical interruption was not only a way to stop and redirect or reformulate others' beliefs and expectations. This strategy also allowed her to realign her traditional gendered beliefs and expectations in unique ways that served the greater good of motherhood while allowing her to contribute after she lost her children.

6.1.2 Advocating and Advocacy

Through her personal experiences, loss, her medical training, ideologies of motherhood gave Breckinridge the authority and gravitas to parlay her own organization as a mission to save other women from the intense, and unnecessary, grief that she had experienced. Thus, she had the professional authority, as well as the personal ethos of a bereaved mother, to not only interrupt the authority that obstetricians were exerting, but also advocate for her, and her staff's, authority. Again, I am not suggesting that Breckinridge exploited the deaths of her children. She truly grieved their loss throughout her life. But like other maternalist activists focused on improving maternal and infant mortality, her deep grief galvanized a lifetime of activism that had lasting impacts on the way pregnancy and childbirth is supported and managed to this day. Unlike male obstetricians, she knew how painful losing children was, and she researched available models of scientific medical care to choose one that would fit the circumstances of

Leslie County. She was uniquely positioned to argue that she truly knew best from both experience and expertise, and similarly she was well positioned to argue that her model of care produced superior outcomes. Working from this ethos, she regularly presented her achievements through numbers and through the expertise of her staff. In the same material that she argued for the benefits of her organization, she proved through advocacy that her staff were well-suited to carry out the mission's goals, therefore enhancing their ethos in the eyes of those unwilling to trust the Frontier Nursing Service or its medical staff.

Advocating for her medical staff often required walking a fine line between ability, knowledge, and authority, so she ensured that donors as well as her network within the state were aware of how she structured the Service. By placing a doctor as the nominal medical director, she was able to argue that she, and her medical staff, did not overstep the bounds of nursing. She also regularly ensured her medical staff received advanced education, even doctorates, in public health, midwifery, and nursing. Her advocacy went beyond simply arguing her organization had good employees or that they followed expectations and laws. She ensured they were more knowledgeable than those who attempted to argue the organization was not authoritative. In this respect, Breckinridge's insistence on educational attainment resonates with many who have had to be more educated and more capable to accorded ethos when audiences perceive them as less credible.

6.1.3 Relating and Relation

The same expertise that allowed Breckinridge to advocate for the authority and expertise of her faculty also allowed her to relate through the scientific professionalism of medical professionals. As Skinner found, using this discourse in medical writing among nineteenth century women physicians signaled that they were experts, helping to buttress the ethos they

lacked due to their gender. This style of communication extended to medical writing directed toward lay audiences (148). By the time Breckinridge addressed her professional and lay audiences, this practice was no longer new. The genre of lay medical texts offered the opportunity for women physicians to counteract the negative stereotypes circulating in media representations (Skinner 70). Similarly, writers for the U.S. Women's Bureau presented data and statistics in an informative genre, establishing not only their authority, but also the factual nature of their research and statistical analyses (Sharer 18). Breckinridge followed suit, collecting baseline data in accordance with social science methodology as well as presenting information from copious Frontier Nursing Service records. The already-established nature of medical writing benefitted her own ethos.

Just as the writers for the U.S. Women's Bureau challenged the informative bulletin genre to personalize their subject matter to their audience to elicit emotional responses (Sharer 18), so too did Breckinridge in her own *Bulletins*. Through frequent images of the children for whom they cared, reminders of their achievements, and short anecdotes about the people and region, the *Bulletins* provided readers with visuals that evoked emotional responses. However, the use of such vivid details and images does not fully explain donor response, especially during the lean years of the Great Depression in the 1930s. Rather, aware of the racial beliefs and fears circulating through the early twentieth century, Breckinridge related her work to prevalent beliefs about who needed to have large families. She reminded her readers that the families of Leslie County were 'old stock,' the fuel that would right perceived racial decline of modern America. Even as her explicit references to Anglo-Saxon heritage faded, the power of Appalachia continued to resonate.

