"Much Instruction Needed Here": The Work of Nurses in Rural Wisconsin During the Depression
Apple, Rima D
Nursing History Review; 2007; 15, ProQuest
pg. 95

"Much Instruction Needed Here": The Work of Nurses in Rural Wisconsin During the Depression

Rima D. Apple
University of Wisconsin–Madison

In October 1936, Mildred Cook was looking for an address in Pulaski, Wisconsin. In the process, Cook, a nurse working for the State of Wisconsin Bureau of Maternal and Child Health, came across Mrs. J.B. This woman was pregnant and due in March, but she had not yet seen her doctor. Cook urged her to do so. The next day the nurse was gratified to learn that the woman had followed her advice and visited the physician. Moreover, she was proud to announce that "Doctor was very pleased with this work."[1] Through her counsel, Cook had accomplished two important goals of the State Department of Health. She had convinced a client of the importance of prenatal medical examinations, and she had cemented a particularly positive relationship with the local physician. Cook's work illustrates the epitome of maternal health care throughout most of the twentieth century in the United States: physician supervised, nurse assisted, medically directed.

Cook was a critical actor in a unique public health experiment, a joint effort that linked federal, state, and county governments and community members in an innovative program to improve maternal and child health in rural Wisconsin. Concern for the welfare of mothers, pregnant women, and young children led many governmental agencies and philanthropic organizations to develop programs to alleviate health and nutrition problems that were exacerbated by the worsening economic conditions of the Depression. In Wisconsin, the Department of Health instituted the Demonstration Nurse Program in which the state Bureau of Maternal and Child Health used federal dollars to hire public health nurses to work in rural counties. Most critically, this program was time limited. The state health officials planned to fund these nurses only for a year or two, after which they expected that the counties would recognize the advantages of county nurses and begin to employ these women with local funding. In other words, the goal was that the County Demonstration Nurses would *demonstrate* the efficacy of public health nurses.

This situation placed nurses like Cook in a precarious position. As state employees, the nurses needed to follow the state program. As public health nurses,

Nursing History Review 15 (2007): 95–111. A publication of the American Association for the History of Nursing. Copyright © 2007 Springer Publishing Company.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

they needed to assure local physicians that the state was not interfering with private medical practice. As demonstration nurses, they needed to develop positive health statistics for the county. As frontline health care workers, they needed to improve the health and well-being of their clients and their children. This balancing of the various, at times competing, aspects of the position was difficult to maintain and could be torturous for the nurse. When she originally arrived in Barron County in February 1940, Louise Steffen, RN, assiduously cultivated physicians, county board members, township offices, and other community leaders, who generally agreed that a county nurse was needed and even offered their support. Yet, it was not until November 1943 that the County Board appropriated the funds; in December, Hazel Nordley, who had succeeded Steffen as demonstration nurse, was named County Nurse in Barron County.[2] In Barron and some other counties, the nurses succeeded in convincing officials to fund the position; in other counties, officials declined to pick up the nurse's salary.

This article is part of a larger study that will analyze the factors that contributed to the success of the program in some counties and that led to its demise in others. Here, I focus on the daily work of the County Demonstration Nurses in order to understand the tensions inherent in their positions and the factors that inhibited and encouraged their practices.[3] I examine the day-to-day activities of frontline public health workers who consistently admonished women to use modern scientific medical discoveries in caring for their families. The nurses prepared statistical studies to provide quantitative evidence of their work and their successes, numbers for the Bureau to use to argue for the employment of a permanent county nurse. In addition, they wrote detailed narrative reports, describing their daily experiences and interactions with patients, physicians, and local officials, as well as expressing their frustrations with local conditions and their pride in their accomplishments. With these data, they expected the Bureau to help them through the labyrinth of local politics. Through the pens and typewriters of nurses such as Cook and Steffens, we can begin to see the strategies of public health nurses who sought to bring modern science and medicine to mothers, while coping with the strictures of the U.S. medical system—specifically, the separation of "public health" and "private medicine."

Concern for High Rates of Infant and Maternal Mortality

Infant and maternal health statistics are critical indicators of the well-being of a nation. In the early years of the twentieth century, particularly in the industrialized countries of the West, high rates of infant and maternal mortality were

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

lamented as adversely affecting national prestige and threatening economic and political power. This was not strictly a question of population growth; that is, the U.S. population in this era grew due, in part, to successive waves of immigration, primarily from Europe. It was, rather, the question of a healthy population.[4] Although scattered local efforts to reverse rising numbers of infant and maternal deaths were initiated in the United States in the nineteenth century, it was in the interwar period that health care providers, social reformers, educators, and politicians joined in a concerted effort to improve maternal and child health.

