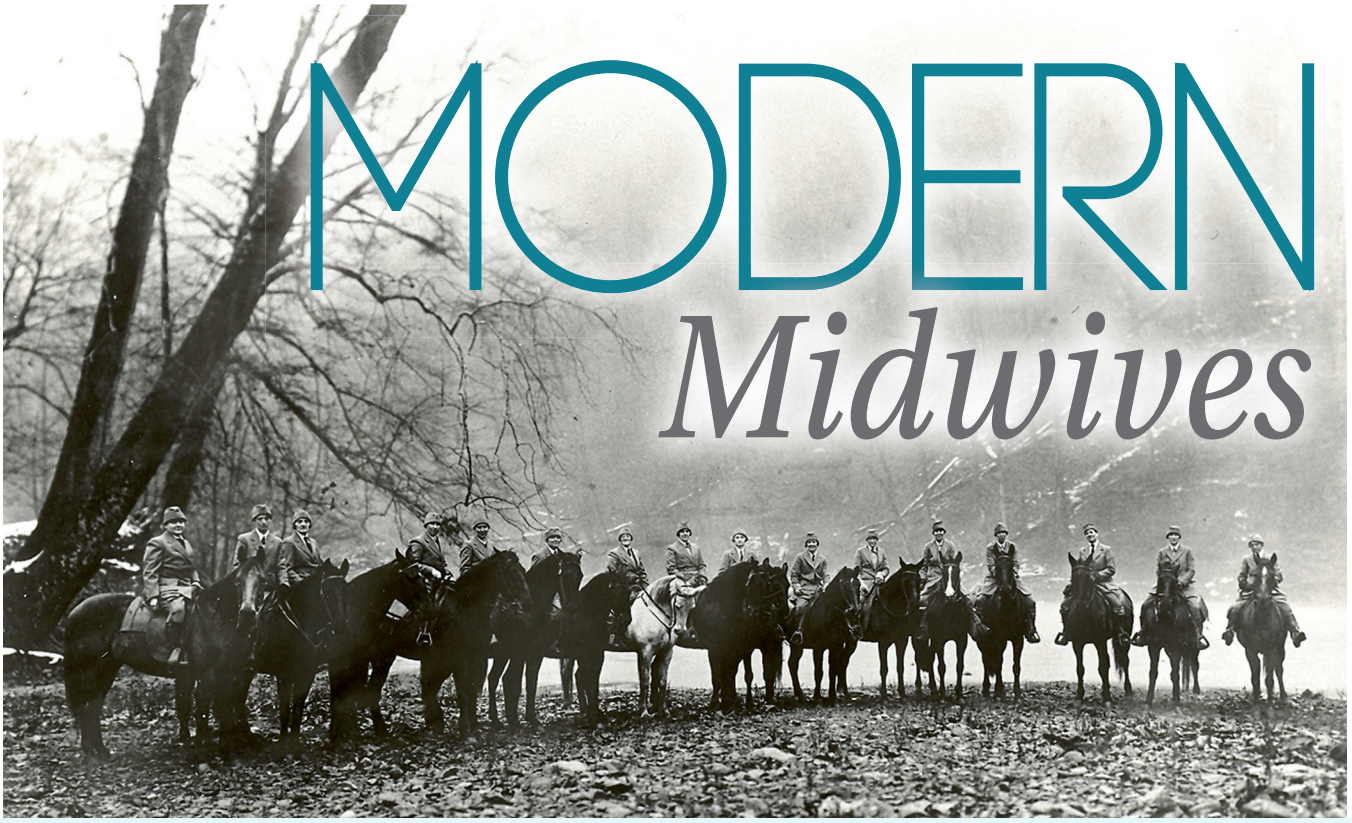
Mary Breckinridge, far left, and her Frontier Nursing Service nurse-midwives in 1931



MODERN *Midwives*

Frontier Nursing University graduates answer the call of today's health care challenges

By Hayley Lynch

Kendra Adkisson sets up her computer at a table in Good Foods Market and Café in Lexington. She calls this her office and counts the flexible work location as one of the perks of her job. Typical tasks include corresponding with clients, scheduling appointments, reassuring new mothers-to-be—and delivering dozens of babies a year.

