

Mitzi Duxbury, RN, 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.

Bio:

Mitzi Duxbury was born in Jersey City, New Jersey. She received her nursing diploma from Madison General Hospital in Madison, Wisconsin, in 1952. She worked as a nurse, mostly in obstetrics, from 1952-64 in various locations, including Fort Riley Hospital in Kansas and the Washington, D.C. General Hospital. She received her BS in Nursing in 1966, her MA in Educational Policy in 1970, and her Ph.D. in Educational Administration in 1972, all from the University of Wisconsin. She worked as Assistant Professor at the University of Wisconsin School of Nursing from 1971-73. From 1972-1976, she worked for the March of Dimes. In 1977, she came to the University of Minnesota as the Director of Graduate Studies and Associate Professor in the School of Nursing. In 1979, she was appointed Assistant Dean for Graduate Studies and was promoted to Professor. She left the University of Minnesota in 1983 and moved to the University of Illinois at Chicago as the Dean of their School of Nursing.

Abstract:

Mitzi Duxbury begins by describing her background, including her education and why she went into nursing. She discusses her experiences as a nursing diploma student; working at Cook County Hospital as a diploma student; and working as a nurse at Fort Riley Hospital in Kansas and at the Washington, D.C. General Hospital. She also describes her experiences as a baccalaureate student at the University of Wisconsin, working at the March of Dimes; and as assistant dean for graduate students at the University of Minnesota. She describes her graduate work; relations between nurses and doctors in the different hospitals in which she worked; the techniques and technologies she worked with as a nurse; developing contracts with North Dakota University for the UMN School of Nursing; the building of Unit F; lobbying for the School of Nursing budget at the state Legislature; and working with the World Health Organization. She discusses midwifery as a nursing specialty; nursing autonomy; the efforts to establish a Ph.D. program in nursing at the University of Minnesota School of Nursing; faculty research and funding; and the Committee for Long Range Planning for the School of Nursing. She also discusses how gender affected her career, and the health care systems of different countries. She talks about Irene Ramey, Ellen Fahey, Lyle French, and other School of Nursing faculty.

Interview with Doctor Mitzi Duxbury

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at the Mitzi Duxbury's Home in Madison, Wisconsin

Interviewed on November 4, 2010

Mitzi Duxbury - MD

Dominique Tobbell - DT

DT: I'm Dominique Tobbell and I'm here with Doctor Mitzi Duxbury. It is November 4, 2010, 10:00 a.m. We're at Doctor Duxbury's home at 4962 Sherman Avenue, Madison, Wisconsin.

Thank you, Doctor Duxbury, for having me down here today.

To get us started, could you, perhaps, tell me where you born and raised?

MD: How short do you want this to be? How brief? I was born in Jersey City, New Jersey. My father was killed in the labor union wars there when I was eighteen months old. I had one older sister, and my mother was pregnant, so we moved back to Wisconsin, where my father's family had been for many, many years. In the old German families, the single brothers have to take care of that widow and children—no questions. No ifs ands and buts; it's their duty. So my mother, then, later, remarried my father's youngest brother, and they were married for fifty-five years or so. That's how I got to Wisconsin.

I grew up here in Wisconsin in the little village of Cambria, which is between Madison and Milwaukee, about forty miles from Madison. It was a wonderful childhood in a small town where everybody knew everybody and their business, and so on.

DT: What led you to a career in nursing?

MD: Ever since I was a little child, I wanted to be a nurse. I don't know why. I don't know if it was the socialization at that time that if you went on to school, you were a

nurse or a teacher. If you didn't go to school, you could be a secretary or a bookkeeper—or go to school also, but differently. I don't know if there weren't any other options, but, even now, I think I probably would have done it again. So many people are in jobs that they don't really like and don't fit well with and haven't found their niche. Maybe that's less so today when women have more options. Even a lot of men are in things they don't really... In nursing, particularly staff nursing which is very demanding physically and intellectually, at the end of every single day without fail, every day, you know you've made the world a little better place. You have that wonderful sense of satisfaction and harmony and communication with patients, living, or dying, or getting well, or on the way out, whatever. It is, I think, one of the more satisfying professions to be in. Now, I don't know the others very well, so I can't speak for them. I think it's very satisfying in that way. So since I was a little child, I wanted to be a nurse.

DT: Was anyone else in your family in health care?

MD: No. No one. But, because of the circumstances of my move here, there was a large extended family, and they all had to take care of these little kids. They felt they did, and they were very active. In fact, my mother was as far away from a nurse as possible. She could not deal with any illness. She couldn't deal with it. If we got measles, my Auntie Rogers had to come and take care of us. She was never good at that. That wasn't her strength.

DT: So you decided to go to the University of Wisconsin for nursing school? Is that right?

MD: Actually, I went to Madison General [Hospital], which was a diploma school, first. That's where most of them went. The University, at that time, was five and a half years, and quite expensive and Madison General, which is now called Meriter [Hospital], had an excellent diploma school. Most nurses were educated in diploma schools; although, in that diploma school, we attended the University for anatomy, physiology, chemistry, microbiology. Maybe that's it. So we actually got some credits for that, and that was good. We got a taste of university life and were close enough to the campus to participate in university life. It was a good experience, very good.

DT: And you were, presumably, spending a lot of time working in the hospital then, during those first studies?

MD: We had a good bit of time. Well, the state had all sorts of rules on how long you could spend in there. You had so many hours of clinical for each course that you were taking and, then, we had to affiliate at Cook County [Hospital] in Chicago for pediatrics, psychiatry, and contagious disease. That was quite an eye opener for someone growing up in a little town to be plugged into Chicago. In the diploma schools, at that time, they had all sorts of rules. You had curfews; you had to be in. You couldn't do this and you couldn't do that. We were quite regimented. In fact, at the old diploma school, we would have like a formal tea once a week—maybe not every week. I don't know. We had food and we had little napkin boxes for our own napkins, where our own white

napkins were kept. Your shoes had to be polished. We were still wearing caps. So it was quite regimented, which was good.

DT: Do you feel that that regimentation and that kind of strictness of your time created a good sense of camaraderie between you and the other students that were there?

MD: Oh, yes. Some are still my friends and I still see them—well, I think all of them, in fact. We have a reunion once in a while, and the ones that live close, I'm in touch with, and the others, sometimes on email if somebody dies or something like that. So, yes, it was a very special sorority. It was good.

We were very busy, and they worked us very hard. They really jammed things in. Some dropped out in the beginning, but most of us hung in.

DT: How long was the program?

MD: It was three years. I entered very early. I got out of high school early. At the end of April, I turned seventeen and I graduated in May. Then, I started here in the fall, so, actually, I was very immature.

[chuckles]

DT: Sure.

MD: I think, somehow, that regimentation, now that we know more about frontal lobe development and judgment centers and things, was a very good thing and it would benefit a lot of young students, rather than turning them loose. That gets into all sorts of political stuff with the military and eighteen years old and all that stuff. So that's, I guess, not a viable option. But I thought for me, personally... Some of the students were more mature. Some of them were a couple years older. Some of them were older than that. They'd had college. But it was a good experience.

DT: What kind of responsibilities did you have on the wards when you were a student?

MD: Not much. We were heavily supervised and *roundly* criticized if we did one little thing wrong. I suppose enough to get the clinical, but I don't think there was ever any time when there wasn't someone hovering over you. You had big assignments, but there was someone checking everything all the time.

DT: That was a nurse supervisor?

MD: A nurse supervisor.

There was more liberty when we went to Cook County, but that was because they had fewer instructors and fewer head nurses. That was just a real eye-opening experience. Like in contagious disease, there was a steam room where they had all the whooping

cough babies. So you were working in this heavy, heavy steam so the babies can breathe. I think that's the first time I saw a baby die. Madison General, by that time, was kind of a gold coast hospital—probably still is, but there, they didn't have any equipment, no supplies. They had burn units for children which is just...the pain that they're in. They had, like, one syringe for all of the injections to prevent...and they would just change the needle, but they only had one syringe. Then, at that time, we didn't have the polio vaccine. So, also, in pediatrics—I think we were there three months—there were these children in iron lungs. You got to know them—some of them couldn't move at all—just through the mirrors and so on. Those were big, heavy cumbersome machines. You just really hooked into them, got really attached to the children anyway, because they were there for a longer period of time. So that was interesting.

Then, we got our psychiatric there, too. Almost every night, the police would bring in people they'd picked up from the street that had gotten into some kind of trouble, so you got to know the Chicago Police Department quite well. As I said, we had this curfew. The Chicago police and the nurses at Cook County worked together very well, because almost nightly, the nurses are literally saving their lives. They'd come in with gunshot and stab wounds and everything. So we would be downtown funning it up and have this ten o'clock curfew. We had to be in this huge dorm that held 1700 students, I don't know...700 students, I don't know, some big number. That was quite close to downtown. It's 1900 West and maybe 500 or 600 South. So we would just stop the police and say, "We're students from the county." "Get in!" Whoo, whoo, whoo, and they'd get us back on time.

[laughter]

MD: I had not worked with police before.

Then, for part of the experience, we went down to juvenile court. We could sit behind the judge there and listen to all these sad things that came through, looking at the psychosocial aspects of all of this. That was a good experience.

DT: It sounds like a really detailed training experience. I've not been fortunate enough to have someone explain to me in so much detail what that diploma nursing school was like, that it was so intense.

MD: When you get done, you feel really able to begin on your own. You still need someone to go through when you have complicated kinds of things. It was a very good experience and I developed a lot of good friends.

DT: What did you once you received your diploma? What time period was this? Do you recall those dates?

MD: That was the fall of 1949 and I got out in 1952.

At that time, young women were all getting married at nineteen and twenty and all this stuff. We were not allowed to marry while we were in school. But, I did so secretly, because my husband-to-be thought he was getting drafted and getting into Korea. Well, that caused a lot of trouble and, then, I had to go back and do my penance and do some extra time or something like that. Then I finished, so... [chuckles]

DT: What rationale did they give for not allowing nursing students to marry?

MD: I think, at that time, they were somewhere between professional nurses and nuns. I think they just thought you don't have time. That's going to take away. I have no idea. But that was a rule at almost all of the schools. There was a time when nurses were treated almost like nuns. Pay them nothing, but great respect. Now, I think they're viewed more as equal professionals in most settings.

DT: Once you had your diploma, what did do next?

MD: Well, my husband actually did get drafted. I wanted to go back to school and get my bachelor's and master's, but circumstances didn't work out like that. He was in Kansas, so he kept whining at me. I should not have listened then. But, anyway, I went to Kansas. Then, he was in school and training and whatever they do there at Fort Riley, Kansas. It was a *huge* center. They had Camp Forsyth, Camp Funston.

At that time, they had all of the... Now, when they get sick, they send them home, but at that time, they kept all the soldiers till they were ready for active duty. They'd come into the hospital and have pneumonia or whatever. Then, they'd have a broken leg. They'd stay there until they were ready for active combat. So you had these huge units of, basically, very healthy eighteen-, nineteen-, twenty-year old men. So, I went to work at that hospital, Fort Riley Hospital. I think I was nineteen years old. Maybe I had turned twenty. Yes, I'm just twenty and a few months. There, they were sending the military nurses to Korea, so they were hiring civilian nurses for the military. I went through all their training and, then, they put me on nights. I'm three or four months out of school, and got 500 of 600 patients. Well, they had excellent corpsmen. The military has an *excellent* health care system, just excellent. In fact, they would have signs up, "We have the best equipment in the world. Take care of it." They had these highly skilled corpsmen. There, they had like one barracks, which was in Kansas, and the first five or six rooms, maybe eight, on each side were private rooms for officers or someone that needed ICU—they didn't have ICU units then—like the really sick ones or someone with a contagious disease, someone who had to be separated, and the rest were always, basically, recuperating and some very healthy young men. They all had duties. Like they had to get up and go to the dining room. If someone had to be pushed in a wheelchair, they had to push them even though they had a broken leg and it was in a cast. They had ashtray duty, because they all smoked. They had to clean the ashtrays and the waste baskets. They had all these duties that the corpsmen kind of took care of. But, basically, they were a healthy lot.

Here I come, a cute little twenty-year-old on night duty with...

DT: [chuckles]

MD: Yes! You see it coming. That didn't last long. Then, I asked to be transferred to OB [obstetrics]. They had a big obstetrical unit. That's where I got into obstetrics, actually. They were playing all sorts of jokes on me. They'd say, "Oh, someone down there is having a convulsion." I'd run out. You had to go to all these barracks. They were sort of separated by an outdoor ramp. In Kansas, they had a law that you couldn't kill skunks because they eat the bugs that eat the wheat or something. I don't know what it was about. A couple times, they'd have these big skunks that were as big as dogs with their little babies behind them walking on this outdoor ramp. That's when they'd call me. "Duxbury. Get down there."

[laughter]

MD: I'd go down there. I actually got very agile where I could jump the fence and avoid the things and jump back on again and get down there. I took a lot of jokes. I wasn't used to patients playing strange jokes on you. There were some other ones that weren't that nice even.

So I asked to be transferred to OB and they transferred me. That's how I became interested in maternal and infant care.

DT: Did you have any supervisors? You had so much responsibility...

MD: I could wake somebody up. But you'd think a long time before you'd wake a colonel up in the middle of the night. The corpsmen, basically, did almost everything. It was more like supervising the corpsmen. They were like super nurses. They were just terrific. It was a lot of responsibility. When I started there, I thought, my god, I'm just out of school. You were like a night supervisor, more or less. Unless there was someone in contagion or that was critically ill, mostly it was supervising the corpsmen.

DT: How did the physicians treat you in that hospital?

MD: Well, the physicians were very good, very good, and very supportive. It's different in the military. In the military, the nurses are all commissioned officers. Often, they out rank the physicians. Their captains and majors and the physicians come in for their two-year stint, and, then, they get out. The nurses were career people. They had very strict guidelines. Nurses had a lot of authority. As far as the medicine and the nursing, that was quite clearly defined. But because of their rank, nurses took no crap from anybody. I didn't find *a* physician, which may be normal in pediatric/maternity, that was not supportive and part of a good team with nursing. There were some you liked better than others. They had like rules for everything. Like the nurses there had the authority to dispatch an ambulance. Here, I don't think a nurse in a hospital could. They had different kinds of medical rules. There, they gave—I don't remember if it was IV [intravenous] or IM [intramuscular]; I think it was IM—Pitocin with the anterior shoulder

of delivery. So you had to be prepared and quick because when the anterior shoulder comes out, they want the Petocin. Everything was written down and they had rules and things for everything. Everything was spotless clean. They had, literally, the Red Cross white glove people coming around. They'd go behind a pipe and see if there was any dust. Everything was good. The women all got up—it was good for the mothers—and went to a community dining room for their lunch after delivery at all meals. So it was very good. We were very busy. They never have a lot of nurses in the military, so they count a lot on the corpsmen that are very well trained for specific things.