Identifying the critical role of mothers in this endeavor, their campaigns were designed to educate women in "modern," appropriate child care practices, such as precise scheduling, dietary supplements such as cod liver oil, and regular medical check-ups. This advice was predicated on middle-class standards for urban families that had the financial and medical resources to carry out such health care prescriptions.[5] Urban mothers who could not afford to attend a private physician were urged to visit the clinics that were being developed in cities such as New York, Chicago, and Milwaukee. The "ideal mother" embraced the increasing intervention of medical and scientific expertise and experts in her childrearing.[6]

The shame of the high rates of infant and maternal mortality galvanized social reformers at the turn of the twentieth century.[7] In reaction to the nation's concern, the U.S. Children's Bureau was established in 1912, with a mandate to "investigate and report . . . upon all matters pertaining to the welfare of children and child life among all classes of our people." Note that the agency was to investigate and report, not treat; yet, within its limited charge, the Bureau accomplished much in its first years, under the direction of Julia Lathrop, a former resident of Hull House in Chicago. It conducted well-publicized studies that highlighted the connections between infant and maternal mortality and morbidity and poverty in rural and urban areas. It produced popular childrearing brochures for general distribution to mothers across the country, among them *Prenatal Care* (1913) and *Infant Care* (1914), which proved to be the most popular of all the federal publications.

Yet, reformers bridled at the limitations of an agency that could do no more than conduct studies and publish brochures.[8] They also pushed for enactment of the Sheppard-Towner Act, which passed in 1921 despite powerful medical opposition.[9] To placate physicians who feared that Sheppard-Towner would lead to state medicine, the drafters carefully distinguished between health education, which was publicly financed, and medical care, which was between patient and physician. The act sanctioned and strengthened the boundaries between public health and private practice by providing matching grants to states restricted to information and instruction in nutrition and hygiene and prenatal and child

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

health clinics. These activities clearly differentiated public health, such as clinics that would *detect* disease conditions, and private medical practice, construed as the *treatment* of disease conditions.[10]

Wisconsin's Reactions

Wisconsin initially used the federal funds to build the Wisconsin Child Health Special, a trailer staffed by Bureau nurses and physicians that moved from village to town to crossroads, offering health clinics in rural areas. As Sheppard-Towner funds declined toward the end of the 1920s, the work of the Wisconsin Child Health Special was augmented by health clinics sponsored by local philanthropic and service organizations, again staffed by Bureau nurses and physicians. With the passage of the Social Security Act of 1935, the state's nurses expanded their educational program and well-child clinics and added an important new dimension to their work: home visits to pregnant women, new mothers, and children.

Because of the sharp demarcation between public health and private medicine, state public health physicians conducted their work in temporary health centers. They saw the clients who attended the centers, and although some clients attempted to attend every center available, the centers themselves were held infrequently in any given location. How often centers could be held was affected in large part by the support of local service and philanthropic organizations, such as the Auxiliary of the American Legion, Women's Christian Temperance Union, Red Cross, and Homemakers Club. Other influential factors included resistance of local physicians, public health nurses' and physicians' perceptions of local needs, and local environmental conditions. For example, it quickly became apparent that attendance would be significantly lower during the harvest season. Because of the clinics' irregular schedule, physicians rarely developed continuing relationships with the clients or the community, and their reports back to the Bureau were often brief.

Identifying Clients

The nurses held a different position, and their reports were significantly fuller as they actively searched the community to identify potential clients even before assistance was requested. Nearly all the nurses related stories about finding patients while simply driving about the area. Grace M. Connors wrote with particular

المنارة للاستشارات
Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

delight in October 1936: "Mrs H: Saw baby washing on the line. Peeked at mail box for name, and went in, and lo and behold she was expecting me, as she had heard that I called on all new babies. Was I glad ever that I had taken the name from the mail box, so that I could call her by name. She had two preschoolers also, and had a number of questions saved up to ask. I find quite a few families by watching for washings on lines on my way to and from some place."[11] The nurses often served as intermediaries between local physicians and clients. They visited clients in their homes, where they noted domestic conditions that could limit successful application of medical advice. They lived in the community. Yet, they were always aware that they stood in an educational, advisory role, subordinate to that of the physician.

