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Narrator

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Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

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In 1970, the University of Minnesota's previously autonomous College of Pharmacy and School of Dentistry were reorganized, together with the Schools of Nursing, Medicine, and Public Health, and the University Hospitals, into a centrally organized and administered Academic Health Center (AHC). The university's College of Veterinary Medicine was also closely aligned with the AHC at this time, becoming formally incorporated into the AHC in 1985.

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20th century. AHCs became not only the primary sites of health care education, but also critical sites of health sciences research and health care delivery.

The University of Minnesota's Academic Health Center Oral History Project preserves the personal stories of key individuals who were involved with the formation of the university's Academic Health Center, served in leadership roles, or have specific insights into the institution's history. By bringing together a representative group of figures in the history of the University of Minnesota's AHC, this project provides compelling documentation of recent developments in the history of American health care education, practice, and policy.

Biographical Sketch

A. Marilyn Sime was born in North Dakota. She received her Diploma in Nursing in 1956 from St. Francis School of Nursing in Minot, ND; her BS in Nursing Education, with a minor in psychiatric nursing in 1959 from the University of Minnesota. She received her MS in Psychiatric Nursing in 1964 from Boston University, and her Ph.D. in Educational Psychology in 1973 from the University of Minnesota. She worked as a staff nurse at St. Joseph's Hospital in Minot, ND, from 1956-57, in the surgical service at the University of Minnesota Hospital from 1957-58, and at St. Andrews Hospital in Minneapolis from 1958-59. From 1960-62, she was an instructor in the baccalaureate program in Psychiatric Nursing at South Dakota State College. She joined the faculty of the University of Minnesota School of Nursing in 1964, first as Instructor (1964-68), then Assistant Professor (1972-74). She was promoted to Associate Professor in 1974. From 1978 to 1995, Sime served as director of Graduate Studies and assistant dean of Graduate Studies. She left the University of Minnesota School of Nursing in 1968 to pursue graduate work in educational psychology at the University of Minnesota. She returned as a faculty member in the School of Nursing in 1972. She retired from the University of Minnesota in 1997.

Interview Abstract

A. Marilyn Sime begins by discussing her background, including her education. She discusses her experiences as a baccalaureate student at the University of Minnesota; working as a nurse at the University Hospital in the late 1950s; working as a nurse in Minot, ND, in the 1950s; her experiences as an instructor at the University of Minnesota; teaching in the baccalaureate program; and her doctoral research. She compares her responsibilities at the different places she worked, particularly Minot and the University Hospital. She describes nursing curriculum changes in the 1960s; technologies she interacted with in the critical care unit; how physicians treated nurses; the efforts of the School of Nursing to secure funding for building Unit F; the concern in the 1960s over the shortage of health care workers; challenge exams for RNs in the 1970s; the Boston University School of Nursing; the rural nursing program at the University of Minnesota; and the Block Nurse Program at the University of Minnesota.

She discusses team nursing; faculty organization issues and discontent with Edna Fritz's leadership; the effects of the School of Nursing being part of the College of Medical Sciences in the 1960s and the changes with the reorganization of the health sciences in the School of Nursing becoming more autonomous in 1970; and relations between the health science units and their faculty after the reorganization. She talks about the practical nursing program; changes in the graduate nursing curriculum and the development of doctoral program; funding; issues of gender; the women's health movement; the development of the nurse midwifery program; the public health nursing program; the relationship between the University Hospital and the School of Nursing; the Minnesota Nursing Association, the American Nursing Association, and the National League of Nursing; and nurse practitioners. She remembers Katherine Densford, Edna Fritz, Isabel Harris, Irene Ramey, and Lyle French.

Interview with A. Marilyn Sime

Interviewed by Dominique Tobbell, Oral Historian

Interviewed for the Academic Health Center, University of Minnesota Oral History Project

Interviewed at A. Marilyn Sime's Home

Interviewed on April 15, 2010

A. Marilyn Sime - MS
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Marilyn Sime. It is April 15, 2010. We are at Doctor Sime's home, the address of which is 8100 West Eighty-Sixth Street Circle in Bloomington, Minnesota.

Thank you, Doctor Sime, for speaking with me today.

MS: Thank you. It's a pleasure to have you here.

DT: Thanks.

Oh! And we have Annie the puppy.

MS: Yes, we have distractions.

[chuckles]

DT: To get started, could you just tell me a little about where you grew up and how you came to go into nursing?

MS: Okay. I was born in a small town in North Dakota and my family lived there till about the time I entered grade school. Then, we moved to a small town in Minnesota for a few years and then went back to North Dakota, so most of my life was in North Dakota. I graduated from high school in a small town, Velva, which is about twenty miles from the nearest sizable city, which is Minot.

After graduating from high school, I knew I wanted to go into nursing, but our family couldn't afford to send me where I really wanted to go, which was the University of North Dakota. So instead, I entered a hospital nursing program in Minot, North Dakota. In those years—this would have been the early 1950s—most nursing preparation was in hospital schools. They were very inexpensive, and that's because you staffed their hospital. They actually made money on nursing students. That was a three-year diploma program in nursing.

After I graduated from that, I knew that I still wanted to get some college preparation. So I worked for a year in Minot, saved up my money, and went to Minneapolis to enter the baccalaureate program in nursing education [at the University of Minnesota]. That was a baccalaureate program that was developed for RNs [registered nurses]. One could either focus on nursing education or nursing administration, and I focused on nursing education.

After graduating from that program—that would have been in 1959—I taught for a few years and, then, recognized that I needed higher education if I was going to pursue a teaching career at a college or university. By that time, I knew that's what I wanted to do. So I got a master's degree at Boston University and got recruited back to Minneapolis. Two faculty from the School of Nursing traveled out to Boston and recruited me.

DT: Which faculty members were they>

MS: Fran [Frances D.] Moncure and Dorothy Titt.

What attracted me back to the University of Minnesota was that the School of Nursing was developing a new and rather innovative baccalaureate program. At that time, it was described as an integrated program. The older model of organizing a curriculum was a medical model which organized courses around medical nursing, surgical nursing, orthopedic nursing, etcetera. Instead this curriculum was organized very differently with a focus on nursing, studying patient behaviors, and arriving at what was considered, at that time, a nursing diagnosis of the patient's needs and developing a nursing care plan around those concepts rather than around the medical conditions. That was quite an innovative program. It was way ahead of its time. It's nothing new now, but at that time, it was very creative. So that brought me back to Minnesota.

Also, at that time—I was teaching in the undergraduate program—there were interesting things happening in the graduate program. The graduate degrees which had been offered earlier were the Master's of Nursing Education [MEd.] or the Master's of Nursing Administration [MNA]. Early in the 1960s, the school moved their master's programs into the graduate school and offered the MS degree, the Master of Science degree, with a single major which was nursing. But the major could have different focuses, different areas of study. That really interested me.

I knew I couldn't continue teaching at a research university with a master's degree, so I went into a doctoral program. I went into the Ed/Psych [Educational Psychology]

program at the University of Minnesota. A nurse friend of mine had gone through that program and really recommended it to me. You could design your own program. They weren't going to make an educational psychologist out of me, but I had to build a program that would work. So I did that very happily.

As I was finishing up that program, I got recruited again back to the School of Nursing. [chuckles] So I've been at the University of Minnesota twice as a student and twice as a faculty person. I got recruited back to teach in the graduate program, to teach graduate students, which is what I wanted to do. That was, I think, in 1972.

DT: Can you tell me a little about your experiences as a student at the nursing school at Minnesota, first as a baccalaureate?

MS: The baccalaureate program that was designed for RNs had two what was called functional specialties, either education or administration. In addition to that, you could select a clinical area that you wanted more experience and content in. So I chose psychiatric nursing. In addition to that, I got very interested in a course that was being offered for nurses in critical care nursing. That was one of the earliest of that sort. I was really introduced to what, at that time, were the cutting edge technologies in medicine. The year I worked in North Dakota, I didn't see any of that kind of thing, because they didn't do any chest surgery or neurosurgery or that sort of thing. In North Dakota, one had to go to Fargo to get that kind of medical care. I sort of had two extremes, a psychiatric nursing experience and a critical care experience. That kind of prepared me to do different things clinically.

That stood me very well when I went to Boston for a master's degree. I, of course, had to work, and I worked at a small hospital that circulated me through all the specialties. I worked nights, so you're pretty much on your own. But I felt comfortable in moving from a medical station to an obstetrical station to whatever. Of course, the mental health background helps you every place. That baccalaureate experience at Minnesota, I thought, really prepared me well for whatever I wanted to do.

DT: How much balance was there between the clinical experience that you were getting there and, say, classes on more theoretical issues?

MS: It was mainly course work. We were already RNs and considered clinically competent. Most of it was course work, but the program was a joint program between the School of Nursing and the College of Education. So there was a lot of course work from the College of Education as well as from nursing. In nursing, the course work would have been then in psychiatric nursing. We had a fairly limited clinical experience, the philosophy being, I guess, you've already done that stuff. We had, of course, a psychiatric nursing experience in my diploma program.

DT: What kinds of technologies then were you interacting with when you were in the critical care unit?

MS: Well, chest tubes, which I'd never heard of before coming out of this little town in North Dakota. There were little machines that created the suction for chest tubes, so under the beds were all these little machines going tick, tick, tick tick, tick. When I first walked into a patient's room and saw that, I was really quite puzzled. I didn't know what it did, but it wasn't complex technology. It didn't take long to learn. Other things I hadn't seen… I hadn't seen head trauma and neurosurgery. I guess those were the major things: chest surgery and neurosurgery and, you know, heart surgery.

DT: With the chest tubes, was it the physician who put the chest tubes in or did the nurses actually have more of the responsibility?

MS: They were usually put in in surgery, but nurses had the responsibility of keeping the tubes open, to keep them draining, so that was a nursing task.

DT: What was a day in the life of a nurse like in practice at that time?

MS: I worked. Of course, when you're a student, you always have to work. I worked for a while at the University Hospital. That's where I got a lot of my clinical experience. It was new, new experiences. I worked on a station that was considered to be Doctor [Owen] Wangensteen's unit. I suppose it was one of the first intensive care units. There, I learned how to take care of Wangensteen Suctions and learned about the chest tube part of it. I usually worked evenings. What was a really new experience for me were the interns, because I'd never been in a clinical situation where there were physician interns. What sort of surprised me is that the interns *really* looked to nursing for a lot of their instruction. They were just as green as I was when I first came. So it became a very interesting collaboration, in my view. I hadn't had that experience before.

Of course, the patient population was much more diverse than I had seen in Minot, and, of course, so were the staff.

