

Dianne Bartels, Ph.D.

Narrator

Dominique A. Tobbell, Ph.D.

Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

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

Dr. Dianne Bartels was born and raised in St. Peter, MN. She attended St. Mary's Nursing School in Minneapolis, earning her diploma in 1964. She worked as a staff nurse and then became head nurse at University Hospital, where she worked until 1970. She pursued some work for her Bachelor's degree at the University but ultimately completed her degree in nursing with a minor in natural science at Marycrest College in Davenport, IA in 1973. In 1975, she completed her master's degree in nursing at the University of Washington. While working on her master's, she worked as an outpatient nurse at Eastside Community Mental Health Center in Bellevue, WA. After completing her degree, Dr. Bartels returned to Minnesota, serving as associate director of Methodist Hospital in St. Louis Park, MN from 1976 to 1979, and then as associate director at University Hospital in Minneapolis, MN from 1979 to 1986. From 1986 to 1989, Dr. Bartels served as a consultant at Creative Nursing Management. Also beginning in 1986, Dr. Bartels served in many leadership positions in the Center for Bioethics at the University of Minnesota, including associate director and acting director, until her retirement in 2011. During her time at the Center for Bioethics, Dr. Bartels completed her Ph.D. in family social science (2001) and became an assistant professor at the University (2005).

Interview Abstract

Dr. Dianne Bartels begins her interview by describing her interest in healthcare and her experiences in nursing school and as a nurse at University of Minnesota Hospital. In relation to her work as a nurse at University Hospital, she reviews medical technologies, relations among different members of the staff, Florence Julian and Marie Manthey's leadership, the development of primary nursing, and the relations between nursing staff at the Hospital and the School of Nursing. Dr. Bartels then discusses all of the following topics in relation to her career in nursing: her time at Mary Crest College in Davenport, IA and the University of Washington; her return to Minnesota as associate director at Methodist Hospital in St. Louis Park; concerns about nursing shortages; her experiences as associate director at University of Minnesota Hospital; the push for a doctoral program in the School of Nursing; the emergence of Diagnosis-Related Groups; issues around nursing unions; the emergence of HIV-AIDS; abortion services at University Hospital; and the effects of budget constraints on the creation of new programs. In relation to her work at the Center for Bioethics (the Center for Biomedical Ethics at its inception in 1985), Dr. Bartels covers the following topics: the creation and funding of the Center; Dr. Paul Quie's leadership; the responsibilities and functions of the Center; the placement of the Center in the AHC rather than the Medical School; major bioethical issues the Center faced; her own leadership within the Center; Art Caplan as director of the Center; Jeffrey Kahn as director of the Center; her doctoral research; and ethical issues in genetics and genetic counseling. She concludes with a reflection on the expansion of the Center for Bioethics.

Interview with Doctor Dianne Bartels

Interviewed by Dominique Tobbell

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

Interviewed at the Home of Doctor Bartels

Interviewed on June 21, 2013

Dianne Bartels - DB
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Dianne Bartels. It is June 21, 2013. We're at Doctor Bartels home in Woodbury.

Thanks for letting me interview you today.

DB: You're so welcome.

DT: To get us started, can you tell me a bit about your background, where you were born and raised, and your educational background?

DB: Saint Peter, Minnesota. I lived there through high school and, then, attended Saint Mary's Nursing School in Minneapolis. That was completed in 1964. Then, in the 1970s, I completed a bachelor's at Marycrest College [in Davenport, Iowa] and, then, a master's at the University of Washington. Finally, ending in 2001, I completed that Ph.D. in family social science at the University of Minnesota.

DT: What led you to pursue a career in health care?

DB: Typical things for that generation. I couldn't decide whether to be a nurse or a teacher and coming from a family with scarce resources, I could work my way through school through the three-year program. At the time, I look back and it's crazy because I spent so much time in administration. But I, as I looked back, I'd saw in an autobiography, I chose that because I just wanted to be a real nurse and not run anything.

[laughter]

DT: Ironically.

DB: Ironically. So about sixteen years of education later, that changed.

DT: What led you to go to Saint Mary's Nursing School and get your diploma rather than a baccalaureate at that time?

DB: Actually, it's the last answer, which is I just wanted to be a nurse and, also, affordability, because I could work my way through school.

DT: Can you describe some of your experiences as a nursing student?

DB: Sure. We were, basically, a part of the hospital workforce. So we had lots of clinical hands-on experience. We had classes in the same building as our dormitory. Saint Mary's is the one which is on the [University of Minnesota-] Fairview campus now. You've probably seen it. I remember having social science from one of the Torrances, who I later learned were sort of famous here. I also remember the most frightening nurse manager I ever met from my first job and one really scary professor. All the rest were lovely people, primarily women, except we had theology as well from the Jesuits.

DT: Do you remember the name of the nurse manager?

DB: Her nickname was Rocky and her last name was Rokusek. I don't think I ever knew her whole name.

[chuckles]

DT: Was that your nickname for her?

DB: That was the one that everyone called her, and we called her that.

DT: You got your diploma and, then, you began working as a staff nurse?

DB: Staff nurse for one year at the University and, then, a head nurse job came up. I applied for it so I became a head nurse after one year of working at the University of Minnesota in the Department of Medicine.

DT: What was your experience like in the Department of Medicine?

DB: It was marvelous. It was a very growing time. It was an exciting time. It turned out that our station while I was head nurse became the experimental station where all the services would test. Like Pharmacy would test new delivery systems. Nutrition would look at delivery systems. So we became a project station and ended up inventing something called primary nursing, which originated on my station, Station 32.

DT: Yes.

DB: The plaque is still at the end of the hall—at least up until a year ago—a hallway if you take third floor from the front desk in the Mayo Building. So it was a very exciting time. We were working with Hospital Administration people, and we were the designated unit. We ended up actually changing practice. Primary nursing is an international phenomenon now.

DT: Yes, I do want to ask you more about that in a moment.

Can you talk about the types of patients that you were working with?

DB: Yes. It was what then was a classic medical ward. So we had lots of people with diabetes, stomach ulcers, cardiac, lung, pretty much anything that didn't need surgery.

DT: Can you describe, maybe, what a typical day might have been for you?

DB: As a nurse manager, the shift was seven to three-thirty. We would all arrive early enough to get report by seven. We'd go to the backroom and have report. The head nurse made out the assignments for who would take care of which patients. You would have, usually, a nurse and an LPN [licensed practical nurse] or an aide with them for a group of patients. That changed with primary nursing so that there was one nurse responsible through twenty-four hours a day rather than shift-by-shift. That was the major change. Often the nurse manager or the nurse in charge on other shifts would distribute the medications for everyone and the rest of the technological, the baths, the back rubs, which were prevalent still in the 1960s were done by everyone else. The hours just flew by with all the interactions and families.

DT: What were relationships like between nurses and physicians?

DB: I thought they were excellent, because it was a teaching hospital, and we knew more than they did when the residents arrived. The ward physicians, the residents, felt like peers and usually that went well. Once in a while, you'd have someone arrogant. Most of the attendings, which is still my stereotype of medicine, were pretty easy going and comfortable. There was one person who was probably what we later would have called the classic medical school model that held rounds and the interns would do their reports and get severely criticized for going wrong. We would sort of be in attendance around the edges. When he came, most nurses would go into rooms, so they wouldn't have to spend time in rounds. It was like the classic old model. It was like the old teaching hospital with a whole cadre—that could be six or seven physicians—coming to each patient's bed. You're reminding me of how things have really... Well, I don't know how much they've changed, because I haven't been on that ward for a while. We didn't even think of it as intrusive. It was just how it was in education. It's what we did, and the patients were there to help.

DT: Would you be comfortable naming who that physician was?

DB: I would prefer not to.

DT: Were there any specific technologies that you were interacting with as a nurse?

DB: Yes, there were many fewer. We had stomach pumps, stomach drainage, things that went in a bottle. Of course, we had catheters. We had IVs. The most challenging people were people who, today, would be in an ICU [intensive care unit] who came in bleeding from their stomach. So we'd be pouring in pints of blood and, also, watching the blood flow out and watching them vomit. We had some really, really very ill people. We also had chronic ones with leg ulcers that might be there for a long, long time.

DT: Were there any kind of new...? I'm trying to think of that period, whether there were new technologies, kind of "high tech" technologies.

DB: The one that I remember most was the pacemaker.

DT: Oh, right.

DB: That was the first one. I remember it because one of the nurse's husband's had stock in Medtronic. [laughter]

DT: I'm guessing he did very well.

DB: She used to be jubilant when we had a pacemaker patient.

