FRONTIER NURSING SERVICE QUARTERLY BULLETIN

VOLUME 52 WINTER, 1977 NUMBER 3

A NEW LOOK AT THE DISTRICTS

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FRONTIER NURSING SERVICE QUARTERLY BULLETIN

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Brief Bits

ONCE OVER LIGHTLY

This special issue of the Bulletin concentrates on FNS district nursing. Its philosophy, our past and present record, as well as our present problems in providing health care to people in their homes and in district centers are reviewed (page 10). The pattern of family care has changed from the horseback days to the Jeep and Volkswagen days; the distribution of the centers changed as roads made hospital services more accessible and as the Buckhorn Dam obliterated two centers. A delightful and informative recollection of early district days by Betty Lester, "The General", appears on page 5.

The principles of personal family care still dominate our district nursing centers but legislation, restrictive in its reimbursement mechanism, has wrought some temporary changes in district services. These restrictions and modifications are reported in conceptual vignettes, in the physicians' perception of the district system, and in Dr. Isaacs' article on national legislation.

The response of FNS committee members to our request for help has been great. Committee members are seeking support of their congressmen for expanded national legislation, such as Mr. Rostenkowski's H.R. 2504. This and similar bills will enable the reimbursement of our district nurses for home and clinic visits in preventive and maintenance care.

We have been assured from our State Capital that the mechanism for reimbursement for services provided by family nurses to Medicaid patients will begin in July.

Rejoice with us that the Mary Breckinridge Hospital has received full accreditation by the Joint Commission on Hospital Accreditation (page 76).

We will continue our invitation to President Carter to visit the Frontier Nursing Service; a letter from the Assistant Surgeon General relates to this (page 68).

Dr. Theodore Cooper's speech (page 81) on the vast importance of private philanthropy in health care, to be coordinated with basic government support, epitomizes FNS's position in providing health services. FNS was brought into existence by Private Philanthropy, which is, in Mrs. Breckinridge's words "the finest flower of free enterprise." We need and must utilize government support for the provision of proven services; we need the philanthropic donations for the innovations in service and education which have not yet received the stamp of approval by public monies.

W. B. Rogers Beasley

—W. B. R. Beasley, M.D.

The Districts Develop 1925-1930

"The Frontier Nursing Service has come into existance in order to provide a district nursing, midwifery and child hygiene service for the inaccessible, difficult areas, mostly in the mountain ranges. Its boundaries are topographical and not artificial. It works on a regional and not a county basis, and divides its nursing areas into districts, every part of which is accessible to its own nursing center. The rural sections need visiting nursing, on a district family basis, much more than cities need it, because they have less of everything else."

—Mary Breckinridge
Quarterly Bulletin of The Frontier
Nursing Service, Inc., Vol. IV,
No. 4, March 1929

The work of the Frontier Nursing Service began in the summer of 1925 from a small house in Hyden which combined an outpatient clinic with living quarters for the first two nurses, Edna Rockstroh and Freda Caffin. Patients came to the clinic and the nurses went into the homes of the patients, thus establishing the pattern of care which has continued for nearly fifty-two years.

In 1925, Mrs. Breckinridge built her own home (the Big House at Wendover) in Leslie County. Inside there was a bedroom for the district nurse-midwife and a small outpatient clinic. The six outpost nursing centers followed shortly thereafter. "In building our outpost centers," Mrs. Breckinridge noted in her autobiography, "we located them from nine to twelve miles apart so that where one district nurse-midwife's territory ended another district nurse-midwife took over . . . . In developing the area coverd by the FNS, we followed the waterways, the natural arteries of travel and trade in our part of the world."[1]

These district centers had many things in common. No center was begun without an invitation from leading citizens of the area who offered land, labor, timber and stone for the construction. They were located near the center of the area to be served and were comfortable buildings with plumbing and central heating, a large living room with an attractive stone fire place, a kitchen and three or four bedrooms for the staff, and a clinic and waiting room for the patients. And, with one exception, their construction and development was supervised by that indefatiguable pair of nurse-midwives, Peacock and Willeford!

"Gladys Peacock and Mary B. Willeford had been with us about two months, in 1926, when I told them to go up to Beech Fork to open up the district there and build the nursing center. They said that they knew nothing whatever about building. I replied that neither had I known anything about it when I built Wendover. If I could learn by doing, so could they. Peacock and Texas rode off with the light hearts of those whose ignorance is total."[2]

That first center, Beech Fork, was an experiment—it was a ready-built house (in pieces) complete with plumbing and instructions. It took twenty-four mule-drawn wagon trips four to five days each to make the sixty-four mile round-trip from Beech Fork to Pineville to unload two freight carloads of house. Even though there were three pieces left over, the center still stands—but that was the last time that FNS ever tried that kind of construction! The other centers were built with local materials, by local craftsmen.

While nurse-midwife Ellen Halsall was supervising the opening of the center at Confluence*, Peacock and Willeford went first to start the Center at Red Bird, then at Flat Creek and, finally, built the centers at Brutus and Bowlingtown*, eleven miles apart, simultaneously, in the summer of 1930. Not only did the nurses cope with construction but, at the same time, they organized the district committees, gave bedside nursing care to the sick, and delivered babies.

—Peggy G. Elmore

[1] *Wide Neighborhoods* by Mary Breckinridge, Harper & Row, Publishers, page 229

[2] Ibid, page 231

*When the Buckhorn Dam was complete in the late 1950's, the Margaret Durbin Harper Memorial Nursing Center at Bowlington, the gift of Mrs. Hiram Sibley of Rochester, New York, in memory of her Kentucky-born mother, and the Confluence Center, the gift of Mrs. Frances Payne Bolton of Cleveland, had to be closed. The Bowlington Center was relocated on Wolf Creek in Leslie County and the money from the sale of Confluence Center to the government purchased Bolton House on Hospital Hill in Hyden as a residence for an FNS physician. The Wolf Creek and Wendover District Clinics were closed in October 1976.

"To me, I really admire FNS because of the long-standing tradition it has and the reason it was developed—for mother and child. Something like that is really needed in this area. It is really useful."

—A District Secretary

The Horseback Days

Excerpts from an Interview with Miss Betty Lester

Question: How did you hear about the FNS?

Answer: When I first heard about the FNS, it was still being called the Kentucky Committee for Mothers and Babies. I was taking my midwifery training—well, or course, all the people in midwifery knew about Mrs. Breckinridge because she sent all of her nurses to be trained in England. She had offered to pay the expenses of any British midwife who would come and stay for two years.

Question: What made you interested in going to Kentucky to be a midwife?

Answer: Well, when I was taking my training, this American nurse came and, of course, all us Britishers were talking about her. She had brought a big album of photographs with pictures of all the horses and dogs and people. I got very interested because I'm from the country and don't like cities very much. So I talked to the American nurse and said I would be interested. She told me to write Mrs. Breckinridge who replied by sending me application blanks to fill out when I received my diploma.

Then, of course, the story went around the hospital that I was going to Kentucky. Well, there was a furor. I was called into the Sister's office and she said, "Nurse, you think you are going to Kentucky?" So I said, "Yes, Sister."

"Well, do you know what you are doing? You've got me on day duty, you've got the Night Sister on night duty, and you've got a doctor within five minutes of you. When you go out there, you've got nobody to back you up. What are you going to do? Have you thought about it?!

I said, "No, I haven't really." I wanted to go and I thought that was it. Then when the Matron called me in and said the same thing to me, I really began to think I was crazy.

So, then they put their heads together. I had only just finished my training and had my 20 deliveries and all the theory, but really was a raw recruit. Well, they knew what I was going to, because Mrs. Breckinridge had told them. They decided I should stay for six more months and do post-graduate work. It really was a help so

when I came, I was all right. —I wasn't all right, but I knew what I was talking about! So that was that.

Question: Were you sent out on district when you arrived?

Answer: For your first delivery you always had to go out with an older nurse, because we wouldn't know what to do. Miss Marsh took me out on my first delivery and I was shown around. I had about a week, I think, with another nurse; then she went to England to get her midwifery. I was just left lamenting on my district! I had a map and I knew some of the branches. Of course, everybody showed me where to go. You know, people in this country are very proud. They are also very hard working.

Question: Was it hard—getting to know the people and to work with them at first?

Answer: They knew me because I wore a uniform with FNS on the sleeve and had a horse—so they knew I was one of Mrs. Breckinridge's nurses.

Question: Did you ever just stop and visit when you weren't nursing?

Answer: Oh, yes. I would sit on the porch with them. They would let me go on talking and I wouldn't think I was getting any response at all. At the end of about a month, I was getting a bit frantic because I didn't seem to be getting anywhere. I told the head of the hospital and she said, "They probably like you very much, but they aren't going to make an awful fuss of it 'til they're sure of you." Well, that didn't help me very much! However, one day one of the patients from my district was over at the hospital and someone asked how he liked the new nurse.

"We like her fine, but she sure is the talkingest woman I ever heard."

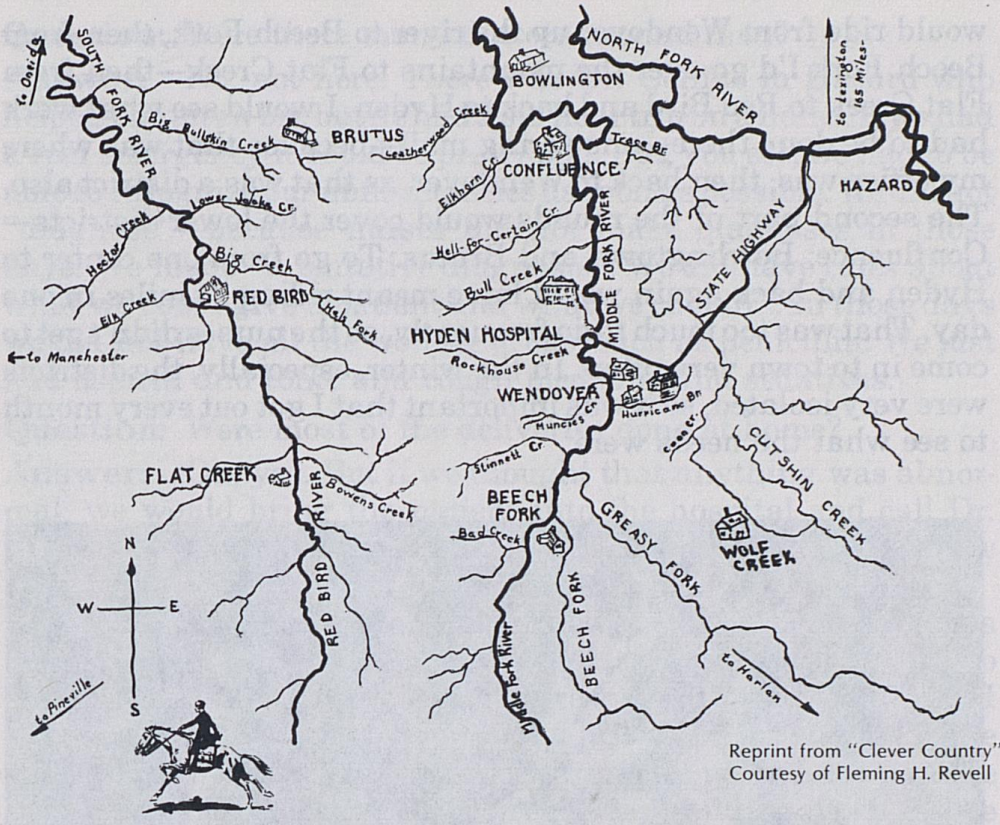
So I got my reputation. I've been talking ever since!

Question: What kind of records did you have to keep?

Answer: Each family had its own folder with the name on the front and the address. We had to put down all the immunizations and all the visits. And, of course, everyones' weight and measurements, how many children, and so on. We kept very careful track.

Question: Did you take those folders on your visit?

Answer: No, no. We had our notebooks with us. Every night,



Reprint from "Clever Country"
Courtesy of Fleming H. Revell

when we came in, we would have a cup of tea and begin writing on the records. Oh, how I hated records! But they had to be done and we had to be very careful.

Question: You were the district supervisor for a period, I understand. What did that job entail?

Answer: Well, I used to do a "round" every month. That meant you rode around to all the districts to see how things were going, or if there were any problems I could help with. And, of course, just to listen to their troubles and the nice things that happened. In the summer we would sit out on the porch and in the winter, we would sit in front of the fire. If anybody needed a second pair of hands to help with a case, or if a nurse were sick, or if the doctor needed to be called, I was the one responsible. Usually, I would stay the night at a center, then ride on to the next one the next day.

Question: How long did that usually take?

Answer: Well, you can't really visualize it now, but the centers were about 12 miles apart. So I would do one center a day. First, I

would ride from Wendover up the river to Beech Fork, then from Beech Fork I'd go over the mountains to Flat Creek—then from Flat Creek to Red Bird and back to Hyden. I would see what work had to be done there—answering mail—because that was where my office was, then back to Wendover, as that was a district also. The second part of the rounds would cover the lower districts—Confluence, Bowlingtown and Brutus. To go from one center to Hyden and back again would have meant riding 24 miles in one day. That was too much to do frequently, so the nurses didn't get to come in to town very often. In the winter, especially, the districts were very isolated, so it was important that I got out every month to see what the needs were.

Miss Betty Lester

Question: Were there many doctors around then?

Answer: No, not here. There was Dr. Collins in Hazard who helped us quite a bit, but he had a six hour trip on a horse. If we had a real emergency it could be pretty bad. But, you see, we had to be able to recognize our abnormalities as soon as possible. We did not "diagnose"—because nurses did not make diagnoses in those days. We made "a tentative diagnosis"! We did have rules about what we could give a patient and what we couldn't. In those days we did not have all the wonder drugs, such as penicillin. We just had aspirin and tonic and cough medicine and sedatives.

Question: Were most of the deliveries done at home?

Answer: Oh, yes. But if we thought that anything was abnormal, we would bring the patient into the hospital and call Dr. Collins. We watched the mothers very carefully. You know how few maternal deaths we've had. We are proud of ourselves!

If it were a normal home delivery, we would go out as soon as the man called us. The patient was not left until one and a half to two hours after delivery to make sure everything was all right. I mean we couldn't go floating around anywhere we wanted while the patient was in labor. If we kept bobbing up and down to the home on our horses, the poor creatures would be dead. So we stayed, sometimes 24 or 30 hours, at the home. The second stage might go on a long time, so we would stay and pray and eventually get the baby. If the delivery was in the night, we always had to have breakfast before we left. No one would ever dream of letting us go without eating, so we usually stayed until the first gray light of dawn.

Question: What happened if you were called out at night?

Answer: We were never allowed to ride alone at night. If Mrs. Breckinridge ever found out that one of the nurses had gone out or come home by herself at night, there would be war! You see, if your horse stumbled and you fell off and were hurt, you could lie there for hours because no one would know where you were. You always left a note to say where you were going but no one would come to look for you at night because it was known that one waited until dawn to start back home. There weren't many telephones so the husband or a neighbor always came for the nurse.

A PROMISE OF GROWTH

The story of Family Nursing at FNS, spanning 5 decades, is punctuated with the personalities of individuals who have helped to shape into reality the dream of a woman whose foresight spawned and nurtured an extraordinary promise of growth.

The people of these Kentucky Mountains have participated in the unfolding of the unique health care system which is the Frontier Nursing Service. They live on the Cumberland Plateau, the western fringe of the oldest mountain range on the continent of North America, the Appalachians. Their homes are situated on the edges of streams which wind through the troughs of the steep, saw-tooth terrain. Others are nestled in remote wooded hollows. These people, most of whom came from independent, self-sufficient English and Scottish stock, purposely chose the isolation provided by the narrow valleys of southeastern Kentucky. Central to their way of life has always been the family and central to the inception and growth of the FNS has been its focus on family care.

The long line of nurses who have come to the mountains began with two American Nurse-Midwives who followed Mary Breckinridge to Leslie County in 1925. Both Freda Caffin and Edna Rockstroh were experienced Public Health Nurses who completed their Midwifery training just before coming to Kentucky. The District Nursing System was launched when these two hardy women opened the first clinic in Hyden. Since those early beginnings District Nursing has provided care to mountain children and their families. Both patient and nurse have been participants in changing health care patterns on the one hand, and on the other, both have experienced the feeling of rootedness provided by tenets which underscore changeless dedication to the care of the person within his family circle.

The people have relinquished a good deal of their chosen isolation to the inroads of education, improved tranportation, financial assistance, and telephone, radio, and T. V. communication. New ideas have at times been resisted, at other times tolerated, and often welcomed. Nursing methods, legal requirements, and sources of financial support have become more sophisticated but certain themes have continued with minimal interruption since our story of district nursing began.

Nursing care in the districts has always been especially characterized by the personal, continuous nature of the relationship between nurse and family. Nursing centers were placed in strategic locations with accessibility as a key consideration. Homes were visited and assessments made of surroundings, of family health care needs, and of teaching needs. Trust was established within the atmosphere most comfortable to the patient, his home. The before-during-and-after relationship with the family when illness or crisis occurred has always been one of the special facets of district nursing. The experience shared before the delivery of a baby formed the basis for instruction of the young mother and father, and the foundation for another trusting, growing relationship with the developing child.

From the outset, nurses whose primary concern was mothers and babies were treating common illnesses in all family members. The foundation emphasis on education and prevention is a vital thread woven through and through the fabric of the FNS health care picture:

> "Preventive work and teaching should grow out of the nursing of the sick. Skilled nursing care, demonstrated over a period of time, should precede teaching and supervision. One terribly sick patient carefully nursed on even one remote creek is a gold mine. Home nursing and care of the sick are taught to a whole neighborhood through the care of that one patient. A nurse . . . having served them in what they recognized as an essential need, finds them willing to listen to advice about diet and sanitation; willing to take shots; and easily led to the prevention of all preventable illness. In nursing the prevention of disease can rarely be divorced satisfactorily from the bedside care of the patient".
>
> —Mary Breckinridge 1948

A sense of adventure, a sense of concern and responsibility, a natural bent toward problem-solving, and a willingness to work hard have always been necessary hallmarks for a nurse who came to the Frontier Nursing Service. A need to be able to work independently but to rely on Medical Directives and on appropriate consultation with the physician, a need to help, yet to give the patient opportunity to assume as much personal responsibility as possible; a need to guide and teach without overpowering the individuality of the patients; each of these dimensions demands self-scrutiny and discipline in order continually to re-align the standards which govern quality care.

The effort to maintain and improve the quality of nursing care was established as a priority by Mary Breckinridge. The professional organization of nurse-midwives began in Kentucky in 1928 and all sixteen of the original members were on the staff of FNS. In 1939, the school to train graduate nurse-midwives began at FNS and, in 1970, the training of family nurses began. Frontier graduates were among the first group to take the recent national certifying exams for family nurse practitioners. The aim for district staffing, with legislative impetus as a spur, is to staff every district with nurses who have received post-graduate primary care training.

Mary Breckinridge rode the length and breadth of these hills on horseback to talk with the people and to enlist their support before starting her nursing service. A renewed effort is now being made to enlist community participation in decision-making. Community committees in each district were involved in the genesis of each district center. Needs have changed through the years but the wholehearted participation of the people is needed now, perhaps as much or more than in 1925.

The nurse on horseback broke the trail for present-day nurses who drive in jeeps on more modern roadways, but often yet on rutted mountain roads or through creek beds. Present-day nurses are required to pass a driving test just as their predecessors were required to take at least five riding lessons before beginning work at FNS!

The nature of the mountainous terrain, the absence of roads, the sparsity of vehicles, economics, all these factors made it a practical necessity, as the district system developed over the years, for the nurse to render much of her care in the homes.

Recently, the district clinics have become more accessible to the patient and an emphasis on responsibility for participation in his own health care has been increasingly proposed to the patient. The amount of time spent by nurses in the district clinics has markedly increased.