Some of the nurses were comfortable in this environment, and their reports radiate a commitment and a passion for their work and their patients. While not glossing over rural problems, especially during the Depression Era, Connors wrote with an enthusiasm and even humor about the people she met. On August 1, 1936, she "Stopped by to see Dr. Andrew at Plainfield, just for old time's sake.... He referred a Mrs. W to me. He had just called there the day before, because the baby just didn't 'act right.' He found they were giving three day old baby sour milk. Visited Mrs. W. 'Well, the cows are in the marsh 2 miles away. By the time they milk them and walk two miles in this hot weather, it is turned a bit.' I found baby getting orange juice but it seemed to agree better than the sour milk!"[12]

Although committed to providing modern medical advice, Connors realized that many mothers had to be led slowly to new methods and ideas and worked with the local physicians to provide them. In one particularly poignant October 1936 case, she reflected: "Mrs. L reported by neighbor – twin boys, 1 mo old, makes 4 children and the oldest will not be 3 until Christmas Day.... Much instruction needed here, but I'll have to go easy, give a little at a time."[13] In contrast, the reports of another nurse, who worked in northwestern Wisconsin, are brusque. Compliant patients were discussed only briefly: "Sept 2 [1937:] Mrs. T – has everything ready for home delivery. Model patient; has done exactly as she was told." Patients who did not fit this picture were described very differently. In June 1937, she visited Mrs. S.H., a Native American. D., Mrs. H's daughter, had "delivered of her second illegitimate child seven weeks ago," at which time D. had been diagnosed with tuberculosis and sent to a hospital for Native Americans in northern Wisconsin. On June 21, the nurse "found our dear [D] at home saying she ran away from the hospital because the nurses insulted her. I tried to tell her she must return and to instruct her as best I could how to care for herself until she could be taken back. This is a difficult family to deal with because both [D] and her mother are such dreadful liars."[14]

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Figure 1. A nurse posed with a Native American mother and her four children in the 1930s. Reprinted courtesy of the Wisconsin Historical Society.

Often at the beginning of their work, the nurses grumbled about the problems identifying potential patients and the resistance they met from defensive and wary residents. Most soon found clients anxious for their advice, however, and resistance waned. Connors confessed in October 1936, "I want them to want me, and not to have to sort of throw myself at them. But I believe in due time it will work out O.K."[15] Her later reports clearly document her success in reaching the mothers of central Wisconsin.

As she was leaving her position in Marinette County in 1942, Nathalie Voge probably summed up the sentiments of many of the state's nurses: "The baby in a box of rags; a rusty barrel for a stove; no windows; rain leaking through the roof; two rooms and eight children; and the chickens picking at the bread which is rising on the table.... There are many a day when I would return

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

home wondering, 'Will I ever be able to teach that family anything?' And then there were days when I thought a Public Health Nurse had the best job in the world. . . ."

Each day a county nurse brings joy, sorrow, and always something new and unexpected, but all in all the joy greatly outweighs the sorrows.[16] At any rate, because of the different personalities of the report writers and the variety of conditions they faced in rural Wisconsin, their narrative reports should be read not as representative but rather as emblematic of their time and place. Whether optimistic or pessimistic, the nurses of the Bureau of Maternal and Child Health conscientiously brought the message of good health to the mothers of rural Wisconsin while treading a fine line between treatment and preventive medicine.

A nurse began her work identifying pregnant women, new mothers, and preschool children in her territory. If another nurse had preceded her, she could start with the records of previous patients. Nurses also made follow-up visits to mothers who had attended one of the state-run health centers. Alternatively, as Connors's example of Mrs. W. demonstrates, local physicians could and did make referrals. When they did, nurses were careful to reinforce the messages women received from physicians. Nurses were careful to maintain a positive relationship with local doctors. On entering a community, the nurse would attempt to visit all the local physicians individually to discuss the program and the Standing Orders under which the nurses usually worked.[17] Physicians could either endorse the Standing Orders or modify them as necessary for their practices. Despite these efforts, some physicians continued to fear the loss of patients. Nurses sought to reassure medical practitioners that they were there to support, not detract from, the practice of the private physician.

Medical referrals were only a limited source of potential patients for these nurses. Nurses also combed through newly registered birth and death certificates to locate infants and mothers. As in the case of Mrs. L., they often learned of impending and recent births from neighbors. Hazel Nordley, who worked in northern Wisconsin in 1940, found that neighbors were crucial. Moreover, Nordley recognized that the early days following birth are critical "teaching moments": "The mothers have so many questions to ask about the new babies and it always seems as if there is so much information to be given at this time." Therefore, she devised a unique system for reaching new mothers promptly in the area; she distributed to each pregnant woman she saw a mimeographed postcard, asking her to complete and mail the card immediately after birthing. Mothers appreciated her consideration and, within months of beginning the program, Nordley reported that many of the cards were being returned quickly.[18] Nurses

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

were also called on to lecture for a local Homemakers Council, Girl Scout troop, or high school class. They used these opportunities to identify other potential patients in the community. In addition to these specific actions designed to locate pregnant women, new mothers, and young children, there was also serendipity, such as Cook's finding Mrs. J.B. in Pulaski.

