

Ida Martinson, 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.

Biographical Sketch

Ida M. Martinson was born in northern Minnesota. She received her nursing diploma from St. Luke's Hospital School of Nursing in Duluth, Minnesota, in 1957; her B.S. in Nursing Education in 1960 and her Masters in Nursing Administration in 1962, both from the University of Minnesota; and her Ph.D. in Physiology from the University of Illinois at Chicago in 1972. After she received her nursing diploma, she continued to work for a year (1957-58) at St. Luke's Hospital, also serving as an instructor in Tuberculosis Nursing. From 1967-69, she worked as an instructor in nursing at Thornton Junior College in Harvey, Illinois. After earning her Ph.D., she returned to the University of Minnesota School of Nursing as an assistant professor (1972-74). She was promoted to associate professor in 1974, and to professor in 1977. While at the University of Minnesota, she was centrally involved in establishing and running the Home Care for the Dying Child Project. In 1982, she moved to the University of California, San Francisco, as a professor in the Department of Family Health Care Nursing in their School of Nursing. Throughout much of her career, she conducted research and worked at Universities throughout Asia, particularly in China.

Interview Abstract

Ida Martinson begins by discussing her background, including her education and why she became a nurse. She discusses working at St. Luke's Hospital as a diploma student, working with Christian Family Service Center, studying tuberculosis nursing in Japan as part of the University of Minnesota Student Project for Amity among Nations, going to the University of Illinois for her Ph.D., working in the University of Minnesota School of Nursing as faculty, and going to the University of California, San Francisco. She describes relations between nurses and physicians; the medical technologies she interacted with at St. Luke's Hospital; and having a joint faculty appointment in the Department of Physiology and in the School of Nursing at the University of Minnesota. Other topics discussed include relations between diploma and baccalaureate nurses; interactions between the School of Nursing and other health sciences schools at the University of Minnesota; interactions with insurance companies; her research in Asia; the building of Unit F; regional planning and nursing workforce in the 1970s; and the Midwest Nursing Research Group.

Martinson describes her research, including her doctoral research, doing research in Taiwan, and the Home Care for the Dying Child Project. She discusses doing clinical work when she was a baccalaureate student; School of Nursing curriculum revisions; concern over the shortage of health care workers in the 1960s; the federal Nurse Scientist Program; the School of Nursing's efforts to develop a nursing doctoral program during the 1970s and early 1980s; the reorganization of the health sciences in 1970; public health nursing; sabbaticals; working with the Human Subjects Research Committee; her work in China; nurse practitioners; the Nurse Midwifery Program; the Program for Human Sexuality and attending a Sexual Attitude Reassessment; efforts by the health sciences faculty to establish a health sciences bargaining unit; the development of the

Block Nurse Program; and a nursing exchange program with China. She talks about the faculty at the University of Minnesota while she was a student, Katherine Densford, and other School of Nursing deans.

Interview with Ida M. Martinson

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at the Home of Ida Martinson

Interviewed on July 7, 2010

Ida Martinson - IM
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Ida Martinson. It's July 7, 2010. We're at Doctor Martinson's home at 12149 East Movil Lake Road in Bemidji, Minnesota.

Thank you, Doctor Martinson, for joining us.

IM: Thank you for coming up here.

DT: To get us started, why don't you tell me a little bit about your background, where you were born and raised, and how you got into nursing?

IM: Okay. I was born in northern Minnesota here on a farm. Actually, believe it was an aunt of mine who delivered me. The physician got too late. I was told I didn't breathe, so they put me in hot and cold water, but they got me breathing.

[chuckles]

IM: When I graduated from high school in 1954, I, then, went to Saint Luke's Hospital School of Nursing in Duluth, Minnesota. When I finished there, I ended up teaching tuberculosis nursing for the degree program at Saint Scholastica [in Duluth] as well as to Saint Luke's nursing students. Saint Scholastica was wanting me to consider going to a Catholic University to get a degree and more work.

Then, I ran into a classmate of mine who had been at the University of Minnesota, and I decided I'll go to the University of Minnesota. One of the programs she had participated

in was SPAN, Student Project for Amity among Nations. I thought that sounded good, since, up to that time, I really hadn't been out of Minnesota that much. So I enrolled at the University of Minnesota to earn a bachelor's degree in nursing education, which was, at that time, part of Education, but we had a lot of classes in nursing. When I finished that, I went right on and started my master's in nursing administration which was part of the School of Nursing.

Why did I become a nurse? Well, back at that time, our choice as women really seemed to be a secretary, a teacher, or a nurse. I think one of the reasons I became a nurse is that when I was in eighth grade, I think it was, my oldest sister was in a terrible car accident. I went into the hospital in Crookston [Minnesota], and she was moaning. I thought, oh, I can become a nurse and help her...

[laughter]

...so she wouldn't have to moan, you know. I was a young kid not knowing much. I think that was one of the factors.

Then, in high school, I took some secretarial courses, but I really didn't like filing or shorthand. The principal at the school said, "Why don't you think of nursing?" So without much ado, I ended up then in a hospital school for a diploma in nursing. Then, of course, once you get into nursing, you always see there's more to learn, and I went on to the University of Minnesota.

DT: Why was your initial decision to go to the Saint Luke's Hospital School rather than going straight to the University?