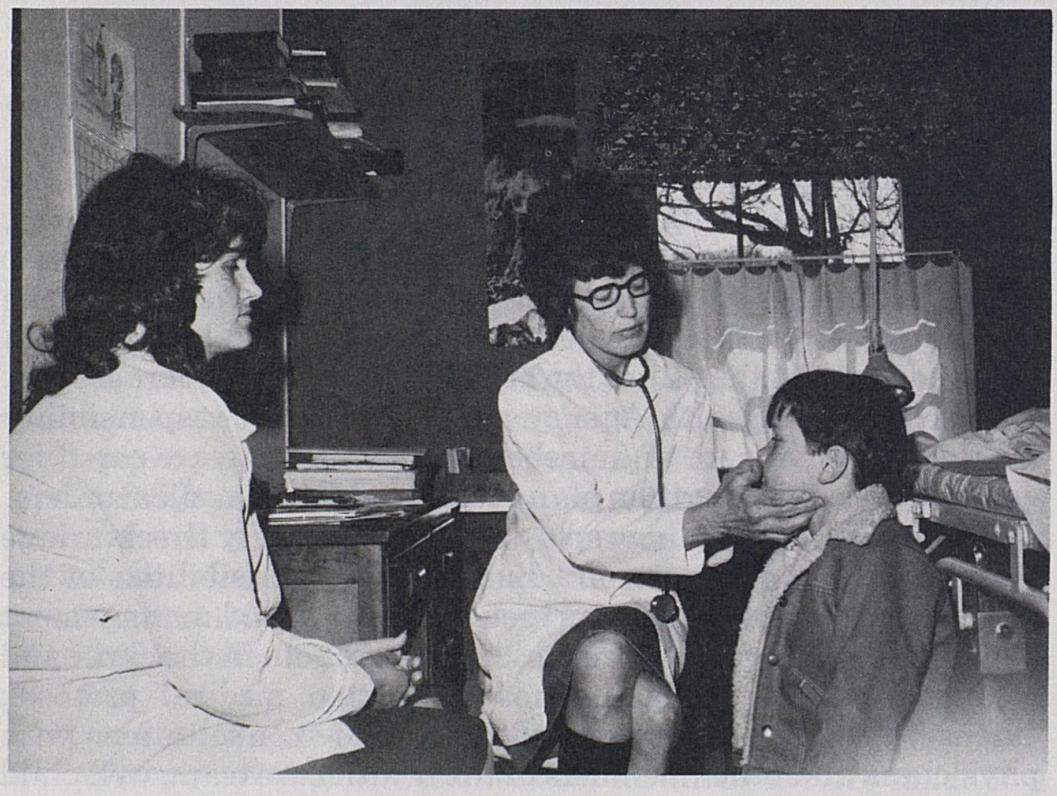
Assessments of family situations, health education, expressions of interest in and introduction to available services, assistance during crises, the treatment of acute and chronic illnesses, and selected prenatal or postpartum visits or home deliveries; all of these are essential reasons for looking with renewed vigor at the role of the district nurse in the home setting. The FNS Home Health Agency now assumes the responsibility for the exclusive care of homebound patients who are cared for under a physician's written plan of care and direct medical orders.

Six district centers now splay out from the Mary Breckinridge Hospital like the fingers of a hand. The responsibilities of the nurses who staff these centers include: the care and management of patients with acute and chronic illnesses, both in the clinic and at home, within the guidelines of written medical protocol; extensive record keeping; referrals and consultation with physicians and other members of the health care team; well child care; prenatal and postpartum care; and the establishment and maintenance of a working knowledge of the families within the district community which they serve.

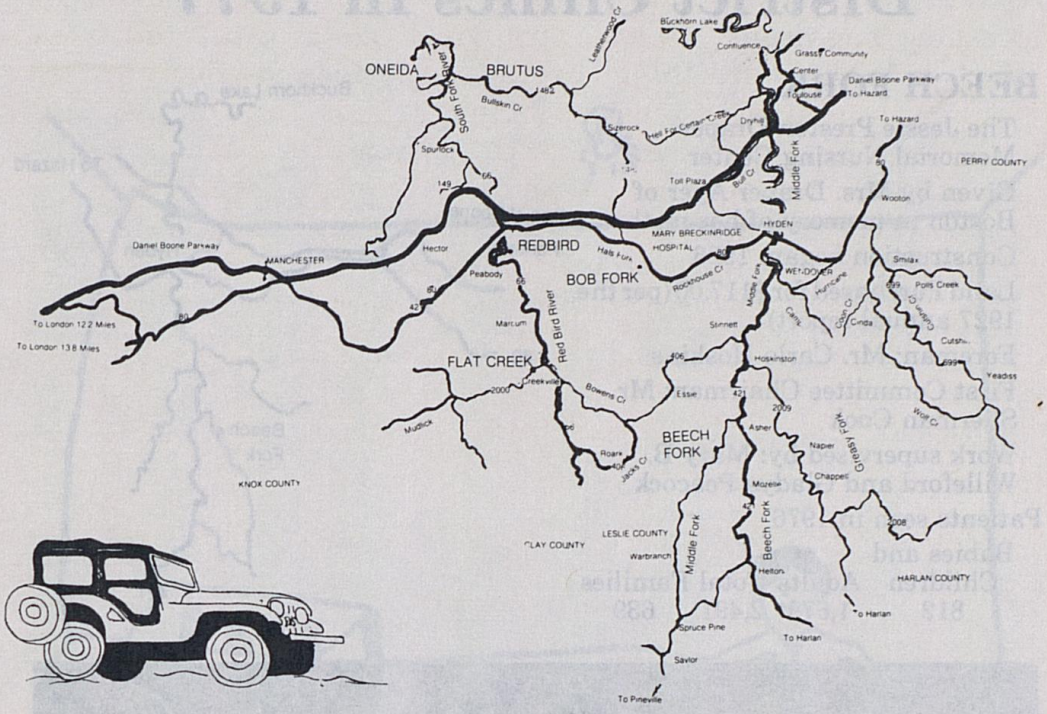
We now have a vantge point from which to look back at an awesome beginning, to look around at our growth, and from which to look toward things to come. A concerted effort to meet required standards without sacrificing flexibility and uniqueness, to achieve efficiency and financial soundness without relinquishing the warm, person-oriented approach begun by Mary Breckinridge will surely be rewarded by a still more satisfying fulfillment of that early promise of growth.

> "We hitched our wagon to a star then, and when we traded wagons for trucks, we held on to the star. The heart of our work has lain in its start with things as they were and its acceptance of the laws of growth. In planning for future growth the Frontier Nursing Service still adheres to the principles that gave it being."[1]
>
> —Donna Murphy, R. N., B. S., C. F. N. P.

[1] *Wide Neighborhoods by Mary Breckinridge; Harper & Row, Publishers, page 358.*



Miss Ruth Blevins—Family Nurse Midwife



"Back in the days when nurses rode horses everywhere, they had to swim across the creeks and rivers. Well, I remember one nurse who appeared on the other side of the river from our house; she hollered to us, wanting to know where to ford. Before we could even tell her, the horse jumped right in and began swimming across. Well, the water rose way up on the horse's neck, so, by the time they reached our side of the river, that nurse was soaked right through to the bones. I just took her in the house and made her peel off her uniform to dry in front of the fire while we talked about the family and gardening."

. . . . .

And a "granny midwife" gave advice:

"When the mother is in labor, remove the chair seat and get her on the chair—the baby will come soon. Tell her to stay in bed and rest, be careful not to change bed or the mother's clothing. Keep baby under covers, give plenty of catnip tea, also deer tongue. For stretching hives, a heaping teaspoon of castor oil. Don't fail to do this; the baby might die. Give the baby a good big pig skin to suck on to survive until the milk comes."

District Clinics In 1977

BEECH FORK

The Jessie Preston Draper Memorial Nursing Center

Given by Mrs. Draper Ayer of Boston in memory of her mother

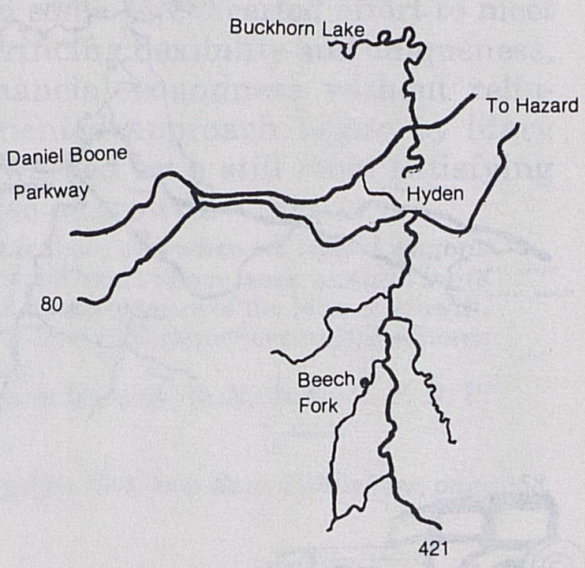
Construction began: 1926

Land Purchased for $117.00 (per the 1927 annual report)

Foreman: Mr. Carlo Hoskins

First Committee Chairman: Mr. Sherman Cook

Work supervised by: Mary B. Willeford and Gladys Peacock



Patients seen in 1976

Babies and Children	Adults	Total	Families
812	1,679	2,491	639

Just over eleven miles south of Hyden toward Harlan, on Ky. 1780 just off U. S. 421, the Beech Fork Center is built on the side of a mountain overlooking the Middle Fork of the Kentucky River. Huge hemlock and beech trees form a backdrop for the white building and the barn, which now houses jeeps and cars. Bustling activity is the characteristic hallmark of this district center, the first outpost center to be built. The clinic area at one end of the house includes two small examining rooms, waiting area, secretarial office, and the small lab and work-up area downstairs, with one extra exam room-office upstairs. The kitchen is used for conferences and paper work as well as for food preparation. The living area of the house includes a small living room with its stone fireplace, two small bedrooms, and a small screened-in back porch. One bedroom is located upstairs over the clinic area. This center presently accomodates the largest staff of any live-in district.

whin you are sick
the husrse GivM You
Medcine, you should Stay
- in Bed.

RED BIRD

The Clara Ford Center

Given by Mrs. Henry Ford of Detroit

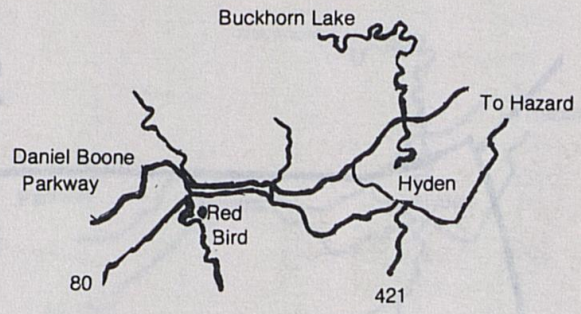
Construction began: 1928

Land given by Fordson Coal Company

Foreman: Mr. Oscar Bowling

First Committee Chairman: Mr. Cicero Feltner

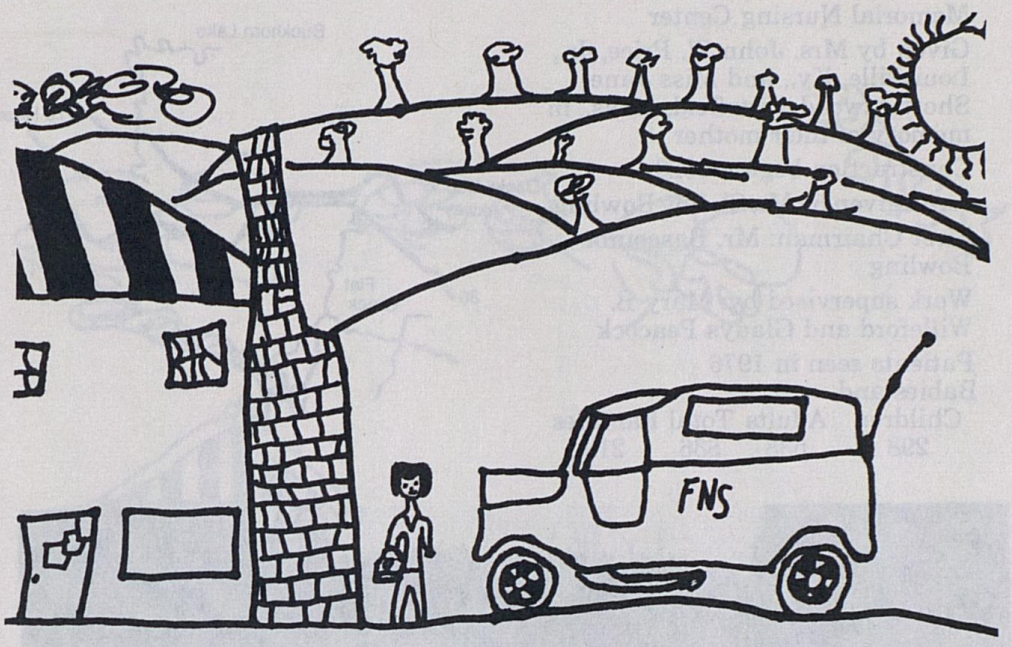
Work Supervised by: Mary B. Willeford and Gladys Peacock



Patients seen in 1976

Babies and Children	Adults	Total	Familes
483	1,137	1,620	443

The Red Bird Center is almost fifteen miles west of Hyden. This, the second outpost center, is a beautiful log building built on a hill looking down on the Red Bird River and over to busy route 66. The rustic living room of the center is raftered with hand-hewn logs and its windows look down on the river. The floor-plan is much the same as other live-in centers with bedrooms and kitchen. The clinic area at the far end of the house includes two examining rooms, a centrally located office, and a waiting area heated by a large coal heater. The barn is nestled in back of a huge boulder and holly trees rim the parking area.



Wheen You are Sick She
give You coughsyrup.

and it help You.

FLAT CREEK

The Caroline Butler Atwood Memorial Nursing Center

Given by Mrs. John W. Price, Jr., Louisville, Ky., and Miss Jane Short Atwood, Pittsfield, Mass., in memory of their mother

Construction began: 1929

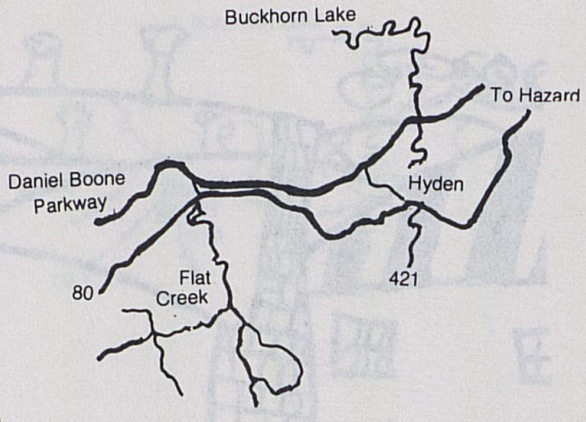
Land given by Mr. Shelby Bowling

First Chairman: Mr. Bascombe Bowling

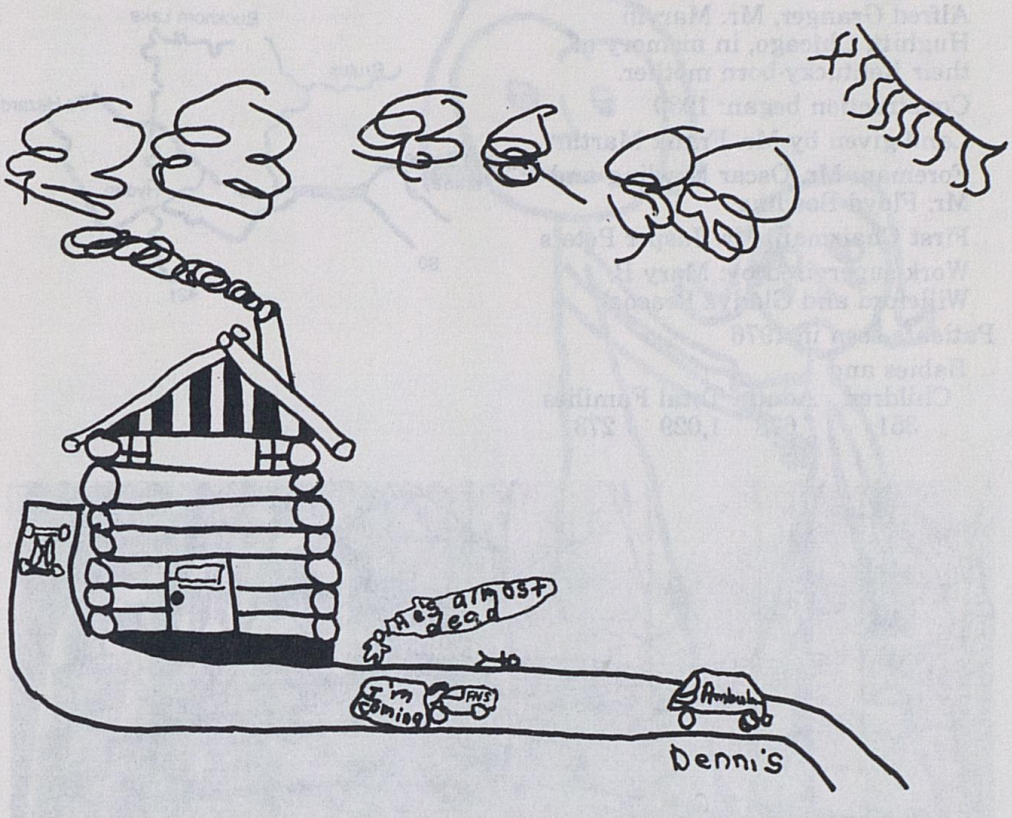
Work supervised by: Mary B. Willeford and Gladys Peacock

Patients seen in 1976

Babies and Children	Adults	Total	Families
298	538	836	212



About fourteen miles west of Hyden and seven miles south on route 66, which runs along the Red Bird River, is the Flat Creek Center. Flat Creek was built just up from the mouth of Flat Creek where it flows into the Red Bird River. The center is a large brown frame building with a circular driveway enclosing the lawn. It is built against a hillside with a valley view to the front and a small stream flowing down to the creek on one side. A screened-in porch is just off the living room and a porch at the clinic end of the house leads into the clinic waiting area. A bright, comfortable examining room with a prized, community-donated refrigerator, awaits the patient. The clinic includes, as well, one other examining room and a combined waiting area and office. Presently, one nurse lives at Flat Creek.



a nurse is a help to you

BRUTUS

The Belle Barrett Hughitt Memorial Nursing Center

Given by Mrs. Charles Frost, Mrs. Alfred Granger, Mr. Marvin Hughitt, Chicago, in memory of their Kentucky-born mother.