Conditions of Rural Life

Nurses would sometimes write about better-off, better-educated women. In Taylor, a town in western Wisconsin, in 1938, the nurse was pleased to report about her visit with Mrs. H.O. Mr. O. was principal of the school in Taylor, and the family had a two-and-a-half-month-old daughter. Significantly, Mrs. O. had been reading and carefully following the instruction in *Infant Care*; her baby was breastfed on a regular schedule and given cod liver oil and orange juice daily. Both regularity of feeding and the administration of cod liver oil and orange juice were keynotes of the advice of state nurses, reflective of the advice in much of the popular and medical literature of the day. Not surprisingly, the nurse had a high opinion of this case: "Baby is apparently on an ideal schedule and appears to be in excellent condition."[19]

But more often, reports from nurses were filled with sad stories of lack of resources, lack of knowledge, and lack of emotion and energy. Typical was a 1940 case in Marathon County in north-central Wisconsin. Through county relief, the family received two quarts of milk a day for eight children. The mother allocated one and a half quarts to the two youngest children, but the family had no eggs, fruit, or vegetables.[20] In another case, a visit to a Black River Falls family in western Wisconsin disclosed that the mother was out picking blueberries, leaving a five-month-old baby in the care of a blind grandmother. The baby slept in a large bed with a bottle propped beside her. There were flies everywhere. "Explained to grandmother that flies were disease carriers, and every effort should be made to keep the flies away from the baby," the nurse wrote later. "Grandmother said this was very difficult as there are no screen doors and the screens on the windows are very poor." In this case, the mother had won $5 in a community drawing and was planning to purchase a baby carriage with some of the winnings. The nurse advised them to buy the carriage and also netting to cover the baby to protect her from flies.[21] Nurses would find homes of Native Americans, Polish and Irish immigrants, and native-born residents where women were to deliver shortly where the ramshackle houses lacked basic utilities and the women lacked the most rudimentary elements of layette and supplies

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

for home birth. Connors cogently explained why many women were not getting prenatal care: "Cannot pay M.D. any more than $15.00 and that is on time. Relief pays only $15.00 for delivery. M.D. can'st [sic] have anywhere from 8 to 16 prenatal visits, delivery, driving anywhere from 5 to 40 miles, post-natal visits, and postnatal examinations for $15.00 a case and not lost [sic] money. These mothers can't have proper food, cod liver oil, and calcium."[22] Lack of economic resources in many cases made it difficult for these rural women and their children to heed the well-meaning advice of the public health nurses who visited them, much less follow the recommendation to visit a physician.

Frequently, nurses described the trials and tribulations of simply reaching potential patients. Steffen wrote with concern that many families lived on country roads that made them difficult to reach. She astutely remarked, "The conditions of the roads [are] nothing new to the residents of the country, but [are] very new to me."[23] Catherine McLetchie colorfully recounted making a call on a family living deep in the woods: "It was necessary to leave the car at a neighbors, and walk through several fields, in one of which a bull was tethered. He seemed only mildly interested in the nurse, who luckily was wearing blue, not red! After walking through woods, up and down hills, and crawling under two fences, in twenty minutes or so the house was reached. Then the whole process was repeated on the return journey. It was a very hot, tired, and perspiring nurse that finally reached the car and relaxed somewhat behind the wheel."[24]

Although written from the perspective of nurses who understood that traveling conditions impeded their ability to delivery optimal health care, such reports are indicative of the problems faced by rural families as well. If public health nurses had difficulty getting to these women and their children, how likely was it that a private physician would make frequent calls? That food and other supplies could be delivered regularly and easily? That families could maintain easy contact with the larger world?

Bringing the Message of Good Health

But despite these geographic and economic obstacles, or perhaps because of them, many mothers were eager to hear about the latest medical advice and be reassured by medical professionals that their children were healthy and normal. Particularly popular were bath demonstrations. Nordley found that among young mothers, "this service is appreciated a great deal" and even "mothers who have children have asked for the bath demonstration."[25] Ruth Exner, in Grant County in 1940, made special efforts to speak to mothers in the early postpartum period because

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

she realized that "young mothers are anxious to learn simpler ways of taking care of their new babies. One thing in particular is the baby's bath tray which has appealed to so many."[26] Given the resource demands of this "appropriate" infant bath, involving sterile cotton, separate washcloth and basin, special "mild baby soap," and the like, and its time demands, it is doubtful that many of the poor, exhausted mothers could continue similar routines daily.[27] Yet, whether they could follow through on the nurse's instructions or merely wanted to have another pair of hands helping in the family, mothers' interest in infant bathing indicates the value they placed on the assistance of health care experts.