IM: I think I had no idea about baccalaureate education in nursing. I don't think that was even an option—it probably was an option, but I didn't know it. It's kind of amazing to me how I didn't end up like in a nursing aid program or in licensed practical nursing. Up to that time, I had been placed in a foster home. I think there were really no funds for me to live in the Cities [Minneapolis and Saint Paul]. I did get an American Legion Auxiliary Scholarship to go Saint Luke's. There, of course, we worked as we were training, so there probably wasn't any tuition.

[laughter]

IM: I know my dad sent me ten dollars every month for spending money or whatever I needed.

[laughter]

IM: So that's how I got there. I graduated head of the class at Saint Luke's. It was there the environment was, well, I should pursue additional education.

DT: What was your experience like when you were working at Saint Luke's?

IM: Oh, it was rather a good experience. The only time I ever got reported to the head of the nursing school is when the head nurse thought I was spending too long talking to the patient's family. When I got to the director of the nursing school, she said, "What were you talking to the family about?" I said, "Well, this person has just been newly diagnosed as a diabetic, and the family was really concerned, so I was trying to *briefly* tell the family about diabetes, and what they needed to watch for, how they needed to be sure to watch that the person would eat." Of course, the director of the nursing school thought that was absolutely what I should be doing, so, instead of getting a reprimand, I really was encouraged that this was part of what she saw as nursing's role was to teach not only the patient but the family. So, where I had been sent to be disciplined, I actually was encouraged. [chuckles]

DT: That's great. I spoke to another nurse who had a similar... She was working at a private hospital and spending time with the patients' families trying to educate in the same way that you were trying to educate them, and she got in trouble by, I think, a physician complained about her. She went to the head nurse and the head nurse did not see it as the nurse's role to educate...

IM: Oh, dear.

DT: ...because the physician hadn't ordained that.

IM: Ordained that. Yes.

[laughter]

DT: It wasn't in the physician's order, so, therefore, she was in trouble. So that's a nice counter experience.

IM: So I had a very good experience with that. I really felt I learned a great deal.

I think, in one way, I'm certainly supportive now of baccalaureate education in nursing. I think we were rather taught that *we knew it*. In one way, we almost had too much confidence for what little we really knew. That was, I would say, one of the weaknesses even though it was a good program. Our basic science courses were at UM-D in Duluth. It was a solid science background, but I still think it was sort of this attitude that when you were a nurse, you knew it. After I finished my Ph.D., I realized I knew a lot about something little.

[laughter]

DT: I know that feeling.

IM: It was really great. I just worked the one year, then, right out of the diploma program. Then, I went down to the University of Minnesota, and that's when I got my bachelor's and, then, went right on to the master's.

DT: In that time working at Saint Luke's, how did the physicians respond to you and treat nurses, in general?

IM: [chuckles] Well, of course, we always had to stand up when the physician came. I still remember that in the middle of the night, if you were working nights, and you needed a physician to come—it would be the interns that were coming—I would always promise them a backrub so they'd come right away.

DT: [laughter]

IM: I look back now and think that was sort of foolish, but it worked. They usually did come. They were tired and a backrub felt good.

[laughter]

IM: But there was nothing beyond the backrub.

DT: Sure.

IM: I loved to do that.

There were different experiences. I know in the operating room—I still remember the physician—I had tangled up a suture when I gave it to him. He scolded me severely, because he said I had delayed the practice of medicine *by at least three minutes*.

[laughter]

IM: He had sort of a game on with himself, I think. He was trying to see how quickly he could do an appendectomy, and I had goofed up his time by messing up that suture.

There were other physicians who were very good and willing to teach so that I came out of there with, probably, too healthy a respect for physicians. It would have been very hard for me to ever criticize a physician or ever imagine that they could do something that, maybe, wasn't quite what they should do.

But that was taken care of when I got my Ph.D. My advisor in the doctoral program taught physiology to physicians, and, then, of course, as a doctoral student in physiology, we had to do ten percent better than the medical students. I was involved in grading of the medical students' papers, and I soon was sort of shocked at what little they knew that I knew.

[laughter]

IM: That, I think, helped me get a more realistic image of the strengths and weaknesses of both nurses and physicians.

DT: When you were working at Saint Luke's did you have much interaction with medical technologies, and, if so, what kinds of technology?

IM: Not really. As I think of technology, I would think of inserted catheters, urinary catheters, IVs. We did have IVs. When I went on to get my baccalaureate, I wrote a paper on how nice it would be if we could speak into some recording machine so we wouldn't have to do all this writing all the time. That was one thing that I really felt the need for, that we spent too much time sitting and writing; yet, of course, it was important to document what we did. I know that was a technology that I thought was necessary to have.

DT: Were nurses allowed to do the IVs at that time?

IM: Let's see. I'm trying to remember. Probably not. We gave medications, though.

I was kind of always interested in like how can I get these people to sleep at night? Now, I look back and I can remember I would give them hot milk and add just a little bit of pepper on top. I was probably really fooling patients. Remember now, this is before informed consent.

DT: [chuckles]

IM: I was always so amazed at how I could get so many to sleep. I would do that hot milk and a little pepper sprinkled on top and, then, a backrub. I can remember one month when I took over the shift at nighttime, they said, "Oh! these people are awake all night." So, I thought, well, I'll try my hot milk with a little pepper and backrubs. I can remember at the end of my month rotation, I think I had the most sleeping, and I was really proud of that.