DT: As you say, it's quite a noticeable difference from when you were in Minot and it wasn't a teaching hospital. How did the physicians treat you at that hospital in Minot? How did they treat nurses, more generally?

MS: There were two kinds of physicians. No one has asked me this question before so this is off the top of my head. There were two kinds of physicians, I think. The year I worked, after I graduated from the program, I worked in the operating room. The two types of physicians I thought were the real Uncle Joe, friendly, fatherly type that really appreciated anything that you could do for them. Then there was another type, who were much fewer in number, who were board certified in surgery—the other physicians were GPs [general practitioners]. So they had this board certification and were so picky and compulsive, I think, about how the operating room should be run. One had his own special nurse. He wouldn't even use the nursing staff at any hospital that he went to; he brought his own nurse along with him. So there was kind of a distrust of the competence of the nursing staff. But, when you think of it, surgeons have a lot of pressure, and this particular one was very busy going—there were two hospitals in Minot—from one

hospital to the other and doing surgery, practically all day. So I guess one couldn't fault him for bringing his own nurse along. It just sort of made you feel taken aback.

But, one day, his nurse was sick, so I had to scrub in instead of his own special nurse. I thought, oh, dear, I hope this goes okay. [laughter] But it turned out to be all right.

DT: What was your responsibility in the operating room?

MS: For a while, I mainly would, what they called, circulate. In that nurse position, you don't scrub in to work in a sterile field. You circulate around the room getting equipment and that sort of thing. I had responsibility for scheduling the surgery and getting the proper room and the proper equipment set up. But, then, toward the end, I became, essentially, a scrub nurse and I would scrub in for the procedures. Mornings, like from seven a.m. to one or so, would be the operating room schedule. Then, in the afternoon, the physicians would be seeing patients on the wards and nurses in the operating room would be preparing the equipment for the next day, sterilizing and cleaning the rooms, that kind of scut work. [chuckles]

DT: Were there any nursing assistants at that point? Was there anyone else doing the scut work or was it all the RNs who were doing it?

MS: It was all the RNs. We had some what were called nursing aids, not so much in the operating room. There were nursing aids in the hospital wards who were responsible for bed making and cleaning the rooms, and that sort of thing. But, generally speaking, RNs did just about everything.

DT: I interviewed a nurse the other day, and she said that—she did a rotation in Miller Hospital in the Twin Cities—as a private hospital, the nurses were required to stand up whenever a physician walked in the room. Did you experience that?

MS: Yes, yes. Always. The diploma program that I went to was a Catholic hospital, and you, of course, stood when physicians entered the room. You also stood when the Sisters entered the room, so it wasn't totally just a male issue. You stood for your superiors. When I came to Minnesota and I was working at the University Hospital, I did not see that behavior persisting.

DT: Do you think at the University Hospital nurses were maybe given different kinds of responsibility or was it very comparable to what you had done?

MS: Much more responsibility. The patient needs were much more complex. A different set of skills were required than I had learned in North Dakota, because, of course, we were serving a different population. I could see quite readily that a baccalaureate degree would, in my view, be an essential entry level degree for nursing practice, that it took that level of skill and competence and experience and general education.

DT: In the University Hospital, were there any diploma nurses or was it all baccalaureate nurses and student nurses?

MS: Oh, I'm sure there were diploma nurses… They hired me, so I'm sure that there were.

DT: But you were going through the baccalaureate at that time?

MS: Yes. I don't know if that made an exception for me or not. I just don't know that.

DT: How were relations between diploma nurses and baccalaureate nurses? Was there any tension or conflict between the different levels of training that were expressed between individuals?

MS: Not that I noticed. Actually, I no longer recall what the make up was of the nursing staff, what percentage were diploma graduates and what percentage were baccalaureate. No, I didn't see that.

Nursing, at that time, was pretty much moving toward a team approach, so there would be a team of nurses working together. That would not only be RNs, baccalaureate or diploma prepared RNS, but it also might be LPNs [licensed practical nurses] and nursing aids. So there would be a team approach for a certain number of patients.

DT: You saw that happening at the University but that was less the case when you were in North Dakota?

MS: Yes, that was not the case in North Dakota. Team nursing was really a concept that was developed at the University of Minnesota. Prior to that, nurses worked pretty much around certain functions. There would be the medication nurse. There would be the nurse that did what were called treatments. Then, a nurse would be assigned to patient A, B. and C, or something like that. With the team approach, the team had a number of patients, but the team did everything for the patients. So there wasn't *a* medication nurse.

DT: What was the impetus for moving towards a team approach in nursing?

MS: It was perceived to be a much better delivery system, that the patients would not have a different nurse every day. There would be a team and the team would be rather consistent. Care could be much better planned and personalized for the individual patient. There would be a care plan that would be developed and written down, so any team member that was working with those patients would know what the whole team plan was, what the objectives were.

DT: Katherine Densford was director of the School of Nursing when you arrived.

MS: That's correct.

DT: What was your experience of her?

MS: What a marvelous woman. I took a course from her. It was called "Professional Development." Can you imagine remembering that from the 1950s? What she did in that course was to really introduce you to a way of thinking about what you were doing, what she considered professional. You wanted to care for the discipline, for its knowledge base. You provided a public service. There was a mandate to care for people. So she really brought in that philosophical, broad approach that sort of moved you from your tiny little orientation, from the little program that you went to. She was an *excellent* teacher. Everybody was sorry to see her retire. She surprised many of us very soon after retirement by marrying.

There was one occasion—I don't remember what the occasion was—when a couple of nurse friends and I were invited to her home for tea or something. It was like going to the White House or something.

DT: [chuckles]

MS: I mean, it was a big occasion to sit there. She'd talk about what her experiences had been. Her international experiences were very interesting. That was a privilege, a rare privilege, I think.

DT: Was Katherine Densford responsible for introducing this team nursing?

MS: No, that was Marie Manthey. I think the descriptive term that she used was primary care nursing.

DT: Yes.

MS: But it was a team approach. She developed that, oh, I suppose that was in the late 1960s. You probably have better informants than I on that. Laurie Glass has probably written quite a bit about it.

DT: And I have spoken with Marie a couple times. I haven't interviewed her yet. I know she's going to have a lot of great information to give.

MS: Oh, I'm sure.

DT: I was familiar with primary care nursing, as you say, yes.

You were an instructor at the University from 1964 to 1968.

MS: That's right.

DT: What was your experience like as instructor in the program?

MS: Those years, I was teaching in the undergraduate program. It was this new integrated program that I mentioned earlier. What was really noteworthy, I think, about those four years was the faculty that I was privileged to work with, *very* bright women who were creating this new concept of delivering nursing education. Among those were Florence Brennan, Elizabeth Whitney, Dorothy Titt, Fran Moncure. They were very creative and bright women who had a new vision, I think, for delivering nursing education. That program, as it developed, wasn't loved by all. There were faculty that felt that too much had been lost and not enough gained by this new approach. But I thought it had very good strengths.

When I left for doctoral study, which was in 1968, I was asked to be a curriculum consultant at Javeriana University in Bogota [Colombia]. They were interested in that kind of a curriculum and how they might integrate their programs that way. So I felt well equipped to talk about that approach from my four years of teaching at the University at that time, and found that this approach for education translated very well into Spanish.

DT: Hmmm.

MS: You know when something is developed in one culture, you don't always know if it's translatable into quite a different culture. But it seemed to translate very well. That was a summer consultation.

Following that summer is when I entered doctoral studies.

DT: Can you talk a little bit about the elements of that revised curriculum about what exactly was different, and what did other people think had been lost by that change?

MS: I'll have to really think back now. [pause] Well, in contrast, maybe, to the earlier approach, a student would be assigned, or an RN—in this case, it would be a student—would be assigned to care for a certain patient, let's say just one patient. So the student would get the patient's diagnosis, would learn about what the disease condition was, would review the physician's orders. Much of the nursing care was delegated by the physician. The physician would order the medication and the nurse would give it. The physician would order a certain level of activity or a certain diet or something, you know, and the nurse would give it.

In this newer approach, we were considering those activities delegated medical care, and what we considered nursing care was a different thing. The nursing care plan came out of the student interviewing, interacting with, having conversations with the patient in order to learn what the patient's needs were, what the patient's concerns might be, what the person might be anxious about, and would try to learn from the patient the coping skills that the patient had, and would, then, develop a plan of care that was aimed at facilitating the patient to use their own coping skills, to add some other support if they could, for a goal of—the term that was being used in that curriculum—comfort. That could be translated into reduced anxiety, reduce fear, a sense of competence, of ability to deal with their health situation.

People who thought something was being lost, I think, was a lot of what might be called medical knowledge. In some of that, what was viewed as the lost medical knowledge was knowledge that the nurse couldn't use for her independent practice, because it was medical knowledge and wasn't nursing knowledge. So that separation was what was being made at that time. That was new.

DT: And the University of Minnesota as ahead?

MS: Yes. Yes, years ahead. Now, you don't even think that was unusual but, at that time, it was.

DT: It sounds like student nurses would, then, be needing to take a lot more course work, say, in psychology and behavioral science.

MS: Yes, they needed a good general education. They needed as much in the humanities and liberal arts as they needed in physiology and anatomy and the physical sciences area.

[break in the interview as the telephone rings]

DT: The curriculum revision and this emphasis on nursing knowledge versus this medical knowledge…at the same time, there was, also, the elimination of the thirty hours of clinical service that the student nurses were providing in the hospital?

MS: Yes, I understand that occurred about that same time.

DT: So the reduction in clinical service was not necessarily related to the change in curriculum?

MS: No. No. Students were admitted to the new curriculum, one might say, so when they entered, there was no requirement for service. They were treated as any other student at the University, despite the department.

DT: Who was opposed to this? Were there specific individuals that were most resistant to the changes or groups? Did physicians have a particular perspective on the curriculum?

MS: I never heard any physician comment one way or the other on the curriculum. I'm sure they thought it was our business. I wouldn't say there was huge opposition but there were people who were leery. They had been nurse educators for a long time. Those names that I named earlier who really impressed me during those four years, that was a wide-spread age group. It wasn't all young whippersnappers. It was a broad spectrum. I think people who were sort of doubtful about that curriculum became more accepting when they saw the results. The students passed the nursing state board exams for licensure. They were well employed. They were very flexible. They hadn't sort of zeroed in on one medical category, like surgery or pediatrics, that sort of thing. They

were very flexible and felt that they could move from area to area. Nursing administrators liked that about those graduates, that they could comfortably work in this area and if they needed help in another area, they could comfortably make that switch. So I think that the view sort of changed when the results were seen.