Moreover, many nurses apparently used the demonstration of a bath as an opening wedge to initiate discussion of other aspects of child care. Thelma Burke understood that a mother could use this practical instruction to learn more. "I've given one infant demonstration bath where the mother 'fired' questions at me," she reported from north-central Wisconsin. "If I can get over the road, I'll return next week to see how much they have been able to follow." Although this young mother was eager to hear about modern concepts, Burke despaired of her practicing them because "Since Grandma, who came from Poland, lives there too, it might be very difficult for the mother to do what she really wants."[28]

Despite their attempted rapport with their patients, there were times nurses simply could not comprehend the lives of these struggling rural women or why they did not embrace modern medical care. At the beginning of November 1937, Mrs. E.S. gave birth to a daughter. When the nurse visited her in mid-November, the parents and two children were living in "two very small, dirty rooms above a vacant store building." The mother was not interested in postpartum care and well-baby instruction. "Mother says she has to work very hard. It is necessary for her to carry water from a store across the street as her husband refused to do this," reported the nurse. Fortunately, the baby appeared well. During a revisit in early December, the nurse reported that the home conditions remained poor and the mother's "diet inadequate. Bread, meat, and milk are all she gets to eat. She says if she purchases other foods, her husband scolds her. Patient appears very tired and undernourished."

Although mothers might resist using physicians for antenatal and well-baby care, nurses did not need to convince them to do so in cases of illness. Because her baby was having trouble breathing, Mrs. E.S. had gone to the doctor, who prescribed treatment. The nurse assisted by demonstrating the proper method of applying nose drops, but she could have little effect on the depressing home situation.[29] Most nurses understood the detrimental effects of poverty in the lives of rural mothers, but when they saw extreme cases like these, which they noted were fairly rare, they were disheartened.[30]

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Other mothers resisted medical advice for different reasons. Some were confident in their own abilities. One nurse was baffled by Mrs. M.F., who would not accept the importance of medically directed well-baby care. Mrs. M.F.'s succinct rationale: "It is not necessary – all my children are well."[31] In other instances, the opposition of a grandmother, or even a father, thwarted the nurse's influence. An astute nurse could, nevertheless, turn around such situations. Some of the most extensive narrative reports concern just such triumphs. Voge called on a three-week-old infant and mother in far northeastern Wisconsin in June 1942. As soon as she entered the home, the father, "the supreme head of the household," came in from the field. The breastfed baby was nursed whenever hungry, a practice approved by the father. Voge, though, was firmly convinced of the importance of regularity. She "took this opportunity to use the cow in comparison with the mother, by saying, 'Surely you would not take the cow in from the pasture and milk her at any time of the day. As you no doubt know, if you did this, you would find that the cow would lose her milk.' The father replied, 'There you are right, nurse, *absolutely*. That would be true of Mrs. too. I did not think of that, but she is like a cow. It's all a habit and if the baby gets in the regular habit, that's right.'" The father was now interested in what Voge had to say in many other areas of infant care. She left him with a copy of *Infant Care*, which he planned to read and explain to the mother. "In this way he could show authority," Voge explained in her report, noting that at the end of the visit, the father walked with her to the car, thanked her, and invited her to come again.[32] Apparently, this father became an enthusiast for medically directed infant care. He was persuaded by arguments that resonated with his agricultural experiences.

Pragmatic argumentation influenced many rural mothers to turn to the state nurses. Slowly, many mothers learned that in following the nurse's instructions, their children were healthier and their lives were easier. Others turned to nurses for assistance because of frightening past experiences, potential future disasters, and current problems. Whether responding to positive or negative influences, such mothers wholeheartedly embraced increasing medical intervention in their lives and the lives of their children.

The nurses' reports are filled with stories about joyous patients who earnestly adopt medically sanctioned infant care. In relating her 1936 travels through eastern Wisconsin, Cook frequently noted that "patient pleased for talk with nurse" and "patient would like to have nurses keep in touch with her and teach care of infant."[33] Marie Skog wrote of a mother in western Wisconsin who was "pleased with success she is having in training for toilet habits" (this with a four-month-old infant).[34] Although patients would seem "uninterested" during

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

their visits, nurses were gratified to learn that the mothers later followed their instructions.[35] They would glory in writing about acceptance by "hopeless" cases and how much the conditions of health and home had improved.[36]

In describing how nurses tempered their clients' reluctance toward medical supervision, some of the narratives border on hyperbole. In September 1937, a nurse visited Mrs. E.E. in Clayton, a small town in far western Wisconsin. Initially, the thirty-two-year-old mother with eight children "resented" the nurse's intervention. However, "after talking to her a while she changed her attitude and asked about feeding her baby and how much water to give him. She also promised to start cod liver oil and orange juice at the time the baby is three weeks old."[37]

What could the nurse have said to convince a mother of eight to change her infant care practices? Or, is it possible that Mrs. E.E. simply saw agreement as the easiest way to get the nurse to leave? Alice Rude faced that question in central Wisconsin a few years later. Mothers would agree with all her suggestions and then she would see the same problems during her next visit. She could not decide whether the mothers "need a little more supervision at proper intervals, or whether it is wasting time to visit them."[38] Nordley believed that the "threat" of more intense supervision could persuade some mothers to acquiesce to her directions. She was particularly concerned to get prenatal patients to visit the doctor early in their pregnancies. Not all her clients were eager to do so, but they went. Nordley concluded, "Some of them are a little reluctant about going but perhaps they will feel they would rather go than to tell me they haven't been there when I call again."[39]

