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## History, Organization and the Changing Culture of Care: A Historical Analysis of the Frontier Nursing Service

By Edith West<sup>1</sup>

### Abstract

**Aim:** The aim of this study was to examine the organizational shift at the Frontier Nursing Service from all female, nurse run and community-people focused to the corporate-consumer focus adopted everywhere else and the accompanying work environment issues this shift brought to the organization.

**Background:** Though it is not possible to isolate a single causative factor nursing's history of cyclic 'shortages' as the problem is complex and interrelated, and there is no simple description in the available literature, there is agreement that the problem is having a negative impact on the current nursing practice environment, the retention of nurses, the profession's ability to recruit nurses, and that the problem is global in scope and heading for crisis if not abated.

**Methods:** Historical analysis of the Frontier Nursing Service located in Eastern Appalachia of the United States and oral history analysis of former Frontier and non-Frontier nurses was conducted using a culture theory framework. Data were collected from 2003-2007, and literature on the Frontier Nursing Service as well as local, world, medical, nursing, sociological and political history was reviewed from 1900s- 1970s.

**Findings:** Findings defy conventional dissatisfaction causes while the Service was nurse-run, decentralized and interference-free. In the 1960s the organization moved to the corporate/business model of health care delivery being used elsewhere. Non-Frontier nurses in practice today mirrored the dissatisfaction experienced by former Frontier Nurses within this organizational culture after 1960 reflecting how deeply imbedded within health care institutions the prevailing culture has become.

**Conclusion:** The empowerment inherent within an international professional community created by nurse leaders, who value and perpetuate their "professional identity" within institutional cultures, can advance the discipline's ability to push for sustained positive change within these environments.

*Key words:* History, Satisfaction, Culture, Organization, Frontier Nursing Service

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## Introduction

Mary Breckinridge established the FNS in a poor, rural, underdeveloped area of the Appalachian Mountains of Eastern Kentucky with few roads and no physicians in 1925. In so doing, she marked the first effort to professionalize midwifery in the US (Breckinridge 1952, FNS Incorporated 2007). She based her organization on an established scheme that existed on the Inner and Outer Hebrides Islands of the British Isles, which was very similar to the terrain of the Appalachian Mountains of Eastern Kentucky, called the Highlands and Islands Medical and Nursing Service (Dodge 1965). Using the Highlands concept Breckinridge expected her nurses to serve as public health and district nurses in addition to being nurse-midwives. Her community-based nursing organization was originally known as the Kentucky Committee for Mothers and Babies and later named the Frontier Nursing Service (FNS).

In the summer of 1923, travelling on horseback, Breckinridge initiated a research study of the health needs of the people of Leslie, Clay, Perry and Harlan counties. She found that women lacked prenatal care and gave birth to an average of nine children, primarily attended by self-taught midwives. She saw high rates of maternal mortality and came to believe that children's health care must begin before birth with care of the mother and follow that care throughout childhood while including care for the entire family from cradle to grave. The FNS became the first organization in America to use nurses qualified as midwives. The health care model established by Breckinridge worked so well that there was an immediate decrease in infant and maternal mortality. Her report on the first 1000 births stated that the study showed conclusively what had in fact been shown before, that the type of service rendered by the FNS safeguarded the life of mother and infant and demonstrated the need to train a large body of nurse-midwives, competent to carry out the routines that had been established both in the FNS and in other places where good obstetrical care was available (Reprint from FNS *Quarterly Bulletin*, Winter 1935).

In the organization's 'early years,' nurses who had equestrian experience had to be recruited from Great Britain as there were no midwifery schools in the United States (US). The majority of these nurses were British though Breckinridge also educated interested American nurses with equestrian experience by sending them to Great Britain for midwifery training. Breckinridge paid full scholarships that included housing, food and transportation, which at the time meant a round-trip journey by ship for her American nurses to go abroad for the required six months of training. She also paid the fare of interested British nurses to come to Kentucky. These nurses contracted to work for the FNS for a period of two years. They could leave before then if they chose, however the Service would not pay for the return trip if they opted to leave before their contracted length of stay. There were few who chose to leave before the contracted length of stay but those that did were able to return on the pay they received as the FNS provided free room, board and transportation for all of its employees.

These nurses' practice environment necessitated fording raging rivers on horseback through some of the roughest, wildest areas of Appalachia, delivering babies, providing district and public health nursing in rustic cabins, many without running water or electricity. Essentially they provided care to people who considered their fellow Americans 'foreign' (Gardner 1931, Hopp 1927, Knechtly 1989; Reid 1992).