I think that was the only one. During that time, also, they created ICUs, so the really high tech stuff, a lot of what we did wouldn't probably be done on a basic room with someone critical enough to be bleeding out.

DT: How were relations on the ward between diploma-trained and baccalaureate-trained nurses? Was there any difference?

DB: Well, because I was a diploma nurse in charge that was very much a non-issue at the time. It became more so. One reason I decided to get a baccalaureate degree is because I assumed it would be expected as part of leadership. After I got the bachelor's, I thought, well, without a master's then I'm back in the same place. That was the sequence of events. No, I don't remember that. I'm assuming most of the supervisors had bachelor's. Some of them were master's students or had master's. The head nurse that followed me had a bachelor's degree, but it was really a non-issue for us.

DT: Can you talk about Florence Julian?

DB: Florence Julian was the director of nursing when I was there. She hired me, actually, which is interesting that the director of nursing was doing the hiring and then sending you to the ward. What do I remember about Florence? She was a kind woman.

She was open. I think she and Isabel Harris were roommates. More of my interaction was with Marie Manthey who became the associate director of nursing. It wasn't that long after I was the head nurse that we began that whole Project 32, so then I would be meeting with Marie and the administrators and Florence Julian wasn't a part of that project. She was a kind person. I think because of her relationship with Isabel, the ideas from the School of Nursing and the Department of Nursing were probably quite interactive and so probably influenced the emphasis on education that came later. But that's speculation. I don't know if that's correct.

DT: Did you have any interaction with Ray Amberg?

DB: I did not.

DT: How long were you at the University Hospital?

DB: Good question. I started in 1964. When did I leave? [pause] Oh, I know what happened. I had a transition. I was head nurse for probably three or four years and, then, there was a project created by Hospital Administration called Community Services. I went to the University of Minnesota to attempt to get my bachelor's degree and worked in Community Services as a job instead of in the Department of Nursing. So I was there—in 1972 and 1973 getting my bachelor's—probably like from 1971 to 1973. So it would have been 1964 up until probably 1970. I'd have to look to be sure of that.

DT: Can we talk about primary nursing? Can you talk about the development of that?

DB: Yes. Of course it was an exciting time because of the implementation that still happens where the people like Marie Manthey who make a difference work with the staff. So the way primary nursing evolved was that we would have staff meetings on how to do things differently and what would work. The concept really evolved out of the nursing staff meetings, many of which were held in Marie Manthey's home, at the time. As they were experimenting with everything else, some of that freed up nurses to be able to be more observant. I think the major thing that we identified is that everything changed every eight hours and whoever was in charge would do the care plan. At some point—it was pretty much a group decision most likely with Marie's influence asking the important questions—we decided that patients deserved to have someone responsible for their care from admission to discharge, and that became the definition of the primary nurse.

DT: How was it received by the nurses?

DB: We created it, so it was received very well.

DT: There were no objections?

DB: No. I think as they started moving into other wards, there probably were more. Now, we had an idea of what it was going to be. It's a change of practice and more

responsibility. But because we created it, we were all very enthused. The surprising thing as I look back is the small ratio of RNs [registered nurses] that were able to do that, but we had CPNs that were able to do everything else, most of the daily care things, most everything. No, we were part of the process. We created it. So it was ours. So we had no implementation problems.

DT: How about with physicians? What were their attitudes?

DB: They came to like it because they learned that they could talk to one person and get real information about what's happened for at least the last twenty-four hours if not the whole week, because there was that surveillance now. They would do morning rounds and that would pretty much be it unless we called for an emergency response. They learned that they could get better quality information. Prior to that, they probably always came to the head nurse who they thought could amalgamate enough from enough people to do it. So it meant a little different communication, but I don't remember any negative reactions to that.

DT: Did the patients perceive any change?

DB: The patients were mostly very sick so I don't know how much change they perceived. The change that they would have experienced is that someone introduced themselves as the accountable person for the duration of their hospitalization. We did get some complimentary letters from patients and their families about their care. I don't know that there were any that specifically talked about because one person handled my care. We would get letters about excellent nurses or excellent care during the duration. What they would have perceived is that they had someone to talk to who could think beyond the next shift. They would get more historical information and more about their expectations from the hospital visit. Many were too sick to notice, so it would be more communication with families. They also appreciated having *someone* that they could communicate with or call when they went home for the evening or something.

DT: Did the shift structure stay the same?

DB: The shift structure stayed the same unless an emergency came up. The orders for how the care was conducted through that twenty-four hours would stay until the primary nurse came back. So it wouldn't change each shift.

Of course, Marie Manthey has written a primary nursing book [*The Practice of Primary Nursing*].

DT: I have interviewed her.

DB: Oh, good.

DT: She was wonderful.

DB: You can tell me if I have a disagreement. She's a good friend of mine, still.

DT: She's great. It was really exciting to hear about that process from her, as well.

DB: A colleague and I, Vivian Smith, wrote the first article on primary nursing. I think it was "The Experience of the Head Nurse in Primary Nursing." That would have been still in the 1960s. [pause] That would probably tell my perceptions then better than what they are now. One of the things Marie has said, which she may have said for you, is to do primary nursing, you need a *non-controlling* nurse manager. I've heard her say that a number of times when I was going to workshops I participated in.

DT: You mentioned, a little while ago, that because of the relationship between Florence Julian, about how there was some kind of good interaction...

DB: Collaboration with the School of Nursing.

DT: I was wondering what were your perspectives on the School of Nursing during that time.

DB: My major perspectives were from the clinical teachers, so the perspective changed, probably. At the time, the School of Nursing would have faculty with their students, so all the wards were experimental, in a way, for students to get their clinical experiences, which they still do. I saw some excellent role models. I saw a few role models that weren't that excellent, but it was a learning experience about what people could do. I think that also influenced me to think that a broader education might be a good thing; although, I didn't believe it would change. I didn't think we could do our nursing practice better.

DT: Would you be able to name some of those excellent role models?

DB: Oooh, who was there? One person who was there was Florence Ruhland. Another was Anne LaBree. Those are all the names I remember.

DT: That's good.

You mentioned making the decision to pursue a baccalaureate degree. You indicated that you began that at the University.

DB: Yes. Unfortunately, I left in dismay, pretty unhappy. I was sitting on the Curriculum Committee. Because of our project status, we had influence on the School of Nursing and or had participation. But when I tried to get my degree under the old system, I had taken one year of classes while working. They must have been part-time classes because I was working fulltime. Then, I found it would take two and a half more years to get a bachelor's degree. That seemed a little much. Then, I came across master's students who had come from Marycrest College in Davenport, Iowa. They said, "Oh, you have to talk to Sister Bridget." I ended up at Marycrest where I could test out

of fifty credits. So I completed my bachelor's degree in nine months and was fully funded by being the housemother of the freshmen girls' dormitory.

DT: Wow!

[chuckles]

DB: So that was an experience, as well. The girls from Iowa and Chicago were both different than my Minneapolis expectations. Then I completed my bachelor's, and then I just kept going on to my master's.

DT: Was Marycrest College a liberal arts college?

DB: Yes, a liberal arts women's college at the time. It has since combined with the men's college and the students move back and forth.

DT: During those nine months, were you exclusively just taking lecture courses?

DB: Yes, I did not need the clinical experience at that time.

DT: I would imagine not. [chuckles]

DB: They were primarily lecture courses. I probably loved it because I had tested out of a lot of science and clinical things, so I had more liberal arts during that time.

DT: From there, you went directly to your master's. What led you to go to the University of Washington?

DB: I applied in a number of places and chose based on the rankings. I remember my final decision was between the University of Washington and the University of California-San Francisco. I don't know if it was the deciding factor, but at the University of Washington, I was able to get a National Institutes of Mental Health fellowship that funded the majority of the cost of my education. So that may have been influential; I'm not sure. I remember those were the two.

DT: You focused on psychiatric nursing?

DB: Psychosocial nursing was the name of it. Yes, it was psychiatric.

DT: Can you talk at all about the curriculum for that and what kind of work you were doing in that program?

DB: Sure. It was basically the introduction to research, graduate level research. We had classes on qualitative and quantitative, theories around mental health. It was just at that time when people were starting to talk about perhaps not blaming the mother for everything. I had some focus on... I think it was called the alcoholism-nursing focus.

So I had a focus on chemical dependency each semester that I was there. What else did I take? It was very much psychosocial, and I would say sociologic theory oriented and mental health theory oriented.

DT: This was soon after a number of new drugs had been introduced in psychiatry. Did you have any thoughts about what difference those drugs made?