DT: How long until those results were seen? How long did this process of revision and transition of the curriculum take?

MS: Well, I was only there from 1964 to 1968, and that's when a lot of the work occurred. When I came back, when I got recruited back after doctoral studies, I was into the graduate program, so I became less aware of what was happening at the baccalaureate level then. I don't really know that there was a view that this is the end, that we were done just now, and we're going to continue. I don't have knowledge about that or direct experience of that.

DT: During the time that the curriculum was being revised and was introduced and during your tenure on the baccalaureate faculty, Edna Fritz was director.

MS: Yes.

DT: What was she like as a director and what was your experience of her?

MS: She, I think, had kind of a stormy period. [chuckles] Maybe a lot of people thought it was over the curriculum, but I don't think it was. My experience was when many faculty became—[pause]…what would be the word?—disenchanted with her, I think it was in 1967, around that period. There was a perception that she had unilaterally disbanded the faculty organization. So for many faculty, it was an organizational thing. Faculty had had responsibility for faculty governance, faculty committees, responsibility for the educational program, selection of students, etcetera, etcetera. There was a perception that she was not supporting the faculty organization, and, in fact, disbanded some committees and developed alternative approaches for faculty organization. I think that was the issue for many faculty who resigned at that time. I was in the process of getting my materials together to enter doctoral study. I had applied for a federal fellowship and was busy writing all those proposals, and, here, around me, there were a large number of people who had chosen to leave rather than stay.

There had been an appeal, I think, from faculty to the dean of Medical Sciences. That's who our director would have been responsible to. There was an appeal made that the faculty organization not be interfered with. Then, that was referred to Central Administration, that appeal. There was a meeting and I was at that meeting at which we were essentially advised that what the faculty needed was a constitution. There was no constitution in the School of Nursing. We had a faculty organizational chart and a description of responsibilities and that sort of thing, but nothing that was called the constitution which was ratified. It has to be ratified someplace, by Central Administration or maybe the Regents. I'm not sure. It was at that time that I resigned for doctoral study, so I don't know if, at that time, there was an effort at working at a

constitution. I think that came later, but I'm not sure exactly when. I think there was a constitution when I was recruited back after my doctoral study.

DT: Yes, my sense of things… I've seen correspondence basically laying out what you just described where [William] "Gerry" Shepherd, the vice president…

MS: I couldn't think of his name. Yes.

DT: I've seen correspondence about the big meeting that he and Bob Howard had had with the nursing faculty and said, "You need a constitution." There were records that a constitution was written, I think, within the next year. I'm not sure if it was after Fritz was fired or if it was while she was still… I think it may have been while she was still in the position as director.

Interestingly, I saw a letter that you had written tendering your resignation. I realized from the timing that you were, obviously, going to do your doctoral work, but in that letter, you had expressed some discontent with Edna Fritz's leadership along the lines of what you just said, basically.

MS: Yes. The faculty was very open and tried to use the system. This wasn't just a bunch of disgruntled people behind the scenes, you know. The faculty were very open about it and what they perceived to be the problems.

DT: There seemed to be, though, eventually a mass exodus of faculty.

MS: There was. I remember a number of faculty developing their letters of resignation and were seeking people to read their letters to see if it was clear and objective and not hysterical. I saw many of those letters.

DT: Yes, I've seen several of them in the archives. They're all very consistent in complaining about Fritz's leadership style.

This might be hard for you to address because you joined the faculty in 1964, and, obviously, she'd already been there four years at that point. But, do you have a sense of whether her leadership style changed while she was in the course of being director or if she had adopted this more unilateral style from the beginning?

MS: I just can't address that. I just don't know. During the time that I was there, I thought she was rather consistent. I didn't see a big change, that something might have occurred and then there was a big change.

DT: You said that she disbanded several committees. Do you recall if that was just a gradual thing? How systematic was that?

MS: There must have been something kind of gradual about it. There was this effort to bring in an external consultation group—I can't remember what they were called; you

probably know—who were to assess the situation and see what needs the school had that needed to be addressed. Faculty were called into a room and men were saying why they were there. We were to fill out this big form. This was all the assessment process. What struck me about that particular organization is that the language in the questionnaire had to do with your foreman and your hours of work. Faculty aren't organized that way. This was a different model. This was an industry model placed in an academic environment. It just didn't seem to be an appropriate way to address [our issues]… And, of course, it didn't work. Nothing happened. There were efforts to try to find out what ought to be done here. I'm sure the firing of Edna Fritz was a last resort sort of thing. There were attempts to make things better before.

DT: What was your sense of how Dean Howard and Gerry Shepherd handled the faculty complaints?

MS: I thought they were very receptive. I thought they felt their hands were tied, that they weren't going to impose something from Central [Administration], and I thought that was wise. I felt we were listened to very carefully. I felt that our concerns were recognized and accepted. We were treated with dignity. So I had no problem with that. Those who were resigning at that time, or deciding to resign, felt if we can't get help here, nothing's going to change. I think most of the resignations occurred before Edna Fritz left. I can't speak for them, but I'm sure some were thinking nothing is going to be different. If we go back and do a constitution, what's going to change? That was an unfortunate period.

But right after that, the Health Sciences was initiated, and that's when things really changed for the school for the better. The school became an autonomous unit with its own dean. Then things really started to happen.

DT: Before we get onto that, I'm curious… Do you know how Edna Fritz reacted to the faculty discontent? That has to be a tense situation going to faculty meetings when you're the director and you know that more than half the faculty is dissatisfied with you. Did you see how she handled things?

MS: [pause] I'm just coming up with sort of a blank. I'm trying to think were there a lot of faculty meetings around that time? I don't think there were, actually. [pause] There weren't any instances that I can think of where there was a clash or an argument or a heavy discussion between faculty and the director. I guess I can't fill that in for you. I was getting detached, of course, at that time, because I was trying to get prepared for doctoral study. I had to get this fellowship in order to afford it.

[chuckles]

DT: The faculty who were disgruntled with Edna Fritz, were they in both the graduate faculty and the baccalaureate or was it just the baccalaureate faculty?

MS: No. I think it was both. The resignations, I think, were from both, if I recall. It was mainly baccalaureate faculty, but there were some others. Of course that was the largest number of faculty, because that was our largest program then.

DT: Fritz was finally fired in 1969, and, obviously, you weren't there at the time. I interviewed Bob Howard and he indicated that he had, ultimately, had to fire Fritz because students weren't passing the state board exams, which is why I asked the question about when were the results coming in for the curriculum revision. At least, in the late 1960s, it seems that the students were failing. I don't know if you have any insight on that?

MS: I think that might have been true the first couple of years, and, then, there was a turn around there. That's my recall. By that time, I was out of that arena, but my understanding is that the students maybe after the first couple of years did very well on their exams.

One issue that I remember people talking about at that time, come to think of it, was what is the state board exam measuring anyway? It wasn't measuring the new approach towards nursing care. It was measuring knowledge from the old model. The state board exams did begin to change, not only in Minnesota but in other states as nursing began to conceptualize its role and its educational goals differently.

DT: So, in a way, it's not been surprising that maybe students initially would fail the exam because they were learning different things.

MS: Yes.

DT: And it took a while for the state to catch up.

MS: Or for the program to have some modifications to meet that concern. I'm not quite sure what happened there, but I know in those years nationally, there was a transition of where nursing education's emphasis was being placed.

DT: One thing that struck me in looking at the material in the archives was that once Fritz was fired, then the Central Administration and Bob Howard received a substantial number of letters of complaint from nursing faculty at other institutions and from nurses in the state who were really angry with the University for having fired Fritz and feeling that Fritz had been done a disservice. It struck me as a paradox, given that it was the nursing faculty who were dissatisfied with Fritz. I don't know if you have any perspective on how Fritz was perceived outside the School of Nursing that might explain this kind of disconnect.

MS: No. No, I don't. I didn't know about those letters coming in. It doesn't surprise me. She was very active in nursing organizations, and I think she was thought of very highly. She spoke at many nursing functions at nursing organizations in the state. I think she was thought of very highly.

DT: What was it like then with the School of Nursing being part of this College of Medical Sciences in the 1960s? How did that affect the school and the faculty?

MS: [pause] See, I only can talk about that period from 1964 to 1968. In that short period of time, I suppose what manifested itself in the Fritz episode was that the faculty felt they couldn't address themselves directly to Central, that there were layers that they had to go through. So, I think there was a perception that that's a disadvantage for a discipline to be organized such that you needed to go through a different discipline before you could get to Central Administration, you know, and Academic Affairs. So that organization had that kind of disadvantage. But if you had very responsive deans and directors all the way up, that wouldn't necessarily be a problem. Organizationally, that put the director in the school some distance from where the power really was, in Central Administration and Academic Affairs.

DT: Did you see that being with the College influenced the school in any other way or influenced your experiences as a faculty member in any other way?

MS: Actually, at this time, it was the College of Health Sciences, I believe, so there was an administrator, dean of Health Sciences, to whom Pharmacy, Public Health, Nursing, and Dentistry all reported to. I think we weren't any different from those other units in that respect, with respect of the organization.

DT: Given that Bob Howard, who was dean of the Medical Sciences, was a physician… Did you feel that, somehow, the Medical School had better representation because the dean of the Health Sciences was a physician?

MS: Of the Health Sciences, that was the *only* representation centrally was that dean. Now, that it was *Dean Howard* was not a problem. He had a reputation for and worked very well with all those science units. I think there was not any particular favoritism paid to the Medical School, for example—at least I didn't see that.

DT: How do you feel things changed, if they did, with the reorganization of the Health Sciences and the establishment of the School of Nursing as autonomous?

MS: Now, this is mainly an impression. I was recruited back after my doctoral study and, at that time, I think there were only about three Ph.D.s in the school, and we were already starting to talk about a goal of developing a Ph.D. program. We knew what had to happen is that we had to recruit research prepared and doctorally prepare faculty, and we needed to get research programs running. I think recruitment of faculty would have been much more difficult if the reorganization hadn't occurred. I think to have a dean and to be an autonomous unit made recruitment much better. So we had pretty good success in recruiting faculty. I don't know that that would have happened under the old organization as easily. You had your own tenure home. There were a lot of implications there.

DT: Did you get a sense of what the impetus was for the expansion and reorganization of the Health Sciences?

MS: No. I really don't have a clear idea of how that happened or why that happened.

DT: [chuckles]

MS: I was in doctoral study then and I was reading about this occurring, and it seemed to me to make sense. But I don't know what the impetus was for the movers and shakers that led that.