## **Background**

Breckinridge, the daughter of a wealthy and prominent Southern family, initially financed the Service through her personal funds. No state or federal agency was either able or willing to help with her project in its infancy though in the organization's latter years these federal and state agencies took over the bulk of the Service's operations once it had become a trusted, established component of the local community. When Breckinridge's personal funds were exhausted, she garnered support through her family connections and friends. She spent much of her time outside the mountains in the early years, developing the base of financial support that survived the depression and enabled the FNS to carry on in the ensuing years. She organized support committees of philanthropic individuals in many large cities, which included Boston, Chicago, Cincinnati, Cleveland, Detroit, Louisville, New York, Philadelphia, Pittsburgh, Providence, Rochester and Washington DC.

The Service began as a decentralized health care system with a hospital and six out-post nursing clinics located within a five-mile ride on horseback to its service community. The region served by the FNS was divided into nine districts. These centres were staffed by public health nurses and nurse-midwives, who held clinics, made rounds on horseback (later via jeep) providing home care, and went to the homes to attend births. They served an average of two-hundred and fifty families per outpost, held immunization clinics at one room schools and provided advice regarding sanitization of wells and outhouses. They also made arrangements for high-risk patients to be seen at Hyden Hospital. The hospital offered nurses and a physician who could perform surgeries. They also brought in visiting doctors who would hold specialty clinics and had a system of referrals developed to ensure that FNS patients could get specialist care beyond the mountains which could not be provided by the Service's own professional staff (FNS Incorporated 2007).

In the 1960s, President Kennedy's Economic Opportunity Act established a plethora of human programs that included job training, head start (children program), domestic Peace Corps and VISTA, job corps and upward bound (high school dropout program). These government initiatives were designed to break the cycle of poverty in Appalachia and across the US but were limited by the fact that they were conceived by and administered from the nation's capital via developmental economists and managers who were also largely from outside of the Appalachian region. This flaw proved to be fatal for both Appalachia as well as the FNS as a number of these programs seriously collided with the projects that were already in power within this region as well as the Appalachian culture (Drake 2001:177).

The costs of delivery for patients in labour by the new government programs were only reimbursed if they saw a physician, not a nurse-midwife. Deliveries outside of a hospital setting were excluded from coverage thus ensuring that most women would have to give birth at hospitals rather than at home (Abramson & Haskell 2006: 1650). In addition, powerful lobbies such as the American Medical Association have attempted to influence legislatures to bar the practice of certified nurse midwives. Nurse midwives have also been denied privileges at hospitals and obstetricians who wanted to partner with them have found that to do so would put them at risk of having their malpractice insurance cancelled. Kentucky remains one of the few states in which nurse-midwifery has been recognized as a valuable part of the health-care delivery system. This reality was due in large part to the political, economic and social network that was forged by Mary Breckinridge long before the institutionalization of health care penetrated and transformed care delivery in Eastern Appalachia.

FNS physicians and nurses responded to this assault on autonomy by partnering to create one of the first certificate programs to prepare family nurse practitioners (FNP), which for all intents and purposes was a nurse specifically trained and certified to do the work that had always been done at the FNS, namely: district nursing, home health nursing and midwifery (In 1970, the name of the School was changed to the Frontier School of Midwifery and Family Nursing (FSMFN) to reflect this addition of the FNP program). This collaboration was done at a time when physicians outside of the FNS vehemently opposed the nurses' role being 'expanded' in this way, opting to support the formation of Physician Assistants instead (W.B. Beasley Letter to K.L. White at Johns Hopkins University, 14 April 1966).

Though many have come to the FNS to study Breckinridge's organizational model over the years in order to duplicate it in rural areas all over the globe and some research has been done at the Service on nurse midwifery and even analysis from a social or ethnographic perspective, no one has ever examined the FNS from a cultural and historical perspective. The major crisis issues (recruitment/retention, work environment and public image) that this organization faced are common to nursing internationally and are issues that still have a negative impact on the profession today. Analysis from a cultural perspective is lacking in the prevailing literature and as a result, the response or proffered solutions to these issues have tended to be simplistic or linear analytic responses to extremely complex socio-cultural and economic problems when looked at holistically.

