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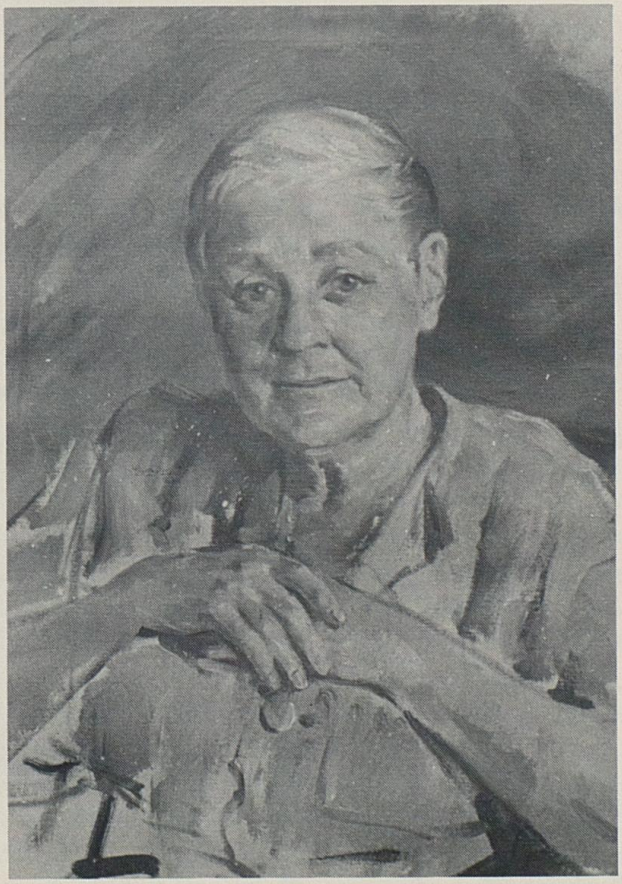
Nurse-Midwifery—



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Front Cover: Lower Left: A portrait of Mary Breckinridge, founder of FNS. Clockwise from top: Eunice K.M. Ernst, Ruth Coates Beeman, Sr. Nathalie Elder, Ruth Watson Lubic.

Comments and questions regarding the editorial content of the *FNS Quarterly Bulletin* may be addressed to its Managing Editor, Robert Beeman, at the Frontier Nursing Service, Hyden, Kentucky 41749.

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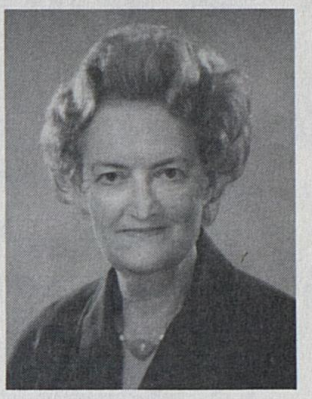
Kate Ireland

FNS IS GIVEN NATION'S FIRST ENDOWED CHAIR OF NURSE-MIDWIFERY



Marvin Patterson

Thanks to the great generosity of Mrs. Jefferson Patterson and Miss Kate Ireland, the Frontier School of Midwifery and Family Nursing now has the nation's first endowed chair of nurse-midwifery education. This is a development of great importance. It materially strengthens FNS in its continuing efforts to provide the best possible education for the professional nurse-midwives that the nation and the world so badly need.

The new chair became possible as a result of two gifts from Mrs. Patterson, FNS' national chairman from 1960 to 1975, whose generous support of the Frontier Nursing Service goes back to the days when it was founded by her father's first cousin, Mary Breckinridge, and from Kate Ireland, who since 1975 has been FNS' national chairman and whose generous outpouring of her time, energy, and financial assistance have been crucially important to FNS over the years.

The new Mary Breckinridge Endowed Chair of Nurse-Midwifery is to be filled by nurse-midwives whose education, experience, and personal attributes have brought them distinction in the field of nurse-midwifery practice and education. FNS Director David M. Hatfield has announced that Mrs. Ruth Coates Beeman, dean and director of the Frontier School of Midwifery and Family Nursing, will hold the first appointment to the new chair. Mrs. Beeman's long career as a nurse-midwife and nursing educator has encompassed positions ranging geographically from the Belgian Congo (now Zaire) to New York to Arizona and has included faculty appointments at Indiana University, Maternity Center Association, Graduate School of Nursing of New York Medical College, and Arizona State University. She has also been a consultant to the New York State Department of Health, and from 1977 to 1982 she was Maternity Care Nursing Consultant to the Bureau of Maternal and Child Health, Arizona Department of Health Services, Tempe, Arizona. In 1980, she was given a Distinguished Citizen's Award by the College of Nursing, University of Arizona. Mrs. Beeman has been dean and director of the Frontier School of Midwifery and Family Nursing since January 1982.

BARBARA SONNEN ASSUMES EXPANDED NURSING DIRECTORSHIP AT FNS

In keeping with the objective of expanding and giving increased emphasis to its nursing services, FNS has redefined and broadened the position of FNS Director of Nursing and has appointed Barbara Sonnen to this enlarged function. Ms. Sonnen assumed her new duties in November.

Barbara Sonnen received her BSN from the College of St. Teresa, Winona, Minnesota in 1960. Subsequently, she earned two master's degrees, an MS in Adult Education from the University of Wisconsin in 1973, and an MSN, also from the University of Wisconsin, in 1980. She is currently a doctoral candidate in adult education with a minor in nursing at the University of Wisconsin. Her professional career has included a number of key positions in nursing and nursing education. Most recently, she has been program coordinator, Department of Continuing Education in Nursing, University of Wisconsin (Extension).

The nursing directorship, as newly redefined, entails increased responsibilities, including the nursing programs of the Mary Breckinridge Hospital, the Hyden Clinic, the district clinics, the continuing education program, and the Home Health Service. Mary Weaver, RN, ADN, CNM, and CFNP, will continue in the important function of Director of Nursing for the Mary Breckinridge Hospital.

The redefinition of the nursing directorship is intended both to reemphasize the importance of nursing in FNS' concept of health care and to assist FNS in adapting its program of care to meet new requirements that result from changes in the economy and in government regulations. The latter include recent Medicare decisions that encourage the early discharge of patients from the hospital to their homes, thereby increasing the need for decentralized nursing services. In addition to bringing her experience to bear on these specialized problems, the new director will be in a position to contribute to FNS' ongoing efforts to define the health needs of the 80's and to continue to update its programs to meet those needs.

Nurse-Midwifery

— A Profession
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THE ART OF NURSE-MIDWIFERY

by Ruth Coates Beeman, CNM, MPH
Dean and Director
Frontier School of Midwifery and Family Nursing

Universally, and from the beginning of time, women have responded to the needs of other women involved in the act of giving birth. Birth, with its mystery, its ritual, its promise, and its beauty, continues to create emotional responses which defy scientific or intellectual explanation, and the art of midwifery, with all its rich folklore, has existed essentially unchanged since human life began.

The term "midwife" as used in the English language came originally from the *medewife* of Old English and Middle English, or *mit* from Old High German, having the general meaning of "being with woman during birth." The more common definition, as currently used, is "a woman who assists women in childbirth." The variety of terms used for the woman who assists at childbirth has from the earliest times illustrated her functions and the regard or esteem her art has enjoyed — *omphalotma*, or navel cutter, in the ancient Greek, *jordmor*, or earth mother, in the Norwegian, and *sage femme*, or wise woman, in the French, to mention only a few.[1]

But what about the *art* of nurse-midwifery? Webster has defined art as "the conscious use of skill and creative imagination." This definition speaks most clearly to the art of nurse-midwifery as we attempt to teach it at the Frontier School of Midwifery and Family Nursing. As we see it, this art goes beyond skill and knowledge. It demands sensitive, even intuitive, awareness of the needs of mothers and a capacity and eagerness to respond to those needs in ways that are knowledgeable, personal, creative, and loving.

Thus we continue to expand Webster's definition by learning to explore our feelings, to open ourselves to our intuitions, and to grow in empathy. We continue to probe for new meanings as we apply our art to expanding practice.

The art of nurse-midwifery is developed from a solid base of nursing and midwifery skills acquired by a combination of study, observation, and experience in all aspects of childbearing. A nurse-midwife refines her art as she learns to center herself on the needs of the pregnant woman and her family. She understands the uniqueness of the totality of experiences that make up the childbearing cycle: pregnancy, labor and birth, and the early postpartum period. She practices her art always within the context of a family-centered approach; she understands her scope of practice, and she knows her limitations. She practices her art within a continuum of health care services that assures an individualized level of care as need requires.

Philosophically, the nurse-midwife acknowledges pregnancy as a period in which each woman embarks on a journey of self-discovery, of great personal growth and lifestyle reorganization.[2] Pregnancy is a time in a woman's life when intense feelings come close to the surface, as the consciousness of life experiences expands to give new meaning to all that has gone before. It is a time in which bodily changes can be exciting and wonderful, or uncomfortable and disturbing. Pregnancy can also be a time of disappointments, as dreams and realities have to be reshaped if unforeseen events threaten the planned birth experience. Pregnancy is a time of growing vulnerability, as the woman's body changes from its familiar boundaries, and the processes leading toward birth take on an inevitability beyond conscious control.

The unfolding events experienced by a pregnant woman provide unique opportunities to practice the art of nurse-midwifery. A pathway is opened to allow the nurse-midwife to get into a woman's expanding consciousness, to explore with her the attitudes and beliefs passed down to her through the multitude of life experiences she and her family have shared. It is a time to explore fantasies, to introduce positive imageries, to replace anxiety with constructive hope. It is a time to help a woman become comfortable and secure in her womanliness and her sexuality, to become aware of, and intimate with, the baby that is growing into personhood inside her. To meet these challenges, the nurse-midwife needs to be confident in her knowledge of the psycho-biophysiology of pregnancy as she guides the pregnant couple through the cognitive and existential experiences that enhance the "wellness" of pregnancy.

As the woman moves through the cycle of childbearing, labor and birth offer her a journey into the unknown. This journey is at the same time an end and a beginning; it ends a lifetime of one set of experiences and begins a new and deeper understanding of life. A woman needs to experience this journey through labor within a mind-body connection that centers on herself. Anxiety, self-consciousness, doubt, fear — all tend to block the spontaneity and flow of labor by setting up an outpouring of neurohormonal agents that are inhibitory to these natural forces.[3] A woman needs to free herself to the timelessness of natural rhythms that miraculously bring forth new life. As she accomplishes this, she will be engulfed by body messages and sensations in labor that are strong and powerful — they can be frightening or they can be exhilarating, but she will be changed forever by these experiences.

The nurse-midwife learns to have an abiding reverence for, and trust in, the natural processes of labor. The presence of this knowledgeable, competent, caring, and skilled practitioner helps reassure the laboring woman that she will have "safe passage" in her journey through the unknown. The nurse-midwife provides for her basic nurturing needs through her ministrations and her presence. The nurse-midwife knows that the massaging of tension-weary back muscles, the proffering of ice chips to a thirsty mouth, the pressure of a hand against the aching sacrum, the light effleurage of the abdomen during uterine contractions are all actions that renew spirit and energize the woman giving birth. Because a laboring woman is so sensitive to external stresses and stimuli, the nurse-midwife assures a place for her that protects the privacy and intimacy of the birth experience: a place that is calm, quiet, warm, comforting, and comfortable.