[laughter]

IM: That was before any research training whatsoever.

DT: Sure. Do you think it was a placebo effect?

IM: I think it was the placebo effect, and I suppose the attention and the backrub. I took time with them. I think that can make a person relax. I enjoyed being with patients and would speak to them and they could talk about their fears. That was probably just as important as the hot milk.

DT: You mentioned that you decided to go on to the baccalaureate because there was more to learn. So why did you decide then to do the bachelor's in nursing education and not just nursing?

IM: Well, at that time, the choice for those who came out of a diploma nursing program was really a choice of a baccalaureate in nursing education or a baccalaureate in nursing administration. Those were the choices so that they could count some of our other courses. There wasn't really any general nursing for us, so I took the education.

By the time I finished that, I thought, you know, I may want to go overseas. I'd gotten interested because of being in Japan under SPAN. I thought it wouldn't hurt to have administration, so that's why, then, I got my master's in nursing administration. My minor, at that time, was in psych nursing, so that I was trying to get as well rounded as I could. The one thing I didn't have was really public health nursing. Of course, I got to Hong Kong after I was married—jumping a few years—and what I really needed was public health nursing, so I ordered a book and read about public health nursing.

[laughter]

IM: That *really* made a difference in my life as a nurse, probably more so than anything. I worked for the Christian Family Service Center. They worked with the refugees who had come from China. I had had, by this time, about twelve months of Mandarin, so I could communicate.

Two illustrations I can give that *really* made a difference in my nursing career for the rest of my life... One was this Chinese mother came in with her daughter and said, "Something is wrong." It seemed to me as I examined her that she had a potential of appendicitis. I said, "Have you been to the hospital?" She said, "Yes, but they won't pay any attention." So I took the child and with my white face went back to the same hospital, same clinic, and, sure enough, she was examined. She did have appendicitis, and they did surgery. It's sort of the idea that a white face could make a difference.

Then, another was I did a lot of home visits and these refugees were just living in tin shacks up in the mountain, really primitive, open sewer and that. This was Hong Kong back in 1963. I found this little girl on a chain. I thought what in the world. I could see no older brothers or sisters or parents around. So, I came back that evening and met the parents. Basically, the story was that she had a high fever. In my thinking, she probably just got spoiled. These were people who had to work every day. They had no relatives. They had no choice but to do it. They didn't want the child to run away, so they put her on this chain. I went back to my Christian Family Service Center, which was really a social [service] organization. I went to them and said, "Now, this is a social worker's responsibility, not nursing."

[chuckles]

IM: “I found this, but I think *you* need to take care of it.” I remember they got involved with the child. They got her off the chain. She got into school. Before I left Hong Kong, I checked on her and she was doing just fine in school.

DT: Ohhh.

IM: That gave me this other idea that—the first was that myself could make a difference—it didn’t always have to be me. I could have it for someone else to do or follow up, that not everything was in the realm of nursing.

DT: That’s interesting. You could figure out what’s nursing, what’s the parameters for what nurses can do, and, then, working with other practitioners to ensure that happens.

IM: Yes. I think those were very helpful experiences to have back at that time.

DT: Yes, definitely.

You mentioned going to Japan. When did you go to Japan and what were you doing there?

IM: That would be in 1959 that I was in Japan. I went under the program, University of Minnesota Student Project for Amity among Nations. I think I had a choice of going to Greece, Japan, and I forget what the third country was. In my home town of Fosston, I talked to the physician [for whom] I used to babysit. He said, “Oh! go to Japan, by all means. You can always go to Europe, but you may never get back to Asia. Go to Japan.” I, then, picked to study tuberculosis nursing in Japan. That allowed me, then, to travel from southern Japan to northern Japan. At that time in Japan, two people with tuberculosis slept in the same bed, one at the head and one at the foot, that type of thing. It was really an interesting experience. We had to write up a paper. It was a very good beginning, when you go to a place you haven’t been, how you observe, what you learn. I really do treasure my SPAN experience; it was a very good experience.

DT: It sounds like it. This is the first I’ve heard, actually, about the program. I’ll have to do some research and look up some more about it. It sounds great.

The bachelor’s, was it a four-year baccalaureate program?

IM: I already had the three-year diploma—all the basic had been at UM-D—so I think I got my bachelor’s in nursing education in two years, on top of my three years of nursing.

DT: Okay.

IM: Then, my master’s, I think that was a year in the summer or... Yes, I think it was a year in the summer.

DT: Were there any notable faculty that stood out to you?

IM: Oh, yes, Fran [Frances] Dunning—Fran Dunning was wonderful—and Isabel Harris. They were both my faculty members. Those were probably the two that I remember the most. Both of them, I would say, made me... It wasn't only how important the clinical work but it was also the knowledge. I would say that both of them played a role in my ultimately going on for my Ph.D. There's so much more to nursing than what my diploma school had taught me. So those would be the two that I would remember the most.

DT: Did you have much interaction with Katherine Densford?

IM: Oh, yes, yes, yes. She was delightful. I know I had her to my home once; that's more when I became a faculty member. Then, I think she had already retired. I got to know her. I would go visit her in the home before she was ill. The last time I saw her before she died, she was in the hospital, and I went to see her. She still remembered me. She had a brain tumor and died of that. I went to her estate sale. I still have some things of hers that I bought.