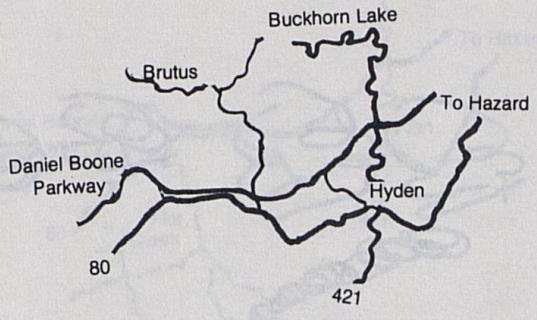
Construction began: 1930

Land given by Mr. Frank Martin

Foreman: Mr. Oscar Bowling and Mr. Floyd Bowling

First Chairman: Mr. Jasper Peters

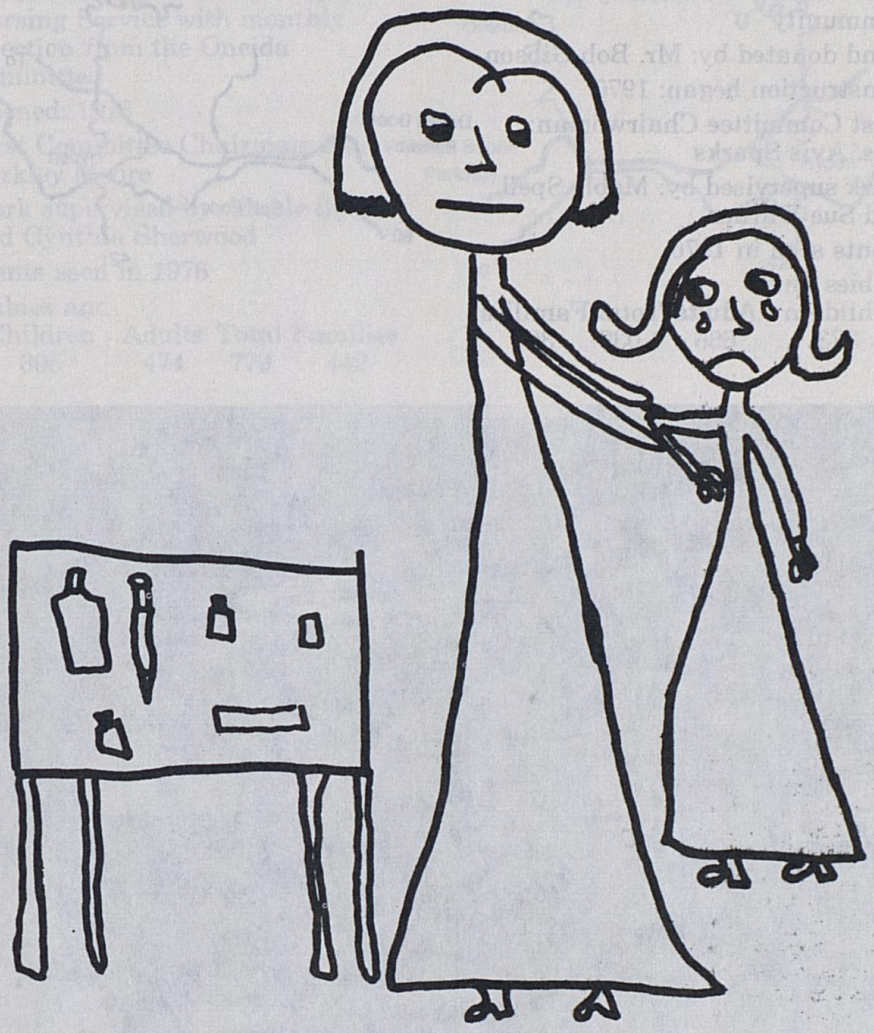
Work supervised by: Mary B. Willeford and Gladys Peacock



Patients seen in 1976

Babies and Children	Adults	Total	Families
351	678	1,029	273

Eleven miles west of Hyden on U. S. 80-421 and north eleven miles on Ky. 1482 is the Brutus Center. At the bottom of the steep driveway is a reminder of horseback days, the Kentucky Pull-Gate which made it possible for the nurse to open and close the gate while still astride her mount. The large white house is beautifully situated on a hill overlooking a wide expanse of fertile bottom-land, a not-too-common sight in this area of perpendicular hills. At one end of the house is the clinic with its waiting area, secretarial office, patient work-up area, and two examining rooms. The spacious, comfortable living area has ample bedroom space for staff and guests, a much-used and well-loved kitchen, and the living room with its expansive stone fireplace and corner piano. The barn is located yet farther up the hill and still provides a home on occasion for animals owned by the nursing staff.



the nurse helps me
When she checks me.

BOB FORK

Betty Lester Community Clinic

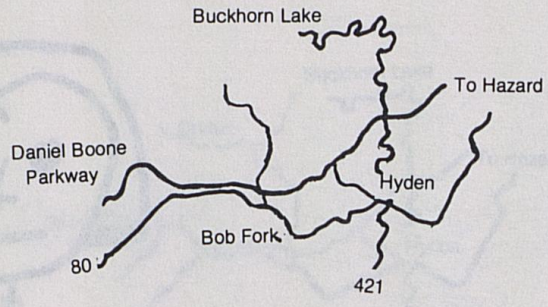
The building is owned by the community

Land donated by: Mr. Bob Gibson

Construction began: 1970

First Committee Chairwoman: Mrs. Avis Sparks

Work supervised by: Mable Spell and Sue Warner



Patients seen in 1976

Babies and Children	Adults	Total	Families
373	666	1,039	307

The Betty Lester Community Clinic, the namesake of a well-loved FNS nurse who still lives among her adopted people in the town of Hyden, is located ten miles west of Mary Breckinridge Hospital on winding U. S. 80-421. The small concrete block building, with its front parking area just off the busy blacktop, is situated with its back to a fast-running stream, is flanked on each side by homes, and is directly across the road from a steep mountain-side of hemlock and a high, seasonal waterfall. The three-room clinic accomodates a reception-waiting area-office, and two examining rooms. The Bob Fork District functions essentially the same as other districts with the exception that no nurses are in residence at the clinic.

ONEIDA

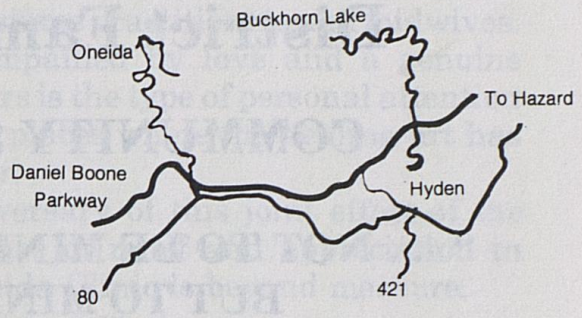
Owned by Oneida Baptist Institute

Staffed and operated by Frontier Nursing Service with monthly direction from the Oneida Committee

Opened: 1976

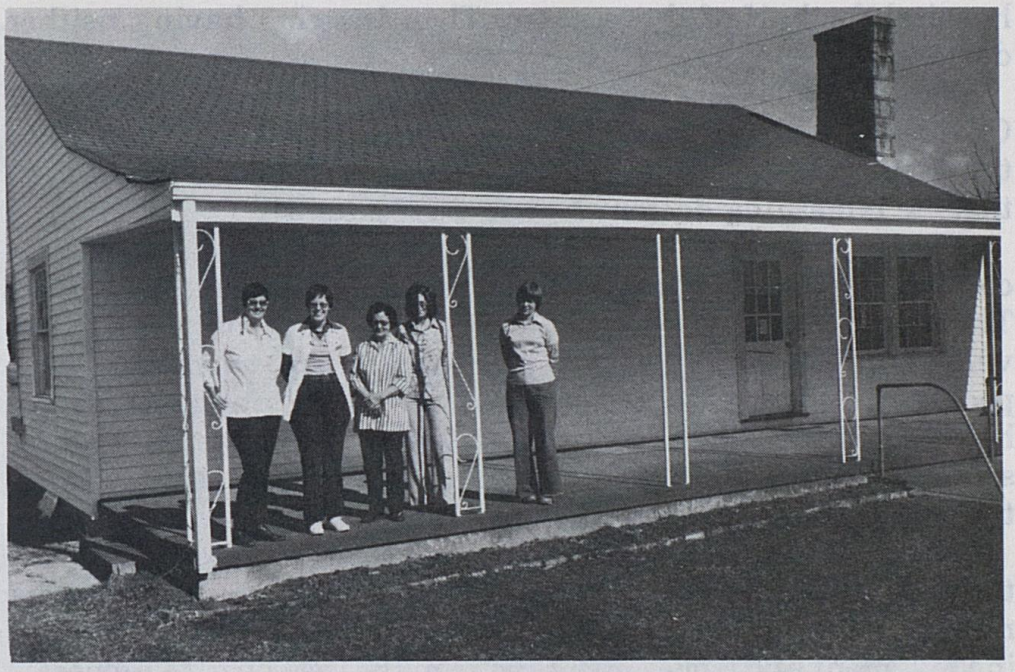
First Committee Chairman: Mr. Barkley Moore

Work supervised by: Mable Spell and Cynthia Sherwood



Patients seen in 1976

Babies and Children	Adults	Total	Families
305	474	779	442



The attractive little community of Oneida, thirteen miles north on route 66 from the Big Creek exit of the Daniel Boone Parkway, is the home of the Oneida Nursing Center, the newest FNS clinic. Its operation began a year ago this spring. The neat, one-story white building has an inviting porch the width of its front. An Oneida resident hand-carved and donated the beautiful cedar sign on the front lawn. The clinic facilities are spacious and well-planned and include a large, comfortable waiting room, secretarial area, examination and emergency care rooms, a lab and work-up area, and a room designated for a planned pharmaceutical set up. The focus of the nursing care at the Oneida Center is in-clinic patient care, but the nurses live in the community and are available for emergency care.

Conceptual Vignettes Of District Family Care

COMMUNITY SUPPORT

". . . NOT TO BE MINISTERED UNTO, BUT TO MINISTER"

Imagine a community with at least one doctor, and nurse, for over sixty years. Then imagine the same community having a hospital for half of those years. Then imagine having neither doctors, nurses nor hospital.

This was precisely the situation of the mountain community of Oneida in 1973, the community's hospital having been moved to the county seat of Manchester seventeen miles distant, and then the one remaining doctor also moved his office.

Three streams—Goose Creek, Red Bird and Bullskin—converge at Oneida to form the South Fork of the Kentucky River. The village of Oneida is located in the center of four converging valleys and, in the valleys, along the rivers, live several thousand people. In the town, besides the local population of several hundred, is the 78-year old Oneida Baptist Institute, a boarding school with 380 students and staff, coming from all over Kentucky, 13 other states and 12 foreign countries.

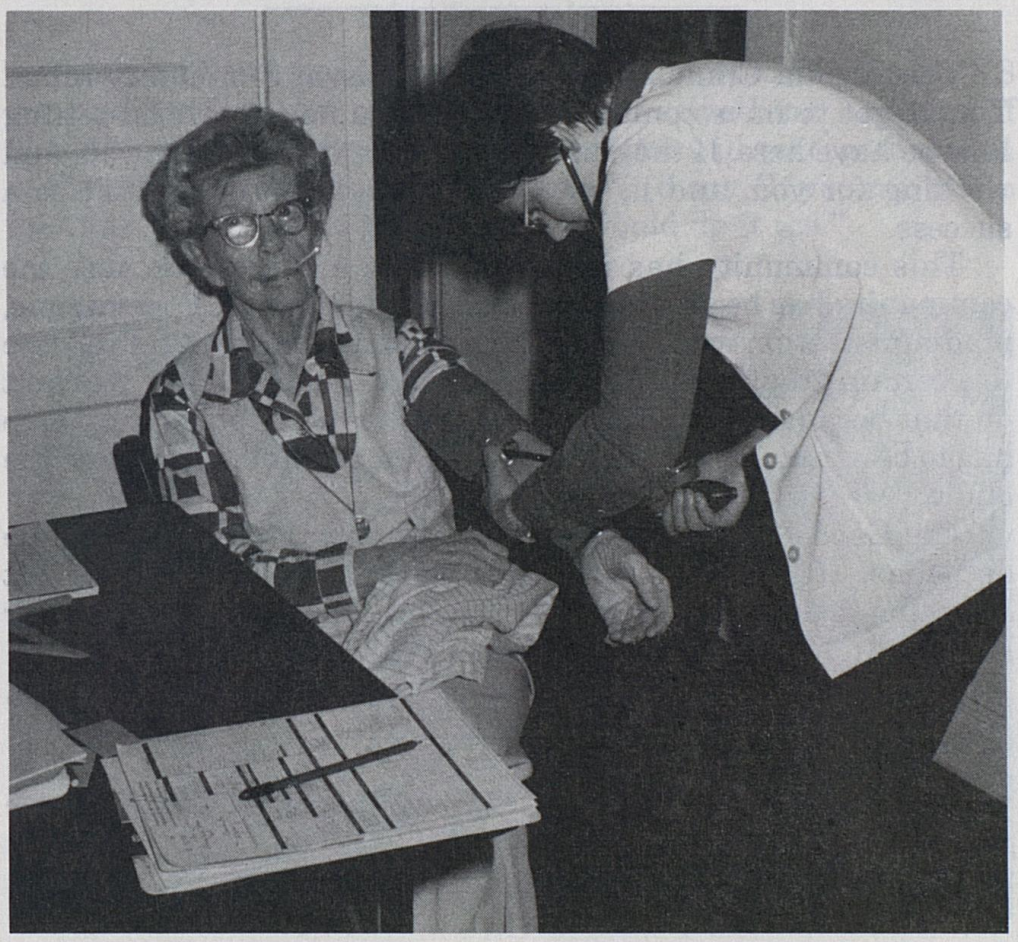
Oneida is a natural place for medical services to be centered for the people in the eastern section of Clay County. Accustomed to a medical service centrally located to meet their needs, it was very inconvenient and time-consuming to make the trip to Manchester for even the most minor medical problem. For some, this involved more than 50 miles of driving and a wait for hours, upon arrival, for the needed help.

After three years of frustration and need, the community roused itself to action. The Oneida Clinic became a reality in April, 1976, staffed by the Frontier Nursing Service, housed in a fine building provided by the Oneida Baptist Institute, and equipped by the local citizenry who raised over $10,000 by solicitation, a box supper and auction, a horse show, etc.

FNS Nurses Mable "Skip" Spell and Cindy Sherwood and their staff provide health care based on extensive training and broad experience as registered nurse practitioners and midwives. Their ministrations are accompanied by love and a genuine concern for their patients. Theirs is the type of personal attention that is just a memory in most places where the healing art has become an assembly-line affair.

As we near the first anniversary of this joint effort of the community and FNS, our sense of relief and appreciation in having the services of the Oneida Clinic is beyond measure.

—Barkley Moore, Chairman
Oneida Nursing Center Committee



Miss Cindy Sherwood—Oneida Family Nurse Midwife

"Miss Browne wanted proof of community support for the proposal. They then presented her a petition with 800 signatures. The population of Oneida is 600."

"An old-fashioned box supper was staged at the festival. Women placed their suppers in decorated boxes. When the boxes were auctioned, husbands or boy friends were bound to place the highest bid. If others discovered whose box was being auctioned, the stakes got high. One box went for $149.00 and several others went for over a hundred dollars."

"A horse show held at Oneida cleared nearly $3,000.00. It was such an overwhelming success that it is now planned as an annual event."

The Oneida Clinic is a success because of community input. You've got to have community input in a neighborhood setting like we have here. If the community is not interested in you, and working for you, and in you, and through you, you can't be a success.

This community has made the clinic a success because the community has been involved every step of the way. For example, if administration were to come out and offer a free program of care to a certain group, our committe would stand up and say "We can't do that because, if we did, our clinic wouldn't be solvent." There has to be a mutual agreement between the administration and the clinic.

The Good Lord gave people dignity and the ability to make decisions. If I think I can help them, I'll try to do it without imposing my standards on them. They should have a part in their health care. They should feel responsible for it.

—Mable (Skip) Spell, R. N., C. N. M.

"Other fringe benefits [for the Oneida nurses] include hair cuts from a neighbor beautician."

"Besides providing quality health care to some 3,500 Clay County residents, the Clinic has been the impetus for instilling a

spirit unparalled in Oneida's history. Local leaders are setting their sights on community needs heretofore not considered, such as an improved water system, a fire department, and new industry."

Sitting around the fireplace in the living room of the Brutus Center, several long-time members of the Brutus community shared their memories:

An elderly lady laughed as she recalled two nurses who used to get together with her for musical gatherings. She would play the piano and sing, while the nurses played an autoharp and sang. "Yes, " she said, "we exchanged records and everything!"

. . . . .

"We just don't want to think about what would happen if FNS went away. We just can't face that. If something happens, if something needs to be done, the committee will get together with every family in the area around here. We'd say, 'If you can't help one way, give us a dollar,' and they would do it too."

Waiting Room, Beech Fork Clinic

Pauline Barnstager, Elizabeth Burns, Rhoda Barger, Hazel Marten, Minnie Burns, Miss Ruth

Brutus District Sewing Circle

"We used to have a regular sewing circle that met at the clinic. Everyone would bring a covered dish and their sewing things. We would spend the whole day visiting and sewing gowns and baby blankets for the hospital."

. . . . .

"Whenever something had to be cleaned up or repaired at the clinic, the nurses would call on us men to have a 'working'. We would all go up there on one day and fix the fence or paint the outside of the clinic—whatever needed to be done. The nurses would have a big dinner for us in the middle of the day."

CARE IN COMMUNITY SETTINGS

Many of the districts have a large amount of territory to be covered. Some, therefore, have established satellite clinics. Brutus runs Leatherwood Clinic and Beech Fork hopes to begin one on Camp Creek, as well as construct a new center clinic.

Mudlick Clinic, a satellite of Flat Creek, used to be in a little store by the side of the road. Now it is on the first floor of the Mudlick Church. The church stands deep in a hollow on the summit of a small hill. It is well kept and its modest white spire looks out over several houses sprinkled throughout the hill area. Next door is a geodetic dome, looking somewhat out of place, but sufficiently low key to earn its rightful niche in the neighborhood. We entered the church and found the clinic, a converted hallway, empty. After a short, uncertain silence, we heard voices downstairs and followed the steep stairway down into the basement which serves as a meeting place for a Head Start program for children, complete with kitchen, bathroom and playrooms or classrooms. There we found two supervisors of the program quilting and monogramming. We introduced ourselves and began discussing the clinic and Flat Creek.

Mudlick Church of the Brethren

They were both generally enthusiastic about the opportunities that a satellite clinic offered. "The nurses are a great help," said one, "if children need shots or a check, the mothers give permission for the nurse to do it at Head Start. The children know the clinic is upstairs and they are always hollering 'bye, Tina' when the nurse goes."

"I've really appreciated what they've done for me," said the other. "I have a boy who has an allergy and I can take him to the clinic in the evening a lot easier than I can take him to town."

They spoke of "going down to the center just to visit and drink coffee, or to talk about the center and what it needs and how we can get it." They reminisced about all the nurses who had come and gone and could not remember any they had disliked. But each new nurse gets a "looking over", nevertheless.

Leatherwood Clinic

All the while the monogramming and quilting slowly neared completion. When we got up to leave they had made substantial progress. We thanked them for talking with us and left the church-clinic.

"You tell Dr. Beasley I'm not gonna go to the clinic again unless they get some of those tricks and turns that don't pinch."

—An Elderly Patient

An important thing to remember as a district nurse is to listen to what your patients have to say. Be open to their ideas and solutions to problems.

ON FAMILY CARE

(Excerpts from interviews with district family nurses)

I first became involved with this particular family because the husband was bedfast with chronic lung disease. I saw the family at home, to monitor his condition and supervise care. His wife actually did most of the care, and she did an excellent job. She had a knack of caring for people.