Breckinridge's numbers and anecdotes positioned the women of Leslie County as willing, caring mothers lacking necessary medical, financial, and knowledge resources. Changing the local medical environment would ensure that these mothers could bear the children the nation needed. Aligning her work with concepts of motherhood, particularly a traditional version of motherhood that had currency in the 1920s, allowed her to normalize modern care regardless of class. In this respect, Breckinridge's rhetorical choices mirrored those of Margaret Sanger. Sanger, by "depicting women as true mothers, as WASPS, as proponents of an economic ethic of fertility, and as victims of patriarchal domination...encourage[d] identification across class lines" (Buchanan, *Rhetorics of Motherhood*, 53). Similarly, Dorothy Day was able to translate the experience of poverty to one "familiar enough to be acted upon" (Weiser 128). Like Sanger and Day, Breckinridge portrayed the women and children of Leslie County as sympathetic figures eager for the benefits of scientific motherhood. They were presented as familiar True Women who simply lived in unfortunate circumstances not of their own making. The multiple appeals to gendered ideologies, racial fears, and familiar scientific discourse likely allowed readers to overlook the lack of clarity in the numerical analyses presented in the *Bulletins*. Breckinridge reaffirmed what audience members probably already believed and left out information that challenged those assumptions. Reflecting a localized version of a larger system of beliefs galvanized a sympathetic response and gifts of money in donors.

6.2 Rhetorical Limits

Racialized appeals within the parameters of maternalism did allow Breckinridge to continue to normalize the idea that married white women and their infants deserved modern prenatal and natal care. She also successfully demonstrated that nurse-midwives who received the training and licensing increasingly typical of any medical profession were able to provide

sufficient care so that women suffered fewer complications than when left alone or to the devices of traditional care providers. Anticipating that nurse-midwives would not be able to manage all complications and might need to seek out obstetrician intervention or sustained postnatal care in a hospital setting, Breckinridge ensured that those women could affordably access care in the case of pregnancy complications. She also demonstrated that charitable funding directed toward lower-cost provider alternatives in a sparsely populated area could resolve economic barriers to medical access. In particular, the cost model, if not the funding, aligns with proposals to increase medical provider coverage in rural areas that I have read about in news and nursing journal articles since the late 1990s. The crisis of care (from a medicalized interventionist perspective) that rural residents now experience, from emergency to obstetrical to end-of-life care, is not new. What has changed is that since the 1920s, traditional alternatives are no longer as available. While advocacy groups continue to promote options that improve access to both scientific medical and traditional alternatives, and the legal regulations are changing as well, our current system with its nominal changes are not enough. At least for obstetrical and maternal care, “We need a reimagining of what maternal health support looks like” (Harper 109).

To reimagine the system that fails so many women, we need to understand not just what ideologies shaped our modern medical infrastructure, but also how those ideologies were applied. The racial beliefs of the Progressive Era became embedded into our modern maternal healthcare system. While women of color have experienced the most tragic results in terms of limited reproductive autonomy and in harm to their lives, on the other side the expectation that white women must have large families as a service to the nation as part of their duty as citizens reduces their reproductive autonomy. Choosing to have few, or no, children implicitly become a failure of white citizenship. Pregnant women become a kind of broken machine that must be

fixed, a conception that justifies reproductive care as equally about surveillance and control (Seigel 13) as it is about ensuring healthy infants. Women's health, both physical and mental, becomes secondary to the primary mission of ensuring that enough of the right kind of children are born and raised. White women become deserving of the best pregnancy care, but only if they are obedient and passive. Thus, a woman's value depends on her ability to meet the God-terms of Motherhood, described in Lindahl Buchanan's *Rhetorics of Motherhood*: "children; home; love; empathy; protection; religion; nourishment; altruism; morality; self-sacrifice; strength; the reproductive body; the private sphere; the nation" (9). Given the tragic number of children and mothers lost due to childbirth and its complications, it is no wonder that women and mothers rose to address an absence of care in the Progressive Era. They helped to formalize and institutionalize the beliefs, processes, and rules intended to address the very crisis they experienced and documented. But it is also no wonder that these very reforms set up a system where Motherhood became a duty of citizenship, where some women must bear children and others should have few, if any. Redefining reproduction as an act of citizenship helps to reinforce the same patriarchy and contributes to erasure of their contributions and stories.

I do not have easy answers to the lack of maternal care that affirms and supports all reproductive choices. But if we are to create a country where families can "raise[e] their children in life affirming environments...[which] means that parents need access to jobs that pay a living wage, access to affordable housing, access to clean, pollution free physical environments, access to education and health care, and access to violence-free encounters with police and other non-Black citizens" (Harper 98), I would also argue that we need to reconstruct ideologies of motherhood to affirm that all people can "define...seek out...claim and...hold on to reproductive safety and dignity" (Ross and Solinger 14). Thus, the ethos that our nation-state has created for

mothers (and its layers of race and class) needs to be re-examined and rewritten so that efforts to manage reproduction do center women's autonomy and agency.