Kendra Adkisson

Adkisson is one of three midwives who make up WomanKind Midwives of Lexington. In addition to delivering babies, they take care of women from prenatal to postnatal care, and practice general gynecology. "We have about 30 patients due every month," Adkisson says. "We do a free consultation, and if a woman decides we're right for her, we start prenatal care."

Adkisson is following in the footsteps of **Mary Breckinridge**, a pioneering midwife and the founder of Frontier Nursing University, where Adkisson received her master's degree in nurse-midwifery in 2012 after many years of experience as a nurse. Breckinridge opened the school 14 years after she began her Frontier Nursing Service, which sent midwives out all over eastern Kentucky. The university was the second school of midwifery in the United States (the first one was started in New York by a Kentucky midwife). It is the longest continuously running midwifery school in the country and graduates the highest number of students.

In Breckinridge's time, the geographically isolated women of eastern Kentucky depended on midwives, but in these modern times, it may seem like midwives are a thing of the past. The use of midwives, however, is actually on an upward trend in the U.S.

A couple of factors seem to be coming together to increase the popularity of midwives. First, many women are seeking to naturalize the birth experience, and midwives are proven to lower the rate of medical interventions such as cesarean sections. While the national C-section average hovers around 33 percent, the C-section rate for midwives is much lower. Adkisson's practice, for example, posted monthly C-section rates from 7 percent to 17 percent in the first six months of this year.

"We have a problem in our country," says Frontier Nursing University President **Dr. Susan Stone**, who has a master's degree in nurse-midwifery and a doctorate in nursing practice. "Maternal mortality rates are rising for three reasons: obesity, higher maternal age and more C-sections. We can help with the C-section rate."

At the same time, changes within the health care system are making it increasingly necessary for doctors to work with other health care professionals, such as nurse practitioners, to provide care. This puts Frontier graduates like Adkisson in position to play a bigger role in health care as these trends continue.

Mary Breckinridge

PIONEERING EDUCATION

Hyden is a remote but beautiful place in which to learn. **Lisa Grove** of Oklahoma City is taking a break from classes, sitting at a picnic table overlooking the lush woods and the Kentucky River, which moves silently below Frontier Nursing University's small campus. Because Frontier became a distance-learning program in 1989, students from all over the country are able to earn a degree here. They come to Hyden for two sessions during their time in the program, completing their coursework online and their clinical work in their hometowns at locations such as hospitals, clinics or birthing centers. Frontier staff certify each of these locations as well as the students' mentors.

"I chose Frontier not only for the economy of it but because there's a legacy here that other schools don't hold," Grove says. "As hard as it is to come to Hyden, I'm glad it's here because of the history. I look into these hills and know they were in these hills. I can draw strength from that."

Like all Frontier students, Grove knows the story of Mary Breckinridge and her fleet of midwives who crossed on horseback the very river Grove is sitting near in order to get to women and families in need throughout eastern Kentucky.

Breckinridge's vision for health care was born out of tragedy. Her own children died very young: 4-year-old son, **Breckie**, died of a ruptured appendix, and daughter, **Polly**, was born prematurely and lived only six hours. Breckinridge made the health of children in remote areas her mission in life.

When Breckinridge founded Frontier Nursing Service in 1925, there was no school of midwifery in the U.S.; nurses (including Breckinridge herself) had to go to Great Britain for midwifery training. In 1939, World War II made it impossible to send nurses there, so Breckinridge founded the school. She believed midwives belonged at the center of primary care for women and families not only in eastern Kentucky but in remote, rural areas worldwide.

A taped interview with Breckinridge, who remained the director of Frontier Nursing Service until her death in 1965, reflects her belief that a child-centered health system benefited the entire family, and that midwives were the answer to the high maternal and infant mortality rates in remote eastern Kentucky.

