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THE HISTORY OF OUR LADY OF THE LAKE COLLEGE, 1993-2000:
A STUDY OF ORGANIZATIONAL CHANGE

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Educational Leadership, Research and Counseling

by

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ABSTRACT

This qualitative research study investigated the history of Our Lady of the Lake College from 1923 through 2000. It endeavored to determine the influence of the times, the events, the people, and the traditions that have contributed to its development and progress in the seventy-seven years that have passed since it was established. The study also sought to document the important institutional events that transpired during this time period and establish a continuity of the College’s progress through the years from a hospital-based diploma program in nursing to a free standing degree granting institution.

In addition to the evolutionary development of the institution, the study also investigated socialization processes inherent in the educational experience that prepared the graduate for the role of a professional nurse, as those issues evolved across the seventy-seven year history of the institution. Socialization into the role of nurse, as a dimension of professional education, reflected changes in both nursing and society.

The qualitative methodology of the study included the review of institutional documents, archival and visual materials, and semi-structured tape-recorded interviews of graduates, administrators and faculty as well as four non-taped interviews. The data obtained from the document reviews and the transcribed interviews were then categorized according to themes, analyzed, and then used to comprise the database for the study, thus contributing to a “thick description” of issues identified in the study.

The historical narrative of Our Lady of the Lake College is presented within the context of nursing, nursing education, and higher education in the United States. An analytical discussion of the institutional experience and students’ experiences within the
larger context of the evolutionary history of nursing and higher education is presented in a separate chapter. Findings related to women's issues of oppression are also discussed. Furthermore, this chapter includes a discussion of the possible meaning and implications of the study.
CHAPTER 1

INTRODUCTION TO THE STUDY

Our Lady of the Lake College, established in 1923 as a hospital-based diploma program in nursing, reorganized as a college of nursing and allied health in 1990, and again reorganized in 1999 to expand its offerings to include arts and sciences, is firmly entrenched in the history of nursing education. The history of the organization’s life cycle provides a fertile ground to explore and investigate one institution’s response to a changing environment in both the profession of nursing and nursing education as well as in higher education. From a broader perspective, the contributing factors to changes in the professional and educational environments reflect a changing society and a changing health care system. Therefore, the study of the evolution of one organization provides a lens through which to capture and record the effects of a changing world of health care.

Despite only slight emphasis on the value of historical research in scholarly journals in nursing, allied health and higher education, there are important scholarly and practical reasons to undertake historical research about our institutions of higher learning. These reasons include the current availability of records and witnesses and the value of historical context for understanding present-day institutions and decisions. Even if an institutional history has been written, the history of the great changes in student life may have been overlooked or treated tangentially. Most institutional histories focus on the personalities of leadership figures, changes in governance, or on the creation of academic programs. The history of the educational experiences of students has largely been omitted from these accounts. Yet “the primary historical sources are still available
at most institutions, waiting for an interested researcher to discover them” (Goree & Dunn, 1997).

Individuals who experienced the effects of evolutionary changes within professional education are still living and available for interviews. They have stories to tell and the freedom to tell them. But these witnesses to our history are aging; they will not always be available. Their unique memories and insights are a perishable resource for those who want to examine the history of nursing education in the United States.

Oral history is one method of capturing the valuable and unique memories of those individuals who lived the experiences that we seek to understand. The social context is at issue when discussing the pros and cons of using oral history methods in the study of higher education for women. As Henige (1982) and Ashby & Ohm (1995) have suggested, a blatant absence of women’s voices in historiography is obvious. Ignoring women as sources is a significant omission or oversight in collecting oral data. Unless researchers have been interested in a topic that happens to be relevant to the experience of women, they seem to have disregarded them as useful informants, presuming them to be uninterested in and unaware of larger questions relating to political or economic change or structural patterns. In most cases, this record of neglect seems to have been unconscious; only that part of a society that happened to be male were considered when researchers established pools of informants (Henige, 1982).

Statement of the Problem

Our Lady of the Lake College, established in 1923 by the Franciscan Missionaries of Our Lady as the School of Nursing of Our Lady of the Lake Sanitarium,
has always played an integral role in educating nursing professionals to provide quality health care to the citizens of the Baton Rouge community and the State of Louisiana. In its seventy-seven year history, the College has transitioned numerous times in response to changes in the nursing profession and nursing education as well as to changes in health care and the society at large. Although its history has been informally summarized in institutional publications, a thorough investigative study has never been attempted to exhaustively document the institution’s responses to a changing environment, nor has a study ever been attempted to document the experiences of students, faculty, or administrators as the institution responded to the changing environment. Within an environmental context, the institutional experience becomes the human experience and can only be fully analyzed post-facto.

As the education of health care practitioners emerges as an important phenomenon in higher education, hospital-related allied health colleges may have an even greater role in meeting the nation’s demand for qualified health care professionals. The Pew Commission (1995) has predicted that enormous demands will be placed on health practitioners and the educational programs that produce and support them. Leaders in allied health education (including nursing education) will be called upon to help respond to needed changes in educating health care professionals and to ensure that health care practitioners are responsive to future societal needs.

Our Lady of the Lake College is one of approximately 220 hospital-related allied health colleges currently operating in the United States. All evolved from hospital-based diploma programs in nursing. These colleges provide a model that deviates from
the traditional model of professional medical and allied health education. In the
traditional model, a university owns and operates a medical center, which provides an
educational environment for health care practitioners. The model from which Our Lady
of the Lake College operates is one in which the hospital sponsors the educational
institution.

Contemporary higher education in America is under intense public scrutiny, as
evidenced by annual media rankings, new and revised accreditation criteria, position
statements of regional and national higher education associations, statements of
governors, topics of national conferences, frequent book-length critiques of American
higher education, public statements of faculty leaders and college presidents, and policy
papers issued by centers for the study of higher education (Bogue, 1994). There is
public concern about the quality of higher education in response to an erosion of
confidence in American colleges and universities. The federal government, state
legislatures, state boards of education, accrediting associations, boards of control,
parents and families, students, and the general public are demanding the reform of
higher education (Upcraft & Moore, 1990). This demand reflects concern about
unacceptable drop-out rates, increased attendance costs, scarce resources, lack of
equitable access, and graduates who are under prepared, underemployed, or unemployed
(Upcraft & Moore, 1990).

With seventy-seven years of archival data to be explored, as well as actual and
impending loss of human participants in the institution’s life, it is time to begin an
orderly and thorough historical exploratory study of Our Lady of the Lake College. In
addition, the College has undergone a major institutional transition from a hospital-based diploma program in nursing to a freestanding degree-granting institution of higher education. Along with associate's and bachelor's degree programs in nursing, the College offers a variety of allied health educational programs. These associate degree programs include Radiologic Technology, Surgical Technology, Physical Therapy Assisting, Clinical Laboratory Sciences, Emergency Health Sciences, and Respiratory Therapy. In addition, the College offers Bachelor of Science degrees in Human Medicine, Biology, Health Sciences, and Health Services Administration.

Within its own history as degree-granting, the College has experienced an expanded mission to include arts and sciences in addition to health sciences curricula, offering bachelor's degree in humanities and behavioral sciences. This latest transition (1999), extending the educational programs beyond the health care environment, will undoubtedly effect cultural changes not previously encountered. Therefore, it becomes even more important to engage in historical investigation to capture the essence of the institution as an educational organization singularly committed to health care education. Of a utilitarian nature is the need to have a single recognized source of historical reference. Many references are made to the history of the College in institutional documents such as self-studies for institution and program accreditation, in written reports by faculty, in official publications of the institution, in speeches, and in conversation. It is increasingly necessary and desirable to have a single reference source to ensure consistency of historical account.
The study of history is the study of human creative endeavors. As such, it provides knowledge and understanding of the past that, when applied to contemporary issues, helps to clarify ideas and options. Research on the past encourages an informed response to current challenges. Research on the past (historiography) defines not only what happened and why but also why it is important. This is significant to the “so-what” issue that is currently being called for in academic scholarship. The utility critique is particularly directed toward the credibility of qualitative research as academic rigor.

**Purpose of the Study**

The purpose of the historical study of Our Lady of the Lake College is to document the institution’s development within the evolutionary context of the nursing and allied health professions, nursing education, and higher education. As a reflection of the institution’s leadership and decision-making processes, its responses to external changes are important to analyze within the environmental context within which they occurred. Such an analysis helps to define the institution’s posture and position as a direct participant in the world of health care and higher education and may also provide a means of understanding changes that continue to occur at the institutional level. In addition to the institution’s relationship to education and the profession of nursing, the study will also explore the College’s continuous, interdependent relationship with its sponsoring organizations, the Franciscan Missionaries of Our Lady and Our Lady of the Lake Regional Medical Center.
The study will also explore the student experience at various times throughout the life of the institution. Because the student body was entirely female for fifty years, the institution provides a fertile field for historical exploration and documentation of women's post-secondary educational experiences as well as socialization to a professional role that was and, for the most part, continues to be predominately female.

Research Questions

As a result of a comprehensive review of the literature and the qualitative research process, three questions are identified as the focus of exploration for this research study:

1. How has Our Lady of the Lake College, as an organization, evolved in the seventy-seven years of its history (1923-2000)?

2. What environmental factors elicited a response of organizational change?

3. How have the institution's experiences affected the students' experiences?

Significance of the Study

This study began with the proposition that the history of Our Lady of the Lake College is of value to its continuing role in health care education and the preparation of health care professionals. A second proposition rests on the foundation of organizational development theory and the response of organizations to environmental change. This framework accounts for the relationship between changing health care and education systems and the response of a specific institution of higher education to these environmental changes. Responsiveness to environmental changes leads to a third proposition that the institution, with a long history of commitment to health sciences
education, is postured to identify and support emerging transitions in the health professions. A fourth proposition of the study proposes that historical research will assist College administrators, educators, and health care providers to more adequately understand their role in preparing health care professionals as well as understanding the emerging role of Our Lady of the Lake College in higher education. And, finally, the qualitative nature of the study proposes to capture the voices of women as they relate they own experience within an institution and a profession existing in a male dominated society. This is important to the study of women and women’s professional roles within American society.

Organization of the Study

This qualitative study is designed to provide an analysis of issues confronting Our Lady of the Lake College from its inception in 1923 to the present in a changing health care and health care education environment, as well as an analysis of the response of the institution to those issues. The study is organized into nine chapters.

Chapter 1 introduces the subject and scope of the study, including a statement of the problem, purpose, research questions, and significance. The remaining eight chapters describe the development of the study and its findings in depth and detail.

Chapter 2 presents an overview of related literature that examines the concepts of organizational development and culture, including the culture of oppression, as well as an overview of the context of nursing and nursing education to acquaint the reader with the external environmental context within which Our Lady of the Lake College has operated for seventy-seven years. The context of the internal environment is presented
as a summary overview of the nature of the process of socialization to the nursing role. In addition, extensive literature reviews continued throughout the course of this study. Therefore, review of literature is intertwined with the data analysis procedures throughout the narrative portion of the study.

Chapter 3 describes the evolution and implementation of the qualitative research methodology employed in the study. Specifically, Chapter 3 addresses the initial identification of the research study and objectives, research participant selection, data collection and methods of data analysis that were used, as well as the means for reporting the data. A qualitative research approach provides the opportunity to develop the study in a manner that allows the researcher to analyze relevant issues as they emerge throughout the research.

Chapter 4 presents the narrative history of Nursing and Nursing Education in the United States. The historical narrative presents a major portion of the external environment within which Our Lady of the Lake College interacted.

Chapters 5, 6, 7, and 8 present the narrative history of Our Lady of the Lake College, organized by life-cycle stage. Chapter 5 presents the history of the institution from its inception in 1923 to 1950 as well as a history of the founding order, the Franciscan Missionaries of Our Lady. This represents the founding and initial growth stage of the life cycle of the institution. Chapter 6 represents the Midlife stage of the organization and Chapter 7 represents the Maturing and Declining stage of the institution. Chapter 8 concludes the narrative presentation of data and represents the Rebirth stage of the organization. Data gathered from archival documents and visual...
materials are the primary source of the historical presentation. Embedded within the context of institutional change, a narrative account of student, faculty and administrator experiences is presented. The data for the personal experience portion of the historical narrative was obtained through interviews with former administrators, faculty, and students.

Chapter 9 includes a summary of Chapters 5, 6, 7, and 8 with discussion and analysis of the institutional experience and students' experiences within the larger context of the evolutionary history of nursing and professional health care education. Furthermore, this chapter includes a discussion of the possible meaning, and implications of the study.
CHAPTER 2

REVIEW OF RELATED LITERATURE

The review of literature for this qualitative study is organized to provide an overview that examines concepts of organizational development and cultural change as well as nursing and education from a variety of sources that focus on the history, evolution, and current state of nursing education. To support the use of oral history as a means to capture the meaning of women's experience, the literature review also addresses utilization of oral history in the study of women's experiences. Extensive and diverse literatures were consulted during the development and course of this qualitative study. The literature review continued throughout the study and is integrated into the narrative of Chapters 2 - 9.

Organizational Culture and Change

Theories of organizational development can be useful in analyzing the relationship of environmental change with the organizational behavior and life cycle of a specific institution. This section seeks to provide a framework within which to explore the changes that occurred in a specific educational institution's movement through predictable life cycle stages. Understanding organizational life cycle models can help institutions maintain, and adapt when necessary, under changing environmental conditions.

According to Bennis (1964), the general structure and design of institutions of higher education are more adaptive and restorative than are traditional bureaucracies and hierarchical systems. Colleges, in general, have been described as having loosely...
connected internal structures (Weick, 1976) and as fluid systems (Cohen & March, 1974) that have a great capacity to survive environmental disruptions (Cameron & Whetten, 1983).

However, as Katz and Kahn (1983) observed, the mortality rate of colleges and universities in the United States is high with 117.6 per 10,000 institutional closings between 1971 and 1981. Zammuto (1983) reported that since the early 1970s, 20 per cent of all higher education institutions experienced a decline in enrollment (the highest in history) as well as the highest mortality rate reflected in the number of closures among colleges and universities, especially small, private comprehensive institutions. Cameron and Whetton (1983) concluded that many institutions are unable to adjust to environmental changes when unusual circumstances arise in their environment.

Trice & Beyer (1993) identified two basic and interrelated reasons to explain the effect of external environments on the internal cultures of organizations: (1) organizations are dependent on their environments, and (2) environments pose many uncertainties for organizations. Trice & Beyer explain:

Organizations are dependent on their environments because they are open systems that must obtain certain inputs from their environments in order to produce outputs and otherwise ensure their survival. Without continued inputs from their environments, organizations would soon use up all of their resources and die. Many of these inputs have cultural content that is thereby brought into organizations. (330-331)

Schien (1992) posits that all group and organizational theories distinguish two major sets of problems that all groups, no matter what their size, must deal with: (1)
survival, growth, and adaptation in their environment and (2) internal integration that permits daily functioning and the ability to adapt. The view of organizations as open, changing systems in constant interaction with their environments emerges.

According to Mitroff (1983), the state of an organization at any given point in time will be the result of the interaction of the behavior of all the organization's stakeholders from the beginning of its history up to a particular point in time. This extended history may be referred to as the "culture" of the organization or of the extended set of stakeholders. Mitroff (1983) identified the following stakeholder assumptions:

1. An organization or social system is an organized collection of internal and external stakeholders. The word *organized* implies that at least one critical property of a stakeholder will be influenced by the property of at least one other stakeholder.
2. Each stakeholder is a distinct and distinguishable entity that has resources, purposes, and a will of its own.
3. There is a network of interdependent relationships among all stakeholders.
4. A new strategy, that is, a change in strategy for an organization, changes one or more of the relationships among the stakeholders. (p.5)

The fundamental assumptions underlying any change in a human system are derived originally from Kurt Lewin (1947). Lewin asserted that all human systems attempt to maintain equilibrium and to maximize their autonomy through and with their environment. Coping, growth, and survival all involve maintaining the integrity of the system in the face of a changing environment that is constantly causing various kinds of
disequilibriums. The function of cognitive structures such as concepts, beliefs, attitudes, values, and assumptions is to organize the mass of environmental stimuli, to make sense of them, and to provide, thereby, a sense of predictability and meaning to the individual. The set of shared assumptions that develop over time in groups and organizations serves this stabilizing and meaning-providing function. The evolution of culture is one of the ways in which a group or organization preserves its integrity and autonomy, differentiates itself from the environment and other groups, and provides itself an identity.

From an evolutionary perspective, we need to identify the issues that any group faces from the moment of its origin through to its state of maturity and decline. Although it may be difficult, sometimes even impossible, to study cultural origins and functions in ethnic units whose history is lost in antiquity, it is not at all impossible to study these matters in groups, organizations, or occupations whose history and evolution are available (Schien, p. 51).

According to Schien (1992), the most relevant model to analyze cultures is one developed by sociology and groups dynamics, and based on the fundamental distinction between any group's problems of (1) survival in and adaptation to its external environment and (2) integration of its internal processes to ensure the capacity to continue to survive and adapt.

Culture is a multidimensional phenomenon, not easily reduced to a few dimensions. Culture ultimately reflects the group's effort to cope and learn and is the residue of the learning process. Culture thus fulfills not only the function of providing...
stability, meaning, and predictability in the present but is the result of functionally
effective decisions in the groups' past (1992).

"Though the essence of a group's culture is its pattern of shared, taken-for-
granted basic assumptions, the culture will manifest itself at the levels of observable
artifacts and shared espoused values, norms, and rules of behavior" (Schien, p.26). It is
important to recognize in analyzing cultures that artifacts are easy to observe but
difficult to decipher and that values may only reflect rationalizations or aspirations. To
understand a group's culture, one must attempt to get at its shared basic assumptions and
one must understand the learning process by which such basic assumptions come to be.

The word culture adds two other critical elements to the concept of sharing. One
of these elements is that culture implies some level of structural stability in the group.
When we say something is "cultural," we imply that it is not only shared but deep and
stable. The other element that lends stability is patterning or integration of the elements
into a larger paradigm that ties together the various elements and that lies at a deeper
level. Culture somehow implies that rituals, climate, values, and behaviors bind
together into a coherent whole. This patterning or integration is the essence of what we
mean by "culture" (Schien, p.10).

Schien (1992) defines the culture of a group as:

...a pattern of shared basic assumptions that the
group learned as it solved its problems of external
adaptation and internal integration, that has worked well
enough to be considered valid and, therefore, to be taught
to new members as the correct way to perceive, think, and
feel in relation to those problems. (p. 12)
Culture is a mechanism of social control and can be the basis of explicitly manipulating members into perceiving, thinking, and feeling in certain ways. When one brings culture to the level of the organization and even down to groups within the organization, one can see more clearly how it is created, embedded, developed, and ultimately manipulated, managed, and changed. These dynamic processes of culture creation and management are the essence of leadership (Schein, 1992).

Culture is most useful as a concept if it helps us better understand the hidden and complex aspects of organizational life. A deeper understanding of cultural issues in groups and organizations is necessary to identify what may be the priority issues for leaders and leadership. Organizational cultures are created in part by leaders, and one of the most decisive functions of leadership is the creation, the management, and sometimes even the destruction of culture (Schein, 1992).

Organizations obtain four types of resources from their environments, which have especially strong implications for internal organizational cultures: Human resources, information, technology, and legitimacy. Inputs of human resources affects (Schein, 1992) organizational cultures because those people who are recruited into organizations will bring their cultural understandings with them. The information that organizations collect from their environments affects their cultures because it is bound to contain cultural understandings prevalent in the world outside the organization. The technologies organizations import from their environments partly shape organizational cultures because technologies include not only the hardware used in performing work, but also the understandings embodied in the skills and knowledge of workers, on which
work is performed. Finally, legitimacy affects organizations' cultures because in order to earn and maintain it, organizations must operate in ways that are congruent with the value systems of the wider society.

At different stages in the evolution of a given organization's culture, different possibilities for change arise because of the particular function that culture plays at each developmental stage. There are particular change mechanisms that are most relevant at each stage. These mechanisms are cumulative in the sense that at a later stage, all the prior change mechanisms are still operating but additional ones become relevant.

If any part of the core structure is to change in more than minor incremental ways, the system must first experience enough disequilibrium to force a coping process that goes beyond just reinforcing the assumptions that are already in place. Lewin (1947) called the creation of such a disequilibrium unfreezing, or creating a motivation to change. Unfreezing is composed of three very different processes, each of which must be present to a certain degree for the system to develop any motivation to change: (1) enough disconfirming data to cause serious discomfort and disequilibrium; (2) the connection of the disconfirming data to important goals and ideals causing anxiety and/or guilt; and (3) enough psychological safety, the sense of seeing a possibility of solving the problem without loss of identity or integrity, thereby allowing members of the organization to admit the disconfirming data rather than defensively denying it.

Schein (1992) identifies three stages within the life cycle of an organization: the founding and early growth stage; the midlife stage; and the maturing and declining
stage. Lorsch (1985) identified a fourth stage: rebirth of the organization. These are the four stages that will be used to frame the current study.

In the first stage, the founding and early growth of a new organization, the main cultural thrust comes from the founders and their assumptions. The cultural paradigm that becomes embedded if the organization succeeds in fulfilling its primary task and survives can then be viewed as that organization's distinctive competence, the basis for member identity, and the psychosocial "glue" that holds the organization together. The emphasis in this early stage is on differentiating oneself from the environment and from other organizations. The organization makes its culture explicit, integrates it as much as possible, and teaches it firmly to newcomers (and/or selects them for initial compatibility).

The implications for change at this stage are clear. The culture in young and successfully growing companies is likely to be strongly adhered to because (1) the primary culture creators are still present, (2) the culture helps the organization define itself and make its way into a potentially hostile environment, and (3) many elements of the culture have been learned as defenses against anxiety as the organization struggles to build and maintain itself.

Proposals to deliberately change the culture from either inside or outside are, therefore, likely to be totally ignored or resisted. Instead, dominant members or coalitions will attempt to preserve and enhance the culture. The only force that might unfreeze such a situation is an external crisis of survival in the form of a sharp drop in growth. If such a crisis occurs, the next stage (transition) may automatically be
launched in that the crisis may discredit the founder and bring a new senior manager into the picture. If the founding organization itself stays intact, so will the culture.

The second stage of the life cycle of an organization is the midlife stage. Often missing in the midlife stage of an organization is an understanding of what the organizational culture is and what it is doing for the organization, regardless of how it came to be. The succession mechanism must, therefore, be designed to enhance those parts of the culture that provide identity, distinctive competence, and protection from anxiety. This can probably be managed only from within because an outsider could not possibly understand the subtleties of the cultural issues and the emotional relationships between founders and employees.

From a cultural perspective, the organization is now facing a very different situation. It is established and must maintain itself through some kind of continued growth and renewal process. It now must decide whether to pursue such growth through further geographical expansion, development of new products, opening up of new markets, vertical integration to improve its cost and resource position, mergers and acquisitions, divisionalization, or spin-offs.

The past history of the organization's growth and development is not necessarily a good guide to what will succeed in the future because the environment may have changed and, more important, internal changes may have altered its unique strengths and weaknesses.

Whereas culture was a necessary glue in the growth period, the most important elements of the culture have now become embedded in the organization's structure and
major processes. Hence, consciousness of the culture and the deliberate attempt to build, integrate, or conserve the culture have become less important. The culture that the organization acquired during its early years now comes to be taken for granted. The only elements that are likely to be conscious are the credos, dominant espoused values, company slogans, written charters, and other public pronouncements of what the company wants to be and aims to stand for, its philosophy and ideology.

At this stage it is more difficult to decipher the culture and make people aware of it because it is so embedded in routines. It may even be counterproductive to make people aware of the culture unless there is some crisis or problem to be solved. Managers view culture discussions as boring and irrelevant, especially if the company is large and well-established. On the other hand, geographical expansions, mergers and acquisitions, and introduction of new technologies require a careful self-assessment to determine whether the new cultural elements to be integrated or merged are, in fact, compatible.

Also at this stage there may be strong forces toward cultural diffusion, or loss of integration, because powerful subcultures will have developed and because a highly integrated culture is difficult to maintain in a large, differentiated, geographically dispersed organization. Furthermore, it is not clear whether or not all the cultural units of an organization must be uniform and integrated.

Unfreezing forces at this stage can come either from the outside or from the inside, as in the first stage: (1) the entire organization or parts of it may experience economic difficulty or in some other way fail to achieve key goals because the
environment has changed in a significant manner, or (2) the organization may develop destructive internal power struggles among subcultures.

The third stage of the organizational life cycle is characterized by maturity and potential decline. Continued success creates strongly held shared assumptions and, thus, a strong culture. If the internal and external environments remain stable, this is an advantage. However, if there is a change in the environment, some of those shared assumptions can become a liability precisely because of their strength. The mature stage is sometimes reached when the organization is no longer able to grow because it has saturated its markets or become obsolete in its products. Maturity is not necessarily correlated with age, size, or number of managerial generations but, rather, reflects the interaction between the organization's output and the environmental opportunities and constraints.

Age does matter, however, if culture change is required. If an organization has had a long history of success with certain assumptions about itself and the environment, it is unlikely to want to challenge or reexamine those assumptions. Even if the assumptions are brought to consciousness, the members of the organization are likely to want to hold onto them because they justify the past and are the source of pride and self-esteem. Such assumptions now operate as filters that make it difficult for key managers to understand alternative strategies for survival and renewal (Donaldson and Lorsch, 1983; Lorsch, 1985).

Little is known or understood about the process of reorganization and rebirth. If one physically destroys the organization that is the carrier of a given culture, by
definition that culture is destroyed and whatever new organizations begins to function begins to build its own new culture. This process is traumatic and, therefore, not typically used as a deliberate strategy, but it may be relevant if economic survival is at stake.

Organizational changes that are true transformations, not merely incremental adaptation, probably reflect culture changes at this level. In the evolution of companies, such transformations occur periodically and at those times, the direction of the changes is not always predictable (Lorsch, 1985).

Evolution of Higher Education for Women and Professional Nursing Education

Within the evolution of higher education in the United States, women have maintained a largely peripheral position. Until the late 1800s, higher education was not well organized or consistently available to either gender. In the late 1800s, women began to establish their own educational institutions. At the same time, the Catholic Church moved toward institutionalizing higher education for women. The number of women's colleges increased from 14 in 1915 to 37 in 1925 and 116 by 1955 (Eisenmann, 1998). Most curricula were focused on the liberal arts. Women were largely excluded from professional education except in those professions that were limited to women -- namely, teaching and nursing.

According to the National Center for Education Statistics (1995), between 1976 and 1987, women and men were equally likely to enroll in college in the fall following high school graduation; but since the late 1980s, women have been slightly more likely than men to do so. Over the past 20 years, college attainment rates among young
women have increased dramatically, while rates for men remain basically unchanged. In the early 1970s, among high school graduates, about 40 percent of women aged 25-29 had completed one or more years of college, compared to 50 percent of similarly aged men. By 1994, more women than men in this age group had attended at least some college. A similar trend has occurred for female college graduates. In the early 1970s, among high school graduates, about 20 percent of women compared to 27 percent of men aged 25-29 had completed four or more years of college. By 1994, a similar number of men and women in this age group had earned a bachelor’s degree or more.

Nursing education has evolved from an apprenticeship education to being properly positioned in higher education. Although women today have many more educational and career choices, nursing remains a viable option. Nursing education began in the United States as hospital-based diploma education. Despite many attempts to position it within the higher education environment, it wasn’t until the 1960s and the expansion of community colleges, that the Associate Degree in Nursing largely replaced diploma education. At the same time, the professional organizations published position statements in the mid-1960s that emphasized the baccalaureate degree as entry level into the profession of nursing. Today, at the turn of the Twentieth Century, only a handful of diploma programs continue to exist. However, baccalaureate and associate degree education, as well as the remaining diploma programs, continue to allow the same entry into the profession. Advanced degrees have also gained momentum. Clinical nurse specialists and nurse practitioners are both educated at the Master’s level and doctoral programs in nursing continue to emerge.

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The evolution of nursing education cannot be extricated from the evolution of
the profession of nursing. It is the term "profession of nursing" that is at the crux of the
history of nursing education. The professional ideology driving the development of
nursing has similarly been the primary influence on reform in nursing education. Many
of the issues that confronted formal, organized nursing education at its origin in 1873
continue to be addressed today.

Many histories of nursing and nursing education are simply chronological
recordings that do not offer interpretation or analysis of the complexity of the growth
and development within the nursing profession. One way to meet the utility critique is
for histories to explain the economic and political struggles of the profession and how
these struggles relate to nursing practice, education, and scholarship (Hezel & Linebach,

The evolution of professional education in health care can best be explored and
understood within a context of systems theory, social change and the process of
professionalization. Systems theory provides a means of studying the interrelationships
between and among individuals and groups of individuals within society. Society as a
system includes subsystems of men and women forming groups of families, the health
care system, educational institutions and other institutions that are organized to meet its
needs.

Just as the health care system is a subsystem of society, medicine and nursing,
along with hospitals, are major components of the health care system. Each component
also comprises a unique system with its own set of subsystems. The dyadic
relationships of nursing with medicine and nursing with hospitals, as well as nursing education with nursing and nursing education with higher education, must be understood to fully appreciate the evolution of nursing and nursing education.

Social values reflect the culture of society as it affects its members. Each subsystem also possesses culture and concomitant values that serve to both perpetuate the culture and socialize the individual members to behaviors appropriate to subsystem group membership. The subculture's value system is reflective of that of the larger society. Social change depends on its systems/subsystems structure to effect change within the larger system of society. Change reflects a change in a value system and is most effective from a bottom-up or grassroots movement (Schein, 1992).

The “process of professionalization” represents a process of change in social values that indicates a transformation that culminates in recognition by society of a group that meets a set of criteria or standards that define a profession. What is a profession? Many historical and sociological analyses of the professions confirm and elaborate on the assumptions about professions that are commonplace both in everyday usage as well as in the scholarly literature. Melosh (1982) refers to this set of assumptions as the conventional interpretation. Within the conventional or consensus interpretation, the professions are portrayed as the legitimate domains of expertise. The members of a profession, in the conventional view, possess extensive theoretical knowledge in a body of esoteric and highly prized knowledge, demonstrate unusual autonomy in work, perform their work with unusual altruism, develop their own code of ethics, set up mechanisms of peer review to regulate their practice and carefully control
access to the special privileges of the profession by setting standards for the education and certification of new practitioners to guarantee their competence and worthiness. In addition, some observers also emphasize professionals' special orientation to work. The professionals strongly identify with their work, making it a part of their personalities that differs from the way that workers in other occupations or vocations view their jobs.

Melosh (1982) distinguishes between the conventional model of professional interpretation and the revisionist model in addressing the professionalization process of nursing. In accounting for the privileged position that the professions hold within the world of work, the revisionist formulations point to social power, while the conventional model asserts that professions win autonomy through their special expertise and their humanitarian concern for their clientele. Critics of the conventional model argue that members of a profession claim their dominant position with the support of a sponsoring elite. Professional dominance is won through the agency of social elites, but maintained at least partly through the broader legitimacy provided by a trusting clientele. Within this context, the ethical codes associated with professions help to justify professional autonomy by manifesting the profession's commitment to service and providing the appearance of conscientious self-regulation.

Critics of the conventional model define professions in a way that makes sharper distinctions among occupations and emphasizes the controlling position of professions in a hierarchical division of labor. This structural analysis helps to locate nurses as workers. Clearly, nurses never gained the large measure of control over their work that defines a profession. The relationship between doctors and nurses in itself poses an
intractable obstacle to nursing’s professionalization. If professions maintain their authority through controlling the division of labor related to their work, then doctors’ own professionalization organizes and requires nurses’ subordination.

The concept of “professionalization in process” adds a new perspective to the argument about social power and professional prerogatives. Aspiring professionals and their sponsors must fight for dominance on two fronts; overcoming external obstacles and also overpowering dissidents in their own ranks. Resistance to professionalization is well documented and is not unique to nurses or to women workers. Even the profession of medicine historically documents the protracted internal conflicts that accompanied the reorganization of medicine.

The internal conflicts and resistance to change within nursing have contributed to the development of the allied health professions. As technological and scientific advances have revolutionized and reformed health care, nursing has been reluctant to transform its own role in relationship to those advancements through reformed educational processes and practices. As a result, other health professions have proliferated in an attempt to deliver health care that represents the scope of modern medical practice. These professions include, but are not limited to, occupational and physical therapy, respiratory therapy, surgical technology, and emergency health science. It is a widely held belief that most allied health professions have their origins in nursing. If that belief is true, then nursing can be assumed to have willingly or purposefully played a role in launching the allied health professions. In doing so, nursing limited its professional boundaries of practice. While this may have been an
attempt to more clearly define itself in order to achieve professional status, the fact remains that nursing continues today to clearly define what it is and what it does within the context of health care.

The process (of professionalization) draws clearer and tighter boundaries around an occupation. An elite within the occupation establishes and defends control on higher ground, instituting educational reform or more rigorous certification requirements to restrict access to the profession. Thus, in their quest for professionalization, nursing leaders have persistently utilized nursing education as a tool to achieve professional status.

The effort to socialize nurses to professional status through nursing education has historically been thwarted by the control of nursing education by the hospitals of which they were a part (Ashley 1976). The refusal to permit the schools of nursing to remain outside the control of hospital administrators was destined to prevent their development as independent educational enterprises. The strict discipline and the incorporation of the schools into the hospital business structure almost entirely negated their educational function (Ashely, 1976; Melosh, 1982; Roberts, 1983).

The hospitals were major instruments for women's oppression both economically and professionally (Ashley, 1976). The development of the nursing profession could not be achieved in an environment where control over the nurse's education resided in those who wished to exploit her for her labor. Apprenticeship, as a social phenomenon, has often been used as a means of keeping oppressed groups in subordinate positions (Ashley, 1976).
Apprentice nurses were taught to be loyal to the hospital, to be obedient and docile, and to accept the poor conditions of work and the stringent discipline. Repressive educational practices instilled in them respect for authority and a spirit of unquestioning loyalty to "master" institutions and to physicians. Nurses were not educated in a manner that might have led them to question the moral or social implications of a system that impeded their professional development (Ashley, 1976; Melosh, 1982; Roberts, 1983)

The Culture of Oppression

Freire (1971) pointed out that the major characteristics of oppressed behavior stem from the ability of dominant groups to identify their norms and values as the "right" ones in the society and from their initial power to enforce them. In contrast, the characteristics of the subordinate group become negatively valued. In most cases of oppression, the dominant group looks and acts differently from the subordinate group (i.e., men vs. women, black vs. white, medicine vs. nursing, women religious vs. student nurses). This attribution of values, over time, contributes to the maintenance of the status quo. The tendency is for the subordinate group to internalize these norms and to believe that to be like the oppressor will lead to power and control.

The oppressed believe that belonging to their group is an impediment to reaching goals of success. Persons who are successful at assimilation become known as marginal. They are on the fringes of the dominant group, have taken on characteristics of the dominant group, but cannot be a member of the dominant group and no longer truly belong to the subordinate group. Marginality leaves them without a cultural
identity. This leads to self-hatred and lowered self-esteem which, in turn, perpetuates the cycle of domination and subordination. This leads to submissive aggression in which the oppressed person, unable to feel aggressive against the oppressor, is not able to directly express it and becomes submissive when confronted with the power of the oppressor. The aggression is then turned inward or towards the subordinate group. Thus, horizontal conflict within the oppressed group is a manifestation of subordination, rather than a characteristic inherent to the nature of oppressed groups. The tendency toward internal conflict represents a mechanism by which the status quo is maintained through a learned fear of aggression against the oppressor (Freire, 1971).

Fear of aggression against the dominant group originally develops as a result of the realization that the subordinate groups could be destroyed if they were to attempt revolt. This fear is the basis of the submission to authority. A secondary fear develops as the process of oppression continues, that is, the fear of change itself and of alteration of the status quo, no matter how oppressive (Freire, 1971).

The perpetuation of the dominant-submissive relationship is based on the premise that the characteristics of the powerful are perceived as being the best that can be obtained. This belief pervades the culture of the oppressed even though it may be more myth than reality (Freire, 1971).

There are three mechanisms that reinforce the myth. The first mechanism is education. If the education is controlled by the powerful and limited to curricula that support their values, little conflict occurs (Freire, 1971).
A second mechanism of reinforcement is reward for behavior preferred by the oppressor. Members of the dominant group may reward members of the oppressed group for exemplifying or proclaiming the values of the dominant culture are correct. This is a ritual of reward. By the same token, members of the oppressed group may be punished through rituals of degradation or expulsion if they are perceived to be a threat to the dominant culture (Freire, 1971).

The third mechanism of maintenance occurs usually when there is a threat of change or revolt and involves the giving of token appeasement of rights or rewards to the oppressed. This serves to halt the momentum toward change and revolt but, over time, further entrench the oppressed into dependency and powerlessness (Freire, 1971).

It therefore follows that the leaders of oppressed groups often possess characteristics and beliefs that resemble those of the dominant culture and maintain loyalty to the oppressor. A dependency relationship fosters a sense of security and, therefore, a lack of self-esteem is no longer a problem. Leaders in powerless groups have also been noted to have negative attributes such as control, coercion, and rigidity. These characteristics stem not only from dependency and low self-esteem, but from hatred of their own kind and a desire to be like the oppressor (Freire, 1971).

Freire (1971) has identified two phases that are essential to liberation of oppressed groups: (1) unveiling of the world of oppression and (2) expulsion of the myths created and developed by the old order. Freedom, therefore, involves rejecting the negative images of one's own culture and replacing them with pride and a sense of
ability to function autonomously. The oppressor is not able or willing to grant autonomy but, rather, it must be required.

Leaders who can facilitate this kind of liberation or change must come from within the larger group, not from the elite, or marginal, persons of the group. Leadership from within encourages development of goals that better represent those of the total group. Freire (1971) has said that this leadership, to be successful, needs to be involved in a continuous dialogue with, and development at, the grass roots.

Utilization of Oral History

Henige (1982) traces oral historians to Homer who outlined the fall of Troy, as recounted in the Iliad, and then to the Greek historians of the Fifth Century B.C. and follows the development of historiography through the end of the Seventeenth Century A.D. when oral history was largely abandoned as a means to collect data at all. It was at that time that historians first began to collect editions of primary sources consisting of such established texts as charters, registers, treaties, early lives of saints, and early chronicles. Large collections of these were published in England, France, and Italy and these forced themselves on the attention of historians, who soon began to pride themselves in their commitment to these documents as “the primary sources” par excellence (p. 13).

Henige defines “historiography” in its literal form as “the writing about” the past (p.1) and as an activity that incorporates any form of historical inquiry, including that based on oral sources (p.2). He further notes that it is important to distinguish between oral history and oral tradition. “Oral history” refers to the study of the recent past by
means of life histories or personal recollections, where informants speak their own experiences. By comparison, "oral traditions" are those recollections of the past that are commonly or universally known in a given culture.

The return to status of oral history as a legitimate data collection method by contemporary historians occurred in the late 1940s and 1950s as a means to obtain information about an illiterate people or social groups (non-hegemonic) whose written history is either missing or distorted. Grele (1975) acknowledges that while much remains in dispute about the value and contribution to history of the oral versus written sources of information, there are some things about oral history with which few would disagree. Oral data does not exonerate the historian from searching for and using written documents exhaustively. Written sources, where available, should be used as background as well as to corroborate the oral data. "Critical questions about reliability, validity, and the representative nature of the data are as essential for oral sources as they are for written material. Oral historians must be selective about their documents and must remain conscious of what their subjects represent" (p. 5).

Portelli (1991) further discusses the debate between written and oral sources of historical data. He asserts that origin and content are insufficient to distinguish oral sources from the range of sources used by social history in general but, rather, turns to form and style as the distinguishing characteristics. Whereas writing represents language almost exclusively by means of segmentary traits (graphemes, syllables, words, and sentences), oral sources are composed of another set of traits (volume, range, rhythm) which are not reproducible in writing, but carry implicit meaning and social
connotations. At the crux of this issue are the validity and reliability of the collection and analysis of data, or of the trustworthiness, credibility, and dependability (Teddle, 1997) of qualitative data obtained through women's voices.

Minister (1991) addressed the blossoming of oral history (1940s and 1950s) in a strongly male dominated society. Although oral historians currently cut across class and ethnic lines in a new commitment to publish the voices of those who were once silent or silenced in the larger human community, oral history method continues to rest upon the assumption that interviewers will conduct interviews the way men conduct interviews. This means that women who do not participate in the male sociocommunication subculture will remain invisible (1991).

Anderson and Jack (1991) make reference to the studies of anthropologists who have observed how the expression of women's unique experience as women is often muted, particularly in any situation where women's interests and experiences are at variance with those of men. In fact, "a woman's discussion of her life may combine two separate, often conflicting, perspectives: one framed in concepts and values that reflect men's dominant position in the culture, and one informed by the more immediate realities of a woman's personal experience" (p.11).

The issue of the structure of the interview as an instrument comes into question. If, in fact, a woman as narrator has two different perspectives, then the nature of the interview can greatly influence the credibility of the data. Thus, the researcher's role as a human instrument (performance) becomes paramount. It is the interaction of the narrator with the interviewer that has the greatest impact on the outcomes of the

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interview process. Thus, if the intent of the interview is to gather information about women's experience in higher education, it is necessary that the interview process ensure that women's discussions about their experiences are informed by the realities of that experience, rather than being a reflection of the values and concepts of the social context of the time. Oral history interviews are unique in that the interaction of researcher and subject creates the possibility of going beyond the conventional stories of women's lives, their pain and their satisfactions, to reveal experience in a less culturally edited form.

To facilitate access to the muted channel of women's subjectivity, Anderson and Jack (1991) suggest that "we must inquire whose story the interview is asked to tell, who interprets the story, and with what theoretical frameworks" (p. 11)? The authors assert that to realize the possibilities of the oral history interview demands a shift in methodology from information gathering to focus on the interactive nature of the interview that allows the researcher to ask for clarification, to notice what questions the subject formulates about her own life, to go behind conventional, expected answers to the woman's personal construction of her own experience. This shift of focus from data gathering to interactive process affects what the researcher regards as valuable information. Those aspects of live interviews -- the laughter, the pauses, the hesitations -- which are unavailable in a written text, hold meaning for the narrator and are the interviewer's to explore during analysis.

Anderson (1991) suggests that the interviewer must develop an awareness that (1) actions, things, and events are accompanied by subjective emotional experience that
gives them meaning; (2) some of the feelings uncovered may exceed the boundaries of acceptable or expected female behavior; and (3) individuals can and must explain what they mean on their own terms. Jack (1991) describes three ways of listening during the interview and during analysis of the interview that sharpen the researcher's awareness of the feeling and thoughts that are behind the woman's outwardly conventional story: (1) listening to the narrator's moral language; (2) attending to the meta-statements; and (3) observing the logic of the narrative.

Jack (1991) suggests that the narrator's moral, self-evaluative statements allow us to examine the relationship between self-concept and cultural norms, between what we value and what others value, and how we feel about ourselves when we do or do not act in a way that others tell us to act. In a person's self-judgment, we can see which moral standards are accepted and used to judge the self, which values the person strives to attain.

The narrator's meta-statements refer to the places in the interview where people spontaneously stop, look back, and comment about their own thoughts or something just said (Jack, 1991). Meta-statements alert us to the individual's awareness of a discrepancy within the self — or between what is expected and what is being said. They inform the interviewer about what categories the individual is using to monitor her thoughts, and allow observation of how the person socializes feeling or thoughts according to certain social norms. It is a way in which the individual "watches" her own language in a social-conscious manner.
Chanfrault-Duchet (1991) similarly discusses what she refers to as refrains or key phrases. Key phrases aim to define a type of relation between the self and the social sphere, that is, the community, and, more broadly, the society as a whole. The key phrase, as a regularly recurring phrase, expresses the harmony, the indifference, the ambiguity, the conflict, and so on, existing between self and society.

Listening to the logic of the narrative allows the interviewer to attend to or notice the internal consistency or contradictions in the person’s statements about recurring themes and the way these themes relate to each other. Listening to how the narrator strings together major statements about experience allows the interviewer to understand the assumptions and beliefs that inform the logic and guide the woman’s interpretation of her experience.


In the 50 years since oral history was recognized as an academic approach, scholars have increasingly recognized the importance of the way culture shapes how people communicate, writes Alistair Thomson, a history professor at the University of Sussex and a co-editor of the British journal “Oral History.” That realization has led oral historians to emphasize that there is no single or universal “right way” to do their interviews, Mr. Thomson says. Oral historians in the past 25 years also have shifted from worrying about bias and fabrication in people’s recollections to recognizing that the so-called unreliability of memory can be a source of clues about the cultural meaning of historical events. (5 paragraphs)

In summary, the collection and analysis of oral history data in the study of women must take into account the feminist perspective in order to help highlight the
different ways in which women receive and interpret the social models of femaleness produced and controlled by institutions such as the family, the church, and higher education. In doing so, collection and analysis are viewed within an interactive framework and together constitute the interview process. The use of the interviewer as human instrument takes on new meaning as compared to the traditional male dominated structures of the interview process. Women interviewing women establish a relationship that informs the interview process by promoting an expression of experience that is not edited by socially defined norms. The process both recognizes and actively explores the social-consciousness of women as they relate their experiences.

Thus, the advantages of utilizing oral history as a method to study higher education for women lies in obtaining the recollection of the women themselves. However, the disadvantage lies in the fact that the lens may be somewhat opaque due to the restrictions placed on women’s voices by social context.
CHAPTER 3

METHODOLOGY AND PROCEDURES

The purpose of this study was to investigate the historical development of Our Lady of the Lake College within the evolutionary contexts of the nursing profession, nursing and allied health education, and higher education. Included in this investigation is an exploration of the College’s continuous, interdependent relationship with its sponsoring organizations, the Franciscan Missionaries of Our Lady and Our Lady of the Lake Regional Medical Center.

A secondary purpose was to explore the student experience within the context of the evolutionary development of the institution. It was hoped that this investigation would contribute to what is known about women’s post-secondary educational experiences as well as socialization into a professional role within the context of American higher education.

The research questions were:

1. How has Our Lady of the Lake College, as an organization, evolved in the seventy-seven years of its history?
2. What environmental factors elicited a response of organizational change?
3. How have the institution’s experiences affected the students’ experiences?

Design of the Study

Since the study required the collection of extensive interviews and documents, qualitative research methodology was chosen to investigate and evaluate the research.
objectives. In fact, a variety of different qualitative research approaches were used to investigate the history of the institution and the student experience from 1923 to the present. The different approaches will be discussed later in this chapter.

The focus of the study was the organizational culture within which the processes of evolution of the educational institution and socialization of the students into a professional role occurred. The concepts of organizational life and organizational culture, therefore, are central to the design of the study. Conceptual assumptions include:

1. Organizations are open, living systems.
2. Organizations have life cycles.
3. Organizations are in constant interaction with their environments.
4. Organizations must continuously adapt to a changing external environment.
5. Culture represents an internal integration of an organization's environmental adaptation.
6. Culture is a set of shared assumptions that develop over time.
7. Organizational culture provides stability and meaning through integrity, differentiation, and identity to the organization.
8. A change in culture is in response to a force creating disequilibrium that unfreezes or creates a motivation to change.
9. Culture is taught to the members of an organization.
10. Culture is a mechanism of social control.
The study focuses on the lived experiences of students as well as faculty and administrators at Our Lady of the Lake College from its inception in 1923 to the present. This covers a period of approximately 76 years. The researcher has been a member of the College community since 1974 as a faculty member and, currently, as an administrator. Throughout the remainder of the document, the researcher will be referred to in the first person, as suggested for writing qualitative studies by Creswell (1994).

The present study attempts to lend an interpretive understanding to the experiences commonly shared by students since 1923 within the specific learning environment of Our Lady of the Lake College. I used variants of two common qualitative techniques: archival analysis and interviews with former students, administrators, and faculty as well as a current student and a faculty member.

The methodological assumptions included the following:

1. The study represents an inductive process.
2. The study design is one of emergence; categories were identified during the research process.
3. The study is context-bound. The history of Our Lady of the Lake College is contextually embedded in the history of nursing and nursing education in the United States. The experiences of students, faculty and administrators are explored within the context of the environment of Our Lady of the Lake College.
4. There is a shared meaning or essences that are mutually understood through the commonly experienced culture of the organization.

5. Accuracy and trustworthiness of the data analyses are determined through verification.

The research methodology utilized for this study has been divided into five stages that include: (a) initial identification of the research study and objectives; (b) identifying the research participants; (c) selecting the qualitative research processes appropriate for the project; (d) determining the means of data display and analysis and, finally, (e) establishing the means for reporting the results of the data analysis. Through an eclectic process of typological analysis, data reduction, data display, conclusion drawing, and verification, the research data were interpreted with respect to major influences on the history of Our Lady of the Lake College and student experiences within that history.

Rationale for the Research Design

The selection of an eclectic methodology for the empirical portion of this study was based on the type of data collected, as well as the purpose and objectives of the study. Tesch (1990) explains an eclectic process of data analysis as "no one 'right way" and refers to a diversity of sources or methods used to analyze the data. The exploration of the history of Our Lady of the Lake College required the use of the qualitative inquiry paradigm to obtain and analyze pertinent descriptive data from both interviews and
archival documents. As a form of scientific inquiry, Munhall and Boyd (1993) describe the process of qualitative research:

Qualitative research involves broadly stated questions about human experiences and realities, studies through sustained contact with persons in their natural environments, and producing rich, descriptive data that help us to understand those persons’ experiences. The emphasis is on achieving understanding that will, in turn, open up new options for action and new perspectives that can change people’s worlds. (pp. 69-70)

Human Instrumentation

Merriam (1988) states that a qualitative approach offers the researcher a unique opportunity to create an understanding of a problem or situation. Because the necessary data are primarily descriptive, the qualitative approach utilizes the researcher as the “main instrument of investigation” (Burgess, 1984) and as the “data gathering instrument” to analyze the data (Lincoln & Guba, 1985). Glesne and Peshkin (1992) describe the qualitative researcher as follows:

Since qualitative researchers deal with multiple, socially constructed realities or ‘qualities’ that are complex and indivisible into discrete variables, they regard their research task as coming to understand and interpret how the various participants in a social setting construct the world around them. To make their interpretations, the researchers must gain access to the multiple perspectives of the participants. Their study designs, therefore, generally focus on in-depth . . . interactions with relevant people in one or several sites.