[brief break as telephone rings]

DB: I was aware of drugs and what they could do, but my clinical experience was in outpatient clinics and the psychiatrists were prescribing the drugs. I don't remember nearly the focus that came later on drugs and basically behaviorism in psychiatry. In the outpatient setting, we had a pretty collaborative relationship. I don't even know what percentage of patients were receiving medications.

I did have an experience about drugs after my second year of my diploma program. I worked at the Saint Peter State Hospital [Saint Peter, Minnesota] for one summer. We had wards of either sixty or eighty patients who were receiving Thorazine and Mellaril. The majority of them had major... I'm not sure of the right word, but they would have even violent episodes. We just saw that Thorazine just changed everything. I think my initial idea was that they were very positive, because I saw the alternative of people being locked in full body restraints in a seclusion room. The fact that they could manage their behavior and wander around the wards and do the social events and do things like occupational therapy, it felt to me, at that time, like they were freeing people.

I guess anything can be overdone in the long run. There have been a lot more questions, but, at that point, I don't remember even looking at the ethical implications of the major antidepressants and anti-anxiety meds. So, no, I don't think I saw a negative effect. Because I was in the alcoholism nursing program, a good part of my clients were maybe in Al-Anon. They were all pretty healthy people that needed to get through a tough time.

DT: I have here that you worked at the Eastside Community Mental Health Center in Bellevue [Washington]. Were you doing that at the same time that you were getting our master's?

DB: Yes, at the same time.

DT: It was primarily an alcoholic...?

DB: Actually, more spouses of alcoholics, and we also did family therapy in the clinics that I was in.

DT: Did you have a lot of interaction with the psychiatrists?

DB: Not a lot. We could call them when we needed them. The director was a social worker, I believe.

DT: I was going to say, were there psychologists or social workers?

DB: Social workers, yes, and there were psychologists at the clinic, as well.

DT: How were relations between the nurses and the social workers?

DB: Fine. Again, it was a wonderful small setting where you were interacting. You each had sort of your own roles.

DT: What led you to return to Minnesota? I have that you became associate director at Methodist Hospital.

DB: Yes. That's what led me here. The psychosocial nursing program was most interesting to me, but I don't believe I had a goal to spend my life in mental health counseling. I remember saying to someone when I kept signing up for education, "It can't help to understand psychology to do administration," so I was already an administrator and thought I would probably continue doing that. Why I returned, basically, it was where job opportunities were, and I chose Methodist Hospital because a friend of mine who had been a supervisor at the U was now the director of nursing at Methodist. I probably had preference; although, you could never say that then. I came and interviewed among a number of candidates, but she knew my track record. To walk out of school and into the associate director level position seemed a better opportunity at the time than doing more clinical work.

DT: What was her name, the director of nursing?

DB: Patricia Robertson.

DT: What were your responsibilities as associate director?

DB: I chaired a whole lot of committees. I attended medical staff committees. I interacted with the education department. I remember the head of housekeeping reported to me, so it was beyond nursing. We started a Nursing Practice Committee, which I chaired. Good question. How did I spend my day? Oh, the associate director did all the hiring for the nursing personnel. So that was nearly a full time job actually, screening and hiring all the applicants for all the positions available in the hospital and, then also, supervising the float pool, which was located in that area.

DT: I know that there were a lot of, both at the state level and national level, concerns about shortages of nurses at various times and particularly during this period. Did you perceive there to be a shortage of nurses at that time?

DB: I'm trying to remember at that exact time. [pause] You may know more because you looked up the times. I think we were recruiting, and I remember years where there was an incentive to bring a second person on, but I don't think that happened specifically

when I was doing that. I don't remember that we were advertising and saying, "Bring another nurse, and you'll get a hundred dollars if we hire them." But, clearly, a nursing shortage existed in or around that time.

DT: Being that you were in charge of hiring, I just thought... I wonder...

DB: It seems like we had an adequate number of applicants. I don't know that we had an adequate number of nurses... Oh, I think we did. When you talk about a nursing shortage today, people post things like ratio of nurses to patients and then you have to hire... I'm sure the ratios were lower in the 1970s than they are now. It seems to me we had enough qualified applicants for the open positions.

DT: Was there a relationship between Methodist and, say, the School of Nursing and the Medical School at the University?

DB: I think almost none. I don't remember any interaction.

DT: Did you have any nursing students come through Methodist?

DB: If we did, I didn't interact with them at all. We must have had some, but I'm not sure we did.

DT: It looks like you were there for three years and, then, you moved to associate director of nursing at...

DB: University Hospitals.

DT: What prompted that move?

DB: All of my opportunities came to me. The person who had previously been the associate director was now the director, so I took her job. She recruited me to apply for a job at the University of Minnesota, primarily, I think, because I always loved the University of Minnesota and the more open environment than what a private hospital could be. I was excited with the idea of returning to the University of Minnesota.

DT: Who was director of Nursing at that time?

DB: Barbara Tebbitt.

DT: I wish I had been able to interview her. She appears in so many of the archival documents. I read she had a marvelous perspective.

DB: She was a powerhouse woman and had national influence on the organization of nurse executives.

DT: What were your responsibilities, then, once you got to the University Hospitals?

DB: Good question. The people who reported to me were all of the clinical nurse specialists and the Education Department. I had a lot of interactions with other departments like Respiratory Therapy and other departments in the Hospital, I think through committees of department heads, primarily.

DT: Did you have much interaction with the Hospital directors, Hospital administrators at that time?

DB: Not a whole lot. I knew them, but not a whole lot.

DT: Did you have any perspective on John Westerman, because he was director when you first got there, I believe?

DB: John Westerman was part of an avant-garde group. Because of my previous experience, actually, because of having been in that primary nursing—John Westerman was also there at that time—I saw them as giving a lot of latitude to the Nursing Department. For instance, Marie Manthey... I don't know whose idea it was to pick a project unit, but once it was done, then Marie basically carried it, and we would meet once every month or six weeks with administration. But the rest of the time, it was ours. So they were able to delegate without pulling back the reins.

DT: That's great. Did you notice any change when, say, Westerman stepped down and [C.] Edward Schwartz came in as director?

DB: I don't remember. Where was that in relation to my time?

DT: Westerman stepped down in 1982 and Edward Schwartz was from 1982 to 1987.

DB: I was trying to remember who he was. Yes, I did know him. What years was I the associate director?

DT: You were there 1979 to 1986.

DB: I don't remember a major change, because it didn't influence the arenas in which I was operating. The Department head group went on. We continued to do the things we were doing in terms of nursing specialization and interactions. I also chaired the head nurse group monthly meetings.

DT: How was that?

DB: Good most of the time. Good unless someone came with a policy that everyone hated and, then, changed their mind the next time. Change is always hard for people, but I think it went as well as it could have.

DT: Traditionally in the history of medicine, there is some sense of hierarchy or some tensions between different medical departments. I'm wondering if there was any of that between the head nurses that represented those different units.

DB: I don't remember reports of that. I assume that that happened. I saw more of that differentiation later around ethical issues where you'd find that different specialties were telling different things to the families, so no one could get a picture. I wasn't at the level of experiencing that at the time. I was sort of in my sector with supervising the master's people.

DT: Barbara Tebbitt was director for the entirety of your time there? Is that right.

DB: Yes.

DT: She was director for a good while.

Were there many interactions or what were relationships like between the Department of Nursing and the School of Nursing during that period?

DB: They were good. Barbara may have been the first master's degree director. I think there was more cooperation because we had someone in the position... I think those relationships were going well with the School of Nursing.

DT: Did the Department have any specific interactions with the deans of the Nursing School?

DB: [pause] I'm picturing Joanne Disch, now...deans of the Nursing School at that time. I think we did, and I don't remember being a part of that. That was probably Barbara's level, as well...expertise. As a Department, we did collaborative projects in research.

DT: You mentioned a little while ago about the clinical faculty for the Nursing School who would come to the wards with their students and supervise the teaching. If I understand it correctly, the responsibility for student teaching sat with the faculty of the School of Nursing?

DB: Yes. Their job was to supervise but they worked closely with the nurse managers. Certainly, the nurses who were taking care of the patients taught them a lot of the skills, because we were sharing patients. They didn't have them independent of any other oversight. So, certainly, the unit people would influence or help or teach a new skill, but the School of Nursing was that faculty in charge.

DT: Were relationships between the clinical faculty and the staff nurses, unit nurses generally good?

DB: Generally good.

DT: Were you aware of the efforts to develop the doctoral program at the School of Nursing that began in 1976?

DB: I was aware of it. I wasn't a part of it.

DT: Did you have an opinion about the virtue of developing the doctoral program?

DB: By then, having had a master's, I would have been in favor of it, I'm quite sure. When I mentioned the equality when Joanne Disch came, the fact that she was a Ph.D. made her integral with the School of Nursing faculty. When people became more peers in terms of education, it worked better.