[chuckles]

IM: She was quite a lady. I know once she said to me, "I know you need to go away from the University of Minnesota. But you should come back to Minnesota, again." This was when I was faculty member. When I left Minnesota then in 1982, I did not go back. I ended up career in California. But I always thought of that.

DT: Were you doing clinical work at the same time you were doing your baccalaureate?

IM: Oh, absolutely. I don't know how I had the energy. I was carrying a full time load as a student and, then, I was also working close to full time at Hennepin County [General Hospital]. At that time, since I was a diploma graduate working for my baccalaureate—it's unbelievable to think about it—I would float charge. One night, I would be in charge of OB [obstetrics] and the next night, I could be in charge of Psych and, then, Medical Surgical. As I look back upon that close to two years, I had *extremely* rich experiences. The thing about Hennepin...the interns that we worked with, the physicians, and the nurses, we *really* all helped each other. No one ever said, "No, I can't come over and help you or answer your question." At that time, there was just like one big open ward. I think it was over twenty beds. What helped us, at that time, is that everyone could see how busy you were. Like if we would get a person who had been shot, they could see that we had emergency things. They would wait; they wouldn't even put on their call button until they could see that we had finished there. I really appreciated how great the patients were, too, because they could see what we were doing. So I treasure that experience there. It was a great time.

DT: In general, it sounds like there were positive relations between physicians and nurses.

UM: Yes. Clinical, at that time, it was really positive. Absolutely. I think all along, I've had pretty good relationships with the physicians. I think I'm probably an optimist.

[laughter]

IM: I really have enjoyed my physician...but it's been more a collegueship now.

When I came to the University of Minnesota after I got my doctorate, I had a Ph.D. in physiology, and I, also, had a joint appointment with the Physiology Department at the University of Minnesota. When I went to the University of Minnesota, I wanted that joint appointment because I really didn't know... I remember Doctor—I can almost see him—Eugene Grim. He was head of the Department of Physiology at the time. He would say to me, after I'd been there for a while, "What do you want to be? Do you ultimately want to be a nurse or do you want to be a physiologist?" I really chose nursing. I learned a great deal. I would serve on the Admissions Committee in Physiology and learn. It was interesting to see *all* of these applications. Every fellow would apply to the doctoral program in Physiology. All women would apply for the master's. Isn't that interesting? Why is it that women don't have that goal to get the doctorate from the beginning? All these little things, you'd pick up along the way.

DT: Did you ever come up with an answer to that?

IM: It was probably the education of women, that we weren't always encouraged to go on.

This, you've got to hear. It's really interesting. When I was a doctoral student, I was working with sodium transfer in inverted rat intestines, very physiological. I had to work with *male* retired breeder rats. They were *huge* rats with big tumors on them. I would just argue. I said, "Why do I have to work with male retired breeders? Why can't I work with the older female?" He said, "Oh, they've had hormones." I think back and I used to say, "But, look at these tumors!" [laughter] "Don't these tumors affect things, too?" Research just wasn't done on women, because of our hormones. Think of how long it's been before, finally, in science now, they are realizing the need to do studies now in women.

Finally, they've learned recently, too, they need to do studies with children.

DT: Yes, it's surprisingly recent.

IM: It is surprisingly recent. That was the attitude back then.

I went on for my Ph.D.—let's see, when was that?—1969 to 1972.

DT: What were relations like between diploma nurses and baccalaureate nurses?

IM: Oh! well, I think it was that attitude I mentioned earlier. Diploma nurses tended to think that they were the cream because they had so much more clinical experience. But, I really felt they didn't have the educational level. It was that idea that they were experienced and not afraid of anything, not a cockiness but over confidence. I've always sort of felt that way. You'll find many, many diploma graduates who think that's just the way to go. I challenge them now. You don't know what you don't know. You just don't. You think you know it, and you don't. Clinically, like I said, at Hennepin, I didn't have that at all. We just all worked together in a tremendous team. I think I was fortunate in my clinical work that it always kind of rose above conflict.

DT: Do you think Hennepin County was distinctive for this collaborative...?

IM: Absolutely.

DT: Okay.

IM: Absolutely.

DT: What set Hennepin apart on that?

IM: Maybe it was because it was a city hospital. There wasn't always the funding. We were always getting kind of the emergency type, so that you always had to be on your toes, and you were learning things. The physicians were also short staffed, so they needed nurses who would be willing to learn whatever they needed you to do while they had to do some more diagnosing or acute treatment. It was a very refreshing place to work. I really was eager to get to work every night. It never was a drudgery. I didn't have to worry about politics, with physicians or diploma nurses or anything. It really rose above all of those issues that were there at that time.

DT: That's amazing.

IM: Yes.

DT: Going back to the baccalaureate... I believe that at the same time you were doing your baccalaureate, the curriculum was being revised in nursing.

IM: I think so. I think there was always constant revision. Not too many years after that when nurses went on for their baccalaureate, they didn't have to go into nursing education or administration. They could come in and get their baccalaureate, so that changed. Even though I was near the end of this specialization... It was really a specialization at the baccalaureate level. I don't remember the year the curriculum change was made, but I know it was made. I, myself, was not part of that, though.

DT: One of the things that that curriculum revision did was eliminate the thirty-hour clinical student service the nurses had to do. You don't have any recollection of that?

IM: No. No.

DT: You went on to do your master's. Your reason for doing that was the same as for the baccalaureate? You just wanted to learn?