The grounding of maternal healthcare reform on ideologies of motherhood also limited their potential impact. As historians of maternalism have documented, by the mid to late 1920s the conditions of motherhood were no longer a political concern. Responsibility for bearing children fell on the individual mother (Ladd-Taylor, *Mother-Work*, 7), with the state ready to step in to enforce legal and medical policies and govern individual women's behavior when she stepped outside predetermined boundaries of behavior (Lay 12). To this day, the failure of the Progressive Era and following waves of feminism to expand scientific reproductive medical care to what it could have been, to ensure that women are in the public sphere for potential other than their reproductive capability, and to address the underlying racist roots of these systems continue to haunt us. If we are to fight back and change our future for the better, it is incumbent on us to remember women *differently*, as Gaillet and Bailey's edited collection calls for, and to not be blinded by charisma or neglect the nuance of those we study.

6.3 Conclusion

Interest in reservoirs of pure whiteness, in a county that had not been changed by the coal industry, provided Breckinridge with a moment in time and place to find her purpose. However, those very elements that provided an exigence led to the loss of her national memory outside of eastern Kentucky and the midwifery profession. Even so, her life and the decades of her devotion are worth examining, to see how the changing rhetorics of motherhood manifested in the life of a woman who did not set out to be a reformer. Examining her life and actions allows us to look past the waves of feminism model that blinds us to the rhetorical power held by women in between waves or who were not social mavericks intent on challenging and changing what was.

In the process of rewriting her life and aligning her actions with her values, Breckinridge adapted circulating discourses and narratives of motherhood, race, class, medicine, and reform to create an organization that continues to impact our lives, albeit indirectly. She contributed significantly to emerging ideas of what modern, scientific medicine could do for individuals across class boundaries. She worked to change her world, though she disavowed political feminism. In tracing her life and her contributions, resisting the often-circulated hero-narrative allows this project to join larger rhetorical conversations about women's rhetoric in response to George et al.'s call to "move...away from the 'waves' model toward a more accurate understanding of women's role in the development of both contemporary rhetoric and life" (3). An individual need not be a feminist to challenge or change one's life, and the false binary of "feminist or not," as Charlotte Hogg reminds us in "Including Women's Rhetoric in an Ethics of 'Hope and Care'" (3) too easily blinds us to the complexities of Breckinridge's conservative reform activism. This project also pushes back against tendencies to see Progressive Era reform as acts of change isolated in time, geography, and class and instead embrace the nuanced, interwoven nature of activism between the World Wars that served as an archetype of the kinds of social welfare that arose in response to the Great Depression. We can interrogate narratives of reform in this period as an interwoven web of concerns about the shape and direction of a rapidly modernizing America in which women (and men) participated. Our tendency to silo their work in our historical, public memory helps to further erase individual and community contributions, particularly of women and limits ways we can imagine a more just future. A feminist retelling, especially one that is sensitive to what is masked and what is not there, is essential to recover women's stories, rhetoric, public lives, and their participation in larger social movements and trajectories beyond the exemplars we remember so well.

I offer my project as joining conversations initiated by Erin Frost and Michelle Eble in *Interrogating Gendered Pathologies*, Kimberly Harper's recent text *The Ethos of Black Motherhood in America: Only White Women Get Pregnant*, and Heather Adams' *Enduring Shame: A Recent History of Unwed Pregnancy and Righteous Adoption*. My microhistorical approach to the rich archival evidence preserved by Breckinridge, her organization, and the University of Kentucky has, I hope, provided a glimpse behind the curtain of women's healthcare and a movement to make pregnancy and childbirth less deadly that situated women as objects of biology with little autonomy or voice. Scholarship continues to reveal silenced, missing, or forgotten voices about women's biology, such as works like Eve Annuk and Marika Siegel's "Pregnancy, Motherhood And/as/or Dissent: The Soviet Micro-rhetorics of Gender" and Kim Hensley Owen's *Writing Childbirth: Women's Rhetorical Agency in Labor and Online*. While research constraints limited inclusion of the women of Leslie County in this project, it is my hope that I have begun to contribute to that aspect. Because rhetorical actions shape our lived reality and relationships with each other and our communities, a rhetorical history such as this project, at the nexus of rhetoric of health and medicine, feminist rhetorical scholarship, race, and class, becomes part of a shift that centers women's dignity, value, autonomy, and agency. By looking deeply into specific women, organizations, and local activism, we can also look out to the broader landscape that has shaped modern society. Perhaps, we can then honor the good Mary Breckinridge and her fellow activists and reformers did, while putting into practice what we can, and should, do better.

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