DT: Certainly, in a fair amount of the correspondence I've seen around it in which the decisions were being made about reorganizing, there was this emphasis on having a team teaching approach within the Health Sciences, this expectation that nursing students would take classes with dental students and medical students and that that then would translate into team practice as well. Did you get any sense of that or did you notice that that had been implemented once you returned, that there was more of an emphasis on this team approach?

MS: No. I think where I saw that more was in the centers. [pause] Now, we did have in the master's program a course in health assessment. Pharmacy students took that course along with our students. Well, that was an example that I saw students working together in a particular course. I think that's the only example I can come up with.

DT: Once you were back on faculty then in the 1970s and the reorganization had taken place, how did you think relations were between the different health science units? Did you have any interaction with the faculty in these other units?

MS: Yes, in a number of committees. There were health science committees, some of which I served on, like the Health Science Promotion and Tenure Committee. I served on that committee for a few years. Then you got to know faculty from the other health science units because you were working together on a certain process of looking at promotion and tenure questions. So through that sort of a committee experience, I got to work with other health science faculty. There was also a graduate school health science…what was called a Unit Committee that dealt with graduate program issues in the Health Sciences. I served on that committee for a while. So the involvement with faculty from other health science units occurred for me pretty much in a committee setting.

Also, I did conduct a research project in the School of Dentistry. I used dental patients as subjects for my study, and these dental patients were undergoing dental surgery being done by dental school students. So through that project, I got familiar with a number of dental school faculty. One was a collaborator with me on that study, and Dean [Erwin] Schaffer was a\the primary person in facilitating that research being done. So through that research effort, I got to know some of the workings of dentistry and some of the

faculty there. I did another research project in the colorectal cancer clinic area, so I got to know some physicians in that area through that sort of effort.

So committee effort and research effort and one course that I know about—I was assistant dean then—in which pharmacy students and our students took the same course together.

DT: Were you practicing clinically at this time?

MS: No.

DT: Do you have any sense of whether a change was felt among nurses who were working, say, at University Hospital, that somehow the reorganization and this reorientation affected their interactions in the clinical setting?

MS: I don't have any information on that. That's a good question.

DT: [chuckles]

MS: I wonder who would be a good source… staff probably.

DT: Yes. A lot about this project is realizing that given an individual's position within the organization and whether they were a clinician or a faculty member or an administrator is a very different perspective on the same…

MS: Yes, I'm sure that's true.

DT: Actually, going back to the 1960s and your time on faculty in the 1960s, one of the things that also changed in, I guess, a curriculum sense was that the practical nursing degree was eliminated in 1966. Do you remember that and what some of the discussions were about eliminating that program?

MS: The only direct experience I had with the practical nursing program was when I was a student pursuing my B.S. degree in nursing education. We were to develop teaching units to get teaching experience and that sort of thing. One of my classmates was teaching a unit on bed bath to students in the practical nursing program. We worked very hard in getting our teaching lesson planned and all that sort of thing. So she needed a patient to demonstrate a bed bath on for all these practical nursing students. So in this big amphitheater in Powell Hall, I was the patient and my friend was giving me a bed bath and lecturing and giving all the information to all these practical nursing students. So that was my single experience with the practical nursing program.

[chuckles]

MS: I was just sort of vaguely aware in the 1960s of people talking about should we still be in this business of vocational education? There had been a number of vocational

education programs throughout the University in other fields and they were slowly disappearing. The University was not doing that work anymore. There were vocational colleges now developing in the state. I remember those discussions of it's about time we get out of that business. We're a senior research university and there are other units in the state that can do vocational education.

DT: When you were working at University Hospital, for example, do you know if you encountered any LPNs on the wards? Did you have much experience with LPNs in practice?

MS: I think not. I think I really didn't.

[break in the interview]

DT: When you were on the baccalaureate faculty, what were you teaching?

MS: I was teaching in the integrated program. We had a team teaching approach so those of us on the faculty I think taught all of what we were calling the nursing courses at that time. We would go to particular units with students for their clinical experience. What clinical expertise we had got expressed that way. The courses weren't organized that Faculty A taught all these courses, Faculty B all these courses. That wasn't the model.

DT: I know you said that the graduate faculty was quite separate from the baccalaureate faculty. I noticed that the graduate curriculum was also being changed around the mid 1960s.

MS: Yes.

DT: Do you have any knowledge of that curriculum change and what led to it and how it took shape?

MS: [pause] At that time—this would have been 1964-1968, in that period—there was a Master of Education Program and a Master of Nursing Administration Program. These were joint offerings with other schools at the University. At this time nationally, nursing was moving away from what were called functional master's degrees and moving toward clinical specialization. That was a national movement. The faculty was deciding that we wanted to institute a clinical master's programs and discussed quite a bit the sort of model that might be used for that, and decided on a Master of Science degree, which would put the program into the Graduate School and discontinue the functional master's degrees that the School of Nursing was offering. I think the first clinical specialty area was in psychiatric nursing and that was around 1964, 1965, some place in there. After that I think it was medical/surgical nursing and, then, after that more and more and more. So they started to grow from that point on. This was a movement into the Graduate School, which I thought was very significant, because it recognized that graduate school had a lot to offer, a unit offering graduate programming. They had high standards and a

master's degree in one discipline meant the same thing as a master's degree in another discipline. They had the same criteria that had to be met. The faculty teaching had to meet certain criteria that the Graduate School established. I thought this was a rather large step for the school to now be giving up its functional and vocational programs and entering the arena of the Graduate School and a Master of Science Education.

That was what was interesting me in the 1960s was this change in graduate programming. That's probably why I got recruited back again, you know. The faculty that were doing that were recruited quite heavily, as I remember, for this first clinical area in psychiatric nursing. We recruited—I'm trying to remember her name—a nationally known person in psychiatric nursing and another person whose name I do remember—it was Grace Sarosi—for planning the medical/surgical master's clinical specialty. [pause] Probably by tomorrow, I'll remember that other name.

[chuckles]

MS: I don't know if it's in Laurie Glass' book. I'll have to look.

DT: If you remember, we can always insert it in the transcript.

MS: I was not involved in the graduate programming at that point, but I was watching with interest. These were good strong faculty that were doing that. There were a very small number admitted, like two or three students, a very small beginning. But it grew very fast.

DT: With all these curriculum changes then at both the baccalaureate and graduate level, what did that mean for the faculty? Obviously, if you're changing the way that graduate teaching is done, you might need differently trained faculty.

MS: Exactly.

DT: Were there concerns about there being a shortage of appropriately prepared faculty?

MS: Well, it depends on what degree you are expecting. I think there was not a shortage of educators with a master's degree in psychiatric nursing and med/surg nursing. When we got to midwifery and child health, I think there was not a shortage of master's prepared educators. As we began to focus more on our objective of eventually getting a Ph.D. program, there *would* be a lack of doctorally prepared nurse educators in those areas. We couldn't have moved into a Ph.D. program without doctorally prepared faculty. I think we were ten years in the planning before that was realized, but necessarily so. Because the educators with master's degrees were not in short supply, I think the master's program was able to grow quite significantly during the 1970s.

DT: One of the things I saw in discussion—I think it was around the revision of the graduate curriculum—was that the school wanted to prepare professional nurses rather

than technical nurses. Does that sound familiar to you? Do you have a sense of what that referenced?

MS: [pause] Are we talking about the 1960s?

DT: Yes, I think this was in the 1960s.

MS: I think in the 1960s, if you read the nursing literature broadly, there was a big focus on are we a profession or not? It was understood we were a vocation but there was argument on whether we were in a technical field or a professional field. So there was a *lot* written on what are the criteria for professionalism? The literature was just filled with that. That was an *agonizing* kind of soul searching…are we vocational or are we technical or are we professional? I think the concern with that term lessened when we started asking a different question in the nursing literature broadly, and that was is there a science in nursing? Is there a nursing science? Here we were giving Master's of Science degrees in nursing and thinking of a Ph.D. So when we started asking that question, I think this concern with *profession* sort of diminished. It was not a concern if you are trying to define the nature of the body of knowledge that you're teaching or researching. So when we started asking the question, "What's the science here"" and we also were asking, "What are the ethics here?" and "What's the philosophy?" those sorts of questions, then I think that idea of professional became less.

DT: Do you think it became less significant then in the 1970s or did it take longer than that for these questions to get asked?

MS: We were still asking that professional question in the early 1970s.

There were some important nursing papers that were being published at about that time that focused more on the nature of the body of knowledge and how does one know something? There were papers written on other scientific knowledge. There's personal knowledge. There's philosophic knowledge. Those sorts of issues began to be debated. As one started to think about a Ph.D. program, those questions became very important.

DT: How did the graduate faculty, the School of Nursing then, particularly those involved with the planning of the doctorate, conceive…what was the body of knowledge that you saw as being central to nursing?

MS: That, of course, was the primary question.

One interesting experience I had… A group of us on the planning committee for the doctorate program met with some faculty from some other units at the University, met with some faculty from educational psychology and physiology, some other faculty who had an appreciation for nursing and were very supportive of our effort to carve out a doctoral program. They would ask us really good questions, and we didn't have answers to them. They would ask us something like, "What is the body of knowledge?" "What is the field of research that's called nursing?" They'd ask us questions like that. We would

say, "Oh, well, it has to do with health, a focus on health." "Well, so do a lot of other people. What about nursing?" "We talk a lot about caring. That's an important concept, caring, people writing papers on caring." "So do other disciplines, you know." [chuckles] These were very good discussions. There was one particular faculty member from Ed-Psych [Educational Psychology]; his area was philosophy of science. He said, "We are seeing a new discipline emerging here."

[telephone rings – break in the interview]

MS: He said, "There is an emerging discipline occurring here at the University." He wanted to study it. He wanted to study how we were going to put together this program, this concept, define its parameters and its area of study. There were members of our faculty who objected to that. They didn't want him to be participating in that way, the rationale being that's another example of another discipline *using* nursing. Well, I didn't see it that way at all. I thought this is a terrific opportunity for someone who knew something about the philosophy of science, for helping you envision the science you were talking about. We hadn't conceptualized it clearly, and neither had the rest of nursing.

We finally did get—it was actually our third proposal a for Ph.D. program—a proposal together that got approved. It's not in Laurie's book, but there were three proposals written. I don't know if all three of them are in the archives.

DT: There is a lot of material around the doctoral planning, and I'm actually certain that I've seen it. I've certainly see at least two of the proposals, and I think maybe even three.