IM: And the fact that, at that time, I was really interested in Asia and didn't know if I wanted to be a missionary nurse or what. I thought it wouldn't hurt to have some administration background. It was an *excellent* course. I remember I had... I forget his name now, but he was labor relations. That was such a new subject for me, but that was one of my favorite courses. I think it was [given name?] Heller. He was just a marvelous teacher and just opened up my eyes to the thought of how labor unions worked and how management worked. That master's in nursing administration was kind of a whole new substantive material for me. It was kind of outside of what nursing had been, and I just treasured that. We did, of course, have some nursing administrative courses, too, and I found that very interesting in thinking from these courses. I really liked my master's in nursing administration.

DT: Who were the faculty who were in charge of that?

IM: There, too, was that, also, Dunning and Isabel Harris? Those two, I knew them many years...certainly Isabel Harris, when I became a faculty member. There would have been others, too, but I don't remember. A lot of those courses in administration were from non-nurses teaching other than the nursing. Our master's paper, that, I know, was Isabel Harris.

DT: I seem to recall that maybe Fran Dunning was in charge of the nursing admin.

IM: I think so, too. Yes.

DT: Her name comes up a lot.

IM: She really was a wonderful person.

DT: That's been my sense talking to people.

Around the time that you were getting your master's, and before that, too, there were concerns about there being a shortage of health care workers in general, and I think, also, nurses and you get passage of the Nurse Training Act in 1964. Were you aware of those concerns?

IM: I think I was. In fact, I think I even got a scholarship for... I don't remember now whether it was for the baccalaureate or the master's. Then, at the doctoral level, I had the nurse scientist scholarship. That was federal. It just came in. I think I was in the first class of the Nurse Scientist Program. I was in Chicago at that time and my choice was between anatomy, biochemistry, or physiology. Those were my choices, and I took

physiology thinking that would be the most useful for nursing, and I think it was. It was a great course.

DT: The federal program determined that you had to do one of those three?

IM: Yes, the Nurse Scientist Program. I think there was only, maybe, forty to, certainly under one hundred of us who got those scholarships. At the end of that time period, there were doctoral programs beginning in nursing.

DT: Sure.

IM: That was kind of the first where nurses could go on other than in education, you see. Nurses could *always* get their doctor's in education. I think getting some basic science, you approach things differently.

DT: Why did you go to the University of Illinois?

IM: Well, my husband [Paul Martinson] was there. He was at the University of Chicago. I was teaching. That was very interesting. The first two years that he was a doctoral student, I was teaching in Harvey [Illinois] at a two-year community school. It was so funny when I look back. All my responsibility was just twenty hours a week. A lot of that was clinical supervision and a course or two to teach. Twenty hours a week. Foolish me. I thought, well, on for my doctorate and be home a lot more.

[laughter]

IM: Little did I know.

DT: Famous last words.

IM: Famous last words, because getting into physiology, we had labs. I was in lab mornings and nights.

A funny story occurred during that time. My husband was a doctoral student at the University of Chicago. He was the one who took the kids to school and went to the teacher's conferences, because I was always in the lab from eight in the morning till five at night, five days a week. I remember my neighbor came out one day where we were living and he said, "Do you know what your husband does all day?" I said, "Oh, I know he's studying." "He sits out in the back and reads books!"

[laughter]

IM: He thought he was lazy, see, and I was running off every morning.

DT: What is your husband's doctorate in?

IM: In the history of religions.

DT: Oh, interesting.

IM: It's been very interesting. Actually, he helped me with one of my first international studies. It was done in Taiwan. I was studying the impact of childhood cancer in Chinese families. This is jumping quite a ways ahead. He looked at the religious aspects of that, so we would interview families and, then, he would follow through going to the temples that they would use, so we got some joint articles on that.

DT: That's very neat.

IM: Yes.

DT: Where did your interest in Asia come from? Was it really that experience in Japan?

IM: That, and, then, my husband's grandparents went out as missionaries to China in 1902. His father had grown up in China, and, then, he himself was born in China. When he was getting a little bit serious about me, it wasn't would I cook or clean or any of that, but would I be learning Chinese? I would say it really was because of *him* that we became so interested in Asia.

The first study that I did then... I was due for a sabbatical at Minnesota and he was due for one from the seminary. I said, "Where do you want to go?" He said, "Anyplace, as long as it's Asia." So, then, through contacts, I ended up going to Taiwan. I was very fortunate. The National Science Council is like our NIH [National Institutes of Health] Program [unclear] National Science Council funded. I was the first nursing research study ever funded in Taiwan by the National Science Council, so that was a breakthrough in that. I had the ability, then, to hire nursing pediatric faculty from two of the leading nursing schools who did the interviews. Then, I would meet with them every other day. I did know some Chinese, but there were still times, I would let conversations go beyond what *I* could comprehend because of the need for them to really understand. From that, my husband would pick up with one of the younger nursing faculty members, and they would go to the temples. It made a very rich, holistic view. We ended up with probably some of the most significant research work ever done in nursing in Taiwan. Right before leaving, we ended up on national television in Taiwan talking about the needs of children with cancer, and we made a call for donations. That one night...it was like *Sixty Minutes*. It's a powerful DVD. That DVD is something I need to get to the archives.

DT: Yes.

IM: That really should be...

DT: Absolutely, yes.