DT: Yes. I do know from having spoken to several of the Nursing faculty who had been there in the 1950s and 1960s that—and even Marie herself mentioned this—as educational changes were being implemented in the School, particularly the push to have faculty be master's and doctorally prepared there was a sense among the Hospital nurses that they were in some way second class citizens.

DB: Yes, that probably existed. I expect it did. It goes back to your diploma and bachelor's program. There's always the question as a diploma nurse, why do I need a bachelor's degree because my patients are well taken care of. [laughter] I expect more of that happened. It didn't affect my purview, because I was working with master's degree clinical nurse specialists, some of whom were potential doctoral candidates, as well.

DT: It's really interesting. At that time, the master's level nurse clinical specialist was an innovation or a development in the 1960s. Do you have any thoughts on what the development of nurse clinical specialist meant for the practice of nursing?

DB: I'm trying to remember. I have a sense I wrote something about that once. [pause] They reported to me, so, of course, I'd be biased. But I think the clinical specialists were very helpful in working with very complex problems and following people with those complex problems over time. Like diabetes management is a complex thing. We had people who were, I want to say, enterostomal specialists who helped people work with colostomies and ileostomies. So they became the major educator for the patients and for the staff about how to manage it. One was a cystic fibrosis nurse specialist who created relationships with all of those families. I think the clinical specialists would see their role, and I think I saw them successful in their role as basically improving the quality of care that complex patients could receive.

DT: So, in practice on the units, would that division of labor be that the clinical specialist would be given those more complex cases and then...?

DB: The clinical specialists would be more the consultant to the case. If I recall correctly, the nurses would initiate the expertise when they thought it was necessary.

Every diabetic had to be assigned to the diabetes nurse specialist, because they would have been in every ward. So I think they appreciated that the specialist had some expertise to contribute.

We also had a non-nurse master's degree person in that group who was the director of Patient Education.

DT: Oh. I think I recall that that was a fairly new...

DB: That position was new and exists today. Actually, that person is still there. She's nearing retirement now. Nancy Goldstein was the director of Patient Education, educated in the School of Public Health. That department, basically, had responsibility for developing patient educational materials I would say for the whole Hospital, but for whoever thought they needed them. There may have been more questions about a non-nurse coming into those roles, but Nancy provided a lot of, again, useful tools and could visit patients and give them information to help prepare them for home visits and collaboration with the nurses.

DT: Do you have a sense of where that impetus came to set up a Department of Patient Education?

DB: No, I don't. It was there when I came, so it would have been prior to the time I got back to the University. I know it existed when I came back, so I don't know how that got started.

DT: Before that time, nurses would have been the ones who would have been most directly interacting with patients and communicating the information they needed.

DB: Yes. A lot of these were written materials, which nurses couldn't create.

DT: Okay. That's where the division of labor came.

DB: Pretty much. I think most often it would be like these are materials that will help you if you have questions. It wasn't like I am going to take over your discharge. Nancy could not have done that. The person in that role could not have done that. So the roles were pretty discreet.

DT: It sounds like, then, that it was clearly a benefit for the nurses to have access to that literature.

DB: Yes. Again, they would request it or the units would say, "I really need something about how you go home with this kind of intravenous technology," or something. By the next time I was back, everything was high tech and there were all kinds of intensive care units and things, so patients were going home with complex problems.

DT: In the mid to late 1970s, there were federal calls for cost containment over concerns about rising hospital costs.

DB: DRGs [Diagnosis-Related Groups]...

DT: DRGs. [chuckles]

DB: ...became the best-known word in healthcare.

DT: Can you talk about that?

DB: [pause] I remember it as having a huge impact. Everyone was talking about it, because it was a means of reimbursement. It didn't influence how I operated, like clinical specialists and those kinds of things. But it felt like a scramble for hospital administrators from what I would hear in department and administration meetings. It changed the way of finance and billing. It was a huge change. I don't know that I can say how it impacted the system. I think the system had some foot dragging from anyone telling University doctors how they could practice and how they could charge. I don't think it was eagerly received primarily by physicians. I don't know that it changed nursing practice a lot.

DT: Kind of related to those rising costs... I've seen that alongside of that was a decline in hospital census. There were fewer patients being hospitalized and those that were hospitalized were for shorter periods. Did you observe that?

DB: Yes. That was correct and that was, I think, part of the administrative worry about the financial sustainability.

DT: Then, it seems like there was increasing competition from other hospitals at that time, too.

DB: Very much so...very much so. I think either at that time or probably more since that time, I felt like the University was a little slow to get on board and the community hospitals were faster. That would be part of the reason. My recollection would have been more about physician resistance to changing the way they conceived of their practices.

DT: At that time, the development of HMOs [health maintenance organizations] also occurred. Did you see any impact on nursing practice or patient care from the development of HMOs?

DB: I don't think so.

DT: Again, around that time, the decision was made to build and expand the Hospital. Did you have any sense of that going on and whether that impacted you at all?

DB: I was on one of the committees. I can't remember what part I was planning.

DT: [chuckles]

DB: There were committees for different designated areas. I don't know if it was around space for the practitioners... I was on the space committee. I was on the Space Allocation Committee. That's right. It did influence a lot of things. That was really my connection, pretty limited. What it did, I think, is create some more collaborative relationships, because we were planning something new and all the departments had to be happy with what was going to happen before we made some of those changes. So I actually would say, thinking back, it was an opportunity for collaboration with a number of departments including the medical staff.

DT: My sense of the way things have worked in academic health institutions is that space is always a contentious issue.

DB: Especially in academic health institutions. Parking was the biggest contention for everyone. If you were a new University nurse, you would negotiate parking rather than salary because it was *so* prized. By the time I was back as an associate director, there were long waiting lists for parking. Because I came in at an associate director level, I had parking. But I knew people like the clinical specialists who had waited five or six years for a contract parking space.

DT: I thought I had it bad waiting eighteen months.

[laughter]

DB: That's good. Parking was my favorite example, because it made a difference to people's sense of quality of life, at least in terms of getting to the Hospital when they needed to.

DT: Given the fact that space is always at a premium, in serving on that Space Allocation Committee, do you recall there being any contention around the way that space would be allocated?

DB: I'm sure there was, but I don't remember around which issues.

DT: We talked about nursing shortages earlier. My sense is that those nursing shortages became more pronounced in the late 1970s, early 1980s. Can you talk about that at all?

DB: [pause] I'm trying to think if I have anything relevant to say about that. Yes, I think there was increased competition for nurses and what salaries you were able to pay made a big difference in that competition. I think we were aware of it. I wasn't a part of that group that set those salaries. It clearly increased competition.

DT: I saw in the archival documents that it seemed like there was some difficulty around recruitment because of supposedly unsatisfactory work conditions. Do you recall...?

DB: I don't remember that. Over the history, the working conditions issue may well have come from the Nurses' Association.

DT: Yes, actually...

DB: The Minnesota Nurses' Association were probably the ones. I don't remember anything specifically about that. There was a rivalry across systems including when I was at Methodist Hospital, especially when I was at Methodist Hospital, between administration and the unions.

DT: Yes.

DB: There was even a nurses' strike. That would be where the working conditions issues would have come up.

DT: I'm glad you brought up unions and the strike. As I understand it, the strike was in June 1984. At Methodist, because you were involved in hiring, did you have that much interaction with the unions?

DB: I think we took them for granted there. I don't remember that being a major bone of contention. I don't remember it being a major issue. We were all unionized. I think the University had unionized and non-unionized nurses, and that's where some of the conflict came from. You didn't have to become a union member to get a job at the University, so I think we had both unionized and non-unionized nurses.

DT: I have here that, I guess it must have been around this time, the Minnesota Hospital Association [MHA] had posed opposition for quite a while about the mandate that baccalaureate degrees be required for professional nursing.

DB: That's probably correct. I wasn't a part of that, no. I knew the people at MHA, but I don't remember being a part of those deliberations.

DT: Another thing that came out of the Archives is that there were, from 1985 onwards, issues around gender pay equity and debates about comparative worth for hospital employees.

DB: There probably were. They were everywhere. So why wouldn't they have been there?

DT: [chuckles]

DB: I wasn't in the position negotiating salaries, so I wasn't affected by that.

DT: I ask these questions not knowing whether someone is going to have a perspective on it, so it's always revealing to know what in a big institution...

DB: Who is impacted.

DT: Right and who has kind of access to those debates and those negotiations, as you say.

DB: My recollection, I guess I would say, was that most of the nurse administrators generally took the same positions as the Hospital administrators. The union was seen as something every administrator had to deal with.