The nurse-midwife's presence also provides boundaries for pain, fear, fatigue, and anxiety. Her presence assures protection from abandonment or entrapment and brings comforting reassurance that all is as nature planned in the intensifying rhythms that culminate in birth. The nurse-midwife confirms a reality to all that is happening.

To be cared for in labor, to be assured of a sympathetic presence when vulnerable, is to know that one is valued. To be valued frees up a woman's energy for bringing forth new life.

Once the baby is born, a woman is launched into her new identity. The sound, the touch, the sight, the nuzzling of a new baby evoke strong ecstatic response in a woman that help bond her to that child forever. A whole new self-concept and heightened self-esteem come in taking on this new role. Now the mother, who has been nurtured and protected in labor, becomes protector and nurturer for another helpless, very vulnerable being. She is energized, excited, and fatigued. She welcomes the sleep of renewal that comes after the work of labor.

The nurse-midwife understands the mother's continuing need to restore her body and spirit, to replenish spent energy. She guards the new mother during the early period of rapid and dramatic physiological adjustment to the nonpregnant state. Her presence frees the mother to sleep and be renewed.

In time, she helps the mother reconstruct events, to review and summarize, to fill in voids, to make a "cognitive map"[4] of the totality of her birth experience. This then allows a new mother to be finished with the "business" of pregnancy and birth and to move on to constructing new family relationships.

Thus, nurse-midwifery, as it has evolved, is an attempt of the professionally prepared nurse to blend her scientifically disciplined learning with the intuitive aspects of the "earth mother" or "wise woman" in responding to the needs of women caught up in the mystique of childbearing. This instinctive, intuitive, quality of the nurse-midwife who never loses her awe in witnessing the miracle of creation assures the continuation of nurse-midwifery as a profession to meet the needs of all mothers to come.

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BIRTH CENTERS AND THE ART OF MIDWIFERY

by Eunice K. M. ("Kitty") Ernst, CNM, MPH
Administrator
National Association of Childbearing Centers

The freestanding birth center is bursting into the arena of American health care. It is a daring demonstration of an alternative to the conventional view of pregnancy as an illness, and birth as a medical event. What precipitated the entrance of this concept of health care delivery for childbearing families? Why is it gaining momentum? And what impact will it have on maternity care?

WHAT PRECIPITATED THE ESTABLISHMENT OF THE BIRTH CENTER?

If one accepts the principle that for every action there will be a reaction, the birth center is a reaction to our concentration on the medical problems of pregnancy and birth, overlooking the fact that the vast majority of women experience a pregnancy and birth totally free of medical problems. There is no question that during the early decades of this century too many mothers and infants died in childbirth. There is no question that the medical problems which left children without mothers, and mothers without children, had to be brought under control. There is no question that any plan for change in providing care to childbearing families should recognize the great gains that have been made through organized programs for prenatal care; improved socio-economic conditions for women that promote better health, hygiene, and nutrition; the control of reproduction through family planning; and scientific advances in medicine, surgery, pharmacology, nursing, and public health. There is also no question that we cannot ignore the problems of today that are at least as complicated as those of yesterday: inadequate preparation for pregnancy, birth, and parenting; inadequate "high-touch" care and inappropriate "high-tech" care; abuse of children and women; and the bottom line of escalating cost.

When birth moved into the acute care setting of the hospital, it seemed like a good idea. It certainly brought sick women and newborns to a place where antibiotics, blood transfusions, and improved diagnostic and surgical procedures transformed potential tragedies into pregnant triumphs. But no one studied what the impact of herding all women into the acute care setting was doing to the normal process of childbirth and the delicate dynamics of family interactions. Only in the last couple of decades has scientific investigation raised serious questions about the routine procedures of the hospital, such as the use of drugs in labor, the separation of mother and baby, the flat-on-the-back position for delivery, and the promotion of artificial feeding.

Only in the past few decades have women had access to medical information that has caused them to be concerned, to question, to become informed, and to reclaim responsibility for their own health and childbirth experience.[1]

During the fifties and early sixties, women organized into childbirth education groups, nursing mothers, and parent support groups to change the way they were cared for in the acute care setting. The presence of husbands in labor, rooming in, and family-centered care came into being as a result of consumer pressure. But for some, the changes were too little or too late (babies don't wait). During the late sixties and early seventies, frustrated with their inability to bring about uniform desired changes, a few women began to take matters into their own hands and stayed at home, often unattended by professional practitioners.

In the early seventies, Maternity Center Association, in New York City, concerned that dissident women would "throw out the baby with the bath water," so to speak, perceiving the growing desire among childbearing women for a safe, satisfying alternative to the conventional maternity care, began to explore alternatives. Even during the three years of investigation and planning for the demonstration of the freestanding birth center, the desire was changing to a demand. The health planning systems that were established nationwide under federal legislation to develop a regionalized system for health services were confronted with articulate women advocating for the inclusion of alternative programs, providers, and practitioners. As a result of their efforts,

many state health plans now include a mandate for alternatives such as birth centers or nurse-midwives.[2]

Resistance to the concept of birth occurring anywhere except in a hospital was, and still is, enormous.[3] Leading members of the Medical Advisory Board of Maternity Center Association in New York resigned in protest to the proposed demonstration of a freestanding birth center. The American College of Obstetricians and Gynecologists, joined by the Academy of Pediatrics and later by the American Academy of Family Practice, took a position against out-of-hospital births. This made it almost impossible to obtain funding for the project. But the Governing Board of Maternity Center Association (MCA), with the support of a few courageous nurse-midwives, obstetricians, and pediatricians, forged ahead to address the needs of a small but determined segment of childbearing families.

Anyone who has read *Wide Neighborhoods* by Mary Breckinridge[4] will see the parallel of the effort to establish the demonstration of the Frontier Nursing Service and the effort to establish the demonstration of the freestanding birth center.

WHY IS THE BIRTH CENTER GAINING MOMENTUM?

The desire/demand of parents caused MCA to define the need for an alternative. In 1975 the Childbearing Center was established as a demonstration model. In 1978 MCA sent a consultant across the nation to look at fourteen other birth centers. In 1979, with support from Jane Leigh Powell, who serves on the Boards of the FNS and MCA, eleven birth centers were studied.[5] In 1981, under a grant from the John A. Hartford Foundation of New York, MCA designed a program for networking information on birth centers. In 1983 MCA, with renewed funding from the John A. Hartford Foundation, established the National Association of Childbearing Centers (NACC).[6] The Network, and then NACC, worked at a policy level, a provider level, and at the public level to identify the need for maintaining quality services. These efforts promoted the drafting of Guidelines for Licensing Birth Centers that were subsequently adopted by the American Public Health Association in 1982.[7]

Eighteen states now have licensure in place, and seventeen states are working on licensure. A pilot program, partially funded by the Pew Memorial Trust of Philadelphia, is now under way to

A typical room in a birth center. This one is in a center in Reading, Pennsylvania, whose director is Diane Lytle, an FNS graduate.

set standards of excellence and establish a mechanism for certification by self-evaluation, site visit, and Board review. Assurance of safety in care of mothers and babies in birth centers is a *sine qua non!*

Market research conducted in parts of Florida, Texas, Alaska, Pennsylvania, upstate New York, and Minnesota show that more than 50% of women would consider using a freestanding birth center.[8] Increasing numbers of childbearing women seek care in birth centers. The satisfaction of users of birth center services is displayed in a fourfold increase in operating centers since 1978, but the real force in the development of the concept is economic. Birth centers are now reimbursed by most major insurers. Blue Cross has written contracts with birth centers in 27 states. HMO's (health maintenance organizations) and Medicaid are paying for services. CHAMPUS (the benefit program for military dependents) is withholding pay until certification is in place. Business, industry, and labor unions have included birth centers in their health benefit packages, and some insurers are offering cash or discount incentives for users of this low-cost service.

The average charges for birth centers in 1982 were 47.7 percent of charges for normal birth in the hospitals serving as back-up for the birth centers reporting. The factors that contribute to cost containment are these:

1. The program is designed to be education intensive, to promote responsibility in parents for preventive health and appropriate use of medical services.
2. The facility is of ordinary construction and equipped to initiate emergency procedures and implement transfer. High tech is reserved for the acute care setting.
3. The birth center, as an ambulatory care facility, is staffed only when a family is in-house.
4. The nurse-midwife subsumes part of the role of the nurse, obstetrician, and pediatrician in high-touch care of mother, anticipating a normal pregnancy and birth.
5. Home follow-up eliminates the need for costly hospital stay.

It is important to view the birth center as a new approach to pregnancy and birth. It is not a cheaper rendition of the program offered by the acute care setting. It represents an opportunity to separate the 75% of women who will experience a problem-free pregnancy and birth and provide a place and program more appropriate to their needs at lower cost; a program that defines midwifery as individualized, personalized "with woman" care, regardless of the education and training of the practitioner.

WHAT IMPACT WILL THE FREESTANDING BIRTH CENTER HAVE ON MATERNITY CARE?

It is acknowledged, even by those who initially opposed the concept, that the birth center is changing the delivery of maternity services to childbearing families in hospitals. One has only to scan hospital newspaper advertising to see that many of the services of birth centers are being embraced by hospital obstetric/newborn services. If freestanding birth centers accomplish nothing more, they have made a valuable contribution to humanizing all maternity services. But is that enough? Do we not need to exhaustively study the reproduction of the human species in a natural habitat? Should we not explore the place of birth as a factor in the outcome of pregnancy, the interaction of the family, and the level of responsibility that prepared parents can assume? Is there any relationship between child abuse or abdication of parental responsibilities and the way we treat human beings as they embark on parenthood and family life? Was there a connection between excessively-drugged birth and the drug generation that followed? *If the majority of women can be safely cared for in a*

different program at one-half the cost of present hospital confinement, with the added benefits of intensive education, improved self-esteem, and greater confidence for nurturing their infants (99% of birth center mothers breastfeed their infants), *should we not aggressively study this promising potential? The National Academy of Science, National Research Council, in an exhaustive search for reliable information on safety factors relating to the place of birth, states unequivocally that we should.* Their conclusion was that it has never been adequately studied. Their recommendation was that it *be* carefully studied.

The Frontier Nursing Service is my alma mater. The most important lessons of my professional career were learned in Leslie County, Kentucky from Mary Breckinridge, Helen Browne, and the families I served at FNS. Birth centers, to me, are "district centers" that have been planted in more than thirty states. The care is based on a basic tenet of FNS philosophy which teaches that if you take care of the mother and father, *they* will nurture and care for their infant.

I think Mary Breckinridge would smile upon this generation of midwives, nurses, doctors and parents who are daring to try new solutions — providing that, like her, they evaluate what they are doing.

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THE POLITIC NURSE-MIDWIFE AND THE SHAPING OF HEALTH POLICY

by Ruth Watson Lubic, RN, CNM, Ed. D., FAAN
General Director
Maternity Center Association

The thesis of this paper is that in order to participate in the shaping of health policy, nurse-midwives must not only enter the world of health politicians, but must do so in a politic fashion. There is an important difference between the two words *politic* and *politician.* The politic person is wise, prudent, sagacious in devising and pursuing measures, shrewd and diplomatic. The word "politician," as distinct from "statesman," is frequently used in a derogatory sense and with the implication of seeking personal or partisan gain. In my judgment, the synonyms for "politic" are those we nurse-midwives should emulate — prudent, wise, sagacious, provident, diplomatic, judicious, wary, well-devised, discreet — as we move into the arena of shaping health policy and dealing with competition and conflict.