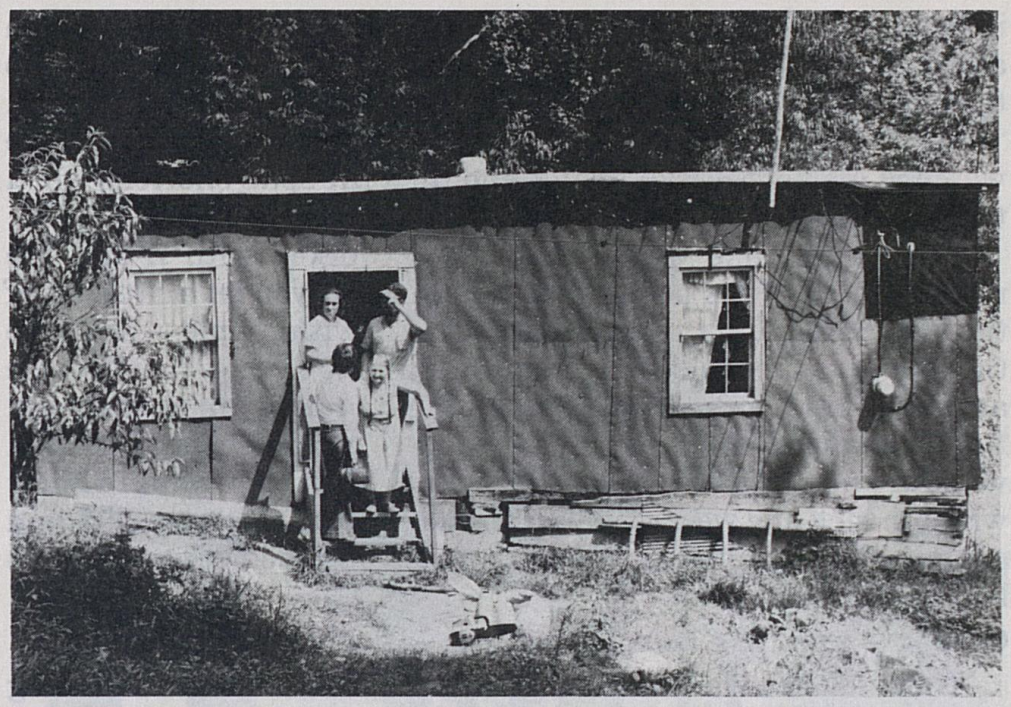
Because I was in the home with the chronically ill patient, the family care just sort of evolved. If there were illness with other family members, I'd usually be asked to check on that person. When one of the boys became ill, I checked him at home and thought he should be seen at the hospital. They followed him up there and found he had pneumonia. After they treated him and sent him back home, I did the follow-up. That's how it got started, and after that they would come to the clinic when they could. When the children got old enough, the mother would send them down to the clinic for their well child checks, and before school one year, she sent all three down for an exam and to catch up on their immunizations.

The oldest child was married soon after I started seeing them. She use to come to clinic a lot to talk about her frustrations. She was young, and there were a lot of questions that she'd never had answered, so she came to me to talk about them and ask my advice.

. . . . .

One patient came here to register for prenatal care. She was followed here prenatally, had her baby at the hospital, and returned to the district for her postpartum care. During the postpartum care, she chose her next family planning method, so we were following her as a family planning patient. I think probably her delivery and postpartum care were instrumental in starting her family into health care activities. Now they're incorporating them into their lifestyle.

. . . . .



Home Visit—Flat Creek District

Usually, in making home visits, you become aware of what people have to put up with at home — the kinds of conditions that particular family lives in. You can relate your care a lot better and a lot more practically to their situation than you could if you've never been to the house and have no idea where they live or anything else about them.

. . . . .

I had never met Z until he walked into the clinic one day and wanted to be checked. Prior to that his wife had been to the clinic to look at the WIC schedule. We always smiled and said "hi", but I never knew her or her family very well. When Z came in I guess it was the start of offering a little bit of everything to the family in terms of health care and support. Z had been a diabetic for seven to eight years and had had a couple of severe heart attacks, and was hypertensive. He had stopped his insulin and wasn't doing anything for himself, I guess because it all seemed too hard and there always seemed too much to do. We got him back on his

insulin and on his hypertension medication. Later, I talked to him and said, "You know, Z, there's something else we've got to do that's just as important as all this and that's your diet." Z said, "Well now, there's no use in talking about all this diet because I've watched a lot of these diabetics and their life span shortens when they go on diets."

Since that time we've consistently worked with Z and the management of his problems. Sometimes, if you let a little bit of time go by, try to stay relaxed and human with people — not force them or give them a list a mile long of things to do — they'll come around. That's exactly what Z did. He had been a sick man and finally realized it. He finally came in to the doctor and said, "I want to know why I'm sick up and down like this. I want to know why I'm sick one week and well the next." The doctor and I again explained to Z what was happening with his blood vessels and his body.

Q: For a long time he wouldn't have asked that, would he?

No. He didn't want to know. He just couldn't see himself doing anything. After he asked, and we told him, he said, "Now what can I do for myself?" I said, "Well, it's got to do with that diet and I know how you feel about it. I know you don't believe in it and you don't want to do it." And he said, "Well now, I'm ready. I'll do whatever you say I've got to do. I want to raise my family and I've got five kids and a wife and I want to do right. You all here have helped me and now I want to do something."

Q: How do you feel the FNS program has helped you deal with this kind of situation?

Before I went into the program, I don't think I knew what the family concept meant. Now, with someone like Z, you don't just work with him, you work with the five little kids and you work with the mother.

Q: That's an example of the family nurse in the true sense of the word, then, because his disease affects the whole family?

Yes, and I think that's what Z realized. Prior to that he didn't see it as having an effect at all upon the whole family. Now, we've initiated family planning, immunizations, well child exams. The whole family is trusting, and that's the biggest thing, I think.

Family weighing in at Creek Clinic

"I'm from Cincinnati. I never heard of FNS 'til I married my husband. You know, I thought it was weird. You know, the nurses running around in jeeps. But I like them, they take time out for you. I'd just as soon have a nurse as a doctor — they're more personal. They take more time with you, it seems like. They talk to you more. You know, a woman talking to a woman can just talk straight out, where I won't always be plain with a man doctor."

It wasn't until I worked as a district nurse in the mountains that I learned how to deal with death and dying. It was only because of my patients that I was able to accept death and talk about it as readily as they.

Interview With Elsie Maier, R.N., C.N.M., M.S., C.F.N.P.

Dean, Frontier School of Midwifery and Family Nursing

After eight years on district — when I look back on it — I think what it's done for me is to give me the opportunity to practice family nursing in the real sense of the word. It is because I got involved with the families at Red Bird that I learned what it really meant to care and to be a nurse — not only a nurse but a friend. It was from the people of the community that I learned what it means to love and what it means to live life at its fullest.

That's the reason I'm teaching right now — because of the experiences I had on district. I felt like I had something to share with other nurses and could show them, through my experiences, the value of family nursing, of getting involved with families to the point of delivering their babies at home, of being with them in crises, even helping them bury their dead. This was brought to the forefront dramatically by the 1970 mine disaster when 20 of the 38

killed were men whose families I had taken care of — been in their homes, helped them raise their children. When I went into the homes after the disaster, the kids would look at me and say "Miss Elsie, do something, get my daddy out of that box, give him an aspirin so he can get up". That's enough to tear one's heart out but it showed that they trusted me and accepted me. The Kentucky people have accepted the nurses for years and years, but each individual nurse has to learn how to communicate and make a way for herself. You have an automatic entrance into the home because you have "FNS" on your sleeve, but until people get to know you as an individual, and see whether you're really trustworthy or not, they may not listen to what you have to say and allow you to participate in their care. They're going to do what they want to do; they may be able to give all the answers and all the instructions that you've given them verbatim back to you, but that doesn't mean that they're going to do it, unless they really feel that what you're saying is worthwhile.

Q: So it doesn't matter whether you're a doctor or a family nurse — it's what kind of person you are?

Right. And that's one of the reasons why, even before the family nursing school was started, that nurses who were out on district had an opportunity to be successful. It was the fact that they cared, were there on an every day basis and could see when people needed help, and did the best they could and taught the best they could. I learned the hard way — we didn't have the family nursing school when I was out on district. Now, with all the growth of the nurse practitioner movement, I feel a major part of what I can do is to share the district experiences that I had. It's not until you work with families over a period of time (and I'm talking about four years, not four months) that you really feel like you know your patients. I must say that I learned more from them than I did from any book and I'm indebted to the people of the Red Bird community for what they taught me. Because they taught me how to live, and they taught me how to be a nurse and how to be a friend to them, because they were a friend to me.

"I think it is really good that nurses come from outside the area. They get to know us and we get to know them. We share their experiences and they share ours."

Creek Clinic—Flat Creek District

The Physicians Speak On The District System

Interview with Alexander J. Alexander, M.D.

Question: What sort of things did you expect from a district system when you came here?

Answer: Well, I think I expected the district system to be one of a number of fairly autonomous rural primary care clinics which were staffed completely by nurses and geared to meet the ordinary needs of health care for a relatively well-defined geographical area which didn't have ready access to a larger area, such as Hyden, where there were physicians and inpatient services. I think that at least as far as Bob Fork goes, that clinic meets that role very well. I think it reaches a significant number of patients; I think it encourages good health care maintenance in a population that otherwise would probably have relatively poor health care maintenance. I think it offers ready accessibility of health care personnel to people who would not have access to similar personnel under other conditions. I think it points out the feasibility of the family nurse practitioner (FNP) operating quite efficiently in the absence of a physician. And I think it operates more efficiently than other outpatient systems which rely primarily on physicians. I think that the role of the FNP is unencumbered by many of the responsibilities and limitations of an office or inpatient-oriented physician.

Question: I gather from talking with you before that you think FNS should stress the FNP even more.

Answer: Yes, I think that's really important. I think that the FNP is the raison d'etre of the FNS. Without it there would be no FNS, and the health care delivery in Leslie County would be much different and, I think, much inferior to what it is now.

Question: You go to the Bob Fork Clinic what — twice a month?

Answer: I go three weeks a month, so I make three visits a month.

Question: Do you feel you could decrease the frequency so that the family nurse would be more autonomous?

Answer: I think Gail makes good use of my time there. I see a very reasonable volume of patients during the three or four hours I spend at the clinic, so that I don't feel that my time is in any way wasted. I do feel that Gail has a very good grasp of the patients' situation. Frequently I don't alter the diagnostic or therapeutic approach to the patient's problems by what I do at the clinic. On the other hand, I think it's reassuring to the patient and to the nurse to have the physician give his stamp of approval. I think the amount of time is probably an appropriate amount of time. I don't think an increased investment of time would yield much improved results, and I think it would be beyond the point of mutual returns. On the other hand, I think that a significant decrease in physician participation in the district clinic would not only undermine some of the psychological, as well as professional backing I think the family nurse has a right to expect but would also make the patient a little uneasy if he were never seen or accessed by a physician.

Question: And you'd like to see the family nurse stressed more in the clinic itself?

Answer: Yes, absolutely. It's a very rewarding experience for me to go in and sit down and see a patient who was presented to me by the patient's family nurse, who knows the patient's past history, his current health status, his current medications, who has a pretty good insight into his economic and social situation, and, who, along with the patient, can answer any questions I may have concerning the patient's clinical situation. It increases my efficiency tremendously and it gives me an insight that I probably wouldn't gain isolated one on one with the patient in a sterile clinic environment such as here in the hospital. It gives a much more comprehensive approach to patient care, not just here in Leslie County, but I think it's something that's readily adaptable to rural and urban communities alike.

"People should consider how the nurses — when I say break their necks, I mean go out just to help the patient. I've seen it done and I think a lot of people show a lot of respect for how the nurses treat them."

Interview with David Coursin, M.D.

Question: What did you expect of the district system when you came here?

Answer: I expected it to be, primarily, a primary care contact with families in their homes — families in their living situations — so as to be promoting preventive medicine and, thereby, be totally unique in America.

Question: And is that what you found?

Answer: No. I found family nurses in situations where they were required to spend more time in clinics and in a crisis-curative kind of medical care. I think that was something that was motivated by economic pressures at the time but I would hope to see a change back.

Question: So you think the nurses should get back into the home?

Answer: Well, I don't think they should stop being able to diagnose and manage, but I think they should be spending more time bringing health to people, because the public won't seek preventive medicine — you have to take it to them and introduce it to them, and then they'll pick it up. I think the setup here, with the district nurses, is beautifully organized for that. I think that is what should be done, and the degree to which you then take care of the more curative kind depends upon the particular needs of the area.

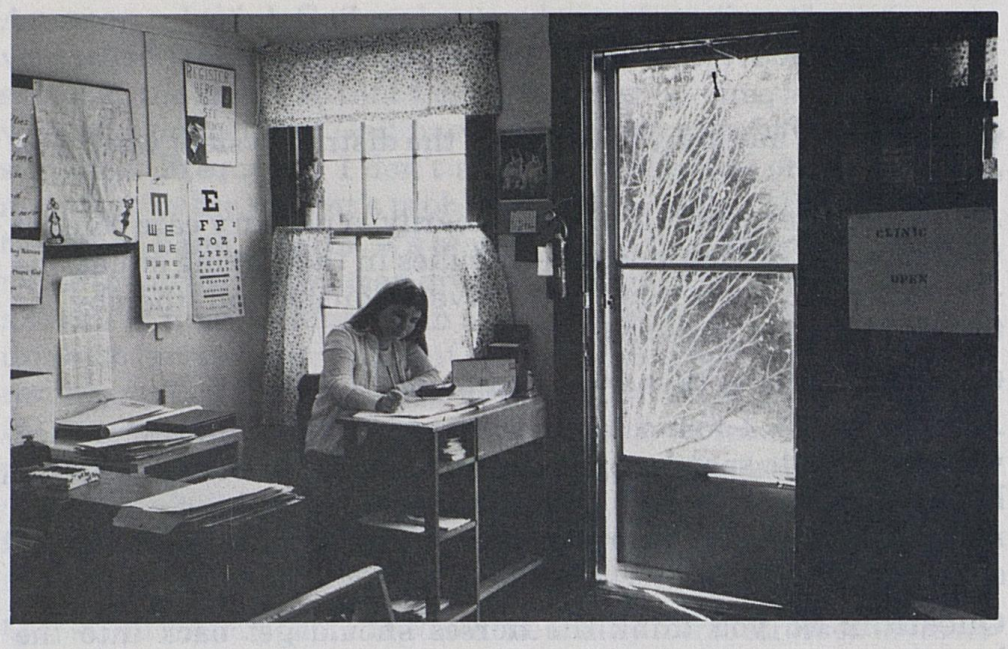
Question: Are you satisfied with the way you, as a physician, fit into the district situation?

Answer: I think it's a tough situation because if we don't start to move back towards the family nurse as the primary responsible individual in the district, focusing her attention on prevention and management of commonly occuring medical problems, we're going to find the district system subtly oriented more and more towards the doctor. And I think that's bad.

Question: Do you think the system is not oriented to the family nurse now?

Answer: I think it's getting away from that.

Question: Why? How often do you go to a district clinic?



Registration—Beech Fork Clinic

Answer: I go once a week and I think the effect of this is that a lot of questions get held until the doctor comes and then the patient is turned over to the doctor. Decision-making is possibly not addressed as fully as the nurse may be able to address it because she knows the doctor will be able to address the question when he comes. It's a fine line because, on the one hand, you have the desire to make sure that the patient is receiving optimum care and, on the other hand, you don't want to be referring people to the doctor too quickly, because that will dull your own opportunities for clinical judgment.

Question: But nurses have to have medical backup. Where do you draw the line?

Answer: I don't think you can draw the line explicitly. I think the line is created as the doctor and the nurses get to know themselves, and the line is created as the system demands. The system is demanding more of a doctor orientation because that's the way we get paid. And I think we need to, and will, get away from that.

Question: Do you think new legislation will help?

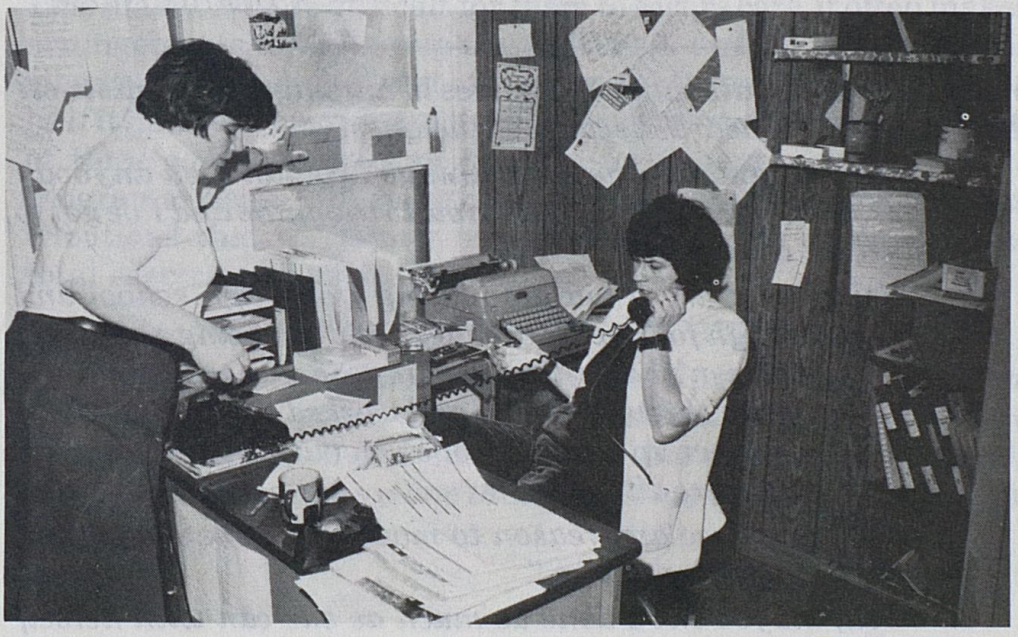
Answer: That will make a big difference, yes.

Question: Do you think, then, that the nurses will refer fewer and fewer patients to you?

Answer: I think I should be seeing the complicated patients — the patients for whom the treatment in the Medical Directives is not working. I think we're more apt to get back to that system when there is no longer an economic imperative for the doctor to see the every-day hypertensive patient just so he can get paid for it.

Question: How would you see the system working at FNS as far as your backup goes?

Answer: I think the best way for the system here to operate would be for the hospital to become the focus of crisis-curative medical care, with the doctors working primarily in the hospital where they are the first line referral for the district nurses; with the district nurses responsible for preventive care and for diagnosis and management of readily treatable and readily recognized medical problems. The physician may visit the districts periodically but we shouldn't be getting into a system where the patient is coming to the district clinic to see the doctor. You'll have the doctors visiting the clinics periodically but I don't think he has to be there as he is presently. I think the danger of



Sharon Koser, Laura Pilotto—Beech Fork Family Nurses

that is that people start coming to the district clinic because they think of it as a doctor's clinic. They're coming in order to see a doctor. If they have to see the doctor, and can't get to the hospital, then those people have a problem and may lose a little bit by the doctor not being there as frequently, but I think those people are fairly small in number. What I'm more concerned about, in terms of a broad effect, is the way in which patients begin to relate to health care as coming from the doctor, and it shouldn't be that way.

I should be an employee of the nurses — is my own feeling. I should be on retainer, so to speak, as a consultant to the nurses and they should be the primary health care deliverers, they are the professional the patient thinks about when they think about ill health. Then, when the nurse needs help, she turns to her consultant, and that's me. I would work mainly here in the hospital because I can function most effectively as a consultant here.

"I love working on the district. I wouldn't work anywhere else. I like the fact that I can be independent and my schedule is fairly flexible, so that if I need to spend one whole afternoon with a patient, I can."

— A District Nurse

What do the patients think of changes in nursing staff on district? Two ladies were heard discussing the question:

X: "I can sit and tell the nurse things I couldn't tell anybody else, then someone new will come to the clinic and I've got to start all over again."

Y: "Well, that's like a kid graduating from high school and going through four years of college and not being able to get a job — he hasn't benefited anything. Same as these nurses. They've gone through school and worked for a while and if someone higher up doesn't move you out, you aren't going to get anywhere either."

X: "But I don't see any reason to move the nurse somewhere else, if it's a good nurse."

Y: "Well, maybe she's done as much as she can with herself and needs to move on. No person can stay in the same place all their life and benefit — you need to change."

Interview with Thomas Dean, M.D.

Question: How well do you think the district system works?

Answer: For the most part it works quite well. Nonetheless, I think there are several ways in which the effectiveness and usefulness of the district system could be improved.