Then, we had a duty when I worked nights there. They check every four hours for fires and report it to I think it was a radar station. I don't know. You have to call that in. Usually the ramp sergeant does that, goes and checks that all the plugs are unplugged from the wall, all this kind of stuff. But they couldn't go through the nurse's dorm at night by themselves. They weren't supposed to. So the nurse from labor/delivery/OB—it was all one unit—had to go with them at night and then call the radar station and say, "Yes, we made our check." So I'm doing that. You had a lot of extra safety rules.

I'll never forget this. I was doing that and I said to the ramp sergeant, "Someone left a lit cigarette in that ashtray. We better check that for fire." Then, one of the supervisors there said, "Duxbury, ain't nobody on fire here but Pappy and me. Move on!"

[laughter]

MD: I was very innocent about all that stuff, at that time. I just remember that distinctly.

It was an *excellent* experience. I got an awful lot of additional knowledge and skill in maternal/newborn, so that was good.

DT: When you were working in OB—this was in the 1950s—were there any kind of monitors for monitoring the fetus at that time?

MD: Do you mean mechanical monitors?

DT: Yes.

MD: No. You just did it.

Then, I had a couple of babies and, four or five years later, I went to Washington, D.C. and I worked at D.C. General [Hospital] there. That was kind of like Cook County. The women got excellent medical care. The medical care was overseen, monitored, by Georgetown University and George Washington. They shared that. They were excellent. I worked mostly in OB admission, labor, and delivery. It was a whole separate unit in the back. There, if someone needed monitoring, there was one room across from the nurse's station and we would assign medical students to sit there with the regular monitor on if we had someone who was eclamptic. A lot of the people had no prenatal care, so they came in with a lot of problems. It was very sad. You'd think in this country... They did

the best they had, but they always seemed to be underfunded and understaffed. I was there for over three years. That was quite an experience. We would have what we called Precip [precipitous] kits in every room in case they delivered right then. The medical students would do the normal deliveries, supervised, of course, by interns and residents. The interns would do the forceps deliveries and the residents did the C-[cesarean] sections, and the residents supervised everything.

Right on the unit across from the nurse's station were two rooms that had five bunks in them. One was for Georgetown medical students. One was for George Washington. Then, there were always three interns that lived and slept there. They would rotate. Then there was also a chief resident and maybe two or three others that, also, lived there around the clock.

I think they had about 12,000 deliveries a year then. It was a lot, and people that had a lot of superimposed medical problems and social problems and things like that. They did a very good job. The nurses were excellent. The medical students were medical students. Interns were interns. They had some excellent chief residents and excellent medical supervision from Georgetown and George Washington. If it was something really bad, they could even call them out at night.

DT: There were attendings, but they just weren't as visible as the residents?

MD: No. I think maybe the residents were what I would call on-site attendings.

DT: Yes.

MD: They made grand rounds there. They used to like to embarrass the medical students and interns sometimes when they asked a nurse a question, because she'd been there forever and heard this spiel forever.

I thought they got, for the facilities and the equipment and number of persons, excellent medical care. Excellent...I really did. I don't know what's going on there today. I guess Georgetown and George Washington aren't there anymore.

DT: Hmm.

MD: I don't know. I think this whole medical insurance business has changed everything around—and not for the good.

I got some very, very good obstetrical experience there.

DT: If you're there in the 1950s, this was maybe before C-sections were being done in an increasing amount. Do you have some perspective on how often C-sections were being done versus just a regular delivery?

MD: They did a lot of C-sections there, a lot of them. Because they had a lot of really sick people and babies in jeopardy and so on, they did an awful lot of sections. Then in your job, you had to scrub for the section and, at the same time, you've got these three or four delivery rooms going around. They had a lot of research going on there. I don't know if they had fewer or more sections. That was, basically, a high risk setting where there would be a lot of sections, and, it's also—let's get real—a training facility for residents. I have no idea on whether they did more or fewer now.

DT: It's hard to put a figure on that.

MD: Right.

DT: You mentioned when you were at Fort Riley Hospital that, obviously, the physicians there had a lot of respect for nurses. Was that the same at D.C. General or was there a different relationship?

MD: At D.C. General, I think there was a very good relationship between the nurses and the chief residents and the interns were only there like a month, so you didn't get to know them. I think the chief residents counted on the nurses to really oversee the interns and medical students, because they couldn't be beside each one all of the time. They worked well together. They partied well together. I think it was highly respectful.

In fact, I remember one chief resident once—he was excellent; I think that was Gale Anderson—when we were having delivery after delivery and had to get other patients in the delivery room. They had about two nurses back there and, then, you had some aids that would clean the delivery room and mop the floor between patients and so on. More than once I heard him. I think this guy was a Mormon; he was very proper and an *excellent*, excellent, compassionate obstetrician. A medical student came in to complain. He said, "That delivery room hasn't been cleaned yet, and I want my patient brought in there." Anderson said—I'd never heard him swear, but I did then—"Get a goddamn mop and clean it yourself!"

[chuckles]

MD: When things are very busy, everybody pitches in. I've seen the chief resident get a cleaning cloth and clean the operating room table to get the next section in. It's very different than like a private hospital. Everybody pitches in.

I know there was one new resident that would somehow try to get a section on nights when the chief resident is asleep. He had us doing a special watch on him, so if he was up to anything...

[chuckles]

MD: No, I've not worked in any place, I think, where I've worked with physicians that were not respectful. There are some that are very arrogant and have a sense of

entitlement, but I can't say really any were not respectful. There was one surgeon when we were students who used to holler and swear at nurses. He was clearly disrespectful, but some of the other physicians would take care of that.

I don't know if my experience is unique because of OB, when it's all hands on deck. When something goes wrong at a delivery, everybody pitches in. Or when the mother is really high risk and needs full attention, everybody pitches in. Sometimes, you'd get some medical student that thinks... They used to complain, "That's not my job. It's the nurse's job," when they were put on constant watch. [chuckles] That wasn't the nurse's idea; that was the medical orders. The chief resident would say, "This is a learning experience for you." And it was. I know other nurses have felt that and rather intensely, but maybe it's my own assertive, aggressive personality that says, "Don't mess too much with me."

[chuckles]

MD: I don't know, but I can't honestly say I've ever felt that.

In fact, after I moved back to Madison—I'm ahead now—one night about eight o'clock, admissions calls me and they want to admit someone with a fever of undetermined origin. They only had two twin beds in a room and they wanted to put her in that room. I said, "You can't. We've got a patient who is having surgery tomorrow." "Well, blah, blah, blah, blah..." About ten o'clock of eleven o'clock at night, I called the chief of infection control at home and told him. Of course, they didn't admit him but that doesn't make this other guy your good friend. To me, that's ridiculous, and that was my job, so...

I have never been threatened or intimidated like some less assertive people might have been or even if someone says something in anger when things are intense, that's episodic, and it's gone.

DT: Yes.

Can you talk about some of the specific things that you would do for the patients, the way you were taking their temperatures, say giving them IVs or anything like that? What was typically your responsibility with the patient?

MD: You have to do a thorough admission, a quick history from someone that's never had prenatal care and no record of anything. Then, you get them to take a shower, and get them in a little gown, and you do all their vital signs, and, then, you monitor their labor very carefully. Then, you try to provide the kind of support they need through labor and provide medication if they need it at a certain point, and not too early. They can't have too much because they've got a fetus in there and so on. And you support them during delivery and, then, you have their postpartum care, which is, also, very important, that they're not bleeding. They could bleed to death very quickly if that uterus doesn't contract.

There's such a joy with the miracle of a healthy baby. Do you have children?

DT: No.

MD: It's like a miracle each time it happens. You see these little things with ten fingers and ten little toes.

[chuckles]

MD: Most of the time, the outcome is really a very joyous experience, after a labor of hard work. That's a very personal joy you share with the mother and the father and whoever is there. It's very, very satisfying.

DT: What techniques were available to you then to monitor the labor?

MD: Well, you had a fetoscope. Basically, what you want to watch is that they're not bleeding, the fetal heart tone is regular, and the rate is good, and how they're progressing in labor, how much the cervix is dilating, and the mother's blood pressure. You don't want her to have a fever or anything, so you do the vital signs. Basically, it's what they do today with machines.

DT: Yes.

MD: A lot of these women at D.C. were quite hypertensive. Some were overweight and some were malnourished. They just had a lot of problems. They weren't the traditional healthy person that's well nourished and has a support family around her and has a good prenatal record and so on.

They had some advantages though, because the babies weren't over medicated. I know when I was in training and someone had a baby, that baby was sleepy and groggy for twenty-four or forty-eight hours. These babies came out screaming and laughing—not laughing literally but just ready to fight the world. They weren't sleepy at all. At first, I couldn't figure that out. Then, I figured, they're not over medicated. They were just healthy, beautiful little creatures of God, I guess.

[conversation as both leave the room for coffee]

MD: I don't know if we're going to get to Minnesota.

DT: Oh, we will. Don't worry. You have such interesting stories to share about being a nurse. I hadn't realized that you had spent so long as a practicing nurse.

MD: Oh, yes. I liked it. Are you a nurse?

DT: No, I'm not.

MD: You must hang around them a lot. You have so many questions to ask.

DT: I spent all the weekend on nursing history.

MD: Good.

DT: I find it very fascinating. I have my own interest in the project, but, also, I'm aware that there are all those people who have such fascinating experiences that others might find useful to really know what it's like to have an OB nurse in the 1950s.

MD: Each one may have a different perception.

DT: Yes.

MD: I think I had the best field, mothers and babies, because there's just something exciting and grand each time a baby is born.

DT: Do you have kids?

MD: I have three. They're not around here. One lives in Bismarck [North Dakota]. One lives in Colorado, and one in lives outside of Saint Paul.

[both return to the formal interview]

DT: What was your rank in the military?

MD: Oh, I was a civilian nurse.

DT: Oh, you were. Okay.

MD: We could use the officer's club and stuff like that, but we were civilians. I think some of those nineteen-year-old recovering bucks on the unit could take advantage of, too. Military nurses take no crap from those...none.

DT: You said you were at D.C. General for three years and, then, did you move back to Madison after that?

DT: Uhhh... Let's see. No, I moved to California. My husband had finished medical school then and we moved to California and were there for a few years where he did his internship, residency, etcetera. I had my third child there, actually.

Then, we moved back to Wisconsin and, then, I divorced him. That's when I went back to school. At that time, nurses were paid very little. That was probably around 1964. I don't know. I thought I had to go back to work, and I worked for about two or three months. They had me on nights and evenings, and I figured out I was probably clearing about eight dollars a month. I had to pay a babysitter at night and one during the day so I

could sleep. There was a lot of federal money around for nurses to go back to school. I was very fortunate; I was given a healthy body and a fine mind, so I just went back to school. Then, I could take classes when the kids were in school and be home evenings and nights and study, and I actually made out better than working.

DT: So you had federal funding to get your baccalaureate?

MD: I'm sure it was federal funding. It was funding from somewhere, and, then, I got little scholarships from stuff, you know, so it worked well. After I got my bachelor's, I taught at the technical college here while I was working on my master's and my Ph.D. I must have had a very good advisor to find all these little monies for me. Anyway, that worked out very well, and I just kept rolling.

DT: How long was the baccalaureate program?

MD: That was very interesting, because, there, if you were already an RN, you could take a test and get all your nursing courses waved. But you still had to have 120 credits. I didn't have anywhere near that. Then, you had to take like trends and issues in nursing and public health nursing. The other nursing courses, you could test out of. I took the tests and I did extremely well in everything but obstetrics...

DT: [chuckles]

MD: ...which was interesting, because that's where I spent most of my... I blame in on the test. I'm very critical of testing now. I remember one question they had and it wasn't specific enough for me. It said, "What do you do if a woman comes in with ruptured membranes?" Well, they didn't say like if they ruptured right now or just came, so I had a whole different vision. If they rupture on the way to the hospital, you want to be sure that there's not any pressure on the cord, and you put them in a knee/chest position and so on. I knew all that stuff backwards and forwards. But, if they came in, as I read it, with ruptured membranes, they could have been ruptured for two or three days. Then, you look for malpresentation, malposition, malnutrition, and infection. That's what you look for. If there's pressure on the cord, it's too late already. So I had a whole series of questions like that that I thought these are rotten questions. They don't know what they're talking about. I don't know if they have that on file, but, someday, I'd like to go over all of those items. Anyway, I passed it high, but that was my lowest score of all the tests I took.

I had to make up, after I took the nursing courses, trends and issues, which was just for returning RNs, and public health, I had like ninety credits I had to do something with. Oh, we had to take organic chemistry, but that was outside the department. Other than that, I don't think I had to take too much. So I almost graduated in sociology. I had enough. I spent a lot of time in the Soc [Sociology] Department, and I took chamber music 1 and 2, and art history. I was just taking things. I wasn't a full time student; it took me a while.

Then, as I said, I went back to work and continued my graduate studies part time. Then, I could make more money—I had three kids to take care—working than I could as an RA [rotating assignment] or PA [permanent assignment] or something I found. Then, I did my dissertation. I worked for one year here. They hired me as an assistant professor in the school of nursing. I only stayed one year and I went to New York.

DT: Why did you end up doing your graduate work in educational policy and administration?

MD: At that time, they had quotas in all the departments...for women. They were very specific quotas, and I probably could have gotten in, but they looked at nurses as being technical people, not academic people. So I don't know that there was a lot of success. They did have some monies out to get your doctorate in physiology, which I wasn't interested in at all. I was more in the psychosocial area, so I took a bunch of courses in psychology. They would have like a seven percent quota for women in most of the different departments. Education didn't. They had, by their own modest admission, the best department of education in the country—still do. I went into education administration and got my master's in educational policy studies. I wasn't interested in the curriculum and that kind of stuff. They had a very good department, very internationally known faculty, and so on. I started my master's there, actually, because a friend of mine had started it there and was talking up the faculty and all of that. You had to take the GRE [Graduate Record Examination] and all that kind of stuff. In soc I think I would have had to wait three or four years to get admitted to the Soc Department. They have a very good Soc Department here, again, by their own admission, and by today's standards also. That's what I did. It was available, of interest because I always thought I could run places better than...

[chuckles]

MD: I had very good advisors, and there weren't many women in grad programs there [in the Department of Educational Administration, i.e., only 4 out of 200 graduate students]. You wouldn't have an all-male student body [in educational policy]. I don't regret that at all. It was good.

DT: What was your dissertation research on?

MD: I used Jerald Hage's *Axiomatic Theory Organizations* and applied it to state boards of nursing. It was interesting. I had a very good committee, very supportive committee. I look at some of these students now... When I was writing, after I collected my data, my advisor was Merle Strong who just died recently. I had really good people on my committee. I could shove a chapter under his door, and in two or three days, he would have written all over it, and get it back to me. Some students now wait weeks and weeks and weeks to get something back. I told him as I'm writing, "I've finished my data, and I'm going to take the whole summer off and just write." And I did. I think I sent the kids to visit their father in California and I just wrote. He knew I was on that schedule and I wanted to finish by the end of the summer. The whole committee was extremely,

extremely helpful. When I hear about other people's committees, I sometimes shudder. I don't know how he did that. Summers are very busy, because they have a lot of teachers coming back and stuff. But he did and I really appreciated that.