The researcher becomes the main research instrument as he or she observes, asks questions, and interacts with the research participants. (p. 6)
Thus, the qualitative researcher is able to examine firsthand the thoughts, perceptions, and experiences of the research participants within their settings leading to “a descriptive record of written and spoken words and behaviors” from the respondents' point of view (Taylor & Bogden, 1984, p.11). Whenever possible, the qualitative research strives for a “thick description” of the phenomena under study (Geertz, 1973). Thick description is the presentation of solid descriptive data, through the discipline and rigor of qualitative analysis, in such a way that others reading the results can understand and draw their own interpretations (Patton, 1990).

Data Analysis Procedures

Table 3.1 depicts the eclectic approach to qualitative data analysis utilized in the historical analysis of Our Lady of the Lake College. The data analysis procedures involved four processes: data collection, data reduction, data display, and verification and conclusion. The approach is consistent with Creswell's (1998) description of a data analysis spiral in which the researcher engages in the process of moving in analytic circles rather than using a fixed linear approach. Data analysis was conducted as a simultaneous activity with data collection, data reduction, interpretation and narrative reporting writing.

Data Collection

The data collection steps as outlined by Creswell (1994) include (a) setting the parameters for the study, (b) collecting information through observations, interview, documents, and visual materials, and (c) establishing the protocol for recording information. The parameters for the study included the setting, the interviewees, the
Table 3.1

Eclectic Approach to Data Analysis

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events, and the process (Miles and Huberman, 1984). The setting for the current study was the campus of Our Lady of the Lake College in Baton Rouge, Louisiana. The primary campus building utilized was the Allied Health Building. My office is located in this building, as are the College archives. Additional sources of visual materials and documents utilized in the study are stored at the Nursing Building. Interviews were conducted in a conference room within the Learning Resources Center of the Allied Health Building. In the case of four of the taped interviews and all four of the untaped interviews, the researcher interviewed the interviewees in their own homes or offices.

Documents, visual materials, and taped interviews with former administrators and faculty were the primary sources of data for historical analysis of the College. The primary sources of information were interviews of former students. This data source was enhanced by comparisons with the interviews with former administrators and faculty. In addition, four untaped interviews with individuals currently associated with the institution were used to confirm historical data as well as to confirm the interpretation of the College culture as it is experienced at the present time. These four additional interviews were conducted late in the study. Hand-written notes were taken during the interviews and expanded into a narrative immediately following each interview. The four additional interviews were with current stakeholders of the institution: the Chief Executive Officer of Our Lady of the Lake Regional Medical Center, the Provincial of the Franciscan Missionaries of Our Lady, North American Province, who was also a member of the Board of Trustees, an allied health faculty
member and an allied health student currently enrolled in the Fall 2000 semester at Our Lady of the Lake College.

Historical Analysis of the Institution

The historical overview of the profession of nursing, as well as nursing and allied health education, provided the identification of period categories within the history of Our Lady of the Lake College. The initial categories of subdivision of the institution’s history comprised four 20-year periods that coincided with major events in society and with critical events within the context of nursing and nursing education. The School of Nursing originated in 1923 and, during the period extending to 1939, was concentrated on growth and maintenance. The decades of the 1940s and 1950s included World War II, which had a significant impact on nursing and nursing education in the United States. Societal changes of the 1960s also impacted nursing and nursing education. Most important during the 1960s and 1970s was the debate within the nursing profession as to the appropriate educational level required for entry into the profession. The impetus for change within the state of Louisiana came in the 1980s, and its effects culminated in the 1990s with the transition of the diploma program in nursing to a freestanding degree-granting institution of higher education. Therefore, the initial chronological framework for the study was subdivided into the following periods: 1923-1939; 1940-1959; 1960-1979; and 1980-1999. This framework guided the selection of informants for interview, the review of archival data, the review of related literature, and the collection and analysis of data.
The approach to data collection for historical documentation of the institution’s life began with a thorough review of institutional documents and publications, archival materials, and visual materials that have been collected by the College, by Our Lady of the Lake Regional Medical Center, and the Franciscan Missionaries of Our Lady. The documents included student records, handbooks, administrative files, minutes, and reports generated by the institution. Secondary sources included newspaper articles, photographs, and reports written by agencies external to the College.

The analysis of the data collected on the originally designated 20-year periods led to a conceptualization of periods of evolutionary development with the identification of new categories used to describe the life cycle of the institution. These categories, as defined by Schein (1992), are as follows: founding and the early organization; the mid-life organization; the mature and declining organization; and the rebirth of the organization. It was further assumed that as the organization moved through lifecycle changes, an unfreezing occurred either within or outside of the institution to effect the change. The systems external to the institution included nursing, higher education, nursing and allied health education, the Baton Rouge community, the Franciscan Missionaries of Our Lady, and Our Lady of the Lake Regional Medical Center, and the Catholic Health Association.

While the Franciscan Missionaries of Our Lady were initially assumed to represent the Catholic Church’s influence on the College, it became apparent during the course of the study that the Catholic Hospital Association, later called the Catholic Health Association, was the major filter through which the Franciscan Missionaries of Our Lady...
Our Lady responded to social, nursing, nursing education and health care trends to influence the College. Therefore, the histories of all of the identified systems external to the College were explored for factors that had the potential to impact the College. When an external factor of potential impact was identified, the College culture was examined through archival artifacts and through interviews to capture evidence of change within the institution.

Similarly, as the history of the College emerged, each apparent thematic change within the institution was examined within the context of its changing external environment for evidence of similar indicators of change. This forward-reverse approach also served to verify the connections and relationships between external and internal events and further confirmed the data.

Further analysis of the data led to a revised subdivision of the institution's history. This analysis indicated that the emerging and initial growth stage occurred from 1923 until around 1950. The midlife of the organization extended from around 1950 until the late 1970s to early 1980s. The mature and declining stage occurred within the 1980s and the rebirth of the organization began in 1990. This designation of the historical stages of the evolution of the institution guided the collection of interview data.

Analysis of Students' Experiences

Semi-structured, open-ended interviews of former students were used to explore the students' experiences. Each interview was tape-recorded and transcribed verbatim.
This approach to data collection also allowed for enrichment, expansion and enhancement of the historical data.

Two former administrators, two former faculty members (one of whom was also a graduate of the class of 1965) and five graduates of the classes of 1929, 1955, 1976, 1985, and 1990 were interviewed. The study included nine audiotaped and transcribed interviews and four untaped interviews for a total of thirteen interviews.

No attempt was made to randomly select informants for the audio-taped interviews. The informants were purposefully selected (Patton, 1990) for their significant contributions to the institution, their ability to recount the appropriate period of study, and their willingness to participate in the study. The two former administrators who were interviewed, Mrs. Maureen Daniels and Dr. James W. Firkberg, were selected for their considerable knowledge of and contributions to the life of the organization. Of the two former faculty members selected for interview, Mrs. Patricia Butler was selected for her contributions to the institution during her employment with the institution that covered the most rapid period of change during the 1970s - 1990s. The second former faculty member selected for interview, Mrs. Jean Lang, held a dual role of former student as well as former faculty member. She was also one of the first married students to be accepted into the program of nursing. Her tenure at the institution extended from 1963 to 1980.

The overall strategy employed for sampling the informants who were former students was one of maximum variation (Patton, 1990). This strategy for purposeful sampling was useful in capturing and describing the central themes that extended or
occurred over time. According to Patton (1990), selecting a small sample of great
diversity will yield two kinds of findings through the data collection and analysis:

(1) High quality, detailed descriptions of each case, which
are useful for documenting uniqueness, and (2) important
shared patterns that cut across cases and derive their
significance from having emerged out of heterogeneity.
(p. 172)

The 1929 graduate can be considered a result of typical case sampling in that she
was selected with the cooperation of a key informant. The 1929 graduate is most likely
the oldest living graduate of the school of nursing. I decided not to interview graduates
of the 1930s and 1940s after a review of student records and institutional archive
documents indicated no appreciable change in the structure or function of the
educational program.

I decided to focus the attention of further interviews to the period of time that
represented the greatest amount of change, which was 1970 - 1990. Because the first
male student graduated in 1977, I turned my attention to the male graduates of 1977 and
1978 and selected one to be interviewed. The 1990 graduate represents one of the last
graduates of the diploma program in nursing.

Late in the study, I determined the need to gain the perspective of the CEO of
Our Lady of the Lake Regional Medical Center, as well as the Provincial of the
Franciscan Missionaries of Our Lady. This was determined following the narrative
analysis of the interview with Dr. James Fimberg, which emphasized the continuing
interrelationships with both the Medical Center and the Franciscan Missionaries of Our
Lady. It was necessary to obtain the perspectives of both of these individuals to confirm
and enhance the narrative analysis. Neither of these interviews was taped and handwritten notes were taken which were then expanded into narrative form immediately following the interviews.

In addition, the final stages of the analysis led to two additional non-taped interviews with a currently employed allied health faculty member and a currently enrolled allied health student to further analyze and confirm the cultural assumptions of the current College culture that were inductively derived in the narrative. These two interviews were also not taped and the same procedures were followed as with the previous non-taped interviews. However, anonymity was assured for these two individuals since both are currently associated with the institution.

The limitations of interviews as sources of data are recognized and acknowledged. The limitations include the following: (a) information received "indirectly" was filtered through the views of the interviewees; (b) the presence of the researcher may have biased the responses of the interviewees; (c) and the interviewees varied in their level of perception and ability to articulate.

Accessibility to the sources of data, both inanimate and human sources, was not a problem. I have been a "member" of the institution since 1974 and currently hold an administrative position that includes responsibility for institutional archives. In addition to materials archived, I have unlimited access to all official documents of the institution as well as student and alumni records and administrative files. In 1996, I coordinated a project that included organizing class photographs from 1923 and compiling them into a "Memory Book" that was published and distributed to alumni. This compilation
presented an ordered approach to identification of individuals within specific graduating classes, identified by year of graduation.

Interview Process

Each interview was conducted in one session, with the researcher allocating two hours for each, but recognizing that a session might be longer or shorter. Only one interview was scheduled per day to facilitate my effectiveness as a human instrument. The session dates and times were determined in cooperation with the interviewee to establish a time that was convenient to both the informant and myself. Each interviewee was asked to sign the “Interviewee Release Form” (Appendix A) prior to the initiation of the interview session.

Each interview session was recorded with a recorder on loan from the Louisiana State University T. Harry Williams Oral History Center. Limited notes were also taken during the interview. To prepare for the taped interview process, I attended an instructional session with Dr. Pamela Dean, former Director of the T. Harry Williams Oral History Center. In addition, Dr. Dean provided the opportunity for me to interview her, followed by an evaluative session that provided immediate feedback. This was most helpful in assessment of use of equipment, interview technique, and researcher responsiveness.

Because of the nature of the inquiry, the interview questions were designed to allow for free flow of thought processes to capture the “essence” of the experience. The basic approach utilized to collect the qualitative data through open-ended interviews was the "general interview guide approach" as described by Patton (1990).
The general interview guide approach involves outlining a set of issues that are to be explored with each respondent before interviewing. The issues outlined are not necessarily taken in a predetermined order nor are the questions actually worded in advance. The outline was shared with the informants at the onset of the interview. The outline then served as a checklist to ensure that all issues were covered. Actual questions were formulated during the interviews in response to the interviewee's specific statements within the context of the research questions. The outlines used to guide the interview sessions are found in Appendix B.

Actual questions posed during the interview process were stated in the most general way so as not to "lead" the interviewee to a particular direction of thought. The context of the interviewee's experiences within the institution included the people, events, settings, activities, and artifacts of the times. Socialization into the role of nurse was of paramount interest in the interviews with former students. The interview issues and questions were guided by the intent to capture the lived experiences of the informants. The categories for the interview questions and probes were as follows: decision to become a nurse; the lived experience with faculty, administration, and students; classroom and clinical experiences; the lived experience with hospital staff and physicians; and graduation and beyond.

The interviews with former faculty were conducted first to give greater insight into both the student and administrator experience, since faculty interacted with both on a daily basis. Administrators were interviewed next to provide an infrastructure that
would bridge large periods of time in the evolution of the institution and allow greater introspection during the interviews of former students, which were conducted last.

A protocol for recording information was established to organize the interview. The protocol included: (a) opening statements of the interviewer, (b) the key research questions, (c) probes to follow key questions, (d) space for interviewer's comments, and (e) space to record reflective notes. Each interview recording was transcribed verbatim following the session.

Data Reduction

Data reduction included a process of selecting, focusing, simplifying, abstracting, and transforming the "raw" data from the transcribed interviews and field notes. This process began with the selection of the conceptual framework and identification of research questions, developed to guide the study as well as the selection of methods of data collection. Thus, the process of data reduction began before the data was collected and continued until the data was actually coded for themes, clustered and summarized. According to Miles and Huberman (1984), data reduction is a key component of analysis which sharpens, sorts, focuses, discards, and organizes data so that conclusions can be drawn and verified. The role of the qualitative researcher is to focus on "critical incidents' in order to make gradual sense of a social phenomenon by using sampling activities such as contrasting, comparing, replicating, cataloguing, and classifying the object of one's study.
The strategy selected for this study corresponds to Lincoln and Guba's (1985) definition of typological analysis which applies to externally derived theoretical categories of new data, examines relationships among the typologies, and allows for their extension and refinement. Categories and variables were modified to fit the data as the study progressed. Following the interviews, I coded the data and developed a typology of categories of concepts for analysis. In conjunction with this approach, and over time, the constant-comparative approach was also utilized. The constant-comparative analysis method of qualitative data as described by Lincoln and Guba (1985) utilizes a simple scheme of unitizing and categorizing processes to identify emerging themes. This method was primarily used in the analysis of the interview data.

Each transcribed interview was first categorized by the four pre-determined categories that were used to develop the outlines for interview: decision to become a nurse; school life; relationships; and after graduation. Following this first division of data, each category was placed in a separate document. The data were then reviewed for the identification of concepts within each category. The concepts I identified were socialization factors within the hospital; socialization factors within the educational environment; and feelings expressed by the former students. The data was then unitized by these concepts and sorted.

Following sorting by concept, I identified recurrent themes occurring within each concept and wrote these down. Then, I refined the categories to be values held by the hospital/profession of nursing; relationships of students with others; and feelings expressed by former students. I then sorted the data by these categories and numbered
the units to correspond with the categories. I then counted the frequencies of each unit per thematic category. 

I then compared the frequencies of each unit per thematic category of all the different interviews, which were time designated. I counted frequencies over the life of the institution and concluded that the following socialization themes persisted over the life of the institution: social isolation, student-to-student support, obedience/conformity, self-sacrifice, self-discipline, fear, and subordination.

**Data Display**

Data display provides for the presentation of information in an organized, accessible, and compressed form in order that accurate conclusions can be drawn or action taken. Miles and Huberman (1984) describe data display as an integral part of analysis as well as a data reductive activity. This activity allows for a more reduced set of data that increases the probability of drawing meaningful conclusions as well as taking the next proper step in the data analysis.

**Conclusion Drawing and Verification**

The final step in the analysis of the qualitative data involves conclusion drawing and verification. This phase is characterized by analyzing meanings, noting patterns, themes and explanations, possible causal flows, and propositions. While the initial conclusions may be vague, they become increasingly explicit and grounded (Miles and Huberman, 1984). Conclusions were verified in this phase by checking results with informants and the analysis proceeded with emerging meanings and validity testing.
Refinement and Validation of the Research Process

According to LeCompte and Goetz (1982), the researcher's central concern should be directed toward an accurate and faithful portrayal of the client's "life ways." Accurate reporting of colleges and universities is not a simple task due to their complex and inconsistent institutional environments, according to Crowson (1987), who asserts that trustworthiness is an especially salient concern and issue in the study of higher education. Lincoln and Guba (1985, p. 300), note that well-designed qualitative research should focus upon "trustworthiness" and "confirmability" rather than the more conventional notions of reliability, validity, objectivity, or generalizability found in quantitative research. The following section addresses several strategies that were incorporated into this qualitative study to address the criteria of trustworthiness.

Trustworthiness

Lincoln and Guba (1985) emphasized the need to meet four constructs in order for well-designed qualitative research to have an established norm of trustworthiness in the research findings. These constructs are identified as credibility (the accuracy of portrayal); prolonged engagement (persistent observation, triangulation); transferability (a study's database may be applicable to another context); dependability (process is consistent, internally coherent, ethically aboveboard); and of confirmability (findings are grounded in data, logical, and acceptable and can be confirmed by someone other than the researcher) of the research findings (Lincoln and Guba, 1985).
Triangulation

Triangulation, the use of multiple data sources and collection methods, was another goal of this study. Internal validation was promoted by utilizing multiple sources of data (documents and interviews), the perceptions of the investigator, and reliance on internal consistency as the criterion of validity wherever possible. Triangulation (supporting a finding by showing that independent measures agree with it or, at least, do not contradict it) was used to counteract bias. Triangulation (Webb, Campbell, Schwartz, Sechrest, and Grove, 1966) also refers to the use of internal indices to provide convergent evidence. The goal is to ensure dependability of a finding by seeing or hearing multiple instances of it from different sources, and by assuring that the findings are consistent with other findings. The goal is to promote reliability and internal validity by utilizing multiple sources of data, the perception of the investigator, and internal consistency as the criterion of validity wherever possible.

Member Checks

Study participants were asked during the data collection phase to review their interviews as well as my interpretations. In addition, the research participants had the option to add to or modify information on the typed transcripts prior to analysis and incorporation of their interview content into the research study report. According to Lincoln and Guba (1985):

The member check, whereby data, analytic categories, interpretations and conclusions are tested with members of those stake holding groups from whom the data were originally collected, is the most crucial technique for establishing credibility. If the investigator is to be able to
purport that his or her reconstructions are recognizable to audience members as adequate representations of their own realities, it is essential that they be given the opportunity to react to them. (p. 314)

Methodological Log

A methodological log was intended to be kept to document how the research evolved, how information was obtained, and how data was collected, analyzed, interpreted, and reviewed, as well as all other procedures and evidence of the research process. These methods are documented to assist others in understanding how the research process was conducted and maintained.

In summary, the study sought internal validity by utilizing multiple sources of data and the validation of the study participants in this research. An external resource person served as an auditor by evaluating the data for confirmability, dependability, and credibility (Crowson, 1987) throughout the study. Credibility for this research study was established through the use of triangulation and member checks.
CHAPTER 4
HIGHLIGHTS OF THE EVOLUTION OF NURSING EDUCATION IN AMERICA

The Origins of Nursing Education

Nursing has its origins in motherhood and has always been a woman’s job. In the mid-Nineteenth Century, most nursing care was done at home as part of women’s domestic duties. Hospitals in this country developed originally as a manifestation of a charitable motivation to provide care for the indigent sick who could not provide care for themselves.

In or about 1750, Thomas Bond, a Philadelphia physician, conceived the idea of establishing an institution solely for the purpose of treatment and cure of the sick. Bond consulted with Benjamin Franklin, who wrote the petition for establishing the first American hospital, which was presented to the Pennsylvania Assembly in 1751 (Ashley, 1976).

As charitable enterprises, the early hospitals were dependent on the charitable service provided by religious orders (Catholic and Protestant) to tend to the sick patients within the hospitals. “Although all of these orders put little emphasis on formal training, they set new standards of cleanliness and conscientiousness (Vicinus, p. 89).” The women of the religious orders recruited the assistance of other women to tend to the patients. These “other” women were considered to be socially marginal and were also often the object of charitable enterprises themselves.
It was Florence Nightingale's vision (Notes on Nursing, 1860) that nursing required training and that middle-class women should be recruited to replace the religious orders and socially marginal women who had traditionally carried out most of the hospital's work. Nightingale herself was an elitist who solicited the support of other elitists, mostly men, to advance her cause.

Hospital training schools, based on the Nightingale plan, were first introduced into the United States with the establishment of three experimental schools in 1873 — at Bellevue Hospital in New York, New Haven Hospital in Connecticut, and the Massachusetts General Hospital in Boston. The Nightingale model advocated replacing nurse-servants with women nurses trained through apprenticeship in hospitals. Apprenticeship was the method of professional education prevailing at the time. In her vision of nursing, Nightingale repeatedly emphasized the womanly qualities necessary to be a good nurse such as caring and sympathy. Women were considered more naturally nurturant than were men. However, she conceded that these "natural" qualities were not sufficient and that education in organizing and administering patient care and in hygiene were equally important (Brand, 1981). She drew upon her field experiences in the Crimean War to further advance the notion of cleanliness and hygiene as the unique contribution of nursing to the care of the sick and the prevention of illness and disease. In conjunction with caring, compassionate, and nurturing qualities of "educated ladies," the emphasis on cleanliness, hygiene, and prevention of illness helped to distinguish nursing from medicine. However, she conceded diagnosis and prescription of treatment to the medical profession, emphasizing that in these areas nurses were to be
unquestionably obedient to the instructions of the doctor. With this directive, nursing was destined to forever be under the control of medical practice and its attempts at professionalization were seriously compromised by this limitation to autonomy.

To ensure that hospital training schools emphasized educational objectives, Nightingale insisted on separate administration of hospital and training school and a separate endowment for the school. The Nightingale plan provided for instruction in scientific principles and practical experience for the mastery of skills. A contractual agreement between school and hospital ensured the use of teaching facilities (Brand, 1981; Ashley, 1976).

The hospital schools established in the United States, however, differed from the Nightingale schools in England in one very important respect: they were not endowed and, thus, had no independent financial backing. In the absence of public or private support, the schools, from the time of their inception, faced financial problems of major proportions. Since the schools were financially dependent on the hospitals, hospital administrators expected to be compensated for providing training facilities by receiving labor from apprentice nurses. It did not take long for physicians and hospital administrators to recognize the advantages to the hospitals in such an arrangement. Hospitals could provide most nursing services using students who were given only room, board, and sometimes a small wage. The hospital was the master and the student nurse was the apprentice, with the latter giving free labor to the former in return for informal training in the traditional manner. It was largely due to this arrangement that
hospitals were enabled to transform from charitable enterprises to proprietary enterprises (Ashley, 1976).

By comparison, medical education did not at first have the same attractive advantages to offer hospitals. Despite much debate over the issues and opposition from many hospitals, medical educators were determined in their efforts to use hospitals as teaching centers. The growth and development of medicine as a science along with scientific developments gave rise to an emphasis on the concept of laboratory teaching, leading to a consensus that a hospital was the best possible laboratory for the study of disease (Ashley, 1976). In a very brief period of time, the medical profession succeeded in establishing connections with both hospitals and universities. In less than a decade and a half, medical education was said to have been revolutionized (Ashley, 1976).

Although modern nursing is also an outgrowth of scientific development, apprenticeship in the field was essentially a method of educating nurses while they carried on the nursing work of hospitals. Graduate nurses were employed outside of the hospital, either in private duty or in public health nursing, where a greater degree of autonomy was experienced. Graduating from hospital training schools did not mean that the nurse would return to the bedside in a more professional role but, rather, that she would altogether leave hospital nursing (Ashley, 1976).

The problems surrounding nursing development were the same as those in hospitals. Growing side by side, the social and ideological forces serving to shape the formation of modern hospitals also served to shape the development of the nursing
profession. Therefore, an understanding of nursing must be viewed in the context of hospital development and its influence on education and practice (Ashley, 1976).

When the first American schools of nursing were established, the family was the institutional model for the operation of hospitals. All policies and procedures formulated to guide management of the "household" were designed to look out for the overall interests of the institution. In this way, nursing mirrored the expected role of women in society. Like mothers in a household, nurses were responsible for meeting the needs of all members of the hospital family — from patients to physicians. In addition, women (nurses) were expected to look out for the needs of men (physicians) in the hospital family. In the absence of the men, women were expected to assume full responsibility for their decision-making functions by taking on the male role themselves. This decision-making role was, of course, relinquished upon the return of the men to the "household." Nurses were, and still are, constantly supportive of the institution, especially of its male members, and constantly busy, keeping everybody happy (Ashley, 1976).

Physicians, male administrators of the hospital, and trustees of the hospital board formulated policies and made decisions regarding the type of discipline and order to be maintained by the nursing staff (Ashley, 1976). The doctrines of discipline, obedience to authority, and male-dominated control greatly influenced the function of the hospital hierarchy.

In 1880, while nursing was a new and unestablished profession, there were 15 schools in the United States. In the next decade this number more than doubled, and by
1900, it had increased to 432. A phenomenal period of growth then occurred in the first
decade of the Twentieth Century so that by 1910, the United States Bureau of Education
reported the existence of 1,129 training schools. During the same period, the number of
hospitals increased in similar fashion. In one decade alone, 1900 to 1910, 1,651 new
hospitals were established. This was an era of unprecedented growth both for
apprentice programs for women and for institutions caring for the sick (Ashley, 1976, p.
21). The growth of new hospitals is attributed to the discovery of antisepsis and its
effectiveness in prevention and cure of illness and disease. Once the deplorable
conditions of filth and vermin were removed from the hospital setting, society began to
recognize and appreciate the contributions of the hospitals to the care of the sick. The
hospital setting was no longer associated with poverty and death, but was viewed as a
restorative institution. Families gave up their duty to care for their sick members and
relinquished that duty to the hospitals. As clientele increased, so did the need for
hospital nurses. On the other hand, the need for private duty nurses diminished. There
was not an immediate move, on the part of the hospitals or of nursing, to reposition
graduate nurses within the hospital setting. The hospitals, driven by economic forces,
attempted to increase their labor force by increasing the numbers of student nurses
admitted to their training programs. As a result, loose admission criteria were further
weakened and prior education was no longer a criteria for admission to training schools.

Schools of nursing, from 1900 on, were absorbed by or established for the
hospitals of which they were a part. The refusal to permit the schools to remain outside
the control of hospital administrators was destined to prevent their development as
independent educational enterprises. The strict discipline and the incorporation of the schools into the hospital business structure almost entirely negated their educational function (Ashley, 1976).

The public accepted this practice of exploiting the labor of these young women while promising them an "education." For decades, the average citizen did not know or question what went on in hospitals, but was persuaded to believe in the moral integrity of these institutions. Hospital representatives perpetuated the myths of their goodwill and good-works in the name of education, charity, and their publicly-defined mission of doing all in their power to provide the best of care (Ashley, 1976).

The hospitals were major instruments for women's oppression both economically and professionally (Ashley, 1976). The development of the nursing profession could not be achieved in an environment where control over the nurse's education resided in those who wished to exploit her for her labor. Indeed, apprenticeship as a social phenomenon has often been used as a means of keeping oppressed groups in subordinate positions. Even in the United States apprenticeship served for a while as "a transition stage between servitude" for both slaves and indentured servants (Ashley, 1976).

Apprentice nurses were taught to be loyal to the hospital, to be obedient and docile, and to accept the poor conditions of work and the stringent discipline. Repressive educational practices instilled in them respect for authority and a spirit of unquestioning loyalty to "master" institutions and to physicians. Nurses were not educated in a manner that might have led them to question the moral or social
implications of a system that impeded their professional development. Within the system of apprenticeship education, the administrative authority for operation of the schools was delegated to a nurse superintendent who also served as the Director of Nursing in the hospitals. The superintendent was also indoctrinated with a commitment to the values of discipline, obedience, and deference to authority. As such, the majority of these school superintendents did little to effect change or to advocate for the students. In fact, her goal was to perpetuate the system (Ashley, 1976).

By design, apprenticeship education does not provide a liberal and general education. It most often stifles intellectual growth and prepares workers only too willing to conform to prevailing customs, traditions, and efforts to maintain the status quo. It is not a system that contributes to change.

Nurse Leaders and the Bigger Picture

In the last quarter of the Nineteenth Century and into the early Twentieth Century, the elite group of nurse leaders in the United States were devoted to establishing hospital schools of nursing, to organizing nursing as a profession, and to reforming the environment of the early hospitals. Because they recognized education as critical to the development of nursing as a profession, they focused on demonstrating the value of a trained worker and emphasized the need to recruit educated young women into the developing profession. Whereas they were successful in achieving the distinction between a trained nurse and a lay nurse, the hospitals seized the opportunity to capitalize on the student nurses as a permanent source of labor. As the cause of the trained nurse gained legitimacy, leaders lost control over the management and mission
of the schools. New programs were no longer established on the initiative of the leaders or under their careful guidance. Hospitals were establishing their own training schools and determining their own standards of operation and education. In response to the uncontrolled expansion of hospital schools, divisiveness within the ranks of nursing began to occur. Nurse leaders openly criticized those trained nurses who went to work as hospital superintendents and set up schools that did not conform to the Nightingale model. In addition, women trained in the older schools constituted a self-conscious elite, separating themselves from the students and superintendents associated with the younger schools (Melosh, 1982).

The training schools stood at the center of the conflict between professional leaders and other nurses (Ashley, 1976). For those committed to professionalization of nursing, educational reform represented a key strategy. Critical of the wide variation in the schools’ programs, they pressed for uniform requirements for admission, standard curriculums, and a program weighted toward academic education rather than ward experience. Committed to professionalization, they also sought to separate nursing education from hospital nursing service. In addition, they struggled to establish and control accreditation of the schools and argued that students should pay tuition rather than receive a stipend. “Throughout, they stressed the value of a professional education -- that is, a program oriented to theoretical knowledge, based in colleges and universities, rather than in hospitals” (Melosh, 1982, p. 38).

In 1893 at the Chicago World’s Fair, a group of prominent and elite nurse leaders from the United States and Canada met to discuss issues in nursing and formed
an association called the American Society of Superintendents of Training Schools for Nurses (renamed the National League for Nursing Education in 1912) and planned the first meeting to be held the following year in New York. The primary focus of this group was educational reform to further the best interest of the nursing profession (Dolan, 1973).

In addition to educational reform, the superintendents were equally concerned about the lack of legal status for nursing practice and the problems this presented in regulation of practice. As an outgrowth of these concerns, society members, at their first convention in 1894 in New York, planned for the formation of a second national organization to address the issues related to the legal status of the practice of nursing. The second organization was established in 1896 as the Nurses’ Associated Alumnae of the United States and Canada (renamed the American Nurses’ Association in 1911) (Dolan, 1973).

With the control of education in the hands of one organization and the control of practice in the hands of another, gaps in communication were inevitable. With the separation of functions, the foundation was laid for continuing lack of unity accompanied by conflicts and misunderstandings. The two separate organizations still exist today, and so do the conflicts and the misunderstandings.

Faced with major opposition to their attempts to improve education in hospital training schools, many nursing leaders looked outward, seeking support for their professionalizing efforts from those in other fields, particularly teaching, social work, and public health. Because of their limited control of basic nursing education, they
concentrated on postgraduate education for nurses, who had already completed hospital training (Brand, 1981). The notion of postgraduate education was justified by the emergence of public health nursing as a working environment for nurses outside of the context of hospitals or private duty. The missions of “positive health” linked nurses in visiting nurses’ association and settlement houses, child welfare and anti-venereal disease associations, factory dispensaries and department store clinics. The public health movement grew out of industrialization and urbanization of America (Dolan, 1973).

For the first two decades of the Twentieth Century, public health nursing enjoyed a professional autonomy that eluded both hospital and private duty nursing. It was obvious, though, that hospital-based training did little to educate the nurse to the public health role. This was the impetus for nurse leaders to look to postgraduate education as an extension of basic training to prepare the nurse to function in a public health environment. In addition, the movement of graduate nurses back to the hospital work environment identified a need for management courses for these nurses (Dolan, 1973).

Teachers College of Columbia University was the first academic institution to establish a postgraduate program for nurses, organized by nurses in 1898. Initially, training school graduates were simply allowed to attend courses in psychology, science, and household economics. The Rockefeller Foundation study of nursing education (1923) recommended that nurses employed by public health agencies should have completed a basic hospital training program followed by a postgraduate course in
public health nursing. This recommendation relegated course work in this area to collegiate courses at the postgraduate level (Ashley, 1976).

**Nursing Education and the University**

By 1917, many nurse educators were convinced that the university was the setting in which their educational plans could best be realized with the least expenditure and the largest gain to the student. They began to formulate plans for new relationships with the university that combined two years of college education with three years of university-controlled nursing course and practice that allowed the university to confer, upon completion of the five years, a baccalaureate degree (Ashley, 1976; Melosh, 1982). However, formulating and implementing plans are two very different phenomena.

Even as late as the turn of the century, universities were often reluctant, and sometimes ungracious, hosts to the professions, both established and emerging. Traditionally the universities were the haunt of gentlemen scholars and clergy, and they viewed themselves as the sole guardians of intellectuality and liberality of spirit. The university remained a rather isolated institution. The notion that higher learning should be applied in the pursuit of everyday affairs was still an alien doctrine and almost devoid of moral respectability (Davis, Olesen, and Whittaker, 1966).

The explanation for the initial incompatibility of nursing with the university lies essentially in this tradition. Nursing was defined as crassly vocational. Academicians viewed nursing as militaristic and technical, and they termed its motivations for higher learning utilitarian. As women, and, moreover, as vocationally-oriented women, nurses
were viewed by tradition-bound universities as a group doubly unfit for whatever higher education had to offer (Ashley, 1976; Melosh, 1982).

But, the values of universities were soon to change under the combined impact of the credos of science, community service, and the common man. Out of the necessity to cope with and assimilate such radical intellectual eruptions as Darwinism and, later, Freudianism, the academic establishment, within a matter of decades, abandoned its dedication to Greek, Latin, and natural philosophy (Ashley, 1976).

In this changing climate, the universities slowly relented to the clamor from occupations barred from higher learning. The ground upon which the values of universities and of the new occupations, such as nursing, were welded was the ideology of professional service with its promises of joining learnedness to altruism and furthering the general welfare.

Since 1909, the growth in undergraduate nursing programs has been steady, although far from pronounced. By 1919, there were nine such programs, by 1929 thirty-two, by 1935 seventy, and by 1961 there were 176. In 1962, diploma-granting hospital schools of nursing still outnumbered collegiate schools by almost five to one (Davis, Olesen, and Whittaker, 1966).

From 1920 to the 1940s, despite the slow but steady growth of collegiate programs in nursing, the ranks of diploma nurses were in increasing demand for the labor force of hospitals. Hospital administrators as well as nurse administrators in hospitals valued the diploma nurse over the university educated nurse. This was due in large part because the university nurse had been educated largely outside the hospital
culture and did not adapt as well to the work environment post-graduation. They simply had not been socialized to the paternalistic and obedient culture of the hospital. For their part, the physicians viewed collegiate-prepared nurses as suspect and criticized their lack of technical skill (Davis, Olesen, and Whittaker, 1966).

During this period, the influence of the collegiate programs spread to the hospital-based training programs in terms of the need for general education courses to support the nursing curriculum. Courses in the sciences and behavioral sciences were introduced into the curricula of diploma programs in nursing. However, these courses were most often modified for nursing students so that they did not meet the rigors of collegiate level courses. The value of nursing education continued to be vested in clinical apprenticeship (Ashley, 1976; Davis, Olesen, and Whittaker, 1966).

Pre-and Post World War II Influences

National leaders in nursing responded to the threat of war in 1940, the year before Pearl Harbor, by forming the Nursing Council on National Defense to address the position that nurses should take with respect to national defense and the many adjustments that may be called for during wartime. Thus, even before the United States became involved in the hostilities, leaders in professional nursing began to coordinate their efforts at the national level. The Nursing Council on National Defense would profoundly affect the course of nursing history. It proposed the study of the nursing profession that became known as the Brown Report (Dolan, 1973) and later reconstituted itself as a committee to implement the report. The Brown Report proposed that nurses be trained in colleges and universities, not as hospital employees.
Not only were nurses, themselves, creating the structures within the profession that would play a critical role in the changes and reforms of the postwar years, but the federal government was also setting up programs, agencies, and patterns of funding that would affect postwar nursing programs. The Bolton Act (Dolan, 1973), creating the United States Cadet Nurse Corps, was enacted into law on June 15, 1943 and marked the first time in the nation’s history that the federal government would subsidize the entire education of a nurse.

As a result of the The Bolton Act, the standard three-year nursing program was accelerated, as cadet nurses were trained in thirty months. The cadets served an additional six-month practice assignment to satisfy state boards of nursing requirements that nurse training programs consist of 36 months of training prior to eligibility for licensure. Nevertheless, it was during the war that an abbreviated curriculum for training the registered nurse was first developed and that the use of both colleges and universities by nursing schools was expanded (Dolan, 1973).

The events of the war, the conditions it imposed on the nation, and the various social forces of the prewar and war years -- all were to lead to a severe nursing shortage that became acute immediately after the war and persisted at high levels until the late 1970s. Peak shortages, virtual crises, occurred in the late 1950s and early 1960s (Dolan, 1973).

By the end of the 1940s conditions were ripe for the emergence of a wholly new, unprecedented way to educate registered nurses. The prevailing perception was that nurses were critically scarce and the shortage would not just simply go away.
Americans were more than ever focused on education as a means of solving social problems and optimistic about their ability to succeed in applying such solutions. At the same time, they had become acutely aware of the new demand for nursing services in a rapidly expanding health care system. The nation needed to maintain the number and quality of nurses to sustain its growth (Dolan, 1973).

At the end of the war, government officials, physicians, hospital administrators, educators, and nursing leaders were working on plans for reform that would improve American health care and the education of health care professionals. Many of these efforts would coalesce into the Associate Degree in Nursing (ADN) movement, for it became increasingly apparent to many during the last half of the 1940s that by educating nurses in two-year colleges, the nation might resolve the concerns of nurses and others about the future directions of nursing education and, at the same time, address the nurse shortage problem (Dolan, 1973).

The crisis in health care brought on by the war and the experience gained by the federal government in administering the funds for the Cadet Nurse Corps had exposed the basic, underlying weaknesses in nursing education to a wider public than ever before. The nursing leaders in the National Nursing Council (formerly the National Defense Council), realizing that the widespread worry over the nursing shortage provided them with the opportunity to gain broader support for the educational changes long sought by nursing, recommended that a national study be made of nursing education. Using funds provided for the task by the Carnegie Foundation, the council engaged a member of the staff of the Russell Sage Foundation, social anthropologist Dr.

In her report, Brown argued that the United States should be educating its nurses at least as well as it was educating its teachers at the nation’s colleges and universities. She further criticized hospital-based programs as inadequate and authoritarian. She recommended the establishment of nursing schools to match the number of the nation’s medical schools and to be distributed throughout the country in colleges and universities (Dolan, 1973).

A collaborative effort by the National League for Nursing, the Kellogg Foundation, and the Teachers College of Columbia University laid the foundation for Associate Degree Nursing in America. Slowly but surely, all the pieces were being put in place. Professional nursing and higher education were in a state of full readiness for the first attempts to educate Registered Nurses in two-year programs based in junior and community colleges. This foundation was based on the premise that basic nursing education might have a separate “technical” aspect that was to be the cornerstone of ADN education. The year was 1951 (Dolan, 1973).

The growth of ADN education during the 1950s was steady, but it was nothing compared to the explosion of the 1960s when, at times, a new ADN program was opening somewhere in the country every week. One reason for the rapid expansion was federal financial assistance to nursing education; another was the rising concern among
Americans over health and social issues, especially those regarding equal access to health care and to educational opportunity for all citizens (Haase, 1990).

Even as ADN education grew explosively, the nursing shortage continued unabated. The national nursing organizations struggled to deal with the largely unforseen consequences of the increasing controversy about nursing education and to sort out their respective roles among themselves. Not only health care but the nation itself was passing through a time of upheaval. The civil rights and women's movements arose, confrontational politics exploded into violence at times, the Vietnam War grew into a deeply divisive issue, and the very social fabric at times seemed to be at risk. Few, if any, of these issues proved to be irrelevant to nursing. The strain of dealing with them took its toll on the profession (Haase, 1990).

In the late spring of 1950, the six existing national nursing organizations endorsed a plan for reorganizing themselves into two units. They would form the American Nurses' Association (ANA), for nurses alone, and the National League of America, which included others besides nurses as members. The latter was subsequently renamed the National League for Nursing (NLN). The reorganization was completed by 1952. The task of fostering the development and promoting excellence in nursing education fell to the NLN (Dolan, 1973).

During the mid-1950s, the NLN's effort to promote its educational arm was quite active. At the same time, the ANA was addressing the improvement of standards of nursing competence that “could not be divorced from concern about the standards of education” (Haase, 1990). By 1959, the ANA had assumed the position that the
education of all RNs should be located in institutions of higher education. Thus began a struggle between the ANA and the NLN over which organization had jurisdiction over matters of nursing education.

In April of 1960, the ANA’s Committee on Current and Long-Term Goals recommended that the “ANA shall promote the baccalaureate program ultimately so that in due course it becomes the basic education foundation for professional nursing” (Haase, 1990, p. 87). This strong position of the ANA was perceived as an attack on diploma and ADN education and a considerable threat to the graduates of those programs. Many graduates of diploma and ADN programs believed that they were entering professional practice and that the ANA goal, were it realized, would exclude them from first-class status in the profession.

In 1960 (as well as in 2000), all three types of nursing programs were preparing nurses for practice that many considered professional. Those outside as well as inside nursing questioned why, if the graduates of all three were equally qualified as RNs, there were three programs at all, and not just one? Or, alternatively, if the programs were distinctly different and producing different graduates, why were the distinctions ignored in lumping together in the workplace? Why did all of them take the same licensing examination? These questions continue to be addressed today.

In 1964, the NLN began to redirect its attention more to the future of nursing education and adopted the following resolution: “to define the steps that need to be taken; study the concept of change and its effect on educational programs; and chart a course for the future of NLN in education” (Haase, 1990, p. 93). With this resolution,
the NLN took a position that was sympathetic toward higher education for nurses but, nonetheless, expressed the belief that hospital schools of nursing would continue to carry the major part of the load for some time to come. (In 1965, diploma schools comprised 69 percent of all programs for nursing education). However, the League further stated that their position did not rule out the eventual shift that would place nurse education wholly within higher education institutions.

In September 1965 the ANA made its first definitive statement on nursing education in its endorsement of A Position Paper on Educational Preparation for Nurse Practitioners and Assistants to Nurses, known ever after as the “Position Paper.” The position set forth was briefly summarized by Haase (1990) as follows:

First, it was asserted that the education for all those who are not licensed to practice nursing should take place in institutions of higher education. This was nothing more than a restatement of the fundamental recommendation of the Brown Report, issued seventeen years earlier.

Second, it was asserted that the minimum preparation for beginning professional practice at the present time, not at some future date, should be the baccalaureate degree in nursing. The refusal to put this off as a goal for future realization was the most controversial feature of this white paper.

Third, the paper described the associate degree in nursing as being currently the minimum preparation for beginning technical nursing practice. The use of the term technical was a subject of much heated debate.

Fourth, the paper declared that education for assistants in health care occupations should be short, intensive pre-service programs in vocational education institutions, not on-the-job training programs.

The ANA also asserted its intention to continue supporting all three categories of nurses delivering health care service: the professional, the technical, and the assistive. (pp. 93-94)

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By 1977, the ADN, more than any other educational program in nursing, had moved nursing education solidly into the general system of education. In just two decades the number of associate degree programs in nursing had grown to 656, nearly half of the total number of nurse education programs in the country. Graduates of these programs were 47 percent of the total number of graduates that year. Approximately 52 percent of all American junior or community colleges had ADN programs. And yet, despite the vigor of the ADN program, the controversy surrounding it would not die. Its accomplishments were just not enough for the growing number of nurses who wanted at least the baccalaureate as the first professional degree. Both national nursing organizations had so named the baccalaureate, designating 1982 as the year for achieving this goal within the profession. The number of B.S.N. programs had indeed grown during the 1970s, but by 1977, they still constituted only 30 percent of the total. Nevertheless, the desire for the baccalaureate as the basic program remained strong in nursing circles (Dolan, 1973; Haase, 1990).

Understandably, with a shift in nursing education to the collegiate level, attention was directed to the preparation of nurse faculty. With pressure from higher education regional accrediting agencies, state Boards of Nursing began to require a minimum of a master’s degree for all faculty teaching in schools of nursing. Initially, with a shortage of available graduate programs in nursing, those graduates of baccalaureate programs in nursing earned masters degrees in other disciplines. However, with the inevitable push to doctoral education and with the nursing profession’s desire to realize professionalization, the master’s degree in nursing became
a more rational requirement for nurse faculty. In fact, Louisiana was one of the first states to require all nurse faculty to have an earned master's degree in nursing by January 1, 1986.

Graduate schools have continued the conflicts and debates between the profession and nursing education. Within the master's programs in nursing, a nurse can either become a clinical nurse specialist (allows for a specialty in education) or a nurse practitioner (a specialized practice role). At the doctoral level, the debate centers around the role of the doctorally prepared nurse and the appropriate degree to be earned. There is support for both a practice degree (such as the DNS offered by LSU Medical Center in New Orleans) and for the academic degree of Ph.D. (for which there are no programs in Louisiana).

Obviously, nursing will continue its struggle to establish itself as a profession, and the issues associated with nursing education will also continue. Today (2000), there are still three levels of basic education for nurses in the United States. Hospitals continue to make little distinction among the graduates of each program. Graduate education continues to proliferate, as does the competing struggle over where the nurse with the advanced degree should practice — in the clinical arena or in higher education.

Nursing has made tremendous strides in its evolution as a profession, but the reality has not yet been realized. It is doubtful that true professionalism can be achieved independent of woman's role in society. There, too, tremendous advances have been made. But nursing, as a female dominated profession, will not advance any farther than women are allowed equality in society.
CHAPTER 5
THE FOUNDING AND EARLY LIFE CYCLE
OUR LADY OF THE LAKE COLLEGE: 1923 - 1949

Our Lady of the Lake College was established in 1923 as Our Lady of the Lake School of Nursing, a hospital-based diploma program in nursing, and remained exclusively dedicated to the educational preparation of nurses until 1990 when it was registered with the Louisiana Secretary of State and the Louisiana State Board of Regents as Our Lady of the Lake College of Nursing and Allied Health, an independent degree granting institution. At that time, allied health programs in radiologic technology and surgical technology were offered in addition to the program in nursing. The 1990 charter was amended in 1995 to change the name of the institution to Our Lady of the Lake College.

From a historical perspective, Our Lady of the Lake College provides a unique opportunity to explore one institution's experiences in providing nursing education continuously since its inception in 1923. Although the first nursing school in the United States opened in 1872, most of the diploma, hospital based nursing schools have since closed. In 1900, prior to the establishment of standards for nursing education, there were 432 schools of nursing in the United States. This compares with 797 hospital-based programs, 218 associate degree programs and 210 baccalaureate programs in nursing in 1966 (Flanagan, 1976). In 1998, there were only 86 diploma programs in nursing, accredited by the National League for Nursing, still in existence in the United States (National League for Nursing Accrediting Commission, 1999). Most of the...
programs closed or transitioned during the 1960s and 1970s in response to changes within the profession of nursing and nursing education, as well as a changing society and a changing health care delivery system. Many of the earlier programs merged with existing colleges and universities; others just closed their doors forever. Our Lady of the Lake College is one of approximately 220 health sciences colleges that have transitioned from hospital-based training programs to independent degree granting institutions of higher education. Among these unique institutions of higher education, Our Lady of the Lake College is one of the largest and most diversified in terms of number of enrolled students and number of programs offered. The College has become a model for similar institutions.

Our Lady of the Lake College is a private, co-educational, religiously-sponsored four-year institution that awards associate's and bachelor's degrees in Health Sciences and Arts and Sciences. Initial regional accreditation by the Commission on Colleges of the Southern Association of Colleges and Schools was achieved in June 1994, with reaffirmation of accreditation in 1999. In Fall 1999, approximately 1000 students were enrolled in the College.

As a reflection of the institution's leadership and decision-making processes, its responses to external changes are important to analyze within the environmental context within which they occurred. Such an analysis helps to define the institution's posture and position as a direct participant in the world of nursing and higher education and may also provide a means of understanding changes that continue to occur at the institutional level. In addition to the institution's relationship to nursing and allied health education
and the profession of nursing, the study also explores the College's continuous, interdependent relationship with its sponsoring organizations, the Franciscan Missionaries of Our Lady and Our Lady of the Lake Regional Medical Center.

While this study documents the evolution of Our Lady of the Lake College within a changing external environmental context, it is also necessary to explore and recognize the internal context that also influenced and was influenced by the evolution of the institution. The evolution of Our Lady of the Lake College, as an institution, in response to both internal and external environmental changes, will be explored within a framework of systems theory, social change and organizational theory, including organizational culture.

Establishing a Presence: 1200s - 1923

The history of Our Lady of the Lake College cannot be extricated from the history of Our Lady of the Lake Regional Medical Center and the sponsoring order of the Franciscan Missionaries of Our Lady. All three entities have evolved to their present day status in relation to one another. This triadic organizational relationship flowed from the singular organization of the Franciscan Sisters of Calais.

The Founding Order

To fully appreciate the organizational culture of Our Lady of the Lake College, it is valuable to trace the history of the founding order to its origins. As Dr. Lynn Pesson noted (Lake Echoes, 1999) in his historical account of the order of the Franciscan Sisters in Louisiana, the Sisters were so busy operationalizing their mission, that they did not keep very good records of their history. I have attempted to summarize
the origins of the order through documents published by the Franciscan Missionaries of
Our Lady as well as historical sources of nursing in society and anecdotal records
appearing in newspaper articles (Monroe Morning World, 1955; Dolan, 1973; "The
living tradition", 1986; Lake Echoes, 1999).

Before beginning a historical summary, it is appropriate and helpful to define
some common terms that help to distinguish the Order of the Franciscan Missionaries of
Our Lady from other groups of women religious and to better understand the
relationship of the Sisters to the Catholic Church.