In other instances, mothers basically needed health care professionals to validate their childrearing practices. In Amery, a small town in far western Wisconsin, a nurse found the mother of baby E. "very anxious about her baby, worried that baby is getting along o.k." Because the nurse found a baby who was on a four-hour breast-feeding schedule, who received the appropriate doses of cod liver oil and orange juice, and who seemed in good health, she "advised mother to continue same routine and stop worrying."[40] This is not to say that mothers were passive in the presence of nursing assistance; they did, though, use the nurses as a check on their own sense of appropriate infant care. Convinced of the need for modern medical supervision, mothers then looked to nurses to tell them how to carry out correct practices. Mrs. H was adhering to a three-hour feeding schedule for her one-month-old infant. When she noticed that the baby often slept longer than three hours, she queried the nurse about using a four-hour schedule. This mother obviously had been convinced of the importance of regularity in feeding and also the importance of regular bowel movements because she had been giving her very young child enemas. Endorsing the four-hour

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

schedule and reassuring the mother that "a stool every other day is all right with the breast-fed baby," the nurse suggested prune juice, orange juice, and cod liver oil, rather than an enema.[41]

Although the nurses were sure of their prescriptions, there were times when their recommendations conflicted with those of local physicians. Attempting to appear in agreement with the physician could place a nurse in a quandary: how to give mothers the information the nurse believed was needed and appropriate while not directly contradicting the physician or undermining his position as the medical expert? (Virtually all the physicians I have identified in this study are male; all the nurses are female.) In some instances, nurses endeavored tactfully to persuade mothers of the validity of their philosophy of infant care, rather than that of the doctor. Rude worried because the physicians of Juneau County, in central Wisconsin, did not advise mothers to boil babies' milk, which she considered vital to the health of the infants. So, she "diplomatically told" the women to "scald the milk in a double boiler for a few minutes."[42] In other instances, medical publications played a major role in shaping child care practices. "The situation here is rather difficult," read a report from the village of DeForest, in south-central Wisconsin. The one local physician "tells the mothers that if God intended for the baby to have cod liver oil the baby would be born with a bottle of it in his hand and if He intended for the child to have orange juice God would send a crate for him from Heaven.... Despite his advice we found quite a few of the mothers following the Infant Care book and giving the babies cod liver oil and orange juice."[43] Because there was a clear consensus between the nurses' Standing Orders and Children's Bureau pamphlets such as *Infant Care*, a mother was receiving high praise indeed when she was reported to be "following Infant Care."

Conclusion

Confident in their knowledge of infant and child care, the nurses of the Bureau of Maternal and Child Health endeavored to persuade mothers to follow the best medical advice available. In addition to directions for infant feeding, bathing, and toilet training, the modern regime was characterized by the regular involvement of the physician in prenatal, postnatal, and well-baby care. The separation of public health and private medicine – the need to ward off any charge of "state medicine" – necessitated that the state nurses be ever alert to the needs and desires of the local physicians (regardless of whether they agreed with the standards of practice promoted by the nurses and the Bureau) and to ensure that women

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and their children regularly saw physicians. However, the nurses were also aware that not all physicians agreed with contemporary well-baby care as set forth in *Infant Care,* and that regular physician visits were impossible or impractical for many women in rural Wisconsin because of their economic or geographic situations. The reports of the Wisconsin public health nurses who struggled to improve the lives and health of their rural clients can provide important insights into the ways that gender relations are reproduced and negotiated and how contemporary health care policy, norms of medical practices, and patient circumstances constrain and define the delivery of health care to those in need.

Rima D. Apple, PhD
Professor of Human Ecology
University of Wisconsin–Madison
1300 Linden Drive
Madison, WI 53706

Notes

1. Narrative Report, Mildred Cook, RN, Brown and Kewaunee Counties, October 1936, Wisconsin Bureau of Maternal & Child Health, Programs & Demonstrations, 1922–61 Collection, Wisconsin Historical Society Archives, Madison, Series 2253 (hereafter WBM&CH), Box 11, Folder 11.

2. Narrative Reports of Louise Steffen and Hazel A. Nordley, WBM&CH, Box 11, Folder 10.

3. For more on the impact of federal funding on Wisconsin's rural health projects, see Sean Patrick Adams, "'Who Guards Our Mothers, Who Champions Our Kids?': Amy Louise Hunter and Maternal and Child Health in Wisconsin, 1935–61," *Wisconsin Magazine of History,* 83 (2000): 181–201.