DT: Can you talk about the impact of HIV-AIDS [Human Immunodeficiency Virus-Acquired Immune Deficiency Syndrome] on nursing practice in the mid 1980s?

DB: I remember the day I heard about it. It was when the director of the Respiratory Therapy Department came *rushing* into my office saying, "There's this new disease and it's going to mean that every one is going to have to wear a mask and gloves all the time. [Dianne pounds her hand on the table] It was like an announcement! This person ran into my office to say this is happening. It may have been even when it was happening in California first, prior to our first, but with the threat or else with the first patient admission. I remember that was the department that took a lead, and I remember it was very frightening, because we knew about it. It was a lethal disease. I don't remember the nurses resisting, but there were physicians locally and all over the country who refused to take AIDS patients into their practice. It probably was a moral judgment. They would talk about safety or that's not my expertise. So they would find other reasons. There were people that would exclude HIV-AIDS from their practice. Certainly, it changed all the infection control rules everywhere.

DT: And that seems that that would have a significant impact on nursing practice given nurses are the one are seeing the patient most frequently.

DB: Sure and dealing with everything that they excrete, which was presumed to be the major way of contagion.

DT: I know you said that the nurses weren't opposed to working. There was no sense that they were opposed to working with these patients, but was there fear among the nurses or concerns about their safety?

DB: I didn't hear it from the group that I was supervising, so I can't reflect. At that time, I wasn't talking to the people on the wards very much.

DT: It's been a while since I looked at the documents, but there were certainly concerns about transmission of cases to healthcare workers.

DB: Oh, sure. Absolutely. It was a national discussion. It was in the media all the time, so no one avoided it. I don't remember anyone ever refusing to take care of an AIDS patient. I remember it being about creating appropriate precautions so everyone was safe.

DT: Given the complexity of AIDS patients, it seems then that the nursing clinical specialists would have had a lot of interaction with the AIDS patients.

DB: They may have. It would be in addition to whatever condition they were taking care of them for, so they wouldn't have been the major...but they would have certainly had to gear up. Sure.

DT: As I understand it, there were a lot of debates around abortion services at the University Hospital in the late 1970s.

DB: There were, and it was very difficult for nurses who did obstetric care. We just wanted healthy mothers and babies. That was their life commitment. So there were nurses that said, "I will not help someone end a life of an innocent infant." There were a *lot* of discussions around policies, and how you could do that, and whether you had a right to conscientiously object. My recollection is the way that was resolved is you could conscientiously object in advance by saying that when you were on, you needed to be assigned to different patients—not every nurse objected—but the bottom line was not if it risked the safety of the patient. Like if you were the only one on the shift when this event occurs, you may not abandon that patient. That was the resolution, but very, *very* hard for people who love infants more than anything and that their commitment in life was to create a safe coming into the world. That was very challenging.

DT: I saw that the University closed the outpatient abortion clinic in 1977.

DB: Yes, that was very controversial.

DT: It seems that one of the major concerns was that medical students didn't have access and weren't able to be trained in abortion.

DB: I read about that in the literature. I don't remember it being an item of discussion in the parlances where I was involved.

DT: Before moving on to bioethics, I wonder if there's anything else that you would like to reflect on about your experiences in nursing administration.

DB: Hmmm, that's a good question. [pause] I think if I look over time, in that first time in the 1960s before we felt there was any constraint on resources, even though we would now call it totally understaffed, it was life as usual. In my personal experience because of the luck that I happened to have being selected to run that unit, I felt there was an open field for creativity. People would just decide to create a new program and would do it and administration would fund it. Cost constraints changed that. So I felt between the two times being at University Hospital, there was more caution. No one would just say,

“We really need to create a new diabetes nurse specialist practice.” It felt like there was less room to create things. I expect the physicians felt that way, too. People who would see themselves as primarily teachers would struggle with that. It felt—although, it was still more open than the private institutions that I knew—more constrained in terms of, what I would say, my experience of the openness of being able to create new programs for patient benefit in the earlier years. It would be a much longer process with many more checks and balances later. I don’t know if primary nursing would have been created if it had come around in the second iteration.

DT: That’s a great observation. There was a lot of innovation in nursing and in medicine in the 1960s and in pharmacy, too, at that time, with the clinical pharmacy movement.

DB: Patient dose units. They experimented with that in our unit, yes.

DT: Why then? That perspective that you shared seems...

DB: I think part of it was constraints probably, at least partially related to DRGs and the fact that they created a competitive environment. People used to just come to the University and stay as long as they needed to stay. So because of the constraints, we had to be much more careful about creating a new program.

DT: Speaking of clinical pharmacy, the clinical pharmacists were a new healthcare provider on the units in the 1970s. Did you have any thoughts or perspective on that?

DB: I didn’t. My experience had been the earlier one with primary nursing. I don’t know when they started rounding routinely on the wards.

DT: I believe it was maybe the late 1960s and early 1970s.

DB: Later on, going to ethics rounds, the pharmacist was always there, so that was totally, totally immersed. But I think I was just unaware of it, because of having a limited sector of responsibility.

DT: If we can move now to the bioethics piece of your career... The Biomedical Ethics Center, as it was called then at the time, was established in 1985. Can you talk about what led to the establishment?

DB: Yes. I believe it was the people from Educational Psychology who probably initiated a discussion about who was responsible for ethics education at the University of Minnesota. So you created a committee, which is what universities do, and I was a part of that committee, because as associate director I was a member of the Ethics Committee and, later, chair of the Ethics Committee. Because I had had the Ethics Committee practice, I was on the committee that involved educational psychologists, physicians, and faculty from a number of different disciplines. That committee met to address those questions. At some point, out of those deliberations came the idea that there should be one mechanism where people could amalgamate their skills to address ethical issues in

the hospital and in education. I was just trying to remember this this morning. I believe Neal Vanselow was the administrator. I think he went to the Northwest Area Foundation and asked for start up funding, but I want to be sure about Northwest Area Foundation. That's my recollection.

DT: They are. Yes, I have them as being the funders.

DB: All of a sudden, we had the funding, so now we had to figure out what we were going to do with creating a model for a center for bioethics. It was a hotly contested time with educators thinking it should all go to education, to medical education, to education psychology. The clinicians... I actually remember one was Ron [Ronald E.] Cranford who was from Hennepin County [Medical Center]. He's a neurologist who was notorious here in the Ethics Committee Movement from the 1980s, so that's why he was a part of it. He was always very outspoken. He objected to philosophers intervening in medical practice. So the dynamics of who's in charge of these clinical decisions was hotly contested in the meetings.

I think it was resolved in two ways. One was that Neal Vanselow appointed Paul Quie the acting director, which meant the director was now a physician. I believe that appointment was in addition to his fulltime pediatric practice.

DT: Yes.

DB: Did you interview Paul Quie?

DT: Yes.

DB: A fabulous man.

DT: Yes.

DB: Because he was appointed at the time there was some consternation.

The other part of it was that we used the funds, besides the seed money for the Ethics Center, I think—well, I know it was—to create research grants for students. So we continued to meet as an interdisciplinary group to allot research grants to students for student applications. That was the way, I think, that we met the intentions of real academics and the clinicians, that we were able to fund research projects for Philosophy and other departments for those who apply.

DT: Were there philosophers serving on that committee?

DB: Yes. Yes, there were. I don't remember who though.

DT: [chuckles] I'm curious about Educational Psychology. What I've read about the history of bioethics, I haven't typically seen psychologists in the mix.

DB: They saw it as their territory because of their expertise in moral development.

DT: I see.

DB: If you look up Muriel [J.] Bebeau, you'll see decades of years of publications in moral development and how clinicians practice. She was in the School of Dentistry. She did decades of research. There was also Jim [James R.] Rest from the Department of Moral Psychology who was initially involved. I remember taking one of his classes, at one point, and sort of learning about this moral psychology stuff. We did have people from Ed Psych, and it was through moral development and how you train clinicians to raise their level of moral development, which you could see why some clinicians react.

[laughter]

DT: Yes, definitely.

DB: It would be interesting if you have time to talk to Muriel Bebeau.

DT: Absolutely.

DB: It's B-e-b-e-a-u. I heard she went to part time, but I believe she is still at the School of Dentistry.

DT: Great. I will definitely look her up.

DB: She's done years and years of research. That was their hook. I believe Jim Rest from Ed Psych was teaching in the Medical School at the time, which is where the combination of voices arrived.

DT: I've seen that medical students had a significant role.

DB: Yes.

DT: They had been agitating since the 1970s. Maybe agitating is the wrong word but trying to mobilize support for ethics training.