Whitney (1999) in The calling: A year in the life of an order of nuns offers the
following definitions:

Chapter: The governing legislative body of a religious
order or congregation. (p. 251)

Congregation: A religious community whose members
are bound by simple rather than solemn vows.
Congregations are not chartered directly by Rome. Since
1752, no new religious orders have been permitted by
Rome. Unlike religious orders, congregations are subject
to varying degrees of government by councils of bishops.
Male religious communities founded since 1752 have
avoided this interference by organizing as "pious
societies," which are not bound by vows. Women weren't
permitted to form pious societies. Therefore, all religious
communities of women founded since 1752 have been
congregations. (pp. 251-252)

Constitutions: The rules originally laid down by the
founder and later modified by various chapters concerning
the basic purpose and daily life of the order or
congregation. Constitutions must now be approved by the
"Sacred Congregation for Religious" in Rome. (p. 252)

Convent: The community dwelling of members of a
religious order or congregation. Current usage limits the
term to mean only the home of women religious. During the Middle Ages, convents could also mean a dwelling of male religious. (p. 252)

Nun: A female member of a contemplative religious order. The words nun and sister are often used interchangeably. They do not always mean the same thing, but the usage is universal. Some nuns are not cloistered, and some sisters are not nuns. (p. 253)

Order: A religious group officially chartered by the Pope, and exempt from church jurisdiction over its affairs. No new orders have been allowed since 1752. (p. 253)

Religious: A person who is a member of a religious order or congregation. A woman religious or a male religious. (p. 254)

Religious life: Life in a religious community, usually under some form of vows. (p. 254)

Secular clergy: The parish priests and bishops of a diocese. Secular clergy don’t take vows. They can own property. Celibacy and obedience to the local bishop are administrative regulations, not vows. (p. 254)

Sister: A female member of a religious congregation. Sister and nun are words that are used interchangeably. But a sister need not be a nun. A nun is under solemn vows, whereas a sister may not be. (p. 254)

Vow: A formal promise in which a person binds himself or herself to a strict set of codes and obligations. Usually made by a member of a religious community, there are usually three vows required: the vow of poverty, the vow of chastity, and the vow of obedience. (p. 254)

When the Franciscan Sisters of Calais emigrated from Calais, France in 1911, they settled in Monroe, Louisiana, to found St. Francis Hospital. Although they originally intended to establish a hospital in the Alexandria area, the Sisters learned,
after arriving in Louisiana, that the funding had fallen through. With the financial assistance of the Rev. Ludovic Enaut, the Sisters relocated to Monroe to establish their ministry of serving God's people and alleviating suffering. This was the order's first established location in North America and Louisiana remains the exclusive site of the order's ministry on the North American continent.

The Order of the Franciscan Sisters of Calais dates back to the 13th century when St. Francis sent Brother Pacificus to France in 1217, where he established the first Franciscan monastery in that country. As provincial of the Order in France, Brother Pacificus was instrumental in multiplying the numbers of brothers and monastic communities in that country. However, the numbers of the poor who were hungry, the sick who were suffering, and the orphans being abandoned among the people of France were overwhelming to the brothers. A different type of religious ministration was required from that of the period when communities lived around a monastery. The solution to this demand came when St. Francis and St. Dominic each founded three religious orders: the first order was for friars; the second order was for nuns; and the third order was for the laity, men and women who continued to lead secular lives (Dolan, 1973). In order to better meet the needs of the French people, Brother Pacificus sent for some sister tertiaries from Italy who worked to alleviate misery. These sisters formed the Secular Third Order which, in time, established convents for women who devoted themselves to works of mercy.

According to historical documentation (1986), the first Franciscan tertiaries, Grey Sisters, were established at St-Pol sur Ternoise, in the north of France, around
1223-1224, before the death of Francis in 1226. Documentation supports their presence in a local hospital in 1263 and in 1377 in a hospital of the Recollets under the name of the Black Sisters. From the 13th to the 18th centuries the Sisters extended their ministries throughout the north of France. After the Thirty Years War, around 1650, there were 70 non-secular convents and almost 1200 sisters. Among all of these convents, dispersed throughout Flanders, six Houses figured prominently in the origin of the Congregation. All but one primarily ministered to the sick within a hospital confided to the sisters. The remaining House was devoted to the care of orphans. All were flourishing in the years prior to 1789.

The French Revolution (1789-1815) took a heavy toll on the religious communities of the Six Houses of the Franciscan sisters. The hospitals were taken over by the government and run by the laity. The sisters were driven from their convents and their communities dissolved. They were forced to return to a secular life.

In 1807, the hospital at Calais was in such disorder that the administration decided to "confide the house" (The Living Tradition, 1986) to four Franciscans who arrived to find about 300 abandoned children and elderly. It was the beginning of a period of reconstruction for the previously existing Six Houses plus the Seventh House at Calais. However, the recovery was inhibited by the decentralization and isolation of each of the communities. Each one functioned independently with its own Rule, customs, resources and habits. It is interesting to note that the published historical account of the Franciscan Missionaries of Our Lady (The Living Tradition, 1986) addresses the forced dependence of the sisters on the administrators of each hospital
establishment. This dependence apparently resulted in what the documentation refers to as "abuse" (p.8). The abuse was described thus: "The consent of the administrators was necessary in order to receive a novice or to admit her to religious profession, right to punish or send her away...." (p.8). This was clearly a threat to the autonomy of the religious order and represented an intrusion by the government owned and operated hospitals into church-related activities.

A union or consolidation of all the Franciscan communities of the region (Diocese of Arras) seemed a desirable goal. The goal of unification was championed by Father Adolphe Duchenne, appointed chaplain of the Calais hospital in 1840, and Mother Louise, the Superior of the Franciscan Sisters of Calais, and was supported by the Monseigneur Parisis, Bishop of Arras, with the cooperation of the Vicar General, Abbe de la Tour d'Auvergne.

On April 12, 1854, an imperial decree from the French Government acknowledged the new unified congregation under the name of "Hospitaller Sisters and Teachers of the Third Order of St. Francis of Calais." In November 1866, the superiors went to Rome to present the Constitutions of the Congregation to the Holy See for approval. The decree of commendation dates to June 5, 1867. Bishop Lequette, bishop of Arras, promulgated the Constitutions on April 8, 1868 and the solemn decree of final approbation of the Congregation by the Holy See is dated March 15, 1892.

The unification strengthened the Congregation and enabled the Sisters to expand their ministry. Around 1910, the Congregation had approximately 800 sisters and had thirty-six houses in France and twenty-four in foreign countries, including Belgium and
Portugal in Europe, as well as on the continent of South America, and in the mission countries of Turkey, Arabia, Abyssinia, and French Somaliland. In 1964, the Franciscan Sisters of Calais solicited and obtained approval from Rome to change their name to the Franciscan Missionaries of Our Lady to better describe the extension of their ministry to diverse areas of the world (1986).

In September of 1911, Mother de Bethanie Crowley and five of the Sisters made their historic voyage to expand the ministry of the Franciscan Sisters of Calais to the North American continent (Lake Echoes, 1999). After arriving in New York City, the six Sisters traveled by train to Pineville, Louisiana, where they learned that the funding for their hospital had not materialized. At the invitation of Father Ludovic Enaut, the Sisters relocated to Monroe, Louisiana and established the St. Francis Sanitarium and Training School. The hospital opened in 1913 and graduated the first class of nurses in 1916.

As the Sisters established their hospitals and nursing schools in Monroe and Baton Rouge, they were undoubtedly challenged to adapt their European cultural beliefs and experiences in nursing and nursing education with the realities and expectations of American culture. The Franciscan Sisters of Calais who immigrated to Louisiana were from France and Ireland, both predominately Catholic countries, and had been educated as nurses prior to their voyage to America. The resolution of cultural contradictions and conflicts most likely occurred within St. Francis Sanitarium and Training School, established in 1913. Although the population of Louisiana is largely Catholic, the northern part of the state, where Monroe is located, is largely non-Catholic.
Monroe was an almost entirely Baptist community when the Sisters arrived. Without tangible evidence to bear witness to their heritage and success in hospital ownership and operation, the Sisters bore the burden of proof of their ability. According to Dr. Lynn Pesson (Gale, 1999), it was "strict discipline and running a tight ship that endeared the Sisters to Monroe" (p. 8). The Sisters' Christian values of love for all mankind and service to humanity became consistently evident to the community of Monroe as the Sisters worked tirelessly to carry out their mission and ministry.

Kauffman (1995) addresses the unique character of early Catholic hospitals within Nineteenth Century American society. Although Catholic hospitals were founded within the boundaries of Catholic ideology, their inherently public character fostered an accommodation to religious pluralism. In a republican climate, infused with the principles of religious liberty, of separation of church and state, and of religious pluralism, the founding orders of American Catholic hospitals were challenged to preserve their religious meaning within the pluralistic setting of the Catholic hospital through the dynamic of denominational interaction (p. 2-3).

In order to carry out their ministry of healing, the nurse-sisters were challenged to reinforce their troops. The original Catholic schools of nursing were operated in conjunction with the hospital as a means of providing nursing education for women religious. The earliest models did not allow lay women to attend. This was consistent with Catholic colleges for women which originated as a means to educate women religious as teachers. The Franciscan Missionaries of Calais did not restrict admission
to its nursing school in Monroe to women religious, but a foundational cornerstone of
the nursing program was to provide a means to educate additional women religious.

The Founding of Our Lady of the Lake Sanitarium

Meanwhile, further south in Baton Rouge, Louisiana, the health care needs of
this river city were growing. According to newspaper articles in the Catholic
Commentator (November 11, 1973) and the State Times (October 10, 1977), Dr. and
Mrs. W. B. Chamberlin bought the Aldrich home at 1303 Main Street in 1914 and
opened St. Mary's Infirmary in 1917. Dr. Chamberlin worked in cooperation with
Monsignor Dressert, Pastor of St. Joseph's Church, to attempt to recruit a religious order
of nuns to take over the operation of St. Mary's Infirmary. Their attempts were
unsuccessful, as were those of Father Racine who had succeeded Monsignor Dressert
and had continued the effort begun by his predecessor.

In 1921, Father F. M. Glasser, who succeeded Father Racine, together with Dr.
Chamberlin, Dr. S. O. Trahan, and a committee of "influential citizens" (1973) met to
again discuss finding an order of sisters to take over the operation of St. Mary's
Infirmary. The Franciscan Sisters of Calais, who immigrated in 1911 and were
successfully operating St. Francis Sanitarium in Monroe, were invited to visit Baton
Rouge. The committee identified the spirit of the order as one of Christian charity
expressed in works of nursing (Sunday Advocate, November 25, 1973).

When Mother deBethanie and the Sisters visited Baton Rouge in 1921, they
were impressed with the city and its industrial growth potential. The population of
Baton Rouge at that time was approximately 21,000. The industrial presence of
Standard Oil and Mississippi River commerce ensured economic growth. Envisioning the growth opportunities, the Sisters recommended constructing a larger facility rather than continuing the site of the hospital at St. Mary's Infirmary. Mother deBethanie selected a site for the proposed hospital near University Lake (later named Capitol Lake) close to the Louisiana State University campus, which was then located at the Pentagon Barracks. The site she chose had at one time been a sugarhouse and was reported to have been a mule yard at the time Mother deBethanie first saw the land that was to become the home of Our Lady of the Lake Sanitarium (Sunday Advocate, January 1, 1978).

The new hospital, to be owned and operated by the Franciscan Sisters of Calais, was constructed with $30,000 in funding, donated by the Baton Rouge community. Our Lady of the Lake Sanitarium opened on November 4, 1923 with a 100 bed capacity. Mother deBethanie served as the first administrator of the hospital until her transfer to Ireland to pursue other duties in 1929. The Catholic Daughters of America donated a statue of the Virgin Mary, which was placed on an island in University/Capitol Lake, to oversee the ministrations of the ill (1978).

The Founding of Our Lady of the Lake School of Nursing

In 1923, the same year that Our Lady of the Lake Sanitarium opened its doors to the Baton Rouge community, the Franciscan Sisters of Calais established Our Lady of the Lake School of Nursing for the purpose of training nurses to assist them in the care of the hospital patients. An unidentified newspaper clipping (1923) from the College archives announcing the proposed opening of OLOL Sanitarium in October 1923
(although it actually opened in November), also reported that applications for the training school to be operated in conjunction with the Sanitarium had been received. The article further reported that "this branch of study...will be in the charge of an experienced nurse and will be conducted along lines of study maintained by Hotel Dieu and Touro Infirmary in New Orleans and Schumpert Sanitarium at Shreveport" (1923). It can be assumed from the article that the three mentioned training schools were already in full operation. It is interesting that there is no reference to the training school associated with St. Francis Sanitarium in Monroe.

Five pages of handwritten notes signed by Mother deBethanie identify the applicants to the first class admitted to Our Lady of the Lake School of Nursing. Five of the first students transferred from St. Francis in Monroe. These students were identified as: Miss Olga Patton, Miss Helen Lucille Funiell (or Fumell), Miss Mabel Fleming, Miss Wilma Patton, and Miss Rose Mary Fagan. These students arrived in Baton Rouge at various times between June 17, 1923 and September 4, 1923. In addition, Miss Cordia Arbour transferred from Hotel Dieu Hospital Training School in New Orleans, Miss Mary Baillio transferred from Charity Hospital Training School in New Orleans, and Miss Honorine M. Duplantis transferred from Touro Infirmary Training School in New Orleans.

The following new (non-transfer) students were also admitted into training at Our Lady of the Lake during November 1923: Miss Ruth Guidry Streble (Addis, La.); Miss M. J. Daudmon (Wilbert, La.); Miss Marie Lillian Charleville (Grosse Tete, La.); Miss Adie Jean Bourgeois (Gibson, La.); Miss Ethel Marie Robeau (Plaquemine, La.); and, Mr. 97
Raymond Money (identified as a male student nurse in a marginal note) (Baton Rouge, La.). Miss Sebrina Major (Baton Rouge, La.) and Miss Eva Mary Kernan (Dutchtown, La.) entered training in December 1923 and "Miss Murphy" entered January 5, 1924 (handwritten notes of Mother deBethanie, 1923-24) to complete the first class. In summary, five students transferred from St. Francis in Monroe, three from other training schools in Louisiana, and nine new students for a total of 17 students.

Of the seventeen students admitted to the first class, nine graduated. In addition, Sister Marie Magdalen Lemoine, a member of the order, also graduated with the first class. The first graduate of Our Lady of the Lake School of Nursing was Miss Cordia Arbour, who completed the program in 1925, but participated in the graduation ceremonies with the remainder of the class in 1926. Miss Arbour had completed 18 months of training at Hotel Dieu Hospital in New Orleans prior to entering training at Our Lady of the Lake School of Nursing and, therefore, was able to complete the program before the remaining students in the class.

Among those in the first class who did not finish the program was the one male student. It is somewhat surprising, given the overwhelmingly female nature of nursing schools of the time, that a male student was even admitted to the program. However, there was an apparent identified need for male nurses, as evidenced by the April 18, 1923 minutes of a staff meeting at St. Francis Sanitarium in Monroe. The minutes document the following action:

... moved and seconded that a committee of three be appointed to interview the Mother Superior in the matter of obtaining the services of a male nurse ... adopted. Drs. Wolff, Graves and Bendel appointed as committee (April 18, 1923).
There is no elaboration to explain the motivation of the staff to explore obtaining the services of a male nurse nor is there any additional information regarding the outcome of the committee's action. The rationale supporting this committee action may have influenced the admission of a male student to the nurse training program in Baton Rouge. Even in the absence of documentation, it remains rational to conclude that an identified need within the internal organization of St. Francis Hospital was significant enough to be given consideration within a second unit of the same religious order and to challenge the conventions held by the larger groups of society, nursing and nursing education. This represents an example of the grassroots approach to change that can occur through a changing value system within a particular culture. Despite the 1923 challenge to cultural norms, however, it would not be until 1977 that a male student graduated from Our Lady of the Lake School of Nursing.

It is evident from the history of the development of both hospitals and nursing schools in the United States that the Franciscan Sisters of Calais created a model that combined cultural elements from similar institutions in both Europe and America. The Sisters established a modern day hospital based on the foundation of charitable service characterizing the religiously sponsored hospitals in Europe and conformed their hospitals and nursing schools to the "good practices" standards of the time in America (Flanagan, 1976, p.43).

The issue of enforcement of nursing education standards became so important that state nurses' associations were organized to work for the passage of nurse practice acts. As early as 1901, state societies were promoting legislation which would standardize nurse training as well as regulate nursing practice.
More importantly, these societies began waging campaigns to convince state legislatures that the nursing profession should be responsible for determining standards of nursing education and nursing practice (p.44).

On March 16, 1904, a group of sixty-four Louisiana nurses met for the purpose of forming an association for the primary purpose of promoting legislation for the legal regulation of nursing in Louisiana. "These Louisiana nurses were among the first in the nation to recognize the value of a licensing board as a means of raising the standards of education and of nursing practice within the profession" (Louisiana State Board of Nursing, 1964). Prior to 1904, only three states had enacted licensing laws for nursing.

The records of the Louisiana State Board of Nursing indicate the following:

When the first attempt at nursing legislation in Louisiana failed in 1904, there followed a period of education and general information to the public and for persons in the health fields which led to wholehearted support for the success of a second bill which was presented and passed in 1912. Act 138 was signed by Governor L. E. Hall on July 10, 1912 and thus became law (1964).

Act 138 was amended in 1926 to revise the length of the nursing course from two and one-half years to three years, although, in practice, all schools in Louisiana were operating on a three-year curriculum in 1918. The equivalent of a high school education was a requirement of the law of 1912, but was not rigidly enforced. Requirements for licensure did not include actual high school graduation until January 1934, although students entering schools of nursing in 1931 were required to present transcripts showing high school completion (1964).
Our Lady of the Lake School of Nursing: 1923 - 1929

When the Franciscan Sisters of Calais established Our Lady of the Lake School of Nursing, they followed the model for nursing schools that was already in existence in the United States and Louisiana. By Louisiana law, the program of study for nursing was to be three years in length, students were required to have the equivalent of a high school education, and nursing education was regulated by the State Board of Nurse Examiners. As previously noted, the curriculum of the nursing program was modeled after those at Charity in New Orleans, Hotel Dieu in New Orleans, and Schumpbert in Shreveport (unidentified newspaper article, 1923) with a nurse superintendent in charge of the program.

A review of the student records of the graduates of the first class that entered the program between July 1923 and January 1924 indicates that the graduates were between the ages of 18 and 34 years at the time of their admission, with an average age of 27 years. All were of the Catholic religion. Each student, upon acceptance into the program, was issued a numbered "Nurse Students Certificate" by the Louisiana Nurses Board of Examiners certifying the satisfactory completion of the "preliminary educational requirements of this Board at this time" (Student Records, 1923). The certificates issued in 1923 were signed by Dr. J. S. Hebert, Secretary of the Louisiana Nurses Board of Examiners. The certificates also locate the Louisiana Nurses Board of Examiners at 27 Cusachs Building in New Orleans, Louisiana.

The academic record of each student is divided into three sections: Summary of Practical Work, Efficiency Record, and Record of Theoretical Work and Examinations.
Signatures of physicians and the "Superintendent Nurse", M. H. Haggerty, R. N. attest to satisfactory completion of requirements on the Record of Theoretical Work and Examinations. It is of note that by the time these students graduated in May of 1926, Ms. Annie L. Smith was identified as the "Superintendent Nurse", indicating that Ms. Haggerty no longer held that position.

The curriculum consisted of subjects that were taught mostly by Ms. Haggerty and a variety of physicians. Some subjects such as Nursing in Surgical Diseases, Nursing Sick Children and Infant Feeding, Nursing in Orthopaedic Surgery, Nursing in Obstetrics, Nursing in Gynecology, Nursing in Communicable Diseases, Nursing in Medical and Surgical Emergencies, and Nursing in Venereal Diseases were jointly signed by Ms. Haggerty and a physician. Other subjects were signed solely by a physician. These subjects included Elementary Chemistry, Sanitation, Elementary Bacteriology, Urinalysis, Materia Medica and Therapeutics, and Elementary Pathology. Dietetics was taught by Mrs. M. T. Best, Dietician and Ms. Annie L. Smith, R. N. taught Ethics and History of Nursing. Physicians who participated in student teaching included Drs. Nicholle, Paulsen, Mahon, C. A. Lorio, L. F. Lorio, Eidson, Riche, Cushmann, Nacq, and King.

The Efficiency Record component for each student consisted of a point system of up to 100 possible points for each of nineteen primary behaviors and seven sub-units of behavior for the Preliminary, 1st year, 2nd year, and 3rd year time periods. The nineteen primary behaviors included Punctuality, Interest, General Deportment, Attention, Obedience, Memory, Neatness (personal, room, work, record),
Conscientiousness, Thoroughness, Reliability, Powers of Observation, Manner to Patients (officials, colleagues, and domestic staff), Consideration of Others, Practical Work, System, Executive Ability, Marked Peculiarity, Character and Work with an average grade reported at the end of each time period. The third year time period was not graded on a point system but by descriptive terms such as excellent and very good. It is of interest that among the list of primary behaviors, "marked peculiarity" is the only behavior that carries a negative connotation.

The Summary of Practical Work component of the Student Record indicated the number of hours spent in each of the hospital departments during the Preliminary, 1st year, 2nd year, and 3rd year time periods. In addition, the hours for each year were divided into day and night. Although the form indicated that practical work experience would be recorded in "hours", it appears that the number of days was the measure actually recorded. An example that is representative of the entire group of records indicates that in the preliminary or probationary period the student worked 93 days and 100 nights; in the first year, 176 days and 40 nights; in the second year, 257 days and 88 nights; and in the third year, 271 days and 70 nights. The hospital departments were identified as follows: Medical; Surgical; Children; Infants; Orthopedic; Maternity; Gynecology; Special; Diet Kitchen; Out-Patient Department; Clinic; Septic; Private Floors; Psychopathic [sic]; Hydrotherapy; and Dressing. In addition, time was accounted for vacation, absence, and illness.

Each student record also denotes the date of program entry, program completion and date of graduation. In addition, the date of final examinations, date and location of
State Board Examination, grade achieved on State Board Examination, and employment following graduation were also noted in each student's record.

The first class of nine nursing students of Our Lady of the Lake School of Nursing graduated in May, 1926. All of the graduates wrote the State Board Examination in New Orleans on November 2 and 3, 1926. All passed the examination to become registered nurses with a score range of 81% to 92%. Four of the graduates entered private duty nursing, one began employment as a public health nurse in Kentucky, one became an instructor at Charity Hospital School of Nursing in New Orleans, one enrolled in a postgraduate course in anesthesia at Charity Hospital in New Orleans and then returned to St. Francis Hospital in Shreveport, and one married and did not enter the employment arena. Sr. Magdalen became a dietician at Our Lady of the Lake Sanitarium.

The first graduation ceremony was certainly a memorable event for all who attended. Several newspaper clippings from local papers reporting the festivities were found in the archives. The graduating exercises extended over four days, from May 9 through May 12, 1926. On Sunday, May 9, a baccalaureate ceremony was held at four o'clock in the afternoon at the Community Club Pavilion. Rev. F. D. Sullivan, S. J., President of Loyola University, New Orleans, gave the baccalaureate sermon. The graduates were entertained on Monday, May 10 at a banquet held at the Catholic Women's Club and hosted by the intermediate nursing class at Our Lady of the Lake School of Nursing. The junior class honored the graduating seniors with an invitation dance, also held at the Catholic Women's Club, on Tuesday, May 11, 1926. The formal
graduation exercises were held on Wednesday, May 12, 1926 at eight o'clock in the evening at Garig Hall. The graduation exercises were held in conjunction with National Hospital Day, observed on the May 12th birthday of Florence Nightingale. According to one newspaper report, National Hospital Day was recognized as the "best means of showing why hospitals exist, of making people better acquainted with hospitals and of building mutual good will which will result in better health for the community" (State Times, May 9, 1926).

At the graduation exercises on May 12, 1926, former Governor John M. Parker presented the awards, Dr. Tom Spec Jones, a local physician, addressed the graduates and Hemann Moyse, a local attorney, spoke on the importance of National Hospital Day. The invocation was offered by Dr. Malcolm W. Lockhart, Rector of St. James Episcopal Church, and the benediction was given by Father F. L. Glasser, Pastor of St. Joseph's Catholic Church (Morning Advocate, Baton Rouge, La., May 12, 1926).

Symbolism and ritual abounded in the presentation of the graduates at the commencement ceremony. The Morning Advocate (May 13, 1926) gave the following description:

The nurses, each dressed in the graduate nurse uniform, a uniform they wore for the first time, marched into the auditorium to the rear of the student nurses in their uniforms. With each member of the graduating class was a girl of about six years old dressed in the uniform of the student nurse. The little "students" followed the graduates to the platform and received the diplomas with the graduates. Then each graduate took off her pin and presented it to the "little nurse" who had escorted her, an action symbolic of her completion of the work of a nurse (May 13, 1926).
The graduation ceremony was a celebration of the rite of passage from student to professional nurse. The little girls who accompanied each graduate may also have been symbolic of the transition to womanhood. Women of this era, and particularly Catholic women, were not expected to enter the world of work. They were traditionally expected to marry and devote themselves to their families of procreation. One can only imagine the excitement and anticipation of these young women as they began their careers in nursing with the knowledge that they had the skills that would enable them to be financially independent in a society that promoted their dependence.

What had led these graduates to this path of independence? For the two graduates who were 33 and 34 years of age, one can speculate that their prospects for marriage and family were diminished and they had to find some way to financially care for themselves. Only one of the records of the original class contained an autobiographical summary. In this summary, submitted in 1923 at the time of her application to the program in nursing, the student wrote the following:

I was born at French Settlement, La., Livingston Parish, Dec. 27, in the year of 1902, the daughter of Mr. And Mrs. ............ My father and mother died when I was only 3 years old. We were twelve children. I was second to the last. When I was five years old my sister took me and I then came to Baton Rouge in 1908. I entered school there but didn't go long as we moved to Bullion in 1909. In the year 1911 we moved to New Iberia. 1927 we moved to Wilbert La., West Baton Rouge Parish. I then attended school at Baton Rouge at the Magnolia school on Dufroic St. entered in the seventh grade, the following year I entered Baton Rouge high school. I went two years there, then went one year to Port Allen High school. Left school when I was eighteen years old in the year 1920. Dec. 14, 1922 I was married at the Chapel of St. Peter and Paul in Lobdell, La. I gave birth to a child July 24, 1923. The
child lived only a few hours. August 4, 1923 I seperated [sic] from my husband (Handwritten note of graduate of 1926).

At the young age of 24 years, this graduate had been orphaned, married, lost a child, separated from her husband and completed her education in nursing. Surely this young woman must have felt pride and accomplishment knowing that she had overcome adversity and challenges that many never experience in a lifetime.

Nursing education in the early twentieth century opened the doors for many middle-class Catholic daughters. It provided them not only the utilitarian achievement of financial security, but the opportunity to escape the rigid social norms of marriage and family. It was widely held that nurses, as women, could occupy a respected role in the world of work or they could marry and have children, but they couldn't do both. Nursing, viewed as a noble and charitable service by Church leaders, largely escaped the debate that raged in the late nineteenth and early twentieth centuries on the issue of higher education for Catholic women.

Opponents to college education for Catholic women objected on the grounds that the "experience would encourage them to seek professional careers, a development that could threaten the social fabric of church and home if it spread to middle-class women (Oates, 1987, p. i). Even as late as the 1940s and 1950s, admonitions against college education for women appeared with frequency in the Catholic literature. For example, in an article published in the May 17, 1941 issue of America, Sister Mary advised that it would be well not to place too great an emphasis on the value of undergraduate study "lest the value of a career or the ambition engendered interfere with
a higher calling [to cloister or motherhood]" (Oates, 1987, p. vii). Similar published
directives urged women's colleges to develop curricula that would contribute to
preparation for marriage and motherhood (p. vii).

With its origins firmly rooted in motherhood, nursing was likely viewed by
Catholic parents as an acceptable alternative or an interim step to marriage and
motherhood. Furthermore, if the educational environment was provided and operated
by an order of Catholic Sisters, an adherence to Catholic doctrine was probably taken
for granted by Catholic mothers and fathers. In fact, out of economic necessity, many
Catholic parents may have sought to enroll their daughters in such a vocational
institution even if the daughter had not expressed an interest in either nursing or any
other vocation. Such seems to be the case in the Guerin family, whose daughters,
Beulah and Goldie, completed the nursing program at Our Lady of the Lake School of
Nursing in 1928 and 1929, respectively.

In a 1991 interview with the author, Beulah Guerin recounted how the parish
priest suggested that her parents send her to Our Lady of the Lake School of Nursing. It
is probable, but unconfirmed, that the suggestion was offered as a solution to economic
demands imposed on the large family in rural Louisiana. Ms. Beulah Guerin recalled
that the parish priest took her to Baton Rouge and told the Sisters that she was eighteen
years old. In fact, she was only sixteen at the time of her enrollment in the nursing
program. She never informed them otherwise for fear that she would be sent home.
The fact that her younger sister followed a year later suggests that their parents viewed
nursing education as a means to provide their daughters financial independence as well
as, perhaps, to contribute financially to the family following graduation. Although the parents could have also been motivated by a desire to expand their daughters' cultural, educational, or even marital opportunities by sending them to an urban area, the sense of urgency and immediacy that accompanied the departure of the Guerin sisters from their home at such a young age suggests otherwise. The priest's willingness to bend the truth of Beulah's age (and most likely that of her sister a year later) also gives support to the notion of economic necessity.

Ms. Lucy Steib, a graduate of the class of 1929 with Goldie Guerin, cited the prospect of adventure and a dream of travel as her motivation to seek a career in nursing. In a taped interview with 92 year old Ms. Steib on March 8, 2000, she shared with the author her goal of becoming a Navy nurse. The Steib family lived in Grosse Tete, Louisiana and Ms. Steib's father worked for the railroad. As children, she and her brothers and sisters would occasionally go to New Orleans on the train with their father, because, as she said, "we could go free." To Ms. Steib, the railroad represented passage to a bigger world with limitless boundaries and freedoms as well as the promise of adventure. The train excursions to New Orleans during her childhood were the only trips outside of Grosse Tete that Ms. Steib experienced prior to going to Baton Rouge to attend Our Lady of the Lake School of Nursing in the fall of 1926.

Whether they were motivated by economic necessity, a search for adventure, or a desire to commit their lives to Christian service, the students who came to Our Lady of the Lake School of Nursing in the 1920s and 1930s could achieve their goals without having to succumb to the prescribed gender-specific social roles of marriage and
motherhood at that particular time in their lives. The Franciscan Sisters of Calais had
created a learning environment that complied with the regulatory standards imposed by
the nursing profession, embodied the Christian values consistent with Catholic doctrine,
and provided a safe and acceptable alternative for young and inexperienced women
from middle-class families. While many of the students who came to "the Lake", as it
became known, were of the Catholic faith, admission was not restricted to those of the
Catholic religion.

Living the Life of a Student Nurse

In the fall of 1926, Lucy Steib left her home and family in Gross Tete to follow
her path to adventure. Her plan was to complete the nursing program at Our Lady of the
Lake School of Nursing in Baton Rouge and then to enter the Navy Nurse Corps. At the
time that Ms. Steib was interviewed for this study (March 8, 2000), she was residing
once again in Grosse Tete on her family's property along with a brother and two sisters.
She was 92 years old at the time of the interview and was in remarkably good health.

Ms. Steib recalled that she graduated from Cherry Grove High School in 1926
and entered "training" in September of the same year, claiming it had always been her
ambition to be a nurse. She had never been around sick people, and certainly had not
experienced death, but she had her ambition, which she referred to as a "calling."
Although other women in her family later became nurses, including a younger sister, she
was the first in her family to seek a vocation.

Our Lady of the Lake School of Nursing, like all hospital schools of nursing of
the time, applied an apprenticeship model, a method of educating nurses while they
carried on the nursing work of the hospitals. The apprenticeship system of nursing education sought to perform two functions: to educate nurses and to supply the nursing service for the hospital. Within these two functions there was an ever present possibility of conflict. The needs of training and of hospital services did not usually coincide and when the two were in conflict, the needs of the sick predominated and the needs of education yielded. The priority pattern of needs of the patient superseding those of the student was firmly established in the hospital training schools.

Our Lady of the Lake Sanitarium, sponsored and operated by the Franciscan Sisters of Calais, was administered by the Sisters and, therefore, differed in some respects from hospitals whose administrators were male. However, the Sisters were also committed to lives of obedience, self-sacrifice, and service and accounted to a Church hierarchy of male domination. Therefore, the cultural values of obedience, discipline, and servitude were sustained and whether they came from the culture of nursing or of the Church, they were the values that were at the core of the process of the socialization of the student nurses.

The special environment of the hospital shaped the students' experiences of apprenticeship and initiation. Nursing schools fit Erving Goffman's (Melosh, 1982) classic definition of a "total institution," a place where the usual social boundaries between public and private life collapse. "Inmates" of total institutions sleep, work, and play under a single pervasive authority. Subordinated to this authority, they lose or surrender many of their normal prerogatives. Their most mundane activities are closely controlled; their most intimate actions are open to surveillance. Total institutions
deliberately construct a separate social world, marked off by systematic and routine violations of “outside” expectations. While normal social rules balance individual autonomy against the demands of social life, total institutions submerge or deny individual claims in the service of institutional goals (pp. 49-50).

Ms. Lucy Steib (March 8, 2000)

It was lonely at first...it was hard. We lived in the old hospital...we had a ward. We lived there about two months and then we lived in the nurses home that was built behind the hospital. It was a two story wooden building. We were two to a room then. There were two girls that left...they got homesick and they left.

We didn't get to go home much, maybe once a week; but then we had to be back by 10:00 P.M. It was hard. This little country girl that had never been out...to leave the country...you hadn't been anywhere...of course, it wasn't that far...but we were limited as to when we could leave....

We could go out once a week on a pass...you could stay out until 10:00 P.M...that is, if you didn't have any demerits. If you had demerits, you couldn't go out that week...you were grounded. You got demerits for not keeping your room clean, having your uniform just so....

We never went out alone. Two or three of us would go out together, and we would go on Third Street and get a soda or something for a nickel or a dime. If we dated, three of us went out together...we always double dated. We never one of us went out alone the whole three years I was at the hospital.

[On meeting men to date] I guess we met them in the hospital. They would meet you or see you somewhere and ask you for a date...Then if one of us had a date, we would get him to bring the other two a date...they had plenty of single doctors that we could of gone out with...but we weren't allowed...you couldn't be too familiar with the physician.

[On meals] We all ate together in the big dining room...breakfast at 6:30 in the morning...we had to be on the hall at 6:45...lunch together...we ate supper at 5:00
P.M... at night, Sister Ann Gabriel used to come into the supply room and we would each buy a drink for a nickel, and a cookie.

[On sleeping] The lights had to be out by 10:00... we had to study and be ready to put the lights out at 10:00. When we could hear Sister's beads coming down the hall, everybody would hurry up and put out their lights...

[On the superintendent and the Sisters] The nursing supervisor of the hospital was the head of the school... Miss Annie Smith... tall, red-headed, real nice... the Sisters reported to Mother deBethanie... Mother deBethanie was very understanding, you know... she didn't take [spend] all her time with students... if it was something special that you wanted to go talk to her about, you could... she would walk around and introduce herself. The nuns were alright too... lots of those nuns were young nuns that came from Ireland and France... a lot of them were in our classes. Lots of times... they [the nuns] would come down by the lake where the nurses were in the afternoons. We would all go sit by the lake... had a little boat... and talk. We would sit by the lake where the statue was, near the statue. I prayed many a time to that statue to let me stay where I was. I knew if I didn't do that, I didn't have any money to go to college. I got along pretty good with the nuns because I could speak French. Lots of the nuns spoke French... you could maybe get a little closer to them... they were kind of timid... I guess they were like we were, away from home for the first time... they were in a strange land... they adapted well and they were very religious... we had to go to mass... whenever they had mass.

[On uniform rules] When we went in training we had to have our blue uniforms... you had a pocket and you had to have your supplies in that pocket... scissors were one of the supplies... I think maybe we had to have a thermometer and a watch. She [Ms. Annie Smith] would meet you at any time and check your supplies... if you were short a supply, you got a demerit. After you got so many demerits, you couldn't go out. She would check your uniform and check your shoes... we had to have white shoes and white stockings, and white canvas shoes... we used to take BonAmi [cleanser] and polish our shoes with the BonAmi when we didn't have shoe polish.

[On obedience] We were scared to death to get sent home

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so we never dared break any of the rules. They would tell us, "You are going to be sent home!"

Goffman (Melosh, 1982) described the use of mortification of the self for inducing new members into total institutions and, indeed, probationers were reminded of their humble status many times a day. Hospital superintendents maintained strict control over students' work and social lives, exercising an authority that extended well past the normal limits of school or workplace discipline. Student nurses had to live in the hospital nursing residence, cut off from familiar surroundings, family and friends. The concept of *in loco parentis* was taken to new heights. Long working hours, early curfews, and prohibitions against socializing with male co-workers further constrained their social lives. The demands of ward duty, as interpreted by the superintendent, reigned over all other considerations. A student nurse had little time she could call her own. Superiors arranged her ward hours and classroom schedules, determined her meal times and study hours, and governed her hours of sleep. On or off duty, her appearance and demeanor had to conform to rigid standards of propriety. Supervisors inspected students' rooms and mustered their nurses before ward duty for inspection. The entire system was very ritualistic and militaristic.

Ms. Steib continues:

We worked 7-3, 3-11, 11-7 shifts ... we rotated about every month or so. It was hard to stay awake, sometimes. If you fell asleep ... they would let you by once or twice, but not too long. They would tell you if you can't keep awake you would have to go home. You made it your business to stay awake whether you were sleepy or not. [If you were working nights] you still went back to your same room to sleep ... you just learned how to sleep in the daytime ... and lots of times you had to go to classes. You
got a couple of hours of sleep and then you had to be at classes. It was hard...the first two years were really hard.

The 1923 report of the Committee to Study Nursing and Nursing Education in the United States, funded by the Rockefeller Foundation, included findings that most, if not all schools, did not provide any concessions for those students who were assigned night duty. The students were expected to attend class whether it was during their sleep time or not. In addition, students were not provided facilities that would promote uninterrupted sleep during daytime hours for those who had worked the night shift.

Ms. Lucy Steib:

After surgery we would have to pick up all the bloody sponges out of the basin and wash them white [sic]...then they had a little board that had four nails...we had to wash those little sponges and then put them out on those nails...just pile them out and then put them out in the sun to dry...when they were white and dry, we had to take them one by one and roll them on our finger...and put them in bags to be sterilized...they would use them for tonsils [tonsillectomies]. We had to patch gloves too...rubber gloves. After they used the gloves in surgery, we had to wash them clean...then you had to blow them up to see where the little hole was...with your mouth...when you found the little hole, you cut a piece from another glove and we had some kind of glue and glued it on there. After every operation we had to scrub on our knees all the instruments and everything...we didn't have to do the floor...they had orderlies that did the floors.

In addition to sleep deprivation, the Committee to Study Nursing and Nursing Education in the United States (1923) reported that educational experiences were almost exclusively dictated by the needs of the hospital for service. This meant that if a student was needed to assist in surgery, she was sent to surgery regardless of whether or not she
had ever been in a surgical suite prior to that time. Similarly, if gloves needed to be mended, she might be sent to the Central Supply area to carry out that task, or she might be sent to the laundry to wash diapers, or to the kitchen to wash lettuce. Purposeful learning experiences were not planned or implemented.

Ms. Lucy Steib:

I found it hard...I couldn't concentrate. I found Anatomy hard...it was all those doctors that taught us. I know Dr. Lorio, Dr. Clarence Lorio, taught us...his brother taught eye, nose, and throat...Old Dr. Trahan taught us obstetrics, and Dr. Weiss, whose son was said to have shot Huey Long...taught us a subject. Dr. Weiss was a nice old man. The doctors, I think they were all volunteer...I don't think they were paid for that. We had to work three different shifts, you know...seven days a week without a day off...there were no other nurses in the hospital...just the private duties and they didn't help us...they would be in their patient's room and wouldn't teach us anything. The class ahead of us always took us and they taught us...then, we would take the class under us...that was how we learned...we took care of each other.

Before 1920, theoretical education was often provided by different physicians who lectured on their specialties in a loosely organized curriculum. Exhausted students could give only perfunctory attention to the lectures, which were held at night or during breaks in their long shifts. Students often seized the opportunity for some much-needed sleep. Most schools began to organize more systematic classroom work and to hire full-time nursing faculty in the 1920s and 1930s, but student nurses continued to provide most of the hospital nursing service through 1950.
Ms. Steib continues:

We got capped...after about six months...then after the first year they gave you a pretty little pin with pearls on it...the second year you got another one, a little larger, and then the third year you got the pin with '29 on it...I still have mine...I have mine on a charm bracelet. We had long light blue dresses with short sleeves...white cuffs and white collar, that you had to put on yourself...we would get them from the laundry room...every week we would have our uniforms...

The self-sacrifice and dedication to service that were expected of the student nurse were markedly similar to the values of the religious orders that preceded organized nursing care in the earliest hospitals. Also similar were the rituals associated with membership in the group. These rituals were markers of progression in the socialization of student nurses to the nursing profession. Just as a novitiate in a religious order received her “veil” after a probationary period, so did the student nurse receive her cap at the end of a successful probationary period. However, she continued to wear the uniforms and pinafores of the student nurse until she donned the crisp white uniform of the graduate nurse.

To survive to progress through the rites of passage, the student had to acquire the stern discipline of the nurse. Strict rules of conduct offered young women a model of the controlled life and her personal demeanor had to be schooled to the same standards.

Ms. Lucy Steib:

...after it was over with you knew it was something that had to be done. Just another chore, you know? If you would, say like stay with a patient that was reacting [from anesthesia] and they were vomiting blood or something...you had to do it...if the nuns knew you couldn't stand it, they would send you home!...they were
watching to see if you reacted...to see if you started vomiting yourself, or something...the one that expired on you when you were on duty...your patient died...and you had to give him a complete bath...if it was a female you had to fill the front and back, and take that chin and raise it up and put a bandage around it so the mouth wouldn't sag open...that was the hardest thing I had to do. One night I was in one of the rooms with a dead patient...Rabenhorst used to come and do most of our work, and one of those boys...he was kind of funny you know, came and closed the door...he closed me in the room with that dead patient. I started to holler and knock the door down...I knew he couldn't hurt me, but they would play all kinds of tricks on us. That was hard too. ...you had to [cope]!...you either did it or go home!

Professional demeanor helped nurses to defend their emotions against the shocks of hospital life, and discipline guided their adjustment to unfamiliar and threatening situations. Nursing brought women into sustained contact with sickness and death, experiences that evoked fear and disgust in laypersons. Nurses' access to patients' bodies violated the boundaries of normal social relationships. They touched strangers and matter-of-factly dealt with their blood, body fluids, and excrement. Through overt instruction and by example, student nurses learned inner discipline and shared rituals that helped to ward off their own uneasiness and fear.

Ms. Lucy Steib:

They said you had to be able to cope with everything...they never did [encourage to be cold and detached]...you couldn't be cold if you wanted to...it was too pitiful...poor people.

For many, hard work helped to control emotions that might otherwise have become overwhelming. Over and over, nurses have explained that they overcame their
fear of the responsibility of night duty by throwing themselves into their tasks.

Confronted with emergencies, nurses discovered their resources for coping. Death was an inevitable part of their work. The literature of the time struggled with the problem of maintaining professional demeanor and warned of the pitfalls of callousness and sentimentality. On one hand, nurses were expected to be compassionate and caring and on the other, not to show emotion.

Ms. Lucy Steib:

After I finished from the Lady of the Lake, I wanted to go into the navy. I wanted to be a Navy nurse and get on a ship and travel...but you had to do six months of private duty first...I had all my papers filled and I was doing my six moths of private duty...I never went into the Navy. I had private duty patients in Plaquemine that I stayed with for 10 or 11 years. Lots of the wealthier patients stayed at home because they could afford to pay a nurse to take care of them. Yeah, I did private duty. When you got with a patient they wouldn't let you go, they just held on. They were usually three of us on a case, one on each shift. You had ...freedom.

Graduate nurses were employed outside of the hospital, either in private duty or in public health nursing where a greater degree of autonomy was experienced.

Graduating from hospital training schools did not mean that the nurse would return to the bedside in a more professional role but, rather, that she would altogether leave hospital nursing.

Our Lady of the Lake School of Nursing: 1930 - 1949

The stock market crash in October 1929 threw the nation into the Great Depression. America did not recover until the beginning of World War II in 1939.
Between 1929 and 1932, over five thousand banks collapsed. By the end of 1930 approximately seven million workers were unemployed. By 1932, this figure had doubled (Flanagan, 1976, p. 78).

The depression affected the citizens of Baton Rouge as it did all Americans. However, the oil-based economy of Baton Rouge enabled it to fare relatively well, compared to other U.S. cities. Throughout the depression, the Franciscan Sisters of Calais used their depleted resources creatively and with generosity to serve the citizens of the Baton Rouge community. They provided food and health services for the poor and needy. The Sisters never waivered in their mission to serve "all of God's people." They proved to the people of Baton Rouge that Our Lady of the Lake was an integral part of the community and that the Sisters' relationship with the community was one of shared interdependence.

According to economists, the depression was triggered by agricultural and industrial overproduction and technological unemployment. The nation's ability to produce commodities clearly surpassed the public's capacity to purchase and consume them. To some degree, overproduction was stimulated by the introduction of installment buying which caused many Americans to overestimate their purchasing power. Moreover, the introduction of new labor-saving machines eliminated the need for thousands of workers.

Throughout the 1930's, Our Lady of the Lake School of Nursing continued to admit and graduate nurses. From 1930 through 1939, ninety-seven women received their diplomas in nursing. Class sizes ranged from four graduates in 1935 to eighteen
graduates in 1939 with an average class size for the ten year period of 9.7. It appears from student records that Ms. Annie L. Smith continued to serve as Director of the School of Nursing until 1943. Among the graduates of the 1930s was Sister Mary Gertrude Hennessey, later to become Mother Gertrude, who graduated in 1931.

The student records remained very similar to those of the first class graduated in 1926. In addition to the record components of "Summary of Practical Work", "Efficiency Record", and "Record of theoretical work and examinations" is added a separate "Record of Preliminary Course", which appears to be a summative evaluation of the probationary period. The preliminary record identifies fifty skills on which the student was "passed off on" either in a laboratory demonstration/practicum or on the ward. These skills are of significance to the historical documentation of the practice of nursing and included contemporary skills such as bedmaking and temperature, pulse, and respiratory measurements, but also skills lost to antiquity such as "counter irritants that included flaxseed, mustard foot bath, mustard paste, poultice, and turpentine stupes" (Student record, 1931). Students continued to staff the hospital on day, evening and night shifts throughout this decade just as they had during the preceding years.

It is assumed that due to the Depression, resources were scarce and that is why there are no pictures or documentation available for this time period. The last formal class picture was taken in 1931 and there were no more in the archives until the Class of 1944. It is also of significance that in the years 1926 through 1931, five of the Franciscan Sisters graduated from the nursing program. It does not appear that any of the Sisters graduated again until 1941 when Sister Mary Edana Cocoran completed the
program in nursing. It is highly probable that all members of the order were needed to assist in meeting the needs of the community during the period of economic depression.

The Bolton Act, creating the United States Cadet Nurse Corps, was enacted into law on June 15, 1943 and marked the first time in the nation’s history that the federal government would subsidize the entire education of a nurse.

In 1945, there were approximately eighteen members of the Cadet Nurse Corps enrolled in Our Lady of the Lake School of Nursing. The impact of the Cadet Nurse Corps is evidenced in the increase noted in the number of graduates of the class of 1946 as compared to the class of 1945. The class of 1946 graduated thirty nurses as compared to the nine graduates of the class of 1945.

Fortunately, the nurses’ home that was constructed in 1926 for Our Lady of the Lake student nurses was replaced in 1941 with deBethanie Hall, which became the residence for the students as well as providing classroom space. A large recreation room that doubled as an auditorium was also included in the design of the building. An annex was opened in 1945 to accommodate the growth of the student body in response to the Cadet Nurse Corps program.

A public ceremony was held to celebrate the opening of the annex. An unidentified newspaper clipping (1945) informs the public about the ceremony and also highlights the Cadet Nurse Corps.

The cadet nursing program will be two years old on July 1 and since the introduction of the program some 112,000 women have been trained for nursing on all-expenses-paid scholarships paid by the government. This was set up under the Bolton Act which was passed in June of 1943 under the U. S. Public Health service.
In return for their education, the young women make a moral pledge to continue in nursing for the duration of the war. Girls 17 and 18 years of age are eligible, and others up to 35 years of age. They may join if they are in the upper third of their class, in grades, and have completed high school.

As a result of The Bolton Act, the standard three-year nursing program was accelerated, as cadet nurses were trained in thirty months. The cadets served an additional six-month practice assignment to satisfy state boards of nursing requirements that nurse training programs consist of 36 months of training prior to eligibility for licensure. Nevertheless, it was during the war that an abbreviated curriculum for training the registered nurse was first developed and that the use of both colleges and universities by nursing schools was expanded.

Our Lady of the Lake School of Nursing graduated 185 women between the years 1940 and 1949. Classes of graduates ranged in size from 8 in 1945 to 30 in both 1943 and 1947. The increase in class size in 1943 represented the inclusion of the cadet nurses while the increased graduating class in 1947 most likely reflected the post-war interest in both higher education and in nursing.

The events of the war, the conditions it imposed on the nation, and the various social forces of the prewar and war years -- all were to lead to a severe nursing shortage that became acute immediately after the war and persisted at high levels until the late 1970s. Peak shortages, virtual crises, occurred in the late 1950s and early 1960s.