The first of these relates to the stability of the health care team that works in the district system, and the continuity of care they are able to provide. I think that a good deal of progress has been made in this area over the last year and I would hope that we could continue to work toward maintaining a stable district staff, as I'm sure this improves both the effectiveness of their treatment as well as the satisfaction that the patients have, and the job satisfaction of the staff themselves.

The other area in which we have an opportunity to increase the effectiveness of the district system has to do with financing. Currently, almost all the third party payors refuse to provide reimbursement for services that are rendered by the family nurse-midwives in the district centers. Because of this, patients who are unable to pay directly for these services have to travel to places such as the hospital where their insurance will cover the services. This makes it more difficult for them to secure care, it often makes arrangements for follow-up more difficult, and, in many cases, it means that the overall cost of the services is greater than it would be if it had been provided in the district centers. We hope that some of these problems may be decreased as the various insurance programs begin to recognize the important potential contributions that the family nurse-midwives have to make to the total spectrum of medical care.

"We always hate to see an older nurse leave, after we've gotten use to her, but I've never been worried that there wouldn't be a good one coming on. We've always had that much faith. Certainly we've cried over many a one that's left, but pretty soon we love the next one just as well."

—A Brutus Patient

Interview with E. Fidelia Gilbert, M.D.

Question: How do you feel midwifery fits into the district system?

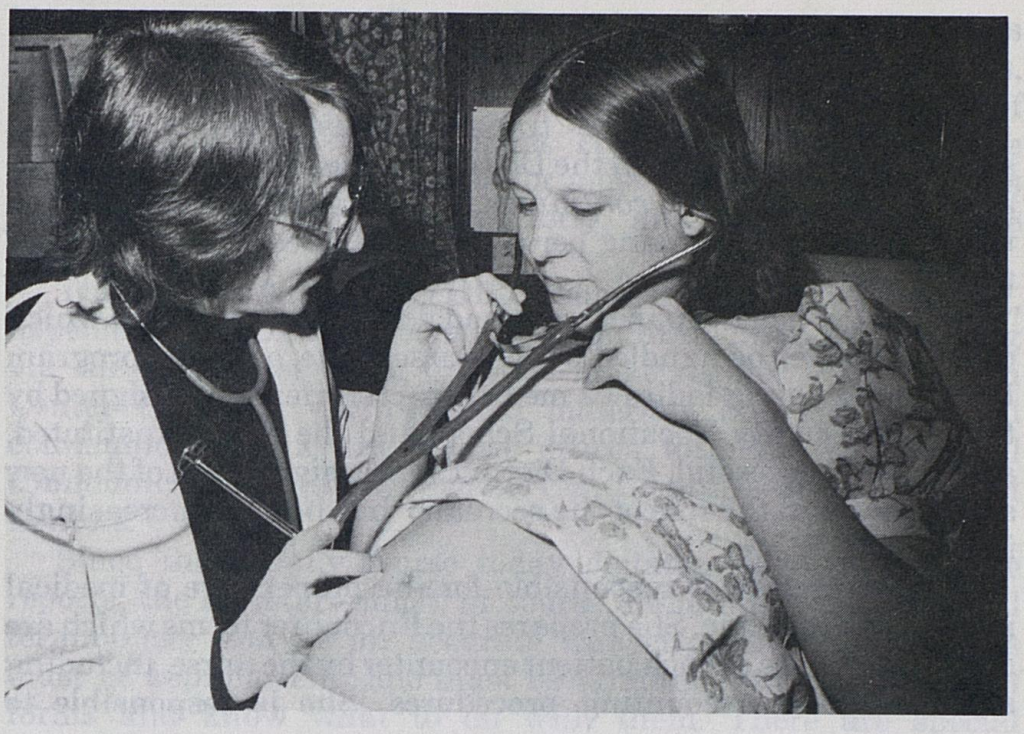
Answer: Well, I guess if you look at the history of FNS, it's not a question of how the districts fit into the hospital; it's how the hospital fits into district midwifery because home deliveries came first and the hospital, when it was built, was kept, more or less, for complicated cases. Now we only have two or three home deliveries a year and it is difficult, with the heavy case load at the hospital, for the girls to go out to do home evaluations and assessments. It's also difficult for many of our patients to come all the way to the hospital for prenatal and postpartum care. It's better for these women to go to the district clinic; perhaps they have other problems with other children, or other members of the family, that can be taken care of at the same time. The district nurse visits in the patient's home. She is, in some cases, almost like a member of the family, so it is easier for the family to relate to the district nurse. I feel that the gap comes between their being at home with the district nurse and then coming into the hospital, with entirely different personnel in charge of their case — people they've not had any contact with. When I go out on district, and take a student along with me, then the patients know us when they come to hospital for delivery. I think district visits are really important from that aspect, because the doctor acts as a connecting link between the district and the hospital as far as the patient is concerned.

Question: Do you think there might be a better way of making that link?

Answer: The ideal thing would be if there were midwives on the district who would bring the patients in for delivery at the hospital. But you can't do that and be a teaching hospital at the same time.

Question: Will the passing of legislation for primary care reimbursement make a difference?

Answer: It will certainly make no difference in our care, because we give it regardless of what the patient can pay, but it will make a difference in what the patient is able to accept, I think.



Gail Alexander with Bob Fork prenatal patient

We have patients who don't come in, or, perhaps, ask not to have this or that test done because they are having difficulty paying. This kind of holds us back!

Question: What do you feel your role as a physician is on the district?

Answer: I feel that my going out saves the patient a trip in here, it helps the midwife who is taking care of the patient, and gets the patient acquainted with us.

"We talk about everything to expect when the time comes. She keeps me informed on how it's doing, how it's growing. She talks with my husband sometimes and he sometimes comes in and watches. All my sisters had home deliveries."

—A Prenatal on the Family Nurse

OUR GALS FRIDAY

Receptionist, file clerk, transcriptionist, cashier, general secretary, liaison between the District Nurse and the community, and most importantly, *continuity* in the District Centers during the changeover of nursing personnel, aptly describes the role of the District Secretary.

In 1971, when the paper work had assumed proportions which could no longer be handled by the nurse alone, a special program for training young ladies as medical secretaries was designed by the Leslie County Vocational School and the F.N.S., instituted, and proved successful. Each District was assigned one of the new secretaries and the role of the secretary has become increasingly important.

Each secretary is responsible for the proper care of medical records in her Clinic. She prepares the Encounter forms which are complete reports of each patient encounter by the nurse, including statistical and accounting procedures. She is responsible to

Red Bird Secretary—Also an FNS baby

Nancy Williams in the Central Record Department for Districts for an accurate counting of all families in her district; arrivals, departures, deaths, births, and any other change in the status of the family or any of its members. These monthly reports have provided Nancy with the basis for most of the district statistics from which her monthly, quarterly, and annual reports are drawn.

The District Accounting Office, supervised by Ann Browning, depends on the District Secretary for accurate financial reporting via the Encounter form. Couriers make regular visits to each Center collecting the prepared materials and delivering all communications to the proper offices forming the essential communications link between the Central offices and the District Centers.

Since the Family Nurse today dictates many of her case reports, the secretary must, of course, be familiar with medical terminology and be an accurate transcriptionist. Her records must be kept current. She must be familiar with a multitude of forms and know what to do with them. There are special procedures for special Clinics held in District; Doctor's Clinic, Well Child Clinic, Prenatal Clinic.

The supervising secretary on District, Ethel Ann Walker, is available for covering vacations and sickness and will go to any District at any time.

As one of the District Nurses remarked ten years ago when the concept of additional training for Family Nursing was being developed, "We cannot take on more responsibilities unless we have some help with records and reporting." The District Secretaries provide that help—and more! The Primary Care System cannot do without them.

The Director and administrators of the Frontier Nursing Service are happy to salute these busy, competent, and loyal young ladies.

Beech Fork—Linda Morgan
Betty Lester Clinic—Carolyn Howard
Flat Creek—Edith Williamson
Red Bird—Deanna Smallwood
Brutus—Tootsie Gay
Oneida—Carol Reed

CENTER MAINTENANCE

The maintenance, repairs and replacements for all the centers (and Wendover) is the responsibility of this department—whether it be a broken washing machine, a furnace that isn't working, a water pump that has quit, a broken window glass, leaking roofs, blocked sink drains, electrical problems, painting, hauling coal for the furnace, or maintaining driveways. And, of course, it includes major repairs like re-roofing a building, replacing a water heater, replacing bathroom fixtures and the like.

The nurses who live at the outpost centers report the needed repairs. If the problem is an urgent one (such as no heat or no water) the report is by telephone. Repairs of less urgent nature are written requests that are sent in via the twice-a-week courier rounds. Emergency situations are handled as quickly as we can manage, whether it be late in the evening or on the week-end or during normal working hours. For practical and economical reasons, requests for repairs that can wait are kept on file and when the list contains several items for one center the maintenance men are sent out to take care of the repairs. The maintenance men are headquartered at Wendover and the centers are several miles away, meaning that the travel time is, in a sense, time lost. So we try and make every trip to an outpost count by doing as many repairs as possible and seeing that maintenance men take with them the materials required to do the jobs. (We aren't always successful but we try hard!). Naturally our two maintenance men are not able to cope with all the problems we encounter. Fortunately the Mary Breckinridge Hospital electrician, John C. Campbell, can come to our aid when needed, as can our FNS licensed plumber, Doc Hacker.

Our maintenance files contain valuable and helpful information. Agnes Lewis, who formerly headed this department, spent countless hours developing a filing system to suit the needs of our scattered properties. As a result of her hard work our job is much easier. We have records of major work done for the past 40 years, and full information on equipment that enables us to get the proper replacement parts when needed. We can look up the sizes of water pipes, find the location of a septic tank, determine how many gallons of paint we must buy to paint the exterior of a center, or how many squares of shingles we will need to re-roof a

certain building—the list is endless. With this information we are also able to estimate costs of major repairs.

And the very backbone of district maintenance is J. G. and Juanetta Morgan, whose unswerving loyalty, and zeal to be sure the districts are cared for, makes this possible,—and is shared by James Stevens, the third member of the team, and their associates Ralph Pace, Clarence Hoskins, and Lawrence Bowling.

"What is the most important thing to me about district nursing? Well, on district a nurse can use everything she knows, every skill she has; she can see the whole picture of the whole district — the total spectrum of health care needs — and set her own priorities for what is most important for comprehensive care for a family, for the whole community."

—A Family Nurse-Midwife

A LETTER WE APPRECIATE

Mary Breckinridge Hospital:

I want to thank all of you that helped me so much in my recent stay in the hospital there.

Dr. Alexander, Dr. Dean, the Lab. technicians, Nancy, the little nurse that worked overtime helping me, and all the staff, nurses aides, and just everyone. They were all so thoughtful and kind. I can't remember all their names, but I'll never forget them in my prayers. I feel like you saved by life.

The doctors and nurses here at Good Samaritan Hospital are wonderful too. I really feel fortunate for such good care.

I'm really proud of our Mary Breckinridge Hospital and the good folks of Hyden.

May God bless everyone.

/s/ Ollie Strange

Buckhorn and Cutshin Clinics

(Independent clinics staffed by Frontier School of Midwifery and Family Nursing graduates, with medical back-up provided by FNS staff)

BUCKHORN

The following description of the Buckhorn Clinic was excerpted from comments during an interview with the Rev. Tim Jessen, Chairman of the Clinic Board, Mary Ann Sparks, Clinic Administrator, and Lucille Lebeau, R.N., C.N.M., C.F.N.P. at the Buckhorn Lake Area Clinic. Buckhorn Clinic is funded partially by an HEW grant.

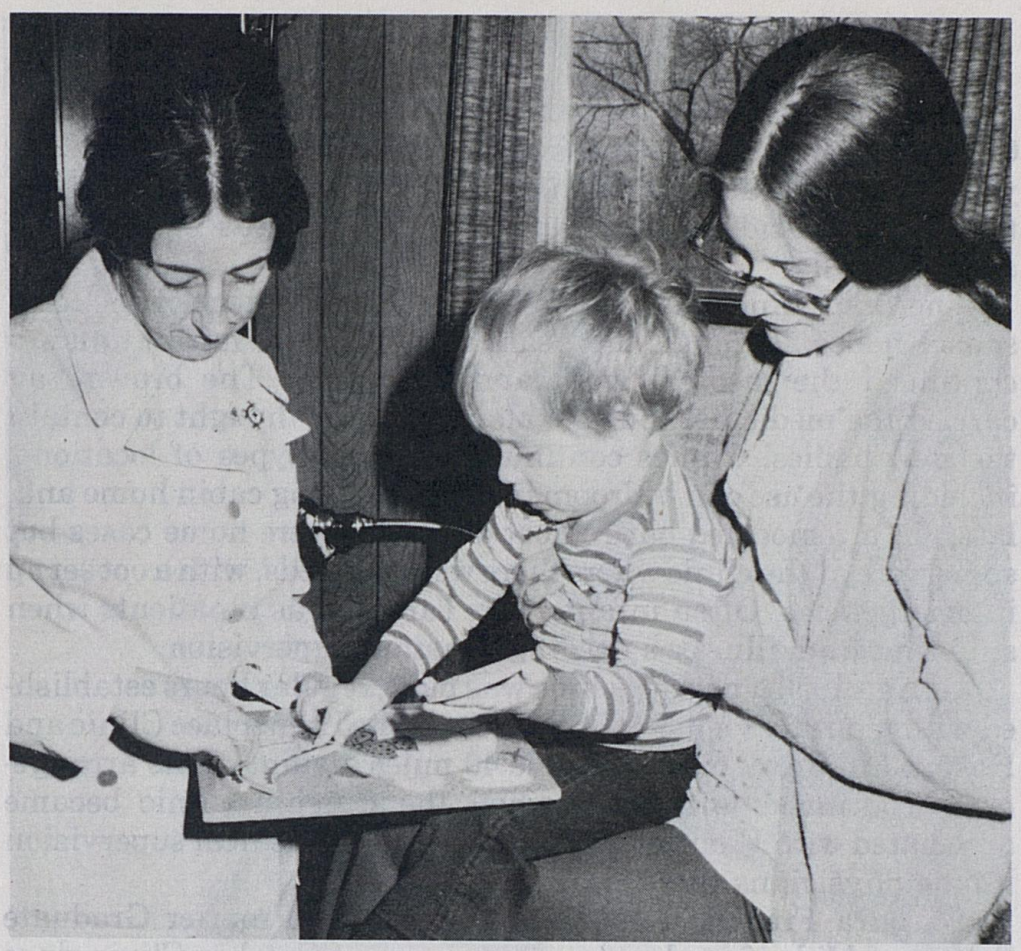
. . . . .

Buckhorn is situated, geographically, in a rather isolated spot. Any way you get here you have to get in over pretty big mountains. Buckhorn is equidistant from several county seat towns: Hazard, Jackson, Booneville. All this means is that the health centers established in the county seats were equally far away from us. Good medical care was available in Hazard and Booneville but not too many patients went to Hyden because the roads were bad.

During the antipoverty days a specific proposal was brought forth that Buckhorn was a natural place to serve a large area that was medically underserved. We formed a committee to propose to the National Health Service Corps that a clinic be established here. NHSC asked if Buckhorn would be willing to take a nurse practitioner instead of a doctor. Things got rolling when we found that a family nurse practitioner from FNS was actually going to come and live here.

The community got involved to get this thing started. There were all kinds of fund-raising activities: pledges of $100.00, a Spring Carnival which netted $2,000.00, bake sales, square dances. The community felt very much a part of the clinic, after having done these things. The services of the Buckhorn Clinic were for other communities as well and, although at the beginning only the people who lived close by were really interested, as time went on and services began reaching other areas, our relationships with other communities evolved.

At the beginning there was no relationship with FNS. It was purely a community sponsored thing. Only after the family nurse



came did details begin working out and we realized we were going to rely on FNS for the clinic's success. Most of the prenatals here went to Hazard for delivery. Now, after they come to Lucille for care, most go to FNS for delivery. The clinic offers pretty much the same services as the FNS outpost centers. Dorothy DeLooff, the first family nurse here, had worked at FNS outposts, as well as in other health care systems, and used parts of all these experiences. Dorothy used the FNS Medical Directives and Lucille, who had also worked at FNS outpost centers, does too.

Dr. Dean comes from FNS for medical clinics two afternoons a month and is available for consultation by telephone at any time.

Our plan for the future is to become financially self-sufficient, and pending national legislation is very important to us in this respect.

CUTSHIN

In 1936 a pioneer work began on Cutshin Creek in Leslie County, now known as the Cutshin Bible Mission. In the early years the area was very much cut off from any medical help and the horseback-riding missionary met many needs with aspirin and soda pills!

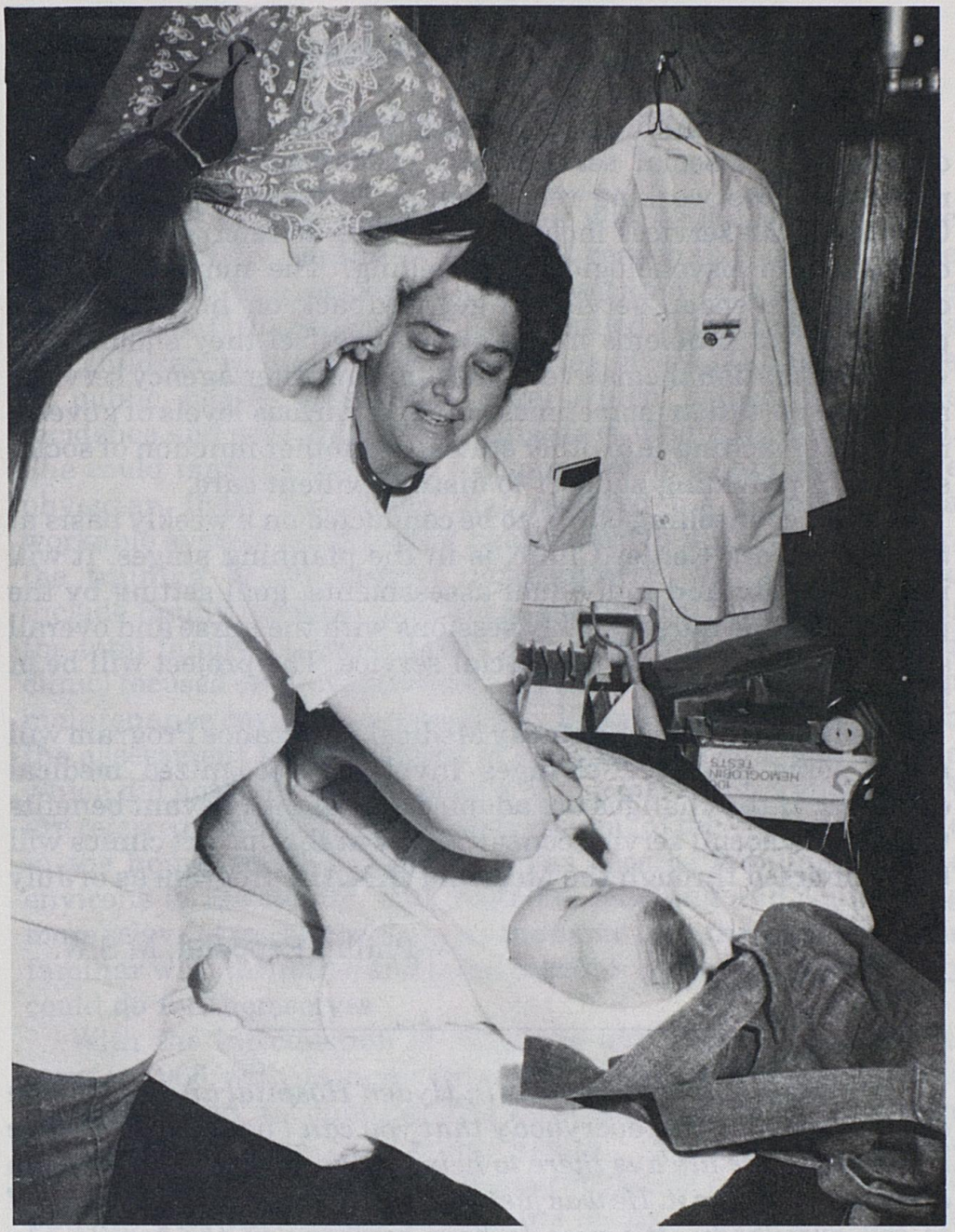
The first clinic was established in the basement of the local school house. Through the years that followed, faithful nurses continued the medical work and midwifery. The brown bag carried the medicines, but the black bag was thought to contain the new babies. Clinics continued in many types of locations, including the use of a bedroom in the nurse's log cabin home and, later, in a remodeled barn. Most deliveries were home cases but some were at the clinic where there were two beds, with a cot set up in emergencies. Often infants were cared for as inpatients when suffering from illnesses needing constant supervision.