4. Jeffrey P. Brosco, "The Early History of the Infant Mortality Rate in America: A Reflection upon the Past and a Prophecy of the Future," *Pediatrics,* 103, no. 2 (1999): 478–85; Alisa Klaus, *Every Child a Lion: The Origins of Maternal and Infant Health Policy in the United States and France, 1890–1920* (Ithaca, NY: Cornell University Press, 1993); Deborah Dwork, *War Is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England, 1898–1918* (London: Tavistock, 1987); Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900–39* (London: Croom Helm, 1980); Seth Koven and Sonya Michel, eds., *Mothers of a New World: Maternalist Politics and the Origins of Welfare States* (New York: Routledge, 1993); Katherine Arnup, *Education for Motherhood: Advice for Mothers in Twentieth-Century Canada* (Toronto: University of Toronto Press, 1994); and Linda Bryder, *Not Just Weighing Babies: Plunket in Auckland, 1908–98* (Auckland: Pyramid Press, 1998).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

5. Recently, historians have begun to address the imbalance between urban and rural studies. See, for example, Lynn Curry, "Modernizing the Rural Mother: Gender, Class, and Health Reform in Illinois, 1910–30," in Rima D. Apple and Janet Golden, eds., *Mothers & Motherhood: Readings in American History* (Columbus: The Ohio State University Press, 1997), 495–516; Curry, *Modern Mothers in the Heartland: Gender, Health, and Progress in Illinois, 1900–30* (Columbus: The Ohio State University Press, 1999); and Julia Grant, "Caught Between Common Sense and Science: The Cornell Child Study Clubs, 1925–45," *History of Education Quarterly*, 34, no. 4 (1994): 433–52.

6. For more on the development of the ideology of scientific motherhood, see Rima D. Apple, "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries," *Social History of Medicine*, 8 (1995): 161–78, and Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick, NJ: Rutgers University Press, 2006).

7. Much of the material for these paragraphs is drawn from Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State*, 1890–1930 (Urbana: University of Illinois Press, 1994). See also Kriste Lindenmeyer, *"A Right to Childhood": The U.S. Children's Bureau and Child Welfare, 1912–46* (Urbana: University of Illinois Press, 1997).

8. Of course, the staff of the Bureau did do more. As letters flooded in from concerned mothers across the United States, staff members would respond with advice and even with money. They also contacted local agencies to provide additional assistance to mothers in need. Much of this they did from their own resources because the Bureau's finances were always limited and their mandate restricted. For examples of the Bureau's work, see Lindenmeyer, *"A Right to Childhood"*; Emily K. Abel, "Correspondence Between Julia C. Lathrop, Chief of the Children's Bureau, and a Working-Class Woman, 1914–15," *Journal of Women's History*, 5, no. 1 (1993): 79–88; and Molly Ladd-Taylor, *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau, 1915–32* (New Brunswick, NJ: Rutgers University Press, 1986).

9. The Sheppard-Towner Maternity and Infancy Protection Act resulted in part from passage of the women's suffrage amendment and politicians' interest in currying favor with the newly enfranchised women. Also, during World War I, approximately one third of the thousands of men examined for military service were deemed unfit for duty. Medical reports concluded that the defects that led to rejection had their origins in early infancy and with proper care would have never occurred. "Wisconsin's Child Welfare Special: Resumé of Five Years' Work, 1922 to 1926," WBC&MH, Box 16, Folder 1.

10. Health clinics were not new with the Sheppard-Towner Act. Various local governmental and nongovernmental agencies had established semipermanent and traveling clinics in the first two decades of the twentieth century. See, for example, Susan L. Smith, *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890–1950* (Philadelphia: University of Pennsylvania Press, 1995) for a discussion of clinics set up by African-American women's clubs.

11. Miss Connor's Case Report [Adams and Waushara Counties], October 23, 1936, WBM&CH, Box 11, Folder 9.

12. Miss Connor's Case Report, 1936.

13. Miss Connor's Case Report, 1936.

14. Narrative Report, Sadie Engesether, RN, Polk-Burnett Counties, June 1937, WBM&CH, Box 13, Folder 8; emphasis in original. Although the state's nurses typically appeared uncomfortable with their Native American clients, most of the report writers tried to be understanding about the effect of living conditions and racism. "Indian mothers often

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

show great intelligence in the care of their children. If there is neglect of the child, it most often is neglect due to inability to secure proper food, clothing, and housing conditions for the family. The Indian mother trusts her child in the care of the white medicine woman. She often will walk considerable distance to get advice or help," concluded one Health Department writer in 1926.