The first change in administrative leadership at Our Lady of the Lake School of Nursing occurred in 1943 with the departure of Ms. Annie L. Smith, who had been the
Director school since at least 1926 (Ms. Haggerty was the first Director of the school). She was replaced by Sister Agnes Marie Fitzsimmons, who received her diploma in nursing from Our Lady of the Lake in 1928. "After a year's service as head of the business office, she went to St. Francis Hospital in Monroe where she was a laboratory technician and taught sciences. She received her B. S. degree from St. Louis University in 1942, and returned to Our Lady of the Lake as director of the school of nursing from 1943 - 1947, when she returned to Monroe as purchasing agent at St. Francis" -(Advocate, Baton Rouge, La., January 1966). Sister Agnes Marie was replaced by Miss Mary Gillen, who served as Director from 1947 to 1955.

By the end of the 1940s, conditions were ripe for the emergence of a wholly new, unprecedented way to educate registered nurses. The prevailing perception was that nurses were critically scarce and the shortage would not just simply go away. Americans were more than ever focused on education as a means of solving social problems and optimistic about their ability to succeed in applying such solutions. At the same time, they had become acutely aware of the new demand for nursing services in a rapidly expanding health care system. The nation needed to maintain the number and quality of nurses to sustain its growth.

In the mid-1940s, student records of Our Lady of the Lake School of Nursing began to reflect the influence of collegiate education for nurses. Although the format of the final record continued to be consistent with records from 1920 -1944, the subject list was now subdivided into the (1) biological and physical sciences, (2) social sciences and (3) medical sciences and nursing arts. The natural sciences area included anatomy and
physiology, microbiology, chemistry, pathology, and personal hygiene. The social sciences subjects included psychology, sociology, history of nursing, nursing ethics, and professional adjustments. It is not clear if these courses were taught by health care professionals or, perhaps, by educational professionals such as university instructors or even high school teachers. The medical sciences and nursing arts subjects remained as they had for the previous twenty years.

Also, noticeably absent from these records is the "Efficiency Record" that evaluated students' character formation (Student records, 1945 and 1946). It was probably around this time that the interview became part of the admission process as a means to determine "aptitude for nursing" which implies that the applicant would already possess certain requisite qualities desirable for nursing that would be further developed through professional socialization, rather than being a process of character formation. This was a conceptual departure from the modeling of the formation process of women religious that had been imposed on the socialization process of nursing students from the inception of the nursing program in 1923. It is considered a dramatic departure in that it likely included a departure from the expectation of requisite behaviors of obedience and self-sacrifice as essential to nursing practice.

The changes in curriculum were no doubt influenced by the increasing enrollment of women in higher education institutions as well as by the decreasing reluctance of institutions of higher education to develop undergraduate professional programs to coexist with liberal education within the university setting. The curricular design of undergraduate professional programs of study within the university setting
emphasized the foundational relationship of liberal learning to professional development.

Curricular changes were also influenced by trends in Catholic higher education. During the 1930s, Catholic higher education was influenced by the Catholic revival in Europe with its emphasis upon the neoscholastic synthesis of reason and faith, the natural and the supernatural. This synthesis was promoted by theologians and philosophers and was identified with the "mind of the church." (Kauffman, 1989, p. 240). In addition, under the leadership of John Joseph Flanagan, S.J. as Executive Director, the Catholic Hospital Association entered a new era which recognized and addressed the needs of a more complex health care system in the United States. Father Flanagan assumed the position of leadership in the CHA in 1947 following the retirement of Alphonse M. Schwitalla, S. J. Whereas Schwitalla was a rigid Catholic separatist who focused on the dangers of a secular society, Father Flanagan focused on what health-care ministry can bring to its public. He "centered on social justice issues to underscore the need to apply the religious ideals in personnel and public relations" (Kauffman, 1989, p. 253).

Father Flanagan called for an understanding of professionalization within the context of Catholic identity. He challenged the sisters to balance their traditional idealism with practical realism as essential to an integrated hospital apostolate by stressing the social justice and professional dimensions of the Catholic identity. He considered it a moral imperative to be as professionally good as possible. Shortly after 1948, women religious initiated the Sister Formation Conference that blended higher
education with the professionalization of teachers and nurses, and prepared women religious to initiate reform and renewal within the context of the Second Vatican Council (Kauffman, 1989).

The contemporary Catholic professionalism infused with neoscholastic idealism is reflected in the catalogs of Mercy Hospital School of Nursing in Baltimore. "In the 1927-28 catalog, the heroic call to nursing was expressed as 'an oblation of herself upon the altar of devotion'; whereas, the 1941-42 catalog described the institution as one "characterized by 'religion and philosophy', and its philosophical and educational principles control 'all aspects of school life' so as to affect the student not only as a prospective professional woman, but also a woman of character and conviction, prepared as the occasion arises in her life to give emphatic evidence of her Catholicity in thought, work, and action" (p. 240). The transformation is described by Kauffman (1989) as from a "docile, self-sacrificing woman to an independent proactive, professional nurse ready to assert and to defend her Catholic principles" (p. 240).

In 1933 there were 1,068 approved nursing schools in the United States; 413 were conducted under Catholic auspices. The first Catholic school to offer a B.S. degree in nursing was St. Xavier College of Chicago, which had merged with Mercy Hospital School of Nursing. Seventy-eight other schools of nursing were affiliated with 42 Catholic colleges and universities while 20, including Mercy in Baltimore, were affiliated with non-Catholic institutions of higher education (Kauffman, 1989).
The post-war years brought rapid growth to the health-care field. In the mid-1940s there were nearly 700 Catholic hospitals in the United States. The labor force of lay nurses had similarly increased.

The position of hospital staff nurse became a viable alternative to private duty nursing and public health nursing during the 1930s. Several of the factors that helped to shape this trend included advances in medical technology, Blue Cross financing, and New Deal public works funding which made hospitals more accessible and attractive to the upper and middle classes. Under pressure from both the nursing associations and state governing boards, many hospital training programs had reformed some of their worst features. By the 1930s, most were attempting to offer formal coursework and had cut back somewhat on their students' work hours. Hospitals, faced with rising demand for their services, a glut of trained nurses, and pressure to reform their schools, began hiring graduates to staff the wards. Unemployed private duty workers usually filled these positions. By 1937, "ninety percent of U.S. hospitals used graduates on their staffs. In 1946 only one-quarter of nurses worked in private duty, compared to seventy-five percent in 1930." (Leighow, 1996, p.13).

As Leighow (1996) noted, hospital jobs afforded many advantages for nurses. Employees worked steady hours and usually received free room and board. Directors of nursing provided a measure of safety against difficult patients, families, and physicians. On the other hand, nurses complained about low wages, split shifts, and hospital paternalism. Heavy patient loads kept nurses from giving quality care.
As was true in the late Nineteenth and early Twentieth Centuries, nurses tended to be single during the 1930s and 1940s. Nurses were also young. Compared with other female workers, few nurses were represented in the age groups over forty-five (1996). Given the demanding nature of the work, nursing was a difficult job for older women. Irregular hours made combining marriage, family, and nursing practice virtually impossible. Those who served as head nurses in the hospital or as training school superintendents were also single. The selection process routinely passed over married women, as well as unmarried females with romantic interests or family aspirations. Hospitals often required staff members to live on-site. Supervisors disliked married workers, complaining that they had high rates of absenteeism and lacked loyalty to the institution. In a society which frowned upon married women's employment, nurses followed cultural norms concerning females' proper roles.

For decades, the average citizen did not know or question what went on in hospitals, but was persuaded to believe in the moral integrity of these institutions. Hospital representatives perpetuated the myths of their goodwill and good works in the name of education, charity, and their publicly-defined mission of doing all in their power to provide the best of care.

The need for public recognition of the value of nursing to society is expressed in the March-April 1947 issue of "Lake Ripples", a newsletter published by the students of Our Lady of the Lake School of Nursing. The author is unknown.

A Good Nurse -- First...

In the past months, much criticism has been directed against the nursing profession -- rightly or wrongly -- for
its failure to meet the nursing needs of the public. Because our profession has not had a public relations program the general public and sometimes even the doctors have little understanding of nursing and what its preparation and practice entails. There is a lack of appreciation of the abilities, skills, and qualities which a professional nurse possesses. We have to admit also that there are some nurses who are lacking in these requisites. Ignoring that fact does not contribute toward solving the problem.

As a rule the embryo nurse enters the nursing school in adolescence, that period in life in which the individual is most idealistic. She is enthusiastic and fired with the zeal and determination to be a Florence Nightingale. Her ideal of service and sacrifice is in contrast to her freshness and youthfulness. Before she is admitted to a nursing school as a preclinical student she must have satisfied the faculty of the school in that she has potentialities as a nurse, and her scholastic average must be such that she is deemed capable of the concentrated study necessary to attain her goal.

Pre-requisite to everything else is character and breeding. First of all she is a lady -- not yet fully developed perhaps, but ready to be molded into an individual of culture and efficiency, who will be an asset to her community in the civic as well as nursing field. The modern nursing school today aims at more than professional competency for its graduates. Vocational education is but one phase of her development; the school strives to develop her entire personality. She is a woman first and then a nurse.

From the day she enters the nursing school, she assumes responsibilities greater than the average vocation ever reaches. A life may depend on her acquisition of accurate knowledge during this preclinical period. Before she becomes even a fledgling nurse she must devote three years of her youth to arduous theoretical study and clinical practice. The days are crowded with classes and there is little time for an abundance of recreational activities. Soon she contacts her first patient in her nursing arts practice period under the competent supervision of the instructor. After six months of study and practice comes the final examinations which determine whether or not she shall be admitted as a student nurse. If this phase is
successfully completed, she is then assigned for supervised experience to a clinical unit. For the remaining two and a half years she alternates her time between classes in theory and ward practice. Many are the pleasures she must forego to attain her goal. Many are the days when she is discouraged, and it seems that she is giving all and receiving nothing. She looks about her and sees her friends working not so hard, and being paid a substantial salary. It isn't always easy to see that her labors are being amply repaid in educational coin which will be far more valuable later than a current pay check would be.

After three years of hard work, interspersed with tears and joys, she becomes a graduate nurse and finally a registered nurse. She has learned that much is expected of her. She must be able to give skilled nursing care, observe and report all symptoms that would assist the physician in making a diagnosis or in determining the method of treatment. She is expected to be nurse, teacher, counselor, consultant, confidant, and friend. She finds herself frequently in need of the wisdom of Solomon. Too often she finds that her personal plans must be altered for the welfare of those committed to her care. The patient's welfare must always be uppermost.

These are the things that are expected of her as a nurse. Is it worth it? Only those who know the inward satisfaction of seeing a patient return to health under her care knowing that they have contributed toward the recovery feel that nursing for the true nurse is like an incurable disease. It gets in the blood and is there to stay. It may be quiescent for a time, but it is always ready to become active again.

If the nurse is expected to be all of these things, has she no rights? First, she wants recognition of her labors. She doesn't want to infringe on others; she merely wants to establish her proper status. Establishment of social status is one of the fundamental human drives and cannot be ignored. She wants a job in which she can do well. She wants to be able to lead a fairly normal life and participate in social and community activities. She wants economic security. Is this too much to ask?

But before she can ask anything the nurse must have something to contribute. Before she can ask the public to understand her she must be understanding. The
public judges, usually not by competency, which they as laymen are not capable of judging, but by the mental and physical comfort given by the implied interest in the patient, by the ability to inspire confidence in herself and the physician, by her ability to minimize the disruption of family routine incident to any illness, and by her little unrequired kindnesses and courtesies.

The public needs the nurse. They are dependent upon her to an almost unbelievable degree. The health of the nation depends upon her. Hospitals are almost wholly dependent upon her. In this crucial time the nurse has assumed a place of importance second to none. The public is at her mercy. She is part of a profession, and demands equal recognition with other professions.

All this is true, but the nurse needs the public too. Her very existence depends upon it. Public service is the sole reason for her being. Unless she provides this service, she has no claim on the public for recognition, work, satisfactory working conditions or economic security. She must first prove to the public that she is worthy.

Can the public and the nurse pool their resources for their mutual interest? Yes — they not only can — THEY MUST!!!! (March-April, 1947).

In making her argument for the public worth of nursing, this young author identifies many of the cultural threads and values inherent in nursing, nursing education, and hospital work. She identifies service and sacrifice as motivating factors to pursue a career in nursing. She also identifies both the profession of nursing and nursing education as closed systems, open to membership by virtue of the characteristics of intelligence, moral character, and genteel breeding. The author asserts that the primary role of the student is that of woman and second of nurse. This hierarchy implies the dominance of the traditional role of woman in domesticity, child-bearing and child-rearing.
The author further attests to the rigors of the academic curriculum -- implying that only the proven are admitted to the elite membership of the profession. She further emphasizes the commitment to care and compassion and the supremacy of the patient's welfare to that of her own. This repeats the tone of self-sacrifice. She addresses the intrinsic reward of nursing as self-fulfillment realized through dedication and commitment to those less fortunate. But she also addresses the need for extrinsic reward for her hard work in the form of economic security.

Father Flanagan of the CHA carried his theme of social justice to apply to the compensation issues of personnel of Catholic hospitals. He observed that "we are sometimes asking our employees to underwrite the charity that we give to others" by paying them lower wages (Kauffman, p.253). He challenged the hospital administrators to apply the religious ideals of care and social justice in personnel relations, including wages and compensation.

The values of self-sacrifice and self-discipline continued to be culturally reinforced within schools of nursing, including Our Lady of the Lake School of Nursing, through rituals such as capping ceremonies which marked the satisfactory completion of the preclinical probationary period (of hard work and self-denial) of the curriculum and acceptance into the selective membership devoted to clinical service. The same issue of the "Lake Ripples" (March - April, 1947) contains an article on the capping ceremony held on March 6, 1947.
Preclinicals Receive Caps
By Hazel Bernard

Seventeen student nurses received their caps at a most impressive ceremony held in the auditorium of deBethanie Hall on March 6th.

Miss Gladys Edwards, class president, delivered the welcome address to those present.

Miss Kitty McLin led her class in singing "My Creed."

Lester J. Williams, M. D., then congratulated the class upon the completion of their preclinical work and complimented their instructor, Miss Bertha Mae Anders, upon the guidance she has given them.

Miss Mary E. Gillen, Director of the School of Nursing, presented the Mother de Bethanie Award to Miss Rita Brumfield for the best bedside nursing and the Florence Nightingale Award for the highest scholastic average to Miss Patsy Ruth Miller. An honorable mention was given Miss Joyce Oliver for the second highest average.

As each student came forward she was presented with her cap by Sister Agnes Marie assisted by Miss Anders.

When the last cap had been received the lights were dimmed and by candlelight the new freshmen students recited the Nightingale Pledge. (1947)

Transformation of Nursing During the 1950s and 1960s

Nursing had experienced an oversupply of practitioners in the 1910s and 1920s and suffered serious unemployment during the Great Depression of the 1930s (Dolan, 1972; Flanagan, 1976; Leighow, 1996). World War II, however, changed this situation dramatically as the military absorbed large numbers of nurses. The war created a shortage for which the profession was unprepared. The 170,599 civilian nurses and the 68,000 in the Army and Navy Nurse Corps proved insufficient for the nation's needs (Leighow, 1996).
The shortage did not improve after 1945. In fact, the demand for nurses rose considerably. Nursing leaders warned that the wartime shortage would continue, perhaps even grow worse. The leaders in nursing proposed several different means of easing the shortage. They called for improved wages and working conditions as a means of retaining personnel. They also tried to recruit more female high school graduates, provide scholarships for needy nursing students, and develop ways of utilizing staff more efficiently. While the absolute number of student nurse enrollments rose, the percentage of female high school graduates entering the profession dropped to a mere five percent during the mid-fifties (Leighow, 1996). In post-World War II American society, the college age woman was not only an eager candidate for marriage, she was likely to be married by age twenty-two. By the mid-fifties educators had become alarmed about the early marriages of undergraduates. Nevitt Sanford complained that too few wanted to prepare for a professional career (Solomon, 1985). In a society which frowned upon married women's employment, nurses followed cultural norms concerning females' proper roles.

Given the demand for health care services and nurses, the leadership realized that educating more high school graduates simply would not fill the void. The professional association, therefore, looked to the ranks of inactive nurses. Women who had left nursing to raise children could be tapped to alleviate the shortage. Nursing leaders argued that older nurses could provide a more stable labor force than new graduates who would likely marry, get pregnant, and leave the profession. Furthermore, they maintained, married women and mothers could return to work without sacrificing
their family life. Hospitals had eliminated the practice of "living in" in the 1940s. Jobs in nursing education, schools, and public health agencies were tailor-made for mothers since nurses employed in these settings did not work rotating shifts, weekends, or holidays.

The leadership recognized that the utilization of inactive nurses would be problematic. World War II had proven that nurse-homemakers often resisted paid labor even in the face of national crisis. Tradition and employer preferences discouraged older, married women from returning to work. Nonetheless, in spite of these obstacles, nursing successfully made the transition from a single to a married woman's profession during the 1950s and 1960s.

This transition occurred for several reasons. The professional associations launched campaigns designed to convince employers to hire inactive nurses and motivate them to work. At the same time desperate health care agencies dropped the marriage bar. They made paid labor more attractive to wives and mothers who previously found nursing incompatible with family life. As a means of securing workers, employers instituted part-time hours, increased salaries, offered refresher courses, and established on-site childcare centers (Leighow, 1996).
CHAPTER 6

THE MID-LIFE CYCLE OF THE ORGANIZATION

Our Lady of the Lake School of Nursing graduated 184 young, single women, including seven women religious in the years 1950-1959. Another 226 women, including three women religious were graduated in the years 1960-1969. Mary Ellen Leblanc Crochet was a 1955 graduate. She shared her experiences as a student at Our Lady of the Lake School of Nursing as well as highlights of her professional career with me in a March 3, 2000 interview.

Mary Ellen Leblanc was 18 years old when she entered the program in nursing at Our Lady of the Lake School of Nursing in 1952. During the interview with Mrs. Crochet, she addressed her formative years in Grosse Tete, Louisiana and her decision to become a nurse.

Mrs. Crochet:

I was from a small town, Grosse Tete. My daddy was a farmer, and he didn't do too good at farming, but we had a lot to eat; we just didn't have any money. I had a real good neighbor who had kids that I used to help her with. She would loan me books. My mother and daddy didn't know how to read or write. But my nice neighbor friend was real good about sharing her books and newspaper and encouraged me to read and get an education. So did some of my teachers in school. Even in grade school they helped me because I was the fifth of six kids and I only had one sister that was ahead of me in school and made it through high school. My brothers just all gave up. It wasn't an expectation of them.

My teachers told me to study and I could most probably become whatever I wanted to be. And then I had a really good English teacher...she had a sister that was in nursing at Northwestern...she asked me if I was interested
in nursing and gave me information about nursing. I even applied for a scholarship up at Northwestern but failed the vocabulary part of the scholarship requirement. In a way, that is probably the best thing that happened to me because I don’t think I would have passed college English and I don’t think I would have stayed away from home that long.

It was a long ways from the little town of Grosse Tete. So then she (the teacher) told me how I could get money to help with my education. The Iberville Parish School Board had a loan program that you could borrow the money and pay it back after you graduated. Somehow we found out the information, here and there. And, so, I got into the Lady of the Lake. I borrowed the money from the school board at 3% interest, and the price of the whole thirty-six months at Our Lady of the Lake School of Nursing was $375.00...for the whole three years. That included room and board and uniforms. Everything was included. It was a fantastic bargain!

Besides my family, the whole little town of Grosse Tete supported me. I was the first one on my daddy’s side of the family to go past high school. Everyone was looking to see if I made it. My cousins and all would talk about me as "the nurse this, and the nurse that." I was always a staff nurse, but they had me running the hospital! Even though my momma didn’t read or write, she always wanted me to get an education. Oh yes, she definitely supported me.

In a manner similar to Ms. Lucy Steib, Mrs. Crochet described her experiences as a student nurse in terms of the living and working conditions as well as the rituals that were a part of the socialization process. In the twenty-six years between Ms. Steib's graduation in 1929 and Mrs. Crochet's graduation in 1955, it is significant to note the recurrent themes of obedience, deference to authority, self-discipline, social isolation, and dedication to service. In addition, Mrs. Crochet echoes Ms. Steib's feelings of fear and expulsion.
Mrs. Crochet:

We lived in the dormitory. There were about 45 girls in my class when we entered ...none were married. There were two nuns in our class ...they were older than we were...they lived in the convent. About 25 of us graduated. We had a probationary period of about six months, I think. Then we got out caps ...at a capping ceremony ...it was a big deal. But I don't think you ever had it made. I was always afraid of getting kicked out.

I was always afraid of breaking the rules. I'll be honest with you, that was the most important thing to me always ...to follow the rules. Sister Agnes Marie would discipline us ...for breaking curfew, being late. I didn't go anywhere because I didn't have anywhere to go. And I think students were disciplined, losing a privilege, if they didn't pass the NLN standardized test. But I was lucky that didn't happen to me.

Most of the students abided by the rules. There were a few that would sneak out to see their boyfriends. I didn't have a boyfriend, so I didn't have to worry about that.

The dorm was nice. We had a big recreation room. We even had a TV, just when TV was first coming in. I think Dr. Levy gave it to us. He was real good to us. The hospital was real good too in providing us with picnics. They had a place out on Perkins Road, that I think belonged to the hospital. I guess the nuns used to go out there too. It was a real nice place. They'd pack us a lunch with either fried chicken or something and we had a lot of outings like that. And even sometimes instead of going to the cafeteria, they would just pack us a picnic to eat in the dorm. We had board games in the dorm. Of course, I was a big card player and liked to play Scrabble.

We usually ate in the cafeteria -- on a regular schedule. And we would have morning prayer too. Everybody would have to; you didn't have to go to the mass, but after breakfast everybody went to chapel for a brief prayer before they went on duty. It was about 6:30 or 6:35 each morning. The majority of students were Catholic, but even if they weren't, they still had to go to the chapel for morning prayer.

I think we had to study. But I had a real good memory and I paid attention. I wasn't very good at taking
notes, so I tried to a study a little bit as I went along so I didn't have to cram. Usually before a big test, I was in bed, 'cause coming from the country I always went to bed early. When it got dark, I was ready to go to bed. And the other girls would be up studying. Sometimes it was hard to sleep with them up and studying. We all had the same sleep quarters even if we were on different work shifts. It wasn't often you had to double back the next day, but it did happen sometimes. And you might have a test in the morning and then go to work after your test. You might have a test at one o'clock and then go to work at three o'clock.

SAM (Sister Agnes Marie), that's what we called her, was the administrator, and she taught us a class too. Doris Karns was also one of my teachers. I think she taught the professional side of nursing. Bertha Mae Anders was our nursing arts instructor. She taught us how to make a bed, how to give a bath. They started us out real simple.

All of our classes were taught at Our Lady of the Lake except for Chemistry. We had to go to LSU to take chemistry. We got there on the city bus ... that was a big deal for this kid from the country. We had to take the bus from right there at Our Lady of the Lake and go all the way downtown to North Boulevard and then transfer to another bus and go somewhere on the LSU campus and then cross the campus to class. I don't think I could have found it if I hadn't been with the others. I used to be scared that I'd get lost.

The instructors were with us on the clinical units for about the first year, but then they turned us loose our second year. Then the head nurse would be in charge of us. On the weekends, the senior student nurse would supervise. And then there was an overall supervisor. The aides (nursing assistants) were great. They knew the hospital and they knew what they were doing.

... When I went in, in 1952, we didn't have to do any night duties, but we had to do days and weekends, and holidays and all; we didn't get regular schedules... I think we were the first group to have a forty hour week schedule... the total of classes plus work was forty hours per week. But because of our classes we would work sometimes from three to ten or three to eleven or seven to eleven and then have a test that afternoon. But, somehow
we made it...we had to! I was accepting...I did what I had to do to make it.
(On coping with death and dying):
    I've lost patients, but they didn't die "on me"; it was usually on another shift. I guess it would have felt like it was a sign of failure ...if they died on me. At the same time it was a moral issue too. I never felt that dying was the worst thing that could happen to a person...when it is a hopeless case, and in pain and suffering...I felt that dying wasn't the worst thing that could happen. If you believe in the hereafter, we are all here just temporarily. Now I would never do anything to harm anybody, but I had to struggle a long time with the use of extraordinary means. I talked to a priest in the hospital and he helped me with that issue.
    Sister Agnes Marie was always there ...if we were upset about anything. She stood in back of the students...she believed in her students and she would fight for us.
(On doctor-nurse relationships):
    I had no problem with the doctors. The doctors were up on a pedestal. When a doctor walked in a room, you got up and you gave him your chair and then, unless it was a dire emergency, you stopped what you were doing and you got the patients' charts and you assisted that doctor. And accompanied him as he made rounds, you took the orders and all of that. And I really think that is a good thing because you got to learn your patients and you got to explain things. There was communication between patient and doctor and nurse. And, because I was raised in the country, and doctors were older than me anyway, I was supposed to get up and offer my chair to someone older than me anyway. I know that later on nurses thought that was ridiculous. But to this day, if a doctor came in, I would most probably get up and give him my chair. The doctor was always right. That's what we were taught.
    I did hang up on a doctor one time...he cursed me out on the telephone...and I hung up. It made me feel horrible. But I didn't like his language so I just hung up. I told my instructor and I didn't get in trouble. He didn't make it an issue...at least I never heard anything else about it.
(First job):
The last six weeks of school I worked on Pediatrics at the Lake because it was where I was going to work. I was a little worried because they only assigned one nurse at a time to Peds. But everyone told me not to worry because Sister Julie was always there and she was a wonderful nurse. So, right after graduation I went to work on Pediatrics. What a first day! Sister Julie had taken a trip to Ireland and it was just me, nineteen pediatric cases and a couple of aides. I survived, but I didn't get off duty until after five o'clock.

I dearly loved Sister Julie—she was a fantastic nurse. She and I had a misunderstanding at one time and I left Pediatrics to work in the nursery. One of the nurses on Pediatrics was married and in order to accommodate her family life, Sister Julie scheduled me to work around the other nurse's schedule which meant I worked a lot of weekends, late nights, holidays, etc. Sister said it was because I was single. I told her I would never be married at this rate! Eventually, I did get married and after I started having babies (six children in all), I went back to Pediatrics to work part-time and Sister Julie and I patched up our differences. I remember making $12.00 a day.

I later went to work in the nursery at Woman's Hospital and was there 20 years until I retired in 1991.

(On what makes a good nurse)
Well, I think a good nurse has to have a feeling for people. You have to be willing to work hard. To be a good nurse is not sitting down at a desk and looking at the monitors.

One of the regrets I have is not continuing my education more formally. I think that was one of the reasons I was always scared.

Among the noticeable changes that differentiated Ms. Steib's experience from Mrs. Crochet's is the cessation of the practice of having students completely staff the hospital and requiring students to work the night shift on a regular basis. This represented a more humane approach to the education of nurses. In addition, the emphasis on apprenticeship had been modified by 1952 as evidenced by the curricular
inclusion of science courses that required the students to go to the Louisiana State University campus for instruction. These were courses designed specifically for nurses and probably did not meet the requirements of academic rigor, but the intent was a major departure from the previous curriculum and a purposeful attempt to partner with higher education to provide learning experiences that assisted in shaping professional education.

In addition, faculty presence was much more noticeable in the 1950s. The practice of requiring students to staff the hospital under limited supervision by senior students was replaced with responsibility for clinical supervision shared by staff nurses and nursing instructors. This change, in a modern sense, recognized the clinical component of the program as an educational experience rather than a means to serve the needs of the hospital and placed responsibility for nursing education with the educational facility rather than with the hospital.

Mrs. Crochet's experience as a graduate nurse also reflects the changing landscape in hospital employment policies and staffing patterns that resulted from the initiative described by Leighow (1996) on the part of nursing leaders to mobilize older, inactive nurses back into the health care workforce. Initially, Mrs. Crochet came into conflict with scheduling procedures that accommodated the nurse who was married with children at the expense of the traditional, single, nurse. In time, Mrs. Crochet benefited from the same system that allowed her to work part-time hours when she herself married and had children.
Vision and Leadership

Sister Agnes Marie who had served as Director from 1943 - 1947 returned to Baton Rouge in 1956 after earning a M. S. degree in Nursing School Administration from Catholic University in Washington, D. C. She was once again appointed Director of the School of Nursing, but she also concurrently held the position of Vice President of Nursing Service. Mrs. Maureen Daniels (2000) recalled during interview that Sister Agnes Marie had insisted on the title of "Vice President." The concurrent roles of chief administrator for both the school and the hospital is reminiscent of earlier periods of nursing and nursing education. It was the conflict between the two roles that led to exploitation of student labor and the conflict in the priority of education versus service. This move on the part of Our Lady of the Lake Hospital was not consistent with then current reform efforts in nursing education. However, it is highly likely that it was because of Sister Agnes Marie's influence between 1943 and 1947 that the changes in hospital staffing patterns and in the conceptualization of apprenticeship learning replaced with educational experience were realized. Sister Agnes Marie possessed a vision that recognized that the replication of the closed social and religious environment of the sisters was not necessary or desirable for the socialization process to professional nursing education. She made a conscious distinction between the socialization process appropriate to the role of women religious and the socialization process to the role of professional nurse, despite the socialization processes occurring within the same culture.

When Sister Agnes Marie returned to "the Lake" in 1956 following
achievement of a graduate degree in nursing, her professional vision and educational enlightenment were even more pronounced.

In an interview on February 14, 2000, Mrs. Maureen Daniels, retired Dean of Our Lady of the Lake School of Nursing, provided insight by sharing her memories of Sister Agnes Marie.

She was a very dedicated religious nun. She obeyed completely all the rules of the order. She loved to, when we had visitors from the National League or consultants or anybody, make sure we would all go out to dinner. But she wouldn’t come with us because at that point Sisters couldn’t eat with lay people. So she was very, very much aware of and obedient to her vows.

During her administration we were breaking away from many of the traditions. One of those traditions was the wearing of the nurse’s uniform by nurse faculty... she encouraged us all to wear street clothes. And that was very, very difficult for some of us to take, so we all agreed that we would wear shirtwaist dresses. And I think in some of the archives there is a picture of me in my shirtwaist dress with my nurse’s cap on my head. It was just hard to give away the trappings, I’d say.

And she was very among God. Basically she was very progressive. And she very much loved education. Loved the students. Wanted the best for them and was extremely dedicated to the precept that you don’t use students for service. She didn’t go with the old diploma thing that the students had to work, work, work. Her favorite expression was “Look, you don’t have to worry about making those beds. How many times do you have to show them how to make a bed? How many beds do they make when they graduate?” Those were the kinds of things that she used to talk about.

She was trying to move it [the nursing program] from the apprenticeship model into true education. But to keep all the flavor and I guess the loyalty, the cohesiveness of the diploma education. I was never aware of any faculty resistance because we all respected her so.
And she had the ability to give you a job to do and she allowed the faculty to do it. [empowerment]

In December of 1956 Sister Agnes Marie was appointed by Governor Earl Long to the Louisiana State Board of Nursing, marking the first time in the history of the Board that a woman religious had received such an appointment. Sister Agnes Marie was also elected in the same year as president of the Louisiana Conference of Catholic Hospitals.

Accreditation of existing programs in nursing was one of the strategies employed by the National League for Nursing to promote excellence in education. In 1952, Our Lady of the Lake School of Nursing applied for and received temporary accreditation status. Notification was received in 1956 that stated in part:

During the fall meeting of the board of review the report of the program of nursing offered by Our Lady of the Lake School of Nursing was carefully reviewed. It is a pleasure to announce that the board approved the program for full accreditation and recommended that it be so listed in the February, 1957 issue of Nursing Outlook (1956, non-identified newspaper clipping).

The newspaper clipping also identified the school as a member of the Conference of Catholic Schools of Nursing and an agency member of the National League for Nursing, department of diploma and associate degree programs. In addition, the article reported that "to date, 510 nurses, including 14 sisters, have completed the program and graduates are holding positions over a wide area in hospital nursing services, industries, offices, the public health field, schools, private duty nursing, the armed services and nursing education" (1956).
The accreditation of Our Lady of the Lake School of Nursing by the National League for Nursing was representative of resolution to conflict that had persisted between the Catholic Hospital Association and the NLN since 1931. In 1930, the CHA passed a resolution to endorse the aims of the Committee on the Grading of Nursing Schools, established by the NLNE, and called for a thorough study of Catholic Nursing Schools. However, in 1931, a rumor spread that the committee was planning to publish a list of one hundred nursing schools that met its standards, of which only one was Catholic. In 1931, there were 403 Catholic nursing schools in the United States. In response to the rumor, the executive committee of the CHA reversed its position to support the NLNE's grading committee and began making plans to create its own set of procedures for evaluating Catholic schools of nursing. This reversal ignited heated controversy among many sister-nurse educators. Many of these sister-educators were members of the NLNE and had formed the Sisters' Committee within the league. Sister Olivia Gowan, O.S.B., was the chairperson of the Sisters' Committee and would become dean of Catholic University of America's newly established School of Nursing later in the decade. She believed that the NLNE was better qualified to evaluate Catholic nursing schools than the CHA's program, which was not composed of professional educators. She objected to the CHA's determination to establish its own evaluation teams as symbolic of a form of Catholic separatism, one that rejected the secular world, unlike the Sisters' Committee, which attempted to cooperate and provide a Catholic influence in a secular, professional organization (Kauffman, 1989). The dispute between the CHA and the Sisters' Committee continued until around 1950 when the
leadership of the CHA changed. As previously noted, Our Lady of the Lake School of Nursing first applied for accreditation status with the National League for Nursing in 1952.

Our Lady of the Lake School of Nursing and, later, the Division of Nursing of Our Lady of the Lake College, has held continuous accreditation by the National League for Nursing since 1956. In addition, full approval by the Louisiana State Board of Nursing has been continuous since 1924.

A collaborative effort by the National League for Nursing, the Kellogg Foundation, and the Teachers College of Columbia University laid the foundation for Associate Degree Nursing in America. Slowly but surely, all the pieces were being put in place. Professional nursing and higher education were in a state of full readiness for the first attempts to educate Registered Nurses in two-year programs based in junior and community colleges. This foundation was based on the premise that basic nursing education might have a separate “technical” aspect that was to be the cornerstone of ADN education. The year was 1951.

Sister Agnes Marie Fitzsimmons had resumed the position of Director of Our Lady of the Lake School of Nursing in 1956. Her own participation and experiences in professional nursing education, combined with trends in nursing education, a shortage of nurses, and a call for a higher order of professionalism within the Catholic church and the Catholic Hospital Association, prompted Sister Agnes Marie to seek strategies to revise and improve the curriculum in nursing. A series of letters written between March 18, 1957 and October 1, 1958 to the following: Miss Leonara J. Collatz,
Executive Secretary of the Minnesota State Board of Nurse Examiners; Sister Creighton, Director of the School of Nursing at St. Bernard's Hospital in Chicago, Illinois; and Sister M. Beatrix, Director of the School of Nursing at St. Mary-Corwin Hospital in Pueblo, Colorado. These letters document the pursual of her goal. In March of 1957, Sister Agnes Marie wrote that she had been interested for quite some time in finding a logical way to integrate science courses throughout the three year program of nursing. She expressed dissatisfaction with "the present method of 'cramming' all the science courses into the first 6-9 months" which she perceived as creating "a burden on students" and "not conducive to learning" (Letter to Miss Leonara J. Collatz, March 18, 1957).

By June of 1957, Sister Agnes Marie was interested in shortened programs and sought assistance from Sister Creighton at St. Barnard's in Chicago. In a June 5, 1957 letter to Sister Creighton, Sister Agnes Marie included a summary of a dialogue that she had with a potential student and the student's mother:

Yesterday when I had an applicant in for personal interview, she asked me what I thought of the "degree program" saying "friends were pressing her to go to a collegiate program." I dryly told her "that was an excellent idea provided she went out of state to a nationally accredited nursing program." She and the mother mulled that one over for a while and then the mother said, "Sister, do you know where the students in this Louisiana State University nursing program are going to get their clinical experience?" As I told the faculty today, the questions they ask - ten years or so ago an applicant's mother would not have known what "clinical experience" meant, nor dreamed of asking about it. This is the results [sic] of the information being distributed to the public by N.L.N.

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...Anyhow, I am going to investigate every angle
of the shortened program or the "either-or program" - the
name I give to Mercy Central's 27 month - 9 month
internship plan, before making any change. (June 5, 1957)

From June of 1957 to October of 1958, Sister Agnes Marie corresponded with
Sister Beatrix of St. Mary-Corwin Hospital School of Nursing in Pueblo, Colorado. The
subject of these letters was Sister Agnes Marie's interest in changing the curriculum to a
shortened 27 month program as well as designing an internship period. She had heard
Sister Beatrix speak at a professional meeting several years earlier and apparently
considered Sister Beatrix to be a reliable and credible consultant. In a letter dated
August 11, 1958 to Sister Beatrix, Sister Agnes Marie confided an uncharacteristic lack
of self-confidence:

Now that I have taken the first step, I am wondering if it
was not a foolhardy thing to have done, as I feel like the
blind leader, leading the blind through a curriculum maze.
(August 11, 1958)

On October 1, 1958, Sister Agnes Marie wrote of her plans to
visit Sister Beatrix in Colorado:

We expect to leave here some time Saturday morning,
October 4, and should arrive some time Monday evening.
As Eloise will do all the driving, we are not going to rush
too much.

I am bringing along some information from State
Boards regarding acceptance of shorter programs -
especially the two year Junior College...I know you do
not have a shortened program but you have a good head
on your shoulders and the 1188 mile trip will be worth it
if just to get your opinion of our feather-brain plans.

The correspondence demonstrates Sister Agnes Marie's intent to revise the
curriculum in some manner to make it more responsive to meeting the demand for

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nurses and for improving student learning without compromising the reputation of excellence that Our Lady of the Lake School of Nursing commanded. A review of student records (1958 - 1962) confirms that the curriculum was revised to shorten the program of study from the traditional three years to 27 months.

During the February 14, 2000 interview, Mrs. Maureen Daniels provided additional insight by sharing what she knew about the curriculum revision that Sister Agnes Marie initiated. Mrs. Daniels joined the faculty of Our Lady of the Lake in 1960. The program in nursing had just transitioned from a traditional three year curriculum into a 27 month curriculum. This transition was a major effort to reform the educational program at Our Lady of the Lake School of Nursing.

Mrs. Daniels:

When I first arrived, the program had just been shortened. Sister Agnes Marie's philosophy was that you taught as much as you could in the shortest period of time and you eliminated all the repetition and everything that was unnecessary. She believed in good students and good educational practices.

She originally asked the faculty to shorten the program to 24 months. The faculty worked and worked on it, and then they went back to her and reported that the best they could do was to shorten it to 27 months...and she agreed.

She was very much a visionary. She was very aware of everything that was going on...not just in nursing, but with politics too. She was an avid reader and she loved classical music. She was an extraordinary woman.

A front page article in the State Times, Baton Rouge on May 30, 1956 reports the previous day's House Ways and Means committee hearing during which Governor
Earl K. Long debated with women club members on the proposed bill to eliminate vote machines in precincts with less than 200 voters. Among those attending was Sister Agnes Marie representing the Louisiana State Nurses' Association. It was reported in the article that Sister Agnes Marie told Governor Long, "Your late brother, Huey Long, said every man was a king...If that is so, every man should have a right to vote." She joined other women leaders protesting the bill. When challenged by Committee Chairman Rober Angelle, a Long leader, who demanded to know if Sister Agnes Marie was "interested in state economy," she replied smiling, "Yes, but not at the expense of clean politics." The article reported that Angelle "angrily rapped for order when some 40 women present applauded loudly." This incident reflects not only her interest in politics, but the commitment of Sister Agnes Marie to social justice and the rights of all of God's people to the benefits of democracy.

Given Sister Agnes Marie's awareness of national trends in nursing education and her involvement in state and national professional organizations, combined with her persistent effort to revise the existing three-year traditional curriculum, it would appear that her efforts at educational reform were likely in response to the national movement to supplant diploma education in nursing with associate degree nursing education. Whereas in many states, the inclusion of associate degree in nursing programs within community colleges threatened the existence of diploma programs in nursing, Louisiana did not have a community college system and, therefore, did not have a ready-made vehicle for incorporation of associate degree in nursing programs. Despite the absence of a viable competitive force, revision of the three year diploma curriculum to 24 or
even 27 months would begin to align diploma education with associate degree education and, perhaps, lend more credibility to Our Lady of the Lake School of Nursing as an educational program within the context of professional nursing.

Mrs. Maureen Daniels confirmed during interview on February 14, 2000 that the faculty were vehemently opposed to the proposed labeling, by the NLN and ANA, of nursing education programs and their graduates as being either "professional" or "technical." Mrs. Daniels further clarified that the adjustment made to the three-year curriculum was not a conscious effort to address the entry level issue that was raging within the national nursing organizations. Mrs. Daniels maintained that the motivation to drive the revision stemmed from Sister Agnes Marie's dedication to efficiency and conservative management of resources.

Mrs. Daniels:

That (the entry level issue) was never in our minds. We disliked the labeling of professional and technical. Sister Agnes Marie said "nurse is a nurse is a nurse." …it was more likely that Sister Agnes said, "Look. These baccalaureate programs turn out their nurses with far less clinical experience in 24 months (4 semesters). Why are we taking three years?" It was that kind of thought.

Mrs. Daniels maintained that Sister Agnes Marie believed the diploma program was as good as the baccalaureate program and urged the faculty to get out of the rut.

The climate in Louisiana was not, nor has it ever been, pro associate degree in nursing. Mrs. Daniels recalled that sometime in the 1970s, LSU Medical Center in New Orleans explored the possibility of starting an associate degree program in nursing in the Baton Rouge area, but:
We dug in our heels and said "no." We held them off because at that time there was a shortage of faculty, a shortage of clinical resources...the whole thing. We didn't want an AD program in the community. (February 14, 2000)

Married Women Join the Ranks

As discussed earlier, the employment arena for nurses had changed during the 1950s to better accommodate a return of older, inactive nurses to the workforce. Their return to active duty, so to speak, coupled with the national consciousness-raising associated with the civil rights movement and associated non-discriminatory laws resulted in a changing profile of women admitted to schools of nursing. For the first time, married women and women who were mothers were admitted to schools of nursing. Similarly, students who married during the course of study were not dismissed and students were allowed to live off-campus (with special permission) rather than required to live in the dormitory.

Norma Jean Lang is a 1966 graduate of Our Lady of the Lake School of Nursing. She was one of the first married students admitted to the program of study. Following graduation, Mrs. Lang was hired to be the Student Health Officer of the School of Nursing and later was appointed to the faculty as an instructor in psychiatric nursing. Her tenure with the school began in 1963 and extended until 1979. Mrs. Lang was interviewed on March 3, 2000 and shared her experiences as a student and as a faculty member.

Mrs. Lang:

I was thirty-two years old when I entered the program at Our Lady of the Lake School of Nursing and I was thirty-
four years old when I graduated in 1966. I decided to attend the nursing school because I had wanted to go into nursing when I graduated high school, but I got married instead. There was no nursing program in the Baton Rouge area that admitted married students. I had a family and I could not commute. In December of 1963, I ran into a former high school friend in a beauty shop. She had on her uniform and was on her way to work. I said, "I wish I was a nurse." She said that I could be and informed me that the Lake now took married students. I went right home and called my husband Bill to tell him that I wanted to apply. He told me to call and get an application and that he would help me all that he could if I got accepted.

Mrs. Lang was accepted and entered the program in September of 1964. There were four older, married women in the class; one was a widow with a young child and three were married and had children. They were a novelty and it became apparent that administration and faculty hadn't really made any plans to accommodate their needs in terms of their family lives. So the first married students were forced to request some concessions.

Mrs. Lang:

For example, we were required to be in chapel at 6:25 every morning...before anything -- clinical, class. Even if we had class at 8:00 or 9:00, we were still expected to be in chapel at 6:25. My children were nine and thirteen at the time and I really wanted to be able to see them off to school on days that I didn't have clinical. So I went to Sister Agnes Marie and asked if I could be excused from chapel on the days that I did not have early morning clinical. She approved my request.

Another example involved the library hours which were very rigidly enforced. The library was open until 4:30 P.M. and didn't reopen until 7:00 to 10:00 P.M. That meant that the married students could not go to the library immediately after clinical and stay to get our work done...we had to go home and then return at 7:00 which cut into the evening hours with our families. We
requested that we be allowed to stay in the library until 5:30 or 6:00 P.M. and then go home. Our request was granted.

Mrs. Lang also identified the areas in which their requests were denied:

There were some requests that were not granted. One had to do with clinical and class scheduling. We had requested that schedules be made out at least three to four weeks in advance. That was especially important to the mothers with small children who had to arrange for childcare. But it never happened consistently. We would arrive for duty on the clinical unit at 7:00 A.M. only to find out that clinical had been canceled. They (the faculty) would also cancel classes on Friday afternoon. They were bad about doing that back then. They never gave a reason...seemed to be at will.

We also asked to order more uniforms than the three we were allowed. I personally wanted five so I could launder them on the weekend and have one ready for every day of the week. They were polyester and cotton...the pink with the white bib...they didn't have to be starched, but they did have to be ironed. But they said, no, three was enough. We also asked that we not have to buy the navy blue cape with the burgundy lining that was $70.00 back in 1964. It was a lot of money. But it was a required purchase.

The original blue and white color of the uniforms that Mrs. Steib wore were later changed to pink and white. The capes were abandoned in the early 1970s. It was not until the 1990s that the uniform was changed to burgundy scrub suits.

Mrs. Lang continued:

We also had some problems with reference books in the library. We asked that they purchase more than one copy of the better books that were used frequently. We had to sign up for the use of the reference book. If you were seventh or eighth on list, you knew you wouldn't be getting it that night. We also asked that we be allowed to use the physicians' library because they had a lot of reference books that we wanted to use, but that weren't in
our library and we couldn't afford to purchase them individually. They would not ever give us privileges to use the doctors' library. Then we asked if we needed a certain textbook for a research paper, that the librarian check it out of the physicians' library and bring it to the school library and we would sit there and use it under her supervision. Sometimes it was done and sometimes it wasn't. I have no idea who made those kind of arbitrary decisions.

When Mrs. Lang attended the school, the 27 month curriculum had already been implemented. However, she still felt it was an old-line school in that it held to a very grueling schedule. The students were expected to be on the clinical unit at 6:30 or 6:35 for report and they got off the unit about 1:00, at which time they had lunch. Then they had to go out to LSU in the afternoon for Anatomy and Physiology and went back to the nursing school for Chemistry from 5:30 to 7:00 P.M. And then it was time to go to the library.

Mrs. Lang:

(on discipline) I found that much was expected of us. We were expected to do something perfectly the first time we did it. Everything was to be done perfectly and there was no margin for any kind of deviation just because you were a learner and learners make mistakes.

Someone I was very fond of in nursing school was viciously attacked (verbally) by one of the faculty in front of the doctors, the staff and her fellow students at the nurses station. She cried and went home. She never came back. She quit. That was unnecessary. It was cruel. We felt like we were on continual probation.

Mrs. Lang also felt that there was some partiality on the part of the faculty toward the older, more mature students who may also have been perceived as better students.
Mrs. Lang:

There was a problem I feel with some of the students who were good and kind hearted, but they were C students. I found that the instructors really were more willing to find me a good learning experience and work with me and they were more concerned about those of us who caught on quickly and learned well. I think that the faculty focused on those of us who were better students too much sometimes and neglected the students who did not achieve as easily.

I’m a motherly kind of a person. I found what was very difficult in my class, and later, when I taught... we’re taking kids right out of high school, 17 and 18 years old who have not really resolved their own crises maybe from adolescence, they’re not adults. And then we’re asking them to deal with these life threatening crises. Deal with the family, grieve with the family, for whatever reason, and I think we ask an awful lot of these kids. I will tell you that I was certainly proud of some of them. They rose to the occasion.

By the way, when we were freshmen we all had to take a Catholic ethics course. It was taught by a priest. Everyone had to take it.

It is apparent from Mrs. Lang’s statements that she and her fellow married students challenged a system that was designed for younger, single women. It appears that accommodations were not anticipated as necessary until these women made formal and purposeful requests. Mrs. Lang also shared that when she first started school, married students were not allowed to hold any office in any student organization nor a class office. She said that eventually changed, but not until the rules were once again challenged.

Mrs. Lang:

There was no commitment to help students succeed if they made a mistake or got behind. It was, you either made the cut or you didn’t. On your own. The classmates
that were weak in some subjects, those people who were good in them tutored them. Helped them out. We all helped each other.

One of the things that really bothered me, that was a constant for me, both as a student and as a faculty member was student discipline. The administration of the school, and I'm separating administration from faculty, thought they could snatch up a student for whatever reason, a minor infraction, and ask them to withdraw from school and face no reprisals whatsoever. This happened in my class and long up into the 1970s.

For example, one girl was late coming to clinical three times in a row and they asked her to withdraw. And she was a really nice person, a good person...and a good nurse. Another girl in my class signed out to go home to her mother and daddy's and stayed at her boyfriend's apartment at LSU. She was asked to withdraw. One girl was asked to leave because she wasn't doing well in clinical, but she had all satisfactory clinical evaluations. Another girl in my class was asked to withdraw when we were on senior vacation in August, before we graduated in December, because she had low scores on the NLN achievement tests (a predictor of success on State Board of Nursing licensing examinations).

It seemed to Mrs. Lang that discipline was arbitrary and without due process. Her concern and examples illuminate the fear that was expressed by both Ms. Steib and Mrs. Crochet. Their fears were of being asked to leave school because of failure to live up to an expected code of behavior that was unclear to them. It seems that the student nurses were held to a standard of behavior that was similar to the character formation standards of the women religious. These standards included punctuality, obedience and chastity.

Mrs. Lang elaborated on the use of National League for Nursing Achievement Tests as a basis for dismissal:
The NLN achievement tests were given at the end of each major unit of study. That was fine. But the National League for Nursing specifically says that these tests are not to be used for evaluation or promotion. However, they were used for evaluation and promotion. This was all in preparation for State Boards (state licensing examination). In the fall before graduation we had "mock state boards" when we took every NLN that we had ever taken all over again to see how well we did. Passing state boards was a criteria to measure success of the school. You were a disgrace if you failed state boards.