## **The Study**

### *Aim*

The aim of this study was to examine the organizational shift at the Frontier Nursing Service from all female, nurse run and community-people focused to the corporate-consumer focus adopted everywhere else and the accompanying work environment issues this shift brought to the organization.

### *Design*

The research conducted comprised primarily a historical analysis of the FNS together with an assessment of oral history interviews with a sample of former FNS nurses and non-FNS nurses presently in practice, as well as a small number of non-nurse Appalachian residents and FNS staff. The goal of this study was to seek the main themes illuminated by an analysis of conventional historical data and of oral history data generated by nurses via taped interviews and surveys (Decker & Iphofen 2005, p. 262, Stern 1980).

To ensure that the research findings accurately reflected people's perceptions, whatever they may be, and to increase the researchers understanding of the probability that the findings would be seen as credible and worthy of consideration by others, corroboration was sought between the nurse narratives and the primary and secondary sources (i.e., archival information, newspapers, journals, books and internet sources). Internal criticism of the historical data focused on authentication of the generator of the data being analyzed as well as on whether witnesses agreed with one another. External criticism to determine if the evidence was authentic and genuine as well as if valid sources which could be admissible as evidence were being used was also crucial to the study.

Streubert and Carpenter's (1999) guidelines for historical analysis were also employed to rigorously assess the generation of data, treatment of data (which encompasses the assessment of

primary and secondary sources), analysis of data (which refers to the analysis of organization, theoretical framework, bias and ethical considerations), and finally the study's significance to nursing. The researcher's interpretations of the findings were also analyzed to determine if the findings were sufficiently and dispassionately explored (p. 333).

### *Sample/Participants*

Twelve former FNS nurses (five British and seven American) were interviewed or surveyed. All twelve were surveyed and nine agreed to be interviewed. Twenty non-FNS nurses in practice participated by submitting the completed survey on-line. The interviews followed the principles, standards and evaluation guidelines set forth by the Oral History Association (OHA 2004) and were analyzed from a hermeneutic perspective (Kvale 1996); that is a final interpretation of the data was reached only after careful analysis between texts, and then testing all or part of these interpretations against the global meaning of the texts, with proper attention also being given to presuppositions and historical context. The survey questions were open-ended and required nurses to either write or type responses to them in 'free-text' style.

### *Data Collection*

Contact information for all nurses who met the criteria of having worked for the FNS was not centrally available, so a purposive sample was drawn using "snowball sampling" (Polit & Hungler 2000) and calls for voluntary participation of former FNS nurses in the *FNS Quarterly Bulletin* and for non-FNS nurses in *RN Magazine* and the *American Journal of Nursing*. The non-FNS nurses were asked to go to a website to take the twelve question survey. The former FNS nurses contacted the researcher for the survey and to set-up an audio taped interview, using the slightly modified survey questions. For example, in addition to the question 'what did you like best about nursing?' these nurses were also asked, 'what did you like best about working at the FNS?' The former FNS nurses who responded contacted other nurses who met the criteria, and more nurses agreed to participate. Successive respondents were selected while data collection and analysis progressed. These procedures served to broaden the scope, range, and depth of information (Denzin & Lincoln 2000, p. 21). Data collection occurred from 2003–2007, saturation justified participant numbers and analysis continued until no new themes were forthcoming. The Oral history narratives of FNS nurses (coded FNS 01- 12) and non-FNS nurses currently in practice (coded SWN 01- 20), as well as nurse and non-nurse FNS staff and community members retrieved from the University of Kentucky's Oral History Project (coded Interview # 1978- 1982) were used in the study to build as complete a picture as possible of the FNS, nurses and the discipline of nursing, within an historical context.

### *Data Analysis*

Verbatim transcripts were made by the University of Kentucky for six British and three American former FNS nurses and the respondents' descriptions were reviewed. Significant statements by all of the nurse respondents were extracted and categorized into thematic clusters and quantified.

Background on the FNS included a review of local, world, medical, nursing, sociological and political history literature from the 1900s – 1970s which was examined for their contribution to understanding further how historical events shaped the FNS and its nurses. Also, archival visits to the FNS in Wendover, Kentucky as well as the University of Kentucky Library in Lexington, Kentucky where one-hundred and ninety cubic feet of recorded interview

transcriptions and all of the FNS's records are presently housed from the early part of the century to the present time. Archival document data were recorded via researcher field notes.