IM: It's just a powerful one. They interviewed just like *Sixty Minutes*. They interviewed a child who was dying in the hospital, and all of that. It ended up that we had enough money to start a child cancer foundation and, within five years, it raised enough money for all children to be treated.

DT: Wow. [whispered].

IM: By, then, when national health insurance came, there was enough political pressure so childhood cancer...all treatment costs are covered, even today yet.

DT: That's wonderful.

IM: It certainly, as far as my work goes, made the most difference in the life of children.

DT: That's quite incredible.

IM: Very few people in America know about this one, because they see me as working with home care for the dying child, which was, of course, very important, too.

DT: What was your doctorate research on?

IM: [chuckles] Sodium transport in inverted rat gut. I had no choice in that. At that time, you studied what your advisor was studying, and that's what he [Dr. Raymond C. Ingraham] All his doctoral students studied it, so I studied it. I had one publication from it. Basically, I would say, it looked like there were some mechanisms involved, possibly hormonal, that affects the movement of sodium transport. I published one paper from it. I certainly learned about the experimental method just being a gold standard, even though most of my work has not been in physiology. It taught me a respect for the method. Everything was very quantified. I think it gave me a rapport with physicians who, on the whole, have more of a science background than some nursing and other prepared in education had, for example. I had no difficulty communicating with physicians over any of the things that happened with care of the dying child. It really was a good background for the work that I ended up doing. I certainly learned always, no matter what I'm doing, to quantify what can be quantified. Then, when you can't quantify it, how best do you tell?

I still think of what I learned with some work I did with stress. What really tells the picture more is this elevated cortisol level or when a mother says, "It's like an eggbeater whipped my brains." There's strength in both of approaches.

DT: Sure. Yes. Absolutely. This is interesting.

[chuckles]

DT: Doing the Ph.D. was less about being a physiologist, but much more, as you say, about learning what it was to do scientific research.

IM: Right.

DT: And, then, you would go and apply that to nursing.

IM: Yes.

DT: Do you feel that that was something that other nurses in your generation who went on to do Ph.D.s...?

IM: For those who made commitment back to nursing, yes. I think some really remained physiologists the rest of their lives and never did come back to nursing in any way. Others came back part way, which was also very good, too.

Maybe I could give this illustration to show there is still a need for basic physiological research in nursing. I had a child—this was Care of the Dying Child—a little girl about thirteen admitted to the hospital, and there was possible abdominal bleeding. She requested the hot water bottle. The nurses said, “No,” because that could increase bleeding. I was involved. I went to the physician, and he said, “Well, she’s dying. It’s okay. She can have the hot water bottle.” My response was immediately, “But shouldn’t we know?” That’s where that physiology...that questioning came. So my question was, “What is the effect of a hot water bottle on internal bleeding?” I did do a series of a rat and a dog study to find out about that. I went then to my physiological colleagues in physiology and we designed a rat study and made a little hot water bottle for the rat, but I had to anesthetize the rat.

[chuckles]

IM: We did this and we published that article. There was good response. I got some interesting ideas. They said, “Why don’t you do a dog? Do the same study, but do it on a dog, because a dog is more the size of a child.” You don’t have to anesthetize the dog. You can train the dog to lay still. So then, we did, also, publish my second study done over in the Department of Physiology.

DT: Oh, wow.

IM: By that time, I ended up more and more involved with home care for the dying child, so I didn’t do any more physiological research after that.

DT: What were your conclusions about the hot water bottle?

IM: The ones that wouldn’t be real hot were probably less traumatic to the dog and the rat, and so, possibly to a child, than cold. The cold continued to show temperature changes, while the heat did not. So I’ve always said, “It’s perfectly safe to give a warm hot [water] bottle to a child.

[laughter]

IM: Someone could pick up that study, now, with the technology that's around with radioactive isotopes and that. That study should still be done.

DT: Once you finished your doctorate, what led you to return to the U of M?

IM: Well, my husband was called to Luther Seminary [Saint Paul, Minnesota]. I thought, okay, if he's going to be at the Seminary, then, I better see if the University of Minnesota wants me. I know I went to Isabel Harris. She was dean at that time, I think. She said, "Well, we really don't have any openings for a person like you." I said, "Oh, what about something in the area of research?" She thought about it and she ended up, then, getting a position for me—but, of course, that took longer than I knew. So I did look around for other positions, too. I did end up, with my first position was assistant professor at the University of Minnesota. That was a great time. Of course, it seemed to me, coming out of a doctoral program, the University of Minnesota needed to get research going. Ultimately, my goal, from the time I got there, was to get research going and, then, we should have a doctoral program in nursing.

As far as outcome during that time, before 1982, one of the things that I worked hard on was working on getting a doctoral program developed. We did a series of seminars where we'd have speakers come in to talk about doctoral programs in nursing. Then, I know I wrote that grant that went to the McKnight Foundation. I think we got a \$300,000 grant to start the doctoral program. We got that grant, and, then, I ended up being recruited to UC-SF [University of California – San Francisco].

The other major thing I did there was a faculty research development grant. We got that. It kind of was a grant for released time for faculty so they could get started in research.

The third thing was we started that Katherine Densford Research Day that's still ongoing. And the other thing was working on that building [Katherine Densford Center]. I tried to build in both laboratory research as well as different types so that you could have it in your research space like it would be a home, a hospital, that type of different environments in which to do research work.