"It seemed to me that eastern Kentucky … would be a perfect demonstration place to start a service that concerns the young child—and to help them, you have to help his mother," Breckinridge said. "You've got to have a hospital within reach, for what good is it to save his life if his father dies of appendicitis? You find if you take as your focus the young child, you'll find it leads you into an entire health system … I decided that the nurse who was a midwife—that was the answer to the rural problem. And it has worked. That's the wonderful thing about it—it has worked."

Grove is now in the eight-day "clinical bound" stage of Frontier's nurse-midwife program. Students coming into the program are already registered nurses, and for students who do the program full-time, it takes two years. The first year of the program consists of a four-day orientation in Hyden followed by a year of online coursework. Then, students return for eight days of courses, which prepare them for their year of clinical practice. In the clinical stage, students must attend at least 40 births and make hundreds of required visits for prenatal care, labor management, breastfeeding support, family planning, general gynecology and more.

"I think midwifery is going to have a rebound with all the health care reform," Grove says. "Advanced practice nurses are cost-effective. I see the model going to doctors managing a satellite of advanced practice nurses."

COLLABORATIVE CARE

What Grove is talking about is known in the health care industry as "collaborative care." That is, doctors collaborate with other health care professionals such as nurse practitioners or nurse-midwives to meet the needs of patients, as opposed to the doctor providing the entire spectrum of care. Stone says this model of collaborative care is supported at the very top: The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives released a statement a few years ago in support of such a model. While this seems positive, the reality is murkier in Kentucky.

There are only about 100 midwives in Kentucky, Stone says, because laws make it difficult for midwives to practice here. There are, for example, no midwives with hospital privileges in Louisville. Women there who want to give birth at a nearby hospital with a midwife must go to southern Indiana.

"Lots of ob-gyns see the value and really want to work with midwives," Stone says, "but I think some of them feel threatened—like we'll take business. But midwives are never going to do a C-section. We're never going to do the high-risk births. You need a physician when something goes wrong. Midwives have different skills to offer. Our focus is on low-risk women and a more natural birth with less intervention. When a midwife is put into practice, the C-section rates go down; the intervention rates overall go down."

Frontier student **Danielle Norczyk** of Florida has been a labor and delivery nurse for nine years at a hospital with more than 7,000 deliveries per year. The doctor she worked with encouraged her to get her master's degree in nurse-midwifery. This came after Norczyk delivered three babies on her own.

"After the third delivery, she said, 'Why aren't you doing this for a living?' " Norczyk says. "She said, 'Get the degree in nurse-midwifery, and I'll hire you.' "

Students and instructors, circa 1940s, of the then-named Frontier Graduate School of Midwifery

There's a big difference between Norczyk's experience as a labor and delivery nurse, and what she is learning at Frontier. The emphasis at Frontier, she says, is a natural approach to childbirth. "Midwifery is completely the opposite of what you learn in labor and delivery," she says. "You shift from medical to natural."

A Frontier Nursing Service nurse-midwife uses a fish scale to weigh a baby, date unknown

IN PRACTICE

So what makes a midwife-led birth different from a typical birth with an ob-gyn? "We're there longer—from transition on," Adkisson says. "And of course, we're there for the entire time of pushing and into postpartum. That's the difference from the doctor, who is called in after a woman has been pushing for a while. Research shows that women need a constant companion through labor, that they do better."

Adkisson does all of her deliveries at St. Joseph East Hospital in Lexington. The hospital director, Adkisson says, is very supportive of midwives. Adkisson's back-up physician practices on the floor above her, so if anything goes wrong, he is only a push of a button away.

Adkisson emphasizes keeping birth normal from the very beginning. "First, we do a lot of waiting on Mother Nature," Adkisson says. "When you induce a woman who isn't ready, whose body isn't ready, it's an uphill battle. It creates an unnatural labor rhythm, and women are more likely to get an epidural. This is what we call the waterfall effect. The contractions stop, then more interventions are needed, and a C-section becomes more likely."