A good group of graduate... There were only like three women in all of ed administration at that time. Now, I think, there are a lot more. They were all guys. We all had our little offices, like maybe six in an office, and we could be there till two or three in the morning, writing and correcting and sharing. At that time, well, you know...doing a dissertation, it's so intense, you really don't want to talk to anybody else about anything that's not related to your... It just detracts. I got it written, and I got it defended, and it was good.

DT: You mentioned a little while ago that one of your reasons for going back to school was—well, you had always wanted to go back to school, it sounded like—...

MD: I did, yes.

DT: ...but also there was more financial security in that. What were your motivations for going on and doing a Ph.D.?

MD: Well, initially, I didn't plan on that. I think my advisors encouraged me to do that. I think that was it. I had a job at the tech college, and I was just doing that part time. I just like school, I guess that's it.

DT: [chuckles] I can relate to that.

MD: I think the graduate school experience is just something really unique when you can focus and you have very bright colleagues, other students that are interested in the same thing. I think that's very stimulating, just exciting. I like school. I'd still be in school if they paid me enough.

[laughter]

DT: I can definitely relate to that.

While you were doing your graduate work, you were working at the technical college teaching. Were you also doing nursing at this time?

MD: No. I was not doing any clinical nursing. No.

DT: Then, when you got your doctorate, you took a job at March of Dimes?

MD: I did. The year before, I think almost all of my data collected. I worked for one year at the University of Wisconsin-Oshkosh. Then, I came back to write my dissertation. Then, Madison, in the mean time, had offered me... At that time, they were all looking for nurse Ph.D.s. So I was there one year. That first year, I didn't care for it

at all. Oshkosh was much better, I thought. [chuckles] There, they were really physiologically bent, I think. They had a couple faculty that had Ph.D.s in physiology, and, somehow, they expected... I didn't really dislike it, but it didn't gel well. I would have had to...

I was active in the Wisconsin Perinatal Association. Wisconsin, Utah, and Denver, I think, were the first sites to kind of regionalize medical care...perinatal. They had a very good system for referral. They had a very good system, a lot of educational programs...and just very good. I was no longer the expert in perinatal, but I knew enough about it, and knew enough about education. They had some real nurse experts there: Mecca Crane in maternal, and Natalie Dahl in neonatal, and Sue Frazier who was on the faculty here. In most of those regional programs, they did some teaching. Sometimes, I did. The March of Dimes had not had a nurse on board since the polio days. They had moved into perinatal and maternal/infant.

Someone from there contacted me or... The two medical leaders in this early regionalization were Stanley Graven, who was a neonatologist and Jack Schneider who was an obstetrician, perinatal—I don't know if he calls himself a perinatal—the high risk obstetrician kind of person. They were all across the country doing things. I don't remember if I heard it from them or however, but I think the March of Dimes contacted me. I might have contacted them, but I think they contacted me through Graven or somebody, both very nice supportive of nursing physicians. I thought, well, I'll take a free trip to New York. I haven't been there in a while. I went there, and they sold me a bill of goods, and so I moved. It was a very, very good experience for me...very good.

DT: This is in New York City?

MD: Well, actually, they're in Westchester and White Plains, but New York City has a big chapter. So I was there.

Have you been into OB? Have you ever heard of the Apgar score?

DT: I have but you'll have to remind me what it is.

MD: That's an acronym [Activity, Pulse, Grimace, Appearance, Respiration] for someone looking at the baby. When I came to the March of Dimes, Virginia Apgar was my boss.

DT: Oh.

MD: She was wonderful. She was just terrific. After I got there, I didn't even see her for four months; although, that was, supposedly, my direct line. She was a wonderful, wonderful person. She said, "Well, Duxbury, I don't have anything to tell you, except when you travel, take two suitcases. Put lumpy in one and smooth stuff in the other."

[laughter]

MD: That's all she said. Then, she died. But I had a lot of support from the vice president and the president, not so much from the physician who was the pediatrician there, whose name I'll just... That part of it wasn't good after Virginia Apgar died. They put me with this other physician. Fortunately, we both traveled a lot on the road and were gone. I just learned to totally ignore him and bypass him and go right to the big boss that made the decisions. That was good.

DT: What were your responsibilities there?

MD: Technically, I was responsible for, they called it, director of health personnel development. Now, it should have been like a vice president for nursing, but they only had one female that had ever been vice president and that was Virginia Apgar. I had the same responsibility for nursing as the vice president for medicine had for medicine. Since he had older established programs, I could develop the programs. I developed funding for nurse midwifery and for perinatal care. We had collaboration. At that time, they were looking at a high risk perinatal nurse clinician that was not at the master's level, but in between. I convened meetings with the American Nurses Association [ANA], the Academy of Pediatrics, OB-GYN, and both of their certifying agencies. We all met in Kansas City [Missouri] at the ANA with their division. We developed guidelines for these programs and everything went well. So, then, I was able to fund some of those programs. I went around to a lot of the chapters and told them what's new and what's exciting. There was a lot of emphasis on maternal nutrition then, and so on.

Usually there was a small group at the airport if I flew in that met me, like the president of the local chapter, and some of their volunteers, and maybe their medical director, sometimes, three or four people, depending on the size of the city. I was flying into someplace in California. When I moved to New York, I dressed very *New Yorky*, you know. I spent a lot of time on clothes and all that stuff. I got out of the plane and there were *hundreds* of people there. I got out of the plane waving at everybody. About ten spots behind me is this country singer, Freddy Fender.

[laughter]

MD: They were all there to see him. God! that was funny. He had a big song out then. I don't remember the name of it, but it was a beautiful, beautiful love ballad. Yes, Freddy Fender. I didn't even know he was on the plane.

I traveled an awful lot and had some interesting experiences. I met Paul Newman once. That was pretty good.

DT: Wow.

MD: I met a lot of those people. I just did a lot of that.

Then, I developed a series of educational modules. They were, basically, designed [for professionals] to do no harm. Some of this was stimulated by Apgar's work. I think I started those when she was still there, before she died. First of all, they didn't know what an educational module was at headquarters. They knew lunar module. That was the contemporary view, at that time. So in-house, they just called it "Mitzi's Modules." Being in education, I developed everything properly and had the objectives, and I had it pilot tested in Austin [Texas].

The first was a series on the first six hours of life, what to do and not do. The first one was just some objectives on neonatal hypothermia. Was hypothermia first? Neonatal thermoregulation was the first one. I had six of them there in the first six hours of life what to do. Thermoregulation is, basically, wipe off the baby, wrap him up, keep him warm, look at him every now and then. Virginia Apgar used to say, "I never thought they'd use an Apgar score in name. All I wanted to do is have somebody look at the baby and get the vital signs and so on." We used to deliver them and lay them over there. They'd be wet like this, not wiped. Those were extremely successful with the chapters. I think the second was on hypoglycemia. Then, we started a series for interpartal care, labor, and, then, maybe postpartal care. They were so successful all across the country and really helped to put the March of Dimes on the map for maternal/infant care and in nursing. There was some drug company, I don't know which now, that came to the March of Dimes and asked if they could translate that into other languages and put it across the world. They gave them permission. They didn't care. They're non-profit and there to serve. So they did that. Then, I got some conversations or notes from physicians that would not let their residents into the labor room until they had read these, gone through these modules.

So they were very successful, as was the funding for midwifery programs and funding for high risk perinatal and preventive and that kind of stuff, so it was a very productive, good five years, or six years. How long was I there? I don't know.

DT: I think it's 1972 to 1977.

MD: Oh, is that right?

DT: Yes. I had a copy of your CV [curriculum vitae] and I think that's what it said.

MD: I got my Ph.D. in 1972, so I couldn't have been there before 1973.

DT: It could be that. I might have...

MD: I could have it wrong on my CV, too.

[laughter]

MD: I think I was there just a little over five years.

DT: The next thing, I have you at the University of Minnesota in 1977.

MD: Uhhh... Really?

DT: Yes.

MD: Okay. It was somewhere in there.

DT: I can double check.

MD: There might be some overlap with the March of Dimes, because they didn't have someone to replace me right away, so they technically hired me for weekends for the next year almost to keep these things going with the staff in there, while they recruited and found somebody. So there may be some overlap in the years when I left the March of Dimes and came to Minnesota.

DT: These educational modules, did you write them specifically for nurses but, then, they got used by interns, as well?

MD: Yes, they were written for nurses, and the intent was to give them to nurses, basically, in rural areas at the primary care level. But they were used in the NICUs [neonatal intensive care unit] and all over, also—and they're still going on. They continue today, but, not, they're all high tech online and flashy color videos and everything.

I could get the best investigators in the country to do these modules as a manager. We had Kathryn Barnard from the University of Washington who did one on maternal/infant bonding, with the attachment process. She was so good. She had some slide tapes or something with it. The others were, basically, paper things. The first one was just done on kind of a test basis to see if they worked. Well, the chapters went crazy, because the nurses all wanted them. It was something in their hand; they could read it at home, and take your little test. It was very good. If I go to meetings today, I still have people come up to me and say, "Thank you for the modules."

DT: It does sound incredible. Your time at the March of Dimes, as you've just mentioned, sounds incredibly productive. I know that the University of Minnesota set up their nurse midwifery program, I think in 1972, 1973, so this was such an important time for...

MD: Yes, it was. Some were starting and medicine wanted to extinguish them. It had more to do with financing than care. March of Dimes doesn't have big money for that.

Then, I also sat on some committees for the March of Dimes: the Medical Advisory Committee, when they would give their grants, or the Research Committee, when they gave grants out and so on. So as far as networking, I couldn't have been in a better

location. I, actually, knew on a personal basis anybody that was anybody in perinatal care, just the experts from across the country.

I was trying to think as I read this, that might be how I got to Minnesota. I'm not sure. I know there were several faculty from Minnesota that were on their Research Committee or their Medical Advisory Committee, and so on. I think it was Nelson Goldberg from the University of Minnesota, but I'm not sure. I know he was at Minnesota, and I know he was on one of the advisory committees there. I don't know if he told the Search Committee about me when they were looking for an assistant dean or if he told me and I found them. But, I think he was the connection.

DT: Interesting.

MD: I guess he died a few years ago. He was an excellent scholar. He might have been department head of Biochemistry or something. I don't know. Anyway, that might be how I got to Minnesota.

DT: What was the impetus behind building this midwifery as a specialty?

MD: Well, I guess you'd best get that from nurse midwives. I think there was a lot about whether they should even be in nursing or not or totally separate. There was a lot of dialog. I didn't get into that political kind of stuff. I knew midwives deliver a very good product. They're extremely well trained.

They approach this very differently. Medicine has almost approached it like a disease or an altercation. I don't know if you've studied [Florence] Nightingale at all? Nightingale clearly defined a difference between medicine and nursing. I'm kind of extrapolating now, so these are not her precise words. But she said, "Medicine identifies or finds an obstruction and treats it with drugs, radiation, or surgery. It implies a specific temporal point. You come in. You've got a problem. They find it. Boom, boom, boom! One of those three ways and goodbye. Where nursing puts the body in the best condition for nature to act on it. Its temporal framework is from the beginning to infinity, as far as your existence is. They look at how can we help the body heal itself?" Out of that, they look at midwifery as one of these natural processes that has additional kinds of stressors and so on to help them through. It's a very different... I think for normal, healthy deliveries, it's a very superior approach. But there were very few schools of midwifery.

Historically, they've been extinguished before from the Frontier Nursing Service where they had done exemplary work, not just in midwifery. They had reduced mortality in that area that they controlled and nobody believed them. So they sent the Metropolitan Life Insurance in to examine their data. People were healthier and living longer where there were midwives for the whole Frontier Nursing Service. That so scared medicine that Blue Cross evolved out of it. These insurance companies have had a major role in defining what care we get and don't get and who gets it. It's a bad system.

DT: The rise again of midwifery, that coincided with a push for the national childbirth movement coming from women after World War II, as I understand.

MD: I think midwifery preceded that. I wish I were more of a nurse historian. I do know about the Metropolitan Insurance Company coming in to kind of verify the data, and they were having healthier babies.

Then, I don't remember if I was at Minnesota or the March of Dimes when I started doing some things with the World Health Organization [WHO]. They had training for all these lay midwives, a lot of them in Africa, and Southeast Asia, and all over where there was nothing, no health care providers at all...just with the simple things that I think Doctor Amelia Maglacas, who was senior nurse scientist at WHO then, established with her different working groups these midwifery kits. They had a short program on how to do this safely. I thought, gee, if they can do that with no training at all and these kits and a six-hour course or something and reduce mortality, these midwives with two years post graduate... They had done a phenomenal job; although, there's always the organizational structural problems that they face and so on.

DT: You mentioned briefly that there is some resistance from physicians about this midwifery. Did you encounter any of that among your colleagues at March of Dimes?

MD: Well, I can't think of any directly. I found some that were very supportive, but mostly if they didn't stay in the private upper class groups, mostly if you're in the ghettos, or in the rural areas, or in the impoverished areas, or if you're doing something that we can't or won't do. As long as they didn't affect the middle class paying patients, I think they thought...and they viewed them as only helpers to them. I found a few of those. There was a fellow in Alabama, somewhere in the South, Charlie Flowers, who was very supportive of midwives, but there were so many clients, women, in that state that had no care at all, so, in that sense, he was very supportive. You know, there seems to be that it's more a function of ratio of physicians to available patients and a geographical set. Like in the West where they don't have, they would welcome them. Midwest? Yes and no. Don't bother in the cities for the rich paying patients. New England, where they have probably too many physicians anyway, just stay out of it. So there are different geographical degrees of acceptance, I would guess. I hypothesize; I have no data.

DT: I think that's certainly the sense I've gotten from people I know that have written on why the nurse practitioner movement in the 1960s and 1970s and a lot of the archival material I've seen. Yes, it's okay as long as you're not interfering with our realm of practice.

MD: And you refer.

DT: I wondered about how this intersects with the nurse practitioner movement in the 1960s and 1970s. Were you aware of this move to have nurse practitioners with, I guess, more clinical autonomy?

MD: Nurses have always sought autonomy, not always successfully. Yes, I was aware of that. They were doing that way back then. I think if physicians really understood what nurses do, there probably would be no resistance at all.

[door bell rings – break in the interview]

MD: I think some of the schools of nursing, in order to get approval getting through their systems, and so on let an important part of nursing go and took over a more assistant to the physician role, which I don't know if it's good for our whole health care system or consumers or what. Time will tell. I think many of them, depending on where they graduated, and how they interned and so on, are secure enough in what is nursing and what is not nursing to keep that nursing role and look at where you are in your lifetime at this point, how it's been based on this, and what you need to go here and look at a whole person system, structure, where you fit into that and how they can help you to waltz better with whatever.