### *Ethical Considerations*

Written informed consent for the surveys and interviews, as well as for storage of the audio interviews and transcripts at the University of Kentucky's archives in Lexington, Kentucky were secured. Confidentiality was maintained via coding of survey and interview data and ethics committee approval were secured prior to all data collection.

### *Validity and Reliability/ Rigour*

To further ensure that the research findings accurately reflected peoples perceptions and to increase the researchers understanding of the probability that the findings would be seen as credible and worthy of consideration by others, corroboration was sought between the nurse narratives and the primary and secondary sources (i.e., archival information, newspapers, journals, books and internet sources). Internal criticism of the historical data focused on authentication of the generator of the data being analyzed as well as on whether witnesses agreed with one another. External criticism to determine if the evidence was authentic and genuine as well as if valid sources which could be admissible as evidence were being used was also crucial to the study. Credibility and corroboration of results was improved by keeping comprehensive field notes during the data collection; analysis of the data by audio-taping the interviews; having the interviews transcribed verbatim, and by triangulation between methodologies (i.e., historical analysis and qualitative survey/interview thematic analysis) as well as between the multiple data sources. Survey reliability was assured via the input of three expert reviewers and a pilot survey distribution.

## **Findings**

Former FNS nurse participants were all retired female nurses who had long careers in nursing (over 20 years) except for one, who was still working as a consultant. Non-FNS participants were also all female nurses and ranged from 'new' nurse graduates (1 year) to over 25 years of experience. The three major themes which emerged from the historical data and oral history analysis were 'Humanitarian-versus-Economic Rewards', 'Moral Inhabitability in the Workplace' and 'Doctor-Nurse-Administrative Oppression.'

### *Theme 1: Humanitarian-versus-Economic Rewards*

The tradition of humanitarianism that is essential to quality nursing has been steadily devalued over time. Its value to the health care system usurped by technological advancement and commercial enterprise. This in turn has generated an ever widening schism within the nursing profession between those who are deemed to be 'in it for the money' and those who are grieving the continuing loss of connectedness to their patient's due to the ever progressive fragmentation of care within the existing institutional culture (Andrist, Nicholas & Wolf 2006, p.133).

Most of the non-FNS nurses surveyed presently in practice reported the reason they chose nursing as a career was the desire to 'help others' and 'make an impact' or described their choice as 'a calling,' something they'd 'always wanted to be' or that had 'chosen them' (SWN 11, 2003, SWN 01 & 02 2004, SWN 03, 05 & 09 2005, SWN 07, 14 & 15, 2006). Although most of the

nurses still in practice cited the economic advantages associated with nursing as a career choice as an incentive, only three of them said they were ‘unsure’ if they would make the same choice again and none of them cited ‘economics’ as the reason for their indecision (SWN 03 2005, SWN 14 & 16 2006). Instead, they cited the lack of ‘value’, ‘respect’ and ‘autonomy’ afforded to the profession and the overall lack of ‘concern for patients within the institutional setting as the main reason for their hesitancy in stating they would enter the field of nursing if they had it to do over again (SWN 03 2005, SWN 14 & 16 2006). It should also be noted that those who said they would choose nursing again were in specialty units or working outside of hospital staff nurse positions where patient to nurse ratios were lower and/or autonomy was higher.

Jean Corner-Rowan, a British former FNS Nurse-Midwife who was at the Service from 1964 – 1966) had this to say about her time working at one of the district outposts (Brutus Centre) prior to 1960:

“Everyone that was there wanted to be there. It was like an extended family... There was little clock watching, except for timing contractions. Excellent *care* [italics added] was the reward” (FNS 05 2006).

This ‘reward’ is something that all of the nurses interviewed or surveyed stated they find harder and harder to achieve. One nurse currently in practice summed up best the disappointment felt by not being able to meet the many expectations of the institution (i.e. administration, managers, physicians, families, patients, ancillary departments and other health care areas such as physical therapy, etc.) even though she fully realized that they were totally unrealistic expectations, even in the most optimal circumstances. Still she admitted, “This is my chief complaint and source of discontent” (SWN 12 2007).