Student records of graduates from the 1960s were reviewed and found to include scores of all NLN achievement tests as well as state board examination scores. Although the presence of NLN test scores within the student records does not verify the extent to which they were used to determine satisfactory academic progress, it does indicate that these test scores were considered important enough to be included in the academic record.

The emphasis placed on the passing rate of graduates writing the State Board Licensing Examination cannot be denied. Throughout its history, Our Lady of the Lake School of Nursing took great pride in the fact that it was never put on warning or probation by the State Board of Nursing which requires an 80 percent pass rate for a school to remain in good standing. At the completion of their programs of study, nursing graduates in all fifty states write the licensing examination, which is a nationally standardized test administered by each of the states. Success on the examination is required for licensure, awarded by the state, to practice nursing within that state. States may grant reciprocity to licensed (registered) nurses who apply for licensure in a state other than the one in which they were initially licensed. So, passing the licensing
examination is a criteria to practice nursing. It has also become a major indicator of program success.

During the interview, Mrs. Lang was asked to address physician/nurse relationships:

The doctor back then was viewed as God ...that was a real problem for some of them. They showed their deity complex on a number of occasions. For example, one day I was sitting at the nurses' station with my back to the hall, reading a patient's chart. And he walked over and snatched the chart and said, "Nurses have no right to the charts when the patient's doctor is on the hall." I said, "Please have it; would you like to sit?" And I moved on. It was an expectation to give the doctor your seat...like an unwritten rule within the hospital...I don't recall being told in nursing school to give up your seat to the physician...it was just something that was done.

As one doctor said, "I don't have ulcers; I'm a carrier; I give them to everyone else." He seemed very proud of that.

It is apparent that some doctors were very supportive of the school and the students. As Mrs. Lang said:

But there were some doctors who just turned themselves wrong side out to help us. Some of them were very protective of the students and very helpful and supportive.

In fact, several gave scholarships for students or regular gifts to the school. Some of the physicians contributed to student scholarships and gifts to the school for many years, even after their retirements.

Two articles in December, 1969 newspapers, The Catholic Commentator (December 12, 1969) and the Baton Rouge Morning Advocate (December 8, 1969) were published with pictures showing Our Lady of the Lake Hospital medical staff signing
their names on the pink student uniforms of graduating nursing students on the last day of their classes prior to graduation. The papers described the signing as "a giggle-punctuated traditional ceremony in the halls of the hospital."

An earlier article in The Catholic Commentator (March 10, 1967) corroborated Mrs. Lang's description of the program of study at Our Lady of the Lake School of Nursing. Excerpts are presented as follows:

Twenty-seven months of study and training are required in the accelerated course offered at the school. These months are divided into three nine-month terms, and each term into two semesters.

In the first nine months, students have both classroom studies and after the first six weeks, training in the hospital. They learn the basic sciences and then begin medical-surgical training and basic patient care.

With the second nine months, the student nurses begin to work in various special nursing areas, including pediatrics, obstetrics, and psychiatric nursing, as well as continuing to work in medical-surgical nursing. They continue their classroom studies too, which are correlated with their clinical experiences.

The third term brings more practical experience in the various nursing areas, more classroom work in conjunction with their hospital work and advanced medical-surgical nursing.

Miss Bertha Mae Anders, nursing school director, said the last semester's courses preceding graduation enable the students to make the transition from student nurse to graduate nurse and make the nurses more effective in meeting the community's needs.

The preceding article may have been written in response to national media coverage of the position taken by the professional nursing organizations to make the baccalaureate degree the entry level into professional nursing. Diploma programs in nursing were understandably sensitive to media coverage that portrayed the diploma
graduate as something less than professional. It was important to the diploma programs in nursing that the public recognize that their graduates were, indeed, Registered Nurses and that they qualified to continue their education at an advanced level. However, saying and doing are two different things.

Mrs. Lang:

There were about 30 of us diploma graduates who were really interested in getting our BSN's. I went over to Southeastern Louisiana University's nursing school to discuss this with the director of their school of nursing. Theirs was a generic BSN program. I asked her if there was any way we (diploma graduates) could fit into their program to work to a B.S. She told me flat no. There was no place at all for anybody from a diploma program because we were not ever taught the psycho-social needs of the individuals and to consider their spiritual needs and whatever. And I showed her the curriculum plan that I had taken with me and it showed that all of those things were taught. But she kept on. She said, "You could not possibly fit into my program." They thought our education was inferior. I often wondered if 'they' thought that I thought that I was inferior. I always told them that there were many criteria by which to judge a nurse.

When Mrs. Maureen Daniels was interviewed, she addressed faculty qualifications and the BSN. The following are excerpts from that interview on February 14, 2000:

In the late 1960s and 1970s there was a shortage of prepared faculty. The requirements for faculty at the time were a Bachelor of Science degree in Nursing and two to three years of clinical experience in the area in which you were going to be teaching.

...I guess it was after Bertha Mae was appointed director and I was assistant director that it was always a big, big problem to get psychiatric nursing instructors. We would be down to the wire and we still didn't have anyone qualified to teach Psych. Jean Lang graduated
from our program in 1966 and was an RN. But she didn't have a BSN, but she was extremely bright. Ms. Anders said, "Heck with it. Jean is our Psych nursing instructor." We encouraged her to get a BSN, but there were too many obstacles. I don't think the Board of Nursing required faculty to have a BSN; I think it was an internal standard. At least, I don't remember having to get an exception for her. Same with the National League for Nursing. Every time they visited for accreditation they recommended that Jean get her Bachelor's degree.

Changing Leadership

Sister Agnes Marie left Baton Rouge in January, 1966 to assume new duties as Administrator of Our Lady of Lourdes Hospital in Lafayette, also sponsored by the Franciscan Missionaries of Our Lady. Upon her departure, Ms. Bertha Mae Anders was appointed Director of the School of Nursing by Mother Gertrude, Our Lady of the Lake Hospital Administrator. Ms. Anders had been associate director of the school since 1960. She was a graduate of Istrouma High School and held a B.S. degree from LSU. (Baton Rouge, State Times, January 3, 1966). A second article in the State Times (January 29, 1966) announced the appointment of Mrs. Maureen Daniels as clinical coordinator in the School of Nursing. Mrs. Daniels had been a faculty member at the school since 1960. She earned her bachelor of science degree in nursing from the Cornell University New York Hospital School of Nursing.

Mrs. Daniels discussed Sister Agnes Marie's departure:

The hospital in Lafayette was in trouble because the administrator had died. They (the Sisters) didn't have anyone else to go. She felt she had no choice but to obey. She said, "That's my order." She did not want to leave. She cried. She loved the Lake and she looked at the Lake as her home. She did not want to leave, but she would not
disobey. And she went to Lafayette and turned the place around. She was tremendous!

Bertha Mae Anders succeeded Sister Agnes Marie as director of the school. Ms. Anders had been the associate director and worked very closely with Sister Agnes, who apparently spotted potential in her protégé. Ms. Anders had been an educator, teaching in the public high schools before she went into nursing. Because she already had a B.S. degree, she was viewed as very valuable to nursing education and was hired as a nursing arts instructor immediately upon graduation from the school of nursing.

Mrs. Daniels:

As the director of the program, she was very vested in the welfare of the students and in their education. Sister Agnes had basically been her mentor. And she carried on the same kind of philosophy and environment that Sister Agnes Marie had. She was very education oriented. Her criteria for any kind of change was what was best for the students. She also took her obligation as a nurse very seriously to make sure that those that got through the program were really qualified. She wouldn't allow any slip-shoddiness...or anyone getting through who wasn't either clinically or academically prepared. She was really very firm in the enforcement of the academic policies which endeared her to the faculty because she would never overrule...well I shouldn't say never. Never is not a good word. Rather than overrule the faculty decision that she thought was a mistake regarding a student, she would get with them and talk with them and try to change their minds. She believed in communication. And she was very perceptive and very dedicated to preserving the quality of the school. Bertha Mae was not Catholic and, of course, this is a Catholic institution. But she made sure that everything that went on in that program was in complete accord with Catholic doctrine.

She upheld the philosophy and the objectives of the Franciscan Sisters. She felt it was a sacred trust for her to do so. She was a wonderful mentor to me because she shared everything. I don't think any decision was
made in that program that I was not a part of. I was not isolated. She shared everything with me...she discussed everything with me. And we worked more as a partnership.

She was professionally active. She became more active after she became director and encouraged participation. She became more active herself and became a member of the Board of Nursing. Around the same time, I became more active too. I was a member of the Board of Directors of the State Nurses Association. That was in the 1960s and 1970s when all the talk was going on about the entry level into nursing and we tried to keep on top of things. We went to NLN meetings and we went to the legislature and objected to some of it. So I would say she was like Sister Agnes Marie in that respect. She also had a great loyalty to Our Lady of the Lake Hospital. We were always aware of what was going on in the hospital.

In 1967 Mother Gertrude was appointed Regional supervisor of the Franciscan Missionaries of Our Lady in this country and Mr. J. B. Heroman was appointed administrator of Our Lady of the Lake Hospital. This was a historic event in that it marked the first time a lay person was appointed to serve as the hospital Administrator. It is interesting to speculate how this decision was made.

Around 1960, Father John Flanagan, Executive Director of the Catholic Hospital Association (CHA) noted the general reluctance among leaders of Catholic hospitals to appoint lay persons to administrative positions. He admonished the leadership of these hospitals for appointing a lay person to a position only to remove her or him when a qualified sister became available. With remarkable insight, he noted that hospital administrators treated the hospital personnel as religious superiors would treat young sisters. Father Flanagan remarked, "We are so secretive; there is so much 'hush, hush,
hush' and there's so much that reposes piously and carefully hidden in the administrator's files and is not shared with anyone" (Kauffman, 1995, p. 254). He admitted that confidentiality was necessary, but that secrecy generated suspicions that things, especially financial reports, were being covered up. He challenged Catholic institutions to be as efficient in a business way and at the same time maintain the spirit of charity and kindness and personal attention that have always been traditions of Catholic hospitals.

It is likely that the decision by the Franciscan Missionaries of Our Lady to hire a lay administrator was inspired by Father Flanagan and the Catholic Hospital Association. This was a turning point in the history of Our Lady of the Lake Hospital in that the hospital now came to be perceived as a business rather than strictly a charitable institution. With finances in the hands of the lay administrator, all departments of the hospital, including the School of Nursing, were carefully scrutinized for the first time.

When asked what she perceived to be Ms. Anderson's greatest challenge as Director of the School of Nursing, Mrs. Maureen Daniels stated that getting the financial support that was needed for the school was the greatest challenge.

Mrs. Daniels:

Getting financial support was a bit on the difficult side. When Sister Agnes was there, she did not ask anyone. Nobody was going to say no to her. After Sister Agnes left and after Mr. Heroman became administrator, we were threatened for the first time with closure of the program by the hospital administration. This was in the late 1960s.

It was strictly a financial issue. We had to do studies to justify our existence. I think that it was the way the budget was allocated; we, the school, were part of the
hospital; we were charged for things for the upkeep according to our square footage. And the nursing school was a big old rambling place. So we had tremendous square footage. So our portion of the budget expenditures was very high. And disproportionate to our revenues. We sent all that we collected for room and board to the hospital, but we kept the tuition. And with the tuition revenues, Bertha Mae upgraded the school in terms of nice furniture for the students. She refurnished the whole dorm. She replaced the old fashioned iron beds with nice little bedroom suites. She put in an elevator. The hospital paid our salaries, but everything else we did out of tuition, which was minimal. But they started to look at it administratively and they had an advisory committee that was close to closing the school until they came and talked to us. I remember, I very distinctly asked the question, "How will the expenses to the hospital decrease if the school is closed? You are charging us according to square footage, we'll be gone, and you will still have those expenses... And besides that, where are you going to get your nurses?" Well, they decided to keep the school. And then also they started to look at the history of the school and the number of graduates. And another point in our favor was the large percentage of graduates that were working at the Lake.

That was the only time that I recall we felt threatened. Aside from that one time, Mr. Heroman was very supportive of the school and allowed us autonomy. He did not try to dictate to us. We were always able to maintain that autonomy. We always had the trust and the approval of the administration and the Sisters. You must realize that the Sisters owned the whole thing. We absolutely had to have their support and we always did.

The decade ended with a transformed American society. The Civil Rights Movement had given both minorities and women their voice. In the wake of the turbulence of the 1960s, the entry level issue in nursing was placed on a back burner while the nation tried to realign and regain balance.
In 1970, Our Lady of the Lake School of Nursing continued to exist adjacent to the Our Lady of the Lake Hospital in downtown Baton Rouge. Bertha Mae Anders continued as the Director and Maureen Daniels was Associate Director. They began to see a change in the applicants to the program in nursing. Mrs. Daniels elaborated:

We started to see a change in the appearance of the applicants. We called it the hippie influence. Before 1970, the applicants always came in for interview dressed as young ladies. Some even wore gloves. Always dresses…church clothes. After 1970, they started coming in blue jeans and very casual. Even the language was different. It was hard to take. I was very much a traditionalist and Bertha Mae was even more so. And we had a hard time dealing with it. Basically, we had to ignore their appearance and just look at their academic records and what they had achieved. The same kinds of things that had always interested us about students…why they wanted to become nurses, their plans, their interests… but it was hard to be objective and non-prejudicial.

Once they were in the program, it really didn't make a difference because we had a stringent dress code...uniform code. And I don't remember it being a problem.

At some point, we decided to make living in the dorm optional, probably because the students were asking to live off campus. I don't remember a rebellion or anything. The responsibility of maintaining the dorm was not hard to give up. We were running a nursing school and a dormitory too. The upkeep and retaining housemothers was a big responsibility. And the faculty were pleased not to have to deal with so many dorm issues…yes, the faculty dealt with dorm issues. It was a whole part of student affairs. We called it Student Welfare. There was a committee of the faculty to handle rules infractions and sanctions. We decided to let the dorm go.
The decision to phase out the dormitory coincided with the proposed relocation of the hospital to its Essen Lane location. At that location, the school would reside within the hospital building and would not have dormitory space. In addition, the profile of the student body had changed. More older, non-traditional and married women were entering the program in nursing. High school graduates had more opportunity as women and were not as limited to the nursing and teaching professions. For the first time since the first male was admitted in 1923, men were once again admitted to the school of nursing.

Men in Nursing

An article in the Sunday Advocate (Baton Rouge, December 9, 1973) discussed men in nursing.

The Louisiana Capital Area Health Planning Council reported an increase of 128 per cent over the male enrollment in nursing in 1971. While the male nurse is not a new concept...what is new is the rapidly growing number of civilian men who are convinced that being a nurse is an attractive career. It is believed that the great jump in pay which nurses have received over the past ten years is a key factor in the men in nursing trend.

...where else can a man earn a starting salary of almost $8,000 after just two or three years of training?...Our Lady of the Lake School of Nursing has three men enrolled...

Frank "Jerry" DiBenedetto was the first male graduate of Our Lady of the Lake School of Nursing, in 1975. Mr. DiBenedetto was from Port Allen and had spent two years in the Navy as a dental technician. He had already had three years of education at Louisiana State University before he entered the program at Our Lady of the Lake
School of Nursing. The class of 1976 included three men. One of those was Bobby
Hunt. Mr. Hunt was interviewed on March 9, 2000.

Mr. Hunt:

Before I had gone to the Lake I was in sales. I traveled
three states and two years back my wife had wanted to go
into nursing, and had done so. During this time, we
moved to Baton Rouge. It made it easier because her
main goal was to go on to anesthesia. I had no desire to
go to nursing school or to anesthesia school at that time.
But the company I worked for had moved us from
Shreveport to Baton Rouge. The next move I was told
was to go to Minneapolis, Minnesota. I just couldn’t see
that move. So I started looking for something else. My
wife enjoyed nursing so much, and at that time she was in
anesthesia. I said, "I think that is something I would like
to do." So I started checking into it, and I can’t
remember, I must have been in my forties, when I first
went to the Lake.

I think that there were two big things that bothered
me. One, was whether I could do the curriculum, and
second, I really had a deep down funny feeling about what
people would think of me going into nursing. At that
time, there weren't very many males in nursing. It was
strictly for women.

Jerry DiBenidetto was the only one I had talked to
some. At that time, I really didn’t know him. There was
no one really I had talked with.

So to get to anesthesia school, I had to go through
the nursing program. But at the Lake School of Nursing, I
was treated very well. No one mistreated me. If anything,
lot of the girls would say that I got special attention.
Maybe I did, I don’t know.

Male students in nursing presented a challenge to nurse faculty, especially in the
clinical area of instruction. First of all, the public strongly associated females with
nursing and males with medicine. As has been noted previously, nursing care requires
the nurse to establish a short-term relationship with the patient that allows the nurse to
invade the personal and private space(s) of the patient. This intimate relationship is built on trust. The patient's recognition and acceptance of the professional role of the nurse, enhanced by the professional behavior of the nurse, is the first step in establishing a trusting relationship. The male nurse was disadvantaged in establishing the nurse-patient relationship by the absence of recognition by the patient of the professional role of the male nurse. The male nurse became suspect as soon as he entered the patient's room and introduced himself as a nurse.

The male nursing student was considered suspect not only by patients and their families, but also by hospital staff and physicians. The nurse faculty had to first overcome the biases of both the hospital and medical staff to gain acceptance for their male students. The hospital climate of "patient protectiveness" necessitated the staff's acceptance as an antecedent to the patient's acceptance of the male nurse. The reputation of the Our Lady of the Lake nursing program as one of professional development and excellence enabled the faculty to gradually begin to overcome the prejudices of hospital and medical staff.

When male nursing students were first being introduced to the hospital environment, nurse faculty conceptually operationalized the role of the male nurse as an extension of the role of the orderly, an existing and accepted male role within the hospital hierarchy and maze of employees. The male nursing student's clinical assignments were initially limited to male patients at Our Lady of the Lake Hospital.

Mr. Hunt:

It seems that at the beginning I was mostly with male patients, and had a great time, shaving some of the guys,
and helping with their bath and all. It really relieved some problems...I had never shaved another man before. That was a totally new experience for me.

All nursing students, male and female, began their clinical experience with physical care activities. Over the course of the first and second semesters in the nursing program, the students learned new skills that were then applied to adult patients in the clinical area. Examples of these skills included fluid management, oxygen therapy, medication administration, and surgical wound care. As the male students became more skilled in the delivery of nursing care, they were introduced to the care of female patients either as their primary patient assignment or in a cooperative assignment with a female student. It must be noted that this same consideration was not given to male patients in the care of female students.

Over the course of the first year of study, the male students' experiences were designed and controlled by the nurse faculty to generate feelings of comfort and self-confidence in the males who were being socialized to the role of nurse. In addition, the faculty promoted an environment, based on professional development and competence, that facilitated the acceptance of male nurses by the hospital and medical staff.

The third semester of the nursing program was designed to provide clinical experiences in obstetrics and pediatrics, the care of women and children. Since Our Lady of the Lake Hospital no longer provided obstetrical services, the School of Nursing maintained a contract with Woman's Hospital in Baton Rouge to provide clinical experiences for students. Students rotated through labor and delivery, the postpartal units, the nurseries, and the gynecology units. The environment of Woman's
Hospital was predominately female; the patients (with the exception of the nurseries), the nursing staff, and the ancillary staff were female. The physicians were predominately male, although a few women obstetricians were on the medical staff at Woman's Hospital in the 1970s.

Mr. Hunt:

…it was a strange environment with all the females. They didn’t know what to do with me, especially when I went for my clinical rotation in OB-GYN at Woman’s Hospital. Back then we had to have consents signed for us to go in for a delivery or any female procedure. But it was all handled well, and I thought it went real well. I was not really put in any awkward situations. I guess people were thinking ahead and planning and it just worked well.

The faculty member who was responsible for first taking male students, including Bobby Hunt, to Woman's Hospital was Mrs. Patricia Givens Butler who was interviewed for this study of February 11, 2000. Mrs. Butler was employed as an obstetrical nurse by Our Lady of the Lake Hospital when she was recruited to a faculty position in 1970 to teach obstetrical nursing.

Mrs. Butler:

…you could pretty much assign a patient to a student without any problems until the male students started appearing on the scene…it was very different. It was kind of scary for me to have to take a male student into an all female area where they were not accustomed to having males, other than the doctor.

When we signed a contract with Woman’s, I don’t remember whether it was ’71 or ’72, but the Lake closed their obstetrical unit. But we did very well at Woman’s. There were a lot of people delivering babies and the students got to see a lot of different experiences. The nurses were, a lot of those were ones that had worked at the Lake, that I had worked with as a part-time nurse. So
my students were very readily accepted and, knowing the nurses, I felt that I got a lot of cooperation from them. They were very helpful. I don’t remember when we started taking the male students over there. But it was quite a shock to the staff and everybody because you still had nurse anesthetists and they were females. At one point, patients started having to be intubated with general anesthetic. And at that point they needed a physician. So there were doctor groups then that took over anesthesia and they had nurse anesthetists that were male. So you began to get more of a male presence back there. Up until that time, the doctor was the male that was allowed in the area. Fathers were not allowed in delivery at that time. Once you started getting male nurse anesthetists and male anesthesiologists, then the male students were not the oddity that they had been and they were a little bit more accepted. I never assigned a male student to a patient without first asking the patient. I felt that this was a very personal experience for her and as the fathers began to be able to go into the delivery experience with their wives, I felt it was a very personal experience for them. And I did not want to compromise that experience. After all, we were on contract there. We were the guests in that department.

I would go in first and asked the patient if they had an objection to having a male student. And you could very quickly tell if they hesitated, if they looked at their husband, or if he made any comments, I said, "How would you like a nice young lady?" "Oh, that’s fine." So many, many women said, "Oh, no, that’s no problem. They have to learn." So you always had patients for your male students, but I never sent them in without asking the patient first. And they did quite well over there. A lot of them really like OB. A lot of them couldn’t wait to get out. Of course there were a lot of girls like that too.

The staff at Woman’s Hospital quite soon became stocked with our nurses. Which again made it easier when you took students in there. They had been through the same program.

As Mrs. Butler pointed out, the strong presence of Our Lady of the Lake School of Nursing alumni, in conjunction with caring and supportive faculty, helped to create a
hospital environment that was receptive and nurturing to all students. Mr. Hunt
reflected on nurse faculty who were especially supportive of him and also on his role as
an alumnus in contributing toward the learning environment.

Mr. Hunt:

There were so many good nursing instructors. I think they were great people, and I owe them a world of gratitude, especially to Mrs. Lang, teaching psych, and Nell Deshotel. The way that they could perceive the problems you were facing/having, and the feel they had for you. They would sit down and tell you this or tell you something else and say, “You know it’s going to work out.” Just do this or do that. They were a tremendous help to me...Mrs. Butler in the OB-GYN course. I think they were great people.

I had no problem with patients. The nurses seemed to accept me. I never had a problem. I never felt isolated or singled out. They treated me well.

(As an anesthesist at Woman's Hospital)...I see the nursing students from the Lake that are really proud to be a part of that program...those that come through Woman’s Hospital. I kind of quiz them a little bit, pick at them some, and they pretty well know. They’re on their toes. I see a real difference in those people...as compared to other students from other programs.

I try to get them (the students) up where they can see and get involved, and ask the doctor a lot of questions. I appreciated that when I was a student. That’s where you learn.

As a student I didn’t feel as comfortable approaching a physician. I felt that I should be quiet, stand back and I felt like I would probably be interfering. I had that feeling, and that is the reason I like to make them [students] at ease. When you are dealing with an OB-GYN doctor, it’s a lot different than dealing with a general surgeon. Some of them think they walk on water maybe, and some know that they are real people. I find that most of the doctors that I deal with day to day are much easier to talk with. Most of them are very happy to answer questions, and I think that all of them like teaching, to a
certain degree, in their field. They feel like they are specialists in their field, which they are.

Mrs. Butler was asked to share her thoughts and observations on the physician-nurse relationship and the physician-student relationship. She also addressed the changing physician-patient relationship that was prevalent in the late 1970s and throughout the 1980s.

Mrs. Butler:

The physicians treated the nurses and the student nurses very nicely really. I knew the doctors from having worked with them at the Lake. And I usually asked permission to bring more than one student into a delivery room; for example, I always asked the physician if he objected to me bringing the students in. I tried to be sure that the students were not going to be in someone’s way in a delivery room. I wanted to be sure they could see and stay out of the way so they could get the experience of what was going on. At one point we had them scrubbing in on deliveries. That didn’t last too long. But the physicians usually got along very well with the students. When the male students started coming in, they were a little bit more concerned about how those males were being assigned to their patients. Other than that, I had no problems with the doctors and I feel that it was because I knew all the doctors ahead of time.

Over time I have seen a lot of change in the nurse-physician relationship. At first it was “I am the doctor, you are the nurse. Do what I tell you to do.” There was one physician in particular that whenever he checked a patient, someone watched him leave the department while someone else went and checked behind him because he would always tell you the wrong thing just to see if you knew what you were doing. So you tried to be sure that your students were aware of, well I did anyway, aware of which doctors to kind of stay away from and which ones not to. Some of them would probably of also liked the hands on treatment with the students, but we didn’t do that either.
Mrs. Butler was asked to explain "the hands on treatment":

Well, they were very friendly. Inappropriately friendly. I know they were with some of the staff. I watched my students very closely. As a staff nurse at that time, if a doctor came on to you or whatever, you had no recourse. You just tried to avoid the situation.

Mrs. Butler was asked what would have happened if a staff nurse reported sexual harassment to the hospital administration:

Oh, the doctor was in charge. He would have denied it and you would have been probably asked to resign. They were in complete control.

And with student nurses, if the student nurse had come to faculty and said "that physician was inappropriate with me," the advice to students would have been to "stay away from him. Don’t give him the opportunity." You didn’t buck the doctor back then. Because nobody was going to support you. They [the physicians] were the ones that brought the patients to the hospital, the hospital gave them the benefit of the doubt. Yes, the hospital administration would have been partial to the physician in a questionable situation. That’s what brought their [the hospital's] money in.

Social changes within the practice of medicine also influenced doctors' attitudes toward and relationships with women in general.

Mrs. Butler explained:

I think the relationship of the physician with women patients, especially in OB (obstetrical practice), changed as the whole environment of women began to change. Women became more knowledgeable about what was happening to them and more interested in asking questions about what was going to happen instead of just going in and saying "You’re the doctor, just do what you will." The doctors used to simply say "Don’t worry honey, we’ll take care of everything. There’s no need for you to hurt." Well, women began to get involved in the natural childbirth movement and saying "I want a voice in
what's going on with my body." And doctors had to accommodate to that because that was where they got their money. So they began to change. And the younger doctors changed more quickly. The older doctors were still very much into the old fatherly role of "I'll take care of you." Kind of a patriarchal role. Domineering type of thing.

The changing relationship between physicians and nurses began to influence doctor-nurse and doctor-student nurse relationships. The younger doctors became much more aware of nurses as colleagues rather than as servants.

Mrs. Butler continued:

...which it used to be. I can remember that if a student nurse was sitting at a desk working on her charts and the doctor came up, you were obliged to get up and give the doctor your seat. And I can remember myself getting in trouble one time because I made mention to students, I guess in front of staff, that if they were working and the doctor was just wandering through, there was no need to get up and give him a chair because you were the one that needed to get through with your work. Which got back to one of the physicians who kind of called me on the carpet for it. But I stood my ground and explained to him that that’s what I thought. That if he was just wandering around, there was no need for them to have to stop what they were doing just to accommodate him.

Mr. Hunt:

We all knew they [physicians] were the respondent superior and I was never taught not to ask questions. I did feel that as a student I was lucky and privileged to be in the O.R. or wherever to watch a procedure. I felt like the best thing for me to do was to not interfere. I knew he (the doctor) was busy and the work he was doing; he didn’t need to be answering a lot of questions that I might have. I think that at that time too, I probably didn’t know too many questions to ask.

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Mrs. Butler:

I can't give you a specific time or place when that authoritarian relationship, some of that dominance of the male physician over nursing, began to change. But nursing did begin to find its voice.

For one thing, nurses became better educated. The educational process enabled them to be more self-assured and to give them more of a voice in saying what needed to be done with a patient. You had to be careful with some doctors to state that in a way that didn't question their authority. So you had to be very diplomatic sometimes to get what was needed for your patient. You had to make it his idea.

Bullough & Bullough (1983) addressed the convoluted way in which nurses communicate with physicians. Nurses were taught that the physician's word was law, that nurses were to stand when they entered the ward, and that it would be rude for nurses to speak to physicians openly and honestly or to even offer suggestions about the nursing care of the patient, a subject which they knew much more about than anyone else. As a result, nurses developed a game that psychiatrist Leonard Stein described in 1967 as a "pattern of transactional neurosis" (p. 8). Stein described the manner in which nurses made suggestions to physicians so that both the physician and the nurse could pretend recommendations had not been made. Nurses were taught to report their observations in terms that did not intrude into the medical arena of diagnosis and treatment. For example, a nurse caring for a post-operative patient who had begun to bleed quite heavily from the surgical wound (a sign of post-operative hemorrhage), was instructed to chart not that the patient was "bleeding," but only that she observed "a red drainage the size of a golf ball on the abdominal dressing" and that the doctor had been
notified. Nurses would simply report the discrete symptoms as if they did not understand the implications and then "wait" for the doctor's "order." Even though nurses "made decisions and acted upon those decisions, they avoided at all costs the responsibility for their decisions" (Bullough & Bullough, p. 9). Such patterns of subservience and feminine submissiveness led to an undervaluing of the contribution of nurses. Though we criticize nurses for submitting to these patterns of behavior, those nurses who attempted to break out of the system were often punished.

Mrs. Butler continued:

And then it gradually began to change, particularly in OB, I think, because the doctors had to work and depend so much on the nurse, since they were not there and had to be called to be there at the crucial time. I think they may have accepted the role of the nurse as a partner somewhat better than they may have in other areas, because they depended on that nurse to get them there for the delivery. Certainly so they could go out and talk to the family at least.

I don’t recall the students being afraid of doctors. I think students knew which ones they needed to be more careful around, to not ruffle their feathers, you know the male ego. You had to soothe some of them and stay away from some of them. I remember one particular physician who was an internal medicine physician and did not like students with his patients at all. He expected students to stay away from his patients and the day they graduated they could take care of them. As long as they were a student nurse, they didn’t qualify. They had to stay away from his patients. He did not want students with his patients. But once they graduated, well then they could take care of them. And I don’t know where he thought they were supposed to learn how to do that. But the obstetricians weren’t like that. Again, I go back to the fact that I worked with these doctors, they knew after I had been back in OB for about seven years that I pretty much knew what I was talking about, so when I worked with them as an instructor, I felt that I got a great deal out of
them and I think it was based on that previous
relationship... a relationship with mutual respect.
Nursing students, typically, at one point at least, were
taught not to offer definitive information; only to state the
facts. Information was sometimes even shrouded. They
were stating the facts, but they used words like “appears
to be.” It was not definitive, it was not conclusive, it was
more descriptive and led the reader to a conclusion rather
than the writer concluding.

They could say that’s what they thought they knew
or what it appears to be. They really didn’t hold a
position of any type of authority to make decisions or to
state positively that something was so. So they would say
it appears to be this way or that way.....

Mr. Hunt concluded his interview as follows:

I think the Lake prepared me for a lot of things in life.
First of all, how to study. My class was very large and it
was totally overwhelming on that first day. It was a
totally new language, a new vocabulary had to be learned.
New terminology and all. That was a little difficult and
there is no doubt I studied more during this curriculum
than I ever did in my life. Much more so than in
anesthesia school. Nursing is such a broad field.
There was a great deal of expectation on the part of the
faculty, and a lot of fear on the part of students that they
wouldn’t be able to meet that expectation.

I think from my point of view, I was married with
two children, I had quit a good job, expense account. I
went to making nothing; into a field that I wondered and
hoped I could graduate from. I wasn’t sure I could. That
was a big fear. I think that pushed me to the point you
have to complete, you have to do well, you have to make
this program.

The men in the class kind of bonded. We studied
together, did class assignments, rode out to LSU together
and back. Our Anatomy, Physiology, Microbiology --- I
think those were the only ones we were taking at that time
were all taught at LSU. One of the teachers would come
from LSU to teach us Physics and Chemistry at the old
School of Nursing. It was difficult. Sometimes we would
finish class at 5:30 or so in the afternoon and come back
to the Lake and go up on the fifth or sixth floor for your
care plan. It made a long day, by the time you got home. It was a full-time job. The curriculum, I found, was much more difficult than anesthesia, because it was so broad, and so new to us.

I can truthfully say for the experience I had, going to the Lake and being trained that no doubt I am a better person, I am a more compassionate person. I think you have more feelings for people. They train you to have you see and perceive things differently. I think you are a more compassionate person. No doubt, I think I was a better parent once I came through it.

To me, a good nurse is one that cares, is compassionate and is a good listener. You listen to what the patient is telling you. To me that is what makes a good nurse.

Mrs. Butler also shared her opinion of the "good nurse":

What made a good nurse? One that was empathetic; not necessarily your bright students. I never felt that a student that was a straight "A" student was necessarily a good nurse. I felt that a student that was a high "C" or a good "B" student had a lot more common sense and had a lot more feeling for the patients and a lot more desire to be helpful than those who could recite the book back and forth and passed every test without a problem. I felt that common sense and empathy meant a lot to being a good student or a good nurse. To be able to understand your patient's family meant a lot because obviously maternal child nursing is a family oriented thing and no matter what area of nursing you are in, it is very important to understand family.

Their desire to be a nurse. The effort they put out. Some kids put out very little effort, which made for very little accomplishment on the unit. Others put out a great deal, and they were really good nurses. They were just plain old human people and they make good nurses.

Mrs. Patricia Butler remained on the faculty from 1970 until her retirement in 1989. When she was first hired by the School of Nursing, Ms. Anders was Director;
Mrs. Daniels was the Associate Director; the hospital was still located on Capitol Lake; and the students still lived in the dormitory.

Mrs. Butler:

...I don’t remember having an office at first. I remember we had a faculty room where we had one big table and everybody pretty much worked around it and ate around it and graded papers around it. And whatever we had to do, we seemed to do in that room. There were a few people that did have offices, but very few. Mostly the Nursing Arts faculty.

As a faculty member you were assigned to clinical and classroom hours. Our course was divided into Obstetrics, Pediatrics, Gynecology, Newborn, so you didn’t teach all the time. But during your time that we had set up for each section, you were in the classroom on Mondays and Fridays and you were in the clinical area the remaining days. I think there were probably about 130 students in the program, divided into three classes...freshmen, juniors, and seniors.

There were no nuns on the faculty while I was employed there. We did have some nuns that came through to become nurses that we taught, and they were usually very much of a delight to teach. Several that I taught were just really dear people and I enjoyed them thoroughly.

The Faculty Role

During the interview, Mrs. Butler was asked to describe what it was like to be a faculty member and what was the greatest challenge that she faced as a faculty member.

Mrs. Butler:

Besides learning how to teach, keeping my mouth shut was the greatest challenge. I was always getting in trouble. It was probably because I had ideas that might have been considered non-conformist, but I felt that it was my job as an instructor and as a person, to put the students’ needs before anything else. I really tried to do what was best for my students, regardless of what else
may be required of them. And I got into disagreements with the administration more than one time over that. Their priority was the reputation of the school, how people viewed the school as a whole, and if they were not being perfect little angels, well then why are you taking up for them?

I just think that my greatest satisfaction, which probably translated into achievement, was the relationship that I had with the students and the fact that I felt that I had, throughout my career as a faculty member, done what I thought was best for students, particularly in the classroom and the clinical area. And I served as a consultant for the state Student Nurses Association for seven years. And I felt that that was important; that I had apparently done well in that area, or either I was a push over, because they kept asking me to do it again, and again, and again. It was an honorary position pretty much and students from other schools asked me to be their consultant. So I was either doing something right or I was easy to get along with. I don’t know which.

As a faculty member, Mrs. Butler was active in student activities serving as faculty advisor to the student organization for many years.

I enjoyed doing that very much. And I got a great deal of satisfaction out of the students. The Student Nurses Association was an avenue to professionalism and to membership in the nurses' organizations. I went to state and national conferences with the students. We almost always had a student on the state board (of the student organization). We had many presidents of the state board; not the State Board of Nursing, but the Student Association State Board. We went to most of the National conventions. I went as an advisor, consultant. No, I was not a chaperone. And I let them know that I was not there as a "I'm gonna see that you do everything that's right or I'll go tell the Principal." These are grown kids,— I mean they were still most of them were teenage, college kids, but I did not want them to feel that I was critiquing every move that they made; that they were adults and I expected them to behave as adults.

Sometimes I was disappointed. Sometimes I was pleased. We had a couple of very harrowing situations
that I prefer not to go into. But for the most part, the students respected me as their consultant or advisor, and did not do things that would reflect badly upon the school.

Maintaining a reputation of excellence was very important to the administration of Our Lady of the Lake School of Nursing. Students continued to be viewed as undeveloped professionals and vulnerable to "bad behavior." The notion of external motivation for good behavior prevailed and Mrs. Butler, who endorsed a philosophy of internal motivation, apparently found herself in conflict with the administration over student behavior. Her description of "getting in trouble" herself is interesting and reflects the notion that faculty could also possess "bad" behavior and be subject to discipline.

Mrs. Butler further addresses faculty discipline:

I was usually called to Ms. Anders' office for something that I had done because I felt the students needed whatever it was and the administrative faculty did not believe that I was doing the right thing. I was a student advisor quite often and had a lot of good times with the kids and they weren't always what the faculty or what Ms. Anders and Ms. Daniels approved of.

In one sense I think they were prudish. I think that if I had been in that situation, and ultimately responsible for the girls' behavior because they lived in the dorm and they were going to the school that I was in charge of, I would probably have been a lot more strict than what I was as a faculty member. I think depending upon the role that you served, you have a different outlook on how to deal with students. And I think their's was a much stricter attitude in those days. They, the faculty tried very hard to see that the students' rights were upheld, and sometimes it was a hard push.
Mrs. Butler's description of the school's administration was very similar to the Matron of Nursing common in early nursing education who was the head of the nursing program, reported to the Hospital Administrator, and was probably somewhat intimidated by the hospital administrator to keep her organization in order. Students had to live by certain order. Faculty had to live by certain order. Both students and faculty were required to adhere to a dress code.

Mrs. Butler:

We were not allowed to wear slacks when I first started teaching. You had to wear a dress. The students had to wear a dress. They had to wear their caps. It seems like they had to wear caps until just before I quit work. You had to be identified. Some way or other you had to be identified as a student. And there was no other way other than the uniform. The uniform of the regular student was a pink dress with a white bib on it and a cap.

As the student body aged, with more non-traditional students enrolling in the program, students became very critical of the pink uniform with the white bib. They felt is was too immature, did not promote an image of professionalism, and was too "cutesy." In response to student pressure, the faculty slowly began to explore other options. The cap was no longer a requirement in 1989, except for official functions such as graduation. The pink uniform was replaced with burgundy scrubs in 1995.

Mrs. Butler continued:

Finally, I remember when we were downtown at the old school, as a faculty we were allowed to wear slacks to work. That was big deal.

It seems like the faculty pushed for it because they could see staff in the hospital wearing slacks and we weren't yet allowed and we had to convince Ms. Daniels and Ms. Anders that we (the faculty) were as equal as the
the hospital employees and that we should surely be allowed to dress in the same way they were.

Ms. Anders usually wore a dress. And I don't remember Ms. Daniels ever wearing slacks. Ms. Anders, even though she was in the office, quite often wore her cap. But she would wear her cap and white uniform to work. I believe it gave her a sense of authority. I think it identified her as the nurse in charge, which goes back again to that Nightingale thing, the matron.

I don't remember Ms. Daniels always wearing a uniform. She wore a lab coat. But I always see Ms. Anders in a uniform, in my mind's eye.

The value of rigid obedience had given way by this time to a value of conformity. This value was affirmed by Mrs. Daniels when she said that it didn't really matter about the hippie appearance of the students, because once they were in uniform, they would all look alike and their differences would be controlled.

Mrs. Butler continued:

When Ms. Anders came to the program, it was run by the Sisters. And, of course, they had a very different way of running a program. Nuns, in those days, were much stricter than they probably are today. I think they are much more open today then they were back then. Ms. Anders came up under that type of regime. And so she naturally, never having gone anywhere else, she went to the School of Nursing at the Lake, she graduated and then she went into the directorship. So she had no other experiences to pull on except that experience that she had received as she went through the program.

I think there were many times that the faculty felt things could have been done differently and, perhaps, better. But she was still pretty regimented and we had to do what she said. I don't think there was an environment of open communications as it is today.

The administration was very proud of our program as a diploma program because we always had students that scored so high on State Board Examinations. They saw no need to make changes until the first NLN visit that I remember. I think the year was 1976.
During the 1950s and especially the 1960s, the leaders of professional nursing set about to develop nursing theory in an effort to further define nursing as a discipline with its own distinct body of knowledge. This was another strategy in the long-time effort to legitimize the status of nursing as a profession. Theorists such as Imogene King, Dorothy Johnson, Betty Newman, Sister Callista Roy, and Dorothea Orem developed models of nursing that provide bases for the development of nursing theories and nursing knowledge (Leddy & Pepper, 1993). All of the existing models of nursing describe four specific concepts that are generally considered central to the discipline of nursing: the person, the environment, nursing, and health. While theory is the knowledge or content for nursing practice, the "nursing process" is the way of using that content. In other words, while theories may differ, the process of application remains the same.

Prior to the generation of nursing theory, nursing content was taught according to the medical model of disease and treatment of the disease. Content was organized by bodily system and function. Anatomy and Physiology/Pathophysiology provided the scientific basis for nursing content. Nursing care appropriate to each medical diagnosis was presented as dependent, independent, or interdependent of the medical plan of treatment.

The development of nursing theory and nursing process transformed nursing education and nursing practice during the 1960s and 1970s. The National League for Nursing, the accrediting body for nursing education programs, revised its standards to reflect a conceptual basis for nursing education. All aspects of the educational program
were to flow from the conceptual framework of the curriculum in nursing. Our Lady of the Lake School of Nursing was seeking reaccreditation in 1976.

In 1974, when I (Linda Pendergast) joined the faculty of Our Lady of the Lake School of Nursing, Ms. Anders and Mrs. Daniels were delighted to learn that I had graduated from a baccalaureate program in nursing that utilized a conceptual approach to nursing education and nursing practice. At that time, with only two years remaining until a NLN reaccreditation visit, there was no indication of a plan for curriculum revision from the medical model to a conceptual model. As I recall, there was little or no evidence of any attempt to revise the curriculum by the time the "League" visited in 1976. I recall being told that "as long as we looked good and our graduates consistently passed State Board Examinations" all would be well with the NLN. Such wasn't the case. I remember that visit as very hostile and humiliating. The faculty was ill-prepared to justify the existing curriculum plan in relation to the standards established by the NLN. The School of Nursing received an unprecedented number of recommendations to address and demonstrate compliance. An interim report was required in 1978 to reevaluate progress made toward compliance with the recommendations and standards established by the NLN for curriculum development and implementation. I believe it was a wake-up call for the faculty and administration of Our Lady of the Lake School of Nursing.

Mrs. Butler:

...NLN came in and it shook up the place for sure. Ms. Anders seemed to be very devoted to dressing up the place for the visitors and was not as aware of the curriculum and educational needs of the students at that
time...I still think it relates back to the fact that she was a diploma nurse, first, last, forever, and could see no need to change something that was working.

I think it (the program in nursing) was probably more in jeopardy than we realized. I think that was a very rude awakening for the powers that be as to where education had gone and we had not. Changes had to be made if we wanted to continue to have NLN accreditation. We had a huge number of recommendations that had to be met to continue NLN accreditation.

In all, there were 27 recommendations from the National League for Nursing in May, 1976. A special progress report was required in 1978 "to demonstrate evidence of progress toward improvement and fulfillment of each of the recommendations" (June 4, 1976 letter from the National League for Nursing). The recommendations included the following:

1. That a budget for the school of nursing which itemizes the different sources of income and
2. differentiates between educational and noneducational costs be prepared and administered
3. by the director with the assistance of the faculty and other designated personnel.
4. That policies for promotion of faculty be defined and implemented.
5. That a faculty development program which is designed to increase the faculty's competencies as teachers be planned and implemented as provided for in the faculty organization bylaws.
6. That the faculty bylaws be revised to (a) clarify the faculty organization versus the faculty committee; (b) delineate membership and voting privileges of all student participants; (c) delete the redundancy related to standing committees, i.e., duties of officers, elections, and meetings; and (d) clarify the selection of chairman of standing committees.
7. That the director of the school actively pursue a plan to complete a master's degree.
8. That the instructional faculty who do not have appropriate preparation at the master's level
develop and actively implement a plan to secure such preparation that is commensurate with the responsibilities of their positions.

9. That the discriminatory policies regarding marriage, student employment, and lack of male student housing be discontinued.

10. That the policy for make-up time due to illness or absence be related to the student's ability to meet course objectives.

11. That a rest and study area be provided for nonresident students.

12. That all medical-surgical nursing courses be planned and implemented which provide for an approach which encompasses broad concepts rather than a disease-oriented approach...

13. That nursing course outlines be developed to reflect the relationship between theory and clinical learning experiences. (June 4, 1976)

The remaining recommendations related to library holdings, course and level objectives, clinical contracts, liability insurance, and minutes of the faculty committee.

Mrs. Butler continued:

It was just astounding to administration (the number and extent of the recommendations). I don’t think it was as astounding to faculty as it was to administration. I think administration looked at it as a slap on the hand and I think faculty looked at it like "Gosh, look at the things we can do. Look at where we need to go. Look at what we can do to improve what we’ve already got." I mean, "if we’re good now, think how much better we can be." I think several on the faculty viewed it more as a "Hey, let’s get this done" type of deal and administration didn’t.

Administration had to change because they had to do this or they couldn’t get approval. But I think that they really resisted that change. I think they resented it. They couldn’t resist it because they had to do it. They had to institute the changes. So Ms. Anders had to appoint faculty members to work on committees to make the changes. There was no choice in what she had to do. But she resented having to do it. She felt that her program
was good. Her students passed State Board. If you’ve got something good going, why change it?

Mrs. Butler commented on the emphasis placed on the passing of State Board Examinations by graduates:

I think she (Ms. Anders) tried, but I don’t think she was a progressive leader. She was diploma school educated and I don’t think she looked beyond that. And if our students passed State Board with acceptable scores, and we usually had 100% passage rate, she was happy. I think that the hospital also measured the school’s success by the number of graduates successfully passing the examination and, thus, eligible to enter the work force.

The school as a whole handled change very poorly. The 1976 NLN reaccreditation visit invoked a change in every area that we dealt with. There were recommendations and I can’t remember them, but I know there were recommendations in every area of the faculty’s job and the student set-up. Administration had to make changes. Faculty had to make changes in curriculum.

The interim report to the National League for Nursing was submitted in 1978, as required, and a revisit was made in 1983. At that time, the School of Nursing was considered to be in compliance with the recommendations made in 1976.
On April 2, 1978, Our Lady of the Lake Hospital relocated to its new facility on Essen Lane in Baton Rouge and soon after became known as Our Lady of the Lake Regional Medical Center. The new facility was housed on a 42-acre site. The need for a more contemporary facility was first foreseen in 1966, according to the Administrator, J. B. Heroman (Sunday Advocate, Baton Rouge, La., January 1, 1978). Planning began in 1971 and construction began in 1974.

The School of Nursing, always an integral part of the hospital, also relocated to the new facility. The school was housed on the third floor of the hospital. There was no residential facility.

Mrs. Daniels discussed the relocation:

We were situated on the third floor of the hospital so it was a completely different environment. Then we became a totally commuter school. And we really had to scale down in terms of space and we had to work, which was a good thing, very closely with our neighbors on the third floor; in fact, with all of the hospital people because we were really an integral part of the hospital. So there were a lot of challenges there. But, overall, it worked out better than we thought; we were very anxious about it. But it worked out very well really. We were able to develop closer relationships with the other departments. The education department— we then had more meetings, collaborative meetings with nursing service people. So it worked out all right.

The Morning Advocate, Baton Rouge, La, April 25, 1979 announced the promotion of Mr. J. B. Heroman to Executive Vice President of the hospital corporation.
and the appointment of Mr. Robert C. Davidge to the position of executive director of Our Lady of the Lake Regional Medical Center. Mr. Davidge was reported to be assuming his new duties on June 1, 1979.

Mrs. Daniels continued:

No, I don't think we lost any autonomy. No, we never did. I think when new administration came in, some of the, not Mr. Davidge because he took Mr. Heroman's place, but some of the assistants, they tried to let's say, take charge. But they did not succeed. Basically, we didn't lose any autonomy.

I think Mr. Davidge came around the same time as when we moved to Essen Lane.

Mrs. Butler commented on her perception of the relationship of the hospital to the school of nursing at the close of the 1970s:

Mrs. Butler:

The school was a by-product of the hospital. They were "over there." And the less you had to tell them (the hospital), the better off we (the school) were. Ms. Anders just wanted to run her own little group.

I think to a certain extent there was a climate of secrecy. I felt that the school was an entity unto itself and the less they had to do with the administration of the hospital, the better. "We are the school, let us run the school, don't bug us." That was the feeling that I ha,

which may have been incorrect, but that was my feeling.

Ms. Bertha Mae Anders retired in 1980 and Mrs. Maureen Daniels was appointed Director of Our Lady of the Lake School of Nursing. During an interview in March 2000, Mrs. Daniels was asked to describe the "lay of the land" when she became Director of the nursing program.
Mrs. Daniels:

Well the lay of the land then was that we were still having difficulties with recruitment of faculty, meeting State Board standards, which then required masters in nursing degrees for faculty. And they had things like two-thirds of the faculty had to have masters and we had to deal with a very rigid State Board of Nursing at that point. It was very, very difficult. It was our main problem. Also, internally, I felt that we had a problem in our curriculum because of overlapping semesters. All semesters did not begin and end at the same time. Because we had the 27-month program, that went through the summer and all of that. So, one of the things that we did almost immediately was to develop what we called the 28-month program. We had a major curriculum revision where we had all semesters beginning and ending at the same time and had a short summer session so that— that helped a lot. It certainly helped with faculty and students were glad to have more vacation and more free time. So that was another challenge, trying to get that curriculum structure changed. Now, also at the same time, there was more emphasis in nursing education on the development of the nursing process and that started even before 1980. But it was ongoing and to get faculty to come in and teach from a framework that was not medically-surgically oriented or based, the medical model, to go to the more holistic model... that was difficult because all of them, most of them were base-educated in what they called the medical model. And that was what they knew and that's what they wanted to teach. So that was difficult too.