MS: The middle one might not have gotten out of the school. The first proposal really hadn't dealt specifically with these kinds of questions that were being asked of us in the planning group, and it was not successful. I was at the meeting of the Health Sciences Policy and Review Council that was going to decide whether to accept or reject the proposal, and they did reject it. Isabel Harris was at the meeting, and she asked, "What are the criteria that you are using? It would be helpful to us to know what the criteria are." Someone from the P&R Council said, "There are no criteria." I think what he meant by that is there aren't any written down. Of course there are criteria. We were *very* disappointed by that effort.

Then another proposal was put together, I think fairly rapidly. And this was just at the time that Ellen Fahey came as dean. She looked at that proposal, and she said, "I don't understand this at all. I don't see what this is about." She wouldn't let it leave the school. She wouldn't submit it forward, which was a *very* good decision on her part.

By the time we did the third proposal… I was a major writer of that, as was Ellen Egan and Catherine Norris. By the time we got that final proposal developed, the planning group had the benefit of many, many, many, many more meetings of course, addressing these questions much more specifically. So it was a coherent proposal and there were areas of study that were named and described. I was director of graduate studies at the time, and as that proposal went through the approval process, I sat in on a number of

those meetings. We were getting the feeling that there was support growing for the idea of a Ph.D. in nursing, not on everyone's part by any means. There were faculty in other units that felt *very* strongly that in no way will there be a Ph.D. in nursing, just adamantly opposed to it and very vocally. It just squeaked by on the P&R Council. I think it was a tie vote, actually on the P&R Council. Somebody—this was at the meeting of the whole P&R Council—announced that that proposal had been defeated in the program approval committee. Mitzi Duxbury from our faculty said, "I don't see how you can say it's been defeated when it was a tie vote. I claim that it was accepted!"

[laughter]

MS: There was another vote then to forward it to the next step with the recognition that it was a tie vote in the P&R Council. To some executive committee, it went next. Then, it was approved there, and, then, approved all the way up the line. It was a squeaked through proposal. When I look back at it today, I would change many things in that proposal because we've gotten a much better concept of what the discipline is all about.

Margaret Newman and Sheila Corcoran-Perry and I wrote a paper called, "Focus of the Discipline of Nursing," which was published. I don't know what the date was on that. Anyway, that was *years* later. That pretty much expressed where we ended up, I think, in conceptualizing what the discipline was about and what the focus of study was about. That paper is cited all over the place now. It got quite a bit of attention nationally. If you Google that, that article…

DT: I certainly will.

MS: …it is cited in books and other manuscripts.

Nursing was at a point that it was asking the question because many doctoral programs… What is our field of research? What is our focus? What will be the science? That question was being asked broadly and many papers were coming out proclaiming this is it. Then, Newman, Sime, and Corcoran-Perry came out and said, "This is it," and that got a lot of attention.

DT: Who in the Health Sciences then were opposed and why were they opposed to nursing having a doctorate program?

MS: Nobody told me their rationale. I don't know. Some of our faculty thought it was just purely sexist. I think other people thought there wasn't an area to research. It's going to be overlapping this discipline and this discipline and this discipline. There seemed to be some concern there for the strict boundaries between disciplines. I don't think people have that view anymore, because everything is interdisciplinary now. But, I think at that time it was, "You're encroaching over into health care psychology," one comment might be. Another might be, "Oh, you're encroaching on some area of medicine," or whatever. I don't really know clearly what people's rationale was.

I guess I can tell this story. One day, after a meeting in the Graduate School, I walked across campus with one of the associate deans of the Graduate School. We were walking across campus on this nice beautiful summer day. I don't know if I should name him or not. He started to ask about this process of getting the doctoral program approved. I described for him how it was a sort of squeaky approval in the initial steps. He said, "Some day, when I write my memoirs, I'm going to describe what that was all about. You cannot believe the opposition to that." He inferred that that had not been made public, but that he was aware of the—the Graduate School was one of the steps of the approval—opposition, and he said, "You can't believe how vicious it was. When I write my memoirs…" So we've got to wait for that.

[chuckles]

MS: I don't know people's rationale.

DT: If you're not comfortable sharing it on the record, maybe when we turn the tape off, I'd love to get his name so maybe I can interview him.

MS: Yes! He would be a good source…

DT: It sounds like it. I would like to be able to talk to him.

[pause in the interview while Marilyn writes the name on a piece of paper]

DT: Great. Thank you.

When you were planning for the doctoral program, were there other nursing schools that had already established doctorates that you were maybe modeling yourselves on?

MS: Yes. We weren't modeling ourselves on others, but there were a few programs… Laurie Glass, I think, describes that quite well, how many programs there were. We held a number of workshops, and we had people in from some of these other programs. We had—what's her first name?—Schlotfeldt [Rozella Schlotfeldt]. I'll think of it later. She was one that came in that was well-versed in doctoral education. So we brought people in like that to these workshops. They didn't specifically say, "This is what this university is doing. You should do something like it." They more came in and said, "What is your thinking?" "How are you conceptualizing the body of knowledge?" "What sorts of research methodologies are you thinking would be acceptable in your doctoral program?" and that sort of thing. There was a lot of discussion nationally whether there was *a* methodology for nursing investigation or whether there were many. If there were many, were some better than others? The whole nation was going through a similar type of discussion. We weren't trying to pattern after any particular school, but we did do some homework in trying to get familiar with what other schools were doing.

DT: It's interesting to think about because I guess the vast number of the graduate faculty had their doctorates in other areas.

MS: Yes, that's true.

DT: Obviously, you did, too.

MS: Yes.

DT: I wonder did that influence as you tried to work through these questions?

MS: I'm sure it did, because we came from diverse fields that had different accepted methodologies and different ideas of what comprises a science. We had faculty whose Ph.D.s were in physiology, in ed/psych, in educational administration, in history, in anthropology. There was a whole variety. That probably helped us think without a lot of fences on methodology and a field of inquiry and what would constitute an acceptable science and evidence of knowledge, issues like that. I think that was helpful.

But when it came down to some nitty-gritty issues, then people could only speak from their own perspective. What was my experience as a doctoral student trying to get through final exams and trying to put a dissertation together? When you got down to that kind of process issues…

[break in the interview]

MS: There was some disagreement. But I think on broad concepts, it helped to have that kind of diversity.

DT: My understanding of nursing doctorates now is that, again, there is still that diversity within the program, the different kinds of tracks that you can do within a nursing doctorate.

MS: Yes.

DT: So it really seems to have been quite an influence on things.

One of the things I realized in reading some of the correspondence and meeting minutes around the efforts to get the doctoral program started is there were concerns expressed by people outside of the nursing school that the school lacked, I think it was, really the intellectual and research capacities to do graduate work. Maybe that was really just a case of, okay, what's your body of knowledge? What's your methodology? I remember feeling that they were saying, "You're just not up to it." There was the thinking that the school wasn't capable.

MS: Yes, I think that's true. I think we were just barely over the boarder.

[chuckles]

MS: I did have some concerns. Do we have enough people here who are actually running their own projects who have gotten funding? When you're bringing in doctoral students, you're going to want to be able to give them research training somehow and if not on your own projects, how are they going to get it? There were very practical questions like that. I think we just had the bare minimum. That's my personal view. I think we just had the bare minimum.

When we sat around to admit students, we looked at that *very* carefully, that an applicant to be accepted would, first of all, have to meet the criteria for admission. But, beyond that, they would have to be matched up with a faculty person who was, in fact, engaging in research in the area that the student was interested in. It had to be that match. If we had no faculty member for this applicant, we couldn't admit the applicant. That was actually very sad for some applicants who were *very* qualified people, but we just didn't have an advisor for them. We paid a lot of attention to that at first. So our numbers were small in the beginning, but, as we recruited more faculty and as current faculty got their own research programs established, then we were able to make more matches. We were very careful about that. Ethically, we couldn't admit a student without a faculty advisor on board. Why put a student through that? I hope that concern continues today.

As faculty got more established in what they were doing, applicants would ask for a certain advisor whose research they were interested in. They wanted to come and study with so and so because they knew that person's work. Then, as faculty research developed more broadly, then applicants became more aware of who was doing what here and is there a good match for me here? If not, as an applicant, maybe I need to look someplace else.

DT: I thought that when you were involved with planning the doctoral program that the school received some funding for that planning process. Did you get federal grants to help with…?

MS: Yes, I think we got some federal funds and I think maybe there was a Kellogg grant in there. Laurie describes that. She has, of course, all the documents. So my vague recall, you know, shouldn't be relied on.

DT: [chuckles]

MS: But there was funding.

DT: Actually, that begs another question I have about how nursing education was financed over the years. Was the school getting money from the state and how well funded was the School of Nursing from your perspective?

MS: From my perspective I'd say, "I don't know."

[chuckles]

MS: I was never in a position to know anything about the school's budget. Working from what it's size was, I just never had that knowledge. Even when I was assistant dean, I was not a participant in budgetary discussions. So I think you're going to have to talk to some administrators about that. I just can't answer that question.

DT: When you arrived back in, what did you say, 1972…

MS: Yes.

DT: …Isabel Harris was dean?

MS: Yes.

DT: What was it like working with Isabel Harris and how was she as a dean?

MS: She was a great dean, I thought. She was very supportive of this really long range goal that we had for doctoral education. She was very supportive of that and sought ways to help with that planning. She was an ambitious recruiter of new faculty and recognized our need for recruiting doctorally prepared faculty and research prepared faculty. She hired some key people for the school…Barbara Redman as an associate dean. She recruited Ida Martinson as director of research and Ellen Egan. She [Ellen Egan] had a Ph.D. in nursing. She was the first one on our faculty. When we got this small cluster of doctorally prepared faculty, things really started to develop, I think. We had very ambitious faculty recruitment efforts going. Faculty were being supported in seeking external funding for their research. So there was seed money that could be obtained through the school and through the Graduate School.

DT: Did any of the faculty who had resigned at the end of Fritz's tenure return once Dean Harris was in charge?

MS: No. The ones I know of scattered to different schools and I think finished their teaching careers in different universities…the ones I think of. I think I was the only one that retired at that time—my only reason wasn't because of the leadership issue—that returned, got recruited back.

DT: That's certainly been my sense, as well. That's why I was so excited to be able talk to you is you saw both sides of things.

I realize this is probably something you may not be aware of because you were at the BU [Boston University] at the time. Something that struck me when Isabel Harris… She was initially acting dean and then she was formerly made dean and, at the same time, Lee Stauffer in Public Health had gone from being acting dean to being made dean. There was some criticism in the local newspapers that the salaries of both of them had been made public.

MS: I remember that. I saw that in the paper.

DT: Oh, you did?

MS: Yes.

DT: Harris with a Ph.D. was being paid less than the Stauffer who only had a master's. What's your recollection of that?