DB: Yes, there were a couple of very active people. I don't know where they fit in terms of that timeline of creating the committee. They may have been the impetus for creating the committee.

DT: The material on the history of the Center certainly suggests that they were...

DB: They were very involved, very dynamic.

DT: When I interviewed Paul Quie, he suggested that, too.

DB: I think you're correct. I think the initiative and the questions came from the students. Health administration needed to figure out how to think about it, so they brought in people like Jim Rest who had already been involved in medical education.

DT: So you were immediately appointed to the Center?

DB: No. I was still in Hospital Administration and, then, at the point where I felt like I was burning out in Hospital Administration... There's more to that, because I was now married and managing another life, and I couldn't work my sixty hours a week like I had. I decided that I was about ready to end my time in Hospital Administration. I talked to Doctor Quie. I was able to work part time, I think, with him. In Administration, Barbara asked me if I would stay another six months. But then, I think I was part time in each position and, then, quit Administration and actually was a part-time assistant working with Paul Quie. Then, when he left, I became the second interim director for the Center.

DT: Can you talk about what the responsibilities and functions of the Center were in those early years?

DB: Hmm. I'm sure we had a mission statement. We were still involved with the committee that was doing research grants. We were involved in creating courses, interdisciplinary courses. Courses in the Medical School and courses in the Nursing School were being developed, and then we worked a lot in developing interdisciplinary courses, as well, which was usually constrained by differing schedules of when people were in class. It was a big challenge to do that.

Because we were a Center and people could find us, a faculty member from the University of Minnesota-Duluth came in. He was a philosopher who had been teaching ethics at the University of Minnesota-Duluth for years. He became an affiliated faculty as did people from the School of Nursing, School of Public Health. People wanted to have a place in the Center. So we became, I think, the place where people who were teaching ethics or interested in teaching ethics amalgamated. It was a place where they could have an appointment. It was attractive enough to them to have colleagues that they weren't paid appointments. They continued their jobs, but looked forward to the Center for being the center of the interaction.

DT: Was there anything to do with the Institutional Review Board [IRB]?

DB: Some of our members were on the Institutional Review Board, but we were two separate groups. We were a department reporting to the Medical School. The Institutional Review Board was separate, and they did the research ethics. I'd say for most of the history of the Center, at most, we had overlapping membership where one person from the Center would be on the IRB. But I don't think we affected each other's practices very much.

DT: Was there any debate about where the Center would be located within the institution, the fact that it was in the Academic Health Center as opposed to the Medical School?

DB: Yes. Being a part of the Academic Health Center with equal status gave the Center exactly the status that everyone on the committee wanted it to have. Otherwise, if you're under... I did say [reporting to the] Medical School and that's not correct. In a lot of places, the bioethics centers become the medical student ethics center, where you teach medical students. That's primarily what you do and, then, interact with other people where you can. It was *very* strategically critical, we thought, where that got placed. We were delighted when it was reporting to the vice president [v.p.].

DT: It must have helped, given that Neal Vanselow was the vice president at the time, that he supportive.

DB: Exactly. He was wide open.

DT: I'm going to be interviewing him in a couple weeks.

DB: Oh, good. Good.

DT: What did you see as the major bioethical issues in the mid to late 1980s?

DB: The abortion issue never went away. I believe euthanasia came on the horizon during that time. A lot of the forums we created actually had debates about physician-assisted suicide. I think those two were the hot issues at opposite ends of life, but similar positions. Those issues were enormous. I'm trying to think if there were other ones. So many of us from the Ethics Committee had been involved in end-of-life care because that's where you get calls. So I think end-of-life care issues stayed very central. [pause] As the Center grew, of course, in order to be of service to the institution, we needed to incorporate research ethics, but that came, actually, after I was director when more faculty were added. The hot button issues were probably not unlike today: abortion and physician-assisted suicide.

DT: Can you say more about your experiences as interim director? What responsibilities did you have? Were there any major issues that you confronted in that position?

DB: [pause] I think the major issues and the major areas that needed collaboration were about how resources would be expended. I think the people who were not in the Medical School were very disappointed that the funds all had to...because the first director had done that. So a lot of my job was to balance interests and figure out how to serve more masters at the time. That may have been partly why we had this group that figured out how to disseminate research funds. We weren't rich. People were, basically, volunteer faculty for most of the Center and teaching in their own divisions, but then involved. A lot of it was working with the people who were the founders to make sure we kept moving.

DT: Was there much interaction with the prominent bioethics institutions like The Hastings Center, for example?

DB: Not initially as acting director, but Art [Arthur L.] Caplan came from The Hastings Center. The other big job, clearly it was interim.

There was another issue, which was that all the units of the health sciences had to contribute to the Bioethics Center if we wanted to have a faculty that could serve. So, essentially, the vice president would tell people what their portion was, which wasn't always simple. That was done at the vice presidential level. Creating the resources from the units to hire people for things that we needed, if we were going to create a freestanding curriculum, was happening.

We certainly knew about The Hastings Center. The interaction of a number of us had been through the National Bioethics Committee network where experts from The Hastings Center were involved, so there would be national meetings where you knew The Hastings Center people, obviously. But we never had formal connections. We may have had people on the same podia at meetings. Is that a word? Podia? [laughter]

DT: We can accept that. [laughter]

DB: There would be probably clinicians and people from The Hastings Center on panels or national meetings around ethics committees, but other than that, we weren't. The Hastings Center was *the* national model pretty much on its own time.

DT: What led to Art Caplan being appointed director?

DB: He applied.

[laughter]

DB: We put out a national notice for a director and Art applied. We were a little surprised. There were actually a number of applicants from around the country, so Art was one of the applicants. Being Art Caplan, of course he charmed everyone on the search committee.

Actually, there was an interesting interaction that I had sort of forgotten about. There's another man, whom unfortunately, you can't interview named Shelley Chou, who was on the Ethics Committee. Brain death criteria was another huge issue. Creating brain death criteria was enormous during those years. Shelley was on the search committee and I was on the search committee. He pointed out that it might be a conflict of interest for me to be hiring my boss, my potential boss. So I did not stay on the search committee...

DT: Interesting.

DB: ...because of his sensitivity to ethical issues. He was *so* sound. He was just wonderful. I reported to him part of the time as interim director.

The search committee did its processes, which involved public lectures, and Art just rocked everyone's boat, so they did everything they could to recruit him to come here and as they say, the rest is history.

DT: That must have been challenging given the limited resources that the Center had.

DB: It was. Essentially, the funding at the time, I think, was for a fulltime director and a halftime associate director. It was later when we got research funds for post docs, for people who could work with us in the Center—oh, and one secretary. So director, associate director, and one secretary were the entire crew. It was limited resources. I'm guessing that Art liked what he saw. The search committee would have been very interdisciplinary. I think he saw a place to create something new.

DT: He was a philosopher?

DB: He's a philosopher from The Hastings Center. He started at The Hastings Center as a career and, then, ended up being, of course, one of the most outspoken and well-known people who ever came out of The Hastings Center. Art came and put bioethics on the map. I was lucky enough to get to stay. He chose me to stay as associate director. Art was not primarily an administrator, so it's good that there was an associate director position. He did put bioethics on the map in Minnesota.

DB: You mentioned earlier about the reticence of physicians, reluctance of them, to have philosophers talking about what physicians might do or not do. With Art Caplan coming as director...

DB: That changed.

DT: Okay.

DB: Partly because Art was so atypical. It was one person who was mostly distressed about philosophers. It was the sense that philosophers would come to extend the argument as far as they could rather than to make a decision. Art was not a philosopher's philosopher. Because he could do the best two-minute spot and identify three relevant ethical issues each time, it was like, well, this is no big deal. The Medical School departments actually started calling us for consultation.

DT: That's quite...

DB: Yes. I think just because Art was not the stereotypical... Again, these were prejudices probably partly from personal relationships, at the time. We consulted to a lot of departments about their issues and their programs.

DT: How do you think it was that Art managed to put Minnesota on the map for bioethics?

DB: Because he's a big map person. He's outspoken. I meet people today that say, "You worked with Art Caplan?" During the time, I would have friends call and they would say, "I heard your boss on the radio!" I said, "What did he talk about?" They said, "I don't know, but he was really good."

DT: [laughter]

DB: He is a media's media person. He could be on MacNeil Lehrer [Productions] perfectly comfortably. He could be at the head of any international meeting or national meeting very comfortably. His persuasive abilities and just his ability to... I think what he does pretty uniquely in my experience is to make *very* complex issues, take them apart, and do the two-minute YouTube synthesis. That was before YouTube, but...