The articulation of the art of midwifery with the world of health care policy is not a simple matter. Education is the vehicle by which the art is ensured continuity, and service delivery is the living demonstration of the art at work. The farther we move from settings in which midwives are caring for childbearing families, the more difficult it is to grasp the art. Because we are the vessels of our art, we interpret through our presence and demeanor.

Mary Breckinridge and Hazel Corbin are two outstanding examples of politic women in the history of nurse-midwifery who were responsible for shaping health care policy. Their accomplishments are with us today primarily, I believe, because of their diplomacy, their recognition of the role of consumers in getting the job done and their sensitivity to the needs of childbearing families. They have provided us with the tools we need to carry the

work forward. In order to do so, we must have access, as they did, to the halls and committee rooms where the powerful sit.

Who are those powerful persons who make decisions regarding the shape of the health care delivery system? Essentially they are those who have or control resources in an organized fashion:

Legislators
Professional associations of physicians
Trade associations of health care models or facilities
Insurers and employers — the "3rd" parties

Surely my readers by now have pen in hand to hastily and emphatically inform me that I left consumers off the list. All of us nurse-midwives know, and frequently I have been heard to say, that "Consumers are our strength." Indeed, they are. But do they yet fit into the above list of the powerful in the United States? In discussing the Japanese system, a recent report on world health systems emanating from the House of Representatives states:

> Japan boasts one of the highest life expectancy rates in the world. . . .It also has fewer physicians per capita than any of the other industrialized nations in our study (Sweden, U.K., W. Germany, Canada, USA). . . .The rate of cost growth has been slower than that in the United States. . . .partly attributable to the lowest per capita hospital administration rate in our study. . . . Another cost saving factor is the use of a standardized fee schedule. . . .[which] is negotiated annually by representatives of government, the medical community and insurance plans.
>
> . . . .because consumers and government make coordinated demands in the negotiations, the Japanese Medical Association's organized strength is confronted with a similar force with which it must bargain. The consumers of health services in the United States are in a much weaker position because they are unorganized and operate without the coordination possible under a system of compulsory health insurance.[1]

In our search for a place on political agendas, our role models are essentially self-interested groups. But, as we have seen, the art of nurse-midwifery is other-centered and not self-centered. We must, somehow, learn from the example of the self-interested without succumbing to its lure, the taste of power; even a minor political skirmish won can whet the appetite. Yet as another art, that of negotiation, is denigrated in favor of confrontation and

adversarial postures, consumers on the sidelines quickly discern the similarity between professionals, both as individuals and as groups, in any jockeying for a favored position. They fear the result will be the same — exploitation of the public.

What goal(s) do we have in mind in seeking political "muscle"? The art of midwifery would say "the improvement of quality and access for all childbearing families and the lowering of cost in the health care delivery system." But I have seen midwives who, in their eagerness to gain control over their practice setting, destroy that very setting through impulsive and impatient behavior, perhaps showing irritation with physician colleagues because of their failure to accept a team relationship share in clinical decision making. As difficult as it may be to keep one's "cool," diplomacy and discretion are essential. In addition to consumers, other observers will not be fooled by acquisitive behavior, especially if inaccurately cloaked in the rhetoric of "harrassment," "suppression," and "unfair trade." I recall clearly an interview in the federal Office of Management and Budget (OMB) a few years ago. I had explained to an official the remarkable savings offered by Maternity Center Association's Childbearing Center and was quickly made aware of his concern that an embrace of the concept might simply mean an exchange of self-interested parties from one group already well known, physicians, to another group, nurse-midwives, who as unknowns, are fraught with many potential surprises (and less ability to support campaigns).

J. Robert Willson has analyzed the dilemma of dealing with physician/nurse-midwife/hospital conflicts:

> The physicians' conflicts are going to be principally with the 26,000 obstetrician/gynecologists practicing some form of obstetrics and gynecology over the country. Most young obstetricians start their practice with obstetrics and continue until their gynecologic practice increases enough to support them. Obviously, they do not welcome competition from nurse-midwives. This situation will probably not improve in the foreseeable future because, although the birth rate is falling, the rate at which we are producing obstetricians is increasing. It is estimated that there will be 34,000 obstetricians by 1990. With the increasing numbers of obstetricians/gynecologists in the face of a falling birth rate, the role of the obstetrician is changing. Thirty or forty years ago, obstetricians were specialists and consultants who

> also did some normal obstetrics. Now, the vast majority are surviving on normal obstetrics and their role as specialists and consultants is diminishing year to year. . . .[2]

Dr. Willson goes on to describe problems with hospitals:

> Hospital administrators have kept departmental chairmen in obstetrics informed about once a week that the unit is losing money. . . .In an effort to reduce costs in an underutilized unit, hospital administration sometimes reduces staffing. This makes it difficult to manage a complication or do a cesarian section in less than an hour or an hour and a half because the crew has to be summoned from somewhere else and, in many instances, they are people who are not familiar with the problem.
>
> Modern advances, such as monitoring and ultrasound, have provided a considerable amount of income for hospital obstetric divisions. Today, administrators are going to resist losing normal patient occupancy that generates income from the regular use of ultrasound, monitoring, intravenous, etc. . . . The result of this is that those physicians who are uninformed about nurse-midwifery will support the hospitals' opposition to any change in the present system. They will oppose it vigorously, even to penalizing those who support the new change.[3]

My experience in developing and implementing Maternity Center Association's Childbearing Center supports Dr. Willson's observations. There are so many who oppose that we tend to forget or to minimize the courageous support we have from the few who, like himself, support us. It is not easy for them to follow their conscience and they are the *sine qua non* of our cause.

Dr. Willson sees that as nurse-midwives and physicians work together over time, relationships will improve and families will be cared for by the most appropriate provider. This change won't come about quickly, in my opinion. It will not, because of the oversupply of physicians in obstetrics. For a while yet, the two professions will be in competition for the privilege of caring for families. The physician/nurse-midwife ratio needs to be altered so that it more closely approximates the needs of childbearing women. In the interim, young physicians are worried about whether they will be able to make a living.

We must be very patient, as patient as were Hazel Corbin and the MCA Board of Directors in those forty years between the establishment of the first school of nurse-midwifery and the

recognition of the profession by organized obstetrics in 1971. Prudence, wisdom, determination and persistence, even when the going is difficult, are absolutely essential attributes of the politic nurse-midwife. How fortunate we are that the art of midwifery has taught us just these qualities as we attend laboring women, assisting them in giving birth. We are not by nature impulsive, impatient, reckless and irritable; the art of being "with woman" does not permit such qualities. We are required to have wisdom, discretion and diplomacy, qualities which equip us to shape health care policy, and in order to succeed, we have only to use the tools of our art.

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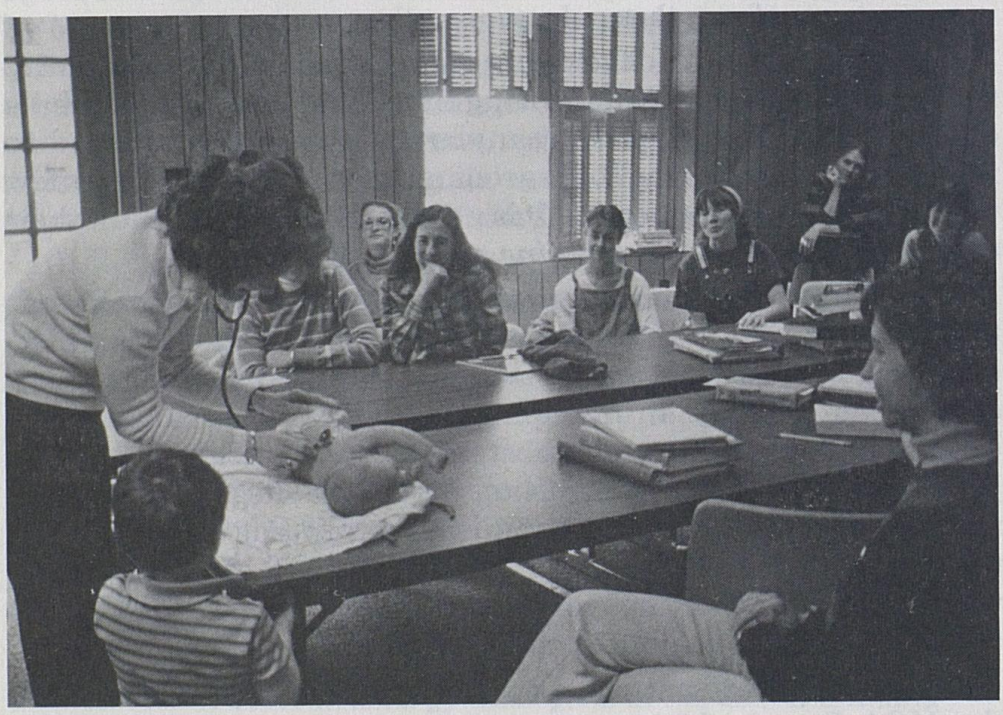

A classroom scene at the Frontier School of Midwifery and Family Nursing. The school, incidentally, is housed in the old Hyden Hospital, which was built in 1927 on a hill overlooking Hyden.

NURSE-MIDWIFERY EDUCATION — PRESENT AND FUTURE PERSPECTIVES AT FNS

By Sr. Nathalie Elder, CNM, MSN
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Demands for nurse-midwives have been growing steadily for the past two decades. Several factors have contributed to this: Client requests, the growth of birthing centers and other alternative birthing options, the holistic health movement, and the economic changes in American society. Nurse-midwives have become valued providers in a "high touch, high tech" culture. They have proven their ability to improve pregnancy outcomes, especially for the poor and the disadvantaged. They have demonstrated cost effectiveness in providing alternatives, as well as traditional care.

In 1982, certified nurse-midwives delivered approximately two percent of the nation's babies. Addressing the convention of the American College of Nurse-Midwives in 1983, President Judith Rooks suggested that this number be increased to ten percent in the near future. In this same address, Ms. Rooks pointed out that the major limiting factor at the present time is "the restricted number of places in our schools." Cutbacks in funding, together with the closing of programs, have created a smaller applicant pool. Two were closed in 1984, and a third announced that it would follow suit in 1985. As a result, the burden of preparing practitioners is left to fewer schools of nurse-midwifery, and these schools are also facing financial cutbacks and a decreased enrollment for the first time. Approximately 200 students graduate from schools of nurse-midwifery annually, and this number promises to shrink even more in the more immediate future.

Nurse-midwifery education is facing the challenge of new directions similar to that of the sixties, when demands for practitioners began to burgeon. It is evident that present strategies will no longer sustain the need for prepared practitioners. New

paths must be found, and these are suggested by the nature of the profession, by current trends in education for the professions, and in societal changes.

NATURE OF THE PROFESSION

Nurse-midwifery as a practice discipline and an art necessitates the wedding of education with practice. This is essential for continued development of the profession's body of knowledge through clinical research and for the education of its practitioners. Clinical practice is the *sine qua non* of nurse-midwifery education. This is best accomplished through faculty with clinical expertise and through practitioners with skills in teaching. The most recent survey of certified nurse-midwives in the United States indicates that a number of master's prepared clinicians are available, i.e., that they are practicing nurse-midwifery. Many CNM's, according to the survey, are participating in the education of a variety of health care providers, such as nursing and medical students. Only 29% reported clinical or theoretical teaching of nurse-midwifery students, while 31.2% indicated that they participate in the education of nursing students.