In order to change, we first had consultants come in. First we tried to teach totally according to the nursing process. We went through various kinds of things. I think one of the things I did when I came in is, up until then, the curriculum chairperson was elected and it changed every year. So the first thing I asked faculty to do was to change our bylaws so that our Associate Director would be the permanent curriculum chairperson so that we would have continuity and we wouldn’t lose from year to year. And we worked very hard on developing our concepts and structuring a curriculum that was not a medical model. And the whole faculty participated in it so it began to get easier. Individual
faculties still had trouble but they... Dr. Joe Ann Clark was the Associate Director and Curriculum Director.

At that time, faculty were returning to school to work on earning the required Master's Degree in Nursing. I think it helped in that it broadened faculty's view. Going back to school was a deterrent, too, because faculty were strung out with trying to go to school and to maintain a faculty load so that anything more on them, and at the same time we'd have league reports and all that other stuff that goes on in a school of nursing. And then a unique problem that I experienced, I think, was that as the faculty came back with their masters, they, I saw them demanding of the diploma students, the same standards that they had experienced in the masters program. And I had to deal with that, not as a whole, but very often on an individual basis. And that was a big problem. Another problem was that we were required to have a certain number of people prepared at the masters level. So I wanted to do everything I could to encourage, assist faculty to go to school. And part of the problem was that there were no hospital personnel policies for this kind of assistance. So I did get...we gave people time to go and then when they came back, immediately they had their masters and some of them immediately left and went to teach in other institutions. Well, that didn't sit too well so we did devise policies to include a tuition reimbursement program. We did supply time for people to go. And they had to work at least a year following the masters. So all that worked out. And it worked well.

Mrs. Butler addressed the appointment of Mrs. Maureen Daniels to the position of Director of the School of Nursing:

Mrs. Daniels was a very good director in many ways. She was much more open than Ms. Anders. Ms. Anders was very secretive about everything. Ms. Daniels was much more open. Mrs. Daniels would listen to you. She may not agree with you and you may not get what you asked for, but she would sit and listen to you and hear your side of it and then make her decision. Sometimes she might agree with you, but it wasn't a foregone conclusion by any means. I felt that she was a little bit more progressive than Ms. Anders was. I felt that she was more attentive to
what was going on in nursing, that she had a little broader scope, or maybe a lot broader scope.

Maybe more in touch with the, about nursing as a profession. She was probably faced with having to do that based on what was happening at that time and what they had already experienced as the catch-up after the mid 70s. They were probably just getting to a point of having accomplished those.

I remember too that when we moved over here to the new hospital, and Mr. Davidge became the Director, or Administrator, the word budget was used. And they were just horrified in the office because they had to come up with a budget. They had never made a budget. They didn’t know how to make a budget. They threw something together. They had no idea of how to make a budget. Of course over the years they began to learn. If they had said they didn’t know how to make a budget, they would have lost face, so to speak. It would have been, “What do you mean you don’t know how to make a budget? You’re head of a department.” And they knew that. They knew that but they had never been required to do it before; to account for every penny. They had to report all the monies. But then I think administration was much more liberal then in meeting the students’ needs, the School of Nursing’s needs; much more open. Mr. Davidge was probably much more open in meeting those needs than Mr. Heroman had been. Mr. Heroman, if I recall, had also been there a very long time. A very long time. Very long. Very old school. And was the first lay administrator of the hospital, as opposed to a nun. So, actually, when Mr. Davidge came, he was the first person from outside the institution to assume the executive leadership position. And outside the state, too. So his expectations might have been totally different from what had become a very ingrained culture of this organization.

After the school relocated to the third floor of the hospital, the faculty more strongly felt the presence of the hospital administration. There seemed to be a generalized feeling among faculty that the hospital administration did not fully support the continuation of a hospital-based diploma program in nursing.
Mrs. Butler continues:

I think the school... we always felt that once, particularly once we moved over here, that the school was kind of placed as an afterthought on the third floor. And we were always saying they were going to chop off the ledge and we’d fall down. I think we lived under several very threatening years there, whether or not the school would be closed. I don’t remember why though. I do remember it being very iffy in there for a while. For awhile the school’s space kept shrinking. Rehabilitation was the buzz word in hospital health care and generated big revenues. In order for the hospital to offer rehabilitation services, they eventually took up all of the school's space on the third floor and relocated the school to trailers in the parking lot behind the hospital. We were there for over two years. It was a time of low morale. I think Ms. Daniels fought very hard to get the school in a better footing, so to speak, with the hospital. To prove that we were an essential part of the hospital.

Mrs. Daniels:

I think that there was more likely a sense of a lack of security among faculty because there were a lot of feelings and concern among the faculty about what was really going to happen to them and to the school. I heard some of them express that they were going to go to work in a baccalaureate program because, I think this was very interesting, the baccalaureate programs in the state at this point would only take them in as instructors no matter how much experience they had. They negated their diploma school experience. So that bothered some of the faculty. There was that. But that was in the 80s, a good thing too because then there was a committee formed for the faculty to look at how we could move the program, what direction we should move the program in.

A lot of them (the faculty) felt like they were treated like second-class citizens in the nursing environment. I heard one that we sent off to a conference or whatnot, come back and say that they were treated poorly by their peers in the collegiate setting.
While faculty continued to struggle with the entry level issues surrounding nursing education, applicants to Our Lady of the Lake College continued to increase. This was very likely a response to the economic crisis in the oil industry that impacted Louisiana so heavily.

One of the applicants to the program in nursing in 1983 was Deborah Gahagan. Mrs. Gahagan was interviewed on March 9, 2000. In addition to the diploma in nursing she earned from Our Lady of the Lake School of Nursing in 1985, Mrs. Gahagan also earned a Bachelor of Science degree in Nursing from Loyola University, and is currently working on her Master of Nursing degree at South Alabama University. She presently works part-time as a nursing instructor in pediatric nursing at Our Lady of the Lake College.

Mrs. Gahagan:

I had graduated from LSU in 1982 with a degree in fine arts, and was looking for a job and couldn't find one, and I had come in contact with a lot of nurses through where I worked. I worked in a bridal shop. And to me, it seemed very interesting what they did and I had been experienced being on the patient’s side with my mother. She was very sick with cancer. So, I kind of knew what nurses did. And I looked into nursing schools, and I knew that I didn't want to go back to school for another four years, so I applied to the Lake. At the time I did not realize that they either accepted you or not. I thought that if you applied, just like LSU, you got in. After I interviewed with Maureen Daniels, then I found out that you were either, you know, not accepted or accepted. So I guess in a way that was a blessing, because if I had known there was a chance I wasn't getting in, I probably would have been very nervous during the interview. But I remember that finding out after my interview that there was about 200 applicants, but only 60 got in. So I felt real fortunate.
Debbie Gahagan is representative of the profile of the typical student enrolled in Our Lady of the Lake School of Nursing in the 1980s. With the school no longer offering dormitory residence, the "college experience" was, in general, not a criteria for selection of an educational institution by most of the women who enrolled. The average student was older, having either delayed her education, experienced an interruption in her education, or made a late career choice to pursue nursing. The abbreviated program in nursing was attractive to women who did not have the luxury of time or money to devote to a four-year college degree.

Mrs. Gahagan continued:

I think the majority of the students in my class were more like me. The students in my clinical group were married. I was married, but I didn’t have any children yet. Some of them had children, and we were kind of close. There were a lot of younger girls in the class just out of high school, or you know, with a few years of college behind them, but I think most of the students there just wanted to get their degree and work, and I think that they found that program would be better than staying in college for a long time.

As Mrs. Daniels had explained earlier, the school was located within the hospital at the time Mrs. Gahagan was in attendance. Mrs. Gahagan continues in her description of classroom and clinical life as a student nurse:

The school was in the hospital. Our classrooms were in the hospital, on the third floor where rehab is right now, and that’s where our school was, and I remember thinking this is very, very hard. It was harder than LSU, I thought. Because not only did you have to study and pass tests, but you had to be prepared for clinical the next day and that was the hard part. It easily compared to a full-time job.

It was a lot different than at LSU where you had a lot more time. You went to your class and anything
outside of that was your time to study. But the Lake program; I mean we were at school all day every day. I mean the whole week. Maybe Fridays we got out half a day after our exams. But we pretty much had class or clinical all day every day.

Mrs. Gahagan recalled that the students practiced basic clinical skills and first went to the hospital approximately mid-way or about eight weeks into the first semester of school. At that time, they gave basic daily care to patients including baths and linen changes and started assessing vital signs.

When asked to discuss the intimacy required in direct patient care, Mrs. Gahagan responded:

I had never taken care of people that I didn’t know. I don’t know that they really prepared us. We had communication lab, but I don’t know. I think it was just expected of you to do it, but within our clinical group, we talked. We had pre-conferences and post-conferences and we talked about those kinds of things (like taking care of a stranger), so that helped me.

I guess the more experience we got, the sicker the patient was that we took care of. So then you realized they really needed your help and that part (intimacy) didn’t matter so much anymore.

In describing classroom experiences, Mrs. Gahagan related that the primary method of instruction was lecture. She said that they were given a lot of written examinations and were required to do a large amount of written work.

Mrs. Gahagan:

I just remember writing a whole lot all the time, and a lot of reading too. You know we had to do all that, but we had lectures, very clear cut, on different body systems and diseases.

I always did good on my exams. I guess I was more fearful of not succeeding clinically. Until I got to
Peds (Pediatrics), I really wondered am I doing the right thing, you know, because I went through two semesters, and I thought this is really hard. And how am I ever going to learn all of this? And then when I got to Peds, I thought this is what I want to do, because I was a lot more comfortable with the children, I guess, than with the adults, and the staff on the floor was younger and very helpful.

Students were expected to be clinically prepared to care for their assigned patients. Mrs. Gahagan recalled how she prepared for clinical experience:

On clinical, I felt like if I wasn’t prepared and I didn’t know how to do something, I might fail and be asked to leave the school. I would be very hard on myself.

We had preclinical on Monday afternoons, and we were given about an hour and a half to go get all the information off our patients’ charts, medications, treatments, and we were expected to show up for report Tuesday morning with the nurses, listen to report on your patient, and expected to know anything that the clinical instructor asked you. So you’d have your drug cards in your pocket and all the stuff on your patient written out, and you just made sure you were busy the whole morning.

You knew that if you weren’t prepared, you were going to be sent off the floor. That would have been really bad. And there were several students that were, if they weren’t prepared. Or they were "dressed down" by faculty in front of other students. It didn't happen very often.

Mrs. Gahagan, a 1985 graduate, repeats several themes that the graduates of 1929, 1955, 1966, and 1977 also addressed. These repeated themes include: fear of failure and expulsion; discipline; social isolation; student-to-student support; self-sacrifice; self-discipline; and clinical excellence. In addition, Mrs. Gahagan recalled the instructional content as continuing to be organized according to a medical model of body systems and disease, despite the requirement of the NLN in 1976 to develop a
conceptual basis for the nursing curriculum. Mrs. Daniels had also alluded to the fact that the faculty had a difficult time creating a curriculum design that was based on a conceptual model and had implemented several approaches to redesign in the years between 1976 and 1985.

Mrs. Gahagan was asked to discuss her experiences in relationship with hospital staff and patients. Mrs. Gahagan continues:

I enjoyed working with the families, especially on Pediatrics, and I didn’t have children. I tried to empathize with the parents, but that was hard to do also. And then as I had kids, I found it made me feel guilty as a parent. Your kids are well, and you’re here and you know you try to just be supportive and thank God you’re not in their place. But you have to empathize with them. You have to take care of them.

We did have interaction with the nurses on the unit, but I think back then we were kind of, you know, not real helpful to them, or not seen as a helpful, although we were, because we had at least two of their patients apiece, but they were very, very busy back then. They had ten, twelve sometimes, or eight, or ten patients. So they didn’t really have time to interact with us. I think they were very busy.

When asked to describe relationships with physicians, Mrs. Gahagan responded:

We did have interaction with the physicians. A lot of them like to teach; probably more so now. I think back then probably not as many. But there were a few that would let us watch when they did a procedure, like a spinal tap, and they would explain it to us.

There were some that were not so nice, just gruff; abrupt. They walked into the nurses station, and the charge nurse knew she better have his charts ready. I guess maybe their patient load was more then, I don’t know, but probably the only interaction we had was if we were in the room and they came in the room. And then a few of them would ask you to leave, too.
We were told to respect them. We were told that if they came in the nurses station and you had their chart you’d give it to them. You’d make sure they had a place to sit; it was that kind instruction; it wasn’t this is how you talk to a doctor or this is how you communicate the patient’s condition to the doctor, or whatever.

A few of the students, I don’t want to say they are bold, but they will go up and tell them something about the patient. I don’t think we would have ever done that in nursing school. I don’t think we would have walked up to a physician and offered a piece of information on his patient unless he asked for it. And I see that now.

There are more female physicians. A lot more. I think they’re more communicative with the students and the nurses. I think it is an asset to have women as physicians since most of the nurses are women.

Mrs. Gahagan’s comments indicate that, in a manner similar to those of previous years’ graduates, the student nurse was expected to cope with difficult life situations with little or no preparation on how to do that. Sick patients, incurable children, and grieving families all had to be cared for with compassion and empathy.

It also appears that in 1985, just as in 1929, nurses were expected to defer to physicians, not ask too many questions, and show respect by offering them chairs and giving them the charts before they asked. In addition, the students were socialized to ignore rude and abrupt behavior on the part of the physician. All physicians were expected to be treated equally because of their status. However, Mrs. Gahagan has noticed a change in the manner of physicians toward students and nurses — the willingness to share information and engage in teaching activities. She attributes some of this change to the fact that more and more physicians are women and suggests that women establish a better relationship with nurses because of their womanhood.
Mrs. Gahagan addressed what she considered to be the qualities of a "good nurse:"

A good nurse in the '80s would be a nurse that had good assessment skills, that had good clinical skills, that could go in, look at a patient, tell what was wrong, know what to do, know what to tell the doctor, and do it all quickly and organized. One of the Licensed Practical Nurses (LPN) that was in my clinical group was able to do that...you just go in, you get it done, you take care of the patient. Kind of a strong person.

I think that the better nurses that I see today are the ones that are confident, make decisions, get their work done quickly without hemming and hawing and just get it done.

Nursing care is holistic. You have to consider all aspects of a person and I think that we teach them that today. Maybe not as much, because the time is shorter, they have less time.

After graduation, I worked on Pediatrics at the Lake. When we interviewed, they told us that we needed to start right away, so the day after graduation, or two days after, we started orientation. So we started in the middle of winter, on Peds (cold, flu, and pneumonia season). We had about two weeks of orientation.

No, I don’t feel that I was prepared to assume the role of the nurse. Back then your orientation time was so short. It was like one week in classroom and one week on the floor with another nurse, and you were on your own, and you might have six to eight patients, and you just did it, and you learned really fast. You learned real fast to be an independent thinker and make your own decisions, because even if there was somebody around to ask, they were too busy. You just pretty much had to do, and you learned. After a winter on Peds, we all felt like we were real nurses.

I stayed there for a few years. And in about seven years, things improved. The patient ratio got less; they really developed the children’s center as a very specialized place.

They started pulling me in to PICU (Pediatric Intensive Care Unit). I spent a year in education and then I went back to Peds and they started pulling us into PICU
because they were so shorthanded, and I just pretty much said if I’m going to work in here, I’d like to take a Critical Care course, which I did, and then I felt better about being in there.

Mrs. Daniels addressed the hospital’s perception of the new graduate:

Well, they (the hospital) always said the graduates that came out of the Lake were better but that was also because they were familiar with the Lake. I think, basically, everyone agreed that all new graduates are green and greener, and that they all need support in their continuing education and that kind of thing. That was a big deal.

At the time that Debbie Gahagan graduated in 1985, faculty were exhibiting signs of frustration and dissatisfaction with their situation. The school had lost its space within the hospital and was temporarily relocated in trailers behind the hospital. With the school located in the trailers and most of the faculty having completed the Master’s Degree in Nursing, they were ready to initiate change.

Mrs. Daniels:

There was a group of faculty who were really gung-ho about wanting to push forward, to do something, because they really felt that the school was in danger. And not so much -- we never thought that we didn’t have administrator support, but we were endangered by the possibility of the baccalaureate degree entering into nursing, being legalized through some legal procedure and made law and then we would be out. And the administration, Mr. Davidge and the Board of Directors were interested, too. But their interests were more and more in how to preserve the school. And the general consensus was that we have to do something.

The cost of the department was a consideration but I think because of the Medicare pass-through funds, and the budgets I did every year, that the maintenance of the school, finances, was not a major concern, although I did have to watch the pennies and had to be very careful.
I think it was more an accountability than frugality. You needed to justify. You didn’t have a free hand to just spend money.

I wasn’t aware of the budgets of the other departments. I knew that they had budgets and that every department had to prepare a budget and that kind of thing. But being aware of the actual budgets, I had no idea. There was no reason for me to know.

I really did feel that we were given the resources that we needed, because whatever I put down in that budget was needed and I don’t think I really ever was denied anything. I, no, I really wasn’t.

We increased tuition a few times. My big problem was trying to keep faculty salaries equitable with other teaching institutions rather than the personnel policies for the nursing services department, and showing the difference. And of course that was difficult because of the thinking of hospital administration at the time was that the faculty don’t give direct nursing care, they work Monday through Friday, they have all weekends off, and why should they get a month vacation, and I was fighting the fact that some of my faculty were not making the same as head nurses. And all of this, and justifying it. One of my big arguments was that if there was a nurse missing on the floor, called in sick, you could get another nurse to come in and do it. But if I was missing a faculty member, I had no pools to get a faculty member. That kind of thing. It was very difficult.

I didn’t have a problem justifying the expense of the faculty earning their Masters’ degrees. I didn’t have a problem with that because the administration had been with me through the dealings with the Board of Nursing where they tried to put us on probation because we didn’t have the number of Masters-prepared people. And I resented that. I fought that. I said to the Board of Nursing, "How can you put our school on probation when we have 100% pass rate (on State Board Examinations), we do this, we do this, and you say I’m on probation because I don’t have the full component of Masters-prepared faculty, even though I have people going to school, and even though there is a shortage and all that...," the redhead got redder.

Well, they said the standard was the standard. This was a hard-nosed group. Not like the Board right
now. And so, I came back with Joe Ann Clark, and with one or two others in the faculty, and we went to Mr. Davidge, and we pulled together a plan that showed we were in compliance. And we went back with this report to the Board that showed how we did on NLN’s, our State Board results, a big old report, and they said we were in compliance. We never did get on probation. We had a lot of support from the administration.

The support from hospital administration was evident in its participation with the administration of the school in confronting the State Board of Nursing and, perhaps, even renewed and strengthened. Around the same time, a commitment was made from the administration and board of the hospital to build a permanent home for the School of Nursing. The new building on Hennessey Boulevard was dedicated in 1989.

The faculty continued to pursue advanced degrees in nursing. Mrs. Daniels continued:

It was very hard on the faculty to work and go to school since they had to commute to LSU Medical Center in New Orleans. The faculty worked very hard and it was a very, very stressful time because faculty were tired. And then there was some disgruntlement among faculty about those that came in with a Masters degree. They didn’t want to take up any of our load to help the others get through. That happened. And when I was able to get more definitive policies about faculty going to school, faculty who had gone to school before this resented the fact that these people were getting more privileges than they had when they were going to school, if that makes any sense. "You didn’t do that for me, why are you doing it for them?" Its because I didn’t have the power to do it for you. I have the power now.

And I got very upset at that point. I told them that they ought to be happy that the school was moving in the direction where we were providing this kind of help. But faculty, that was a big problem at that point. Getting the prepared faculty. That was a major thing that I had to deal with.
We always managed. But it was always a concern. Are we going to have enough faculty? It got better towards the last three or four years. Up until, I guess, the late 80s it was always a concern, but it did get easier.

The faculty had been meeting to decide, given the political milieu, what to do with this program in nursing. We investigated a lot of things. We spoke with the various schools in the area and we gathered a tremendous amount of information. We looked, at the same time, at Touro School of Nursing in New Orleans was trying to do a merger with Tulane. And we were watching them and the problems they were having. And we were looking at other schools throughout the United States and we did a tremendous amount of work on it. We came close to merging with Loyola University. I, from the very beginning, one of the things I wanted was for our graduates to have an opportunity to get a B.S. in Nursing without being penalized because they were from a diploma school. And I had spoken with so many of the graduates who had come in and said how difficult it was. How they had to repeat so many courses. They got no credit. A prime example, they have Anatomy and Physiology at the diploma level, even had college credit from it at LSU, and then when they went to another state-supported university in Louisiana, they were required to go back and take the Botany that was a pre-requisite to the Anatomy and Physiology. That kind of thing. Even though they didn’t have to take the anatomy and physiology. This kind of thing just was very difficult for me. So, I did want an opportunity for our graduates to be able to get their baccalaureate degree without too many problems. I think that was a big thing. We spoke with Loyola University in New Orleans. We met with their faculty. We did a lot of work with them. And for a while, it looked like we could move in that direction. Then the Director of the program went off to, she was working on her PhD or something, and it all collapsed. Nothing more came of it. Then we worked very closely with Holy Cross in New Orleans. And we got close to them but it became increasingly clear to us... it came across loud and clear that whatever college granted the degree, they had control over the program. And I think it began to be that we had the money, we had the facilities, we had the faculty, we can grant our own degree. So that’s the way it went.
On initial analysis, it appears that the decision to transform the diploma program in nursing to a free-standing, degree-granting institution is a rather novel and unprecedented idea. However, that same idea had been generated and reported by the National Commission for the Study of Nursing and Nursing Education in 1970 in what has come to be known as the Lysaught Report (Dolan, 1973). In their report, the Commission suggested that:

Those hospital schools that are strong and vital, endowed with a qualified faculty, suitable educational facilities, and motivated for excellence be encouraged to seek and obtain regional accreditation and degree-granting power (Lysaught, 1970, p. 109).

Approximately 40 years prior to the Lysaught Report, the Catholic Hospital Association convention of 1930 passed a resolution that urged nursing schools to separate from the hospitals with which they were affiliated (Kauffman, 1995). This action by the CHA was in response to the Goldmark Report on nursing education, issued in 1923, which helped bring about a shift from the nurses' training schools to academic nursing schools. The report called for a greater emphasis on nurses' educational needs and criticized the majority of nursing schools that, as departments of hospitals, focused on the needs of a particular hospital rather than on the students' need for a well-rounded education.

Edward A. Fitzpatrick, dean of Marquette University Graduate School, claimed in the September 1926 issue of Hospital Progress, there was "considerable justification for the conception of the school of nursing as a separate institution affiliated with the
hospital, with a separate budget, a separate endowment, and controlled primarily by educational considerations" (Kauffman, 1993). In 1931, there were 403 Catholic nursing schools which were hospital-based diploma programs in nursing (1993). It was 60 years after Dean Fitzpatrick's visionary suggestion that Our Lady of the Lake School of Nursing transformed to Our Lady of the Lake College of Nursing and Allied Health.

Mrs. Daniels further described the transition process:

There was a lot of interest in trying to facilitate with LSU. They (hospital administration) saw us going with LSU here, and they thought some members of the Board of Directors were thinking along those lines. But I brought up the fact that if we go with a state supported school, and they grant the degree, they have the control. That is not in keeping with the philosophy and objectives of the Franciscans and besides that, we would be responsible to the Board of Regents and we would no longer have a school. It would be LSU's school. Well, they still asked me to go to talk to them at LSU and I did. It became increasingly clear that an association with LSU was not the answer.

Brue Chandler was the Executive Vice President of the Lady of the Lake Medical Center. Mr. Davidge, who was the previous Administrator became President of the whole Lake complex. Mr. Chandler was solely responsible, as I understood it, for the whole hospital and of course, the School of Nursing. He was very much an ally. I found him to be always an ally. I certainly did. I really had no trouble dealing with any of the administrators. I jokingly said about some of them when they came in, "I have another child to raise," because it was a matter of educating them to really what are the needs of the nursing school. They were not aware of that. But as time went on, I felt that I had an excellent relationship with Mr. Chandler. It didn't mean that I could go over there and get everything I wanted right then and there. But he was very interested; he found this a challenge. And he was very interested in moving the school in the right direction. And he was very supportive of us granting the degree. I don't think anyone in
administration really realized what that was going to involve. They didn’t realize...that you just couldn’t change the title and award a degree. They didn’t realize that they had to establish a whole college.

Mr. Chandler, Dr. Joe Ann Clark and I went to Virginia to visit the College of Health Sciences in Roanoke, which was one of the first ones in the south to do this. And they were very supportive of the move they had made. And they highly recommended it and we talked about all the things that go on and what had to be done. There was no problem starting the college here, because at that time, all you had to do was go down to the Board of Regents and tell them. And, but the big thing, of course, was getting the Southern Association of Colleges and Schools' (SACS) approval and accreditation. That would be the big thing. We had consultants come in. Dr. James Fimberg (who was to become the first president of the College) was a wonderful ally to the diploma school and he came in and in essence told us what we would have to do. And it was a very hard process. We had trouble with the Board of Nursing. They couldn’t understand.

I wanted to have the school safe and situated before I retired. That was one of my goals. I, and I was pleased when they, when the decision was made, "yes we are going to become degree-granting." At one time I didn’t feel that way. I felt that that would create too much of a problem in the community and among the nurses. But then as I began to see what was going on, and when I saw the issues of control coming up, who would control the program, I didn’t want anyone to control the program, except ourselves.

My goal was to maintain the identity of it; Heritage and tradition and the Catholic philosophy, and the standards. I was very vested in wanting it to work.

My vision was to establish a college of nursing and allied health. To be very frank, I preferred it to be Our Lady of the College of Nursing and Allied Health. This college was established primarily to safeguard the nursing program. Allied health? Yes because I always felt that most of Allied Health -- Physiotherapy, Inhalation Therapy, Occupational Therapy, all of this, but not Radiology, but all Surgical Technicians -- all of these things had their roots in Nursing and were under the
purview of Nursing. So as far as I was concerned, it
should be that way. I wanted Our Lady of the Lake
College of Nursing and Allied Health. Again, to keep the
identity of Our Lady of the Lake too. I was interested in
that. I know at one point, when they were drawing up the
articles of incorporation or something, they sent them over
to me and here I saw this thing, this new college would be
St. Elizabeth’s College.

Evidently, the Sisters got together with
administration and they decided on what they wanted to
call the college and the sisters, God love them, said, “St.
Elizabeth” for some reason or another. Well, when I got
it back, I called Mr. Chandler, and I said, “Mr. Chandler,
sixty years of history down the tubes. This just won’t do.
I will not carry this project through with this name.” And
then one of the Sisters called me immediately and wanted
to know what the problem was. And I told her. And she
said, “I never thought of that.” She said, “That’s no
problem.”

When asked what she considered to be the greatest challenge that she faced as
administrator of the School of Nursing and what she considered to be her greatest
achievement, Mrs. Daniels responded:

Well, I think spearheading the move to be degree-
granting. Also, I feel that our relationship with Loyola.
I would not do anything that would not allow our
graduates to get a BSN.

Loyola University offered a BSN completion program for Registered Nurses on
their New Orleans campus. They were very interested in establishing a Baton Rouge
campus to offer the same RN to BSN completion program. With a long history of
graduating diploma nurses, Baton Rouge was full of RN’s who provided a ready
population for Loyola’s program. Our Lady of the Lake College entered an agreement
of mutual understanding with Loyola University of New Orleans. The agreement
provided that Loyola would offer the general studies component of the associate degree in nursing program of Our Lady of the Lake College. In return, the College would provide the facilities for Loyola's BSN completion program on the campus of Our Lady of the Lake College.

Mrs. Daniels continued:

And that relationship with Loyola, in the beginning, before we were ever SACS accredited, gave our students the college credits that were transferrable if they wanted to go anywhere else. And also, Loyola, to me, was very accommodating in that they were really vested in what was best for an RN who wanted to get a degree. Their philosophy impressed me because they looked at the RN as being a professional, that they just needed to add to her knowledge. Give her an opportunity to add to her knowledge and not be penalized. They were very liberal with giving credit. They did everything they could to enhance that student getting the degree. So I was very pleased with that. To me, that was part of the whole package until, of course, the College became SACS accredited. I was no longer here but I understand why. Loyola was no longer here because we could do the same kind of thing ourselves. And I don't know what the program's policies are. Hopefully, they are as liberal or as student-friendly as Loyola has been, which they should be. And I think if it's up to the nursing faculty, it will be... But anyhow, I was happy leaving with the school situated. It was safe. I knew when I left though that this was the beginning of a whole new era.

Aggie Haugh is a 1991 graduate of Our Lady of the Lake School of Nursing. Her class was the last diploma in nursing class to graduate. The following May, 1992, the first class of Associate Degree in Nursing graduates became the first graduating class of Our Lady of the Lake College. When Mrs. Haugh entered the program in 1989, the school had been relocated to a new building at 7500 Hennessey Boulevard that had
been designed and built specifically to house the School of Nursing. Mrs. Haugh was interviewed on March 8, 2000.

Mrs. Haugh discussed her decision to become a nurse:

I've always wanted to be a nurse ever since I was a little girl. My grandmother was a nurse, and it was always in the back of my head that I was going to do it, but I never thought that I was smart enough or could just do it. So anyway, I got married when I was twenty, worked, put my husband through school, then we had the children, and there was just always something missing, like I needed to do something for myself. And so I decided that I was going to go back to school and be a nurse. And so I started looking around at schools and talking to people.

We moved to Baton Rouge in '80. And I started asking people and people kept talking about the Lake, the Lake or the General, the Lake or the General, and to me, the Lake just had - it was just a better place to go. I don't know. It was just a better place. So I waited till my children were in school, and then I went back. Went to LSU, took my prerequisite classes and still didn't know if I had gotten accepted or not. They told me, since I was thirty-two years old, and since I had a family, that it would be best if I tried to get some classes out of the way at LSU before I applied to the Lake. So that's what I did. I worked really hard, made good grades, and then applied and got accepted. I was real excited, and that's how I started, and I was real nervous. I didn't know if I could do it, but I was going to try. My husband was real supportive. He said the years are going to pass anyway, so you might as well be doing something. And so that's when I decided, and that's how I got started.

The year at LSU, it was almost a whole year, was a real eye opener - I wasn't a very good student in high school - and so I had to work probably twice as hard as somebody who had studied real hard in high school. Things that they had good background on, I had to learn all over again. At LSU, I met some girls that were in a pre-nursing program and they didn't know if they were going to get accepted or not either, so we kind of started bonding there. I worked really hard. I had the highest grade in my Microbiology class.
I was nervous because I had heard a lot of stories about nursing school and how hard it was, but I was going to try. I was going to give it all I had, and sat the kids down and said okay, "mama's in nursing school. That's her first priority, basically." That we have to give up, everybody's going to have to give up a little something to support it, and the kids and everybody were great. We ate off of paper plates, and everything else.

I was one of the older ones in the class. I was one of the older married people. But I remember when Mrs. Daniels was there and she came in and she said that "the staff we have here is excellent. If you do what they say to do, you're going to be fine." I remember her saying that.

I used to keep telling myself over and over and over again just - they know what they're doing. You do what they say. You study and you'll do fine. And I did.

Mrs. Haugh discussed classroom and clinical experiences:

I remember the chemistry class. That wasn't fun, that night class. But I used to bring a tape recorder and tape record, but then it got to where it was too much to tape because it was a whole day's lecture. You just couldn't tape all that.

We were in class all day from eight till three. The first nine weeks or first semester, and then we started doing clinicals after lunch. Going to the hospital. You went on Monday, got your patients, what problems they had, and then you would go home, make a pathology card of the illness, look up, figure out your care plans, and be ready to go work the next two days.

We had blood pressure clinics. I remember doing that; practicing on other students. Blood pressure clinics, and basically, we even learned along with another nurse. But we were very well-prepared before we went in. We knew what we were doing. We knew how to do Accuchecks. We knew how to do everything from videos and talking and watching.

I also felt that we were very prepared. We knew what was expected of us. We knew that they (faculty) were there for us. I never did anything unless I felt comfortable doing it without making sure I knew, but we were very well prepared, I felt, whenever we went to clinicals.
Well, it was difficult if you didn't study, I guess. But, usually, the lectures coincided with the tests so if you listened and if you studied, and if you didn’t understand looked up in the book. Usually the tests were pretty much right on target with what the lectures were and what they taught us.

We were taught that we were never to assume that a patient was, for example, sleeping. We would chart "patient in bed with eyes closed." You know that kind of thing, because you don’t know if they were sleeping or not, like that kind of thing. You could say they were in bed with eyes closed, the respiration is this, this, you know, but you never could say they were sleeping because they may not have been. But you could take it as they were, but it was that you knew they were in bed with their eyes closed.

Mrs. Haugh was asked to describe relationships with hospital staff, physicians, and patients. She responded:

The nurses on the units in the hospital were helpful. Sometimes I think they would welcome us with open arms. Like, oh, good, the students are here, you know, to help. But they did help us. They did help if we asked them a question or whatever. They did help us.

We didn’t deal too much with physicians one-on-one. Not very much at all that I remember. We would see them come in, make their rounds and then discuss, or they would make rounds with the head nurse. We watched them, but we really didn’t have much to do with that. I don’t know. Maybe we were hiding.

Yes, I thought they were (to be feared). And still today I feel that way to some point...sometimes I felt we, not knew more, but we knew more maybe how the patient felt than how they perceived things, and would try to relay that and it was strictly a medical type thing. I still fear some (doctors) to this day. Because if you call them for something, and they don’t want to be bothered, some of them put you down and are rude. Because you caught something that they didn’t catch, and you’re calling to make sure that they want to do this, or is this what they want to do, or do they want to add this lab, or do they want to do this, and they don’t like it.
I just kind of learned which ones were - well you learned eventually which ones were nice and which ones weren't. I did work for a physician, just one-on-one; I was his nurse. And when I worked for him, I talked to him just like I would anybody else, and we got along fine. If I was nervous about something, I would tell him, and he was fine. He was fine. They're just regular people, but sometimes I don't know. I still fear - I still fear them, and I've been out ...ten years.

When asked if she remembered ever being in conflict with faculty, Mrs. Haugh gave the following description:

I can remember one (faculty member) when I was on a med-surg floor. I got unsatisfactory on every care plan that I ever turned in probably the whole time. And I never really understood why. I knew what I was doing. I just never could - we just clashed. But finally I got it, but some of the instructors, I felt, looking back, I know they didn't mean it, but at the time I thought they were picking the worst patients, giving me the sickest patients, kind of intimidating like you better know all these medicines before you go in. "I'm going to ask you, and if you don't know, you are going to be in trouble." So we were up learning all the medicines, learning all that they were, what you needed to do prior to, and that was real intimidating. I'd go to bed at one or two in the morning and get up at five to be there for seven, six or seven. And some days they didn't ask you. But if they did, you better know it. And that was real, that was hard. That was hard. A lot of anxiety. Lot of sleepless nights. I was too scared to feel ill. In fact, when at the end I graduated and I got the perfect attendance award, they laughed. They said "you were too scared to miss." And I said "you're right." I never missed a day.

I didn't know from week to week if I was going to make it or not. From week to week. I always knew my stuff though, so I never got in trouble for it.

I was humiliated one time by a faculty member. But I don't remember anybody else. I was one time. That was the one younger than I was. I don't remember anybody else. We were all kind of just scared the same. Same frame of mind, I guess.
When asked to describe the student-to-student relationships, Mrs. Haugh responded:

We got a lot of support from each other and I still see them (fellow classmates) today at the hospital and we like hug each other, "how are you doing?" and it’s been what, 10 years.

It's like we survived a traumatic event together. And now we’ll laugh about it. "Remember at nursing school when we did this and this?" and we’ll hug and, it’s something. And I was always told once you went to nursing school and you made those friends, they were your friends for life, and I really think that’s true.

Although her experiences occurred sixty-two years after Ms. Steib’s in 1929, Aggie Haugh related experiences that repeated the same cultural themes that appear to be a part of the socialization process. These repetitive themes include the following: social isolation; fear; student-to-student support; obedience/conformity; self-sacrifice; self-discipline; discipline; and deference to authority.
The transition of Our Lady of the Lake School of Nursing (1923 - 1991) to Our Lady of the Lake College (1990 - 2000) involved innumerable issues. Three events critical to the success of the transition were as follows: (1) commitment of the Franciscan Missionaries of Our Lady (FMOL) and the Board of Directors and administration of Our Lady of the Lake Regional Medical Center to the transition project; (2) approval of the Louisiana State Board of Nursing; and (3) regional accreditation of the College by the Commission on Colleges: Southern Association of Colleges and Schools (SACS). These events were carried out within the context of the overriding question of whether or not a transition should occur at all. The critical political issue was whether Our Lady of the Lake School of Nursing should expand its mission to enter the highly competitive higher education market or leave nursing education to the existing educational institutions in the community.

The primary impetus for change originated external to the School of Nursing from the nursing profession. In 1965, the American Nurses' Association issued a position statement that endorsed collegiate education as the appropriate environment for nursing education. Prior to the 1960s, the majority of nursing education programs were hospital-based diploma programs, such as Our Lady of the Lake School of Nursing. Throughout the 1960s and 1970s, many of these hospital-based programs closed. At the same time, many community colleges opened and offered associate degree programs in
nursing. The establishment of associate degree programs in community colleges was mutually satisfying to the health care industry, the profession of nursing, and higher education. For hospitals, the transition of nursing education to community college settings meant that they no longer had to bear the financial burden of operating educational programs, but still had a ready supply of nurses to meet the demand. For the profession of nursing, community college nursing programs meant that nursing courses were given college credit and students had access to baccalaureate and graduate degrees in nursing. This academic articulation was essential to the credibility and recognition of Nursing as a discipline and as a profession. To the institutions of higher education, nursing programs within their settings meant access to large grants and external funding sources specific to nursing education programs.

The trend to establish associate degree programs in community colleges was largely ignored by Our Lady of the Lake School of Nursing in the 1960s and 1970s. The hospital and the School of Nursing enjoyed a mutually satisfying relationship. The School of Nursing was organizationally a department of the hospital. The mission of the Franciscan Missionaries supported commitment to both health care and to education. The health care industry was thriving, the applicant pool to the school was stable, demand for nurses was high, and little notice was given to the external political forces. In addition, as previously stated, Louisiana did not have a community college system, as did many other states.

In the early 1980s, however, financial constraints within the health care industry sparked competition and a need to explore and fund additional health care programs. As
the hospital began to expand its in-house services, such as rehabilitation services, physical resources became scarce. The School of Nursing found its physical space shrinking. In addition, there were recurrent rumors that the hospital would close the school. Faculty and school administration began to feel threatened. Recruiting and retaining qualified faculty was becoming increasingly difficult. Recommendations for increases in faculty salaries were repeatedly denied by hospital administration. Morale was low.

Mrs. Maureen Daniels, Director of the School of Nursing began to view the situation as critical. The Faculty Assembly appointed a task force to explore and determine the future direction of the School of Nursing. The report of the task force recommended that alternative options to diploma education be explored. Among those options were (1) merging with another degree-granting institution, (2) offering a degree program in a cooperative relationship with another institution, or (3) becoming a free-standing degree-granting institution.

Meanwhile, the Director kept hospital administration informed of faculty concerns and the progress of the Task Force. It was no secret that the hospital and the Baton Rouge health care community depended upon a steady supply of graduate nurses to stabilize its work force. Support was solicited from Elizabeth Henry, the Vice President of Patient Care Services (Nursing Service), who advocated collegiate education for nurses.

The interdependence among the School of Nursing, hospital administration, and Patient Care Services constituted a political system. The key players were the Director,
Mrs. Maureen Daniels, and faculty of the School of Nursing; Mrs. Elizabeth Henry, the Vice President of Patient Care Services; Mr. Robert Davidge, the President of Our Lady of the Lake Regional Medical Center; and, Mr. Brue Chandler, the Executive Vice President of Our Lady of the Lake Regional Medical Center. Ultimate authority resided in the Board of Directors of the hospital and the Franciscan Missionaries of Our Lady.

Mr. Brue Chandler met with the Task Force of the Faculty Assembly and reviewed its report and recommendations. With faculty persistence, Mr. Chandler presented the recommendations to Mr. Robert Davidge for approval and submission to the hospital Board of Directors which gave support to the Task Force to continue its exploration.

Mr. Robert Davidge was interviewed on September 27, 2000 and asked to describe his thoughts and concerns when he was first presented with the recommendations of the Task Force. Mr. Davidge related his belief that education is another form of ministry that provides an opportunity to teach the values of Catholicism. Just as he values Catholic health care, so does he value Catholic education as faith-based.

Coming from Tallahassee, Florida to Baton Rouge in 1979, Mr. Davidge was pleased that Our Lady of the Lake Hospital provided nursing education within a Catholic health care environment. He believed that Our Lady of the Lake School of Nursing could provide an education for entry level nurses that was superior to the nursing education that was carried out within Florida's community colleges.
Mr. Davidge related that the recommendations of the Task Force coincided with factors that were amenable to the establishment of a free-standing, degree-granting institution. These factors included the following: a depressed economy; the availability of buildings on the campus as physicians relocated to hospital owned office plazas; the substantial funds that were received through Medicare pass-through funding; the availability and industriousness of a qualified faculty; and the availability of Dr. James Firnberg as a consultant to accreditation and transition procedures.

Continued discussions among faculty and the Task Force more clearly determined the direction the faculty wished to take. The faculty recognized the longstanding commitment and support of the Franciscan Missionaries of Our Lady (FMOL) to nursing education and believed that retention of identity with the FMOL was essential to continued financial support. Therefore, the option of merging was eliminated. A cooperative relationship with another institution was considered viable if the degree could be awarded jointly; again to retain identity. However, this option was determined not possible because only one institution could award the degree. That left the third option: to establish a degree-granting institution. Obstacles to this option included credibility with and approval by the Louisiana State Board of Nursing, meeting the accreditation standards of the Commission on Colleges of the Southern Association of Colleges and Schools, and satisfying the accreditation criteria of the National League for Nursing.

Although the Louisiana State Board of Nursing could grant initial approval to the new program, it could not grant final approval unless the parent institution (college)
was fully accredited. The National League for Nursing will not even review a program for accreditation unless the parent institution is regionally accredited. The Southern Association had previously accredited only one other similar institution, the College of Health Sciences in Roanoke, Virginia, although other regional accrediting agencies had accredited numerous similar institutions.

By this time, Brue Chandler, the Executive Vice President of the Medical Center was meeting regularly with faculty and assisting in the exploration of options. At some point his skepticism gave way to enthusiasm and he became a very valuable and powerful ally.

In determining which degree level was to be awarded, the faculty considered the current student population, the other nursing education programs in the community, the credentials of the current faculty, time constraints, financial requirements, and the accreditation criteria of both SACS and the NLN. Although faculty overall embraced baccalaureate preparation, they recognized the need for associate degree access for non-traditional students who comprised the majority of the current student population. In addition, there were already two baccalaureate programs in nursing and another diploma program in the community. Although all faculty held Masters degrees in Nursing, no one currently held an earned doctorate. Because SACS accreditation was integral to final approval by the Louisiana State Board of Nursing and accreditation by the National League for Nursing, attention was given to the amount of time needed to achieve SACS accreditation. To achieve full membership in the Commission on Colleges, it is required that at least one class be graduated. This would require at least four years for
an institution awarding bachelors degrees and at least two years for an institution
awarding associate degrees. In addition, time was required to complete the self-study
and for commission approval procedures. Added to all these factors was the financial
aid dilemma. Students could not receive federal financial aid until regional
accreditation was achieved. The Board of Directors of the medical center was willing to
provide financial grants/stipends to students enrolled in the nursing program until
federal financial aid could be awarded.

In addition to the above factors, the faculty also addressed the general education
degree requirements. First of all, there was not a pool of general education faculty
available to the School of Nursing. Additionally, there was an ethical concern
associated with the general education component of the degree requirements. Because
the institution would not achieve regional accreditation for at least two years, and more
likely four or more years, even if it granted the Associate Degree in Nursing, students
earning general education course credit would most likely not be able to transfer that
credit to other institutions. In the case of nursing course credit, students could take
challenge exams to be awarded transfer credit.

In view of all these factors, the faculty determined that the Associate Degree in
Nursing was the most feasible degree to pursue. However, because Baccalaureate
nursing education was also valued by the faculty, they (the faculty) explored Bachelor of
Science in Nursing (B.S.N.) degree options. Loyola University in New Orleans offers a
B.S.N. completion program through its City College division. Negotiations began with
Loyola University to offer the general education component of the associate degree as
well as to develop an off-site campus (at Our Lady of the Lake College) to offer its B.S.N. completion program. Being a Catholic institution, Loyola's mission is compatible with that of Our Lady of the Lake. Loyola would benefit from the association through financial compensation for each general education course taught in addition to free use of physical facilities to support the B.S.N. completion program, which was assured an available pool of qualified applicants from among the numerous diploma graduates of the School of Nursing (1923-1991). Our Lady of the Lake College would benefit from the provision of its general education component by an accredited institution and the accessibility of baccalaureate education for its associate degree graduates. Our Lady of the Lake students would benefit by earning general education credit that was dually transcripted by both Loyola University and Our Lady of the Lake College. In the issue of transfer of credit, the student would transfer accredited Loyola course credit. Additional incentive and benefit was awarded to diploma and associate degree graduates by Our Lady of the Lake Regional Medical Center, who provided 100% tuition reimbursement to nurses pursuing a B.S.N. degree at Loyola University. Our Lady of the Lake Regional Medical Center was to benefit by having a steady supply of graduate nurses as well as experienced nurses with a B.S.N. The prospective students of Our Lady of the Lake College, the majority being non-traditional, would benefit from being able to earn an associate degree in less than four years, enter the work force at Our Lady of the Lake Regional Medical Center and complete the B.S.N. degree at no additional financial expenditure. The Loyola B.S.N. completion is very attractive to
working nurses, in that it is offered largely in non-traditional formats to accommodate varying work schedules. All in all, everyone could benefit.

When negotiations were finalized with Loyola, the faculty set about to design an Associate Degree in Nursing curriculum to articulate with Loyola's B.S.N. completion requirements. Our Lady of the Lake College of Nursing and Allied Health was chartered in April of 1990, and registered with the Board of Regents on April 26, 1990.

Selection of the original Board of Trustees also involved political process. The hospital had conceptual difficulty in granting independence to an institution it fully subsidized. Although the hospital preferred to restrict appointment of trusteeship to previous lay hospital board members and members of the clergy and Franciscan Missionaries of Our Lady, stipulations existed in both SACS criteria and Medicare guidelines (Medicare pass-through funds provided the largest portion of funding for the College) that limited the number of hospital board members and members affiliated with the religious order. The remaining seats on the College Board of Trustees were filled by members of the higher education community: a previous Chancellor of LSU and A & M College, Baton Rouge; the Dean of City College, Loyola; and the Dean of the College of Business Administration at LSU, Baton Rouge. This allowed a balance on the board among lay business leaders and medical professionals who supported the health care industry, members of the religious community, and representatives of the higher education community, all having a stake in the success of the College.

A second critical event in the transition process involved the approval of the program in nursing by the Louisiana State Board of Nursing. This event was political in
nature for a variety of reasons. First of all, the Board of Nursing had never encountered an institution of higher education that was not currently regionally accredited. Secondly, because the parenting institution was non-traditional, the Board of Nursing was skeptical of the credibility of the nursing program as an associate degree program that was philosophically congruent with traditional associate degree programs. There was an assumption among some of the Board members that the proposed associate degree program was merely the diploma program in disguise. The philosophical approach to the two programs is quite different, and the Board needed to be assured that the intent of the faculty to establish an associate degree program in nursing to replace the diploma program in nursing was legitimate. To that end, the board members closely scrutinized the proposed curriculum and, in particular, the Statement of Philosophy and the Conceptual Framework.

In addition to its concern for legitimacy, the Board of Nursing expressed concern regarding the competitive interest of the proposed program in nursing in relation to the other programs in the same community, as well as with other associate degree programs of nursing in the state. Although no other program formally opposed the proposed associate degree program, there was certainly potential for them to do so, especially Southeastern Louisiana University, which heavily competes with Our Lady of the Lake for clinical facility resources and is located across Essen Lane from Our Lady of the Lake Regional Medical Center. However, because SLU is based in Hammond, it is generally held that Our Lady of the Lake College has priority within the community of Baton Rouge. In addition, Our Lady of the Lake College limited recruitment to a seven
parish geographical area in which there are no other professional nursing programs, except those in the Baton Rouge community. Fortunately, Board approval was sought at a time when the number of applicants for all programs was high and the demand for nurses was great.

After considerable consideration and legal consultation, the Louisiana State Board of Nursing granted initial approval to the associate degree program in nursing in July, 1990. The first class was admitted in August, 1990. The last diploma in nursing class graduated in December of 1991, and the first associate degree in nursing class graduated in May, 1992. In 1991, the Application for Initial Membership was submitted to the Commission on Colleges: Southern Association of Colleges and Schools. Thus began the third event critical to the transition process.

It was at this time that Dr. James W. Fimberg was hired as a consultant to assist the College in its accreditation effort. Dr. Fimberg had retired from the Louisiana State University system, where he had most recently served as Chancellor of the LSU-Alexandria campus in Alexandria, Louisiana. Since retiring in 1989, he was working as a consultant with the National Science Foundation and also served as a consultant to institutions who were seeking accreditation or reaccreditation with SACS. His tenure in higher education was widely recognized and respected. Dr. Fimberg met with the College administration and the faculty to review and plan the College's accreditation process.