DT: That's a really neat way of conceptualizing what makes nursing different from medicine, I think, that approach.

MD: I think most nurses have that. Some don't. I don't know if they don't get it or they've lost it. Most physicians that work closely with nurses know they have something. They're not sure what it is or how it works, but they know they have something that gets people better faster.

DT: Yes. [chuckles] Those do sound like incredibly productive times at the March of Dimes. It begs the question: why did you leave? Why did you return to academia?

MD: I missed university life. As I told you earlier, I'd be a student my whole life if I could afford it. That was a little removed. They let me—although, it was against their general structure—do a little research of my own, but that's very different than doing research in an academic setting with all of the support. So I was doing a little something on nurse burnout and nurse turnover.

Then, the Minnesota option and I'm from the Midwest and I came back.

DT: Were you hired as director of graduate studies or you were hired as assistant dean?

MD: I was hired as assistant dean and, then, I think you're elected as director of graduate studies, but it's almost always the same person. Yes, I was hired as assistant dean for graduate studies.

Irene Ramey, who was the dean, was a wonderful person. She had a little mean streak in her, punitive, retaliative streak, but she was a *great* person, a visionary person, an incredible administrator, and a fun person to be around. She was very specific. She didn't play any games. She hired me to get that doctoral program approved. They were

having trouble with the Graduate School. But what they didn't tell me was that she was dying of cancer, when I came in. Maybe she didn't know; I don't know. No one said anything and I didn't know. She was dean, an active decision maker as she's on her death bed. I think the last visit of someone over there, a couple days before she died, she said, "Get the grant in. Get back there and finish writing it, and get the grant in." So she was very determined and able, knew the discipline. She was one of the first nurses to get a Ph.D. in nursing from NYU [New York University]. She was a great person. I learned a great deal from her.

DT: I've heard from one or two other people—everyone speaks so highly of Irene Ramey—a story where she would call people into her office and would yell at them if they'd done something awry. Does this jibe with your recollection?

MD: Well, I don't put up with that crap in the first place, and maybe she knew it. When I first came, you get an awful lot of mail over in the Graduate School on this and this. She said to me that I should write all these answers out and, then, give them to her and she'll sign them. I said, "You've got to be kidding. I sign my own letters. I'm not your secretary or your administrator. I'm hired here as assistant dean. I'm prepared." I remember her looking at me like this...just looking at me. Then, there was a quiet spot, and, then, I said, "I understand contracts you sign, and you're the dean, and I wouldn't send out any letter unless I'm sure of our policy and position on that. But I'm not writing letters for you." She said, "All right." That was the end.

DT: Hmmm.

MD: Another time she told me to do something I didn't want to do. She wanted me to get some faculty member kicked out of that underground parking.

DT: [chuckles]

MD: I said, "If you want him out, you kick him out. I've got nothing with that person" It was a high priority getting underground parking; otherwise, you had to walk several blocks.

I never had anything with her. She was always *very* supportive. I was very careful that I knew what were her decisions and what was my implementation of those. I never made decisions for the school. I came to her with certain things and once it was approved, it was good. The dean, that's a busy, busy job.

Like when we developed the contracts with North Dakota [University], it was all left to me. The dean there, I don't know if she had written to Irene, but I know she contacted me personally and approached the idea and so on. I went to Irene and she just said, "Do it. Handle it." That was the end of it. She always got copies of my communications. She, of course, had to sign the contracts. So we developed contracts with Minnesota when Elisabeth Zinser was dean there to bring graduate education to North Dakota. Our faculty went up and taught there. Then, we had the North Dakota—a lot of them were

faculty members that were not prepared at the master's level—come to the Twin Cities campus, and we arranged housing for them. We, actually, made a little money off of that deal. We did that for quite a few years until there were enough of their own to get going.

Some of the restructuring we had to do to get the Ph.D. program through the Graduate School... I think they'd turned it down once before I came; I'm not sure of that. I think they turned it down once with my first shot there. Then, the second time, it went through. We had to do some faculty reorganization. We had some very good faculty, but they weren't involved in active research. They talked about it more than doing it. Now, we had Ida [Martinson] who was a researcher, and I recruited Sue Donaldson just before I left, who is a well known researcher, both of them in the IOM [Institute of Medicine], actually. God, I'm going to leave some active people out, I'm sure. There were many others had little projects going. They had this whole regional system for education going. Now, before I came, I think Floris King was assistant dean for graduate studies, and she had written and gotten a doctoral program grant approved. I think that was before I came. I'm not sure on these dates.

DT: That's accurate.

MD: Did you talk to Floris?

DT: She talked to me briefly on the phone. She didn't want to be interviewed.

MD: Oh. Anyway, she's a very good person, a very bright person.

Then, we had some other really good faculty that weren't, as I said, actively involved. Once they're tenured, they get positioned and it's sometimes difficult. Then, we had these regional programs where the enrollment was increasing. There was heavy demand for that. Then, we took on North Dakota. So we had to do something to get the faculty more involved in research. After my first shot in the Graduate School, we had no researchers there. We had two or three. Oh, god forbid, if I'm missing somebody.

DT: Marilyn Sime?

MD: She was very good, but I don't think she had an active research program, a *funded* research program that I recall. They may have had little programs. But as far as external funding, which is kind of what the Graduate School looks at, the University looks at... They may have had a little funding from some private thing, but I don't think any big research grants, other than Ida, and, then, myself... I brought some in. I think I had two big grants while I was there. I don't really remember. I know when I left, I took three grants with me. I know I had some.

You don't have a list of the tenured faculty that were there?

DT: I don't have it with me.

MD: That was thirty years ago.

DT: Yes. Isabel Harris? She had a Ph.D.

MD: Oh, yes. Izzy. She was a former dean. She was excellent, *excellent*.

DT: Did she have a research program though?

MD: I don't think so. She had been in administration. I don't think so. She was a wonderful person, a very bright woman, had a vision. She was very supportive of me.

DT: Ellen Egan. I think she was there.

MD: Oh, yes, Ellen was very active there. I don't know if she had... I don't recall if she had an outside funding research program. Some of the faculty were still working on their own Ph.D.s.

Anyway, I kind of looked at what we would have to do with the responsibilities and the faculty and the money that we had and, clearly, we had to get more funded research. How are you going to do that?

Oh, oh, Elaine Mansfield was there. She may have had a little funding. I don't know. I just hate to say that.

DT: I can definitely check up in the archives and see who had funding.

MD: Okay, good idea. I think Ida Martinson did. She was always a high energy go-getter, a fun person. I'm trying to think who else was there.

DT: Was Sheila Corcoran?

[break in the interview]

MD: I think Sheila did not have a Ph.D. yet. I think she was still working on it. I'm not even sure about that.

We had a lot of excellent faculty that was spending their time on other things. We had several meetings like, first of all, how are we going to cover and who's going to cover North Dakota? I remember Ruth Weise who had a terminal master's, but she could have been given an honorary doctorate. She was very bright and *very* energetic and *very* supportive of Minnesota. I can remember a faculty meeting when we were laying out plans on how we were restructuring the curriculum, and you're going to teach more, and you're going to have these young faculty coming in spending more time on research and so on to get this doctoral program approved, and Ruth Weise was probably middle age then, maybe forties, fifties, I don't know. She was already in charge of a lot of the regional program. They were a lot of work...to fly up there or drive up there, and spend

those hours and, then, get back here and have a seven-thirty class in the morning. Some of the faculty were complaining, “I’ve got all these committees I’m doing, and blah, blah, blah. How am I going to have time to do pilot work and get grants out?” Ruth Weise stood up, and she said, “I’m too old to go back and get my Ph.D. But I’m not too old to teach. You get these young junior faculty doing pilot work and getting research grants in and I will teach *double* if I have to in the regions and here to get that doctorate program approved.” That kind of shut up a lot of the complainers. We had to kind of restructure things curriculum wise and a lot of taught. Ida taught. I went up there for a six-hour session, which almost killed me myself, teaching some research methods or something—I don’t remember—...

[chuckles]

MD: ...at North Dakota. We had fun up there. Elisabeth Zinser had us all in one house. We had pizza and stuff, and would talk about a lot of stuff. It was a very good experience. Then, I think Zinser left, and they had a bunch of people up there and a new person. She had gotten special funds from the State of North Dakota, the state itself. That was a good experience.

Then, the second time, I did a little more homework, I think, mellowing up to... That graduate school approval program had some people on it that *maybe* should have retired a long time ago, intellectually—not age wise. Some of them didn’t even think women should even belong in the University and so on. But there were some strong supporters, people that actually read the stuff or had worked with nursing. In the graduate college, most of them are not physicians.

I remember Vern Weckworth in the School of Public Health, I think working with nurses. There, the School of Public had a nursing program and, then, the School of Nursing, and, then, later, got it together. I don’t know if working with him... He was very bright, just generally a well read person, or if he had personal interactions or what, but he was very, very supportive and very aggressively supportive to approve the Ph.D. program in nursing...very much.

The second time, we had more research. Ida, I think, had a bigger grant. I brought a couple in. Somebody else had funded research that I’m missing...I mean big grants. Oh, maybe, you could pick that up in your... I think Elaine Mansfield... We had a lot of program grants. I’m not talking about those program grants, but research grants. I’ll probably wake up at two o’clock and, oh, god! how could you forget that?

DT: [chuckles]

MD: I don’t even know when it got approved. Do you know?

DT: I think it was finally in 1982...1981, 1982.

MD: No, it must have been before 1982. I think I was gone in 1982, wasn’t I?

DT: I think you were still there... You left in 1983.

MD: Oh. I left in the fall of 1983. Okay.

DT: Yes. There were three proposals that went forward.

MD: What were their years?

DT: I don't have the years written down. It was a little unclear from the record how many times it went forward, but maybe it was in the fall of 1981 that it went forward and, then, finally, got approved in the spring of 1982. I think Ida had speculated, or maybe it was Marilyn Sime that had speculated, that the second proposal never made it out of the School of Nursing, that Dean [Ellen] Fahey didn't want to send it forward or something.

MD: Fahey wasn't there then.

DT: She came in 1980, 1981.

MD: I think Irene was there when it got approved [by the Graduate School].

DT: No, I don't think so.

MD: Their memory might be better than mine.

DT: This is actually from looking at the documents in the archives.

MD: Hmmm.

DT: It may have been when Dean Ramey was there that it got approved at one level, but didn't go all the way through.

MD: To the regents?

DT: Yes.

MD: And the Higher Education Board [correctly: Minnesota Higher Education Coordinating Board, MHECB]?

DT: Yes.

MD: Or maybe it was that AHEC [Area Health Education Consortium], or whatever they had there. They had a lot of control over things. I can't really recall what it was about.

I know the first time I was there, I thought they had it about ready to go through, and it went and it wasn't approved. Then, we came back and did some restructuring and some

research building and getting grants out and things like that. I don't remember if someone over there said, "You need at least three currently big-funded outside research grants, or maybe some..." I looked at other colleges and schools with research programs and some of them, they didn't have that. But, anyway... We did some restructuring, pilot work, grants.

What dates do you have? Was that for final approval by the Graduate School or the University?

DT: Finally approved by the Graduate School in 1981, I believe.

MD: That was the final approval in 1981?

DT: Yes.

MD: Yes, that makes sense. Was Fahey there then in 1981?

DT: Yes.

MD: When did Irene die?

DT: In 1979.

MD: Ohhh.

DT: Then, Inez Hinsvark was acting dean for, maybe, year, no more than a year.

MD: Oh, yes, I remember that. I very distinctly remember that. So Irene died in 1979. She had a great influence on the school.

DT: Yes, for just those four years that she was there.

MD: Was she there for just four years?

DT: Yes.

MD: When did I come? In 1977, did you say?

DT: Yes.

MD: So two years, I worked with her.

DT: Yes.

MD: Well, it was a good two-year learning experience. She was not in good health. Nobody told me that before I came, and nobody told me after I came for quite a while, till the vice president [of health sciences]... What was his name? Lyle.

DT: Lyle French.

MD: Lyle French, yes. I said, "Nobody told me."

At that time, if you got your budget through the University, you could lobby that budget with the Legislature. I came in the fall, and she had me right down there lobbying the different legislators. I had to do homework on each one of them. There, you didn't have a computer with all their voting record and all this kind of stuff. We had computers. So I had to find out a lot of stuff about a lot of people. They all knew Irene personally. That's how she got the building, you know.

DT: Yes.

MD: Did someone tell you the story about how she got the building?

DT: No. That was going to be one of my questions.

MD: That was before I came. We were in Powell Hall when I came, but she'd already gotten funding for the building. This is just hearsay; I didn't know that part of it personally. But she knew them. She knew who was who in the city and who to influence.

She had me down there doing that. Fortunately, I'd been politically active all my life, and I'd been a member of the League of Women Voters. I was not uncomfortable at all doing that, but that was a big responsibility for someone to plunk here. I really hadn't been on the Board of the School of Nursing and blah, blah. That was kind of my baptism.

Then, she never said anything. I just told her what I was going to do restructuring the graduate program and she said, "There's going to be a lot of noise if you're going to double their teaching load." Some of them were teaching three credits a quarter and not in research and not much in service. But most of them were energized and wanted the doctoral program to go through and were willing to put their effort out.

I think Sime might have gotten... Did you talk to Marilyn?

DT: Yes.

MD: I didn't know if she was still alive or not. I knew she wasn't well for a while.

DT: She was in good shape when I met her in the spring.

MD: Good. I would expect she would have gotten some funding. She was a bright, able woman—as was Ellen Egan. Did you talk to Ellen?

DT: No. Is she still alive?

MD: The last I heard, her memory was failing. She was still alive...I don't know. My memory is failing.

DT: It seems pretty good today.

[chuckles]

MD: I think it had been sent through once before I came and not approved, and probably shouldn't have been approved because they didn't have the research. I don't know if that caused conflict between Dean Ramey and the assistant dean for graduate studies at that time or what, but for the University of Minnesota, it needed more funded research. Period. There were people on that—was that graduate college or graduate school?—...

DT: School.

MD: ...Graduate School that needed more convincing about nursing even being in the University, and it went all the way from there to strong supporters like Verne Weckworth or people that knew anything about the discipline.

We went back and Irene told me, "You're going to take a lot of heat trying to restructure the program and keep those regional programs going, and push, push, push for research." Well, if they wanted a graduate program, the doctoral program, they had to do that. Period. We had some rehires, but that was after the program was approved, when I hired Sue Donaldson. I don't know if you've talked to her?

DT: No, I haven't.

MD: I think she either came in with big grants or a history of being able to get big grants and so on. Then, we lose Ida, and, then, I'm gone, so I don't know what went on after that.

The second time it didn't get approved. I think I was there. What year did you have that?