University medical centers, where many educational programs are situated, have not proven satisfactory as clinical sites. These tertiary, high tech, centers often provide only one type of experience for both clients and students. While this type of setting offers invaluable experience, their philosophies may be at variance with that of the nurse-midwifery educational program, as when all clients, regardless of risk factors, are placed on monitors. Medical students may also be in competition for deliveries. Hence, a situation prevails in which clinical practice is available, i.e., in birthing centers, but that experience is not in close proximity to the educational facilities which provide the theoretical and research base for practice. The questions to be addressed are: "Can the two be brought together?" and, if so, "How can this be accomplished?"

In answer to the first question, the survey previously cited indicates that a number of CNM's are engaged in the education of nursing students and nurse-midwifery students. This demonstrates the availability of an instructional pool. It is inherent in many practice professions that knowledge is a sacred trust, bringing with it the ethical responsibility to share that knowledge,

to pass it on to the next generation, and to proffer some repayment for one's own education. Trends in education suggest the answer to the second question, "How can education and practice be brought together to meet current demands?"

TRENDS IN EDUCATION

New models of education are being created today to meet the changing student population and its needs. Spurred on by the economic situation, the marketing model has become the educational thrust of the eighties. In the marketing model, emphasis is placed on the student as consumer and the educational program as product. The student in higher education today is an adult learner who must remain on the job while obtaining an education. Part time students in graduate programs of nursing have tripled in many places. This is the result not only of the economy, but also of the impetus for education given by the American Nurses' Association's 1985 Resolution, now a "fait accompli," which mandates baccalaureate level education for the beginning practice of professional nursing.

Peters and Waterman's research subtitled *Lessons from America's Best Run Companies* identifies the "attributes of excellence" which are translated into "success." Three of these are especially applicable to nursing and nurse-midwifery education. They are: the ability to manage ambiguity and paradox, maintaining closeness to the customer, and providing productivity through people and through "hands on" — value driven — activities. Both nurse-midwifery and nursing education, wherein most nurse-midwifery programs reside, provide some prototypes which illustrate and utilize these priniciples or attributes.

Educational institutions which are "close to the consumer" recognize the principles of "andragogy" (adult learning) propounded by Malcolm Knowles. The most relevant principle is the realization that learning is highly individual, that it takes place in a variety of ways, and that it is not confined to the educational institution or classroom. It furthermore acknowledges that the adult learner comes with an accumulation of knowledge and skills and is capable of pursuing his/her own learning goals through independent study. This accumulated knowledge and skills can be tested and recognized through credit-granting without repetitious experiences devoid of challenge or growth.

A number of models based upon these principles have been developed. Among them are transfer programs whereby potential students take challenge examinations and are given advanced standing, pre-service master's preparation for students holding a baccalaureate degree in another field, honors programs for the A.D. (two-year) RN to proceed to a master's degree, and, more recently, the first professional degree in nursing at the doctoral level. The most flexible and independent program is the New York Board of Regents' External Degree. This offering allows the student to pursue his/her learning goals at the place of his/her choice and in the manner of his/her choice. Only the outcome —not the learning process — is measured, and that is done through carefully designed evaluation procedures which determine that the student has attained the level of preparation desired for practice in the profession.

Nurse-midwifery has capitalized on a number of these models. The modular system, pioneered by the University of Mississippi, opened the doors for self-paced, self-directed, independent learning. A growing number of schools, including an experimental program, offer advanced placement through evaluation of clinical and theoretical knowledge. Off-campus experience with clinical preceptors has provided for integration of the professional role and synthesis of learning. It also affords experiences in a variety of settings designed to meet individual student needs and goals for future practice.

The Frontier School of Midwifery and Family Nursing has utilized a number of these approaches, such as the modular curriculum, off-campus integration experiences with preceptors, and advanced placement of students in the program. It now moves into a new phase in the development of an Educational Mobility Project. This project is designed to provide post-baccalaureate preparation for nurse-midwifery to increasingly larger numbers of students by combining the rich resources for theory development and testing which are available in a university setting with the clinical resources to be found in birthing centers and other nurse-midwifery services which are not currently associated with educational programs.

The project has three administrative components:

(1) *Affiliation with the innovative university school of nursing at Case Western Reserve* will strengthen the theory base, research,

and evaulation aspects of the program. It will also afford students the option of obtaining graduate credit from Case Western Reserve's Frances Payne Bolton School of Nursing for the nurse-midwifery courses which would be applicable to a master's degree at that institution. Joint faculty appointments, mutual curriculum planning, and faculty exchange will enrich both programs of study. Students from Case Western Reserve will have the opportunity to pursue clinical experience and research at FNS.

(2) *Affiliation with the National Association of Childbearing Centers* will generate alternative birth experiences to complement those of the hospital care settings. This will facilitate the development of practice skills and provide opportunity for theory testing and role development as the student evaluates a variety of approaches to the childbearing event. Birthing centers will benefit from the mutual sharing in the FSMFN (Frontier School of Midwifery and Family Nursing) curriculum and the challenge of young, inquiring minds, as well as the added care to clients.

(3) *The development of independent study methods, materials, and evaulation procedures,* the third administrative aspect, is crucial to meeting individual student needs and to increasing the number of CNM's. Self-study modules and materials, combined with qualified preceptors and other resources, will allow the student to pursue learning goals independently and come to FSMFN for orientation and evaluation relative to various levels of the program.

Three critical phases combining orientation and evaluation have been identified:

Phase I includes physical and health assessment, well-woman gynecology and family planning, part of the content of the family nurse practitioner segment of the traditional FNS offering. Students such as certified nurse practitioners desiring advanced standing could test out of this phase (through clinical and theory examinations) and go into orientation to the next phase.

Phase II, Introduction to Nurse-Midwifery, consists of normal and selected risk aspects of antepartum, intrapartum, postpartum, newborn, and family planning care, in addition to theories and concepts of practice. Students are introduced to nurse-midwifery concepts and practice through an intensive orientation period consisiting of theory presentation, simulation labs, and clinical experience with one-to-one supervision. Nurse-midwifery

modules are presented, with guidelines for their use during the remainder of the program. Carefully designed tools and procedures evaluate ongoing achievement of clinical and theoretical objectives. Student self-evaluation is built into the structure of both formative and summative evaluation. The intense orientation period is followed by clinical experience with faculty preceptors at a variety of sites selected to meet individual student needs relative to program objectives.

Phase III focuses on professional role development, theory testing, care of groups of essentially healthy women/newborns, and collaborative care of selected clients at risk. The pattern of intensive theory followed by clinical preceptorships will be repeated as in Phase II. Emphasis will be placed on integration and testing of theories by students as they assume the professional role with increasing independence for management and decision-making. Carefully designed evaluation tools and procedures, as described above, are again utilized. Student seminars, case studies, and teaching projects, as well as clinical experiences, provide vehicles for integration of knowledge and skills. This phase will be concluded by a final evaluation period in which attainment of program objectives will be evaluated.

"To everything there is a season," goes the proverb. The season for pioneering educational programs in nurse-midwifery has arrived, and FNS, true to its name, is in the frontier of the movement, planning to meet the challenges of the eighties, giving direction for a bright future.

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THE "FNS DEMONSTRATION" — WHERE HAS IT LED?

In preparing this article, the *Quarterly Bulletin* called not only on its own resources, but also on its readers. Following a general invitation to our readership, we sent a questionnaire to a small group of alumni, hoping to reach persons who would be representative, knowledgeable, and articulate. The response was warm, generous, and perceptive. We wish it had been possible to contact many others, but we do not have the resources to handle a large response. Because the sample was relatively small, we drew no statistical conclusions. Nevertheless, the survey was most instructive. It brought us much useful information and many valuable ideas and perspectives.

There is no possibility of publishing all the quotable wisdom that came our way, and few respondents are quoted in this article. Yet everyone who contributed made an impact. All letters and questionnaires were read carefully. We are grateful to those who responded, and we acknowledge their kind efforts by listing them at the close.

We feel cheered, even inspired, by this contact with our readers. We hope they will wish to share their ideas and experiences with us on an ongoing basis.

Next May, the Frontier Nursing Service will be sixty years old. Sixty years is a significant length of time. It is long enough to establish perspective. And it is long enough to show how goals and accomplishments stand up against the changes of time.

"In the beginning," FNS was called "The Kentucky Committee for Mothers and Babies." That title reflected the purpose for which FNS was founded, and which has continued to be one of its main concerns. Three years later, in 1928, the name was changed to "Frontier Nursing Service," not to change goals, but to expand their scope. Each of the three words in the new name was, and still is, crucially important.

The "frontier" of those early years could be defined geographically. Roughly, it described the mountainous area of southeastern Kentucky. Today, FNS serves on a wider frontier. Someone has said that knowledge is like an island in a sea of ignorance — the larger the island, the longer the shoreline. And FNS, with its ever-growing record of health pioneering, now looks out across an ever-lengthening frontier to a world that still needs the kind of care that FNS provides and symbolizes, and which offers FNS continuing opportunities to serve.

The other two words in the name that FNS recast for itself —"nursing" and "service" — carry implications that are sometimes overlooked, but which lie at the heart of FNS' sense of

purpose in the world. In the following pages, we look again at the values they represent and try to understand what they mean today.

We began our inquiry with Mary Breckinridge's statement that her purpose was not merely to improve health care in Appalachia, but also to *demonstrate* how care could be made available anywhere in the world. We suggested that the system of care she wanted to create embodied four basic concepts: (1) educational preparation and assignment of nurses as both nurse practitioners and nurse-midwives, (2) providing continuity of care — including preventive care and health education, (3) decentralization — reaching into communities by means of neighborhood clinics, home visits, etc., and (4) joint practice — a continuous interweaving of the skills of nurses, doctors, and others as needed.

We realized that this was probably an oversimplification, and we expected our readers to suggest modifications and corrections. Most of our respondents, however, *did* accept the definition, believing perhaps that it was broad enough to allow individual interpretations. However, a few respondents, usually persons whose experience gave them a special historical perspective, seemed to see things somewhat differently. Elsie Maier Wilson, who graduated from the Frontier Graduate School of Midwifery in 1963 and remained on the FNS staff until 1978, wrote:

> The FNS demonstration was more than that outlined in the questionnaire. . . . To me, the FNS demonstration was meeting the needs of people wherever they are and for whatever they needed. It was providing low-cost, comprehensive family care by using first, nurse-midwives and later, family nurse-practitioners, along with a host of interdisciplinary personnel and referral sources. It was caring about *people* where they are, whatever their station in life, whatever their need. It was improvising with what you had, using common sense and creating a trust relationship so that, for example, diagnostic testing would not have to be done for the sake of malpractice liability issues. It was being honest with patients and facing hard truths together with family and FNS support. It was being available to people and if unable to meet the need, finding someone who could! That's the spirit that I remember. . . .

Edith Anderson and Joyce Wiechmann, FNS graduates who now teach at the University of Mississippi Medical Center, saw the basic concepts as follows:

> (1) The nurse-directed health-care team, utilizing physicians for consultation and referral, is the model used for the FNS demonstration.