So it was just a very exciting, wonderful time.

DT: Indeed, it was an exciting time for the School of Nursing, in general, and for the Academic Health Center.

I'm curious. When you were a student, the School of Nursing was within the College of Medical Sciences?

IM: I think it must have been, yes, but I wasn't even aware of that.

[chuckles]

DT: But, then, when you returned, the health sciences had been reorganized.

IM: Yes.

DT: Now, the School of Nursing was autonomous.

IM: Autonomous, right.

DT: What was your experience, then, being in the School of Nursing in its new administrative organization?

IM: I think that's what probably allowed me, for example, to get on the Human Subjects Committee, because we were an autonomous school then. We, also, had to have a representative on Human Subjects. That would be one.

I know I myself thought that Public Health Nursing should be part of the School of Nursing. I thought that was wrong that they were not in Nursing at that time. Of course, it has, now, become part of Nursing. I had thought that should have happened a long time ago. I thought that should have happened at the time of the reorganization. That was beyond...I didn't have any influence about it. I just know I always thought that was wrong. I worked with Delphi Friedlund, a faculty member in the School of Public Health Nursing. When I got involved with home care for the dying child, I had Delphi make a home visit with my very first family that I worked with. She did a write up on that, about the child. I knew the people in Public Health Nursing, but I always felt they should be part of the School of Nursing. That was a separation that was not conducive for nursing, as I saw it.

DT: Do you know why that separation existed?

IM: In my more cynical moments back then, I used to think it was just because there was money for the nurse practitioner programs. Nurse practitioner programs should be in the School of Nursing, but they've got them over there, and they don't want to give up the money. That was probably all the thinking I did.

[chuckles]

DT: You mentioned that in your earlier education one thing you felt that you had not had so much of was public health nursing. So it sounds like even when you were a student...

IM: Yes, I wanted that.

DT: And there was still that separation.

IM: A separation that I did not think... It bothered me because that seems to me... I really think in home care and public health nursing, you really need a lot of education.

There, you're more apt to be alone without all the rich resources of physicians and other health care providers in the hospital. With my grant, how I operationalized that then...I always paid a dollar more to the nurses working in the home, because they had more responsibility.

[laughter]

DT: And along with that, the nurses working in rural areas, the rural nurses. There was a Rural Nursing Program at Minnesota, I believe.

IM: Yes, that was kind of near the end when I was there. I know they worked with Jean. I forget her name. It starts with K. [Kingen] She's still alive. But I didn't have much to do with that. She was instrumental in starting...like we have a nursing program up here. It's getting more and more baccalaureate-based now. She did a lot. She'd be a very interesting one for you to interview, if I can remember her last name.

DT: It's not Gene [Eugenia] Taylor, is it?

IM: No, not Gene Taylor.

DT: I've interviewed her.

IM: How is she doing? Okay?

DT: Yes, she's doing well.

IM: Great.

DT: She's spry! Very energetic.

[chuckles]

DT: With the reorganization, did you get a sense of how the other faculty in the School of Nursing felt about the reorganization and the new staff?

IM: I think everyone was happy with it. I think on the whole, it seemed like we were then more on our own two feet, that, really, nursing, now, was a school in its integrity. Of course, that, then, allowed us to go in with the Pharmacy [Department] and have the joint Densford-Weaver Building [Weaver-Densford Hall]. I think that would be one of the good things.

I, also, think we became more aware as faculty members of sabbaticals. Up until then, there weren't many sabbaticals. I felt like I was breaking the mould by going on a sabbatical. I remember...he was the vice chancellor of the Health Sciences, David something. I don't know why, I guess he must have lived in Stillwater or some thing, so I had him out to dinner one night. My husband was saying, "It's time to go on a

sabbatical. Aren't you eligible?" I remember asking David. I can't remember his last name. He said, "*Of course*, you can have sabbaticals."

[laughter]

IM: Nursing always has the trouble of who teaches your course when you go on sabbatical and all of that. I did go on sabbatical. That's, then, when I went to Taiwan and did this first study. I think sabbaticals are important for faculty to get away. That type of thing...I think, then, we were mainly too insulated. We didn't know of some of the benefits. I would say we really didn't know the benefits of being in the University. That's not too harsh, is it? [laughter]

DT: No, no. That's actually something that I haven't heard yet, so that's great information.

You mentioned that you obviously had interaction with the School of Public Health.

IM: Yes.

DT: How were relations then and how much interaction did the School of Nursing have with Medicine, Dentistry, and Pharmacy. Obviously, Pharmacy, you shared a building with.

IM: I think my only contact with Dentistry was when I would go get my teeth fixed. I think we all did that, so it was that kind of a clinical thing. Medicine... Well, for my first...not the faculty grant, but home care for the dying child, I had two physician consultants. Actually, I'd gone to John Kersey. He's a physician. I thought he could be a co-investigator with me. He said, "No, Ida. *This is nursing.*" He saw very definitely this was nursing. I said, "Well, then, would you be willing to be a consultant?" "Absolutely." So I had John Kersey and Mark Nesbit, two physicians, who were consultants on my grant.

Now, B.J. [Byrl James] Kennedy was also there, but he worked with adults. [chuckles] I know with some of the things I would do, Mark and John would watch out for me. I remember once, we met with B.J. Kennedy, so B.J. Kennedy could hear what I was doing. I think B.J. Kennedy was powerful, and I think they [John and Mark] did not want me to get involved in politics. I really appreciate that. I didn't really at that time know what was going on, but I was very happy to help B.J. Kennedy when I was going to do it.