When British and American FNS nurses were asked if they would ‘choose nursing’ if they had it to do over again, they overwhelmingly responded ‘no.’ They felt that the opportunity to develop ‘relationship’ with your patients was, regrettably, a thing of the past largely due to the fact that the patient care which allowed nurses to make that connection had been given to non-licensed personnel and that patients are moved on so quickly through the system. The biggest impact cited by former American FNS nurse Anne Lorentzen, who was a Public Health Nurse at the Service from 1963 –1965, and her British Nurse Midwife colleague with whom she shared quarters at one of the FNS Outposts in the 1960s, Jean Corner-Rowan, whose tenure at the FNS was from 1964- 1966, was the change from home to hospital births. This change required less time to get to a patient and allowed midwives to care for more than one patient at a time but also inevitably decreased the ‘one-on-one’ care and interrupted the midwifery students from following a labour from front (pre-natal) to (post-natal) finish (FNS 02 & 05 2005). When asked if these nurses would work for the FNS today, Anne, Margaret (Maggie) Willson [picture 1] a British former FNS Nurse-Midwife from 1955- 1967 and Judy Haralson-Rafson an American former FNS Nurse Practitioner from 1971 – 1976 (one of the first graduates of FNS Family Nurse Practitioner Program) also said ‘no.’ The reasons cited were that the district nursing clinic model that made the Service comprehensive and innovative prior to 1960, when it was nurse founded and run and focused on the *person as patient* and not the *client as consumer* [italics added] no longer existed, and that, unfortunately, the FNS is not that different now from hospitals and clinics elsewhere in the US (FNS 01 & 02 2005, FNS 07 2006).

All of the nurse narratives revealed a love and respect for the ‘independence’ and ‘importance’ of the practice, what this practice environment offered both personally and

professionally, the administrative style they worked under or a combination of all of the above. These 'rewards' had less to do with salaries, public image or even a favourable work environment but had much more to do with the people and the work, which often took precedence over personal comfort or salary.

### *Theme 2: Moral Inhabitability & Work Environment*

A study by Peter, MacFarlane & O'Brien-Pallas (2004) concluded that work environments had significant *ethical* [italics added] implications for nurses, chief among them, feelings of oppression, powerlessness, exploitation, marginalization, and interpersonal hostility. Work environments were perceived as dominated by medical or business values where nursing perspectives were marginalized and the study concluded that the work environment was '*morally uninhabitable*' for nurses (Peter, *et al* 2004, p. 359).

Institutional work outside of Appalachia in the 1940s and 1950s was described by nurses as 'routine,' 'domestic' and a 'drudge' (Cohen 1948, p. 70). By contrast, 'early years' FNS nurses described their work both within the hospital setting and out in the district as, 'the first time we used an education', 'more independence (in Kentucky) than anywhere else that I've ever worked', 'hard, to be sure, but it was freedom that I had not experienced before or since', 'enjoyable' and 'unique' (FNS 01- 12 2003/05/06). These statements are very different from the descriptors such as 'rude, harsh, petty and tyrannical', which were being used to describe the matrons or nurse supervisors in institutional settings in the UK and US at the time.

Former British FNS Nurse, Maggie Willson who began her tenure at the Service as a Nurse-Midwife, and later as an administrator described the FNS administrators as 'kind and excellent teachers with a good sense of humour (picture 2). All of the former FNS nurses, among them Molly Lee, British former FNS Nurse-Midwife who was at the service first as a Nurse midwife, later as an instructor and who was at the FNS the longest of all of the nurses interviewed (1950 – 1970s) and British former FNS Nurse Elizabeth 'Hilly' Hillman who was at the Service from 1949 – 1954 (picture 3) also described the FNS administrators as 'just enjoyable to be around', 'having high expectations and yet facilitated students' development of skills in a gentle manner', 'warm hearted', 'fair and just', having a positive attitude', 'gracious and effective *leaders*' [italics added] (FNS01- 12 2003/05/06).

The following responses are from nurses in institutional practice settings today when asked what they did not like about nursing; 'I do not like *not* being treated as a professional by the doctors,' 'I don't like the fact that nurses are not respected as the true professionals we are,' and 'you receive no respect for the knowledge and responsibilities we have from administration, management and other professions, the thought still being that we should just do what the doctor says' (SWN 10, 2003, SWN 01 2004 & SWN 05 2005). Further evidence that this trend continues even amongst nursing administrators was made by the following nurse, who stated that she was told by her director of nursing, 'tough, suck it up, this is the way it is,' when she complained about not being able to provide a 'safe' care environment for her patients when, on her first night working in an institutional setting, she was assigned eleven patients, five of whom were postoperative patients (SWN 07 2006). Another nurse alleged, 'nothing could have prepared me for the way doctors treat nurses and the fact that administration backs up the doctors over the nurse' (SWN 08 2004).