(2) The health-care system is directed by the patients (clients) for whom it provides care, via the local community committee. It is the patients, therefore, who give ultimate direction to the director of the health-care team. (3) The public health orientation of the nurse-midwife is the means of equipping her to be a change agent in the community. (4) Health care is most readily received by the client when it is delivered in an environment with which the client is familiar and which is readily accessible to the client.

This view stresses the principle that the nurse is "the person who is expert in managing and maintaining health but is also prepared to recognize abnormalities and consult/refer to the physician and others when indicated." It is the patient, acting through local committees, who has ultimate control of his own care. And it is the public health orientation of the nurse that adds the essential emphasis on preventive health measures.

We sense here certain questions of terminology. The terms "nurse practitioner" and "joint practice" were not known in Mary Breckinridge's day, and in some contexts today they may connote practices that appear to be at odds with her intent. Still, there are areas of overlap. The nurse practitioner program at the Frontier School is strongly oriented to public health principles. The phrase "joint practice" — that continuum of care in which nurses, doctors, and others, working as colleagues, move into and out of the caring process as their abilities are needed — does not in itself specify how the process is to be directed. To some, the term implies control by a doctor. Yet if "joint practice" principles are envisaged in a situation where direction is given by the nurse, the health care system that results will surely have a close resemblance to what Mary Breckinridge had in mind. Perhaps terms like these mean too many different things today and need clearer definitions.

Actually, as we review these issues, we think we should ask a different question: Are we not really talking about those two other words in the FNS name — *nursing,* with all that that implies about ongoing personal care, including preventive care, and *service,* in that best definition that connotes unselfish concern and unstinting dedication?

In fact, the thread that seems to run most visibly through the responses to our survey is a sense of eager, even passionate, dedication to the service of humanity. This dedication seems almost to have the qualities of a faith, a deeply held concern for the wellbeing of mankind, however that is to be achieved.

Whatever else FNS may be, it is passionately concerned with *caring*. As one of our respondents put it, "there *is* something special here" — and we hear this feeling confirmed constantly by those who come to FNS to visit, to explore, or to study.

Some of our readers reminded us that Mary Breckinridge did not intend the FNS demonstration to apply only to rural areas. This, of course, is true. The demonstration was meant to show how health care could be brought to *any* community that needed it, and readers did report a number of programs in urban areas that embody many of the FNS concepts. It is true that FNS itself has always operated in a rural setting, and that its school has always drawn nurses who were attracted to rural practice. But this should not obscure the universality of Mrs. Breckinridge's grand design.

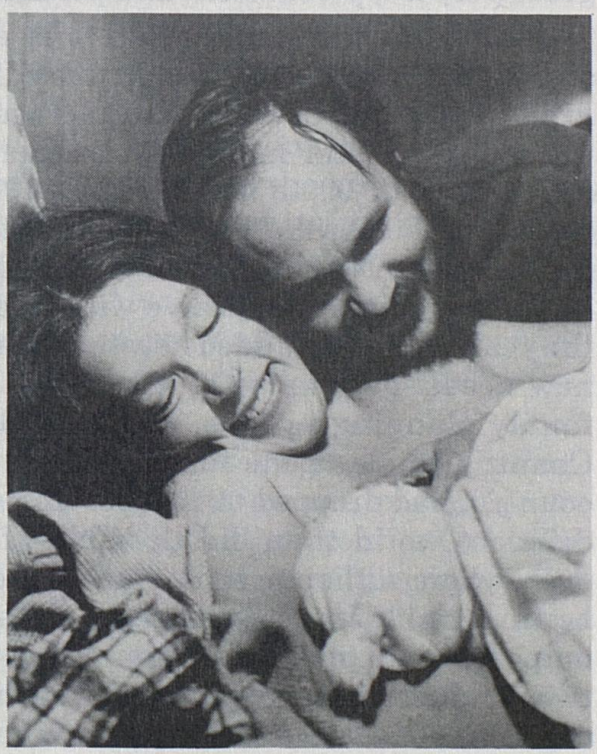
Whatever the area or the culture, there is one aspect of health care that shows up repeatedly in what our respondents say: There is never enough of it. At one extreme, the services do not exist at all. At the other, the services are available, but they cost more than the community can afford. Between the extremes can be found many combinations of need and ability to meet need.

This problem seems always to have existed. Virtually every health project has had to work out some kind of compromise between need and the practical ability to provide care. In an area that is inadequately served, efforts to bring in good health care generally focus on four principal objectives: (1) *Detecting* health problems in time to take care of them. (2) *Preventing* problems by educating the public, creating healthful conditions, and teaching individuals how and when to ask for help. (3) *Decentralization* —extending the outreach of health care through outpost clinics, home visits, etc. (4) *Developing support systems,* both financial and organizational.

At FNS, the first three needs were met by placing the district clinics in locations where help was available within two or three hours, by staffing the clinics with professional nurses whose skills included nurse-midwifery, family nursing, and public health nursing, and by keeping the nurses in continuous touch with their communities so that they could teach the principles of health maintenance as part of the routine of providing care. Financial support came largely from the generosity of FNS'

many friends, for few of the mountaineers could afford to pay fully for their care.

From this starting point, FNS has evolved through six decades of experience to become the FNS of 1984; we will speak of this subsequently. And the FNS demonstration has had its own impact. However, it is hard to assess this impact. Some of our graduates tell us of active and successful programs that were consciously patterned on the FNS model. Others tell us that they, as FNS graduates, have influenced other programs by means of the knowledge and experience they brought from FNS. But there are many other programs that have come into being in response to the needs of their own communities and, because they faced similar needs, they often developed in similar ways. Debbie Goldstein, a recent FNS graduate who is now working on the Navajo Reservation in Chinle, Arizona, commented that "an FNS-like model tends to develop in rural areas I've worked in." Beyond this, there is no way of measuring the influence FNS has had on the many health officials, teachers, and students who have come to Hyden over the years to study the FNS model. What *is* clear is that Mary Breckinridge's design for FNS has worked in



The art of nurse-midwifery centers on mother and child in a family environment. Increasingly, fathers and children are participating actively in the childbearing experience. In this scene at FNS, a young mother shares her happiness with her husband and baby.

Appalachia and in other communities where it has been copied, and its validity has been confirmed by those many other agencies that have worked out similar programs in their own environments.

All of the successful projects seem to have had one thing in common: forceful leadership. Like Mary Breckinridge herself, the successful pioneers seem invariably to have been individuals of passionate conviction, persons dedicated and fervent and possessed of the kind of compelling personality that overcomes resistance and commands support. Commonly, they show an almost religious devotion to the cause of humanity, with a readiness to make great personal sacrifice. In fact, it seems unlikely that anything short of consuming dedication could have brought about the advances that have been achieved. New programs have consistently been opposed, sometimes because of ignorance, sometimes through natural resistance to innovation, sometimes as a result of distrust of social evangelists coming in from "the outside" and upsetting an established way of life, sometimes because of the fear of competition or disruption. Whatever the reason, there have been few situations in which pioneers could have succeeded had they not been individuals of great purpose, persuasion, and persistence.

And what has come of all this devotion and effort? One significant result is obvious at once. In the region served by the Frontier Nursing Service, there has been a significant decrease in the mortality and morbidity associated with childbirth. FNS delivered its 20,000th baby in May, 1983. In all these years, only eleven mothers were lost in childbirth, and two of those were cardiac cases. No mother had died in childbirth since 1952.

Thus a primary objective was accomplished early. And over the years, FNS has added new services and facilities, adapting to new needs. For example, it began a program of counseling in family planning in 1958, and by 1983, the birth rate in Leslie County, which at one time had been one of the highest in the country, had dropped to 16.8 per thousand. Today FNS serves a different world than did the FNS of 1925. Paved roads reach everywhere, although some of them are narrow and steep and can be impassible in the winter. Mrs. Breckinridge built her first outpost clinics on sites so placed that help was never more than two or three hours away. But that measurement reflected the capacities of a horse. Today, almost anyone in the area can reach

a hospital in thirty to forty-five minutes. Patients needing the facilities of a tertiary care hospital can be transported by ambulance from Hyden to Lexington in just over two hours, and in certain emergencies, patients can be helicoptered to Louisville, Cincinnati, or other large cities. Such services have saved the lives of distressed premature infants, of men with chests crushed in mining accidents, and of others with severe burns.

The nature of home health care has changed. In Appalachia, as in other communities, rural and urban, it has been realized for many years that a nurse or doctor can serve a wider clientele when patients come to the office than when the nurse or doctor must spend time traveling to homes. Thus, with better roads, more patients are coming in to the clinics, and there are fewer home visits of a routine kind. Telephones also help; a timely exchange of information can often eliminate the need for an actual visit. On the other hand, government policies that encourage early discharge from the hospital tend to increase the need for care at home, and thus to increase the number of home visits to persons recently discharged. And, of course, there is no reduction in the need to visit patients chronically confined to their homes, or to visit homes in certain emergencies. Current government regulations and insurance practices, however, create problems in providing services. Home visits by Home Health nurses, for example, are reimbursable, but visits by nurses from the district clinics are not. Nevertheless FNS' district nurses *do* continue to make home visits when they can — often on their own time. They feel it is important to do this, in part to maintain better contact with their patients, in part to gain understanding of family situations and living conditions. Also, they often tell us that it is much easier to give instruction in preventive health measures during a home visit than during an office call. Home births, however, are rare.

Mrs. Breckinridge's first nurse-midwives were trained in England, but when World War II interrupted this source of supply, she founded her own school, originally called the Frontier Graduate School of Midwifery. The educational program was amplified thirty years later by adding a curriculum for family nurses. Mrs. Breckinridge had often spoken of wanting to do this, but it did not become possible until 1969. The first family nursing class entered the school in June 1970, and the school was renamed the Frontier

School of Midwifery and Family Nursing. Today the school continues to respond to changing needs. Sr. Nathalie Elder's article elsewhere in this issue describes a significant plan to adapt nursing education to the new requirements of the 80's.

Yet, remarkably, in an age where health care has seemed to become increasingly impersonal, FNS has retained a great deal of its "personal touch." If it rarely presides at a home birth today, it offers home-like birthing room facilities at the Mary Breckinridge Hospital, in addition to standard labor and delivery facilities. Its Home Health Agency continues to visit the chronically ill. It provides "hospice-like" care to the terminally ill, both through Home Health and by providing at the hospital as many of the comforts of home as possible. The district clinics reach into their communities to provide needed help and services. For example, the district nurses often set up temporary screening stations in the community — typically, at a post office or at a store — to test for high blood pressure, and then advise those who need help how to get it. The nurses often teach free classes on health care. Sometimes they take on projects that are not specifically related to health but which contribute to the well-being of the community. A notable example was the assistance given to the Big Creek community in making land available for a much-needed volunteer fire house. Some have published directories that list poison control centers, agencies to call in cases of child or spouse abuse, and other social services.

The kind of concern and care that all of this represents is especially needed in a day when health care costs are exploding, when technological methods tend to replace caring, when malpractice suits have put many health care providers on the defensive, when government regulations tend to squeeze out personal attention in order to establish the means of control.