15. Miss Connor's Case Report, October 31, 1936.

16. Narrative Report, Nathalie Voge, Marinette County, August 1942, WBM&CH, Box 13, Folder 1.

17. Typical Standing Orders for both nurses' home visits and centers were

1. Breast feeding if possible.
2. Regardless of breast or bottle, on a four-hour schedule, omit 2 A.M. feeding as early as possible, omit 10 P.M. feeding at 6 months; on three meals a day between twelve and fifteen months.
3. Regardless of breast or bottle, begin weaning to cup at nine months, complete by ten months. No breast or bottle after one year.
4. Regardless of breast or bottle, dietary supplements of cod liver oil and orange juice. In 1933, these were begun at six weeks; by 1937, by four weeks of age.
5. Bowel training to begin at three months and be completed by six months.
6. Trained for night wetting by two years.

Drawn from typescript, "Points on Which Doctors Should Agree," 1/12/37, and Dr. E.A. Taylor, "Child Health Center: Technique and Standards," WBM&CH, Box 6, Folder 2.

18. Narrative Reports, Hazel Nordley, RN, Forest County, January, February, April 1940, WBM&CH, Box 1, Folder 4.

19. Narrative Report, Demonstration Nurse, Monroe and Jackson Counties, June 1938, WBM&CH, Box 12, Folder 3.

20. Narrative Report, Dr. Ernest Newman, Schofield [Marathon County], April 23, 1940, WBM&CH, Box 8, Folder 4.

21. Narrative Report, Demonstration Nurse, Monroe and Jackson Counties, July 1938, WBM&CH, Box 12, Folder 3. For more on the campaign against flies in this period, see Naomi Rogers, *Dirt and Disease: Polio Before FDR* (New Brunswick, NJ: Rutgers University Press, 1992).

22. Miss Connor's Case Report, 1936 .

23. Narrative Report, Louise Steffen, RN, Barron County, February 1940, WBM&CH, Box 11, Folder 10.

24. Narrative Report, Catherine McLetchie, RN, Shawno County, August 1942, WBM&CH, Box 13, Folder 13.

25. Narrative Report, Hazel A. Nordley, RN, March and May 1943, Box 11, Folder 10.

26. Narrative Report, Ruth Exner, RN, Grant County, July 1940, WBM&CH, Box 12, Folder 5.

27. *From Morning Until Night* (c. 1937) provides a visual record of the nurses' bathing demonstration. This 16-mm silent film, part of the "Judy" series of silent movies, was produced by the University of Wisconsin for the State Department of Health in the 1930s. It was used in infant-care classes at centers, in high schools, and among community groups. The involved step-by-step demonstration begins with the mother scrubbing her hands and arms up to the elbows. Then the mother washes the infant's eyes and ears with

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

dampened sterile cotton, weighs the infant, washes the infant's face with a wash cloth, soaps the infant on a changing table, places the infant in a basin and rinses her, dries the infant, and then oils her, before dressing her in a light shirt and diaper. A copy of the film is located in the Archives of the Wisconsin Historical Society.

28. Narrative Report, Thelma Burke, RN, Marathon County, March 1939, WBM&CH, Box 12, Folder 17.

29. Narrative Report, Monroe and Jackson Counties, November 1937; Narrative Report, (Miss) Marie Skog, Demonstration Nurse, Monroe and Jackson Counties, December 1937, both WBM&CH, Box 13, Folder 3.

30. For examples of these cases, see Narrative Reports, Hazel A. Nordley, RN, June 1940, January 1941, February 1941, WBM& & CH, Box 12, Folder 4; Narrative Report, Sadie Engesether, RN, February 1937.

31. Narrative Report, Monroe and Jackson Counties, April 1938, April 22, Camp Douglass Route, WBM&CH, Box 13, Folder 3.

32. Narrative Report, Nathalie Voge, June 1942.

33. Narrative Report, Mildred Cook, RN, October 1936.

34. Narrative Report, (Miss) Marie Skog, Demonstration Nurse.

35. See, for example, Narrative Report, Ruth Exner, RN, October 1940.

36. See, for example, Narrative Report, Elizabeth Murrisy, RN, Marathon County, June 1940, WBM&CH, Box 12, Folder 17; Narrative Report, Sadie Engesether, RN, February 1937.

37. Narrative Report, Sadie Engesether, RN, February 1937.

38. Narrative Report, Alice N. Rude, RN, Juneau County, February 1940, WBM&CH, Box 12, Folder 10.

39. Narrative Report, Hazel Nordley, RN, February 1940, WBM&CH, Box 12, Folder 4.

40. Narrative Report, Sadie Engesether, RN, May 1937.

41. Narrative Report, Monroe and Jackson Counties, June 9, 1938, Fairchild, WBM&CH, Box 13, Folder 3.

42. Narrative Report, Alice N. Rude, RN, June 1940.

43. Narrative Report, Dr. Bessie Mae Beach, Dane County, DeForest, WBM&CH, Box 6, Folder 15.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.