During 1956 a new log clinic was built, regular hours established with monthly visits by Dr. Martin of the Homeplace Clinic and Hospital in Perry County (some 40 miles distant). This arrangement continued until 1973 when the Cutshin Clinic became associated with Frontier Nursing Service for medical supervision by the physicians there.

Barbara French, a 1962 graduate of the Frontier Graduate School of Midwifery, has been the nurse at Cutshin Clinic since 1963. In February, 1976, she returned to FNS to enroll in the Family Nursing Program while two other Frontier School of Midwifery and Family Nursing graduates, Lorraine Johnson and Clara Jefferis, staffed the Clinic. Upon completion of the course, Barbara resumed her duties as a family nurse-midwife.

Cutshin Clinic maintains regular hours five days a week. Home calls are made to the elderly on a regular basis, as well as emergency calls. A monthly clinic is held at Big Laurel Mission located fifteen miles away on the edge of Harlan County. Approximately 6,000 patients were seen in 1975, coming from the immediate area and also from Harlan County and distant parts of Perry County.

—Cutshin Clinic Staff
Yeaddiss, Kentucky



"The most important things to a family are births and deaths. If a nurse can cope with these situations, she can make it with her families."

Social Service In The Districts

In keeping with the tradition of district clinic patient care, the department of social services has endeavored to develop and maintain close working relationships with the district nurses. Currently, the services include responding to referrals for financial aid and psychological counselling. The nurses can also consult with social service to get feedback on how to handle psychological problems in the event they feel they should deal with the situation themselves. Coordinating inter-agency services and transportation (sometimes between various levels of government and reaching into other states) is another function of social service in providing support to district patient care.

A pilot counselling clinic, to be conducted on a weekly basis at the Beech Fork Center Clinic, is in the planning stages. It will involve family and individual assessments, goal setting by the patient and the nurse, weekly sessions with the nurse and overall supervision and support by social service. The project will be in full-swing by April 7.

It is hoped that the Kentucky Medical Assistance Program will adopt some proposed changes involving recognized medical expenses. If the changes are adopted, one of the relevant benefits will be that social service consultations at the district clinics will be reimbursed through the Medicaid (KMAP) program as of July 1, 1977.

—Phillip Reppond, M.S.W.

"My great grandfather was in Hyden Hospital and was in the waiting room telling everybody that you can't beat the care there because they're always there to help you and when they try to do anything, they do it. He was just so pleased with Hyden he wanted to tell everybody. It's nice to hear someone in the family say something like that."

—A Leslie Countian and
Outpost Center Employee

The Impact of Legislation on District Nursing

The FNS district nursing system was established to make health care more readily available at reasonable costs and the nurse-midwife was introduced as the most appropriate health care worker to staff the districts. She was skilled in the care of mothers and children, where the greatest need lay. She was knowledgeable in public health (preventive care) which helped reduce the incidence and severity of certain diseases, disability and trauma. She could manage the more common problems and refer to the physician those conditions that required his skill. It was a workable system for bringing health care to a rural area. Later, the training of the district nurse-midwife was broadened to include family nursing, to increase the nurses' skill in the care of the total family. Approximately 30% of district visits (home and clinic) focused on preventive care for the mother and child, 30% on maintenance care of the chronically ill and disabled, and 30% on the assessment and treatment of common ailments and trauma which did not require the skill of a physician. Approximately 10% are referred for medical care. Forty percent of the visits were made in the home, which helped the nurse become familiar with the environs of the family, and made her teaching and counselling more relevant to the problem. At the same time the family become familiar with the nurse and learn from her some of the things they could do for themselves.

With the introduction of Medicare and Medicaid reimbursement in 1966, with its increased costs for health care agencies, this pattern began to change. The only nursing visits that were reimbursable were the "home health" visits ordered by the physician and were limited to the curative care of the homebound patient. The chronically ill and the disabled on Medicare and Medicaid had to travel to the hospital or doctor's office for care unless they were willing to pay for it themselves. This caused a reduction in preventive and health maintenance care. With the opening of the new hospital in 1975, with a larger physician staff whose services were both necessary for utilization of the increased number of beds and reimbursable by Medicare and Medicaid, this

pattern has intensified. Home visits were reduced. This decreased the opportunity for providing and reinforcing the need for preventive and health maintenance care. With increased district fees to cover costs, patients were more apt to postpone care until the illness became more critical. The more acute the illness, the greater is the need for physician care, and greater the cost to both the patient and institution.

These factors produced major changes in the provision of health care. Total district visits dropped from 34,555 in fiscal year 1974 to 23,921 in fiscal year 1976. Hospital outpatient visits during the same period increased from 24,415 to 31,745. The most marked decline in district visits occurred in the 15 and under age group — from 12,046 visist to 6,402; and in nurse-midwifery visits which declined from 4,718 to 2,415. These are the two population groups that are most responsive to preventive services. The number of district visits to the sixty-five and over age group remained the same but "home health" visits for curative care increased from 3,047 to 5,404, with a concommitant decrease in maintenance care.

Hospitalization of the sixty-five and over age group has increased by 40-50% between 1974 and 1976 at FNS. A study of diabetic care[1] provided by FNS in 1974 indicated that hospitalization of the diabetic patient could be reduced by 70% with a concurrent reduction in diabetic-related complications. Seventy-four percent of the care was provided by the nurses, with a heavy focus on preventive and health maintenance care. This resulted in a major reduction in health care costs. Average cost per diabetic per year was $309.00, including hospitalization, outpatient care, drug and laboratory costs. Nationally, the average cost for hospital care *alone*, at $118.00 per day, was $637.00 per year for the diabetic patient. Dr. John Runyon[2] of Memphis, Tennessee, has shown similar results in his program of care of the chronically ill but further studies are needed of other chronic conditions to determine their responsiveness to preventive and maintenance care.

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[1]Gordon, Karen, and Isaacs, Gertrude. "Reduced Hospitalization through Decentralized Care of the Chronically Ill"; Paper submitted and accepted for publication. Aspen, Inc.

[2]Runyon, John W., M.D. "Ambulatory Health Care Approach to Chronic Illness"; Paper presented at the Naval Regional Medical Center, San Diego, Calif., Feb. 12, 1976.

Findings such as these raise serious questions about the economics of the present health care system. At question is a reimbursement system that focuses on curative care to the exclusion of prevention and maintenance and on centalized medical care in preference to decentralized health care.

Legislation has been introduced this year for the reimbursement of family nursing which includes preventive and health maintenance care, and may soon be a reality. Both the House and Senate have introduced bills for Medicare reimbursement for the "physician extender" which includes the family nurse. This legislation is restricted to rural health clinics. The House bill further restricts reimbursement to the non-physician directed clinics where no physician is directly available for supervision. These restrictions were considered essential because of the limited funds available at this time. Neither bill will, however, supercede state laws or state regulatory mechanisms regarding the use of "physician extenders".

There is still some lack of clarity in the Kentucky law regarding the use of the family nurse. Medicaid reimbursement has been approved for the family nurse through Kentucky Primary Care Center Licensure Regulations. The State expects this program to be implemented in July, 1977. Should the Medicare reimbursement be approved as introduced, and Medicaid reimbursement be implemented as proposed, the FNS district nursing system would again be able to function as originally designed. Preventive and health maintenance care could be reinstated to its former preeminence; district visits, including home care visits, could again come to the forefront; and the overall costs of health care be reduced. True, this would cover only those patients that have Social Security and Public Assistance Benefits, but it is a major step forward in the recognition of the primary care nurse and her potential contribution to health care. Much more remains to be done before such care can become a reality for all citizens.

—Gertrude Isaacs, D.N.Sc.

ON BUILDING A CENTER

By Gladys M. Peacock

When joining the staff of the Frontier Nursing Service most of the nurses think that all they need in preparation is a three year hospital training, public health experience, and a midwifery certificate, but after we had been in the hills a few weeks we thought differently. To be a good nurse in the mountains one needs, besides the above qualifications, to be horsewoman, stable boy, mechanic, carpenter, plumber, acrobat, teacher and bluffer. . . .

We had been riding the trails just two months when our director told Miss Willeford and me we were to go to Beech Fork to open up a new center, the first to be built. . .

On the first morning we arrived at the site at seven o'clock and found twenty-five men all waiting to work and all waiting for us to tell them what to do, and we did not know anything ourselves. We laid the plans on the ground and pored over them. We finally made out enough to get the men started. We divided them up—half were to dig the foundation for the barn and the other half were to cut down the trees on the house site.

All the men were busy when the foreman came up to me and said, "What about sills?"

"What about what, Mr. Hoskins?"

"Sills."

I felt swamped. What were sills? Surely he couldn't be talking about window sills yet, before the foundations were dug. I looked wise and thoughtful.

"Well, Mr. Hoskins, I'll ask Miss Willeford. Mrs. Breckinridge may have said something to her about them."

I climbed up the hill to the barn site and found Willeford and called her to one side.

"Willeford, what about sills?"

"What about *what*?"

"Sills."

"What the dickens are sills?"

I wished I knew! I said: "Well look here, old sport, Mr. Hoskins has asked about sills and we can't let him think we don't know what they are. "Well, come on, let's bluff. You start."

We scrambled down to where the foreman was standing.

"Mr. Hoskins, Mrs. Breckinridge didn't say anything to Miss Willeford about sills." Willeford chipped in very casually, "Er—what do you suggest, Mr. Hoskins?"

"Well, I reckon you can get all you want off Luther Moseley's land. He said you could have all the timber you needed."

We delegated four men to go with Mr. Hoskins and we followed slowly at some distance away. We were certainly going to learn what a sill looked like. Soon two enormous trees came rolling down the hillside. Sharp blows of four axes rang out. Little by little, slowly and evenly, the men hewed until the two large trees were made into four even blocks of thirty feet long and eight inches deep. So these were sills. The whole of our house was to rest on these blocks. No wonder Mr. Hoskins thought these important. From now on we would too!

Excerpted from The Quarterly Bulletin of the Frontier Nursing Service, Inc., Volume 25, Number 1, Summer, 1949

CHANGE SHOULD BREED CHANGE

New doth the sun appear,
The mountains' snows decay,
Crown'd with frail flowers forth come the baby year.
My soul, time posts away;
And thou yet in that frost
Which flower and fruit hath lost,
As if all here immortal were, dost stay.
For shame! thy powers awake,
Look to that Heaven which never night makes black,
And there at that immortal sun's bright rays,
Deck thee with flowers which fear not rage of days!

—William Drummond
1585-1649

(The above was found—marked—in Mrs. Breckinridge's copy of the OXFORD BOOK OF ENGLISH VERSE, a gift to her from her mother on her 31st birthday, February 12, 1912, Ft. Smith, Arkansas.)

URGENT NEEDS

For District and Home Health Agency Staff:

20 inflatable face masks for emergency cardiopulmonary resuscitation (CPR). Cost ..... **$ 100.00**

For Frontier School of Midwifery and Family Nursing:

Installation of a one-way microphone from the delivery room to the observation room—for teaching purposes for nurse-midwifery students. Materials and labor ..... **$ 200.00**

For the Maintenance Department:

1 7 inch circular saw. Cost ..... **$ 50.00**
1 Variable speed sabre saw. Cost ..... **$ 54.50**

For Primary Care Center Extensions:

6 hand-held, mini-cassette Stenorette tape recorders (replacements) at $150.00 each ..... **$ 900.00**
6 pocket calculators at $20.00 each ..... **$ 120.00**

RADIO SPOT: Heart Attack Explanation

Narrator: When you turn on your faucets, you expect water to come out, and you would probably be very angry at someone who plugged it up with mud. Now when you heart pumps out blood, it expects blood to come back. If blood is plugged up somewhere in a blood vessel and doesn't come back, your heart will be more than just angry. Part or all of it will die. That's called a heart attack. Some people plug up their own blood vessels by eating large amounts of food with sugar and food like lard with lots of fat in it. Hearts don't mind a little sugar and fat, but too much may be harmful. How happy is *your* heart with what *you* eat?

This message is brought to you as a public service by the Frontier Nursing Service.

OLD COURIER NEWS

From Annie Carrithers ('71) in Powell River, B.C., Canada

I'm still living on the coast of British Columbia but doing a lot of traveling. When I need work or just want to (!), it's relatively easy to get on as a cook in the woods around here. Things are going well and there's lots to learn.

. . . . .

From Ann Proctor ('74) in Washington, D. C.

Tomorrow night I'm having dinner with Mary White who has just been a courier with you. I want to catch up on everything she did. Washington is practically paralyzed what with Inaugural activities and ice, but we are going to try to get to a Bluegrass concert which is being given as one of many Inaugural activities.

. . . . .

From Alison Bray ('38) in London, England

My time with you seems like a dream now, but it was fun and I am so grateful to you for giving me such a good time. The rest of my trip went very well and I had a lovely weekend with Gib and Bee McIlvain, as well as my visits with Agnes Lewis and Dorothy Breckinridge. Cynthia [her niece, Cynthia Bray ('75)] is flourishing.

. . . . .

From Marianne Mayer Fuchs ('68) in Madison, Wisconsin

After graduating from Beloit College, I went on to nursing school and received my B.S.N. in 1975. Now I work in the labor and delivery rooms of a Madison hospital. My husband finishes law school this spring and among other alternatives, we are considering the possibility of moving to Hyden so that I could re-join the FNS, in a professional capacity this time! At any rate, I have written for information about opportunities in nursing there and Gil and I plan to visit Hyden while on vacation.

. . . . .

From Margo Squibb ('77) in Middlebury, Vermont

College life has been fun, but incredibly busy. My classes are all interesting and the work is challenging and the quality of teaching is very high here. However much I learn here, in my mind it will never compare with what I learned in Kentucky. I really hope that I can come back some day as I was just beginning to feel at home when I left. Wendover is always in my mind and I hope I can come and visit sometime — maybe this spring.

. . . . .

From Lisa Greene ('76) in Sevilla, Spain

All the flowers are coming out in Sevilla now and I keep thinking about the dogwood and redbud of the hills. The other day I found a burning bush, just like the ones in front of the Big House! School is going well and I'm also taking a Spanish Flamenco dance class and teaching two kids English two hours a week. This Friday I am going to Cordoba with our Art History teacher and will leave from there to spend the following week in Madrid with a friend. I still remember going to all these places with my family when I lived here before, but I know I'll appreciate them much more now, ten years later. My parents are coming to visit. We'll spend a few days here in Sevilla and then go up to Pamplona to visit old friends. I think about you all often.

. . . . .

Babies

Born to Mr. and Mrs. David Shaw (Heather Anne Johnson '70) a son, Michael Lewis Shaw, on January 7, 1977, at Queen Charlotte's Hospital, London, England. (See Old Staff News). We congratulate the young gentleman and his parents!

Born to Mr. and Mrs. James E. Davis (Julie Breckinridge '67) of Vestal, New York, a daughter, Julia Harrison, on March 3, 1977. This young lady is a great, great niece of the late Mrs. Mary Breckinridge.

. . . . .

Carrie Lou Morgan Parker ('66) of Gaithersburg, Maryland, is now on the staff of the Crime Laboratory/Inspection Service in

Washington, D. C., and has recently become a member of the FNS Washington Committee.

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Candy Dornblazer Steele ('53) of Palo Alto, California, writes that she has decided to go back to school for a master's in maternal-child nursing, hopefully this fall at the UC Medical Center in San Francisco. Since twenty-five year old exams don't count, she must take elementary algebra again, to get ready for the Graduate Record Exams, and statistics!

NURSE MIDWIVES LISTED BY *MEDLINE INDEX MEDICUS* AND *INTERNATIONAL NURSING INDEX*

You will be pleased to learn that one has been able to retrieve citations from MEDLINE with the subject heading Nurse Midwives since January 1975. The MEDLINE file now cites 72 articles that mention this subject, including 31 in which this subject is the central theme of the article.

During 1975-76, articles on Nurse Midwives appeared in *Index Medicus* under the heading of Nurses, to which Nurse Midwife was a cross reference. However, in January 1977 we made Nurse Midwives a full subject heading for *Index Medicus* use, as well as for MEDLINE. It just happens that no articles on this subject were indexed for the January and February 1977 issues. As soon as one comes along, it will appear in *Index Medicus* under the heading Nurse Midwives.

Some of the journals that we index for MEDLINE are not included in *Index Medicus*. However, all of the citations appear in the International Nursing Index as well as MEDLINE. The International Nursing Index is published quarterly, with an annual cumulation, by the American Journal of Nursing Company in cooperation with the National Library of Medicine.

Clifford A. Bachrach, M.D.
Head, Medical Subject Headings
National Library of Medicine
Bethesda, Maryland.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
ROCKVILLE, MARYLAND 20857

BUREAU OF COMMUNITY HEALTH SERVICES

FEB 17 1977

W. B. Rogers Beasley, M.D.
Director
Frontier Nursing Service, Inc.
Hyden, Kentucky 41749

Dear Dr. Beasley:

The President has asked me to thank you for your letter of January 28. He is most appreciative of your kind invitation, but regrettably he and Secretary Califano will not be able to visit with you and members of the Frontier Nursing Service staff in the foreseeable future.

President Carter and the Public Health Service are aware of the important contribution that the Frontier Nursing Service has made to the provision of primary care services to communities in Southeastern Kentucky. The approaches to the provision of health services to underserved and isolated rural areas that your organization has employed over the years have impacted on the concept and development of primary care services and attendant models for outreach well beyond the borders of Leslie County.

In closing, the President and the Public Health Service share your commitment to address the serious health problems confronting rural and economically depressed areas across the county.

Sincerely yours,

Edward D. Martin

Edward D. Martin, M.D.
Assistant Surgeon General
Director

YESTERDAY, TODAY, TOMORROW

by Anne A. Wasson, M.D., A.B.F.P.

The Elizabethan expressions of yesterday are still heard in the mountains and, as students come to the Frontier School of Midwifery and Family Nursing, a listing of local terms is given them to help them understand the language of the area.

Today the liberated world has a new language requiring more than a list, more than an up-to-date dictionary.

We work through and develop nursing processes and objectives, have daily concurrent reviews regulated by the new UR Regs. and do retrospective audits to meet Joint Commission and Medicare-Medicaid requirements. UR Regs. will soon be obsolete and we hope to become a delegated KPRO hospital in May. At that time the Health Care Coordinator (HCC) will be able to assign a length of stay to a patient admitted according to criteria set up by the medical staff. She may assign to the 90th percentile, if the admission diagnosis falls in categories 1, 2 or 3. She must get further definition of assignment from her Physician Advisor if the patient falls into category 4.

The Health Record Analyst (HRA) gathers data for audit review from the PAS-QAM system provided by CPHA from coded data on all inpatients. The codes generated from the hospital chart will give us answers on an A, B or C form, indicating disease by H-ICDA code, age/sex distribution, test information and treatment. Data is generated and computerized for audit studies, research and government reports.