And what of the impact of FNS "beyond the mountains"? It is hard to measure, but we can start by noting that many FNS graduates have gone to far places, full of the knowledge and concern and enthusiasm they acquired at FNS, to dedicate themselves to health care in their chosen parts of the world. Recent records indicate that in mid-1984 there were 66 FNS graduates working in 33 foreign countries. Many more are scattered about the United States — at the last count, in 48 of the 50 states. Some are in urban centers, some in remote areas. Their

reports tell us what has always been clear: there is never enough health care. Sometimes the need is almost desperate. Sr. Anne Wojtowicz, writing from Holy Family Services in Weslaco, Texas, reports that in 1983, over 1,100 babies were born in Hidalgo County, Texas, without any trained medical help. Elsie Wilson speaks of a large population in a well-to-do part of Florida that is not poor enough to be eligible for government health assistance, yet cannot afford private care. Many of our graduates have become actively involved with the birthing center movement. They tell us of mothers' growing interest in the more natural conditions these facilities provide. At the same time, our nurse-midwives often report that it takes major effort to get new birthing centers established because of the resistance of regulating bodies, organizations and persons who fear competition, and those who instinctively object to change.

Yet headway *is* being made. And where we find success, we generally find, as we have noted before, the presence of strong leadership. In another article in this issue, Ruth Lubic stresses the need for nurse-midwives to be "politic." It is clear that this has been an essential element in those who have succeeded in establishing new projects in the face of opposition. It is also clear that abilities of still another kind are necessary: In the United States, at least, those who run organizations of any size need increasingly to be expert in administration and cost control. The passionate drive of the pioneer must be joined, once a new program is established, by competence in management, in order to preserve the gains and make it possible to continue them into the future.

The example of FNS has not, in general, produced "like copies." Rather, it has inspired others to seek out need and to devise "custom made" solutions. Some projects resemble FNS more in the spirit of their care than in any particular practice of it. Respondents who tell us they were inspired by FNS have applied their energies to enterprises ranging from small practices to many-faceted projects like Lend-A-Hand Center in Walker, Kentucky, founded in 1958 by FNS graduate Peggy Kemner and Irma Gall, a teacher, who created, in a group of old farm buildings, a center to provide such diverse services as a home health service, a clinic, Sunday school and Bible school, 4-H projects, and a variety of social programs.

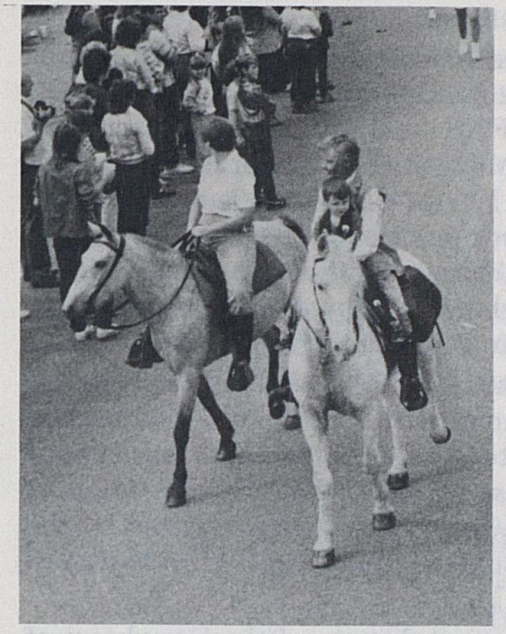
A still different need appears in communities where cultural predisposition creates resistance to new forms of health care. A number of our respondents, not only overseas, but in this country as well, stress the need to be "culturally relevant," as Debbie Goldstein expressed it — and she added that she and her fellow midwives on the Chinle reservation found it invaluable to go through a cultural orientation that included taking sweat baths and working with medicine men and women. Others speak of making use of local people and local facilities, of training "village workers" (mainly in third world countries), and of learning to incorporate local medical practices and customs whenever possible, in order to win the confidence and support of the community and to make practical use of existing capability.

After nearly sixty years, the "FNS demonstration" has proved durable. Its vitality, we believe, wells from its very basic concern for human beings, combined with a practical understanding that it can meet its objectives by placing the responsiblity for care in the hands of those who *do* care, who are *qualified* to provide care, and who can *reach out* to those who need care, The three words in the name Frontier Nursing Service are still vital, individually and in the familiar combination. Today's frontiers are not so much geographical as they are cultural, social, and technological, but they are frontiers none the less. The spirit of FNS is still that of *nursing* — treating health as a continuing need, to be nourished and cared for and to be provided for at all times, not just when illness descends. And *service* remains the constant goal, with all that the word implies in defining need and working faithfully and lovingly to meet the need. If the FNS demonstration has the qualities of a faith, that is not entirely a conincidence. Conviction and dedication have been the driving forces. In this tumultuous and uncertain time, this kind of faith is not only desperately needed — it is one of the few things on which we can rely.

ACKNOWLEDGMENTS

We express our appreciation to these kind and thoughtful individuals, whose generous responses to our request for ideas and information were received in time to help us prepare this special issue: Edith E. Anderson, Jackson, MS; Susan B. Baker, Huntingdon, PA; Susan Barry, Livingston, TX; Mary Bradish, Peru, IL; Madonna Burget, San Pedro Sula, Honduras; Dr. Eva F. Gilbert, Cascade, MD; Debra Goldstein, Chinle, AZ; Erica Goodman, Hyden, KY; Martha H. Groggel, Salt Lake City, UT; Christina M. Guy, Dresden, ME; Ellen Hartung, Rogersville, TN; Margaret Kemner, Walker, KY; Linda Kilheffer, Khanjunpur, Bangladesh; Mary Ellen O'Brien, Brownsville, TX; Sheila Ward, Monticello, KY; Joyce L. Wiechmann, Hollandale, MS; Elsie Maier Wilson, St. Petersburg, FL; Sr. Anne D. Wojtowicz, Weslaco, TX.

MARY BRECKINRIDGE FESTIVAL — 1984



Left, above: For many years, Molly Lee has led the Mary Breckinridge Day Parade on horseback and in traditional uniform. Although she retired last winter, she returned from England and led the parade once again.

Right, above: Betty Lester, one of the most celebrated and best loved midwives in FNS history, was Grand Marshall of this year's parade. Miss Lester was recently honored on her 85th birthday.

Below: A general view of the parade.

BEYOND THE MOUNTAINS

by Ron Hallman

A distinguished group of FNS friends gathered in Louisville on September 11th at the invitation of our new committee chairman, Mrs. Hugh Williams, to watch slides and hear an FNS "update." It was gratifying to have two FNS trustees in attendance: Mary Stites and Florence Rawleigh (courier, 1942), as well as Mrs. John Harris Clay, who is an honorary member of our Board of Governors. Two more members of the FNS family who joined us for the meeting were Barbara Christianson (courier, 1939) and long-time supporter Frannie Heyburn. The presentation was sponsored by the St. Marks Episcopal Church Women of Louisville.

Later that day in Lexington, the Kentucky Committee of the Breckinridge Family met at Sarah Stanfill's home with representatives from the University of Kentucky and Jim Klotter, State Historian, to learn about Mr. Klotter's newest book, *A Timeless Circle — The Breckinridges of Kentucky*. The Breckinridge Family Committee is now chaired by the recording secretary of the FNS Board of Governors, Mrs. John Marshall Prewitt.

Various state chapters of the National Society of the Daughters of Colonial Wars have asked for presentations about their organization's national project — Frontier Nursing Service. On October 2nd, I responded to such a request with a slide show and talk to the Michigan State Society in Ann Arbor. Ann Davis-Garvin, a nurse-midwife and graduate of the Frontier School, took some time from her new duties at Women's Hospital of the University of Michigan to speak to the group about her experiences in Kentucky, as well as her work in Ann Arbor. We are indeed fortunate to have many graduates, like Ann, providing quality maternity care throughout the U.S. and in many other countries.

The development of the FNS model as a unique rural health care system was once again the topic in an entirely different setting on October 18th, as our national chairman, Miss Kate Ireland, addressed the faculty, graduate and undergraduate students of the University of Rochester Medical Center. Kate spoke at the invitation of Dr. Loretta Ford, dean of the university's School of Nursing, and a member of the FNS National Nursing Council. Dr. Ford was a consultant to the Frontier School in the early 1970's, during the inception of our family nurse practitioner program.

"Congratulations" are once again extended to Boston Committee chairman Whitney Robbins, who initiated and hosted a most successful Boston Courier Reunion at her home in Medfield on October 21st and organized the fall meeting of the committee on the 22nd. FNS courier and volunteer coordinator Danna Larson traveled to Medfield from Kentucky to greet some old friends and meet a few volunteer predecessors at the

reunion. We brought with us a video tape of the newest FNS films, which were received with enthusiasm at both meetings. So many loyal FNS friends attended the two gatherings that space prohibits listing them by name —but to each of you (and you know who you are) we express a sincere "Thank you!"

The final fall stop on the FNS "Beyond the Mountains" calendar was Minnesota on November 7-8 for courier recruitment at two colleges, Macalester and Bethel, and two private high schools, Breck and St. Paul Academy. The trip could not have been a success without the interest and aid of former courier Beth Miner, who "brainstormed" with another former courier, Marianna Fuchs. My enjoyable (but too brief) visit with Beth and Rany Miner rekindled our hopes to enhance FNS courier recruitment in the Twin Cities.

ROBERT WOOD JOHNSON FOUNDATION AWARDS SUPPLEMENTAL GRANT TO FRONTIER NURSING SERVICE

The Robert Wood Johnson Foundation of Princeton, New Jersey recently approved a grant of $325,464 to Frontier Nursing Service, in four-year support of plans to strengthen the organization's capacity to provide essential health and medical care to its service population.

The grant, which is being made under the Foundation's supplemental Service Grant Support Program, will support a series of strategies for enhancing (1) coordination among clinic sites, (2) communication systems, (3) recruitment of physicians and advanced registered nurse practitioners, and (4) productivity, and also for developing a marketing plan for FNS Primary Care Services.

NEW YORK BARGAIN BOX

The Bargain Box, a symbol of the long-time support from the FNS New York Committee, has been sold, according to a letter recently received from Mrs. Muriel E. Haggerty, Committee Chairman.

Mrs. Haggerty requests that shipments of clothing, bric-a-brac, and other items be halted at this time. Mrs. Haggerty states, however, that the New York Committee is continuing to make plans for the future and will consider the possibility of opening another Bargain Box project if that should become feasible.

IN MEMORIAM

We wish to acknowledge our appreciation and personal gratitude to these friends who, by including FNS in their wills, have made a continuing affirmation of interest and belief in the care of mothers and babies and their families by the Frontier Nursing Service. Such legacies are added to the endowment fund.

MISS DOROTHY M. ANDREWS
Evanston, Illinois

MISS EDYTHE G. BALSLEY
Kennett Square, Pennsylvania

MRS. MILDRED GARDINOR FISHER
North Brunswick, New Jersey

MRS. JEAN H. GALLIEN
Cleveland, Ohio

MR. IRVIN A. KIRCHER
Cincinnati, Ohio

MRS. HAMILTON M. ROBERTSON
Alexandria, Louisiana

These friends have departed this life in recent months. We wish to express our gratitude for their interest in our work, and our sympathy to their families.

MR. DENVER ADAMS
Hyden, Kentucky
Former member, FNS Hyden Committee

DR. ARNOLD B. COMBS
Lexington, Kentucky
Member, FNS Medical Advisory Committee

MR. C. VERNON COOPER, SR.
Harbor Oaks, Florida
Father of FNS Board member C.V. Cooper, Jr.