MS: I just remember reading that in the paper. Isn't this astounding? Is this another women's issue? That sort of thing. I think there were some alterations made in salary following that. I was not close to the players at that time.

DT: It's interesting that you read about it.

MS: It was in the Minneapolis paper. It was quite an issue. There might have been some editorials on it, too. I don't recall.

DT: I remember seeing several letters written mostly by frustrated, angered nurses in the community. I know that in response to the press coverage, the Regents did revisit the salary issue and they bumped Harris up. I don't know that she ever got as much as Stauffer.

MS: Hence the [Shyamala] Rajender issue, you know.

DT: Yes.

MS: That was across campus.

DT: It was pervasive, really. How do you think issues of gender affected you in your work on the faculty?

MS: Well, in the 1970s and 1980s, when I was quite active in senate committees and health science committees and other committees across campus, there was no trouble getting on a committee, but you would kind of recognize am I the token woman here? I'm the only woman. [chuckles] Am I the token woman? Surely, there are other women faculty who would be interested in this particular committee. I was interested in serving on those committees to get a better appreciation of the total university and its many facets. But, sometimes, clearly, it seemed like, oh, you are the token woman. I didn't feel ever discriminated against, but I sometimes felt, well, we'd better have a woman on here but we really don't care too much about what you have to say.

[chuckles]

DT: Around this time, the women's health movement is building when you have a lot of women criticizing the paternal medical system. Were you or any of your colleagues in

nursing involved in the women's health movement at all or have any particular perspective on that?

MS: I think faculty were quite involved in that, different aspects of it probably…individuals. Some of our faculty were very involved in the *Roe v. Wade* and others were championing breastfeeding in public. That soon was legislated that that was permissible. Some were very involved in health programs for women and children, the WIC [Women, Infants, and Children] programs and that sort of thing. I think in various different ways, the faculty were championing certain positions. I don't know that they were marching out on the street with signs…

[chuckles]

MS: …but in very appropriate ways were supporting the advancement of women's rights and responsibilities.

DT: Did this factor at all into the discussions that the faculty were having then about developing the graduate program? Was there any feminist agenda within, I guess, the curriculum work that the faculty was doing, that if we establish a doctorate in nursing that's a way of advancing women's participation in health care?

MS: [pause] I really don't think so. I'm trying to think of whether any mention of that appeared in the publicity for the doctoral program. I don't think that was an issue, advancing women—advancing nursing, of course, which, at that time was not strictly a woman's profession. We had a number of men in our master's programs. Still, it was a predominately female field. I don't think that was a rationale for wanting a doctoral program.

DT: It's interesting you mention *Roe v. Wade*, because—I'm not sure of the exact date—sometime in the mid 1970s, the head of OB/Gyn was hired. I think it was Doctor [Konald A.] Prem who was appointed.

MS: Yes.

DT: He was opposed to abortion, I recall, and there was a lot of opposition to his appointment. Do you remember any of that?

MS: The only thing I remember hearing—I didn't hear about his opposition to abortion—was that he… I don't think I should do this hearsay.

DT: If you're comfortable… I can try and verify it as much as possible.

MS: Well, the story I heard was that he had a sexist attitude toward staff; let's put it that way. That's what I heard.

DT: Hearing what the rumors or the stories were is actually valuable. That's not to say that then we take that as a given, but it's valuable to know how people were perceiving things and the stories they held to.

Isabel Harris was dean for a few years, and, then, she stepped down and returned to the faculty?

MS: She did.

DT: Then, Dean Irene Ramey replaced her?

MS: Yes.

DT: Do you know why Isabel Harris decided to step down?

MS: No. No, I don't. When Irene came, what year was that?

[pause]

DT: I should know. Laurie [Glass]…

MS: Yes, she has [a list of]…what happened when.

DT: Yes.

[long pause as Marilyn searches for date]

MS: In 1975, she came. She was 1975 to 1979 when she died.

DT: How did the faculty receive Dean Ramey's appointment?

MS: I think very favorably. She was one of my favorite people in the whole world. [chuckles] I really liked her. She liked her faculty. She was the only dean that I served under who would come down to the cafeteria and sit down at a table and have lunch with you. She was very informal with her faculty. She had high standards. She, of course, was a major player in our getting the new building. She was very supportive of the Ph.D. program planning—of course, that didn't occur on her watch. That was later after Dean Fahey came. She didn't live long enough. [Irene Ramey died June 28, 1979]

DT: Talking about getting the new building built, Unit F, there seemed to be a lot of difficulty with getting the state's approval for that building.

MS: I wasn't on the building and planning committee, so I'm kind of on the outside here. We wrote a proposal for a School of Nursing building seeking federal funding, which had to be matched by the state. We were unsuccessful in getting federal funding for that, but did get encouragement to resubmit a proposal with another health science discipline,

sharing the same space. So another proposal was developed with Pharmacy, and that one was successful. I don't know if the trouble of getting it funded was from the state side. This is what I knew about the federal end of it: the first proposal not accepted but the second one was.

DT: It looked to me as if the federal funding was there, and, then, the state pulled out and said, "We don't want to fund this anymore."

MS: Ohhh, okay.

DT: One of the things that I had seen was that the state, particularly Senator John Milton, was fed up with the health sciences and thought that the University was big enough already and didn't need any more space and so were rejecting the funding on that level and were willing to forego the federal funds, and I've seen that Dean Ramey had lobbied incredibly hard.

MS: Yes.

DT: It seems that she was quite well connected politically. I wonder if you have any sense of how she came to be so politically influential.

MS: I don't know. She was an imposing figure. I don't know if you've seen any pictures except a head shot?

DT: Just a head shot.

MS: I remember her getting in a discussion with another dean or administrator type from another unit, and they were arguing over some principle. This other administrator was a fairly short man and Dean Ramey just *towered* above him and would be looking down at him…

[laughter]

MS: …and very politely and graciously would be giving him her point of view, but she was an imposing figure. She would capture attention just walking in the room. You could not know she was there. She was very intellectual and she could argue. She could argue rationally and logically a point, and I think she probably was very good in the political arena.

DT: And it seems that the school really needed that building.

MS: Yes. We were in Powell Hall which was falling apart. It was imploded just after we moved out.

DT: There was a need as the school was expanding its research capacity.

MS: Yes.

DT: It needed space for labs.

MS: That's right. We didn't have good teaching labs, and we needed labs where clinical situations could be simulated. You know, new kinds of equipment were coming. We didn't have the space for doing that kind of thing.

DT: Another big issue, when you were first on faculty in the 1960s and then, again, in the 1970s, was this national and state concern over a shortage of health care workers, including nurses. What was your experience of this concern over nursing shortages?

MS: [pause] I was teaching the graduate program at that time, I think. The activity that I was involved in that really was focused on nursing shortage was how do you get educational programs to the people who want them? We were hearing from potential applicants that they couldn't move into the Twin Cities. They had responsibilities at home. They had a job. They had a family. How were they going to be prepared to fill these positions that were going lacking?

So we started a lot of outreach at that time. We were taking course work from the master's program to Rochester, so that the people in that geographic area didn't have to travel to the Twin Cities to get the course work. So we brought course work down there. Then, if they were going to be having a certain kind of clinical experience, we'd arrange for it down there, and they would only have to come to campus probably just a few times to meet with their advisor and to get thesis advisement. I think there was one course they would have to take on campus. I know I drove there weekly teaching these courses down in Rochester. That was an effort to meet some needs for master's prepared people. We'd try to bring stuff to them to facilitate their study. We did the same with Duluth. We took courses up to Duluth…Duluth, Rochester, and one other place.

DT: Was it Saint Cloud?

MS: Maybe Saint Cloud. I don't think it was Moorhead. I don't think we went that far west. That was one effort.

Now, at the baccalaureate level, I can't talk to that specifically.

Also, at the same time—I'm thinking of the master's education now—there was some question about the large number of nurses nationally, RNs, who had gotten baccalaureate degrees in some other field. They couldn't afford to go to the baccalaureate program in nursing, for example, or there wasn't one near them, but they had a baccalaureate either before they got their nursing diploma or they got a baccalaureate afterwards. There were large numbers of these people and they were seeking entry into our master's program. The faculty weren't sure that we should be admitting them without their getting baccalaureate level nursing courses.

So we did do a project. I headed up a project that was called the "Entering Behaviors Project," in which we studied that question. We admitted nurses with baccalaureate degrees in other fields into the master's of nursing program and, then, studied them for a period of years to see were they as successful? They would meet the same admission standards. Did they graduate at the same rate, etcetera, etcetera? In any measure we had, there was no difference. They were as successful. So we changed our admission requirements and didn't require them to go someplace and get some kind of a baccalaureate nursing courses before they could come in. Other schools, I think, did the same thing.

DT: I remember seeing some material related to the challenge exams for RNs in the early 1970s. Was this related to this question?

MS: No. I think those challenge exams, as I recall them, were to challenge out of course work. This study had to do with can somebody without a baccalaureate in nursing be successful in the nursing *master's* program? So they weren't challenging out of anything. They were just proving that they could be successful.

DT: Yes. So the challenge exams then were a way of testing out…?

MS: I think it was testing out of something, yes.

DT: I saw some correspondence from RNs out state Minnesota saying, "We want to develop ourselves, but we can't come to the Twin Cities." The school was building extension courses further afield. Is that overlapping with the courses that you were teaching at Rochester and Duluth?

MS: No, those were master's level. I think you might be talking about RNs wanting to seek a baccalaureate.

DT: Maybe that's…

MS: I think that's maybe what you're… Yes.

DT: I was a little unclear on what the challenge exams corresponded to, but it was for RNs wanting baccalaureates, but not being able to come to the Twin Cities to do it?

MS: Yes, and not needing the whole package.

DT: You didn't have any involvement…?

MS: No, I wasn't involved in that.

DT: Do you think then the concerns about there being a shortage of nurses was not an issue in the 1960s? Do you think the nursing shortage was really something that was experienced in the 1970s instead?

MS: It seems to me there's always been a nursing shortage.

[chuckles]

MS: I don't remember time, except during the Depression years that I heard about nurses not being employed or fully employed. In my personal experience, once I got out of the diploma school and became an RN, I could be employed any place. I was guaranteed a job. It didn't matter where I went. I could go to Minneapolis and I could go to Boston and what not and could *always* get a job.

DT: The Nurse Training Act was passed in 1964, which I think was, in part, geared to increase the number of increasing enrollments in nursing schools. Then, in the 1970s—this is, again, something that I think Dean Ramey was quite heavily involved in—President [Jimmy] Carter vetoed the Nurse Training Act and wanted to reduce federal support to nursing schools. Do you remember any of this? Were you aware of that?