The characteristics that are said to put nurses at risk of developing 'moral distress' include human resource constraints, competing value systems, the nurses' role as advocate, the lack of administrative and managerial support and the lack of nurse-physician collaboration.

This, in turn, contributes to staff 'burnout,' 'turnover' and cyclic nursing shortages (Corley, Minick, Elswick & Jacobs 2002, p. 381, Pendry 2007, p. 218).

### *Theme 3: Doctor-Nurse-Administrator Oppression*

Assumptions about gender have historically been branded as the cause for many of nursing's woes. For the FNS, disruptions to the nurse-physician relationship had less to do with gender role assignments or even any prevailing patriarchal social mores and much more to do with the move to institutionalized care, its accompanying hierarchy and ingrained cultural patterns that they were forced to adopt in the 1960s with the coming of the 'War on Poverty' initiatives and the advent of Medicare/ Medicaid into the hills. With this came a curtailment of autonomy that was due in large part to the government, which linked payment for services within these walls to physician (male or female) dominance.

When Dr. Beasley replaced Helen E. Browne as Director after her stroke in the 1970s, it was a time when what has commonly been referred to as the 'second wave of feminism' was in full swing. As the then Committee Chair and cousin of Breckinridge, Marvin Breckinridge, lamented when attending a health meeting in Washington DC as a representative of the FNS:

The antagonism toward men! And a couple of prominent nurses said to me, "What a pity you've got a man as the head of the FNS." I said, Dr. Beasley is a splendid medical director and has a great respect for nursing. But they were just being horrid about it and I couldn't understand it. (Interview #780H 141FNS07 1978)

Perhaps the reason this antagonism could not be understood by those within the Appalachia region was due to the fact that in the organization's early years physicians there viewed the nurses as colleagues, neither as menials nor competitors. The prominent nurse leaders at this health meeting could not have known how staunch a supporter Dr. Beasley had proven to be to FNS nurses nor how instrumental he was in the creation of a Nurse Practitioner Program there when other physicians refused to support nurses in this 'expanded' role, preferring instead to create physician assistants that would not threaten their existing sole point of access to the health care system. Indeed, had Dr. Beasley not been committed to it, the program certainly would not have come to fruition. It was due as much to the respect for his long standing within the professional medical community as to the political support of the local and state communities in the face of such overwhelming opposition. The FNS organization, Mary Breckinridge's personal renown and her political connections within the medical, local, state and national communities (which survived her death) also contributed to the opening of the program. This was one of the first in the country and still exists today. It should be noted that when Dr. Kooser resigned in 1943 as the FNS Medical Director after twelve years of service to join the Navy, subsequent medical directors who came to the FNS from the outside seldom stayed more than two years. Doctor Beasley joined the service in 1956 and remained longer than any other doctor since the Second World War.

British former FNS Nurse Molly Lee (picture 4) related a common complaint of nurse's at the FNS who were there when these changes were occurring in the following discourse: one night when on her own for a delivery she called the physician to use the vacuum extractor. The doctor wouldn't allow her to use it. She had been taught to use this device by a physician and had used it successfully in the past without having to call the doctor. Molly expressed frustration

and a sense of failure because as a result of the delay, the patient developed a fourth degree laceration that needed sutured. The doctor then had to come to suture the patient; also something Molly had done successfully many times before on her own. She recognized immediately that this physician was “stitching it wrong” because She’d “stitched quite a loom herself when she had tears,... bad tears” (FNS 04 2005). Molly’s inability to care for her client competently or advocate for her safety made her feel ‘timid’ about challenging the physician as well as “foolish” in her own eyes for her powerlessness (FNS 04 2005). This physician was female, which raises some intriguing questions concerning gender role and institutional culture perceptions. Molly left the FNS, as did many of the others, shortly after these changes citing the decline in professional practice as well as patient care as the driving force behind her final decision to leave (FNS 04 2005). She had also asked for clarification from administration regarding this issues and was told she must “call the physician” (March 18 FNS Staff Meeting 1965, p1). Administration now backed the physicians over the nurses due solely to the regulatory and consequent cultural changes imposed upon the organization in its latter years.

A nurse who graduated as recently as 2006 mirrored the frustration cited by Molly when she stated that she too disliked the fact that she had to always “clear things with the medical doctor” that could be done solo by the nurse (SWN 17 2006). Other nurses practicing today had the following to say about physicians they worked with, ‘they can be ungrateful and I am disappointed by that fact. I am disappointed that there seems to be an “us” against “them” attitude with the doctors,’ and that they (the nurses) would like more “respect” from them (SWN 02 2004, SWN 16 2006).