MR. ASTOR COUCH
Hyden, Kentucky
Former member, FNS Advisory and Hyden Committee

DR. HOWARD M. FREAS
Red Bank, New Jersey
Former FNS Medical Director

MISS DORIS GIBSON
Kansas City, Missouri
Frontier School alumna

DR. JOHN S. HARTER
Louisville, Kentucky
Member, FNS Louisville Committee

MR. EDWARD MORGAN
Wendover, Kentucky
Former FNS employee

MISS ADELHEID P. MUELLER
Minneapolis, Minnesota
Frontier School alumna and former FNS staff member

MR. SQUIRE R. OGDEN
Louisville, Kentucky
Member, FNS Louisville Committee

MRS. ETHEL SMITH
Whitesburg, Kentucky
Mother of FNS staff member Lillie Campbell

MEMORIAL GIFTS

We wish to express our deep appreciation to these friends, who have shown their love and respect for the individuals named below by making supporting contributions in their memory to the work of the Frontier Nursing Service.

Joan Lee Martin
Alice E. Whitman
Anne A. Wasson, M.D.

Dr. Frederick Zerzavy
Alice E. Whitman
Anne A. Wasson, M.D.

Doris Gibson
Alice E. Whitman

Mr. Carl H. Danforth
Alice E. Whitman
Anne A. Wasson, M.D.

Mrs. Irene Beasley
Anne A. Wasson, M.D.

Mr. Walter C. Begley
Mr. and Mrs. Claude Baker

Mr. Peter von Starck
Mrs. J. Cranston Hodupp

Miss Edythe G. Balsley
Mrs. Eugene F. Hogenauer

Mr. Albert B. Comstock
Mrs. Albert B. Comstock

Mary Buckner Thomas
The Very Rev. and
Mrs. Robert W. Estill

Ruth Simonson Morley
Mabel Ross, M.D.

Margo Squibb
Mr. and Mrs. Gordon J. McKinley

Harriet L. Kurfees
Dr. and Mrs. James F. Kurfees

Mrs. Charles Beach, Jr.
Miss Kate Ireland

Mr. Tom Jones
Miss Kate Ireland

Ethel Smith
Mr. and Mrs. Walter S. Lewis

Ann Oliger
Mrs. Richard R. Pesce

Mr. Charles P. Bowditch
Mrs. Charles P. Bowditch

Mary Dow Novotney
Mr. and Mrs. Larry N. Dow

Mr. Walter E. Chaffin
Mr. and Mrs. Elmer S. Goheen
Mr. Alfred M. Hunt
Mrs. Paul B. Ernst
Miss Kate Ireland
Mr. C. Vernon Cooper, Sr.
Hyden Citizens Bank
Mrs. J. Gibson McIlvain, II
Mr. and Mrs. William G. Hayward
Ms. Jane Smith Taylor
Mr. J. Gibson McIlvain II
Mrs. Andrew B. Young
Mr. and Mrs. William E. Glenn, Jr.
Mrs. J. Cranston Hodupp
Valley Forge Gun Club
Mrs. J. Gary Barthell
Mr. and Mrs. Eddie J. Moore
Mrs. Walter N. Haldeman
Miss Julia D. Henning
Mrs. T. Floyd Smith
Mrs. Thaddeus Longstreth
Mr. and Mrs. E. Bruce Mumford
Mr. Bruce Haldeman
Mr. Kelvin Smith
Miss Kate Ireland

FNS OPENS NEW DISTRICT CLINIC AT YERKES, KENTUCKY

The Frontier Nursing Service has opened a new district clinic at Yerkes, Perry County, Kentucky, approximately twenty miles northeast of Hyden. The new clinic is to be known as the Shopp Folk Health Center at Yerkes. It joins the four FNS district clinics (at Beech Fork, Big Creek, Pine Mountain, and Wooton) and two affiliated clinics (at Buckhorn and Cutshin) as part of the network of outlying services through which FNS serves Leslie County and surrounding areas.

Lucy Wilson Van de Kamp, FNP, a graduate of the Frontier School of Midwifery and Family Nursing, will be the director of the new clinic, and Dr. Jean Sullivan, FNS family practice physician, will be available one day a week by appointment.

The center will offer a variety of services, including assessment and treatment of minor illness, for both children and adults; management of chronic health problems such as diabetes, high blood pressure, and lung disease; well-child care; immunizations; influenza shots; pregnancy examinations; and family planning. It will also provide physical examinations for school sports and for employment and insurance purposes. Like all FNS services, the clinic will emphasize health education and the prevention of illness.

NBC NIGHTLY NEWS VISITS FNS

NBC Nightly News, which has been preparing a report on modern birth alternatives, returned to FNS on December 6th to complete videotaping a series of interviews and studies of activities at the Frontier School of Midwifery and Family Nursing. NBC had begun this work last winter. It is understood that NBC tentatively expects to include some of this material on its Nightly News program during January.

NOTES FROM THE SCHOOL

On November 1 of this year, we marked our 45th year as a school of nurse-midwifery. By a considerable number of years, we have the distinction of being the oldest school of nurse-midwifery in continuous existence in the United States. Just about the time we marked that anniversary, we discovered the lecture notes from the very first classes taught here. Interesting that some things about nurse-midwifery never change. Finding those notes gave us a great sense of history and connection with all nurse-midwives down through the ages.

Our sense that we are really beginning to move ahead in meeting the challenges of modern-day nursing education got a really tremendous boost when we learned that Marvin Patterson and Kate Ireland have joined in a generous gift to establish the Mary Breckinridge Endowed Chair of Nurse-Midwifery at our school. This is the first endowed chair of midwifery in the country, and we are greatly excited about it, and deeply appreciative. I am personally very grateful for the honor of being appointed to the new chair.

On a more mundane note, we are busy and thriving. We have sixteen students currently enrolled; ten more will be joining us in January. We are already interviewing students for advanced standing status, to join the incoming class at a later date. We will fill our last faculty position in a few weeks. What an impressive faculty we have! — experienced, committed, and caring. They are wonderful role models for our students.

In November, six of us went as a faculty group to Cleveland to continue our dialogue with the faculty of the Frances Payne Bolton School of Nursing, Case Western Reserve University. We worked hard, as we went through our modules and materials to compare similarities and differences in our respective programs. We each have unique strengths and are philosophically committed to the same goals and standards for our graduates. We met socially with many of the professional and community leaders in Cleveland who support nursing in our respective programs. We came away excited and energized by the potential we see for a strong affiliation between our two programs.

As we headed into the holiday season, I was busier than ever with a grant proposal that had to be in Washington by December, and curriculum committee meetings to prepare for a new class entering in January. Somehow, though, it's still easy to find time to touch base daily with the students and staff who make this program so special.

We've also welcomed many visitors this fall. Dr. Joyce F. Fitzpatrick, dean of the Frances Payne Bolton School of Nursing at Case Western Reserve University, spent two days with us in September, visiting the school and getting a look at FNS. Then we had a site visit by Dr. Carol Panicucci and Dr. Gloria Mayer, for the American Nurses' Association, in connection with accreditation for our continuing education program in

family nursing practice. While some of our visitors have been professional, there have been others who have come to see us in order to know how to help us meet the special needs we have. Some of these visitors have been very generous with scholarship help for our students. We continue to enjoy the support of so many friends of FNS, and we are grateful to be part of such a large community of caring and sharing.

— *Ruth Beeman*

FIELD NOTES

This fall we have been kept extra busy with special occasions and guests. Miss Betty Lester celebrated her 85th birthday on September 9, and about fifty friends joined her at Wendover to honor her on her birthday. On Friday and Saturday of the same week, the Board of Governors met with the FNS staff for the regular September meeting.

Each Fall, FNS hosts several open houses so the donors have a chance to observe the work they are supporting. Mr. and Mrs. Ralph Peters (London, Kentucky), Ms. Teresa Beam (Indianapolis, Indiana) Mrs. Gwen Faith (Atlanta, Georgia), Mrs. Zadie Scott (Atlanta, Georgia), Mrs. Josephine Christian (Atlanta, Georgia), and Mr. John West and his daughter Sarah (Lexington, Kentucky) spent October 4th and 5th with us. The group was able to visit the hospital and outpost clinics and also participated in the Mary Breckinridge Festival activities. On October 29th and 30th, another group arrived. The group included Mrs. Forrest Layton (Louisville, Kentucky), Mrs. Wadsworth Larson (New York, New York), Mr. and Mrs. Rufus Fugate (Hyden, Kentucky), Mrs. G. Norton Clay (Lexington, Kentucky), and Mrs. Harry La Viers, Jr. (Irvine, Kentucky).

Two representatives from the Oaklawn Foundation, Mrs. Paight and Mrs. Arnold, visited us in mid-October. The Oaklawn Foundation has been generous in giving scholarship money to students who attend the Frontier School of Midwifery and Family Nursing.

The National Society of the Daughters of Colonial Wars held their fifth Frontier Nursing Service tour October 12-13. The group continues to have FNS as their national project and, once every three years, members of the society meet in Leslie County for their fall meeting.

Five colleges brought students for tours of FNS this fall. Union College's Appalachian Experience class came for a visit and decided to use FNS as a field placement site for one of their students. Lees Jr. College's human development class was shown the birthing films and had lunch at Wendover on their visit. The Somerset LPN students were at Wendover for lunch and also toured the hospital. Purdue University brought eight community health nursing students for an overnight stay and tour, and Northern Kentucky University did the same with 27 students.

Mrs. Daltias Churchil, of West Sumatra, who visited FNS this fall, stands with Courier Brenda Johnson outside the Big House at Wendover.

Mrs. Daltias Churchil, principal of the School of Nursing in Padang, West Sumatra, Indonesia, and Beverly Bird, a nurse from Australia who is getting her nurse practitioner degree at Columbia University, were our guests also. Mrs. Churchil teaches and was interested in learning about the Service and FSMFN. Ms. Bird was interested in learning how the nurse practitioners operate in the outpost clinics and in joint practice with the physicians.

FNS opened a new outpost clinic on November 3. The clinic, Shopp Folk Clinic, is located in Yerkes, Kentucky (Perry County), and Lucy (Wilson) Van de Kamp is the nurse practitioner.

The couriers continue to provide help as needed to the various departments. A pre-school was started in the Garden House basement this fall for employees' children. The school meets two mornings each week, and there is an average of nine students attending. The school was started (1) to give couriers a chance to work with children and (2) to begin positive healthy attitudes at an early age. The school is staffed by the couriers. The couriers who have been aboard this fall include Ruth Johnson (Portland, Oregon), Brenda Johnson (North Grafton, Massachusetts), Laura Sharon (Chevy Chase, Maryland), Pattie Davis (Belmont, Massachusetts), Tia Casertano (Cheshire, Connecticut), Deb Chadbourne (Portland, Maine), John Thoemke (St. Paul, Minnesota), Nancy Olin (Somerville, Massachusetts), and Maria Fernandez Gimenez (New Haven, Connecticut). Cis Chappell (Princeton, New Jersey) volunteered for six weeks. Barbara Townsend (Dallas, Texas), better known as Macaroni the Clown, came during the week of the Mary Breckinridge Festival and worked in the community promoting the festival.

Thanksgiving at Wendover was enjoyed by 48 FNS'ers. Marty Bledsoe and Deirdre Poe (in Molly Lee's absence) led 25 hikers through the woods in

the morning and joined those already gathered for the turkey and dressing feast at the Big House. It was a beautiful day and all present were reminded of the blessings that each had received during the past year.