DT: [chuckles]

DB: ...to be able to do the two-minute synthesis. I remember one time I'd been out somewhere in the state teaching ethics—we did also teach all round, so that was another function of the Center—and I was coming back listening to the radio. What did Art say? He was talking about cloning. He said something like, "Essentially, it's creating twins born apart." Now, that just explains the whole thing. You could read neuroanatomy and every textbook in science tomes and never have a clue. He was able to make complex issues accessible to the public. So he became a media rock star, in a way, as much as anyone from academia ever is, which is so often true if you watch. He's not on MacNeil Lehrer and stuff as much, but he's so often quoted when people are looking for serious discussions on ethical relations.

DT: Yes. Absolutely.

DB: And he loved the media, so that helps.

DT: [chuckles]

During the late 1980s and early 1990s, the University was embroiled in the scandal around ALG [Antilymphocyte Globulin] and Doctor [John] Najarian. Did the Center take a position on that?

DB: The Center did not take a position on that, as I recall. I don't know if I can... [pause] I don't know if I can justify why we didn't take a position though. I think it was just so hot. I think the justification was that we're an academic health center and we don't have to play... The national investigators have been there, and the Hospital is dealing with it. It felt like we didn't need to, but it may have been a wise political decision on Art's part not to enter into the territory.

DT: Art Caplan was director from 1987 to 1994. During that time, there were quite a number of changes in the leadership of the Academic Health Center. Vanselow stepped down in 1989 and, then, Cherie Perlmutter was acting v.p. for a time, and, then, Robert [Andy] Anderson and, then, William [R.] Brody. Do you have any sense of whether things changed for the Center depending on who was the vice president?

DB: Cherie was very collegial and liked the Center. I think Brody pretty much had a sense that we were doing good things, so he let us continue. I never felt like there was suddenly opposition or people taking resources from the Center. It may have been under Brody that they were able to create permanent funding for Center faculty, as opposed to dunning each of the units for what it would take. It was probably during Brody's time, actually, that we expanded. Art may have come with conditions that we would expand. I don't remember if that was a condition of his employment.

Did you interview Art Caplan?

DT: I haven't. Funnily enough, I was at Penn [University of Pennsylvania] while he was there. I never took a bioethics course, which is a shame. When I first started at Penn in the history and sociology of science, that department and the bioethics program were not particularly connected. But during my time there, who subsequently became chair of department worked very hard to bring the two together. So, by the time I left, we had a bioethicist, Jonathan [D.] Moreno, on our faculty.

DB: Oh, sure.

DT: Everyone heard about Art.

DB: Did Art have the same impact when he arrived there?

DT: Yes, yes.

DB: It's Art's charisma that he carries to have that kind of influence.

DT: Yes, he was a big name there.

Do you know why he decided to step down?

DB: I have a theory, and I think he may have said it, which is maybe why I have the theory. It is that, in a way, he felt like [University of] Minnesota was minor leagues and the Ivy Leagues were the big league. I think he just felt like it was an opportunity to get back to where the real power was. He was a guy from the East Coast. He had had all the interactions with the ethicists who are now at Georgetown [University] and everywhere there, so, I think, in a way, it was coming home. But I do think he felt like it was probably a step up to move back toward the Ivy Leagues.

DT: How did the Center come to then hire Jeff [Jeffrey P.] Kahn as the new director?

DB: Same process, a search committee, an interdisciplinary search committee from every unit that had an involvement or had a faculty involved with us, and interviewing candidates from around the county. Actually, what's interesting—I told Jeff this—is Art Caplan... Oh, another thing we created at the Center, and it may have been before Art was here, was the Midwest Bioethics course. So we had a collaboration with the University of Wisconsin [-Madison], and did courses. Art Caplan suggested that Jeff Kahn be invited to interview. He said, "He's a guy that's really made an impact in that program at Madison." I don't know if Art would actually say this—he might—but I told Jeff that it really was Art's suggestion that we talk to him. Then, I was at the Midwest Bioethics Course, a part of it, one of the times when he was the main leader because it was being held in Wisconsin. He had good relationships with people. He was able to be a good leader, so we recruited him to apply. Then, it was the normal search committee process.

DT: I guess between Art and Jeff being hired, you were....

DB: Acting director.

DT: How was that experience? [chuckles]

DB: Actually, I think it was just fine. I remember an analogy that fits our previous conversation. At the first faculty meeting, I said, "Our job is to create something new, because we have been planets orbiting around the sun of Art Caplan. Now, we have to figure out how to make our own dynamics to continue the mission of the Center and do what we're doing." We were able to continue to collaborate, to do the courses, to do searches, whatever was necessary at the time.

[break in the interview]

DB: I was happy to recruit. I think I had reached my limit in administration, my interest in being primarily an administrator. By then, I was back in school, as well. I was in my Ph.D. program so that I could be a real faculty, because I was teaching and didn't have a union card. It felt like, finally, a union card, so that was probably the major reason for my Ph.D., which I should reconsider sometime.

[pause] I forgot where I was going with that.

DT: What was your...?

DB: My role. Basically, I felt like it was to hold it together, because we started the search, but it ended up being a long search. We selected a candidate that didn't come at one point, or chose not to come, and then, we went back through the rounds. So it was a long process. My objective was always to have a director. After Art Caplan, you know who would think you could be a director following in his footsteps? Art was a wonderful colleague...he was a wonderful colleague.

DT: How would you characterize Jeff Kahn's impact on the Center?

DB: I mentioned that Art Caplan was not an administrator. Jeff was an excellent administrator as well as an excellent politician, I would say. What Jeff did is create our formal relationships University-wide, for instance, with the vice president for Academic Affairs. I think he connected us much more to the broader University.

DT: We talked about what the major bioethical issues were when the Center was first established. Did you see any change in what those issues were through the 1990s and 2000s?

DB: Yes. Partly because I became involved in teaching in the genetic counseling program, I was aware of it. The issues related to genetics became huge. Jeff understood those. They were the big news. The more high technology and issues around genetic screening, genetic technologies, interventions became front and center in a lot of ways.

DT: You mentioned about your decision to pursue the Ph.D. to get your quote-unquote union card. [chuckles] What led you to do the Ph.D. in family social science?

DB: Because having been in psychosocial nursing, it was similar to the things I already knew and was interested in. Families had just always fascinated me. While I was working, I took a course in family social science because I was that interested and loved every minute of it and, then, started exploring whether that would be a good one. The other reason is that I had taken three or four philosophy courses. Probably because I'm a nurse clinician at heart, I did not enjoy the time and to get a Ph.D., I would have faced four—it must have been quarters at that time—quarters of logic and I couldn't think of a worse way to spend the end of my school time.

DT: [chuckles]

DB: I really was not that comfortable in philosophy and what you had to do to do that, and I was *very* comfortable with family dynamics coming out of psychosocial nursing and counseling. I was able to justify it not just to myself, I don't think. When I describe bioethics, I talk about it as looking at issues from beginning of life to end of life, all of which are family issues. So talking about family planning... Oh, the other big issue in the 1990s was reproductive technologies. We wrote a book, *Beyond Baby M [?: Ethical Issues in New Reproductive Techniques]* Dianne M. Bartels, Reinhard Priester, Dorothy E. Vawter, and Art L. Caplan]. Reproductive technologies are all about family making, genetic counseling. It becomes family whether people know it when they come in or not. It created a big change.

Jeff Kahn had been very involved in those kinds of issues and was very fluent, and he, also, had a relationship at [Johns] Hopkins [University] with people who had been very involved: Tom [L.] Beauchamp and Ruth [R. Faden]... I just lost her name. Ruth Macklin was another one. [pause] Anyway, she's still there. So Jeff was very familiar

with the issues that were front and center at the time so that was another reason why I think he was attractive to the search committee.

I believe I followed Shelley Chou's advice from the last time. I did not appoint myself to be on the search committee. I took the reports from the search committee.

[laughter]

DT: What was your dissertation research on?

DB: My dissertation research was on families and genetic counseling, because I had been teaching genetic counseling and had already done some research with my colleagues, one from Genetic Counseling and one from Ed Psych. And I had already done national surveys of genetic counseling, genetic counselors. I actually hadn't thought of it as a dissertation project till I went to a committee and they said, "Don't you already have like hundreds of people you've interviewed?" I said, "Yes!" They said, "Well, why don't you turn that into your dissertation?" [laughter] The other thing about family social science is it was very student friendly. It wasn't about passing enough muster. People were very collegial in the department. So actually, I believe it was a committee member that suggested to me that I'd already done research that was relevant about genetic counseling and that that was relevant enough to the situation.