Activities of planning for innovative changes, structural control for credentialled organizations, delivery control by concurrent activity and correction of risk factor, admission validation and continued stay reviews for quality control and retrospective studies, are part of the daily life within the hospital for medical and ancillary personnel. All of this is part of the accountability process.

Computerized data is a necessary tool of the modern world to do meaningful research, complete audits (required by law), and to provide quality patient care, removing possible risks to the people for whom we care. It is predicted that more and more computerized information will enter the medical scene. This means that health care workers must add to their already full armamentarium of medical knowledge an understanding of statistical analysis and systems methods. This is necessary to ask the proper questions of the computer and to code the information correctly, making the reams of print-outs useful. Means, modes, rates, percentiles, statistical sampling units, are now necessary for study of hospital inpatients, as well as epidemologic studies of disease caused by environmental contaminants.

In the 1930's, President Roosevelt created an "alphabet soup" of such as the WPA, PWA, NRA, NYC, CCC, etc. Today the alphabet soup is forever expanding and language is littered by letter designations for agencies and individuals within the agency.

I was once asked if I called my patients "clients". To my lawyer I am a "client" but, even in this enlightened day of a new language, I hope I am still a "patient" to my doctor.

For today and tomorrow I must, of necessity, understand the language of the process of quality control for patients. But I hope I will continue to hear the Elizabethan expressions of yesterday in these mountains.

RADIO SPOT: Seat Belts for Peds

Sound: Auto wreck

Narrator: The number of children killed by every kind of disease known to man does not even begin to equal all the children killed in automobile accidents because they did not wear their seat belts. It only takes a few seconds for your children to be thrown against the windshield during a car crash. Before you turn the key, take those few seconds to buckle their seat belts. It could save your childrens' lives.

This message has been brought to you as a public service message by the Frontier Nursing Service.

RADIO SPOT: Reducing Salt

Music: "Chestnuts Roasting on an Open Fire."

Announcer: There's usually more than just chestnuts roasting when it comes around to holiday meals. But, whether it's roasting or not, some food, like garlic, popcorn, potato chips, pretzels, salted nuts, and olives, is naturally high in sodium salt. Too much sodium salt is one of several factors that increases your chances of having high blood pressure, or hypertension. And, high blood pressure is one factor leading to a stroke. Think about it next time you say pass the salt.

This message is brought to you as a public service by the Frontier Nursing Service.

OLD STAFF NEWS

From Dorothy Degnitz in Wapenamanda, New Guinea — December, 1976

I'm still working and teaching student nurses and paramedical workers here at Wapenamanda. Sandra Rhodes is planning a home leave this coming year and Nancy Leland Michan and family are leaving for the U. S. A. next week. They expect to settle in Ohio. I had a nice visit with Sandra Tebben in Nigeria this year before returning home for a short six week visit.

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From Cynthia Waller in Grand Rapids, Minnesota —December, 1976

Well, I'm finally an official R.N.! I'm working in Duluth, at a large hospital on the neurology unit. Needless to say, the job is stimulating and I'm learning tons and tons. We just switched over to total patient care which keeps us all running. I plan to stay about a year, then, hopefully, I can get into some type of community nursing or public health — maybe even rural nursing. Life has been extremely good to me this last year, and I have what seems to be an exciting future before me. I also have some fine memories of my summer at FNS.

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From Harriet Jordan Palmer in Los Altos, California — December, 1976

If all goes well I hope to drive east in July and August and drop by FNS. Have been accepted for the first review class in nurse-midwifery in San Francisco at the University of California. Needless to say, I am ecstatic! Finish in June and will be back to birthing. Childbirth education is exploding here and I love it. Teach a lot, occasionally attend births, aid the transition to parenting and push the professional community to move faster with progress and family centered maternity care.

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From Florence Walter in Jos, Nigeria
—December, 1976

I am not currently doing maternity work but am the School Nurse for a cooperative mission school — some fourteen or more missions and/or denominations cooperating with a total enrollment of about 450 children, in all twelve grades. Founded for missionary kids, it also serves the community with many day students from the homes of government personnel and businessmen and women. Some twenty or more nationalities are represented. I have a 12-bed sick bay (2 wards), nice dispensary and a dental clinic served by a mission dentist who visits the school one month of each semester. I really miss the maternity work but find real joy in this work as well. I appreciated the training I received at FNS.

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From Shirley Heisey in Lebanon, Pennsylvania
—January, 1977

My time at home is almost at an end and I leave on the 15th for Zambia. I will be serving at Macha Hospital again, but not in an administrative capacity at this time. There are more nurses than there were but fewer midwives and our maternity work has been growing with more than 500 deliveries in 1976. I am the only midwife from the states but there are two from Holland and two Zambians.

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From Susan Hull in Newtown, Connecticut
—January, 1977

I can't believe all the adjustments I have been forced to make. I really think life is much simpler in Nicaragua! I just don't get along in a machine-oriented world. Yesterday the time clock ate my time card and it took three people to get it out. I work on a post-intensive care unit. All the machines are buzzing and flashing at you all the time and more attention is paid to the machine than the patient. Maybe if the patients flashed and buzzed they'd get better care! But there is a lot to learn so I am trying to make the best of it. I am enjoying being with my family as it has been years since I have had any time with them.

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From Judy Haralson Rafson in Berea, Kentucky — January, 1977

We are enjoying Berea but there are moments when I do miss FNS. I'm busy with a fourteen credit hour load at Eastern Kentucky Universtiy plus working six to eight hours a week for the Mountain Maternal Health League doing family planning annual exams, checking patients with problem symptoms and doing the IUCD insertions — enough work to keep me from getting totally rusty, yet a flexible scheduling system worked around my class schedule.

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From Margaret Bartel in Johnson, Kansas

I will soon be leaving for a three year term of mission service in Central America. My address after April 28 will be Apartado 4520, San Jose, Costa Rica.

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From Frances Crawford in Columbia, Missouri

I came home on furlough from Honduras in November. My furlough was to have begun in August but I was in the process of adopting a Honduran baby. The family brought him to me when he was eight months old. He weighed eight and a half pounds and couldn't raise his head and was almost dead of diarrhea, pneumonia and severe anemia. I took him home for a blood transfusion, TLC and lots of food. By the time I was planning to leave for the U.S., his family (his mother had died when he was born) insisted I take him with me and the American Embassy wouldn't let me without legal adoption complete. Daniel Jeremiah Crawford is now twenty-eight months old. He has blonde hair and big brown eyes and dimples and he is quite a handful! He has complicated the life of this "old maid" in more ways than I dreamed possible but I love and enjoy him more each day. We got home and I began to search for graduate schools. The University of Missouri School of Nursing offered me a teaching job immediately and help to get my master's. At present I'm an Assistant Instructor in Maternal-Child Health and hope to be a full-time graduate student by September and to stay in the U.S. until I get my M.S. I'm enjoying the students but find the language

nursing educators use today the hardest part for me to learn! I'm also getting a refresher course in relationships between nursing education and nursing service.

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From Joyce Stephens in Newent, Glos., England — January, 1977

"Foxleaze" (her new home) is in a beautiful spot, at the end of a little lane, near the top of a slope running up a long wooded ridge. The house faces south along the hillside and eastwards there is a most lovely sweeping panoramic view across the Severn Valley to Bredon Hill, the Cotswolds, etc. The house is situated in the middle of one acre — half an acre behind is orchard which is kept mown by a farmer's sheep — a great help! The other half acre is to the front and I'm developing that. We were moving shrubs right up until December when the ground froze.

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From Nancy Sandberg in Addis Ababa, Ethiopia — February, 1977

I am very thankful for the years I have spent at FNS. Everything I learned there has been useful here. We're seeing over 2,000 patients a month and don't have an M.D. — so I am finding the experience gained in the practitioner course very valuable. I work with five dressers and several other auxiliary workers. We have a good relationship so work is enjoyable.

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From Clara-Louise Schiefer Johnson in Moorestown, New Jersey — February, 1977

Our first grandbaby is three weeks old today! Our daughter, Heather Anne Shaw, had a son, Michael Lewis Shaw, on January 7 (See Old Courier News). Her husband, David Shaw, was with her the whole time which she *much* appreciated. Eric and I are thrilled to be grandparents and can't wait to see this dear baby. I'm flying over next month for a visit.

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Born to Mr. and Mrs. Paul Watts (Janet Dunlap) of Waseca, Minnesota, a daughter, Catherine Lynn, on December 5, 1976, weighing 7 lbs. 7¼ oz. Both parents and the paternal grandparents, Mr. and Mrs. Ed Watts of Hyden, are, or have been FNS employees.

Their many friends among the old staff will be saddened to learn of the deaths of **Ruth O. Boswell** of Newton, Massachusetts, and **Betty Scott Jakim** of Ann Arbor, Michigan. Ruth was with the FNS in 1945 and 1946, first as the Hyden Clinic nurse and, later, as a student in the Frontier Graduate School of Midwifery before going on to a distinguished career in public health nursing. Scotty first joined the FNS staff in 1947, completed the nurse-midwifery course in 1950, and, during the next few years, efficiently and cheerfully filled many positions in the FNS—as a "floater" on all districts, as the Beech Fork district nurse-midwife, as Hospital Midwife and relief Hospital Superintendent.

Our sincere sympathy goes to Ruth's and Scotty's families.

RADIO SPOT: Well Child Checks #1

Sound: Baby crying

Narrator: Babies can't talk or complain. They can only cry if they are not happy. Babies cannot tell you they feel sick, they know nothing about worms or whooping cough or lockjaw. If you have children, make sure they are protected through well child checks. Well child clinics at the Mary Breckinridge Hospital in Hyden and district clinics are held Monday through Thursday in the mornings and afternoons. During a check, your child's growth and development is evaluated to see if your baby is doing things that are normal for his or her age group. For more information on well child checks, contact your family nurse or doctor.

This announcement is brought to you as a public service message by the Frontier Nursing Service.

MARY BRECKINRIDGE HOSPITAL ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

WE PASSED! That was the good news conveyed to the staff of Frontier Nursing Service by the Director and the Hospital Administrator upon receipt, in early March, of the report of the Joint Commission survey conducted in November 1976. The letter of notification to Dr. Beasley from the Director of the Department of Accreditation Programs of the Joint Commission, A. Walter Hoover, M.D., said, in part:

> "The Joint Commission on Accreditation of Hospitals is pleased to inform you that your hospital has been awarded two-year accreditation. This decision was reached by the JCAH Board of Commissioners after a review of the findings from the most recent survey of your hospital. Through the award of accreditation, the Joint Commission commends your efforts toward providing patient care of quality.
>
> "Among the important elements in the meaning of voluntary accreditation are substantial compliance with the standards, and continual progress toward optimal conditions. As a condition of two-year accreditation, your hospital will be required to conduct an Interim Self-Survey on or about the first anniversary of your last survey. At that time, you will be sent a form on which to report your progress toward implementing the enumerated recommendations."

It is particularly gratifying to the FNS to have received full, two-year accreditation the first time that the Service asked for the Joint Commission survey of its hospital, especially since it is unusual to gain two year approval on the first try. This accreditation will reduce the number and intensity of government inspections of the facility and indicates that the quality of care we provide is equal to the quality provided by university hospitals which are accredited by this same commission.

BEYOND THE MOUNTAINS

For its annual meeting at the English-Speaking Union on February 9, the New York Committee invited the National Chairman, Kate Ireland, and me to report on the field work of FNS and to join the committee at a reception afterwards. Mrs. R. McAllister Lloyd, our energetic and staunch New York Chairman, introduced Katie who emphasized the timeliness of the services provided by FNS. The fifty year demonstration of family care through nurse-midwives and specially trained district nurses is an example that is being much studied by those responsible for contemporary delivery of health care.

Katie pointed out that the new Mary Breckinridge Hospital has required a vast increase in staff and is in the process of resolving problems common to all new hospitals, chief among which is how a large new facility, during its start-up period, throws the budget off balance.

Miss Dorathea Eberhart, Chairman of the famous New York Bargain Box activities, modelled a charming sample of the Bargain Box contents, a Bonwit Teller frock for $10.00, and presented the National Chairman with a check for $1,500. She discussed the pleasures and problems of volunteer work at the Bargain Box and earnestly sought more recruits.

The entire committee was excited by the needlepoint rug being created for sale by the Philadelphia Committee. Mrs. Robert Gawthrop, chairman of that committee, and her daughter displayed the exquisite completed central section of the rug and sold tickets.

During the question and answer period, thanks to former staff member Margaret Hobson, we reported to the committee Brownie's award from the American Nurses' Association and the C.B.E. from Queen Elizabeth II. Dr. Helen Tirpak of the FNS National Nursing Council, who wrote her thesis on the FNS, was there to catch up on the latest developments. Brooke and Betty Alexander, who had been such wonderful hosts the night before, personally introduced me to several of the committee members whom I had not met before. Old courier Anne Rose Stewart and her daughter Amy were there and I had the pleasure of interviewing Amy as a potential courier. I was especially delighted to meet the mother of Horace Enriques, volunteer EMT of last

summer, who is planning a tea for FNS in the Greenwich area later in the spring.

Following the reception, Katie took Dr. Kenneth Warren and me to the new production of Le Prophete at the Metropolitan. Dr. Warren, a former classmate from the London School of Tropical Medicine and Hygiene and an old friend and visitor to FNS, has recently been appointed the new Medical Director of the Rockefeller Foundation. He introduced me to Dr. John Knowles, President of that Foundation, who recollected Brownie's visit with him when she spoke on FNS at the Massachusetts General Hospital several years ago.

New York brought pleasures such as comparative pricing on Volkswagens which are $150.00 cheaper in New York than they are in Kentucky, and a reception at the United Nations with another former classmate, Presiding Bishop John Allin. An evening with Brooke and Betty Alexander is always a joy, for Brooke, as a former Governor of FNS, is particularly helpful in reviewing our plans and problems. Kate was most grateful for the opportunity to talk further with members of the New York Committee at a luncheon given by Mrs. Lloyd on February 10.

All of our committee members had been written in February requesting that they write their congressmen asking support of House Bill 2504, introduced by Mr. Rostenkowski of Illinois. This bill will modify the Medicare Act and authorize payment of rural health clinics for the services provided by nurse practitioners and physician assistants to Medicare patients. This would mean that the services of our district nurses would then be reimbursable. The response from the committee members has been great and I hasten to thank every one.

On Monday, February 28, a one day hearing of this bill was scheduled by the Subcommittee on Health of the House Ways and Means Committee. FNS was among the groups who responded to the invitation to testify concerning the bill. Others included Senator Clark from Iowa who is presenting a similar bill in the Senate, Johns Hopkins University, the American Medical and American Nurses' Associations and four rural programs in east Kentucky and Tennessee. The Governor of North Carolina emphasized the urgency of this bill in that clinics are closing in those poor areas where there is no third party support. With pleasure I noted that data from the FNS which had been presented

by Dr. Gertrude Isaacs at a previous hearing of this committee was cited by three different individuals during the course of the day. Dr. Isaacs and Karen Gordon demonstrated that because of the home and clinic care of diabetic patients by FNS family nurses, the hospitalization of diabetics in this service area is 70% less than that of the average diabetic in the United States.

On Saturday, March 5, Dr. Isaacs, Lillian Link Levine, (a student in the School), Tina Guy, (the Flat Creek district nurse), Helen Stuckey, (a Home Health nurse), and I participated in a Joint Practice Conference in Louisville called by the Kentucky Medical Association and the Kentucky Nurses Association. This conference focused on the complementary roles of medicine and nursing in providing total health care. It emphasized that part of primary care where these professions overlap and a detailed discussion was led by members of the National Joint Practice Committee, one of whom was Dr. Flood, President of the West Virginia Medical Association. An example of nurse practitioners and physicians working together in Morehead, Kentucky, was reviewed thoroughly. The group recommended that Kentucky hospitals consider establishing a Joint Practice Committee to clarify the joint practice of nursing and medicine in the hospital. Nurses have a strong role in "caring" for patients which they are able to do independently. Both nursing and medicine cooperate in the curing activities of health, but the "cure" of complicated diseases is solely the responsibility of the physician. These and other aspects of Joint Practice were discussed. We were proud that the Mary Breckinridge Hospital Medical Staff By Laws include an Article identifying nurse-midwives as colleagues of the medical staff. The former inclusion of an Article indentifying family nurses as colleagues of the medical staff had been removed at the recommendation of local Medicaid surveyors. With the accreditation of the hospital by the Joint Commission, re-inclusion of the Article is under consideration as a re-emphasis of our commitment to Joint Practice.

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Governor Carroll's Task Force on the Reform in Welfare Legislation held an open hearing at the Capitol in Frankfort on March 15. This meeting was chaired by Senator Thomas Ward and included representatives from District IV of HEW. The

restrictive influence on the provision of health services under the present Social Security legislation was the theme of the presentation from Frontier Nursing Service. We emphasized the need to provide reimbursement to family nurses and nurse-midwives for the preventive and curative services which they are providing in medically underserved areas. In asking about the FNS, Senator Ward cited his friendship with Dr. Alexander of our medical staff and discussed the historical background with British midwifery, enabling us to describe FNS to those at the hearing. This was followed by an enthusiastic round of applause for the work of Frontier Nurses. In commenting on the hearing, Commissioner Gail Huecker of the Bureau of Social Insurance, pointed out that the need for employment and the need for good housing is as significant as the need for manpower to assure optimum health for a community.

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Upon the recommendation of Mrs. Burgess Standley, Chairman of the Development Committee of our Board of Governors, a group of four Governors and one staff member attended an intensive one-day seminar on deferred giving, emphasizing the "unitrust" approach, by the Philanthropy Tax Institute. This was held at L'Enfant Plaza in Washington and demanded the full attention of National Chairman Kate Ireland, Mrs. Standley, Mrs. William Street, Miss Helen Browne and Dr. Rogers Beasley. A report of this seminar will be considered by the Board of Governors at its April meeting and will doubtless be of importance to our program.

While we were in Washington, Mr. and Mrs. H. H. Newell of the Washington Committee entertained the Committee as a compliment to this visiting group. The party enabled us to renew old friendships and meet many committee members whom we did not know. Mrs. Kloman, the committee chairman, asked that we review the concern of FNS for contemporary health legislation which will lead to the reimbursement of family nurses, nurse-midwives and other physician extenders. At the party Brownie introduced Carrie Morgan Parker and her husband, George. Carrie is an FNS baby and former courier whose mother was an early staff member.

—W. B. R. Beasley, M. D.

HEALTH CARE LEGISLATION AND PHILANTHROPY

By Theodore Cooper, M.D.
Former Assistant Secretary for Health of the
U. S. Department of Health, Education, and Welfare

The Hon. Tim Lee Carter, Representative from the Kentucky Fifth District, introduced into the *Congressional Record* on February 9, 1977, the following speech made by Dr. Cooper at the 10th Annual Conference of the National Association for Hospital Development held in Houston, Texas:

I am very grateful for the honor of having been named to receive the Association's Achievement Award for 1976. There are a great many people in this country who have made very substantial contributions to preserving private philanthropy as the keystone of the American voluntary health care system. A lot of them are in this room, and I am proud to be in your company.

The 1976 Achievement Award could rightfully go to any of you — or to all of you. But I am glad to accept this distinction because there is no one here who feels more strongly than I do that private philanthropy — for its own sake and because of what it represents in American society — is a priceless resource and one that we must never abandon, either by design or by folly.

I know quite well that there are those who believe that philanthropy has a short future in the American health system, that the certain arrival of national health insurance will mark the certain departure of voluntary giving.

Let me just say that while I understand the thinking behind that prognosis, I also understand the major and undiminished need for philanthropy in the health field. And I think I appreciate, as well as anyone does, the irreplacable loss that the health care system would suffer if national health insurance or any other manifestation of social or economic policy brought an end to the tremendous rewards that accrue from the voluntary donation of funds and personal energy in the spirit of philanthropy.