## **Discussion**

Historically, nursing like many other disciplines has attempted to emulate those corporate entities that have risen to power in order to attain the respect, political clout, organizational power structure and professional autonomy that these bodies have attained. However, the profession has also inherited a culture that has proven to be self-defeating as it has perpetuated many of the corporate cultural traits that have proven to be incongruent with its professional identity and goals (Lipset 1963, p. 12, Freidson 1986, p. 6). As a result, the culture of institutionalized nursing has been described by nurses as ‘oppressive’ due primarily to the lack of power and control within the existing health care delivery system (Cleland 1971, p. 1548, Davies & Beach 2000, p. 189). In addition, nurses have often felt ineffectual and trapped in a national culture that does not value their unique contributions as humanitarians or as skilled health professionals. Consequently, they are unable to meet the needs of their patients and often feel like cogs in the wheel of the health care industry; trapped by structural and bureaucratic rigidity in which they are forced to work (Thierry & Mitroff 1992, p. 6).

Analysis of the FNS revealed the change between the relationships that existed between administration and physicians as well as the ‘moral inhabitability’ of the work environment, in its ‘early years’ versus its ‘latter years.’ Moreover, these relationships defied the conventional causes of disenfranchisement cited by nurses outside of Eastern Appalachia while the organization was nurse-run, decentralized and relatively free from outside interference. Narratives of nurses in practice today not only supported many of the issues raised by former British and American FNS nurses but also reflected how deeply imbedded within institutional cultures these crisis issues have become and remain. Yet in most cases liberation from

oppression is said to come from unveiling the cycle of oppression and the myth developed within the system and not from the leadership or even the dominant group within it (Freire 1971).

Limitations of this study include the small number of nurse participants due to the researcher's limited access to nurse participants and a lack of research available on this topic, which necessitated a more exploratory than explanatory approach, and also points to the need for further research. The oral history data is also subject to bias due to the selective memory of nurse participants, possible telescoping of actual events, embellishment, exaggeration and negative or positive attribution of events to outcomes or external forces by respondents, even though the researcher made a concerted effort to triangulate between methodologies as well as multiple data sources.

## **Conclusion**

Lafer (2005) argues that *there has never really been a 'nursing shortage,' but there has always been cyclical "shortages of nurses willing to work under the current conditions created by hospital managers"* [Italics added] (Lafer 2005, p. 27). The nurse interview and survey data presented here indicate a strong consensus regarding both the cause and potential solution to this problem and until these voices are heeded, the cycle will continue. The question emerging from analysis of the FNS, which needs to be posed to the profession as a whole is, "Has the embracing of institutional identity (namely, business medical models) within the nursing profession, its higher education and practice settings impeded the discipline's ability to impact more successfully for sustained, positive change within these environments?"

What is necessary to heal nursing's identity crisis, a major causative factor to its cyclic nursing shortages, is for the profession to embrace the changes wrought by science, technology and global economics while simultaneously recommitting itself to the community-based and service (or people) oriented vision of its founders. These are not mutually exclusive concepts and either concept should not be embraced as of superior value to the other. What can be gained from this historical analysis is the need for nursing to rediscover its core values and begin to use them to shape the social context of our times, instead of vice versa. The empowering value inherent within a 'morally inhabitable' environment created by strong nurse leaders, who value and perpetuate their 'professional identity' in the marketplace and push for sustained positive change therein, cannot be underestimated for the profession, to keep nurses in practice and to improve client care practices.

## Pictures

Picture 1: Margaret (Maggie) Willson [picture 1] a British former FNS Nurse-Midwife from 1955- 1967 on a home visit.



Picture 2: Former British FNS Nurse, Maggie Willson (standing) with FNS administrator Helen Browne (to her right), FNS Founder Mary Breckinridge (to her left) and Mary's sister and staunch FNS supporter Marvin Breckinridge [circa 1960s].



Picture 3: Former British FNS Nurses: Molly Lee (left) & Betty Hillman (right and lower)...  
Then and now (center) [circa 1950-1960].



Picture 4: British Former FNS Nurse-Midwife Molly Lee successfully delivers twins in the home of a client in an Eastern Appalachian cabin (circa 1950s).



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