DT: That may have been 1978, 1979, maybe. I don't have that date in my head.

MD: Okay. When was it finally approved?

DT: Approved by the Grad School in 1981 and, then, final approval from the regents and the MHECB [Minnesota Higher Education Coordinating Board], or whatever it was called at that time, was in 1982.

MD: Once it clears the Graduate School, the University is [unclear]. So 1981. Yes, that makes more sense. I know it was approved when I was there. I remember our celebrations and so on. That was our big hurdle. You say Fahey was there then?

DT: Yes. It looked like when Fahey arrived in 1980 that she was attending a lot of the meetings after that with the doctoral committee. Floris King, she had mentioned to me that when Fahey arrived, she thought that Fahey had, basically, taken over the committee work. But I don't know if that's your recollection?

MD: Fahey arrived in 1980, and this was approved in 1981. Hmm. I don't know. Who was on that committee?

DT: Marilyn, I think Ida was on there, Floris King, you. I'm trying to think who else was. Ellen Egan. Maybe Elaine Mansfield was on there. Basically, all the doctorally prepared faculty.

MD: And this committee did what?

DT: This was the doctoral committee that was in charge of developing the proposal for the graduate degree.

MD: Okay.

DT: That's my sense. There were subcommittees within that. I know that for the third proposal that went, I think you and who else? Three of you...maybe Marilyn was one that took on the finishing of that proposal and did a lot of writing of it.

MD: The proposal that went out was a committee...?

DT: Yes.

MD: I think Fahey could write. Hinsvark could write. Sime can write. I can write. Ida... Different people have different strengths. So I don't know. Anytime you have a proposal written by a committee, I could see people drafting certain sections and, then, people respond and you redraft.

DT: That may be.

MD: I don't even remember being on that committee to tell you the truth.

DT: It's so funny. There's a lot of material in the archives from this committee, and I think whoever was charged with writing... I know there was a three-person subcommittee, I guess, for that third proposal, and they were primarily in charge of finishing it. You'd probably remember if you were one of the ones who was hands on writing. I know that they would bring their draft proposal to the doctoral committee and

there would be discussion of it and, then, every time that the proposal was sent, say, to the Graduate School, and based on the Graduate School's feedback, then it would come back to the committee for further discussion on how...

MD: I don't think it went to the Graduate School until it was done. It went, formally, to the Graduate School when the dean sent it out.

DT: These were the earlier versions, when they'd gone to the Graduate School and been rejected and came back.

MD: Oh, the first two.

DT: Yes.

MD: Yes, I think they sent back formal comments and things like that, and, then, you picked up the informal stuff. I thought that second one went in shortly after I got there, maybe a year after I got there. I think I had to rewrite a lot of that. I didn't realize there was a committee doing it.

DT: I don't know who was individually charged with what, but I think it makes sense that one or two people were charged with the writing.

MD: It might have been Marilyn Sime because she was a very good writer, and a very bright woman. Ida could write, but she's a physiologist, so she approaches it differently than all this academic nonsense.

DT: [chuckles]

MD: So I don't know. As I recall, not much was going on with that when Hinsvark was there.

DT: It didn't seem like it. As you pointed out, the first one got rejected by the Graduate School because there was a lack of research oriented faculty.

MD: The second one, too.

DT: Yes, so both of them. I know one of the other complaints from the Graduate School that I saw was, again, what is nursing? What is nursing research? You haven't laid out the parameters of the body of knowledge that you are going to be researching. Do you recall that?

MD: Well, yes. Irene was an NYU graduate. I think Ellen Egan was an NYU graduate. At that time, there was a big thing in response to university questions like that. What the hell is nursing? So they were developing different conceptual formulas or conceptual structures—some called them theoretical frameworks, which they really weren't—on what is the discipline? There was an incredible researcher, Martha Rogers, from NYU. I

think Ellen was trained under her, and, maybe, even Irene. I'm not sure, but they had her kind of conceptual framework. At Minnesota, they actually had a course called "The Structure the Discipline," and "Conceptual Frameworks." I'm not sure if they had two courses or one just on that stuff.

There was and still is—there is less now—emphasis on what is it? What is nursing? Well, then the ANA got involved and talked about the diagnosis and treatment of human responses to real or potential health problems. That's the definition on nursing. Well, people want to know what the hell do they mean. If someone asks me, I refer back to...just take Nightingale. All of these conceptual frameworks or structures or theoretical postulates come from that. When I moved to Illinois, I said, "Do you have a conceptual framework for your...?" They said, "We're eclectic."

DT: [chuckles]

MD: I thought, holy hell, this is going to be fun. They had a researcher there called Myra Levine, who had her own conceptual framework which was, essentially, conservation of energy, and nursing has to identify what you need as a person to conserve energy before you... It's just Nightingale, but there are loose ends. There are loose ends in all of them.

I can understand why the graduate school will say, "What is it? What is it you're going to study?" We do draw from many other disciplines, because we're looking at wholeness.

DT: It seemed that some of the Graduate School committee thought that nursing was trying to encroach on their domain, so with health psychology or physiology.

MD: Yes, well... We're users.

DT: [laughter] It makes sense, because so many of you were trained in different disciplines.

MD: That's right. Well, we had to be to substantiate our... It's like some of those things you have to prove. That most farmers live in the country; you had to have a research study to prove it. That's where the money was. It's a Willie Sutton principle. That's where the Federal Government provided the money, physiology, psychology, and so on.

DT: I've seen in the archives—you mentioned Verne Weckworth giving his support—that the deans of the other health sciences were very supportive about nursing getting...

MD: I think they were. Who was Public Health...? Was that Lee...?

DT: Yes, Lee Stauffer.

MD: And I think Lyle French was, mostly. Who was the dean of Medicine?

DT: Neal Gault.

MD: Oh, yes.

DT: I think Erwin Schaffer was Dentistry and Larry Weaver was Pharmacy.

MD: Oh, yes, I remember all of those boys. I don't think any of them were opposed to it, were there?

DT: No. They all offered their support.

MD: I think so.

DT: It seemed like it wasn't coming from within the health sciences as it was these...

MD: Well, the health sciences—Minnesota is a little like this; Wisconsin is more like that—really don't belong in a university anyway. Wisconsin has that idea. Traditional academic disciplines here, since they have so much money, have to pay attention to them.

There was a famous educational philosopher, Thorstein—what the hell is his last name? I'll probably think of it in five minutes—in the 1850s or 1860s from Wisconsin. We have, as you probably figured out, a very different system for higher education than UK. Thorstein Veblen is who that was. He made a statement like, "Schools of medicine and schools of law have no more place on a university campus than schools for tap dancing." He believed—and I think he's right—that if you want to be a physician, you come to a university and get anatomy, physiology, organic, inorganic, micro...all those things you need, and, then, you go to a medical center to learn medicine. He said the same about law...philosophy, history, everything you need and, then, you go and study law. Keep the university pure for true academic disciplines, not practice disciplines.

We made a real mess in our structure here because they all want their kids from the university whether they're in practice things or not; so, there's a lot of that on the Madison campus, and there's some of that on the Minnesota campus, that health sciences probably doesn't belong on the university campus in the first place, and the Graduate School is not made up of health science people.

I think Irene had done her homework and I probably continued that on the health science end of it. So I don't know if there was a lot of resistance. I can't think of anybody specifically in the health sciences that was opposed to it.

DT: No. I haven't come across anyone. It seemed that that resistance came from the Graduate School.

I think Ida had mentioned that you and she had done a lot of work behind the scenes to get the Ph.D. approved.

MD: Yes. There was a lot of, well, not negotiation, but certainly socialization and education of people. I think I sat on the Graduate School council for a while, didn't I.

DT: Yes. You sat on the Health Sciences Policy and Review Council.

MD: Oh, that was it. Okay. There, they have fingers into a lot of the traditional departments, too.

I know that Mayo Graduate School, during that time, somehow became incorporated into the University. I don't remember what that was all about, but I remember there was some resistance to that. I don't know if it's [unclear]. I think they already had students at Mayo and students back here, but they weren't formally aligned in some way. Are you talking to anybody from the history of Mayo?

DT: I will be. I know that the Medical School has had a complicated relationship with Mayo over the years. Mayo set up their medical school in the 1970s, and until that time, their residents were being trained for their Ph.D.s and Master's by University of Minnesota faculty. So the Mayo residents also were enrolled in the University's Graduate School. So I think some of that was going on.

MD: Yes, some of that was going on. Then, they wanted to get approval or degrees or something from Minnesota. I can remember a lot of dialog about that. I was very supportive of that, because I had been at the March of Dimes and I knew both institutions that way. Anyway, I don't know how I wandered into that.

I think I was a factor in getting Mayo approval—one of many—whatever approval they wanted. I thought it had something to do with degree granting.

DT: Yes, I can imagine.

MD: I'm not sure.

DT: The Mayo was depending on the University for its basic science training and whatnot at that time, I think.

MD: Oh. I don't know.

Where were we before I wandered?

DT: I think you were talking about your role on the health sciences Policy and Review Council.

MD: Ida was on that, too, wasn't she, for a while?

DT: It's possible. I just know that you were on it and you were the Nursing School's representative, and that you did a lot to get the Ph.D. proposal approved. You were the spokesperson for it.

MD: I think so. I think that's fair. I remember sitting on that, and, all at once, as you talked about that, I remembered this big deal at Mayo. There was some big deal with the School of Dentistry. I don't remember what that was about. Some of them were very narrow thinkers and others were not. I think just by my background—I don't know if my nature—I don't tend to be that constricted.

DT: Ida told the story, I guess when the final proposal for the Ph.D. went to, it must have been the Graduate School committee, and it went up for a vote and it was tied about whether to approve it or not. Someone from the Graduate School said...

MD: They were not going to let me vote.

DT: Yes.

MD: I was on that council.

DT: Can you tell that story?

MD: Well, I'd totally forgotten it till now. Didn't it go through the health science council first and, then, the Graduate School?

DT: Yes.

MD: I was on some Graduate School committee I thought, but I don't really remember. Yes. I'd totally forgotten that. They took a vote and they were tied, and they weren't going to let me vote. Then, I cited examples of when other people had voted on things from their department. I don't know...probably with my big mouth, I said, "I should have a double vote, because I know more about it."

DT: [laughter]

MD: I remember that. I didn't really threaten anybody, but I wanted a review of all the votes they'd taken and if they people from the departments have been voting on their own...and I think they let me through. I really don't remember that. There's probably something in the minutes about that.

DT: Yes, probably. I know Ida had said that, basically, the proposal squeaked through, and it was in large part because you stood up and...

MD: Yes, there weren't going to let me vote! I remember that. They said you can't vote on your own proposal. I think I wanted some kind of a historical review of how many

other people had voted on proposals and why couldn't I vote? I'm elected by our faculty. Oh! I'm glad Ida remembered it. I would never have remembered that, but now that you mention it, I remember that. They told me I couldn't vote, yes.

DT: So it seems like you had such a big hand in getting it, based on what you've told me, but, in addition, this big meeting that...

MD: It was the last end. If I had been very meek, I'd gone back to the school and said, "They wouldn't let me vote, Irene," but that's not my style. No, they voted and they let me vote. There were people on there that said, "Let her vote!" That kind of indicates that there was a hardcore there that was, no way, Hosea, is this getting through and other people that you could educate and had greater vision.

DT: Yes. Do you remember...? Was there anyone else in the Graduate School—you mentioned Verne Weckworth—whom you recall being supportive and who kind of went out on a limb for you?

MD: There were. If I looked at the minutes or heard the names, I would probably... I could probably go over every one of them if I had the committee lists, which I don't, and I'm not going to retrieve it, and say, "Supported," "Didn't support," "Supported," "Didn't support." Most of them did, I think—counting me.

[laughter]

MD: I'm glad Ida remembered that story.

DT: One of the other committees that you were on in the late 1970s, it looks like, was the Committee for Long Range Planning for the Nursing School.

MD: Oh, yes.

DT: That also related to the University's long range planning. It seemed like that was, also, another contentious experience for the school.

MD: Oh, really?

DT: From the minutes of the meetings, it looked like it.

MD: It could have been, because our doctoral program would be included in there, regional programs in nursing would be included in there. People, when they see some of these things, rather than looking at state needs, it becomes very political, and they look at internal budgets, and what's this going to cost and so on. I don't remember much about that committee. I tend not to be terribly quiet if I feel it's an important issue. I tend to be an active committee member and do my part.

DT: One of the things I've seen... It was, again, one of these things where the school put forward their long range plan in a proposal, and a lot of it talked about how the school wanted to build its graduate programs and the regional programs. A lot of it was focused on, once the Ph.D. was up and running, what the Ph.D. program would do. I saw correspondence or minutes of meetings. I think this must have been some health science council had said that the Nursing School had a lack of realism about what the school could achieve...

MD: [laughter]

DT: ...and accused the nursing faculty of being defensive about what they could achieve.

MD: Hmmm.

DT: Does this sound familiar at all?

MD: Uhhh... No. Who wrote this? Is that someone that's responding to our long range plan?

DT: It looks like it was someone from University Central Administration. Each health science unit and, then, presumably each school within the University had to write a long range plan.

MD: So they said we weren't realistic?

DT: Yes. My interpretation is that you were too ambitious and didn't have the capacity to do what you said you were going to do.

MD: Oh, they may have gotten some desires and wishes mixed up with reality. I don't know. Do you know what year this is?

DT: This was 1979.

MD: That would have been me.

DT: Yes. It says that you were a member of that committee.

MD: Okay. I came in the fall...is that from spring 1979?

DT: The long range planning went through from... I don't think it began in 1979. It may have begun in 1978 and continued through 1980, I believe. Of course, they would have planning every so many years.

MD: Yes, I think every five years or something, you had to do it. Well, I don't know. Didn't we accomplish what we set out in the long range plan?

DT: I haven't matched it up. All I know is that the school had to go back and rewrite its long range plan a couple of times.

MD: I think that's not unusual for any department, is it? At some of the higher levels, they want to match that with budget and reality.

DT: I guess this was a period where there were massive budget cuts. In reading it, I was wondering whether there was some kind of gender issue going on there.

MD: There are always gender issues in a university, still today. There were gender issues when I was a student, and when I was a faculty member, and there are still gender issues today, in nursing particularly, because the whole faculty, practically, is female. There is no other department... Although, women have made a lot of strides... I think they're over half in the law school students, and so on, but no one that's almost all as in nursing.

I don't know. I'd like to know if we accomplished... We may have had broader vision than soldiers to do it, but I don't know. We had a doctoral program. We had a regional program. They were very successful. The University of North Dakota went on to develop its own graduate program. All of that is a little slower than you'd like. I don't know what else we had in there that they might have... I'm not sure who's reviewing that.

DT: Yes. I'm trying to think who was... Well, it was President [C. Peter] Magrath, so whoever was working under President Magrath.

MD: He left then, I think, when I was still there. Didn't he leave when I was still there? Peter, I liked him.