Though the emphasis in Adkisson's practice is on allowing birth to unfold naturally, she is not against a woman getting an epidural. One-third of her patients choose to have one. "There is a time and a place. An epidural can be a great thing. It can allow a woman to relax, let her get in a power nap. Sometimes I actually wish a patient would agree to one," she says. "There are women who come to us and say, 'I definitely want an epidural.' And we're fine with that. But we want women to make an educated decision, not just 'what my sister did' or 'what my mom did.' She needs to make that call herself."

Part of that education, Adkisson says, is knowing that an epidural increases the risk of C-section. Adkisson has a lot of pain-management tricks up her sleeve to help women go without an epidural if that is what they choose. These include the pain-relieving power of water, changing positions, and what she calls her "Mary Poppins bag" full of massage oil and aromatherapy products. For the birth of

her own child (attended by a midwife, of course), Adkisson chose hypnosis as a means of pain relief. "With massage, position changes, getting her into the tub, she's less likely to get an epidural."

Another difference includes a midwife's preference for intermittent fetal monitoring instead of continuous monitoring. Adkisson calls this an evidence-based approach. Does the evidence support the procedure? If the answer is no, she doesn't do it. "Midwives don't do as many ultrasounds," she says. "We only do them for evidence-based reasons. In a lot of practices these days, women are having three or four ultrasounds."

Laura Mann-James, a Frontier graduate who is now a teacher at the school, refers to the Cochrane Database of Systematic Reviews, which she says is the gold standard for health care review. These reviews, Mann-James says, show that midwives are on the right track with their emphasis on a less-medicalized model for birth. "The midwifery model of care is actually the most evidence-based practice available," she says. "It's all about keeping normal normal."

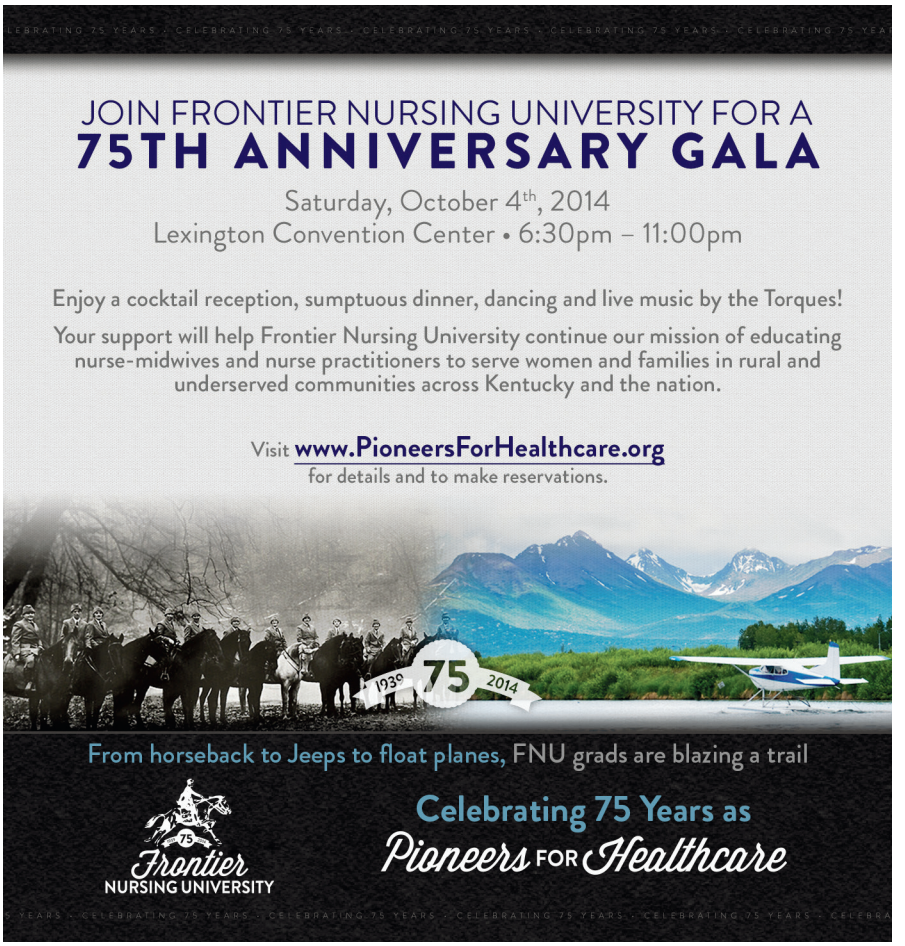
Mann-James sees doctors and midwives as being integral parts of the same team. It's not an either-or model, but rather a system of providing for the needs of each particular patient. "At this point, we can say that every woman should have a nurse-midwife as part of her prenatal care, and some women also need a doctor," she says. "Some women need advanced care, and I'm very grateful that we have that level of care. It's a team approach."