We welcome the following new employees: Emmalene Bowling, microfiche clerk; Maureen O. Brown, M.D.; Pamela Burns, RN; Emma Campbell, secretary, Yerkes Clinic; Lenora K. Campbell, LPN; Ruth Clatterbuck, secretary, Wendover; James Clyde Collins, Respro/FNS; Ernesto Cordova, M.D.; Deborah Dixon, LPN; Susan Dolf, FNP; Sean Flood, M.D.; Perry Fugate, housekeeper, Yerkes Clinic; Connie Gilbert, secretary; Delana K. Hollifield, RN; Teresa Jones, nursing assistant; Phyllis A. Lewis, M.D.; Pamela Mattingly, R.T.; Sandra Melton, front desk clerk; James P. Parshall, D.O.; Mary Rice, nursing assistant; Barbara E. Sonnen, FNS Director of Nursing; Lisa Stamper, pharmacy technician; Jean E. Sullivan, M.D.; Mike Thorpe, biomedical technician; Joaquin M. Valdes, M.D.; Lucy Van de Kamp, CFNP, project director, Yerkes Clinic; Kenneth Weaver, DME coordinator; and Lora Gail Wells, pharmacy technician.

We bid farewell to Safooh Allouch, M.D.; Cynthia Boulton, FNP; Diana Edenfield, M.D.; Ruth Farler, nursing assistant; Jaley Farmer, nursing assistant; Rosemary Holland, nursing assistant; Barbara Howard, insurance clerk; Alice Lindsey, M.D.; Laurie Matthews, M.D.; Kathy Morgan, secretary, Wendover; Peter Morris, M.D., FNS Medical Director; Barbara Morrison, RN; Deanna Napier, secretary; Lisa Napier, pharmacy technician; Peggy Napier, pharmacy technician; James P. Santacroce, M.D.; Gail Sizemore, RN; Carolyn White, RN; and Diane Wilson, RN, Coordinator, Home Health Agency.

COURIER AND VOLUNTEER NEWS

Susan (Harding) Preston (Courier, '69), Campton, New Hampshire — "I was a courier with FNS somewhere around 1969. I enjoyed my experience so much. I have since had two children — both born at home with midwives and my husband — highlights of my life."

Andy Erdman (Courier, '82-83, '84), Princeton, New Jersey — "I am currently enrolled in a Career Development program at the J.F. Kennedy Medical Center about 40 miles from Princeton. This will lead to further training or gainful employment. Hope all is well with all of the FNS family. I will never forget the time I spent down there."

Virginia Welfare (Courier, '84), Evanston, Illinois — "This term (nursing) is my last, so I'm trying to organize my records, apply for a job, finish the correspondence course, go to school, and somehow fit my family and friends in. After a wonderful rest at FNS, my anxiety level is back up to what it usually is."

Susan (Williams) Beckhorn (Courier, '73), Rexville, New York — "I'm sorry you haven't heard from me in a while. My summer with you still rates as one of the greatest experiences in my life — some day I will visit. Fred and I are enjoying sharing our life with our 15 month old Fern. Her favorite word is 'hoohoo' — horse."

Mary White (Courier, '76), Cambridge, Massachusetts — "Am back at school — a poverty stricken graduate student at Harvard Divinity School. I still think of FNS often; of the many unique experiences I had there; of the wonderful people."

Emily (Wesson) Millard (Volunteer, '78), Orono, Maine — Letter from Emily's mother after the death of Emily's grandmother, Mrs. Frederick Simonds: "Mother was one of those people who seemed happiest when doing for others, and I know it gave her special pleasure to knit for the Frontier Nursing. I am glad to be able to tell you that Emily, who was married in 1981 to Dr. Peter Millard, and lives in Orono, Maine, now has two children. They have a little boy, Cameron, two years old, and on September 21 she had a baby girl, Maria Elizabeth. Both were home deliveries."

Deborah (Ray) Dawson (Courier, '70), Manhattan Beach, California — Letter from Deborah's mother: "Debbie had a baby girl, 8 lbs. 7 oz. on Oct. 14. Her husband, Chan, was an excellent coach for the natural childbirth delivery and she could not have done it without him."

Ann Bentley Carrithers (Courier), Neuquen, Argentina, was married to M. Denis Lamonde on September 29 in Gates Mills, Ohio. Her parents have given us an "at home" address after October 28 in Neuquen, Argentina.

Lee Fox (Courier, '76), Weston, Connecticut — Lee, now an RN, writes, "For the last 3 years I have been working in the Yale-New Haven Hosp. Pediatric ICU. Last spring I also taught pediatric nursing at Yale University and hope to do so again."

Mrs. Charles B. Beggs, Jr. (Courier Mary McIlvain, '62) has assumed the responsibilities of chairman of the FNS Detroit Committee from another former courier, Mrs. William W. Wotherspoon (Mary Bulkley, '45).

Betsy Frazier-Youngman (Courier, '80), Gates Mills, Ohio competed last summer in Spokane, Washington for a place on the three-member U.S. Women's Olympic bike racing team. She was tenth overall, in a competition among 70 women, and was first alternate. Betsy also teaches 7th grade biology and 6th-to-8th grade outdoor education at Hathaway Brown School in Shaker Heights, Ohio.

FRONTIER NURSING SERVICE, INC.

Director: David M. Hatfield, M.B.A., F.A.C.H.A.

Administrative and Support Services
Director of Operations: Charles Coleman, B.S.
Director of Finance: John L. Gilman, Jr. B.B.A.
Director of Development: Ronald G. Hallman, B.A.
Director of Personnel: Darrell J. Moore, B.A.
Director of Nursing: Barbara E. Sonnen, R.N., M.S.
Coordinator of Wendover and the Courier/Volunteer Program, Danna Larson, B.S.N.
Donor Secretary: Ruth O. Morgan
Dietitian: Barbara Baird, M.S., R.D.
Food Service Manager: Mae Campbell
Housekeeping: Lillie Campbell
Laboratory: Sr. Pat Skowronski, M.T., (ASCP)
Maintenance: John C. Campbell
Medical Records: Betty Helen Couch, A.R.T.
Pharmacy: Joe R. Lewis, R. Ph.
Physical Therapy: Beverly Limbo, R.P.T.
Purchasing: Nannie Hornsby
Respiratory Therapy: Diana Fortney, C.R.T.
Social Work: Ruth Ann Dome, B.S.W.
X-Ray: Mike Dooley, R.T.

MARY BRECKINRIDGE HOSPITAL

Medical Staff
STAFF PHYSICIANS
Maureen O. Brown, M.D., Family Practice
Ernesto D. Cordova, M.D., General Surgery
Sean P. Flood, M.D., Family Practice
Phyllis A. Lewis, M.D., Pediatrics
Andre F. Lijoi, M.D., Family Practice
Medical Director
James P. Parshall, D.O., Obstetrics/Gynecology
Jean E. Sullivan, M.D., Family Practice
Joaquin M. Valdes, M.D., Internal Medicine
Dental Staff
Carol Lee Walker, D.M.D.
Nursing Staff
Mary Weaver, R.N., A.D.N., C.N.M., C.F.N.P., MBH Director of Nursing
Betty McQueen, R.N., Hospital Nursing Care Coordinator
Martin Bledsoe, R.N., C.F.N.P., FNS Clinics Coordinator
Patricia R. Campbell, R.N. Oncology Nurse

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING

Ruth C. Beeman, R.N., C.N.M., M.P.H., Dean and Director
Sr. Nathalie Elder, R.N., M.S.N., C.N.M. Nurse-Midwifery Education Coordinator
Nancy J. Fishwick, R.N., M.S.N., C.F.N.P. Family Nurse Instructor
Sr. Kathryn O'Meara, R.N., M.S.N., C.F.N.P. Family Nurse Education Coordinator
Deirdre Poe, R.N., M.S., C.F.N.P., C.N.M., Nurse-Midwifery Instructor
Wendy L. Wagers, R.N., M.S.N., C.F.N.M. Nurse-Midwifery Instructor
Alice Whitman, Registrar

DISTRICT NURSING SERVICE

Jessie Preston Draper Memorial Nursing Center (Beech Fork)
Sue Lazar, R.N., M.S.N, C.A.N.P. Project Director
Sr. Joan Gripshover, R.N., F.N.P.
Community Health Center (Big Creek)
SUCCESSOR TO The Carolina Butler Atwood Memorial Nursing Center (Flat Creek), The Clara Ford Nursing Center (Red Bird) and The Betty Lester Clinic (Bob Fork).
Susan Hull, R.N., B.S.N., C.F.N.P., Project Director
Rose Rokis, R.N., B.S.N., M.A., C.F.N.P.,
Wooton Center
Sharon D. Koser, R.N., B.S.N., C.F.N.P., Project Director
Lisa M. Robinson, R.N., F.N.P.
Pine Mountain Center
Gertrude Morgan, B.S.W., R.N., C.F.N.P., Project Director
Yerkes Center
Lucy Van deKamp, R.N., C.F.N.P. Project Director
District Records: Nancy Williams

HOME HEALTH AGENCY

Glenna Allen, R.N.
Sandra Gross, R.N.
Stephanie Krueger, R.N.
David Newman, R.N.
Anna Lisa Palmquist, R.N.C.

Frontier Nursing Service, Hyden, Kentucky 41749, 606-672-2901
Frontier Nursing Service, Wendover, Kentucky 41775, 606-672-2317
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C.F.N.M. indicates family nurse-midwives who have taken and passed the national certifying examination
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ALUMNI NEWS

This is one of those times, which occur twice a year, when the *Quarterly Bulletin* goes to press simultaneously with the *Alumni Newsletter.* As always, the *Newsletter* is filled with news of alumni and of activities and developments of interest to alumni. In this situation, the *Quarterly Bulletin* naturally defers to the *Newsletter* in presenting alumni news. We will, of course, continue to publish this kind of information when we can do so without upstaging the *Newsletter* — that is, every other issue.

The *Alumni Newsletter* is distributed to members of the FNS Alumni Association. For information, write to either: (1) Alice Whitman, Registrar, Frontier School of Midwifery and Family Nursing, Hyden, Kentucky 41749 or (2) Ronald G. Hallman, Director of Development, Frontier Nursing Service, Wendover, Kentucky 41775.

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Mr. David M. Hatfield, Editor

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Its motto:

"He shall gather the lambs with his arm
and carry them in his bosom, and shall
gently lead those that are with young."

Its object:

To safeguard the lives and health of mothers and children by providing and preparing trained nurse-midwives for rural areas where there is inadequate medical service; to give skilled care to women in childbirth; to give nursing care to the sick of both sexes and all ages; to establish, own, maintain and operate hospitals, clinics, nursing centers, and midwife training schools for graduate nurses; to carry out preventive public health measures; to educate the rural population in the laws of health, and parents in baby hygiene and child care; to provide expert social service; to obtain medical, dental and surgical services for those who need them, at a price they can afford to pay; to promote the general welfare of the elderly and handicapped; to ameliorate economic conditions inimical to health and growth, and to conduct research toward that end; to do any and all other things in any way incident to, or connected with, these objects, and, in pursuit of them to cooperate with individuals and with organizations, private, state or federal; and through the fulfillment of these aims to advance the cause of health, social welfare and economic independence in rural districts with the help of their own leading citizens.

From the Articles of Incorporation of the
Frontier Nursing Service, Article III.
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