DT: He was there at least a chunk of time that you were there. It's hard to keep track of the change in leadership.

MD: You need like a crib sheet.

[chuckles]

DT: It just struck me in the comments that were being made from Central Administration that would they have been saying this about another school that wasn't all women?

MD: That probably could be. I would say that probably could be, because they're looking at it from a different scope. If you've got all these long range plans, and you're the president or you're a committee or a council reporting to the president from the whole University... I liked the president. I can't recall. There were a couple associate chancellors or something there that weren't supportive at all. I can't remember their names right now. If you've got these long range plans and you think they can do it, and it

goes to the higher education coordinating board they had... What the heck was that? It was something for the state.

DT: It was Minnesota something or other. [Minnesota Higher Education Coordinating Commission.]

MD: I thought that was just an extra...whatever. They had that. If it comes to the president of the University and these are great exciting plans, and you think they can do it, and, then, you've got pressure from the state, "Hey, we need educated nurses," then you've got to fund it. That may be an administrative backup plan, you know. I don't really have to fund it because I don't think they can do it. I don't know what that's about; I really don't.

As far as what's in our plan, I don't remember it. I remember being on that committee and writing the thing, but that wouldn't come from me. That would come from the faculty and the dean. I think I probably wrote that long range plan with a committee. I can't remember what would be in there, other than increasing enrollment, increasing the Graduate School enrollment, more research, doctoral programs, regional programs. Those are the kinds of things that they did. I would think that's what would be in there.

DT: That was there. I guess when you wrote it, this was before the Ph.D. had been approved. It was while it was in the works, but it hadn't been approved yet. That may have been some of the issues.

I know that, in the late 1970s and early 1980s, the University was facing substantial budget cuts. President [Jimmy] Carter, for the School of Nursing, he had reduced or nixed the Nurse Training Act or there was a lot of retrenchment.

MD: Yes. I don't know that that was at the Graduate School level though. I don't know. I should just shut up, because I really don't know.

DT: You had mentioned the building of Unit F. That was another controversial issue. Dean Ramey had done all this amazing networking and gotten legislative and federal support and funding for the project. Looking in the archives, she wrote letters and had breakfast meetings with every single member of the Legislature, it seemed like. She was really good at political networking. It seems that getting the building built faced, in the late 1970s, hurdles because the state wanted to pull support. They kind of renege on their commitment for the building and there was a potential loss of federal funding because of that. Do you recall any of that?

MD: I think she had cleared all the approvals that she needed. When I first came, I was in Powell Hall. Then, we moved to Unit F. Wasn't Irene still alive? No, she died before we moved into F. That's right. Yes, I remember Hinsvark in her old office. The story was—I don't know if it's true—when she was trying to clear one of these legislative hurdles, she invited members of this legislative committee to visit Powell Hall. I don't know if this is true or not. She checked the long range weather and selected a date, so

when they came over, it was pouring rain and leaking right into the building. She took them in the tunnels underneath or whatever, and said, “This is...” And that cinched the deal. Now, I don’t know if that’s true or not, but that’s the story.

DT: [chuckles]

MD: Irene could be a big flirt sometimes, too. She was a very attractive woman. I don’t know if you’ve seen photos of her.

DT: Oh, yes.

MD: I probably have some somewhere. She was a gifted photographer. That’s one of her photos right here. This one.

DT: Oh, wow.

MD: She was a New Yorker, you know.

DT: Ahhh.

MD: She signed it, dated it. Let’s see what date it is. Oh, down here...1965. That’s Washington Square, of course, in New York.

DT: Yes.

MD: She was a lot of fun and very bright, very tall—at least compared to me. She could intimidate people, I think. I think some faculty she intimidated.

Anyway, that’s the story I had about how they got the building through.

DT: It did sound like things were incredibly cramped in Powell Hall.

MD: Oh, it was impossible; it was impossible. Without a new building, there really wasn’t research space. You had to take it from someone, which is not doable. That was all kind of part of the package, too.

DT: It’s all wrapped up in the Ph.D. program. If you need the school to do more research, you certainly need space.

MD: You need space, yes.

DT: What was Ellen Fahey like as a dean?

MD: I didn’t realize I was there that long with her, but I guess I was. Ellen was a fun person. She was an attractive person. Compared to Irene, who had more structure and vision... I don’t recall learning that much from Ellen, as I did from Irene, which was like

a learning experience every day. She [Irene] was well grounded in research. Ellen did a lot in the area of University relations and that kind of stuff; although, Irene was very good at that. Irene would target her homework. Ellen could write well. She was a very flamboyant, interesting, kind of fun person.

I think by the time Ellen came, I had two or three grants going, and was like over my head trying to keep up with them. I think I had a little grant from the March of Dimes, and I had one from MCH [Maternal and Child Health], from the fed [federal government]; that was a big one. Then, I was program director for a post doctoral program for the Robert Wood Johnson Foundation, headquartered in Princeton, New Jersey. So I had a lot of other stuff going on.

I didn't realize when you said that Marilyn said that Ellen rewrote something...

DT: That was Floris King who said that.

MD: Oh. Floris probably was on that committee, wasn't she?

DT: Yes, she originally chaired the committee and she said, when Fahey arrived, Fahey tried to take over the proposal and Floris King felt someone else did, I guess.

MD: That may be true. Where was she, Ellen Fahey, before she came?

DT: I don't know, actually.

MD: Someplace in New York, one of the SUNY [State University of New York] systems, I think. I don't think she had been dean of a place with a vibrant, strong doctoral program or a much smaller, less structured, certainly not a land-grant institution. So I think in the beginning, she was more involved in minutiae that should be faculty and didn't sort all that out. But, she was a bright woman, and I think she got it sorted out. Maybe she stepped on some toes there. I really don't recall much about those committees, except being on them.

[laughter]

DT: A lot of the faculty who were at the School of Nursing when you were there had done their training at the school as well. They were Minnesota products. It struck me that you were something of an outsider having gotten your education elsewhere.

MD: I was an outsider. Ellen Egan graduated from NYU; that I remember. I think Marilyn Sime graduated from Minnesota.

DT: She got her bachelor's at Minnesota, but did her Ph.D. at Boston University.

MD: Oh, that's right. They had some of that. Some of them were just kind of in-grown, Minnesotans, bright, able people. What was your question?

DT: Was there any tension from the faculty because you were an outsider?

MD: There's always tension. Nobody wants a boss... Particularly faculty members don't want a boss, someone coming in and churning everything up and saying, "Hey, you've got to do more research, and you've got to teach more, and you've got to lighten up the load on some of these new Ph.D. graduates so they can get their research mounted," and so on. I think, generally, I would say I had some very good friends on the faculty. There weren't many nurses with Ph.D.s around at that time, so we had to recruit them, like Bernie Feldman. She was in Public Health. We kept trying to recruit her into the School of Nursing. She was in charge of AHEC there, so she was kind of integrated, because AHEC was funding there regional programs. Mansfield, Sime, Egan, and Ida already had their doctoral degrees. I'm sure there were some more. A lot of them were working on that in different departments in the University, and, then, we recruited some. Was that your question?

DT: Yes. You had mentioned earlier about the public health nursing in the School of Public Health, that the School of Public Health had its own nursing program, and eventually, the Public Health nursing moved into the School of Nursing. Were you there when that happened?

MD: No, I think that was after I was there. They had a good collaborative relation. Was that Alma Sparrow who was head—I think so—of public health nursing there in the School of Public Health? There were some very good people there and, sometimes, there was exchange teaching.

I'm still processing, did people resent me when I came there. Maybe I don't even want to know.

[laughter]

MD: I think an outsider that comes in—I was known in maternal/infant around the country, pretty much, because of the March of Dimes visibility—there's always a tension between Minnesota and Wisconsin, maybe athletically, maybe... Well, academically, Wisconsin usually outranks them. But athletically, particularly in hockey, and, sometimes, at football and things like that, they are always competitors; although, they root for each other if they're playing somebody else. Minnesota is geographically much more isolated than Madison is. We're an hour and a half from Chicago, and Milwaukee. I don't know if there was any... I don't think anybody likes a new boss coming in with new things. Technically, with Irene not well, she told me where she wanted the graduate program to go and let me alone. I met with her every week or anytime I had a problem or anything; it wasn't that. She just didn't get involved in that stuff.

DT: I asked the question, not that I've come across anything within nursing, but I know that in the Medical School, the Medical School has a reputation for being parochial in

many ways and kind of taking care of its own and being more critical, skeptical about non-Minnesota people.

MD: Right.

DT: So I wondered if that translated into Nursing.

MD: I think there was some of that in Minnesota, but not in the Graduate School. In fact, they looked for outside people. Here, in Madison, it used to be— I don't know if they still do it— that if you graduate here, they don't hire you. You're supposed to go away and distinguish yourself, and, then, you can come back. They can make exceptions to that and, in rapidly evolving disciplines, they made some exceptions, like stem cell or whatever. But, generally, you're expected to go away, distinguish yourself, and, then, come back. I don't know that Minnesota had that kind of feeling there, partly because of the geography. It's like there's nobody around us, so we've got to do it all ourselves. It's worked for them. It's been an excellent school, excellent university.

DT: It was the only school of nursing for several states.

MD: Hundreds of miles between the next one.

DT: Yes.

MD: You see how that's developed with their theater and their art institutes and their music. They're it.

DT: Yes. I wasn't expecting you to say that you had been made to feel like you were an outsider. I was just curious.

MD: No, I think they actually appreciated that, because they don't have it as much, I would say, unlike the Medical School. I could be totally oblivious to it, because coming from this kind of a background, we were supposed to go away. I know there were some networks, because they were all from the same place and never left anywhere, so they had some networks. Izzy, Isabel Harris, did a great deal... She was a big picture person, not provincial. When she was dean, she kind of established that and just the hiring of Irene Ramey, who was a New Yorker from Texas—she'd worked in Texas before she came there—says something. Many big universities or schools of nursing really don't like to hire their own in administrative positions. I'm surprised that the Medical School was like that. They're kind of provincial anyway in some ways.

DT: It's not that I encountered it myself. I've just heard from people that that's how they talk about the Medical School. Maybe it's a more recent thing. I've just noticed that so many of the physicians I've interviewed did their training at the University of Minnesota.

MD: That are on the Medical School faculty?

DT: They were on the faculty in the 1960s and 1970s.

MD: That would be, probably, based on need and a lot of people's view of Minnesota. It's just so damn cold, you're going to die, so don't go there. They may not be able to recruit, so they build it themselves. Maybe that's become more established. Most universities want to go *outside* to bring new ideas in.

DT: Yes, that's what I was thinking.

MD: Well, they may not be able to. It is the coldest place I've ever been in my life.

DT: [chuckles]

MD: No, it is.

DT: You mentioned a while back about when you first arrived at the school that Dean Ramey had you present the budget to the Legislature.

MD: To lobby it through.

DT: Oh, to lobby it through. What was that experience like for you? How did the legislators and the lobbyists respond?

MD: Well, you try to make an appointment, and, if you can't, they say, "They might have open hours here to here," whatever. You go in and you talk about the need for nurses. I would have my little...need for nurses. I, also, lobbied before the U.S. Congress for the American Nurses Association. There, they'd give you a written thing and, then, you answer the questions. They have people sitting on...guests and different Congress people are interviewing them all. I don't know if I did that with the March of Dimes. Probably. So I was not uncomfortable with that. I had in my own mind a structure, presenting certain things, like the need for nurses in the state. I would always try to tie that to patient needs, how up in northern Minnesota and these parts how people can't get this and they can't get this and they need nurses and they need this, and how cost effective they are and, then, get down to the role of the School of Nursing, and, then, what we have in the budget for this. Each step along the way, if they already know all this, forget about it. But I tried to tie it to their region and have a few names...the director of nursing from Mercy Hospital in [sounds like Puh-too-see] that would know them and maybe contact them ahead of time. It's a skill. It's an art.

DT: Those are powerful arguments you are making. They sound very powerful, particularly given there was a national shortage of nurses and other health care workers, especially in rural areas.

MD: Yes. First, you look at who you're going to lobby. You have to know a little about them. That was not so easy; now, it's easy with the computer. Then, I would talk to

people—sometimes Irene, but she wasn't about much; she was very busy—that knew him. Is he easy? What is he like? Blah, blah, blah, blah. I'm trying to tie that with some... Sometimes, you fly by your pants, because you had to do it right away. You try to tie that locally. That actually prepared me well for Illinois, because those regents, that's votes for this guy. That's votes. They're not naive about that either. You never mention that, of course, because you're trying to be a-political and just look at the need. You don't mention that. That's votes. If you happen to know the director of the hospital or the director of nurses in their little hospital and their special needs and know something about the community around it... It's an art. I usually called first, and, then, you'd usually write a thank you or call them with a personal thank you. If you get to know their staff, that's *really* helpful. I had done a little bit of that as a volunteer before, just for political stuff.

DT: Did you find the legislators generally responsive?

MD: The legislators love nurses. They're kind of tight when it comes to giving money to them. No. I think they all like nurses. I've never had anyone that was angry or disrespectful...sometimes short because they're in and out of a meeting and you want to get to them before this vote goes here or whatever. No. I liked that part of it.

DT: It's interesting, because I know that in the 1970s, particularly the second half of the 1970s, some legislators were getting quite fed up with the Medical School. I think that's why there was some of the problem with funding the F. Senator John Milton, I think, from one of the northern counties, thought that the University and the health sciences were big already, that they had plenty of money, they didn't need any more money. So they were tightening the state purse strings, basically.

MD: I don't remember that name specifically. Well, you never talk or reflect or imply in anyway anything negative about any other University department, the Medical School or what. Sometimes, they'll bait you.

DT: Yes.

MD: Never, you never do that. It's just not done, because that's your institution.

They have some strange ideas. Like sometimes—I don't know who I was talking to once—he felt they didn't need more operating budget, because they got these grants in. I realized he was totally ignorant of a federal grant. You have so much indirect cost recovery and that you're supposed to have for their housing and their heat and lights and their space for the grant and so on. You have to sign these slips on every one that works for you. Somehow, they just think that's extra money for the University and you don't have any extra responsibilities, when, in fact, it may be extra money, but the extra responsibilities are usually more than the money covers, so you've got to kick in anyway. Some of them are just really...start from base one on that. That does build a base for more space. If we're bringing in research grants, we're going to have to have more space. Lyle French had to sign off on those, and when you sign off as the administrator,

you're basically saying, "We have the space and the support system, so this investigator can carry out this grant." So that's a responsibility. Somebody's got to find you a space then. I think that was okay.

DT: In general, it sounds like you had good relations with Lyle French.

MD: I liked him; I think he liked me. He was always fair.

DT: He treated the nursing school well?