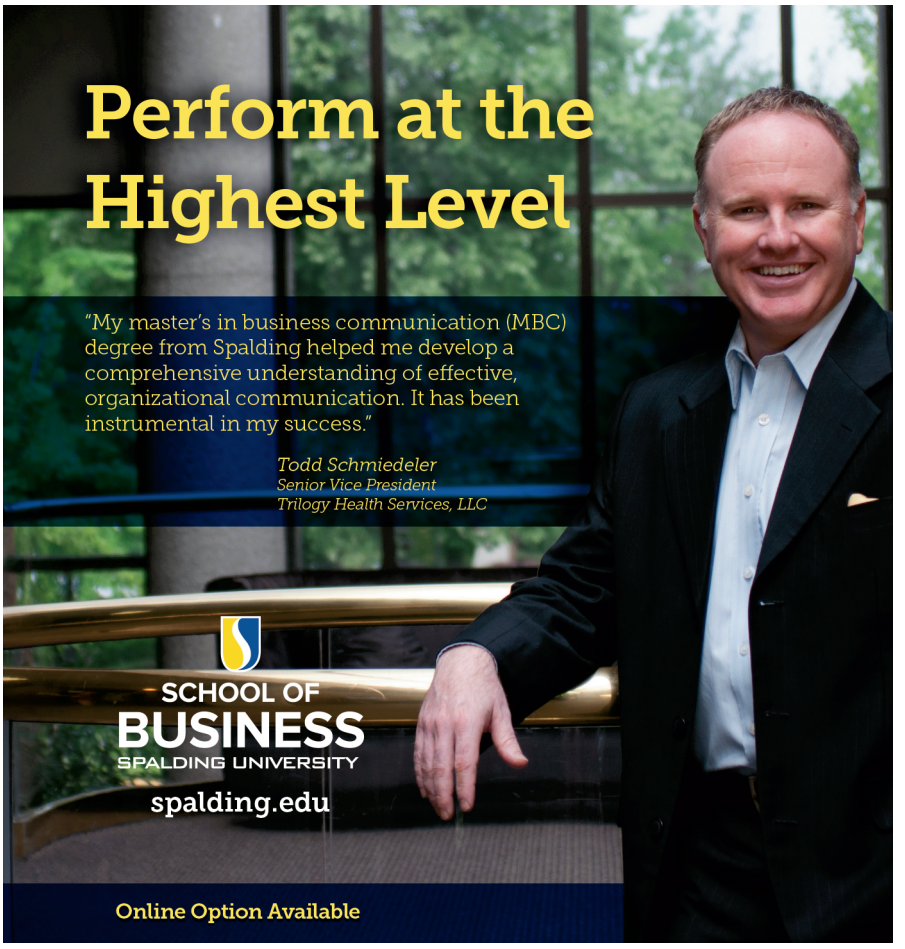
For Adkisson, being on that team means being present for one of the most important experiences in a parent's life. All the long hours and the intensity of a midwife's job are worth it, she says, because the reward is so great.

"It transports me. I am totally present—you have to be—a woman is having a baby; another human is about to be in the room," she says. "It's an honor to be in the room with her, that she's letting me watch this."

There is a reason Adkisson places so much emphasis on the birth experience, on keeping it as normal as possible and not intervening unless absolutely necessary. The birth experience, she says, can affect parents long after the baby is born.