The Commission on Colleges: SACS recommends a minimum of 18 months be spent in self-study. The College Board of Trustees, along with hospital administration,
urged the faculty to adopt a shorter time frame in order to achieve accreditation by the end of 1992. Because SACS was unlikely to initiate the self-study process until early 1992, the faculty maintained that to shorten the time frame was a risk to achievement of accreditation on two counts: (1) failure to comply with the Criteria and (2) to ignore the time frame recommended by the accrediting agency could be interpreted as minimizing the importance of the self-study process.

Rather than jeopardizing institutional accreditation by shortening the time frame, the faculty recommended that the self-study time period be 18 - 24 months, but that the goal of the institution should be full membership (accreditation) rather than the usual status of candidacy. The faculty could not find evidence that any institution had ever been granted full membership without a period of candidacy within the Southern Association. There was one exception: a technical institution that moved from the commission accrediting technical institutions to the Commission on Colleges. Nonetheless, the faculty so firmly believed in the excellence of the institution and its program(s), that it persuaded the Board of Trustees to approve the proposed extended timetable for achievement of accreditation. In so doing, the faculty demonstrated remarkable cohesion and collegiality. This unified force greatly impressed and influenced Board approval.

Prior to entering self-study in 1992, the College initiated a certificate program in Surgical Technology and an associate degree program in Radiologic Technology. This was done in case candidacy was achieved rather than full accreditation, since new programs cannot be added during the period of candidacy. In addition, it was necessary
to include all programs of study in the self-study report. The target date for submission of the Self-Study Report was April, 1993 with the Affirmation Committee visit planned for November, 1993. That would allow the Commission on Colleges to determine institutional status in June, 1994, with accreditation status retroactive to January, 1994.

Also, prior to entering self-study, the faculty conducted a salary survey in conjunction with the establishment of policies regarding appointment to rank, promotion, and termination of faculty. The report of the survey was presented with recommendations to the Board of Trustees for a revised salary schedule. In negotiating salaries, the faculty played on their favor with the Board. The Board also recognized and appreciated the integral role faculty were to enact in achieving accreditation.

Because the number of full-time faculty was relatively small, the burden of self-study would fall on all full-time faculty, all of whom carried full-time teaching loads. In the end, faculty were able to negotiate 10-month contracts with a sizeable salary increase. For its part, the Board, in approving the salary plan, provided incentive for continued faculty commitment to the transition process.

A major concern of faculty at this time was the determination of a Chief Executive Officer of the College. Mrs. Maureen Daniels was Acting Dean of the College and planned to retire upon the appointment of a permanent Dean. With the impending retirement of Mrs. Daniels, the need to hire a Chief Executive Officer for the College was imperative. The initial search committee consisted of representatives from the Board of Trustees, Administration of both the Hospital and the College, and College faculty. Dean Jim Henry of the LSU School of Business Administration and a member
of the College Board of Trustees, chaired the committee. The hospital administration
arranged for the firm of Heidrick and Struggles to coordinate the search.

The initial search was not successful, but it was a learning experience for the
search committee. The hospital selected Heidrick and Struggles to coordinate the search
because of their previous relationships with the firm in filling hospital management and
executive positions. However, there are at least two distinct service divisions of
Heidrick and Struggles. One division serves hospitals and one serves higher education
institutions. Because of their previous experiences with the firm, the hospital made
contact for this particular search with the same branch with which it was familiar.

There were essentially four candidates that Heidrick and Struggles recommended to the
College search committee. Although Dr. James Finnberg had interviewed with Heidrick
and Struggles, he withdrew his application prior to recommendation to the search
committee. All four of the recommended candidates had previous experience with
hospital administration, all were women, and all were nurses. Only one had higher
education experience and that was as the Director of Alumni Affairs.

During an interview (September 27, 2000), Mr. Robert Davidge discussed his
role on the search committee. He related that, at that time, he believed that a nurse was
necessary to run a nursing school and had not yet developed an awareness or
appreciation of the role of a college administrator.

The faculty, including myself, on the search committee felt somewhat
disappointed in the candidates that were recommended by the firm of Heidrick and
Struggles. In previous meetings with the firm representatives, the faculty had
specifically recommended that applicants have previous higher education experience. Because the hospital administration was unaware of the firm's division devoted to searches for higher education institutions and because the faculty historically and consistently deferred to the hospital's authority in decision-making situations, the search did not produce a candidate that was qualified to lead the institution. The contract with the firm of Heidrick and Struggles was terminated and the search was postponed. To fill the position vacancy, the Board of Trustees appointed Dr. David Hull as Interim Dean of the College. Dr. Hull had previous experience as the Dean of Students at Louisiana State University and had been hired by Our Lady of the Lake Corporation to fill the upcoming vacancy in the position of the Executive Director of the OLOL Foundation. However, the incumbent to that position had not yet retired, although it was known that he would be leaving within the year. The Board of Trustees of the College charged Dr. Hull to find his replacement in the College prior to assuming the position in the Foundation. Dr. Hull, however, came into disfavor with the hospital Board of Directors only a couple of months into his tenure as Interim Dean of the College and was terminated from both his present and future positions within the Our Lady of the Lake Corporation. The search issue became critical.

Mr. Davidge (September 27, 2000) credited Dr. David Hull with helping him to understand the college as an entity separate and different from the hospital. Dr. Hull was instrumental in assisting hospital administration to appreciate the operational structure and function of an institution of higher education and how it differed from a health care institution.

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In the meantime, the faculty had been working closely with Dr. James Fimberg, as a consultant in the transition and accreditation processes, and recognized the value of his contributions to the College. Dr. Fimberg was approached and asked to seek the position of Dean of the College. Dr. Fimberg was then put in contact with Dr. Jim Henry, the chairman of the search committee. Negotiations began and Dr. Fimberg assumed the position of Dean of the College in January 1993, with the understanding that the title of the position would be changed to "President."

The First President

Dr. James Fimberg, the first President of Our Lady of the Lake College was interviewed for this study on February 22, 2000. Dr. Fimberg's educational credentials include the following: B.A. in Education from Southwestern Louisiana Institute, now the University of Louisiana-LaFayette; Masters degree in Educational Administration from LSU; and an Ed.D. from LSU in Educational Research with a minor in Communications.

His experience and work history include: three years of public school teaching (1956-1959); went to LSU in 1959 in what was then called the Bureau of Testing, which was part of the Junior Division; continued to work on a doctorate while at LSU; in 1961 was recalled to active duty in the U.S. Army during the Berlin Wall/Cuban Missile Crisis; returned to LSU following that brief tour of active duty; in 1962 became Assistant Registrar for Institutional Research on the Baton Rouge Campus; in 1964 became coordinator of Institutional Research for the LSU System and also for the LSU and A&M College-Baton Rouge; 1968 was full-time with the System Administration; in
1980 named the Assistant Vice President for Academic Affairs and Director of Institutional Research for the LSU System; also during that time held a tenured position in the College of Education; was first appointed as Assistant Professor in 1969 and went through the ranks to full professor; in January of 1984 went to LSU-Alexandria as Chancellor and remained there until June of 1989, when he retired from LSU.

As the College's new Chief Executive Officer, Dr. Fimberg's primary challenges were to establish the institution's independence from the hospital and to achieve regional accreditation. Both challenges were critical to the success of the College. The external challenges encountered in establishing the College as an independent institution can be summarized as establishing an identity within the health care community, the higher education community, the religious community, and the community at large. In fact, the posturing of the College within its external communities was an institutional goal within the first planning document created by the College.

The independence of the institution was a requirement for regional accreditation by the Southern Association of Colleges and Schools (SACS). The College was expected to demonstrate its independence in governance and budgetary control. SACS was insistent upon a clear distinction between the administration of the hospital and the administration of the college and the board of the college versus the board of the hospital.

Dr. Fimberg:

I think it was very appropriate for this institution to not separate itself completely from the hospital, but to distance itself to show that it was an independent operation, although an affiliate of Our Lady of the Lake.
Regional Medical Center. So, my discussion with the hospital administration and the Board was along that line.

Dr. Fimberg's title was initially Dean of the College. The issue of the title of the position was also associated with the independence of the College. The choice of the title of Dean was peculiar within a higher education context for that of a Chief Executive Officer. However, when examined within the context of hospital ownership of the College, the nomenclature was more understandable.

The hospital administration continued to view the College as a department within the hospital. Because there already was a President of the Corporation, it was viewed as undesirable to appoint another President to preside within the Corporation. This was but one more example of the dominance theme that the hospital historically had imposed on the educational entity. Dr. Fimberg was asked to address the conceptual conflict in the title of President. He responded as follows:

Well, if this was going to be a school within a college, if it was just going to be a nursing school, then I think the title of Dean was probably appropriate. That's what it is when you are looking at a school within a college, or a college within a university, but if this institution was going to achieve collegiate status, then I think the titles at the institution had to reflect common practice. Common practice for an institutional head is the President of the institution. I knew of no other instances, except in those schools which were still transitioning from a nursing school to a college. There were probably a dozen or so or more, I guess, in that process at about the same time. Some of those people were still called Deans, some of them had administrative positions at the hospital where the college or the nursing program had not made a full transition from being a department of the hospital to being a free-standing institution.
The common denominator of all colleges that transitioned from diploma programs in nursing was their relationship with a sponsoring hospital. The model of sponsorship and governance common to these institutions is unique among colleges and universities offering programs in nursing and allied health.

From the sponsoring hospitals' perspective, the model was also alien. As prior departments of the hospitals, the schools of nursing were subject to the same administrative hierarchy as all other departments in the hospital. The relationship was similar to that of a parent-child relationship in which the hospital provides an environment and services to support the child (school), but the hospital maintains control and authority, and the child is never expected to be autonomous. The model does not allow for the child to "grow up" and become independent of the parent hospital. The development of independent colleges evolving from hospital-based diploma programs in nursing represented a conceptual leap on the part of the hospitals that required that the hospital release the child to be an independently functioning institution.

Dr. Fimberg described the College's experiences in establishing conceptual and actual independence from the hospital:

I'm sure it was outside of the model, but I did not find it extremely difficult to establish the difference. It was a daily, I don't want to say daily battle, but it was a daily struggle to say we are not the hospital. We are an affiliate of Our Lady of the Lake Regional Medical Center, and I am not sure to this day (it is now 8-10 years later) that everybody at the hospital understands the distinction between the college and the hospital. We are an affiliate of Our Lady of the Lake Regional Medical Center. We are not Our Lady of the Lake Regional Medical Center,
it's Our Lady of the Lake College, which is a separate entity. And I think part of that was getting separate bylaws, a separate constitution, filing as a separate 501C3 corporation with the Secretary of State in Louisiana. It was a daily struggle, but I don't know that it was done with significant resistance from hospital administrators. I think the rapport I had with the senior administrators of the hospital was very good and aided the transition.

Dr. Fimberg's 35 years experience in higher education earned him the respect and recognition by the hospital administration as the authority on higher education governance issues. The administrative authority for the College had to reside with the College President if the institution was to be viewed as a legitimate member of the higher education community.

Another factor which helped to legitimize the College as a member of the higher education community was approval by the state legislature for the College to be a member of the Louisiana Association of Independent Colleges and Universities (LAICU). Membership in this association provides the College with some state funding. Other members of LAICU are Tulane University, Loyola University, Our Lady of the Holy Cross College, Xavier University, Dillard University, Louisiana College, and Centenary College. Five of these private institutions are located in New Orleans and three of them are Catholic. The remaining two are located in the central and northern parts of the state and are both non-Catholic. Therefore, Our Lady of the Lake College is the only private, Catholic college outside the city of New Orleans and the only private college outside the city of New Orleans in the southern part of the state.
Dr. Fimberg added:

Bill Arceneaux, Dr. William Arceneaux, who is the President of LAICU, and I have known each other for years. We had many discussions about the role of Our Lady of the Lake College name, what impact we could have on the city of Baton Rouge and the Greater Baton Rouge area. There was no independent college in the Baton Rouge area, and if I am not mistaken from what Bill told me, we were the only city of its size in the United States and/or the only capital city in the U.S. not to have a private college or university. I think Bill felt that Our Lady of the Lake College (and I think he rightfully felt) that we could have an impact on higher education in southcentral Louisiana (whatever Baton Rouge is considered.)

The original name of the College, as chartered in 1990, was Our Lady of the Lake College of Nursing and Allied Health. As Mrs. Daniels indicated during interview, she considered it important to keep the historical tradition of the nursing program present in the name of the College. The name of the College was later simplified to Our Lady of the Lake College.

Dr. Fimberg:

I think the name change helped to simplify what we were and I think it has also helped the Board understand that in approving additional degrees, the college could really serve a niche population in Greater Baton Rouge, not trying to be LSU, not trying to be Southern University, not trying to be Baton Rouge Community College, but have a Catholic force, have the religious overview and serve the population in this city in a different way than any other college or university was doing or can do.

Throughout its development, the name of the College has been a recurring topic of discussion among the Board of Trustees, administration, faculty, and staff. It is
generally held that the name of the College should reflect its mission, its heritage, and its sponsorship. As previously discussed, Mrs. Daniels challenged a prior attempt to change the name to "St. Elizabeth's College." She strongly opposed a change in name from that of Our Lady of the Lake College of Nursing and Allied Health. Since that time, though, many within the College have been challenged by the associated identity with Our Lady of the Lake Regional Medical Center and the historical presence of Our Lady of the Lake School of Nursing. The name of the College is felt to be somewhat limiting to the perception of the public in identifying the College as a transformed institution. This is not to say that those associations are denied, or in any way not desirable, only that it is difficult to promote and market the College within the perceptual limitations of the public that are influenced by the name of the College.

Dr. Fimberg continued:

I think it will continue to come up, because the people are always going to say, "Oh, that's the hospital. That's the nursing school." I think 100 years from now somebody is still going to say, "Oh, yeah, I know, the nursing school at the hospital."

Despite the legal and conceptual transformation of the College from that of a diploma program in nursing to a two-year degree-granting institution, internal transformation was still in process when Dr. Fimberg assumed the Presidency. Dr. Fimberg was asked to describe what the College looked like internally when he arrived.

Dr. Fimberg:

Internally it looked like a nursing school that had been here for 75 years. It just fit the mold of the traditional diploma school of nursing. There were a goodly portion of faculty members who had never taught in a collegiate
setting. So, I think one of the internal issues was
developing a different mind-set in the faculty about what a
college is, and what the role and responsibility of a
collegiate faculty is, versus what the role and
responsibility of a diploma program is within a hospital. I
think, and I am not a professional in nursing, but my
observation is that faculty rights and responsibilities in a
diploma program did not extend very far. Mainly, the
Director of Nursing called the shots at the direction of the
hospital administration. That's the way diploma programs
operate. That is not the case in a collegiate setting, and
there is a very delicate balance between faculty rights and
responsibilities and administrative authority in a collegiate
setting, and it is not easy to strike that delicate balance. I
think, without being very careful, you can tilt that balance
either way and it just doesn't work.

I think the first two years here from '93 to '95 (I am
just picking a time period, I don't really know what the
time period was), it was a real struggle to have
administrative authority, but have participation from the
faculty. I think faculty were somewhat reluctant to
participate for fear of some recrimination of some sort.

It is important to note here the reoccurrence of reference to fear. The theme of
fear was consistently identified throughout the interview data with former students and
now appears on a faculty level as deference to administration.

Dr. Fimberg continued:

And too much so (deference to administration/authority). They would not exercise their responsibility to a degree. They have rights, and they have responsibilities. And like I say, it is an extremely delicate balance, and it is not achieved everywhere. I think it was achieved here. At least in my own mind I was very pleased with where we came and I think that would be, if I had to say what were your achievements during your tenure, that would certainly rank among those achievements. To watch this faculty develop...
Faculty deference to authority was also observed in the annual budgeting process. Dr. Fimberg's approach to the planning and budgeting process was one that involved institutional participation. Upon his attempt to implement this approach, Dr. Fimberg made the following observations:

I don't think there had previously been any faculty input into the budgeting process, and as you know, on our last accreditation or reaffirmation visit we were commended for two things. One was the participation of everybody in the budget process. I think, and this is my personal feeling, and I don't know how widely held it would be by senior administrators, but my feeling is that the more participation you have in the budget process, the more people understand what they and the institution can and cannot do financially. I think that helps significantly in developing an understanding of the whole budget process, and what we could do, what we couldn't do, where we were going, what we wanted to do, and I didn't mind saying, "we're saving money, we're putting money in the bank, we had a surplus this year." I think we ought to have a surplus.

Dr. Fimberg thought it was very important to develop a significant reserve. The College receives approximately 68 per cent of its revenues as a direct grant from Our Lady of the Lake Regional Medical Center. A large part of this grant is money that the hospital receives from Medicare reimbursement in which federal dollars for training are funneled to the hospital and through the hospital to the College for support of nursing and allied health training and education through the Omnibus Budget Reconciliation Act of 1989.

Medicare has historically paid providers (of health care) for its share of the costs they incur in connection with approved educational activities, which include graduate
medical education and nursing and allied health education. The costs of approved
nursing and allied health education programs are separately identified and "passed
through"; that is, paid on a reasonable cost basis (Federal Register, September 22,

There have been significant demands upon the Medicare reimbursement dollars
and those dollars are shrinking, largely because of the complicated process that the
federal government goes through to not reimburse for certain services and certain
patients in the hospital. So, the hospital has been getting fewer reimbursed dollars from
Medicare every year to support the educational programs at the College.

In the Balanced Budget Act of 1997, Congress proposed to eliminate funds
derived from Medicare choice patients from the formula used to determine Medicare
pass-through reimbursement funds to hospitals that supported nursing and allied health
educational programs. This elimination threatened to cost hospital-sponsored schools of
nursing and allied health millions of dollars. Dr. Fimberg and other members of the
Consortium worked for three years with Congress to restore to the reimbursement
formula, the funds associated with Medicare choice patients.

Dr. Fimberg:

We managed to get the law changed. And I say, we. That was
our consortium. And our consortium grew from the six
institutions to 20 - 25, I don't know how many there are now, that
helped us lobby in Washington to get the law changed to get our
reimbursement back for Medicare recipients. So that's going to
be ameliorated to a degree. We're not going to get everything
back, but we'll get a portion. It only affects institutions that are
affiliates of hospitals.

Opposition came from very strong groups. I'm not
sure the medical community as a whole embraced our getting the
law changed again. The Association of Collegiate Schools of Nursing did not agree with us at all. They wanted this money to go to master's level preparation of health care practitioners or nurse practitioners, where we wanted it to go to entry level health care workers.

They never understood; I don't think they understood the schools in transition or the schools who had converted diploma programs to associate degree programs. They still saw us as hospital-based, and I can tell you that was a struggle, and will remain one because I - this battle, you know, we've won the battle, the war will rage on, and I have, even since retirement, reminded the leaders of our consortium know we should continue to be very vigilant in what we're doing.

In the 1991-92 fiscal year, the private grant from the hospital provided $678,000 in revenue to the College. This represented 62.33 percent of the College's total revenue.

In comparison, the grant received from the hospital in the 1993-94 fiscal year totaled $2,275,000 and represented 64.32% of the total revenue of the College. In the past five fiscal years (1996 -2000), the grant received from the hospital has remained at 2.4 million dollars. In the current 2001 budget, the grant was reduced to 2.16 million dollars. This has necessitated that the College seek other sources of revenue to offset the reduction in grant dollars.

Dr. Fimberg was rightly concerned that the direct grant from the hospital would be cut, and believed it was important for everyone at the institution to know the revenue sources, which included student tuition, outside sources, interest income, and the grant from the hospital. His goal was to have $5,000,000 in reserve, so that if the hospital's reimbursement was cut severely and it could no longer support the College, the institution would continue to survive.
Dr. Fimberg:

Letting everybody know what elements went into the budget and then getting everybody involved on the budget process, I think, helps them understand what we were faced with.

The governance structure of a hospital is very different from that of an institution of higher education. A hospital governance structure is hierarchical and allows, actually compels, bureaucracy. The governance structure of a college or university is intended and is designed intentionally to avoid bureaucracy and to promote democracy. The faculty play an integral role in the formation and implementation of educational policy. The conceptual role of faculty governance has been somewhat difficult for hospital administration to understand. Part of the difficulty is that some people view the faculty as hospital employees and subject to the same rules, regulations, policies, and procedures which apply to all hospital employees.

Dr. Fimberg discussed his view of the conceptual differences of governance structures, the issues involved, and the conflicts experienced.

Dr. Fimberg:

Well, I have to tell some interesting stories. Number one, I think I view faculty at this institution much like a hospital administrator would view the medical staff. The administrators can run the hospital, but they can't run the hospital without the medical staff, and so there is again that delicate balance. The same exists between college administration and college faculty, there is that delicate balance again. You can't run it without the administration because that's the oil and grease. If you don't have the faculty, you don't have an institution. I am always reminded of the story, and this is a famous historian and I can't remember his name, when General Eisenhower became president of Columbia University. He put
together his inaugural speech (I'm not sure this is a true story, but it makes for a good story), and called a faculty leader in, and he was trying his speech out on him, and the speech started off, "Fellow employees of Columbia University," and the faculty member stopped him right there and said, "General, let me remind you we are not employees of the university, we are the university."

So there is that delicate balance. So, that said, hospital administrators are somewhat more dictatorial with hospital staff, excluding medical staff, about the way a hospital operates. And, I am talking about Bob Davidge right now, if he would be sitting in this room with us today, would not disagree with my saying this, does not to this day (I don't think) completely understand collegiality, nor understand that the college president role is different from the president of the hospital. He is a retired Air Force Colonel who thinks like the military does, doesn't understand that associate professors don't supervise assistant professors. I don't know that he wants to understand it. That's always been an issue, not a serious one. Bob and I had an outstanding relationship, and understood each other very well. He just didn't understand how an institution operated. He thinks we are saying that every issue must be decided by a representative committee and everybody vote on everything which, of course, is not the case, but didn't understand the concept of collegiality.

Mr. Bob Davidge confirmed (September 27, 2000) his lack of understanding of the College structure:

I don't understand the College's environment of authority, nor do I want to. It simply does not make sense to me. But I am a hospital administrator and will leave College administration to those at the College.

The issue of a governing board of the College as separate from the governing board of the hospital was central to the issue of the College's independence from the
hospital. Dr. Fimberg discussed the creation of the College Board of Trustees as separate from the hospital's Board of Directors.

We had to be very careful about that (establishing the difference), because if you look at the SACS criteria, they clearly state that there cannot be a dominant force on the Board, and here again, another one of these delicate balances. For Medicare reimbursement purposes we had to have four Board members in common with the hospital board. For SACS purposes there couldn't be a dominant force on the Board that exerted undue influence from the hospital. So, here again, one of these issues and one of these delicate balances to make certain that we had people on our Board who would think independently of the hospital. Now, a lot of them had hospital connections and either were on the Board (hospital) or had previously been on the Board of the hospital. There was, in my tenure, never, not one instance of any undue influence on the part of the Board, and I think we had a very clear understanding from the very beginning.

Dr. Fimberg was asked to comment on the strategic planning process of the College, beginning with the decision to establish a two-year associate degree-granting institution.

Dr. Fimberg:

I think it went through a very rational process deciding what it was initially going to be. I think there were several possibilities, one to continue the diploma program; two, to close the program altogether, which probably has happened as frequently as anything else to diploma programs of nursing across the country, to have an associate degree program, to have a baccalaureate degree program. I think all those were the considerations. When you look at Southeastern, had a baccalaureate program in Baton Rouge, Southern University had a baccalaureate program in Baton Rouge, nobody had an associate degree program in Baton Rouge. I think that was a very well thought out decision to have an associate degree program. I don't want to say our direction has
changed, as our direction has expanded to have the BSN completion program, but again, that program is not offered by a Baton Rouge institution. So we have unique, non-duplicative sorts of efforts not just in nursing education but in other health science fields as well.

I never felt any pressure from the hospital or the Board for anything, or the Sisters. I think what may have eliminated any pressure was the fact that we established our own goals. We had, I think, an excellent planning process, a very participatory planning process. We developed our own goals and our own outcomes measures and kept the Board fully informed about what we saw as the strategic direction of the institution, and they bought into the plan. I rarely went to the board and said "What do you think about this?" I went to the Board and said "Here's the direction we're going to go in and you can either decide that's where we're going or you can decide that's not," and not in so many words. But I think it's wrong for the Senior Administrator of an institution to go ask the Board's opinion about the strategic direction. I mean you, with your staff and with your faculty, you'd say, "Here's this institution; here's where we ought to go," and then you present that to the Board. And then if the Board does not concur, then you go back and tinker with it a little bit more, and then come back, but I don't think it's the Board's position to tell the administration. Here again, one of these delicate balances. It just depends on your rapport with the Board, and I think the President ought to have the kind of rapport with the Board that allows the Board to have the faith and trust of the President. The President has to have the faith and trust of the Board. When that goes away, the President needs to go away.

I'm sure there were times when they (the Board) thought that our ambitions and goals for the institution were a little bit grandiose. But they never put the brakes on anything that we tried to do. The Board was extremely supportive of everything that I proposed during my 6 and a half-year tenure here. Never. But, of course, the other thing is, you've got to know how far you can go with the Board. I think that comes with experience and exercising some good judgment. I can say in my 30 years at LSU nobody ever told me no. But I also knew how far I could go to get away with it. That's probably not the right word
to use, and I've always said I graze just outside the fence. You know, I'll stick my head out through the barbed wire and graze on the other side of the fence, but I'm not going to take a running start and jump over the fence and graze in the other pasture.

And then sometimes you move that fence out a little bit, you know, and you kept extending yourself, but I think that's the mark of a good administrator. You know, you take this job and you want - the Board has enough faith in you to hire you as the leader of the institution, and then, by God, you had better lead. That doesn't mean sitting around and letting the institution develop, that means getting out there and doing it. And we had the kind of staff that could do the work. And I think we brought in some outstanding people here and brought in some really young folks as well who wanted to do stuff, and they did, and I can sit here and name them and you know who they are, but, you know, they're not here anymore. But, I think we had assembled an excellent administrative team. And it worked as a team. Got a lot done. I didn't have to do very much.

Dr. Fimberg was asked to explain what made a good match or a "good fit" between the President and the Board of Trustees.

Dr. Fimberg:

I think the main thing was to have the same values the sisters have...compassion, understanding, respect and dignity. And I think we tried to instill those values in everybody who was here and hopefully, the faculty and the staff for the most part. You know there's always some slip-ups; but for the most part that those values showed in the classroom, they showed in dealings with students. It doesn't happen all the time. Not everybody feels they were treated with respect all the time. And there are going to be instances where it doesn't happen. Not every time do we understand each other. And not every time does a faculty member understand a student, but you set that as the overriding values and you hope that, a huge percentage of the time, that at least people feel that. And I think that in developing our mission to be closely aligned to the mission of the Sisters and letting everybody know
that it's a religious institution which was founded by a religious order. We have that heritage, and this is what we stand for. I think that certainly helps.

The Mission Statement of the College was created and clarified during Dr. Fimberg's administration. The Mission Statement and Institutional Goals are found in the College Catalog (Summer 2000) and are as follows:

**College Mission Statement:**
Our Lady of the Lake College is an independent Catholic institution predicated upon the values and philosophy of the Franciscan Missionaries of Our Lady. Seeking to be faithful to the ideals of its heritage, the College is committed to meeting the health and educational needs of the people of God with compassion, understanding, respect, and dignity. The College offers selected undergraduate and pre-professional educational programs which provide the basis for excellence in the practice of health care and academic achievement. In addition, the college espouses the goals of life-long learning and seeks to provide educational programs which support academic, personal, and professional growth (p. 7).

**Institutional Goals:**
In order to fulfill its mission, the following goals are identified:

1. Promote the Franciscan values of compassion, understanding, respect and dignity.
2. Offer selected undergraduate and pre-professional educational programs which provide the basis for excellence in the practice of health care.
4. Provide educational programs which support academic, personal, and professional growth (p.7).

Under Dr. Fimberg's leadership, the College became mission driven. The values inherent in the mission were more clearly defined and applied to all aspects of the College. The Mission Statement appeared on all marketing materials, on the backs of
business cards, all institutional publications, and was framed and hung on walls throughout the College buildings.

When asked what external factors may have been advantageous to the development of the institution, Dr. Fimberg offered the following comments:

Well, I think one thing that has helped us significantly was the fact that we could hold the SACS Criteria in one hand as we developed the institution with the other hand. And, well, not in cookbook fashion, but we knew what the rules were. And I think that helped. You know, if you believe that the SACS criteria will help an institution be a strong institution, which I firmly believe, and then if you know what the rules are, then you can develop your policies and your procedures from the ground up, which not many people have the opportunity to do, to coincide with the criteria needed to be accredited, and if you believe those criteria will help you develop a strong institution, you've got it made. And so you want to talk about outside influence, I think that was one of the outside influences.

Because the institution was a new one, the self-study process was divided into two phases: the compliance phase and the evaluation phase. In the compliance phase, institutional policies and procedures were reviewed with the Criteria. The outcome of this phase was the establishment of many new policies and procedures. In the evaluation phase, the institution's policies and procedures were evaluated for effectiveness. The evaluation phase is the usual self-study process for reaffirming institutions. The policy-making phase (compliance phase) was carried out through the standing committees of the Faculty Assembly. The evaluation phase was carried out through the committees of the self-study. In retrospect, the faculty was able to maintain its cohesion and collegiality fairly well throughout the self-study process. Although
most faculty were active participants in the process, a few dug in their heels and remained passive and essentially non-contributory. More assertive and enthusiastic faculty picked up the slack of their passive colleagues with little repercussion. Faculty leaders emerged during the process who continue to exert influence in faculty decision-making.

Dr. Fimberg continued:

And I think the other thing that helped significantly in this was the fact that Harry Nickens (President of the College of Health Sciences in Roanoke, Virginia) and I developed this consortium, and that we had institutions in Ohio and Indiana and North Carolina, Virginia, Florida which, some of which were religious, had religious sponsorships, Seventh Day Adventists, Lutheran, and it seemed that those of us with a religious heritage were significantly better off than those without. I think having the Presidents of those institutions get together twice a year, and meeting on different campuses each time we met, enabled us to see the best parts of those institutions and come home and try to emulate some of that on our own campus.

We also collected a ton of data from those institutions, and so we had salary data, we had teaching load data, we had space data, we had "you name it" data. And so we were able to benchmark ourselves against all those institutions. The faculty and staff were informed of those benchmarks so they knew where we stood. The Board was informed of those benchmarks, so the Board knew where we stood, and I think that just, you know, again developing that understanding with everybody helped the institution progress.

Dr. Fimberg's style of leadership is one of honesty and openness. This approach transcended every interaction he had with College constituency. It was a basic guiding principle. Dr. Fimberg was asked to comment on his leadership style.
Dr. Fimberg:

That (leadership style of openness and honesty) came from my prior institution tour. I tried to do that there, and that met with some opposition. And I'm sure some people here weren't just absolutely delighted that we threw open the books, but that's just the way that I do business.

Dr. Fimberg's leadership style no doubt influenced his relationship and interaction with faculty. As previously stated, when he came to the institution, the nursing faculty was essentially the only faculty on campus, with only three other allied health faculty. During interview, Dr. Fimberg was asked to address both the structure of the faculty and the eventual influence of the addition of non-nursing faculty on the faculty as a whole.

Dr. Fimberg responded:

It's as we said before, a lot of the nursing faculty, which is still the largest single faculty on campus, and I don't want to just dwell on that but just to use that as the example, had not had collegiate experience, but everybody coming into Arts and Sciences had prior collegiate experience. And I think nursing faculties operate like nursing faculties have done for 100 years, and still do today. Collegiate faculties operate a little bit differently.

As previously addressed, Our Lady of the Lake College had an agreement of mutual understanding with Loyola University in New Orleans to offer the General Studies courses, beginning in 1990. Approximately mid-way through the self-study process, a crisis occurred that was precipitated by the Executive Council of the Commission on Colleges: SACS. With no warning, the Executive Council issued a statement of reinterpretation of Condition of Eligibility Number 6. Institutions seeking
and reaffirming membership must comply with all thirteen conditions of eligibility. The reinterpretation of Number 6 required that an institution must offer all courses leading to at least one of its degree programs. That meant that the relationship with Loyola to offer the general studies courses violated the requirement.

Dr. Fimberg related how he learned of the Executive Council decision at a meeting in Chicago:

We were not yet accredited. I'll never forget. I was at a meeting in Chicago, walked into the hotel lobby.... Walked into the lobby of the hotel, ran into Jim Rogers, who is the Executive Director of the Commission on Colleges of SACS. He says, "Jim, I've got news for you." I said, "What's that?" He said, "The executive council just voted that an institution must offer all work leading to at least one degree." And I said, "What does that mean?" He said, "It means that you've got to offer your general studies work." I said, "Look, we're halfway through the accreditation process. We can't do that." I said, "You can't make that retroactive." He said, "Well, we've done it."

It was of interest, of course, as to what prompted the Executive Council to carry out this action. The faculty and administration of the College felt justifiably threatened that the action was a political maneuver by the Council to thwart accreditation. By this time, there were two similar institutions in the accreditation pipeline with the Southern Association. Was the legitimacy of this type of institution being questioned? What were the implications for accreditation outcome? Repeated communications with the Commission on Colleges indicated that the action was not specifically directed toward the three institutions which originated from diploma programs in nursing, although they
conceded it was unfortunate that these institutions were adversely affected by the reinterpretation.

Although the College planned to offer all courses following accreditation, it was forced to terminate its agreement of mutual understanding with Loyola University to offer the general studies component of the degree programs in December of 1992 (Loyola continued its B.S.N. completion program). Beginning in January, 1993, all courses leading to an associate degree were offered by Our Lady of the Lake College. Students were advised that course credit earned in 1993 would most likely not be transferable.

Dr. Fimberg discussed the events surrounding these issues:

I came back (from Chicago) and, fortunately, we had a Board meeting shortly after that and I think the meeting was in May. Our Board met in June, and I informed the Board of what the problem was and the board just immediately said, "Hire somebody and offer the courses. When do you think you can have it done?" And I said, "January." Paul Murrill, who's a former Chancellor at LSU, was on the Board at that time. He said, "Why can't you do it in August?" Well, this was June, and I said, "Paul, I don't think we can put it together for August." He said, "I could put it together for August." I said, "Well, I don't think I could, but I can tell you I can have somebody and have it in place by January."

It was in place in January. But here again, this is one of those decisions, this is a policy shift that the Board has to approve and one that the Board did not hesitate one moment in saying, "This is what we need to do to get accredited, this is what we need to do. Do it."

The commitment of the Board has been here from the beginning and, I've said repeatedly, I've had not one instance of lack of support from the Board. And I think this is as good an example as you're going to find of Board support.
The remainder of the accreditation process was uneventful and in June, 1994, the College achieved its goal of full membership in the Commission on Colleges: Southern Association of Colleges and Schools. This achievement was significant in that full membership was awarded without the usual period of candidacy preceding membership. No other beginning institutions are known to have received initial accreditation by SACS without candidacy. The first health sciences college that transitioned from a diploma program in nursing to achieve SACS accreditation was the College of Health Sciences in Roanoke, Virginia. This college, unlike Our Lady of the Lake College, failed on its first attempt to achieve candidacy and then entered a period of candidacy prior to accreditation. Georgia Baptist College of Nursing, another college transformed from a hospital-based diploma program in nursing, followed Our Lady of the Lake College in the accreditation process and also received candidacy status prior to full membership.

Following regional accreditation of the institution, the Louisiana State Board of Nursing granted full approval to the program in nursing. Accreditation by the National League for Nursing was achieved in 1995 and reaffirmed in 1999.

The decision to offer the General Studies courses had a major impact on the College development. Dr. Fimberg identified two ways in which that decision benefited the College: (1) it helped to establish the credibility of the College as a legitimate collegiate institution, and (2) it provided additional revenues to offset the more expensive professional degree programs. Accreditation and approval standards of nursing and allied health programs typically require a very low student/instructor ratio in
the clinical areas. For example, for continued approval by the Louisiana State Board of Nursing, the ratio cannot exceed 10 students to one faculty member in the clinical component of instruction. In comparison, arts and sciences ratios can be significantly higher. Even when class sizes are small, one instructor can teach a class of 20 - 25 and carry a greater class load. So fewer faculty are needed to teach a greater number of students.

Dr. Fimberg continued:

We were able to hire a lot of the same faculty members as adjuncts that Loyola was using. But again, they were adjunct faculty members, and being part-time, did not have participation in the faculty, which I think has been a disadvantage to this institution and I think we could get into a long discussion about advantages and disadvantages of part-time faculty. I think this institution still needs a larger core of full-time Arts and Sciences faculty, and have less dependence on part-time. For budgetary purposes, you have to be careful because any enrollment shift can result in too many full-time faculty and then you're going to dig a budget hole. And if you have enough part-time faculty... well, you just don't hire somebody that semester. So, here again, another one of those issues and another delicate balance, particularly institutions of this type where you have a large number of part-time Arts and Sciences students whose intention it is to move into one of the professional programs.

The issue of Arts and Sciences students progressing to professional programs of study has been of concern since the transformation of the College in 1990. All students entering the College are first admitted into the Division of Arts and Sciences (formerly called General Studies) where they complete the pre-requisites for entry into either the Division of Nursing or the Division of Allied Health. There are many more students in
Arts and Sciences than there are places for them in the professional programs.

Admission into the Nursing and Allied Health programs is very competitive. Without degree programs in Arts and Sciences, students who are not admitted into the professional programs have no progression options.

Dr. Fimberg commented:

The issue was what do you do with them? And so, one of the first things we did was develop a general studies associate degree. You might look at that as a booby prize, but for people who didn't get into a program, at least they could go away with something. You know, associate degree in Arts and Sciences, or whatever, with a dollar will buy you a cup of coffee at most places. I mean it's not a terminal degree that provides you job opportunities, but it shows that you followed a pattern of work to achieve a goal, and it will provide the background for further study. But it gave them something, and I think in doing that, then that then leads to well, why can't we just keep them here and offer a few more courses and some more degrees and go into the baccalaureate level? The College is now approved (by SACS) to offer bachelor's degrees, but it's going to take a while for those programs to develop. But I think that was the right direction to go.

I don't think the direction of the College will ever change significantly. I had, at one time, thought we would get to maybe 2,000 students. That's not going to happen without a greater physical presence in the community. We're kind of tucked away in a medical office complex. Very nice facilities comparable to anybody's anywhere, nice surroundings, just a great place to be. But it doesn't have enough physical presence to serve the public relations purposes of the institution. And without a campus that is visible, then I think I was a bit optimistic in my projections of enrollment. I figured we'd get to 1,800 to 2,000 students, but right now I don't think that's possible. Maybe 1,200. You know, that's off the top of the head. And what's wrong with 1,200?

Establishing a physical presence in the community has been a major concern for quite
quite some time. The challenges to overcoming the image of "just a nursing school" are compounded by the absence of a visible campus. When the institution was established as degree-granting in 1990, the Nursing Building at 7500 Hennessey Boulevard was the single college building. In 1994, the Allied Health Building at 5345 Brittany Drive was acquired and in 1996, the Science Building was built adjacent to the Allied Health Building on Brittany Drive. In 1997, the General Studies Building on the corner of Dijon and Hennessey was acquired, bringing the total of College buildings to four. In 2000-2001, the College will be adding one building on Essen Lane and possibly two more on Brittany Drive. Because of the discontinuous design of the campus, it is still impossible to say "there is Our Lady of the Lake College."

The Board of Trustees has been grappling with the issue of a visible campus and has given serious consideration to a number of options that would give the College a more substantial presence within the community. Dr. Frnberg was asked to comment on this issue.

Dr. Frnberg:

In fact, we had two different groups of architecture students from LSU work with us in developing master plans, and, you know, just to me the big thing was one of finance. If we could come up with 10 to 20 million dollars, that somebody would just drop in our laps, we could have that physical presence, but you know when you're dependent on the hospital and their revenues were declining because of Medicare reimbursement business, that just wasn't going to happen. And hasn't happened yet, and I don't see it happening tomorrow.
While reliance on Medicare for support of the College budget can be considered a disadvantage, there are advantages in being associated with a major regional medical center. Dr. Firnberg addressed the advantages of the College's relationship with the hospital.

Dr. Firnberg:

Our big advantage is that we have that great big hospital right across the street, and that provides the clinical facilities that we utilize to the max, although we use other facilities, and there are certain procedures that we can't do here. They won't allow our Emergency Health Science students to do live intubations, which they have to do, so they have to go to another facility to do that. There's no ob/gyn at this hospital so our nursing students have to go to Woman's hospital to do that. I think everybody ought to have a rotation through Charity Hospital just to see what the situation is there. I think we have a significant advantage in having these clinical facilities.

The hospital, of course, also benefits from its relationship with the College. The College is the largest producer of area health care workers that are needed throughout the health care industry.

Dr. Firnberg:

I think it's a symbiotic relationship, and you know, win, win, if you want to look at that. They would certainly get to see all of our students rotating through that facility and, hopefully, know the ones that they want to hire upon graduation. Otherwise, why would they want to spend the money to operate the program? As long as we're providing health care workers for the greater community, then we're fulfilling our mission. The mission is not solely for Our Lady of the Lake Regional Medical Center to hire our graduates, but for the graduates to stay and work in the greater community of Baton Rouge, and provide a service to this area.
The Franciscan Missionaries of Our Lady continue to be a strong presence and a consistent source of support for Our Lady of the Lake College. Although they now function peripherally to the College, their interest and enthusiasm for the College has never wavered. Their mission is twofold: health care and education. The College effectively integrates the FMOL mission.

Dr. Fimberg reflected on his relationship with the Sisters:

When the Board had asked me to take this job, I went and introduced myself to some of the sisters. I went to see Sister Brendan Mary, who was the Provincial, and said, "Well, Sister, I guess you can tell that Fimberg is not your typical Irish Catholic name," and I said, "My father was Jewish, my mother was Presbyterian, I'm a Methodist, but I went to a Catholic school for twelve years." And her response was, "We're all God's children."

I've enjoyed my association with the sisters. And I think, without exception, I got along very well with all of them. A brief struggle with one or two along the way, but probably got along with some of them better than a lot of other folks. I just I think they're special folks, and they've got a mission that I think, if everybody would emulate to a degree, the world would be a lot better off. I've enjoyed my association with them, and today, you know, still do. Still see some of them and saw one at lunch recently. Got a big hug.

The continuing support of the Franciscan Missionaries of Our Lady is integral to the success of the College. Sister Brendan Mary, Provincial of the North American FMOL was interviewed on September 28, 2000. She related that she had come to Baton Rouge from Ireland while Sister Agnes Marie was Director of the School of Nursing in 1963 and graduated from the nursing program in 1966. She said she barely had time to blink before Sister Agnes Marie had sent her off to earn her Bachelor of Science degree.
in Nursing in St. Louis. She affirmed Sister Agnes Marie's dedication and commitment to professional education and excellence.

When the College was transformed in 1990, Sister Brendan Mary was one of the first members of the Board of Trustees. She recounted that she was pleased that the School of Nursing was transforming to collegiate status. She thought that the transformation was a sign of progress and provided more options to students who wanted to continue their education.

Sister Brendan Mary shared her concern that the addition of the allied health programs may have been an over-extension from the primary mission of the College. She continues to seek assurance that the College is "good enough" at what it does, continuing the tradition of excellence (September 28, 2000). She also discussed at length her concern for the spiritual environment of the College. She said that for too long the Sisters believed that the Catholic values of the FMOL were observable to everyone within the organization. Just as the Sisters have sponsored a mission effectiveness campaign for the hospital, Sister Brendan Mary would like to see some sort of educational program provided for College faculty and staff that would develop greater awareness of the Franciscan tradition.

During the interview on September 28, 2000, Sister Brendan Mary confirmed that in the earlier stages and even in the mid-life of the organization, the Sisters had the same expectation of the student nurses as they did themselves. She said, "We overemphasized religion. It took us a long time to realize that the student was a nurse
and not a Sister" (September 28, 2000). Sister Brendan Mary expressed that she thought the College should place more emphasis on medical ethics as well as general ethics.

At the close of Dr. Fimberg's interview, he had one more story to tell:

This was our last accreditation visit. Apparently, during the visit some of the SACS visitors expressed concern about the influence that the Sisters or the Board might have, or the hospital might have, on the college. And so they dispatched Harry Nickens, who is President of the College of Health Sciences in Roanoke, to visit with Bob Davidge, who is the CEO of the Medical Center. And so Harry goes to see Bob to ask him about the undue influence. And Bob thinks, well, he really ought to go see one of the sisters. And so he sends him to go see Sister Magdalene O'Donovan. And so Harry goes to see Sister Magdalene, who at that time was serving on our Board. And so in Dr. Nicken's conversation with Sister Magdalene, and I think I'm quoting Harry correctly, she says, "Mr. Nickens, let me explain something to you. The final authority of operation of the college does not rest with the college Board. The final authority does not rest with the hospital Board. The final authority rests with the Sisters." Harry goes back and he tells the SACS committee in their executive session that night that same story, and adds, "And they report directly to God." And that was the end of the concern. And so that was the end of that story, and they didn't ask any more questions about undue influence on the Board of the college.

Dr. Fimberg was unquestionably successful in establishing the College as a legitimate presence within the higher education community. In response to his leadership, the College grew from a student population of 220 in 1990 to 961 students in 1998. Programs in Physical Therapy Assisting, Emergency Health Sciences, and Medical Laboratory Technology were added to the existing Allied Health programs. All Nursing and Allied Health programs are accredited by their respective accrediting
agencies. The College's accreditation and its substantive change as a bachelors degree-granting institution was reaffirmed in 1999 for a ten-year period by the Southern Association of Colleges and Schools.

In 1998, the College was approved as a four-year institution to offer a Bachelor of Science degree in Nursing. Since that time, additional bachelor's degree programs have been added in Arts and Sciences and Allied Health.

There is no doubt that Dr. Fimberg's previous experience in higher education helped to establish the College's independence from the hospital. He was able to win the confidence and trust of hospital administration, the faculty and the Franciscan Sisters.

With his keen business sense and attention to financial detail, Dr. Fimberg earned the trust of hospital administration. During an interview (September 27, 2000), Mr. Davidge confirmed his trust in Dr. Fimberg:

Jim Fimberg made it easy to trust him. He was very experienced and well respected within higher education. He knew what he was doing. I trusted his judgment. I had utmost confidence in his ability.

A New Era of Leadership: 1998-2000

Upon Dr. Fimberg's retirement in 1998, Dr. Michael Smith was appointed President of the College. Dr. Smith's prior administrative experience includes that of Chancellor of LSU-Eunice. Like Dr. Fimberg, Dr. Smith brought years of higher education and administrative experience to the position. His challenge is to expand the programs of study, to continue the growth of the College and to further establish the
College within the religious community and the community at large, while maintaining its presence within the healthcare and higher education communities.

While the College has always defined its identity in relationship to its Catholic tradition and sponsorship by the Franciscan Missionaries of Our Lady, it has not fully explored what that identity means in terms of its educational programs and other areas of function. This situation is not unique among Catholic colleges and universities.

On August 15, 1990, Pope John Paul II issued an apostolic constitution on Catholic higher education entitled "Ex corde Ecclesiae." The Apostolic Constitution described the identity and mission of Catholic colleges and universities and provided General Norms to help fulfill its vision. Recognizing that the Apostolic Constitution "Ex corde Ecclesiae" is normative for the Church throughout the world, this document seeks to apply its principles and norms to all Catholic colleges, universities, and institutions of higher learning within the territory encompassed by the United States Conference of Bishops (United States Catholic Conference, July 2000).


In an attachment to the agenda of the September 28, 2000 meeting of the Board of Trustees of Our Lady of the Lake College, Dr. Smith included the "Background, Requirements, and Discussions Related to Ex corde Ecclesiae" (Minutes of the Board of
Dr. Smith summarized the requirements of "Ex corde" that directly and most immediately affect the College:

1. That "to the extent possible, the majority of the board [of trustees] should be Catholics committed to the church."
2. That the college or university "should strive to recruit and appoint Catholics as professors so that, to the extent possible, those committed to the witness of the faith will constitute a majority of the faculty."
3. That the college or university "president should be Catholic." There is an exception clause.
4. That Catholics teaching theological disciplines have a "mandatum" from "competent ecclesiastical authority." The "mandatum", the norms explain, is the Catholic Church's acknowledgment formally given by the "competent authority" -- the local bishop -- that a Catholic theology professor "is a teacher within the full communion of the Catholic Church."
5. That the institution "provides courses for students on Catholic moral and religious principles and their application to critical areas such as human life and other issues of social justice."

The Ex corde document had also been distributed with the agendas for the Board of Trustees meeting in March and May 2000. It was briefly discussed at both meetings.

The document was also distributed prior to and discussed at the May and August 2000 meetings of the College Faculty Assembly. In addition, Dr. Smith and Dr. Carole Grover, Vice President for Academic Affairs, met with Bishop Alfred Hughes on September 1, 2000 to discuss the details of a proposed implementation plan. That plan was also discussed at the May and August meetings of the Faculty Assembly. Two separate memorandums were also sent to College faculty in order for Dr. Smith "to
respond more thoughtfully to concerns raised at the two Faculty Assembly meetings" (Minutes of the Board of Trustees, September 28, 2000).

The vast majority of the faculty and Bishop Hughes have found the implementation policy, as drafted, to be satisfactory. Dr. Smith has also discussed implementation procedures with Fr. Thomas Chambers, President of Our Lady of Holy Cross College in New Orleans and with Msg. John Stryckowski, an advisor to the U.S. Conference of Bishops. Both Fr. Chambers and Msg. Stryckowski believe the policy, as drafted, is appropriate.

It is Dr. Smith's plan to present a revised draft of the implementation plan to the faculty for discussion and also to Bishop Hughes. After all concerned (faculty, Bishop Hughes, and the Board of Trustees) are generally satisfied with it, Dr. Smith plans to present it to the Board of Trustees for formal adoption at the March or May 2001 meeting of the Board.