MS: Yes, I think I was aware of it, but I wasn't very political at that time.

[laughter]

DT: I remember I saw memos and letters from Dean Ramey to faculty and to nurses in the community saying, "Write your member of Congress…"

MS: Yes, yes. I recall that.

DT: Something else I saw from the early 1970s, 1973, was that there was an effort to establish the Health Sciences Bargaining Unit, to have all the health sciences represented in one unit.

MS: To bargain for?

DT: I guess salary, kind of as labor, trade union, almost. Do you remember any of that at all?

MS: No, I don't.

DT: Was the School of Nursing involved with establishing the program in human sexuality? Were nursing faculty involved in the teaching that program?

MS: [pause] Who spearheaded that?

DT: Richard Chilgren was head of it for a long time.

MS: So that would have been Public Health?

DT: It was actually in the Medical School.

MS: You see, I'm not familiar with it, obviously.

[chuckles]

MS: I don't know who might have been involved in that.

DT: It was interdisciplinary, and I wasn't sure to what extent the School of Nursing… It's just one of those questions I'll ask other folks, too.

MS: And see what you can find out, yes. As these interdisciplinary programs grew, it would often be like one faculty member who would be very involved in that, have that particular interest, and maybe the rest of the faculty wasn't particularly aware of that. I got very involved in the establishment of a freestanding disciplinary minor out of the Graduate School in interpersonal relationships research. Probably very few of the faculty in the School of Nursing were aware that I was involved in establishing that minor. I'm sure that's repeated many times, especially in these freestanding interdisciplinary programs and centers.

DT: That's why I'd like to try to talk to as many people as possible, because even where there's shared experience, there's always those nuances.

MS: I wouldn't be surprised if some nurse midwifery faculty were involved in that.

DT: I noticed the nurse midwifery program was developed in the early 1970s, also.

MS: Yes.

DT: How did that come about? Was it a smooth development?

MS: Sharon Rising was the one who initiated that. I don't recall that being any kind of a problem. The master's curriculum, at that time, had a number of core courses and then students would have a choice as to a number of clinical oriented courses. So, if there was any concern or discussion on the part of the part of the faculty, it would be that the midwifery students would need to be taking these other core courses, because they were required of all in the master's program. There might have been some discussion around that. I was teaching those core courses. I do remember some midwifery students asking, "Why do we have to be taking these courses?" Of course our response was, "That defines the field of nursing. That's defining the discipline." Students didn't like taking those courses until after they had taken them. Then, they had things to say about how that really helped in their practice.

DT: so it really was just a further development of the graduate program?

MS: Yes. We were seeing that it wasn't difficult to add another clinical area of study in that master's program model because there was a core that took care of the science part of it and the research part of it and what is the discipline part of it, and then added on to that could be these various clinical areas. So as we folded them in, there didn't seem to be any problems. Public Health Nursing in later years got folded in very easily because of that model. I was on that task force that led to that.

DT: You don't know how the obstetricians felt about the nurse midwifery program?

MS: I don't have any [knowledge of that]… Kathleen Dineen could certainly tell you a lot about that. She was the second director of the midwifery program.

DT: How do you spell her last name?

MS: D-i-n-e-e-n.

DT: The Public Health Nursing seems to be an interesting one. For the 1950s and the 1960s, Public Health Nursing was in the School of Public Health. Is that right?

MS: Yes.

DT: So the task force that you were on, was that about bringing Public Health Nursing back to the School of Nursing?

MS: Yes. It was about bringing the *master's* in Public Health Nursing into the School of Nursing. I don't think we had ever had a master's in Public Health Nursing in the School of Nursing. We had Public Health Nursing courses that students could take, but the master's degree in Public Health Nursing was an MPH degree. Was that in the late 1980s or 1990s? [Marilyn checks her notes]. That was in 1988-1989. There was a Public Health Nursing Task Force that I was a member of. The big issue was can public health nursing at the master's level be moved into the School of Nursing? The reason for asking that question, as I understood it, was that Public Health Nursing in the School of Public Health had lost [National League of Nursing] accreditation. To continue, it needed a new home. Because we had the model we had for the master's programming, it could very easily be done…just take the core courses and the public health nursing courses, bring over a couple faculty. We can do it. There's no problem; we could do it, and it was done.

DT: Had there been any discussion before the late 1980s about reintegrating the Public Health Nursing into the School of Nursing either at the undergraduate level or the graduate level?

MS: It was integrated into the baccalaureate level. I don't recall discussion of integrating it into the graduate, because it would be a duplication of what the School of Public Health was doing.

DT: Was it awkward to have some Public Health Nursing faculty in the School of Public Health and not in the School of Nursing, that there was this separation between what was still fundamentally a nursing program?

MS: I don't know when that decision was made. See, Public Health Nursing has bounced back and forth, I think, over the many years. It, first of all, was thought to be essential in a baccalaureate program and, then, it was thought to be, well, that's something extra. It would be an add-on to a baccalaureate program. Then it was integrated into the baccalaureate program. Then, I don't know how it got decided or when that at the graduate level, Public Health Nursing should be an offering in the School of Public Health. That, I suppose, sounds logical.

[chuckles]

MS: I don't know when that decision was made or how it was made. I just participated in the decision to move it back to the School of Nursing.

DT: There were a couple of organizations that were operating in the 1970s, at least, but I wasn't entirely clear what it was they were doing. So I don't know if you'll be able to shed some light on this. There was a Committee on Institutional Cooperation and the Agassiz Region Nursing Education Consortium.

MS: I'm remembering those names.

DT: It looked like they were involved with regional planning.

MS: Was that during Ellen Fahey?

DT: It was earlier than that. I think Dean Ramey was involved, but I think also Dean Harris was involved. It was regional planning about nursing workforce, to make sure that enough nurses were going to be in the Upper Midwest.

MS: Oh, yes, I remember some of that. I was not a participant in those efforts. I do remember that terminology and that effort. Yes, regional planning; that was a big deal there for a while.

DT: By the end of the 1970s, it seemed planning terminology was being used also in the Health Sciences. The School of Nursing, I think along with the other health sciences, were asked to draw up long range plans for the school.

MS: Yes.

DT: This seemed to cause some difficulty for the School of Nursing or, at least, the School of Nursing had some trouble getting their long range plan accepted by Central Administration. I think Dean Ramey began this, but it was Dean Fahey that continued defining that. Do you know much about that?

MS: I just remember being involved in meetings at which long range plans were discussed and written down.

DT: [chuckles]

MS: I was not a participant beyond that. You're saying we had difficulty getting those approved. I wasn't aware of that. I have no firsthand knowledge of that.

DT: I think it was not Central Administration, but the AHC [Academic Health Center], so I think people in Lyle French's office were concerned. I have "lack of realism" written down here. There was a lack of realism among the nursing faculty about what the school could achieve and what it could do. It strikes me that it was somehow tied up with whatever ambivalence there may have been outside of the School of Nursing regarding the doctoral program.

MS: Yes, probably. Yes, they were probably talking about our long range plans. For ten years, that's all we talked about.

DT: Speaking of Lyle French… How did you and your colleagues in the School of Nursing experience Lyle French?

MS: I didn't have any personal dealings with him at all or even a conversation, I don't believe. [pause] I can't recall what years… I think he and Dean Ramey had a good working relationship, as I think back at that. I remember her talking about him in very favorable terms. I was just not in that level at that time.

DT: It's interesting that when we were talking about Bob Howard, you had said that he was very supportive and there was no favoritism shown. I wonder with Lyle French coming as vice president of the Health Sciences in 1970 whether you felt any difference. It sounds like maybe you just didn't have any reason to encounter…

MS: Yes, I had no reason to.

DT: How were relations with the University Hospital, and like Ray Amberg—this would be in the 1960s—and then John Westerman in the 1970s? Was there any close relationship between the School of Nursing and the University Hospital?

MS: Well, it would have been the major learning environment for the undergraduate program, not for the graduate program. [pause] As a faculty member, I did not have any experiences with the hospital administration. As a student, I did, as a doctoral student. I did my dissertation research on the University Hospital with very fine cooperation of administration. My academic activities were more in the classroom and a research environment, not in the hospital.

DT: What was your doctoral research on?

MS: The title of it was "Preoperative Information and Responses to Surgery." No, that was the title of the second study. The dissertation was "Level of Anxiety and Recovery from Abdominal Surgery." I looked at what patients' experiences were before abdominal surgery and followed them through the recovery period. I was really testing a theory that high fear people and low fear people before surgery do worse afterwards and the moderate fear people do best because they are *properly* fearful.

DT: [chuckles]

MS: The data did not support that theory at all. Low fear people do best. High fear people do worse.

DT: Just a couple more questions. [chuckles]

Given that you had experience at these other institutions, Boston University before you even came to the University [of Minnesota], how distinctive do you think the School of Nursing at the University of Minnesota was in terms of the relations within the school and, then, relations between the School of Nursing and the other health sciences?

MS: How distinctive?

DT: Do you think the School of Nursing was comparable to other schools of nursing or was there any distinctiveness to it in terms of how relations were within the Health Sciences?

MS: Well, the only other school of nursing that I would have been familiar with would have been BU. My sense of BU was that their School of Nursing was really independent. I think they no longer exist. They had started a doctoral program which the university ceased to support, and, then, they closed the master's and the baccalaureate program. I don't know why all of that happened. I still get alum stuff from a non-existent school, you know.

DT: [chuckles]

MS: My sense was that the school was so separate and that that university [Boston University] was going through a lot of rescission of funding, that whole period. They were very vulnerable. I wouldn't see that happening here at the University of Minnesota. I wouldn't see any of the Health Sciences units being dispensable. We had more health science units than most universities do.

DT: What role did the Minnesota Nurses Association [MNA], the ANA [American Nurses Association] and the National League of Nursing [NLN] play for the School of Nursing?

MS: Of course, the NLN is an accrediting body.

DT: Yes.

MS: …so it accredits programs. Regularly one has an accreditation visit. It's a lot of work getting your accreditation report ready and all that sort of thing. I think the University programming has never had difficulty with NLN accreditation.

The MNA, the Minnesota Nurses Association, back before a lot of collective bargaining started to occur in that organization, was a very strong supporter of nursing education and had a strong section that dealt with nursing education issues, which I chaired for a while and, for most of the time, I was a member of the MNA. They also had a section that was very supportive of nursing service and administration. But, then, the MNA became so involved in its union work and these other efforts just fell by the side. I think faculty ceased to be members because that professional functioning, the broader professional functioning not the bargaining stuff, became less important to the MNA Board. They just didn't pay any attention anymore to those issues as major issues. So I became sort of disappointed in that organization and I resigned. I don't know when it was. It was probably in the late 1980s.