"It sets the stage for parenting. It sets the stage for how a woman views herself for the rest of her life, that feeling of 'I just did that. I can take on anything the world sends me.' I love the bond that happens when her partner sees what she can do, that admiration," she says. "That and the babies. Cute babies."





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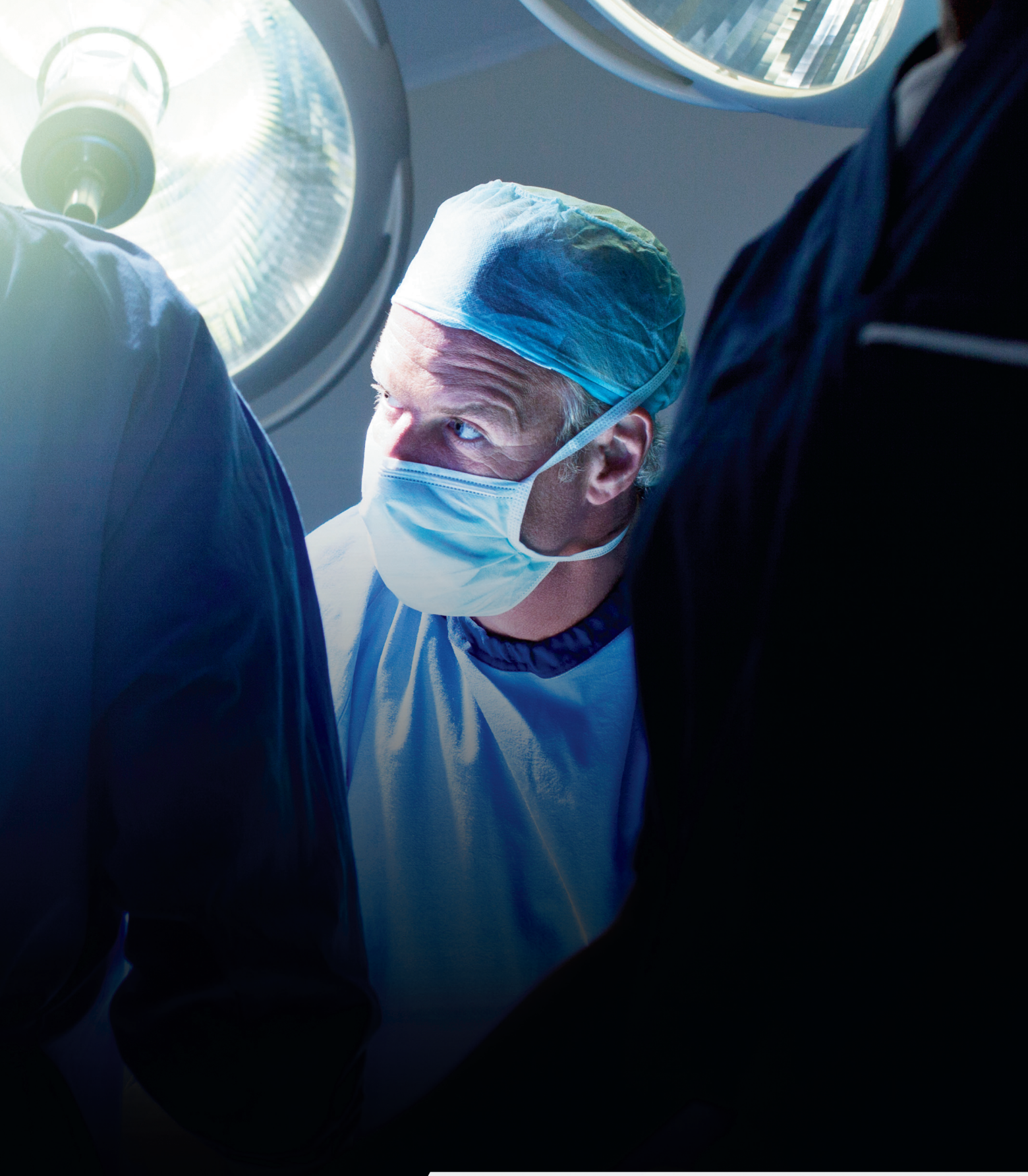

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