Such a loss to the health care system might be calculated in dollars, but it would be reflected in research not carried out, services not provided, and innovations not exploited.

In short, the loss of philanthropy would hit hard at the very places where our health care system is most in need of creativity

and freedom, in the places where new ideas and new approaches to old problems can lead to needed change.

And without the capacity for change, the health care system would be in grave danger.

In the last decade, we have seen enacted more health legislation of more far-reaching consequences than ever before in the 200 years of our country's existence. In the spirit of assuring to every American a right to health, we have legislated and implemented vast programs that run the gamut of the whole health enterprise — from the pursuit of basic knowledge to the provision of care for millions of people who might otherwise not have equal access to it.

I do not have to recite that parade of laws — indeed there isn't even time enough for me to do it. But I would call your attention to a subtle but vastly important change that has occurred in the form and intent of this legislation.

Broadly speaking, we have moved from legislative action whose intent was primarily to make health care more plentiful and more available, to legislation that seeks to constrain the growth and function of the health care system, to increase its productivity, eliminate unnecessary utilization, and improve the quality of care.

It is not an oversimplification to say that the driving force behind these legislative measures — in fact the driving force behind virtually every health policy decision — is rising cost. We have entered a period in the evolution of the American health care system whose most distinguishing characteristic is sharply escalating expenditures for health care — expenditures by private citizens, expenditures by the Nation's hospitals, and expenditures by government at every level.

No one can seriously quarrel with the need to contain the rising cost of health care. And neither can anyone take issue with the objectives of seeing to it that we make the best use of the resources we have, avoid waste, and strive for care of the highest quality that can be achieved.

But because I happen to agree with Thomas Jefferson who held that government exists to do for people what they cannot do for themselves, I think we all have to be acutely alert to the consequences that can follow from a too-easy assumption that government can make it all come out all right — that government can keep health care costs in line, make sure that the system has

everything it needs in the right place at the right time, and that everybody who seeks health care will get the best there is.

The consequences of that kind of naive thinking can be disastrous. As you people know all too well, they can literally dry up not just the philanthropic gift, but the spirit of philanthropy itself. The closer we come to the idea that government can and should assume every responsibility of the public good, the closer we come to foreclosing any form of private voluntary initiative in the health field.

For example, as urgently as we need to make health planning an effective tool for improved efficiency and productivity, we must also guard against regulation in the service of better health planning that makes it difficult for hospitals to accept philanthropic contributions. We all understand that there are times when a private donation might lead to an inappropriate capital expenditure, and we ought to be able to prevent that. But to do it through a regulatory mechanism that cuts off private support for appropriate and necessary purposes as well is simply wrong.

We don't have to throw out the baby with the bathwater, and the way to avoid that is to be able to tell the difference.

Discussions about national health insurance tend to focus on a number of key issues—the cost, both to individuals and to the Nation, the kind of benefits to be covered, the financing scheme, controls on cost and utilization, and other critically important questions the answers to which will shape not just the insurance plan, but the entire health care system for years to come.

But there are other factors that simply must not be overlooked in the rush to devise a health insurance plan that Congress will enact, the President will sign, and the country can live with.

One of those factors, of course, is the impact of national health insurance on philanthropy, an issue that very deeply concerns both the donors and the recipients of the nearly $4 billion that is contributed annually to the health care system.

There is some logic in the prediction that national health insurance will sharply reduce—if not in fact eliminate—philanthropy in the health field. From a purely economic point of view, the need for philanthropy might seem to disappear when a national health insurance scheme assures hospitals full reimbursement for all activities associated with patient care.

But such reasoning equates philanthropy with charity. And it fails to recognize that all great medical centers—and even many hospitals of more modest scope—are able to undertake projects and programs only because generous organizations and individuals are willing and able to provide the necessary support.

Furthermore, the kind of activities made possible through philanthropic donations and private grants are likely to represent innovations, in both research and services, for which public funds are often not available.

By and large, the public's money ought to be used to exploit proven advances in the provisions of social services—including health care—and to seek new knowledge in problem areas that have a major impact on individuals and society.

Moreover, at a time when Federal spending is under extremely tight restrictions, tax dollars have to be spent to make sure that mandated goals—like paying for health services for the elderly, the disabled, and the poor—are not being neglected.

What this means, of course, is that both national health insurance and tight Federal health budgets tend to make philanthropy an increasingly vital and important source of funds for the health care system—the kind of venture capital that can point the way to significant change.

I flew down to Houston today with John Grupenhoff, a man I have known and worked with for many years who ably represents your Association in Washington, and who has a deep understanding of the issues that all of us—in both the public and the private health sectors—have to wrestle with.

One of those issues, of course, is the fact that tens of millions of Americans have either no health insurance protection whatever or are covered inadequately by plans that foster expensive and inappropriate use of the Nation's limited health resources.

We have to correct these defects. But in doing that, we have to guard against devising a system that might create new problems or make old ones worse.

To foreclose private philanthropy would be a grave mistake.

To add materially to the demand for health services without making certain that the system can respond would be a grave mistake.

And to institute an insurance system that had no effective mechanisms for cost containment and quality assurance would be a grave mistake.

I am confident that many people within and outside the Federal government are well aware of these considerations. But I am equally sure that it will take the best and most enlightened leadership of the entire health industry to design a responsible health insurance system, and once it is adopted, to make it work.

That kind of leadership has to come from the Public Health Service, and I think we are increasingly able to provide it. But it has to come from the private sector as well, from people like yourselves, from the medical profession, from the insurance industry, and from parts of American society that have up until now, shown little interest in how our health care system works and what its problems are.

We have made it too easy for the American people to think that government can fix everything. Even when government policies are wrong—and sometimes they are—the public looks to government to find solutions.

Well, believe me, government doesn't have all the answers. Laws and budgets can't make everything right. Fine pronouncements about national health goals and strategies are not worth anything unless they articulate the will and command the support of private citizens, taxpayers, private industry, and those who are able to share with others in the spirit of philanthropy.

As long as I have a voice in the leadership of the Federal health effort, I intend to be as forceful as I can in the service of preserving a viable, independent, and creative private and voluntary health enterprise for this country. I feel sure you share that purpose, and I invite your help in making certain that neither government nor the private sector ever forgets it.

Again, I thank you for the honor of receiving your Achievement Award. I will do everything I can to merit your confidence.

FAMILY PLANNING

In the past six years, from 1971 through 1976, Frontier Nursing Service has delivered 1,503 babies. Twenty-two percent of the couples who had these deliveries subsequently have had a sterilization, indicating that family planning is a most important part of FNS services. Please note that 30% of the spouses sterilized were males. It is interesting to note that in one year, 1972, 54% of the individuals requesting sterilization were males.

RADIO SPOT: Reading Labels

Sound: Cash Register

Person A: (reads a few ingredients from a label on a can)

Person B: What are you doing?

Person A: Checking these labels.

Person B: What for?

Person A: Well, I'm just looking to see how much sodium salt is in each product. Sodium salt is one of several factors that increases my chances of getting hypertension or high blood pressure, which can lead to a stroke. So, I'm making sure these canned foods I buy are low on sodium salt by reading the labels.

Person B: That's all you're doing—reading the labels to make sure the amount of sodium salt in the package is low?

Person A: That's all. Here, want to help?

Announcer: Read the label before you buy.

This message is brought to you as a public service by the Frontier Nursing Service.

"NEITHER RAIN, NOR SLEET . . . ."

From Our Printer: "I thought you might be interested (I started to say amused but thought better of it!) to learn that on Friday, January 9, we received the missing Bulletin proofs which you had mailed on December 23. What really flabbergasted us was that the same mail delivery contained a letter which had been mailed on January 6—in Ireland.

"My cup runneth over."

FIELD NOTES

Edited by Peggy G. Elmore

The Fifty-second Annual Meeting of Frontier Nursing Service, Incorporated, will be held in Louisville, Kentucky, on Thursday, May 26, 1977, at the Ramada Inn, following luncheon at 12:30 p.m. The Ramada Inn is located at the intersection of I-64 and Hurstbourne Lane, two miles west of the Watterson Expressway.

Arrangements for the Annual Meeting are in the hands of the FNS Louisville Committee, under the chairmanship of Mrs. James W. Stites, Jr. We shall look forward to seeing many of our friends in Louisville on May 26.

. . . . .

The somewhat trying weather which faced most of the country in January and February forced FNS to cancel the meeting of its Board of Governors scheduled for mid-January. Telephone conference calls were arranged for several Board Committees and among the important matters discussed was the expansion of our computer accounting activities. Subsequently, the Executive Committee, which exercises the authority of the Board when it is not in session, authorized a vast increase in the amount of bookkeeping and billing and keeping of the general ledgers to be done by computer. We are now beginning to put these functions onto the computer. Charles Thornbury, our Controller, has had only four days vacation in the last two years. The increase in computer activities will provide the controller's office with some relief and will enable up to the minute financial reporting.

. . . . .

The Spring meeting of the Frontier Nursing Service Board of Governors is scheduled to be held at Wendover and Hyden on Saturday, April 16, and Sunday, April 17, 1977, with the usual excellent attendance expected. On occasion our Board have been greeted, at the spring meeting, by forest fires and by high water but we think we can, at least, promise no ice and snow for an April meeting!

. . . . .

The College of Allied Health Professions at the University of Kentucky gave a luncheon presentation to our staff on March 8 on their Kentucky January Program, a highly organized effort on the part of the University to make field placements for senior students in dietetics, x-ray, physical therapy, laboratory technology, pharmacy, nursing and medicine to rural health programs or home health agencies as part of their professional training. Although FNS is committed already to undergraduate students for January 1978, we hope we will be able to develop an affiliation which will be beneficial to young students from this area as well as to the university.

. . . . . .

The Frontier Nursing Service is most grateful to have received a fetal monitor, a gift from the National Foundation March of Dimes. Our nurse-midwives are constantly demonstrating that they are up-to-date with the scientific care of high risk mothers and babies. We appreciate the help in obtaining this valuable piece of equipment which we received from the chairman of the local March of Dimes Chapter, Mrs. Edward A. Mattingly, and from Dr. John Duhring of the Department of Obstetrics and Gynecology at the University of Kentucky who is also making arrangements, via a telephone hook-up with UK, to aid our staff in an interpretation of the findings. Dr. E. Fidelia Gilbert, our obstetrician, in expressing her gratification with the gift, said: "I think we can use it wisely".

. . . . . .

With the admission of twelve new students to Family Nursing IA on January 31, the Frontier School of Midwifery and Family Nursing now has thirty-one registered nurse students in the four trimesters and seven interns. The midwifery interns will be spending some time at FNS, during the spring months, and some time at other sites—the Booth Maternity Hospital in Philadelphia, the Public Health Service Hospital at Pine Ridge, South Dakota, and the Metropolitan General Hospital in Cleveland, Ohio.

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During the winter months Frontier Nursing Service has offered observation and experience to nursing students from Berea and Spaulding Colleges in Kentucky and from Winona State University in Minnesota and from Illinois Wesleyan. A medical student from McGill University in Canada has been with FNS to help with a special research project.

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The Courier Service has been busy this winter—with the couriers available as needed for rounds and transportation and as extra hands in the ER, hospital and district clinics, the pharmacy, lab., x-ray, medical records, central supply, research. Margo Squibb stayed on through January, aided by Deborah King of Dover, Massachusetts. When Denny Doak, who had returned last fall to help coordinate courier activities, left, old courier Lydia McAnerney of Concord, New Hampshire, was on hand to take over. We are extremely pleased that Debby King will return to Wendover in early April, before Lydia leaves, to take charge of all courier and volunteer activities for a year.

The junior couriers during this quarter were Ruth T. Butler, Oyster Bay, New York, Rebecca (Becky) Reed, Millington, New Jersey, Virginia (Nina) Clark, Andover, Massachusetts, and — just arriving—Anne L. Grogan of Rome, New York. Two young men, Sam Powdrill of Van Cleve, Kentucky, and Woodrow (Woody) Wilson of Allegan, Michigan, arrived at the beginning of the year to volunteer their services for some months and to gain experience in the health field with a view to enrollment in a Physician Assistant program in the fall.

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We feel that a word of thanks is due to the entire FNS staff—couriers and volunteers most definitely included—who managed to keep going and get the work done during what is officially considered one of the worst winters in Kentucky in many a long year. There were many days when nerves were frayed, and we did have some vehicle accidents, but no one was seriously injured and the patients were seen.

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In February, the Frontier School of Midwifery and Family Nursing had a site visit from the American Nurses' Association for the accreditation of the Family Nurse Program, similar to the accreditation of the Midwifery Program by the American College of Nurse-Midwives. Representing ANA were Dr. Joan E. Mulligan, a nurse-midwife, and Dr. Catherine DeAngelis, a nurse and a pediatrician, both from Wisconsin, and Mrs. Margaret L. Jones, from the faculty of the Vanderbilt Family Nurse Clinician program. The decision from ANA is not expected until sometime in April but the report of the site visit has been shared with us and was most favorable.

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Other professional guests this winter have included Miss Georgia Padona, Assistant Director of the St. Luke's-Presbyterian-Rush University Community Nursing program; Miss Margaret McLean and Mrs. Hope Toumishey from Memorial University in St. Johns, Newfoundland; and Dr. Ingeborg Mauksch, Senior Program Consultant for The Robert Wood Johnson Foundation, with two graduate students in primary care. Laura Pilotto, the family nurse at the Beech Fork Nursing Center, enjoyed a visit from her parents, Mrs. and Mrs. Giacoma Pilotto from Italy, and Wendover was pleased to entertain a member of the Washington Committee, Mrs. Dulany Claggett, Captain Claggett and their daughter Amne. Two other most welcome guests were Agnes Lewis and Leigh Powell who slithered in for an all too short visit in January.

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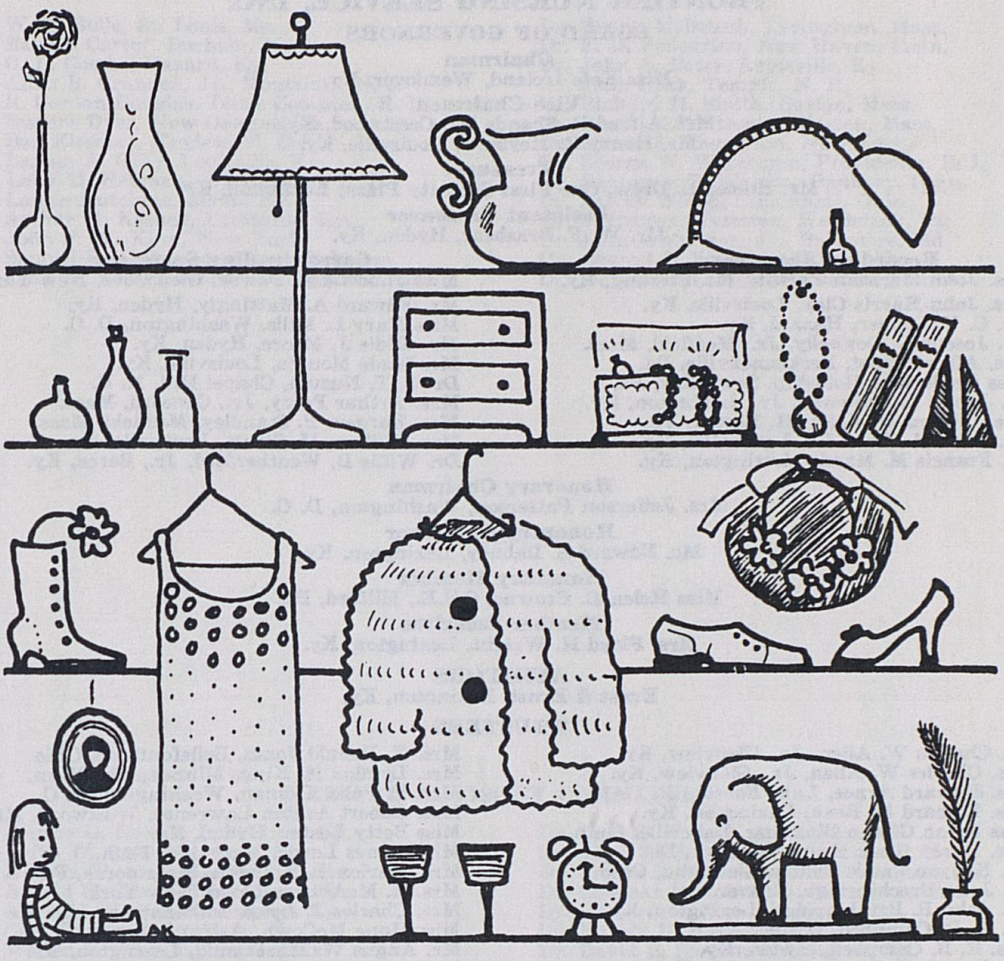
Laurie Johnson Snead (on leave of absence from the School) and her husband, John, are the proud parents of Ian Snead, all seven pounds of him! Ian was born at home on March 8, 1977, delivered by nurse-midwifery student Ida Laserson, under the supervision of Senior Nurse-Midwife Molly Lee, who knows all about such things as home deliveries.

WHITE ELEPHANT



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SEND IT TO FRONTIER NURSING SERVICE
1579 Third Avenue, New York, New York 10028

You don't have to live in or near New York to help make money for the Nursing Service at the Bargain Box in New York. We have received thousands of dollars from the sale of knickknacks sent by friends from sixteen states besides New York. The vase you have never liked; the ornaments for which you have no room; the party dress that is no use to shivering humanity; the extra picture frame; the old pocketbook; odd bits of silver; old jewelry—There are loads of things you could send to be sold in our behalf.

If you want our green tags, fully addressed as labels, for your parcels—then write us here at Wendover for them. We shall be happy to send you as many as you want by return mail. However, your shipment by parcel post or express would be credited to the Frontier Nursing Service at the Bargain Box if you addressed it

FRONTIER NURSING SERVICE
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F.N. indicates nurses who have completed post-graduate education in Family Nursing
C.F.N.P. indicates family nurses who have taken and passed the national certifying examinations.

FORM OF BEQUEST

For the convenience of those who wish to remember the Frontier Nursing Service in their wills, this form of bequest is suggested:

> "I hereby give, devise and bequeath the sum of ..... dollars (or property properly described) to the Frontier Nursing Service, a corporation organized under the laws of the State of Kentucky."

HOW ENDOWMENT GIFTS MAY BE MADE

The following are some of the ways of making gifts to the Endowment Funds of the Frontier Nursing Service:

1. **By Specific Gift under Your Will.** You may leave outright a sum of money, specified securities, real property, or a fraction or percentage of your estate.

2. **By Gift of residue under Your Will.** You may leave all or a portion of your residuary estate to the Service.

3. **By Living Trust.** You may put property in trust and have the income paid to you or to any other person or persons for life and then have the income or the principal go to the Service.

4. **By Life Insurance Trust.** You may put life insurance in trust and, after your death, have the income paid to your wife or to any other person for life, and then have the income or principal go the the Service.

5. **By Life Insurance.** You may have life insurance made payable direct to the Service.

6. **By Annuity.** The unconsumed portion of a refund annuity may be made payable to the Service.

. . . .

The principal of the gifts will carry the donor's name unless other instructions are given. The income will be used for the work of the Service in the manner judged best by its Trustees.

FRONTIER NURSING SERVICE, Inc.

Its motto:

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

Its object:

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

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

Contributions to Frontier Nursing Service, Inc. are tax deductible under Section 501 (c) (3) of the Internal Revenue Code of 1954.

Gifts of stock should be sent to

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Mr. Homer L. Drew, Treasurer
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Gifts of money should be made payable to

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and sent to

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Wendover, Kentucky 41775


FNS