MD: I thought he did. I don't think he ever really understood what nursing is doing and trying to do, but he knew they were important. I don't think most physicians—he was a physician—really understand what nursing is about and what you do. They kind of know something works there. Whatever they're doing, it enables me to better practice medicine. That's my personal feeling. I don't know if that's... A lot of them are married to nurses, so they may understand it a little bit better. They think they're like mini-doctors or they think they want to be doctors or something. Ours is much more satisfying rather than just a little peek at, as Nightingale, was saying, an obstruction. I'm sure that's satisfying when you're successful and take care of that obstruction, but a lot of them don't.

DT: Even when you specialize in OB, you still are seeing more of the whole.

MD: Absolutely. You're thinking about when this baby is going to go home. Who's at home? Is the mother going to get enough rest? I think a lot of postpartum psychosis is caused because the mother has no rest.

I used to make these slips, particularly for mothers-in-law but for husbands also, because the woman goes home with the baby, and she can't say to the mother-in-law, "Clean the toilets." "Do the laundry." "Do the dishes." The mother-in-law and the father-in-law come in and they're going to help the mother for the first week, and all they want to do is play with the baby. Well, bull crap. The new mother can't tell them that. So I'd write them these notes to give to their relatives. How to help the mother: the mother needs to attach and learn the baby's cues; the baby learns the mother's cues to have a happy baby. To do that, they need to spend time with each other. To do that, the mother needs rest, rest, rest. If you want to help, clean the toilets, make the meals. That isn't exactly, but that's the general gist of it. I can't tell you how many mothers, six, eight, twelve weeks later, said "You saved my life. I gave that to my husband," or "I gave that to my mother" or "my mother-in-law and they were stunned, but because it was signed by the nurse RN..."

They look at the whole thing and what this baby needs and the mother needs to get off to the best start possible. Women, today, I think, do not get enough rest to attach to that baby.

I love those newborns, the first few hours of life. I love working with them. They are all different, totally different. They have little personalities already. They have little ways of communicating, which you have to be very sensitive to. I had the privilege of working with a night nurse. She worked nights and, at that time, they had big nurseries full of babies, and they stayed there for five, six days. They didn't want to wake the mother up at night, so the babies were right in this nursery. This woman with a diploma knew more about babies than anyone I've ever met. She had, like, twenty babies there, maybe two nurses in there. She'd hear a baby, "Ohhh, that baby is cold." "That baby is wrapped too tight." "That baby is in pain." "That baby is sick." "That baby is hungry." "That baby wants to be turned." "That baby pooped." Whatever. I'm exaggerating a little bit on the sound, but she could communicate with all these babies and they were all totally different. I think I only spent, maybe, four or five days in that nursery at night, but I learned more about how to observe a newborn...

Mothers today don't have that chance—they rush them in and rush them out—to just sit and study the baby. Babies are very powerful, effective communicators. They can't talk, but they can certainly let you know when something is wrong. If you don't learn how to identify that...that's the most important thing for mothers and babies, to learn each other's communication, and it takes time and a rested mother that has time to just spend with the baby. I got, actually, pretty good at that. I could, in short order, study the babies and know which one is... Sometimes, you have to play with it. Some are wrapped to tight. Some are wrapped too loose. Some like it loose. Some like it tight. Some want it on their side. It's a fantastic area.

DT: Yes.

MD: And we lost that *whole*... There will never be a time when we can research that, never again.

DT: Because, now, mothers are being moved out of the hospital...

MD: Yes, never a time when you're going to have that many normal, healthy newborns that you can just study over that period of time. The first six, eight hours of life, or couple hours of life, that's exciting.

What other committees do you have there?

[laughter]

DT: I've only got a few more questions for you. I actually wanted to follow up... When you mentioned briefly about gender and how gender played a role at every level of your career... It's a big question to ask, but maybe if you would spend some time elaborating on the way in which gender influenced your career?

MD: Hmm, that is a big question. I think since I selected nursing in the beginning, before I knew that there were quotas on everything, maybe I was less directly impacted. I

think I was impacted, first, when I came here and I wanted to play in the university band—I was a very good clarinetist; I collected a bunch of state and regional medals—and all men. No women in the band. Now, of course, that’s changed. I think I probably heard more about gender discrimination...

I came from a family of five girls. My father always felt women were quite superior to men, and he said so. He used to say, “They’re brighter than men. They’re more moral. They have more ethics. They work harder.” And, then, he would say, “I’ll bet you pound for pound, they’re even physically stronger.”

DT: [chuckles]

MD: He had that... we could do anything. I don’t think he knew what it’s like in the real world and getting jobs and getting into graduate schools or undergraduate program or whatever.

I think, in some ways, gender has helped me. I don’t know. That’s such a big question, I can’t answer it. I think some of the very traditionalists are surprised that a woman can write as well, or is bright, or since they don’t understand the discipline, they don’t understand why that’s satisfying. I think in the real world, a lot of them still think nursing is a step below medicine, which it really isn’t. Medicine is an undergraduate professional program. Now medicine starts wanting, offering... So when they say, “Medical doctor,” that’s an undergraduate professional degree. But being male, they set the law. They set the standards.

I think that’s one of the things that’s wrong with our total health care system. If they want prevention, they’ve got to go to nursing. They call prevention now getting a vaccination and mammography. They think that’s prevention. No, it isn’t.

We were not skilled at marketing and how to sell our product. There is incredible organized resistance... What would happen for example if, suddenly, half of the people didn’t get diseases or into trouble [with their health]? Well, our medical care system would collapse. I think that’s a lesson from that Metropolitan Health Insurance Company with the Frontier nurses. That’s what scared them.

Then, I worked with the World Health Organization, and they had this primary health care model, which was fascinating. I went to Thailand to study it. It was only implemented in Thailand and Cuba and they wouldn’t let us go to Cuba, and probably still won’t let us go. There, they had such a structured system that was incredible. This was organized at the Alma-Ata WHO conference in the 1980s or so and only implemented in Thailand in the rural area and Cuba.

Basically, what they do is they find a community leader, like a mother or grandmother, and she’s going to be responsible for this twelve people, for their health. They have a name for her depending on where you are. Then, they have lessons every week. She goes to lessons on what’s new, and infectious disease prevention, and clean water, and

clean sewers, and whatever is going around, all that stuff, child rearing. Everything is in there. They have continual lessons every week. They continue to learn, and they get very knowledgeable after a few years. These are taught by another community leader, which in Africa would be like a tribal chief or the medicine man or the next person up there. He has ten of these mothers, so if each mother has ten and he has ten, you've got 100 people covered. Oh, they have a lot in geriatrics and childhood nutrition and all this stuff, childhood vaccinations. Above them—you have ten of those—they have one nurse. She teaches these guys, had good materials appropriate, and they teach this, so you've got 1,000 people covered with one nurse. Then, above that it multiplies in some ways.

I visited one of those in Thailand in a rural area. Thailand didn't have these diploma schools or associate degrees. They have all baccalaureate programs. The Queen Mother got a master's degree in nursing from BU [Boston University] sometime many years ago. We had a lot of students at Illinois from Thailand. They'd go back. They view their education very different. They may have two or three children and go away to study for four or five years and think nothing of it. They're doing it for their country. So it was great. There, they had a lot of geriatric, too, and they had these geriatric centers next to the newborn and day care. They had reduced childhood malnutrition by fifty percent in a period of nine months using the WHO model.

But when you have a for profit model and you have device manufacturers and drug companies and physicians—I hate to put them in them in there, because most of them, I think, really want to serve—you have all of these organized, powerful international agencies against it.

Now, it's being revitalized again. [Doctor] Halfdan Mahler was the director general, at that time, of WHO, and I think [Professor Thomas Adeoye] Lambo was his associate chief when they first introduced that. Part of this umbrella was...I told you about the delivery kits that they had. These were in African areas; they weren't part of the total WHO plan. It was a marvelous plan with *incredible* outcomes. But, the money isn't there, the money for the profit seeking, device, drug, etcetera. In fact, some of the WHO officials even had their lives threatened because of... It's very political.

DT: That's incredible. Coming from Britain, the health care system there is quite different from what it is here, but there is much more emphasis on primary care because its the state budget that's going to collapse [if secondary and tertiary care costs grow too large].

MD: I used to go there every year on Nightingale's birthday. There was a group here called The Florence Nightingale Society out of California. I think they finally petered out. But, they'd go there every year on Nightingale's birthday and, then, they went to some little town where something happened, and they'd like knight a few people or whatever. We wore gowns and these huge feathers. Then, we went to Nightingale's cemetery where she's buried and, then, to her home where she grew up. This all takes

two or three days. Then, the last day, we were at Westminster [Cathedral], and you know how it goes down to the altar...

DT: Yes.

MD: ...there are these long rows and we sat there in our academic robes and these big feathers. All the nurses from all the common law countries were there. They come in their uniforms, and they have little Nightingale lamps. It's a big celebration.

But I never understood why the home of Nightingale, nursing there failed to move in an academic setting the way the rest of the world...I mean, New Zealand, Australia, Canada. What was the resistance in Britain?

DT: That's a really good question, and I don't know, unfortunately, despite being from Britain. I've studied somewhat the British history of medicine, but not nursing to the same degree that I have for the U.S., so I don't have a good understanding of how nursing developed in Britain. The way that the health care system is set up is that, from my recollection from being a kid and seeing what nurses did, nurses seemed to have a more autonomy in their communities. That you'd get a district nurse...

MD: Just like a public health nurse.

DT: Yes, and the midwives...

MD: The midwives are way ahead of here.

As far as academic credentials, they're doing that now, but we would visit certain schools of nursing and intellectually and research and everything, they were light years ahead of everybody, but not the academic credentials; they were delayed. Maybe it's because they don't like those kinds of people in universities. Maybe it has to do more with...but medicine is there.

DT: Yes. I'm going to have to look into this. I really don't know. I never even knew really many people who were into nursing. I knew a lot of physicians, but, of course, the medical school is, literally, undergraduate education in Britain. You go straight from high school to medical school.

MD: Oh, I didn't know that.

DT: Yes.

MD: But they incorporate the basic sciences?

DT: It's a five-year degree, and I think you have two years of basic science and the rest mostly clinical.

MD: It's basically the same as...

DT: It's similar, but, you're eighteen when you go into medical school.

I'll have to look into this. I don't know anything about the credentialing of nursing in the U.K. [United Kingdom]. In the U.K., there is more of a division between vocational training and academic training just across the board.

MD: Right, all of Europe, I think.

DT: Yes. Vocational schools are there to do a particular job and there has, at least in the past, been less integration; although, I think a lot of the old vocational schools and polytechnics are now universities. This is a great question.

MD: That may be a superior model. I think, ideally, if they just kept the academic disciplines in the universities and had the practice disciplines in practice settings...but, then, some legislator's kids wouldn't have the right to be a graduate of the University of Minnesota or whatever.

DT: Yes. That's what makes...

MD: How is the doctoral program going there now? It's booming right along, isn't it?

DT: At Minnesota?

MD: Yes.

DT: Dean Connie Delaney seems to...

MD: Who is the dean there now?

DT: Connie Delaney.

MD: I know that name. I don't know her though.

DT: I think she came from Iowa, I want to say. Yes, she's a wonderful dean. Everyone speaks so highly of her.

MD: Has she been there a while?

DT: I think for at least five or six years. It may be longer. I know the history up until the late 1980s. [chuckles]

MD: Fahey left.

DT: Then, Edwardson.

MD: Oh, yes, Sandy [Sandra] Edwardson. She was a faculty member there before. I knew her well.

DT: It may be that Connie Delaney replaced Edwardson.

MD: Did Edwardson retire or just resign as dean?

DT: I don't know.

MD: I didn't know who came after that.

It was a wonderful time when I was there. We had a vibrant, exciting faculty, and we were doing exciting things, and we got the program approved, which is what I was hired for.

DT: What led to your decision to leave the University then?

MD: Well, Illinois came open, and one of the physicians that I'd worked with at the March of Dimes was at Illinois, and he said, "They're looking for a dean. I think you would be perfect. You better check it out." So, I did, and I got hired, and moved to Illinois.

DT: Do you think the University of Minnesota School of Nursing is in any way distinctive from, say, the one at Madison, Illinois, or...?

MD: I think they had a unique role in developing the discipline. I think that was a strength at that time, because they had some good faculty, Marilyn Sime and Ellen Egan, Sheila maybe. I can't even remember who was there at that time.

DT: Pat Crisham was there.

MD: Oh, yes, Pat Crisham. She was doing ethics kind of stuff. So maybe they had some distinction in that. I don't know that they had anybody in history, actually.

DT: No, I don't think so.

MD: Their midwifery program was strong, at that time. Is it still going well?

DT: I don't know.

MD: Oh. I think Kathleen Dineen was in midwifery and did a good job there. I don't think, at that time, she was doctorally prepared but I think she got her doctoral degree.

I think they've done some work in defining the discipline, and Crisham did some work in ethics, but I think there were other places doing work in ethics, particularly Boston. BU or BC [Boston College] would be more outstanding in ethics. They were just launched.

When did they take their first doctoral students in? I think they took in, like, three when I was there.

DT: It would have been 1983, I think. Maybe it was the fall of 1982, actually. That would make sense.

MD: I think there were, maybe, two or three there. I don't know.

Then, shortly before I left—I really didn't plan on leaving—we got some outside money, and I think Irene did that, and it just started funneling in. Maybe it was Ellen Fahey; I don't know. I can't remember the woman's name, but it was a big scholarship for a funded professorship [Cora Meidl Siehl Chair in Nursing Research for Improved Patient Care], or something. I'll remember the name in ten minutes, I suppose.

DT: Was it Katherine Densford?

MD: No, I don't think so. She had died long before. Don't they have some funded nursing professorships?

DT: They do.

MD: Well, I think of this one in a minute. A Q comes before my mind, but I don't know why—maybe from another place.

With that, I hired Sue Donaldson, who was a well known researcher with funded research and so on. Then, shortly after that, an invitation came from Illinois and Donaldson has never forgiven me for hiring her and...

[chuckles]

MD: She actually moved up there and everything, and, then, several months later, I'm gone. She was very solid, and, also, a physiologist.

Ida left. When did Ida go to...?

DT: I think it was 1982, maybe 1983.

MD: Maybe 1982. I think she was gone long before I left.

DT: I think she left as soon as the Ph.D. was approved.

MD: Oh, did she? Okay.

When Hinsvark was there, it was a little lumpy, that kind of transition. Then, a new dean is a little lumpy.

You mentioned something that other faculty said that I hadn't thought of but getting involved in faculty committees. That would never have entered my head to do that. I don't think Irene ever did that. She was involved in the outside world and the Legislature and the discipline and getting the rest of the University to support us and things like that. I think there might have been some friction there then.

DT: Ida had mentioned that Ellen Fahey was maybe a factor in why she left. She said that Ellen Fahey took away her secretary and, then, she couldn't manage without a secretary.

MD: Ohhh, yes.

DT: It seemed had ruffled more than a few feathers.