The adoption of the implementation plan for Ex corde will position the College more firmly within the religious community and will guide the College as it further defines its Catholic identity. It is of importance to note that Dr. Michael Smith is a member of the Catholic faith, although that criteria was not a consideration in his appointment to the position of President in late 1998.

The adoption of the implementation plan for Ex corde is also important to the establishment within the community at large. Dr. Smith has been instrumental in increasing and accelerating marketing efforts within the community at large. As the College has become more enrollment driven, due to decreasing revenues from the
hospital and greater dependence on revenues generated from tuition and fees as well as other revenue sources, marketing has become increasingly important to the success of the College.

A component of the marketing strategy is the College's Catholic identity. As the only Catholic college in Louisiana outside the city of New Orleans, and within a geographical region that is predominately Catholic, it is important that the College be recognized as a Catholic institution of higher education by the Catholic community.

In addition, the College continues to struggle with its traditional image as a "nursing school." Increased marketing strategies, coupled with the addition of baccalaureate degree programs, are considered responsible for the Fall 2000 enrollment increase of 14 percent over Fall 1999. For the first time, the College exceeded an enrollment of 1000 students.

With increasing enrollment comes the need for additional physical facilities to accommodate the increasing numbers of students, faculty and staff. The College has acquired two more buildings and the promise of a third. One of the three buildings should be ready for occupancy in early 2001. Another is the former Channel 33 building which will provide "a front door" on Essen Lane and help define a campus and should be ready in early summer of 2001. The acquisitions will help to alleviate the current and projected space shortages.

Whereas the question of a visible campus was still an issue during the past year, with the addition of three buildings in the same area, it now looks like the campus of the college will remain adjacent to the hospital complex. That decision has probably been
made. The availability of buildings, along with the College's commitment to healthcare education, makes sense both economically and symbolically.

It would be impossible not to compare and contrast the leadership styles of the College's two presidents. Dr. Fimberg's approach to leadership was appropriate to the re-developing institution in its childhood. At that time, the College required a paternal figure to provide surrogacy to the parental role that the hospital had sustained since the founding in 1923. As the College established independence from the hospital, a strong, involved leader was needed to provide psychological safety to internal as well as external constituencies who all had a stake in the success of the College. As an allied health faculty member stated during interview on October 6, 2000, "Dr. Fimberg always knew what was going on. He kept personally involved with all internal aspects of the College and its programs."

In comparison, Dr. Smith has created a decentralized administrative structure, which is appropriate to the College at this point in its continuing development, which is similar to that of adolescence in human development. Whereas Dr. Fimberg was the final authority on all decision making matters of the College, Dr. Smith has delegated more authority to three vice presidential positions that were created in 1999 and 2000.

Since little is known about organizations that have experienced rebirth, it is difficult to determine how much of the previous culture will be retained. Organizational changes that are true transformations, not merely incremental adaptation, probably reflect culture changes at this level. In the evolution of companies such transformations
occur periodically, and at those times the direction of the changes is not always predictable.

In order to determine how the culture of the College may differ from the previous culture of the School of Nursing, I decided to interview both a current Allied Health faculty member and a currently enrolled Allied Health student. These interviews were conducted the first week of October, on the 4th and 5th, respectively. Both were non-taped, semi-structured interviews. Anonymity was assured for the interviewees because they are currently associated with the institution.

The Allied Health faculty member was interviewed in her office on October 4, 2000. She has been employed as a full-time faculty member with the institution for five years. She was asked to describe the changes within the institution that she has observed or experienced over the past five years. She responded:

When I first came to the College, I didn't know what to expect. I had never taught before and really didn't know what was expected. But everyone was so very helpful, especially Dr. Joe Ann Clark [the Dean of Academic Services], in helping to get our Allied Health program off the ground.

As time went on, it was clear that nursing was the dominant force on the faculty and within the College. It was frustrating for a few years, because it didn't seem that we or our students mattered as much to the College as a whole [as did Nursing]. Dr. Fimberg was very involved in everything that was going on and I think he understood our frustration.

There is a certain level of professionalism among the faculty of Allied Health and Nursing that is not shared with Arts and Sciences faculty. I mean, we take our disciplines very seriously. We expect our students to be professional and we respect them for who they are. We respect their individuality and want them to succeed. I do not think we are as much into discipline as is the nursing
faculty. Maybe it is because we have smaller classes and fewer faculty and get to know each of our students individually. We spend so much time with them. We bond.

It is very rewarding to be a faculty member in this institution. We feel very cared about, now. We feel we are important to the institution more than we did before.

The Allied Health student who was interviewed on October 5, 2000 shared her experiences as a student at Our Lady of the Lake College:

I wouldn't want to be in school anywhere else except Our Lady of the Lake College. I went to LSU for a couple of years and it was nothing like this. I hated it. Nobody cared about me. The faculty members never knew my name. Nobody cared whether I passed or failed. When I came here, it was so very different. Having the same two faculty members with you every day makes a big difference. We are like family. I know they want me to pass and they help me a lot. It is hard, though. The courses require us to study a whole lot more than I was ever used to doing. And the tests are hard too. But that is what makes us so good when we graduate. I am close to all my classmates too. We are all different, but we get along. I think it is because of the caring and respect that our faculty have for us that we have the same for each other.

Everyone at the College cares about us -- from admissions to financial aid. We even have a relationship with the housekeeping staff. Everyone is very professional.

As the College has grown and developed, it has done so essentially around the Division of Nursing. Although it is still early in the life cycle of the transformed institution, it seems that the current culture of the College places the student at the center of the educational environment; however, this change has not yet been fully realized within the Division of Nursing. Both the Allied Health faculty member and the
Allied Health student feel cared for, respected and appreciated. Noticeably similar to the historical culture is the value placed on professional excellence. Based on this very small sampling, it is posited that there are, in fact, at least two separate cultures operating within the College. This is not unusual in that subcultures often have their own distinguishable characteristics. However, it is desirable that the organized groups within the whole share a common culture.

No doubt the recent change in presidential leadership will have an impact on the culture of the organization. In addition to a new President, the College also has a new Vice President of Academic Affairs who came to the institution in 1999, and in August of 2000, a new Acting Dean of the Division of Nursing was appointed. Also, in August 2000, a new Vice President was appointed to the Health Career Institute, which is an expansion of the existing continuing, non-credit unit of the College. How the institution adapts will depend largely on its leadership.
CHAPTER 9
DISCUSSION AND CONCLUSIONS

The purpose of this study was to investigate the historical development of Our Lady of the Lake College within the evolutionary contexts of the nursing profession, nursing education, and higher education. Included in this investigation is an exploration of the College's continuous, interdependent relationship with its sponsoring organizations, the Franciscan Missionaries of Our Lady and Our Lady of the Lake Regional Medical Center. A secondary purpose was to explore the student experience within the context of the evolutionary development of the institution. It was hoped that this investigation would contribute to what is known about socialization to a professional role within the context of American higher education as well as women's post-secondary educational experiences.

The research questions were:

1. How has Our Lady of the Lake College, as an organization, evolved in the seventy-seven years of its history?

2. What environmental factors elicited a response of organizational change?

3. How have the institution’s experiences affected the students’ experiences?

Our Lady of the Lake College has always been a component unit of Our Lady of the Lake Regional Medical Center, the Franciscan Missionaries of Our Lady, the Catholic Church, the health care industry, nursing both within the state and nationally, and nursing and education. In recent years, it has also become a component of allied
health education and a major producer of allied health practitioners. All of these social components external to the College influenced its culture and its evolution. The institution’s internal structural units include trustees, administration, faculty, staff and students.

The application of the conceptual framework of organizational behavior and change informs the organization, discussion, and analysis of the evolution of the institution and the factors that elicited a response of organizational change. The evolution of the institution can be viewed by the division of its life-cycle into four distinct phases: the founding phase (1923 - 1949); the mid-life of the organization (1950-1979); the mature and declining institution (1980 - 1989); and the rebirth (1990 - present).

Organizations evolve through a series of life-cycles in response to a changing environment which can effect a state of disequilibrium of the organization. In order to adapt to the changes within the environment so that balance and stability are regained, the organization must unfreeze its culture to accommodate change.

Schein (1992) explains the process of change as follows:

All change occurs through the mechanisms of disconfirmation, the creation of guilt or anxiety, and the creation of psychological safety. When these three factors are in appropriate balance, the system is unfrozen and becomes motivated to change. Change then occurs through cognitive redefinition of key concepts, and the resulting behavioral changes become refrozen in the personalities of the individuals and in the norms and routines of the group (p. 312).
Schein (1992) further explained the triadic factors that result in change. Disconfirmation results from disconfirming data that causes serious discomfort and disequilibrium within the organization. The connection of the disconfirming data to important goals and ideals of the organization causes anxiety and guilt. Psychological safety refers to the sense of seeing a possibility of solving the problem without loss of identity or integrity, thereby allowing members of the organization to admit the disconfirming data rather than defensively denying it.

The importance of visionary leadership can be understood within this context. Vision often serves the function of providing the psychological safety that permits the organization to move forward. New visions are most important when people are ready to pay attention, and they are only ready to pay attention when they have consciously or unconsciously been exposed to accumulated disconfirming information (Schein, 1992).

The unfreezing of the culture of Our Lady of the Lake School of Nursing that resulted in changing transformations to each succeeding life-cycle stage occurred in response to both internal and external forces. The first life-cycle transformation, from the early developing to the mid-life of the organization, was spirited by the leadership of Sister Agnes Marie Fitzsimmons who served as Director of Our Lady of the Lake School of Nursing from 1943-1947 and again from 1956-1966. Sister Agnes Marie's visions were influenced by the effects of World War II on nursing and nursing education, by the Catholic Hospital Association, and by her own educational and professional experiences.
The second life-cycle transformation to the mature and declining stage of the organization occurred when disconfirming information was received from the National League for Nursing during the accreditation process in 1976. This coincided with the relocation of both the hospital and the school to Essen Lane which symbolized continuing support of the Sisters and the hospital administration to the school of nursing. Within just a short time, however, the school was relocated to trailers behind the hospital.

The relocation to the trailers caused much anxiety among faculty. This was the first time that the school had received disconfirming information from the sponsoring hospital which implied that the school was dispensible by the hospital.

The return of the faculty to graduate school to earn advanced degrees in nursing as required by the Louisiana State Board of Nursing resulted in their becoming increasingly aware of and sensitive to the entry level into nursing debate and the concomitant educational issues. This awareness lead to the decline of the school of nursing and the rebirth of the organization as a transformed institution of higher education. Table 9.1 summarizes the external influences on the evolution of the organization at each phase of its life cycle.

Throughout the evolution of the organization, the socialization of students into the professional role has been the preeminent function of the institution. Students from 1923 to the present have experienced the culture of the institution through the shared basic assumptions that have persisted as the organization moved through its sequential life cycles. It is the essence of the shared assumptions that has determined the student's
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<td>Catholic Hospital Association</td>
<td>Relationship with Nursing and Nursing Organizations</td>
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<td>Catholic Hospital Association</td>
<td>Relationship with institutions of Higher Education</td>
<td>Relationship with Higher Education Community</td>
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<td>Relationship with Accrediting Agencies of Higher Education</td>
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<td>Relationship with the Community at large</td>
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<td>Relationship with Religious Community</td>
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experiences within the context of the institution's experiences. Table 9.2 summarizes the predominate themes that emerged from the study in the interviews with former students across the life-cycle of the organization.

"Organizational culture can be analyzed at three levels: (1) visible artifacts; (2) espoused values, rules, and behavioral norms; and (3) tacit, basic underlying assumptions" (Schein, 1992, p. 47). Schein argues that unless one digs down to the level of basic assumptions, the artifacts, values, and norms cannot really be deciphered. If the basic assumptions and their relationships are explored, the essence of the culture can then be explained.

It is helpful to return to Schein's (1992) definition of the culture of a group as presented in Chapter 2. Schien defines the culture of a group as:

...a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems (p. 12).

As a mechanism of social control, culture can be the basis of explicitly manipulating members into perceiving, thinking, and feeling in certain ways. When culture is brought to the level of the organization and even down to groups within the organization, one can see more clearly how it is created, embedded, developed, and ultimately manipulated, managed, and changed. These dynamic processes of culture creation and management are the essence of leadership (Schein, 1992).
Table 9.2

Repetition of Socialization Themes by Former Student Interviewees

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<tr>
<td>Vocational Calling</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Rituals of Inclusion</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Self-sacrifice</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Obedience/Conformity</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Rules/Discipline</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Domesticity</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Religious Practice</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Care/Compassion</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Subordination To Physicians</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>And/or Institution</td>
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<tr>
<td>Student-to-Student Support</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Fear</td>
<td>X</td>
<td>X</td>
<td>X</td>
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To understand a group's culture, one must attempt to get at its shared basic assumptions and one must understand the learning process by which such basic assumptions came to be. The assumptions are the residue of the learning process as the institution has learned to adapt to external and internal stresses and pressures.

Following a thorough exploration of the artifacts, values, rules, and norms of behavior of Our Lady of the Lake College over the life of the institution, the basic cultural assumptions of the School of Nursing were identified and compared to the emerging assumptions of the college culture. Table 9.3 presents a comparison of the assumptions.

According to Kilmann, Saxton, & Serpa & others (1985), when cultural elements change or are changed, people experience loss and react with grief. Loss triggers two impulses: one is to hold on to the past, the other is to rush headlong into the present to avoid the anguish.

As the College has developed, it has been observed that the Division of nursing seems to have held onto its past. The culture of the Division of Nursing is not pervasive throughout the College. The culture of the College "feels" different than that of the current Division of Nursing. It is helpful to summarize how these assumptions evolved over the life of the institution.

**Founding and Early Growth: 1923-1949**

In the first stage, the founding and early growth of a new organization, the main cultural thrust comes from the founders and their assumptions. Schein (1992) explains that the cultural paradigm that becomes embedded if the organization succeeds in
fulfilling its primary task and survives can then be viewed as that organization's distinctive competence, the basis for member identity, and the psychosocial "glue" that holds the organizations together. The emphasis in this early stage is on differentiation.

Table 9.3

<table>
<thead>
<tr>
<th>Cultural Assumptions School of Nursing</th>
<th>Emerging Cultural Assumptions College</th>
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</thead>
<tbody>
<tr>
<td>Nursing education requires character formation</td>
<td>The student is at the center of the learning environment</td>
</tr>
<tr>
<td>Students do not have the same rights as patients</td>
<td>Student/faculty interaction is valued</td>
</tr>
<tr>
<td>Program success is determined by licensing test pass rates</td>
<td>Human beings have equal rights</td>
</tr>
<tr>
<td>Clinical experience is the most important component of nursing and allied health education</td>
<td>All students have potential; Student potential is to be nurtured and cared for</td>
</tr>
<tr>
<td>Nursing is elitist; not everyone can be a nurse</td>
<td>Student success is valued</td>
</tr>
<tr>
<td>Conformity in appearance, behavior, and cognition is required/valued</td>
<td>Individuality is celebrated.</td>
</tr>
<tr>
<td>Students and faculty must defer to authority</td>
<td>Institutional effectiveness is multidimensional</td>
</tr>
<tr>
<td>Fear is the basis of submission to authority</td>
<td></td>
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<tr>
<td>The hospital is the respondent superior</td>
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<tr>
<td>Professional education is more important than liberal education</td>
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</table>
from the environment and from other organizations. The organization makes its culture explicit, integrates it as much as possible, and teaches it firmly to newcomers.

Ms. Steib's account of life as a student nurse is consistent with Schein's (1992) view of a newly established organization as described in the literature. Analysis of the historical relationship of Our Lady of the Lake College with Our Lady of the Lake Regional Medical Center suggests a prolonged dominant-subordinate environment. In the beginning, the Sisters were the dominant presence and exerted their control through the socialization process of student nurses. Although the Sisters, themselves, were surprisingly autonomous in carrying out their ministry within the Catholic church, their commitment to a religious life required strict adherence to obedience, self-sacrifice, and service. In order to fulfill their ministerial mission, they sought to socialize their protégés to the same cultural beliefs and customs. They kept the life-style of the students as similar to their own as was possible without requiring the lay women to takes vows. The Sisters created a controlling environment, imbued with the values of their own culture that required the students to share in the belief system in order to gain membership into nursing. Thus, the value system of the Sisters as women religious was infused into the professional development of nurses and became the value system of the culture of the school of nursing. Failure to obey resulted in expulsion; thus, the fear of being sent home and failing in one's personal goals.

The Sisters created an educational environment that approached what Goffman (Melosh, 1982) referred to as a total institution where "inmates" slept, ate, worked, worshipped, and played together. A total institution is one which is a closed system,
allowing very little interaction with the external environment. It is apparent that the environment created by the Sisters was very close to that of a convent. The Sisters kept the students very close to them, both physically and culturally and cared for them in the absence of their parents.

Religious themes in nursing were common at the turn of the nineteenth century and well into the 1930s nationwide. "Character formation" was a term used to describe the formal process of socialization to membership within an order or congregation of women religious. The concept of character formation was very prevalent during this stage of the institution's life cycle. In fact, the student records of the era identify and enumerate the behaviors on which the student was graded as "primary behaviors" (pp. 101-102 of this document).

As Kauffman (1993) pointed out, the Sisters were challenged to create an apostolate within a pluralistic society where the sick were viewed as suffering children of God. The Sisters were very maternal in their approach to care of the sick within a homelike environment that was very domestic and socially isolated. Families were not allowed to stay with their members during hospitalization. Similarly, students were allowed very little contact with the outside world.

Nursing was considered a vocational calling, as was the commitment to a religious life. Within the religiously sponsored environment of the hospital and school, where the sisters were also nurses, it is not unusual or unlikely that a distinction between the two vocations would be somewhat blurred. This was part of the normal
process in the evolution of nursing, whether the sponsoring order was Catholic or Protestant.

The hierarchical structure of the hospital did make the distinction, however, between the sisters and the nurses. Both nurses and physicians approached the sisters with respect and reverence appropriate to their calling and mission. In contrast, Nightingale's military influence on nursing and hospital structure imposed the hierarchy of nurse-to-nurse subordination as well as physician-to-nurse subordination. While Nightingale placed nursing, as a profession, forever under the control of medicine and physicians, nurses took it upon themselves to perpetuate a rank-and file-order within nursing.

While the Sisters cared for the students, providing them with food, clothing, shelter, and the opportunity for education, the actual educational process was delegated to the lay "nurse superintendent" who was responsible for socializing the students to the role of nurse. The rank-and file-order was further reinforced through the practice of senior students supervising junior students. As is common to all apprenticeship relationships, the concept of superior/inferior pervaded nursing education.

Control of nursing education by hospitals led to the exploitation of students as workers to staff the hospitals. This was not in keeping with the model that Nightingale had created. Her model postured the educational facility as separate from the hospital, and funded by an endowment from the hospital. The refusal to permit the schools of nursing, in this country, to remain outside the control of hospital administrators was destined to prevent their development as independent educational enterprises. The strict
discipline and the incorporation of the schools into the hospital business structure almost entirely negated their educational function.

The culture of Our Lady of the Lake School of Nursing, during the early period of growth, was a composite of the values of the Sisters, the nursing profession, and the hospital hierarchy. It is important to distinguish the source of the values in order to track their longevity over the life of the institution.

The cultural values infused from the Franciscan Missionaries of Calais included the religious values of faith, compassion, care, respect, dignity, obedience, self-sacrifice and service, acquired through a socialization process known as character formation. In addition, the Sisters conveyed a strong work ethic characterized by long hours and self-denial. The Sisters cared for both the students and the patients with compassion within an environment of social isolation.

From the evolving definition of the profession of nursing, the culture of the institution reflected order, discipline, cleanliness and hygiene (domesticity), uniformity, and elite membership. The nursing model has always placed the patient at the center, as the focus of care and compassion. Nurses were expected to always place the welfare of the patient before their own. When the needs of the patient and the needs of the student were in conflict, the needs of the sick predominated and the needs of education yielded. The priority pattern of needs of the patient superseding those of the student was firmly established in the hospital training schools.
Change in the Early Developing Organization

Proposals to deliberately change the culture of the organization in its early growth period, either from inside or outside, are likely to be totally ignored or resisted. Instead, dominant members or coalitions attempt to preserve and enhance the culture. The only force that might unfreeze such a situation is an external crisis of survival. If the founding organization itself stays intact, so will the culture.

As Schein (1992) further explains:

...the implications for change at this stage (founding and early growth) are clear. The culture in young and successfully growing companies is likely to be strongly adhered to because (1) the primary culture creators are still present, (2) the culture helps the organization define itself and make its way into a potentially hostile environment, and (3) many elements of the culture have been learned as defenses against anxiety as the organization struggles to build and maintain itself (p. 305).

If the organization is not under too much external stress and if the founders are around for an extended period of time, the culture evolves in small increments by continuing to assimilate what works best over the years (Schein, 1992). Such seems to have been the case with Our Lady of the Lake School of Nursing. No significant changes either internally or externally occurred to necessitate cultural change in the years 1923 to approximately 1949.

According to Schein (1992), basic cultural assumptions defined during the founding and early development stage of an organization are strongly clung to by the members of the organization. One of the mechanisms available to effect change is for
leaders within the organization to locate and systematically promote hybrids in the organization who represent the main elements of the culture, but who have learned some other assumptions that are considered more adaptive.

Sister Agnes Marie Fitzsimmons appears to have met Schein's (1992) criteria for identification as a hybrid within the organization. She served as Director of the School of Nursing from 1943 - 1947. She had received her diploma from Our Lady of the Lake School of Nursing in 1928 and had earned her B. S. degree from St. Louis University in 1942. When she returned to be Director of the program in nursing, she brought with her a natural curiosity, a commitment and dedication to education, and an awareness of changes in the world of nursing, nursing education, and health care.

In 1943, the organization probably looked much as it did in 1923. The School of Nursing had little interaction with the external environment outside of the hospital and remained rather isolated. There was no participation in national nursing organizations or accrediting agencies to provide neither confirming nor disconfirming information. The only national organization that influenced the school was the Catholic Hospital Association and it is unknown how much information was filtered through the hospital to the school. However, the Sisters were very much aligned with the Catholic Hospital Association and were kept aware of changes in health care, nursing and nursing education.

Sister Agnes Marie moved fluidly through the boundaries of the school and the hospital to the broader social environment. It was during her tenure (1943 - 1947) as Director that the "Efficiency Record" was deleted from the student records (1945 and
1946). The "Efficiency Record" recorded the evaluation of the students' character formation. The deletion from the records implies that the applicant would already possess certain requisite qualities desirable for nursing that would be further developed through professional socialization, rather than being a process of character formation, which was the model applied to the socialization of women religious.

The first students to graduate from the Cadet Nurse Corps were admitted to the program in nursing in 1943 and completed the program in 1945. The cadets were trained in 30 months as opposed to the traditional three-year curriculum. This was obviously Sister Agnes Marie's first introduction to a shortened curriculum.

Also in the late 1940s, Father Flanagan, Executive Director of the Catholic Health Association, called for an understanding of professionalization within the context of Catholic identity. He challenged the sisters to balance their traditional idealism with practical realism by stressing the social justice and professional dimensions of Catholic identity. He considered it a moral imperative to be as professionally as good as possible (Kauffman, 1993).

Sister Agnes Marie heeded the challenge and left "the Lake" in 1947 to attend graduate school. She earned a M. S. degree in Nursing School Administration from Catholic University in Washington, D. C. She returned to Our Lady of the Lake School of Nursing in 1956 and continued the cultural transformation that she had begun in 1943.
The Mid-Life of the Organization: 1950 - 1978

Whereas culture was a necessary glue in the growth period, the most important elements of the culture at the mid-life of the organization become embedded in the organization's structure and major processes (Schein, 1992). Hence, consciousness of the culture and the deliberate attempt to build, integrate, or conserve the culture become less important. The culture that the organization acquired during its early years comes to be taken for granted. The only elements that are likely to be conscious are the credos, dominant espoused values, company slogans, written charters, and other public pronouncements of what the organization wants to be and aims to stand for, its philosophy and ideology.

The culture of the early organization of Our Lady of the Lake School of Nursing continued to be reinforced through rituals and traditions such as the probationary period, capping ceremonies, and graduation. These rituals and traditions served to celebrate the culture, ensure its continuance and further solidify it.

Schein (1992) discusses the difficulty in deciphering the culture and making people aware of it at the mid-life stage because it is so embedded in routines. "It may even be counterproductive to make people aware of the culture unless there is some crisis or problem to be solved" (p. 315).

The cultural characteristics of the institution at its mid-life included a shared administrative responsibility for the School of Nursing between the lay nurses and women religious. Under Sister Agnes Marie's leadership, faculty were empowered to facilitate change and institute curricular changes. Emphasis was placed on social justice.
in terms of compensation and employee rights; there was less blind obedience and loyalty to the master hospital; and, students were treated more humanely through changes in hospital staffing patterns and service requirements.

The cultural values that persisted at this stage of the organization's life cycle included: care and compassion; social isolation and grouping; elitist membership; self-sacrifice; deference to authority; and, rules. The cultural value of obedience gave way to conformity and compliance. Emerging values included: social justice; professional excellence; and, program excellence.

Under the direction and leadership of Sister Agnes Marie, the traditional three-year curriculum was shortened to 27 months. She was also instrumental in seeking and obtaining program accreditation by the National League for Nursing. In addition, she was responsible for revising the admission standards to allow married students to enter the program. She stressed professionalism and excellence and inspired others to follow her example.

It is highly likely that it was because of Sister Agnes Marie's influence that changes in hospital staffing patterns and in the conceptualization of apprenticeship learning replaced with educational experience were realized. Sister Agnes Marie possessed a vision that recognized that the replication of the closed social and religious environment of the sisters was not necessary or desirable for the socialization process to professional nursing education. She made a conscious distinction between the socialization process appropriate to the role of women religious and the socialization
process to the role of professional nurse, despite the socialization processes occurring within the same culture.

When Sister Agnes Marie left Our Lady of the Lake School of Nursing to go to Lafayette in 1966, she left the institution in the care and leadership once again of lay nurse administrators. Had Sister Agnes Marie remained for several more years, she may have effected even greater changes in the culture of the organization. Her openness to professional development and curriculum revision in keeping with advances in nursing and health care, as well as her commitment to social justice, were not continued to full potential after her departure.

Among Sister Agnes Marie's greatest accomplishments was her placement of the student at the center of the educational enterprise. She recognized their potential for development and personally applied the Franciscan values of care, compassion, and social justice to her administrative role. With her departure, the presence of the Franciscans diminished and lay nurses once again were left to socialize the students to the nursing role.

Because of Nursing's traditional commitment to subordination of its own members, socialization of nurses by nurses requires subordination. Deference to authority, obedience, self-sacrifice and discipline are hallmarks of subordination. Thus, once Sister Agnes Marie left the organization, the student lost her place at the center of the educational paradigm and was subordinated to the lowest level of the social order. The concept of character formation returned to the culture. This is associated with the elitist nature of membership in nursing. Whereas, elitism was once equated with wealth
and position in society, elitism came to refer to the required behavioral characteristics that were perceived as necessary for a nurse to possess and to be "formed" during the socialization process. These characteristics include the following: respect for authority (physicians, nurses, and rules); obedience; and self-sacrifice.

With nursing education at Our Lady of the Lake School of Nursing so closely integrated with and controlled by the hospital, and with the school in the hands of lay nurses, the patient was once again placed at the core of the educational paradigm. Patient rights always superseded student rights. This paradigm continues today.

**Mid-life Organizational Change**

Unfreezing forces at this stage can come either from the outside or from the inside, as in the first stage. The entire organization, or parts of it, may experience economic difficulty or in some other way fail to achieve key goals because the environment has changed in a significant manner. Or, the organization may develop destructive internal power struggles among subcultures (Schein, 1992).

The NLN accreditation visit of 1976 was the force that unfroze the culture of Our Lady of the Lake School of Nursing during its mid-life cycle. Often missing in this phase is an understanding of what the organizational culture is and what it is doing for the organization, regardless of how it came to be (Schein, 1992).

The School of Nursing was administered by Ms. Bertha Mae Anders following the departure of Sister Agnes Marie to Lafayette. Ms. Anders measured the institution’s effectiveness largely by the graduates' success on the licensing examination. Although she participated in nursing organizations on a local and state level, she was seemingly
not as interested or concerned with reform issues in nursing education. She basically believed that as long as the graduates passed State Board Examinations and provided capable nurses to the hospital, there was no need to change the learning environment. According to the accounts by those who knew her, Ms. Anders was very much a traditionalist who perceived her goal to be perpetuation of the system. This is reminiscent of the lay superintendent of the earlier schools of nursing.

The recommendations imposed by the National League for Nursing on the School of Nursing in 1976 constituted disconfirming information and had a dramatic effect on the educational practices of the school. The recommendations called for a change in practically every aspect of the educational environment. If the school was to survive in a dynamic world of healthcare education, many changes were required. The faculty of the time reported a feeling of anxiety and concern for the future of the school.

The long-term commitment of support by the hospital to the school of nursing and the combined leadership of Ms. Anders and Mrs. Maureen Daniels, the Associate Director of the school, provided the psychological safety that was needed for the faculty to design and implement the changes that would satisfy the recommendations of the NLN. This was a turning point in the life of the institution in that it opened the boundaries of the School of Nursing to the larger world of nursing education. No longer would nursing agencies of accreditation approve or condone its member schools simply on the basis of longevity and history of excellence.

Schein (1992) posited that the succession mechanism must be designed to enhance those parts of the culture that provide identity, distinctive competence, and
protection from anxiety. The identity and competence of the institution resided in the history of excellence of the diploma program in nursing. In addition, the Catholic tradition was equally valued as critical to the organization's identity. The hospital administration's continuing commitment to financially support the school as well as the relocation of the school with the hospital in the late 1970s served to provide protection from anxiety.


Following relocation of the School of Nursing with the hospital to Essen Lane, the focus of the school administration became the adaptation to the new physical environment. For the first time since the very earliest years of the institution, the school was a physical part of the hospital. But, this close physical relationship was short-lived.

By 1986, the school had been temporarily relocated to mobile trailers behind the hospital. The relocation of the school produced anxiety in the faculty in terms of continued support of the school by the hospital.

Coinciding with the relocation to the trailers, the faculty members had all completed graduate degree education programs. They now questioned the excellence of their product, the diploma-prepared nurse, and were exploring strategies to reposition the program in nursing within a higher education environment.

According to Schein (1992), the mature stage is sometimes reached when the organization is no longer able to grow because it has saturated its markets or become obsolete in its products. Maturity is not necessarily correlated with age, size, or number
of managerial generations but, rather, reflects the interaction between the organization's output and the environmental opportunities and constraints.

The Rebirth of the Organization: 1990-2000

If an organization has had a long history of success with certain assumptions about itself and the environment, it is unlikely to want to challenge or reexamine those assumptions. Even if the assumptions are brought to consciousness, the members of the organization are likely to want to hold onto them because they justify the past and are the source of pride and self-esteem. Such assumptions now operate as filters that make it difficult for key managers to understand alternative strategies for survival and renewal (Donaldson and Lorsch, 1983; Lorsch, 1985). The cultural values applied to the socialization process that persisted over the life-time of the institution included the following: self-sacrifice; obedience/conformity; rules/discipline; domesticity; care/compassion; social isolation; subordination to physicians and/or the institution; student-to-student support; and fear.

The Culture of Oppression in Relation to Change

Despite being a female dominated profession with origins in religious domesticity, the struggle and advances of nursing to professional status has largely, but surprisingly, been omitted from study by feminist scholars. Roberts and Group (1995) suggest that the absence of an extended dialogue between women scholars in the broader academic community and women in nursing has led to difficulties in understanding nursing as a predominantly woman's profession. It may be, though, that
the exclusion of consideration to nursing by feminist scholars is but one more example of oppression of women by women as well as by the patriarchal society.

Women in nursing experienced much more autonomy at the turn of the twentieth century than they do today. Although nursing was steeped in traditional feminine roles, nurses were less regulated and restricted in the nineteenth and early twentieth century. This was largely due to the fact that nursing was practiced in homes and the community. Once nursing entered the hospital it became subject to domination by physicians and hospital administrators. Nursing education, controlled by the hospitals, socialized nurses to be submissive to the authority within the hospital structure.

Apprentice nurses were taught to be loyal to the hospital, to be obedient and docile, and to accept the poor conditions of work and the stringent discipline. Repressive educational practices instilled in them respect for authority and a spirit of unquestioning loyalty to “master” institutions and to physicians. Nurses were not educated in a manner that might have led them to question the moral or social implications of a system that impeded their professional development. Within the system of apprenticeship education, the administrative authority for operation of the schools was delegated to a nurse superintendent who was also employed by the hospital and was indoctrinated with a commitment to the values of discipline, obedience, and deference to authority. As such, the majority of these school superintendents did little to effect change or to advocate for the students. In fact, her goal was to perpetuate the system.
By design, apprenticeship education does not provide a liberal and general education. It most often stifles intellectual growth and prepares workers only too willing to conform to prevailing customs, traditions, and efforts to maintain the status quo. It is not a system that contributes to change.

Implicitly and overtly, the literature and culture of apprenticeship subverted the dominant ideology of woman's place in society. Seldom explicitly feminist in their ideology, the schools nonetheless empowered young nurses as women by expecting much of them, and by denying the cultural contradiction between femininity and commitment to work. Despite the fact that they could be both women and workers did not preclude the fact that their role as women in society continued to be compromised. Nurses, as women, still had to make a choice as to whether they wanted to fulfill their commitment to their profession or whether they wanted to fulfill the expected domestic role of women in society, i.e., marriage and children. Although men could do both, women could not have both a profession and a family.

Through the process of nursing education, the dominant culture has successfully maintained the culture of oppression. Through the years, the Sisters relinquished educational control of the School of Nursing to individuals who were rewarded for their adherence to the cultural norms, while the hospital maintained administrative control of the resources necessary to successfully operate the school; namely, physical space and financial resources. As the educational process became more complex, faculty were added one by one and also socialized to the norms. The early faculty had also been educated within a diploma system of nursing education and, thus, shared the value
system of the culture of Our Lady of the Lake School of Nursing. The most important requirement of faculty was that they valued diploma education in nursing. This basic belief perpetually reinforced the cultural beliefs, customs, and rituals associated with apprenticeship learning and promoted the continuation of loyalty to the sponsoring hospital.

The continued debate within the profession of nursing as to the appropriate education required at entry level to the profession has created and perpetuated divisiveness and uncertainty among all nurses as to the adequacy of their own educational preparation. The relationship of nursing to higher education is at the core of the issue.

As faculty in diploma programs grew in numbers and subsequently reflected the values of their own baccalaureate education, a new dilemma arose. The baccalaureate prepared nurse faculty in diploma programs were challenged to compromise their own educational value system. However, because they exercised free will in choosing their employment environment, it is assumed that either (1) they placed greater value in the diploma system of education, (2) deluded themselves into believing they could compromise their own value system, or (3) hoped to effect change within the diploma value system.

In the late 1970s and early 1980s, when the faculty of Our Lady of the Lake School of Nursing were enrolled in Master's degree programs to meet the educational requirements of the Louisiana State Board of Nurses, they were once again exposed to the heated entry level into nursing debates. As a result, the faculty began to express
dissatisfaction and conflict in their role as nurse educators within a diploma program in nursing. In fact, several of the long-time faculty members resigned to take positions in baccalaureate programs in nursing within the city. Their loss was viewed as a loss of both investment and resources. The administration of the hospital had invested heavily in assisting the faculty as they pursued graduate degrees in nursing and losing them after they completed their degrees was threatening to the maintenance of a qualified faculty. Thus was formed the committee that ultimately recommended transitioning the diploma program in nursing to an Associate Degree in Nursing program within a free-standing degree-granting institution.

The transition process required the faculty to revise the curriculum as well as the desired outcomes of the educational program. While the curriculum revision appropriately placed the Associate Degree Nurse within the acute care hospital environment, this also served to meet the needs of the sponsoring hospital and thus "served the needs" and "pleased" the dominant force by promoting and perpetuating the cultural values that included control by the hospital over the educational program. Relationships with administrators and physicians were not threatened.

Subordination has continued to be a critical factor within the socialization process. Student nurses are still socialized to be submissive to physician as well as faculty authority. Students continue to express fear of authority just as they have since 1923. Fear is known to motivate submissive behavior, which is characteristic of subordination.
Domesticity continues to be a predominante theme in nursing education and further perpetuates subordination. Student nurses continue to be required to give their patients baths as well as to do the linen changes.

Although it has been more than forty years since Sister Agnes Marie expressed concern that students were required to repeatedly make beds, bathing and bed-making are still a large part of the nursing skills curriculum. Bedmaking is probably the single most often repeated task. The justification is often explained as "bathing the patient is the best way to learn assessment skills." It is more likely that bathing and bedmaking, as domestic skills, are used to further socialize the student to domestication and subordination. In addition, it is likely that the hospital is exploiting the student for free labor.

While leaders in nursing continue to address the issues of professionalization and entry level into the profession, the world of health care is marching on, transforming itself, and redefining where, who, what, and when health care is being delivered. The nursing faculty must position themselves on the leading edge of change, rather than clinging to an aging and time-warped culture. Opportunities are abundant; change is critical to success.

Implications of the Study

The implications of the study focus on leadership, which is important to change, whether it is in nursing or in higher education or in corporate America. Many experts on nursing leadership have argued that the lack of nursing leaders is due to a lack of persons with initiative, self-esteem, and assertiveness in the nursing profession. It is
argued that the style of leadership within nursing has evolved because nurses are an oppressed group, controlled by forces of society that have determined its leadership behavior.

Cultures (Schein, 1992) basically spring forth from three sources; "(1) the beliefs, values, and assumptions of founders of organizations; (2) the learning experiences of group members as their organization evolves; and (3) new beliefs, values, and assumptions brought in by new members and leaders" (p. 211). A deeper understanding of the cultural issues of a group is necessary to identify what may be the priority issues for leaders and leadership. Organizational cultures are created in part by leaders, and one of the most decisive functions of leadership is the creation, the management, and sometimes even the destruction of culture (Schein, 1992).

As any group encounters adaptive difficulties, as its environment changes to the point where some of its assumptions are no longer valid, leadership is critical. The ability to perceive the limitations of one's own culture and to develop the culture adaptively is the essence and ultimate challenge of leadership (Schein, 1992).

Table 9.4 compares the values that have persisted within the Division of Nursing throughout the evolution with the values that are currently espoused by the College. The current values are taken from the proposed Revised Mission statement and Institutional Goals of the College (2000) that are derived from the Revised Mission Statement of the Franciscan Health Care System.

Leadership requires not only insight into the dynamics of the culture but the motivation and skill to intervene in one's own cultural process. To change any elements
of the culture, leaders must be willing to unfreeze their own organization. Unfreezing requires disconfirmation, a process that is inevitably painful for many. The leader must find a way to say to his or her own organization that things are not all right and, if necessary, must enlist the aid of outsiders in getting this message across.

The implications for leadership are multiple. The most important point is that leadership starts the change process in the first place. This involves a number of different functions that are often not well understood by leaders. First, they must provide the disconfirming information that initiates the change process, and then induce
the anxiety and guilt to motivate change. Even more important, at the same time, leaders must find a way to provide enough psychological safety to get the members of their organization to accept the need for change and begin the traumatic learning process that will lead to the desired change.

**Conclusion**

Our Lady of the Lake College was established on the firm foundation of Our Lady of the Lake School of Nursing. The educational environment has perpetuated the values of the Franciscan Missionaries of Our Lady as applied to the provision of health care. The nurses and allied health professionals, who have been educated in this environment, approach health care with care and compassion, respect, and dignity. The excellence of the educational programs has been validated by the demand of employing health care agencies for the graduates of "the Lake" and the various external agencies that accredit nursing and allied health educational programs.

However, analysis of the historical culture provides a view of a subculture within the educational environment that verifies the continuing subordination of students in the professional socialization process. This was the predominate theme that emerged from the analysis and is reflective of the traditional and oppressed status of women in society.

Individual, group, and institutional changes are needed to overcome decades-old patriarchal structures and practices. Re-assessment of the processes of socialization into the nursing role must be considered. Strategies to eliminate submissiveness and subordination must be explored. Such strategies can begin in the classroom where
students are often subordinated to faculty. A climate of care and nurturing can be created that equalizes power and control and places the student at the center of the learning experience.

Learning strategies should be developed and implemented that purposefully promote positive communication skills with physicians and others in positions of power and authority. Students should not learn fear; rather, they should learn how to communicate in such a way as to retain their own dignity and respect.

Rather than defer to the expectations of hospital staff, faculty must construct learning experiences for students that minimize domesticity and maximize professional skills and ability. For example, students should not be required to bathe their patients and make beds if those duties are not considered a part of the duties of the professional nursing staff. The enormous amount of clinical learning time that a student spends on domestic activities could better be spent acquiring skills that are required for contemporary nursing practice.

While much of nursing practice today is supported by technological advances, students rarely get opportunities to develop the skills necessary to understand or apply the technology. For example, it is not expected that student nurses learn how to read and interpret technologically produced data that is reported on monitors in critical care areas of the hospital. Yet, monitors are becoming standard features in hospital based nursing. It would be better for students to learn expected behaviors within the educational environment, then to be required to learn those behaviors after graduation in an apprenticeship model of education within the hospital. It would also be more cost
effective for the hospital, if graduates entered practice with the requisite skills necessary
to function in today's health care environment. If nursing, as a profession, is to continue
to grow and develop, it must redefine itself in terms of today's technology and what it is
that nursing does that is uniquely nursing.

Nurses, as women, must overcome their subordination and then seek to
eliminate the sexist structures within the environment of the health care agencies where
they are employed. Roberts and Group (1995) report that "feminist nurses envision a
-time when all women unite to change the structures of hospitals and agencies so that
divide-and-conquer tactics will no longer prevail" (p. 335). Nursing education can play
a vital role in the transformation of values.

Until the historical subjugation of women is reversed and women in nursing
control their own profession and until the transformation of values occurs, there will
continue to be nursing shortages, professional disunity, and lack of autonomy. The
basic struggle will be accomplished when women's values are translated by nurses into
organizational contexts that force a change from patriarchal structures to ones that value
the human in all people.
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APPENDIX A

RELEASE FORM

INTERVIEWEE RELEASE FORM:

Tapes and Transcripts

I, ___________________________ do hereby give to the T. Harry Williams Center at LSU all right, title or interest in the tape-recorded interviews conducted by ______________________ on ______________. I understand that these interviews will be protected by copyright and deposited in the LSU Libraries for the use of future scholars. I also understand that the tapes and transcripts may be used in public presentations including but not limited to audio or video documentaries, slide-tape presentations, or exhibits. This gift does not preclude any use that I myself may want to make of the information in these recordings.

CHECK ONE:

Tapes and transcripts may be used without restriction __________

Tapes and transcripts are subject to the attached restrictions __________

______________________________  _________________________
Signature of Interviewee  Date

______________________________
Address

______________________________
Telephone Number

318

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IRB EXEMPTION FORM

Application for Exemption from IRB (Institutional Review Board)
Oversight for Studies Conducted in Educational Settings
LSU COLLEGE OF EDUCATION

Title of Study: A History of Our Lady of the Lake College: 1923-2000
Principal Investigator: Linda C. Pendergast

Faculty Supervisor: W. Richard Fossey
(if student project) Name (Print)

Dates of proposed project period: From January 2000 To August 2000

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<thead>
<tr>
<th>ITEM</th>
<th>YES</th>
<th>NO</th>
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<tr>
<td>1. This study will be conducted in an established or commonly accepted educational setting (schools, universities, summer programs, etc.)</td>
<td>X</td>
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<td>2. This study will involve children under the age of 18.</td>
<td>X</td>
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<td>3. This study will involve educational practices such as instructional strategies or comparison among educational techniques, curricula, or classroom management strategies.</td>
<td>X</td>
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<td>4. This study will involve educational testing (cognitive, diagnostic, aptitude, achievement).</td>
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<td>5. This study will use data, documents, or records that existed prior to the study.</td>
<td>X</td>
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<td>6. This study will use surveys or interviews concerning content that is not related to instructional practices.</td>
<td>X</td>
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<td>7. This study will involve procedures other than those described in numbers 3, 4, 5 or 6. If yes, describe:</td>
<td>X</td>
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<td>8. This study will deal with sensitive aspects of subjects' and/or subjects' families' lives, such as sexual behavior or use of alcohol or other drugs.</td>
<td>X</td>
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<td>9. Data will be recorded so that the subjects cannot be identified by anyone other than the researcher.</td>
<td>X</td>
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<td>10. Informed consent of subject 18 and older, and/or of the parents/guardian of minor children, will be obtained.</td>
<td>X</td>
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<td>11. Assent of minors (under age 18) will be obtained. (Answer if #2 above is YES)</td>
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<td>12. Approval for this study will be obtained from the appropriate authority in the educational setting.</td>
<td>X</td>
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Attach an abstract of the study and a copy of the consent form(s) to be used. If your answer(s) to numbers 6 and/or 7 is(are) YES, attach a copy of any surveys, interview protocols, or other procedures to be used.
APPENDIX B
INTERVIEW OUTLINES

Interviews of Former Students: Proposed interview questions and associated probes

1. Demographic Information
   Name, address, date of birth, age when entered the program of study, age when
   graduated, brief work history.

2. Decision to attend Our Lady of the Lake College and Career choice.
   Parental education? Expectations of parents? Choice of school? What did your
   friends do? Siblings? Was the decision acceptable to you? Influence of others?

3. What was it like when you attended Our Lady of the Lake College?
   Curricular and extracurricular extractions. Was it what you expected?
   Friends? Teachers? Physicians? Mentors? Who was the greatest influence on
   your educational experience? What did you do for fun? What were the rules?
   What were classes like? Facilities? Hospital work? Patients? Do you
   remember how it felt to be there? Good experiences? Bad experiences?
   What were the expectations of the teachers? Administrators? Physicians?

4. Can you describe how student nurses were viewed by the medical and nursing
   staff?

5. What did it mean to you to be a student nurse?

6. Can you give an example of how you changed as a result of your experiences?

7. What personal anecdotes do you recall that had meaning to you or were just
   memorable? People? Events?

8. How well do you feel you were educationally prepare for the nursing role?
Interviews of Former Administrators: Proposed interview questions and associated probes:

1. Demographic Information
   Name, address, educational credentials, brief work history, date of employment, date of termination, positions held.

2. What brought you to Our Lady of the Lake College? What challenges did you perceive?
   Who was the previous administrator? How long?

3. What was the college/school like at that time? Students? Faculty? Other administrators? Program(s) offered? Organizational structure?

4. What external influences impacted the college/school during your administration?
   What was the internal response to those influences?

5. What was the relationship of the college/school with the FMOL? Hospital?

6. What were the major issues you had to address as an administrator? What were the strategic choices?

7. What changes occurred during your administration?

8. What was the state of the institution at the time of your departure?

9. What were your most significant achievements? Disappointments?

10. What personal anecdotes do you recall that had meaning to you or were just memorable? People? Events?
Interviews with Former Faculty: Proposed interview questions and associated probes

1. Name, address, educational credentials, brief work history, date of employment, date of termination, positions held.

2. What brought you to Our Lady of the Lake College? What was the college/school like at that time? Students? Faculty? Administrators? Educational program(s)?

3. How would you describe the role of faculty? What were the priorities in nursing education? What was it like to be a faculty member? Workload? Committees? Faculty/student relationships? Faculty/administration relationships?

4. What were considered to be the qualities of a “good faculty member”? How did faculty develop those qualities?

5. What were considered to be the qualities of a “good nurse”? How did students develop those qualities? How was the educational program structured to achieve those quality outcomes?

6. What was going on in the world of nursing and nursing education at that time? How did the school/college respond?

7. What was the school/college’s relationship with the FMOL? Hospital?

8. What were the most significant challenges or issues that you confronted as a faculty member?

9. What were your most significant achievements or contributions as a faculty member? What were your greatest disappointments?
10. How did the college/school change while you were a faculty member? How did you feel about those changes?

11. What personal anecdotes do you recall that had meaning to you or were just memorable? People? Events?

12. What was the state of the institution at the time of your departure?
VITA

The author's name is Linda Carol Rakestraw Pendergast. She received her Bachelor of Science Degree in Nursing in 1971 from the University of Southern Mississippi in Hattiesburg, Mississippi. In late 1973, she accepted a position as instructor at Our Lady of the Lake School of Nursing in Baton Rouge, Louisiana.

In 1985, Linda Pendergast earned her Masters degree in Parent-Child Nursing from Louisiana State University Medical Center in New Orleans, Louisiana. Her research interest was in designing and implementing developmental interventions for high-risk newborns and their parents. In 1987, she received professional certification as a Neonatal Intensive Care Clinical Nurse Specialist. She is also certified as a Prepared Childbirth Instructor and is licensed by the state of Louisiana to practice nursing.

In 1990, she was appointed to the position of Director of the Institutional Self-Study for the initial regional accreditation of Our Lady of the Lake College and also served as Director of Institutional Research and Planning. In 1994, she was appointed as Dean of Support Services which is the administrative unit responsible for student services and operational services of the College. In 1999, her position title was changed to Vice President of Support Services.

Linda Pendergast currently serves on the Louisiana Adoption Advisory Board and holds the office of Secretary. She also serves on the Advisory Board to Catholic Community Services in Baton Rouge. She has presented at numerous state and national conferences on a variety of subjects related to nursing, infant and child development, parenting, higher education effectiveness, student development, adoption and adoption related issues.
DOCTORAL EXAMINATION AND DISSERTATION REPORT

Candidate: Linda Rakestraw Pendergast

Major Field: Educational Leadership and Research

Title of Dissertation: The History of Our Lady of the Lake College, 1923-2000: A Study of Organizational Change

Approved:

[Signatures]

Major Professor and Chairman

Dean of the Graduate School

EXAMINING COMMITTEE:

[Signatures]

Date of Examination:

October 20, 2000

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