The ANA, the American Nurses Association, I think has done a lot to support the efforts of nursing as a social mandate. It sees the broad issues. It supports a lot of publication efforts. It has seed money through its foundation for research. I think probably most members of the faculty were ANA members, and gladly so.

DT: One other question I forgot to ask about the 1970s was as the school was working on graduate education, there was nationally the nurse practitioner movement.

MS: Yes.

DT: What discussions or were there any discussions taking place about starting a nurse practitioner program?

MS: I remember discussions that had to do with what were nurse practitioners doing? Were they doing nursing? Were they doing more physician assistant sorts of activity? The role of nurse practitioners, of course, started out very vague. There were different interpretations of what that all meant. Nurse practitioners were certified by nursing organizations, not universities, not educational programs. So if you were to have a nurse practitioner program of some sort, you would, of course, have your academic requirements of anybody else getting that level of education, but the *practitioner* part of it would be a set of requirements set by some organization outside of the school who would be either licensing or certifying them for that kind of practice. So that became sort of an awkward thing. We did have areas of study in the master's program that were preparing practitioner types, pediatric practitioners and adult geriatric practitioners, that sort of thing. But as students would meet our requirements for getting the master's degree, there were these additional requirements they would have to do, either more hours of study or more clinical placements or something of that sort that these certifying organizations

would be making requirements of for them to sit for their license or their certification. That was confusing to students that we would have one set of requirements for the degree but for the practitioner certificate, you would need to meet another set of requirements that we didn't control.

DT: Right.

MS: So there was some debate back and forth about how can one meet this new need, and not be setting the standards for it. It's being set someplace else. Now, I think it's a much different situation in the schools; they're full of [nurse] practitioner programs, as I understand it.

DT: Do you think the nurse practitioner movement was a positive thing for nursing practice?

MS: Oh, yes. Yes. The area of responsibility was much more clear and there were mechanisms to ensure quality practice at that level, and jobs were opening up. Our first practitioner program, of course, was the midwifery program. That's a very successful program.

DT: It seems that in Minnesota there was so much concern through the 1960s and at least through the early 1970s about there being a shortage of physicians, particularly in rural areas of that state, and that the nurse practitioners could meet that need. The nursing school had a rural nursing program.

MS: Yes, there was a rural nursing program. I don't remember now how long it lasted. It must have started in the 1960s?

DT: I think so, yes.

MS: It got phased out at some point. I don't recall… Laurie could probably tells us in here someplace. [laughter] Yes, there was concern about distributing caregivers into rural areas.

DT: Were nurses going out into those areas? A lot of the focus in the state was mostly concerned with dentists and physicians, and I wonder whether nurses were more willing to go and work in those communities.

MS: Well, if you recruit from those communities, they're likely to go back. I think a lot of the outreach that we were doing was supportive of that idea. But you can't always bring the people in. Now, there is technology that you can do outreach much better, do it through the Internet or all kinds of other ways.

[pause]

DT: Do you have any other things that you'd like to share about the 1950s, 1960s, and 1970s that we haven't already covered?

MS: [pause as Marilyn checks her notes] There was one interesting project that I was involved in that was attempting to develop a new model of nursing care that would get care to elderly people living in their homes, thereby reducing the necessity for nursing home placement and that sort of thing. We called it the Block Nurse Project. Four of us, Ida Martinson…

DT: I remember Laurie talks about it in…

MS: Yes. O'Brien [correctly Barbara O'Grady], I can't remember her first name, and Marjorie Jamieson and I sat around Ida Martinson's kitchen table planning this project. How can we get nursing to seniors to keep them in their homes? Page sixty-four. [pause] Ida Martinson, Marj Jamieson, Barbara O'Grady… She was head of the state public health nursing. We developed the Block Nurse Program. What the model was is that nurses living in the community could give nursing care to the elders in that community, but you just don't go give nursing care to your neighbor. So Public Health Nursing was involved to maintain quality control and ethics and see that people properly were supervised and licensed, that sort of thing. Then, other aspects of a community would be engaged as companions, or befrienders as some models called it. The Boy Scouts and the Girl Scouts would be involved. People keeping their elderly neighbor's sidewalks shoveled. There was a backup physician, but the physician orders would come from the elder person's own physician…pharmacy and other aspects of the community. It was funded by the [H. B.] Fuller Company, which was located in the Saint Anthony [Minnesota] neighborhood.

We set this program up and it was *so* successful. It was just advertised in the newspaper, "If you'd like to receive some nursing care at home, give us a call, and we'll see what can be arranged." Nurses came out of the woodwork in these communities and they wanted to participate. So they were given appointments with the Public Health Service so all the quality control issues were taken care of.

People started coming from other countries to study this model.

DT: Hmmm.

MS: People came from Japan and they instituted this model, I guess, in some neighborhoods in that country in some of their cities.

The Block Nurse Program finally merged with another model of the same sort and became a larger sort of concept, and it moved in many different communities and neighborhoods. It's still operating. That was quite an initiative. It got some awards for being a new creative delivery system and that kind of thing.

DT: Where did you get the ideas for it?

MS: Just sitting around the table, you know. Ida Martinson was concerned about caring for the child dying of cancer, and she was concerned about they are going to the hospital and doing this dying when it could be done much more comfortably at home under proper circumstances and care. So she had that idea in her head. We started thinking about what could we do with the elderly people? Now, the dying child probably would get its care and nursing service from some hospital or hospice set up. So what would be an idea for the elderly in the community? Then we started thinking, well, the communities are full of nurses. So we thought about that idea and Barbara O'Grady from Public Health said we could easily find a way to appoint these people and get the status of a public health nurse and give them that kind of guidance. It just kind of grew around cups of coffee. [laughter]

DT: That's great.

MS: It expanded from there and, then, we began to think what other community resources might be interested? People all over that particular community were very interested in participating and providing whatever little piece of service they could. It was a very interesting thing. It just *happened*.

DT: Did it continue to be funded by…? How is it funded beyond the initial grant?

MS: There was a proposal written for funding. It did get funded, and it got funded to be studied and evaluated. We got some federal funding for that and we got some other kind of funding. I wonder if we reported it. There is a paper that we published. [pause as Marilyn looks for the paper] I was trying to get my head in order, so I pulled some things out.

DT: [chuckles]

MS: Maybe in this paper, it describes the funding. I don't recall right off the bat. Oh, here it is, I think. No.

DT: I'm sure I'll be able to find it. Actually, Laurie might have it cited in her book.

MS: It might be in her selected research. Anyway the title of the paper is "The Block Nurse Program."

DT: I can just do a search for that.

MS: Here it is…just smaller. The founders are editors there. I don't remember if it discusses funding in that paper. There was funding that came later. Oh, here's an article in here. Here's the Block Nurse Project getting an award. [pause] Here's an article on the Block Nurse and maybe it has some discussions in there of funding. Certainly the evaluation piece was funded. It must be mentioned in there. There's a picture in there of Bernadine Feldman. She was the one that did the evaluation study.

DT: I suspect I should even be able to find it in the archives. I should be able to find the proposals that got funded.

MS: Oh, yes, I would think so.

DT: That's such a fantastic program.

MS: It was very successful. The clients just *loved* it. Everybody could come to their home. The pharmacist delivered the drugs, and the nurse would come in, and the neighbor would come in and go grocery shopping. It was well planned.

DT: Yes, that's incredible.

So, in 1987, it was funded by the Kellogg Foundation and the Division of Nursing in the Department of Health and Human Services [reading from the article].

MS: That sounds right. Yes.

DT: That's fantastic. This is great.

Who else do you think I should be talking to?

MS: For those issues that had to do with higher administration and the politics of everything, Deans, I'm sure you've talked to Sandra [Edwardson]. Too bad Ellen Fahey is not available. She's deceased. She lived through some very important years, I think, for the school. [pause] Then talking to that Graduate School person…

DT: Yes.

MS: Have you talked with Cherie Perlmutter?

DT: No. She's on my list, though.

MS: Somebody like her would have a knowledge base that I lack.

DT: Is there anyone else who was on faculty during the 1960s when all the issues around Edna Fritz were happening?

MS: Somebody who is still alive… [pause] You don't travel to Texas?

DT: Yes, I travel. I definitely have the capacity to travel.

MS: The faculty who were resigning that I think is not deceased—all the others I think are deceased now—would be Fran Moncure. I have no address or anything for her, but I knew she was at, I think it was, Houston. That's kind of close to the Gulf and it was very

humid when I went down there. I remember that. [chuckles] Well, she's probably well retired by now, and I have no idea where she is. She was one of the group of dissatisfied faculty.

One who *did not* resign and one of the few that remained is Dorothy Fairbanks. She was Dorothy Moe and then Dorothy Fairbanks. She retired from the School of Nursing maybe a little bit after I did. She would have a whole different perspective, I'm sure, of the Edna Fritz period.

DT: Ida Martinson? She's in San Francisco?

MS: That's the last I heard.

DT: Well, if you think of any other names, do let me know. I'd like to speak to as many people as I can from different perspectives.

MS: You're mainly interested in those early years or…?

DT: Right now. I'm trying to speak to people in each of the Health Science units about the development of the Academic Health Center. So just for the sake of being able to speak to people in all the units, I'm focusing, for the time being, on 1960s and 1970s.

MS: Okay.

DT: But, certainly, I plan to then revisit the 1980s and the 1990s.

MS: One person you might want to talk to is Patricia Tomlinson. She was on the faculty during our spurt of growth here before the doctoral program. I don't remember now when she was recruited. She must be in here someplace. I chaired the recruitment committee for her. She came in as a family nurse scholar. She's mentioned here on page 112. [pause] It must have been in the 1980s.

DT: Okay.

MS: She was also an alum of our baccalaureate program.

DT: Oh, good.

MS: She got her Ph.D. elsewhere. She would have an interesting perspective for you.

DT: Right. I like to talk with one of the students, as well. Yes, absolutely. That would be great. I will definitely look her up.

[long pause as Marilyn reviews her papers]

MS: It takes you way back when you start reading the list of names.

DT: Well, thank you so much, Marilyn, for all the information you've given me.

MS: Oh, it was a great pleasure.

DT: I think I mentioned when we spoke on the phone, and again in one of the letters I sent you, I may like to talk to you again once I've done some more research on the 1980s.

When did you retire from the University?

MS: Nineteen ninety-seven, December 31st.

DT: Yes. I suspect I'd definitely like to talk to you again once I get into the 1980s and 1990s. That's two more decades of great information that you have. [chuckles]

Well, thank you.

[End of the Interview]

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