I continued to collaborate. Those people are Pat [Patricia] McCarthy Veach and Bonnie [S.] Le Roy. We've been collaboratively working, writing, and doing research up until the time that I left the Center, actually.

DT: How did you end up teaching about genetic counseling?

DB: Because, at the same time as the Center had just been created, the Department of...I think at the time it was Molecular Genetics, but, now, it's a part of DSM...DSH. [chuckles] It's part of the Genetics Society Development Department [Department of Genetics and Cell Biology and Development]. Actually, that was an interesting piece. I met the people in that department. Bonnie Le Roy was one and Richard [A.] King who had an ethics consultation about what information to disclose to a family where they had discovered that the person he thought was his biological dad was not. Classic, one of those genetic issues. So we met and they were creating a genetic counseling program at the same time as the Center was kind of up and running. So we started to collaborate. They believed that ethics was important to teach, so we created an ethics course, a genetic counseling program, and Bonnie and I co-taught the ethics course until I retired.

DT: Going from clinical nursing to nursing administration and, then, into bioethics and working in the area of genetic...

DB: From end of life care to genetic counseling.

DT: Yes.

DB: It was primarily an education for me, so it was always exciting, and they're still much too complex for me to address a lot of the issues, and they're still in the forefront. But it gave me a language to be able to be a part of the conversation. What I can do, I think, is relate what clinicians do to the conversation that's out there about the ethics of reproductive technology, including genetics.

The other case that came about was the Molly Nash case where they created a donor sibling.

DT: Ohhh.

DB: So the hot issues were in that arena. Because I was learning genetics, teaching genetic counseling, you have to learn the language. Ethics is a language, and genetics is a language. So because I was there, it just was a good platform to know enough to address current relevant issues.

DT: Molly Nash was a...

DB: A Fanconi anemia [F.A.] patient that is still alive. She comes back for interviews periodically. John Wagner is the person from the Department of Bone Marrow Transplant. So the University of Minnesota became the place where we did the first publicized transplantation where an embryo had been created for the purpose of supplying stem cells for a child who was ill.

DT: That embryo was...

DB: The embryo became Adam Nash. They did just an umbilical cord stem cell donation. It was the prerequisite to *My Sister's Keeper* [a novel by Jodi Picoult]. [laughter]

DT: Yes, I've seen that.

DB: It was the first case. I don't think the baby has ever been called again to offer more organs or anything. [chuckles] That was huge.

Jeff Kahn, again, was very comfortable to be a part of the national committees that were looking at these issues. He really did bring the ability to communicate about the issues as well as the expertise. He created the relationships across the University, outside of the health sciences. He and Art both created a lot of national relationships. He was on a lot of boards that made decisions around those genetic counseling issues.

DT: Do you recall the ethical reasoning around the Molly Nash case?

DB: Yes. The major opposing view was Kant's never use a person as a means to another's end. There were articles in the newspapers, so if you look at the Nash case,

you'll find things in the [*Minneapolis*] *Star Tribune*. The other issue is that you're, again, dealing with what could be a human life from a prolife perspective. That became a core of the debate. Of course, it's life. So the debate moved from not, is it life, but when does personhood occur? That debate by people on the pro side said, "This is a little cluster of eight cells. We're taking a cell to test." The people who were concerned about it from the other side said, "It's a life you're killing. All those stored embryos are babies waiting to die in your refrigerators at the University of Minnesota." It also has to do with donating, creating embryos in storage. The major argument, I think, is really that... You probably have to believe two sides. One that you're not stopping a life of a person in order to create another, but this is to save a child's life, so it's different than the issues which the opponents... I hope you can sort this out.

DT: [chuckles]

DB: This is fun. I could sort it out for you later. I could put them in columns.

DT: Sure.

DB: The opponents also say, "It's the beginning of a ride down a slippery slope to genetic engineering. So next, we're going to be selecting for intelligence and selecting tall boys and demure skinny girls," or whatever. All of the current debates got fit into this one, as well. There were the pros and cons. I think the ultimate argument is you are saving a life, and these children with this disease will die before they attain maturity, probably, without the transplant. The people who are opposed will always be opposed to any intervention. Like IVF [in vitro fertilization] will always be opposed to this issue and people who see the lives of these kids who have been saved.

DT: Was there any ethical discussion about once Adam Nash was born that he was born explicitly...

DB: That was the argument about never use a person as a means to another's end. That was exactly the argument that he would be, and it was long before the movie, so we hadn't thought about all the future technology. That was a concern. The other related concern is what kind of a life would a child have if they believed they only existed because their sister was dying. Would their parents really value them? It's still a debate that we've asked questions about. The people who have used the technology—we only had five people in our sample who had children—ended up using it, and two of them, I think, decided not to even test the embryo, but to take a chance that it was okay. One had a match that was a non-matching donor and they loved the child anyway. That was another piece of research later, with Heather [A.] Zierhut, I did, which is going to be published in the *Journal of Genetic Counseling* soon.

DT: Oh, great

DB: I can send you that when it goes through.

DT: That would be great. I'd love to read it.

DB: That is around the perceptions of families about the experience of creating embryos and IVF and reproductive technologies.

DT: Do you know with the family who didn't test the embryo to see if it was a match, did they screen the fetus for Fanconi anemia?

DB: This would have been an experience where already a child had been born, the child had been born with it. Yes, the embryo would have been screened. This one, I don't know. It's maybe in our research. I'm not sure it is. These were parental decisions. That's an excellent question. I would assume they screened and selected embryos that were not F.A. affected, because that was the goal. But I don't know that we actually... That's a wonderful question. Someone will ask us that, so we'll have to be prepared to write back to the journal.

[laughter]

DT: There's obviously a significant difference between testing an embryo cell versus doing a genetic prenatal diagnosis. It is just curious, the rejection of one intervention and whether you'd have the other. I met a father with an F.A. child...

DB: Ahhh.

DT: ...and also having done a fair amount of reading around prenatal diagnosis and the reasons why parents support prenatal diagnosis, not wanting to have another affected child.

DB: So bioethics has always stayed really interesting, even post retirement. Heather and I finished that study when we went to Geneva, Switzerland, to spend a month to do the research at the Brocher Foundation in Geneva. So, yes, it's been a pretty exciting time.

I think we were back to Jeff Kahn. His familiarity and comfort with those issues as well as the national panels addressing them was an important part of what he contributed to the Center, I think.

DT: Going back to the bioethics being interesting... It seems there's always going to be an ongoing discussion with every situation.

DB: Absolutely. Some of the debates will always go back to the original person who was in the abortion debate if we're anywhere in reproductive technology.

DT: It does seem that you might have one issue and, then, obviously, it brings in a lot of the others.

DT: People have said genetic counseling really doesn't bring up new issues, but it changes the frame because if you're my twin, and I get a breast cancer...if I get susceptibility and decide to have my breasts removed and not get cancer, and you don't want to know if you have it, it brings up all the issues that are with every medical intervention, plus the fact that it's more than one person you're often diagnosing.

DT: Yes.

Do you have any other reflections on the Center of Bioethics and how its history has been?

DB: We've been fortunate, because we were able to expand enough to create a master's program in bioethics. We are a part of the centers like The Hastings Center and the other national centers that exist. In a way, I would say where we've come is basic to the end of a vision that we had in the beginning in that community that you could have not only people who do a little bioethics within their careers but people that could serve a function of having a master's in bioethics. The Ph.D. program is yet to be created and, hopefully, the resources are there and the interest that that will happen.

DT: Do you have any other thoughts on the history of the Academic Health Center and the Center for Bioethics?

DB: [pause] I would say we were very fortunate. The committee that created the idea of the Center was very fortunate and the Center continues to be very fortunate to be in an environment that is willing to embrace the idea that bioethics is an important discipline and an important adjunct to a lot of disciplines, that we can create practitioners with the education to practice in an ethical way. In some ways, I would say I celebrate the success of what we've been able to do—and I expect it to continue. I expect it to continue because of the good relationships we've had the majority of the time the center existed.

DT: Great. We've covered a lot of ground and I appreciate you sharing all these thoughts.

DB: I presumed you were coming just to talk about the Center for Bioethics. So I really had to reflect to go back to my beginnings at the University of Minnesota. It was wonderful.

[chuckles]

DT: You've had such an interesting and varied career.

DB: I did. I couldn't have imagined. There was nothing like bioethics. There were rules to follow as a nurse like standing up when the doctor came in and wearing your cap at all times. At the time that I became a nurse, I never even imagined the possibilities of an academic career, so I've been just fortunate that my interests were in the right place at the right time.

DT: A wonderful career, really.

DB: Yes. It has been.

DT: Well, thank you so much.

DB: Thank *you* so much.

[End of the Interview]

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