MD: I think you're right, and I think Ida, being a funded researcher... Ida was internationally known. She'd done all this stuff in China, and still does with Paul [Martinson]; although, I don't think they're very active. Ida was a lot of fun. She just was a lot of fun, and bright, and creative. I'm sure she had offers all the time. I think you're right; I think Ellen came down really hard on her. I think she picked on me, too; I never thought of it. But, I don't take picking on much.

DT: [laughter]

MD: This was like her first big school with some very prominent faculty, instead of saying, "How lucky I am to have these faculty..."

I remember some of that stuff with Ida now. Yes.

DT: It strikes me that the deanship of the Minnesota School of Nursing... It'd be hard to follow on from Dean Ramey, because everyone had so many positive things to say about Ramey and she died prematurely. That's got to be a hard situation to move into.

MD: She was highly respected by everybody, fondly thought of by most—not that she didn't have a few enemies, not that she didn't have a tweak once in a while where she might have been vindictive or something. I never felt that. She felt very lucky that she was able to recruit me. I don't remember her ever criticizing or correcting... She surely must have, but I don't really remember any of that at all. She might make corrections to something. Like if we had an important faculty document that was going out, I would run that by her. She had a wonderful sense of humor, a wonderful sense of humor. Yes, she was really quite a person that made her mark in a short period of time. You said she was only there three years?

DT: I think four years.

MD: Four years. Well, to get a new building and a doctoral program approved and, certainly, she had to get money for the doctoral program and faculty, that's major.

DT: Yes. It certainly sounds like she had a remarkable influence on the school.

MD: She did. She understood the discipline, so she didn't have to go through all this stuff with Ellen and Marilyn that were all on the structure of the discipline and theoretical frameworks and couldn't get off it to apply or test it. When Hinsvark was there, I don't think that was easy for Ida either. I don't know, some people instead of saying, "Look what great faculty I have. That makes me look great. That makes the school look great," just have a crush-you [mentality]. They lost some other faculty. And that was not easy for Ida to leave Paul and her children here and go to San Francisco. But, Ida, being Ida, she's incredibly resourceful, and a very bright, likable person. I could always talk to Ida researcher to researcher; although, she's in the physiology area. She has no time for minutia. Some administrators focus on minutia. I have little time for minutia. I liked Ida, and it was a great loss to the school. She waited till the doctoral program was approved; although, some of it hinged on her being there.

DT: Right.

MD: I'm trying to think now of that money. I don't know if Ellen got that. I think it was Irene, but before it kicked in... It was somebody's estate, some woman had created a professorship in the School of Nursing. Sue Donaldson was that first professor.

DT: I'll be able to look that up and find out.

MD: I don't know if they were a graduate or just some friend.

What else have you got there?

DT: Really, I was wondering if you had anything else you wanted to share with me about your experiences at Minnesota.

MD: I liked it there. I didn't like the cold weather.

DT: [chuckles]

MD: I was never so cold in my life.

I had some funny experiences. Have you talked to Bernie yet?

DT: No, I sent her a letter and called her a couple of times but I haven't been able to get through. Actually, Ruth Weise had suggested I talk to Bernie, so I will definitely follow up with her when I get home.

MD: Ruth Weise was an extraordinary faculty member, excellent, excellent. She should be given an honorary doctorate by that school at some time.

I think I probably answered... I have some that are not academic at all, like that parking ramp that was two or three blocks away...and so cold. Oh, god! that concrete... Do you park there?

DT: Yes, but I park even further away, because I don't have a parking spot. [chuckles]

MD: I had parking spot there, and it was so cold and, then, that concrete gets cold.

DT: Like a wind tunnel.

MD: Then, there was an exhibitionist in there. He'd hide behind cars and waited for women to come out. Bernie can tell you this story. I got so damn livid mad. He *jumps* out at me. People had been reporting this guy. By the time they'd call the police or anything, he's long gone. We didn't have cell phones or anything like that. I got in my car once. It was about five o'clock at night, just getting dark. He jumps out. I'm in my car backing up. He jumps out of the car next to me. He sits and waits until he sees a woman alone. Well, I got so damn mad, I started chasing him with my car. I started running him down.

[laughter]

MD: I thought how dare you? He ran down the stairwell, and I came around the other way looking for him.

DT: I hope he didn't do that again.

MD: Not to me. He probably thought that one is crazy. I was using profanity and honking at him and shaking at him! I was about half my size that I am now. I was going to get out of the car and beat the crap out of him if I ever caught him or hit him with my car. I think I told Bernie that night or something. Bernie embellishes the tale a little bit.

That was the first time I got a fur coat. I'd lived in Madison, but we're really, even on the coldest days, about ten or fifteen degrees warmer because of Lake Michigan and Chicago's extra pollutants in the air. I thought it was going to be like Madison, but that extra ten or fifteen...and, then, walking from that ramp to the School of Nursing, almost parallel to the Mississippi River, which is *blowing* like this. Oh, my god! I thought my eyeballs were going to come out of the back of my head.

DT: [laughter]

MD: I remember when Ellen came. I think she interviewed in the summer or the fall. I don't know. She'd wear these chiffon...

[break in the interview]

MD: ...scarves around like this, flying. I said, "Forget it in the winter. Get some boots, shearling boots, something over your legs, and a fur coat. Forget the..." She used to tell that story. I don't know my exact words, but she'd tell that story about her introduction and my orientation advice to her.

DT: Its still good advice now, I think.

MD: She was a fun person, but she did take out after Ida. I think she probably did some things. Ida was all faculty, and I was assistant dean for graduate studies. Technically, I reported to her, and she shouldn't have anything to do with Ida in the first place. I should be doing that. She did get into minutia. I think that's right. I don't know if I just let it roll over me, or in the beginning, she thought she needed me because I had the connection, but I found her a lot of fun. She was no Irene Ramey though, not with a vision. Yes. But she was very good socially and did good things for the University that way. I think she did bring in some money.

It bothers me that I can't remember who Donaldson was, but I think that was the first year the money was freed up.

DT: Densford was renamed Dreves, and she died, I guess in the 1970s.

MD: I think she was a great leader, too.

DT: It wasn't her money?

MD: No. This was... I don't remember. I think it paid almost a full faculty salary.

DT: I'll be able to find it out. I'll be able to let you know. I know that information is available.

MD: Oh, yes, I think it was a big deal. I don't know if Ellen got that money or Irene. It was somebody's estate. Are you going to talk to Sue Donaldson on the phone at all?

DT: This is going to be my next question. Who do you recommend that I talk to?

MD: Oh. I think Donaldson was a very important figure. You can ask her... Do you need a phone number?

DT: Oh, sure, if you have it?

MD: Yes, I've got her on email. I think she just left Emory [University]. She became the dean at Johns Hopkins.

DT: Oh, okay.

MD: Then, she left there and went to Emory. But she's in the IOM.

[break in the interview as Dr. Duxbury leaves to get the IOM membership list]

MD: I think she just retired from Emory, which is another thing... Let's see. When did Ida get into the IOM? I might have gotten Ida in.

DT: What year did you become a member?

MD: Nineteen eighty-three, I think.

DT: Do you think Sue Donaldson is still in Atlanta [Georgia]?

MD: I'll get you her phone number in a minute and her email. I just sent her an email.

I don't know what year she got in or if I've got her in.

[Reading from the membership list] Oh, Martinson got in in 1981. She must have got me in. No, it wasn't Ida that got me in. It was a physician—I don't remember his name—from someplace in Tennessee. Ida probably helped maneuver that through for me. Donaldson got in in 1993. If I had an old one of these... Was she there in 1993 or was she already gone?

DT: I don't know.

MD: They just have the addresses where they are now. I think I got in 1983, just before I went to Illinois—no 1984. It that right? I think it was 1983. I think there might be a mistake here. Whatever...1983 or 1984. Ida was already in. That would have made Fahey upset. Fahey came in 1984 or 1983?

DT: Fahey came in 1980, I think.

MD: Nineteen eighty? Oh, yes, I left in 1983.

DT: Yes.

MD: Yes, that would have bothered her.

DT: Do you mean she would have been jealous?

MD: Very. This is very distinguished. There were only—if I guess, I might guess wrong—I'll say ten. When I got in, there were probably ten nurses in here from the whole country. I don't think they list them by discipline. I don't think Minnesota has anybody in here now. Let's see—well, they must have somebody from the School of

Medicine. They list them several ways. Oh, Minnesota has, wow! eighteen. I don't know if any of these are nurses.

DT: Yes, I don't know.

MD: Karen Asche, Michelle [sounds like Burros], Alice [sounds like Stop-uh-les], Georgie [sounds like Stop-uh-les], Ashley Haase-Osterholm, Deborah Powell, Paul Quie, Camille [sounds like Or-gar-boh], Selma Vickers, and Susan Wolf.

DT: I know some of those names. I don't know if any are in nursing.

MD: They did a good job there. I knew there was a dentist that got... Oh, yes, yes, yes. There was a dentist that was in there. He must have died, because he's not in there anymore. Madison has ten in, too, and two nurses. I don't know if any of these are nurses.

DT: I don't know the current faculty very well. I know a few people.

MD: Oh. Let's see Donaldson. I'll give you her address. I just got something that said she's moving. Sue Donaldson...this is probably her office phone. They'd probably have to forward it. This is what they have, "She was a distinguished professor of nursing and interdisciplinary science at the Nell HodgsonWoodruff School of Nursing, Department of Physiology, School of Medicine, Emory University." I think I just sent her an email and I got an automated email back that says she will not be getting her mail there anymore. They'll only do it for four months. Anyway, here is the email: sue.donaldson@emory.edu. Her phone there—someone will answer a phone I would expect—was 404-727-8164. She had a fax number. The IOM just met; they always meet in October, and I sent her an email that said, "Are you going? I'm not going this year, blah, blah." I got an automated thing back with a new email on it where she can be reached after. I can look that up for you or you can get the automated email.

DT: I can always get back in touch with you if I can't find her any other way.

MD: Okay.

DT: That would be the easiest thing to do.

[break in the interview]

DT: That's all the questions I have.

MD: Ida would know who was at... In fact, Ida might have gotten that big funded thing. I think it was for her home care and dying child stuff. I don't know what I'm talking about.

DT: [chuckles] I'll find out, and I can let you know.

Is there anyone else that you suggest I talk with?

MD: Ruth Weise, did you talk to her?

DT: I did, yes.

MD: Ellen Egan, I don't think she's able to talk. I think she has some deterioration or something. But maybe she died; I forget. Bernie knows all that stuff. She's up there, Bernie Feldman.

DT: Yes.

MD: I suppose you talked to Sandy Edwardson.

DT: No, but she's on my list.

MD: I don't know what she'd have to offer. Sime, you talked to. They had some faculty clichés there. As an oral historian, you have to separate out...

DT: Yes.

MD: Let's see. Donaldson, I'd definitely talk to. Do you have a directory of the Academy of Nursing?

DT: I don't, but I'm sure I can get one.

MD: She may have a home address in there. She only had a business address in here.

DT: I'm sure I'll be able to find her.

MD: Tell Donaldson that I recommended her; otherwise, she might say she's too busy.

DT: I certainly will.

MD: Bernie Feldman, you've got. Ruth Weise, you've got. I'm trying to think of some of the really junior faculty who were there. Oh! would you like to talk to a student, former student?

DT: Oh, yes, sure. Absolutely.

MD: I had one there who is now a faculty member.

DT: Oh, okay.

MD: She worked as an RA for me.

DT: Oh, great.

MD: Susan Henly. She was Susan [sounds like Schuh-len-dek]. I'm not in touch with her much.

DT: If she's still at the school, I'll be able to...

MD: Yes, yes. She's still at that school. She was one of the graduate students and was an RA for me on one of my research grants. In fact, her name was Susan [sounds like Schuh-len-dek]. Another RA for me was George Henly and they, eventually got married, so they met on my grant.

DT: That's great.

MD: I found her the other day, oh, maybe a year or two ago, she had published a very good paper in one of the better nursing journals, so I sent her an email, and she sent back to me. Sometimes, I get more mail than I can answer.

DT: [chuckles]

MD: She sent me a picture of herself, George, and the children, which I haven't answered. So apologize for me. I'll get to it; although, it was a year ago. She's just an extremely bright, hard working, able person. She was there from a student perspective, a graduate student, from the program, program development, what happened to Ida, all this stuff.

DT: That's great.

MD: She's very quiet and soft spoken, so you may have to have more directive questions. She probably doesn't ramble the way I do.

DT: You're not rambling.

MD: That's a luxury of getting old; you can ramble.

DT: That's the best thing for me.

[chuckles]

MD: She's at Minnesota now...

DT: Great.

MD: ...and a faculty member. I think she was gone for a while, like in North Dakota or Canada or Pennsylvania, and, then, came back to Minnesota. She was there as a graduate student, so she was there through a lot of the transition.

DT: Yes, she'll be great to talk to.

MD: Yes, I would talk to her. You can use my name that I said to talk to her. She might have a lot of insight.

Let's see, who else? That's a student. I didn't know many undergraduate students, or I'd suggest one. Are you talking about Judy Plawecki?

DT: Hmmm, I don't know that....

MD: Am I still on that tape?

[break in the interview]

MD: I didn't have much to do with the undergraduate program.

DT: It seems like there was a real division between the undergraduate faculty and graduate faculty.

MD: I think there was, yes. The graduate faculty had to be approved by the graduate college to teach there. There need not be that, but to teach graduate students, you had to have some kind of—I think they even ranked them—approval from the graduate school, some committee over there. Yes, they committee themselves to death sometimes.

DT: [chuckles]

MD: A lot of the undergraduate faculty had terminal master's degrees, so would not be approved in the graduate program unless you built up a case and went through... I think they had a good preparation in the undergraduate program there. We got many of them and they were well prepared. But that's a whole other story with that administrative stuff.

DT: Yes, so it would be valuable to talk to anyone who was involved with the undergraduate program.

MD: Judy Plawecki knew that program and I did not. My total focus was on the graduate program.

DT: Yes. It seems like that was more than enough work.

MD: Yes.

DT: You mentioned the faculty clichés. Are you comfortable identifying those?

MD: Well, I think Sime, Egan, Corcoran, and Pat Crisham were kind of tight and [unclear] and tried to control this and have a lot of control. They had a couple leakers that kept me advised if it was anything I needed to head off or whatever, so that was not all that tight. They tended to do a lot of group think, which is not always healthy.

Something you mentioned earlier... I think there were mostly Minnesota people that hung together, and it was some of the outsiders with new ideas. I think they were not terrible supportive of the psych mental health group or midwifery group. They were kind of rigid in some ways and had to be massaged.

But everybody there was supportive of the doctoral program and wanted it moved and wanted to do, some with nudging, others with shoving, what it took to get it through. It was a good time.

DT: Well, thank you so much for sharing so much with me. This has been a wonderful learning experience and lots of great stories. So thank you!

MD: I enjoyed it very much. Thank you for coming. I appreciate it.

[End of the Interview]

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