[laughter]

DT: So you never had any problem with him [B.J. Kennedy]?

IM: No, I never had any problem with him.

My greatest problem was one pediatric oncologist. I had actually wonderful...there was a woman, too, that was so good, but one was just a hold back. He did *not* think it was right to have children die at home. Finally, almost at the end of the study, he made a referral, and it was a tough one, really a tough one, but I brought in just the most experienced, best nurse I could get. She did a beautiful job. So, at the site visit, he did speak positive of the study. But it wasn't always easy. The good thing that came out of that—he never let any of his patients go into the Home Care Project—it gave me kind of a natural comparison group. So I did use his patients to show how much the cost was for them dying in the hospital versus those that died at home under care. So out of that came some *good*, but, at the time, it was sort of a frustration for me that he wouldn't refer...

DT: What was his name?

IM: [pause] Oh, I've known it all these years? No, that could be the guy out in California. He wasn't a problem. What was it? It will come.

DT: You can tell me...

IM: Or when I read the transcript.

DT: Yes, exactly.

IM: You would like to know, huh? [laughter]

DT: Names are always welcome. [laughter]

IM: Both Nesbit and Kersey were just marvelous. Kersey was my neighbor, so that made communication so good. I could tell him... We usually would end up going in to work at the same time and coming home. That's how I kept him up to date on what was happening with the children.

DT: You came home and networked?

IM: Right.

I think moving the Academic Health Center was really important.

DT: Yes.

You mentioned about your work on the informed consent committee, the Human Subjects Research Committee.

IM: Yes.

DT: How did that come about?

IM: I was already in this field with death and dying before this Human Subjects came up. In fact, my first home care during the pilot stage, there was no Human Subjects Committee, and, here, I was going into the home. I would get permission just from the mother and the father, but it didn't go through any committee. So I had a real interest in that, that how will death, dying, and research be done through the Human Subjects Committee?

Laurie Glass... You know Laurie Glass?

DT: Yes, I do.

IM: She was my master's student, and I was trying to get her to study kind of the physiology of dying. I think by then we had the Human Subjects Committee. That was kind of difficult. We found this nursing home where the nuns said, "Yes, we can predict when a person is going to die. We know." She was going to go do temperature measurements to see what happened as a person was dying. It seemed to me from my work, from observation, that it was likely as they were nearing death—this was just observational work—that they would kind of reflect the temperature of the room they were in, sort of like the body was trying to lose its physiological ability to maintain the difference in... I thought that would be a good thing to study. So that was going to be her study. She did a measurement of two fingers and the toes and a chest measurement. Well, as she went in, it got to be that, in a year, we only had five who died. We began to realize probably her coming in and giving all this attention every four hours...

DT: Sure.

IM: You should talk to her sometime about that. [laughter]

Anyway, those were things that had to come up in the Human Subjects Committee. We couldn't go up to this older person in bed and say, "We want to study how you're dying," you know. So we did something like study what happens with bed rest upon your temperature. Laurie probably will remember this all better. I had that interest in Human Subjects. It was really difficult, because you wanted to be sure you could allow freedom for people to do research and, yet, be sure people knew and understood. Just at that time, all of this stuff was coming out, that they had done those syphilis studies.

DT: Sure.

IM: That was sort of a shock. Those were always... I would come back from those meetings in the Human Subjects Committee just worn out from all that was going on. It was certainly an interesting time.

DT: Do you recall who else was serving on that committee at that time?

IM: I don't remember now. I can almost see them, but I can't remember any of their names. I think I served maybe one or two years.

DT: What were those conversations like? Were there different factions and attitudes towards human subjects research?

IM: Oh, yes. People were doing research before. There were a lot of attitudes...why do we need this? We are not like these people who did the syphilis studies, and that was true. But it was federal guidelines and we had to develop them. It was kind of a fight, at times. We could get quite passionate. Yet, I think for the University of Minnesota, it was a start. I'm sure it's changed a lot since those days, but we did begin. It just seemed like a whole new thing was coming where every research had to go through. I know we would talk about chart review type of research. How much is this research? How much of this is evaluation? Shouldn't it be classified research? All of those issues. What about if you want to analyze some of the student papers? Do you have any permission from the students? There was a lot, just a tremendous amount of issues.

DT: Yes.

IM: But I found it kind of interesting. [chuckles]

DT: Did you get a sense, when you were going out and doing your research with patients, how patients felt about informed consent?

IM: They seemed kind of not to care. They weren't... [laughter] I suppose on the whole, none of them had probably been hurt by any studies. They kind of thought it was just a lot of paperwork, kind of the bureaucracy of a university. It was more that. Most of them didn't have much interest. What I found, also, interesting...how do you make it, then, so at least what you write is understandable? Because of their lack of concern, I think it made me realize, well, we have to be all the more careful then. There won't be that pick up as there should be. Now, I think, things have changed. I think people are a little more attuned to them, and, yet, know the importance of it. Actually, even today, with research studies with the Asian population, they don't want to sign their name. That's kind of a no-no. So what they usually do, then, is have a witness to a verbal okay. In some cultures, they just don't want to use their signature that way.

DT: Sure. I can imagine.

[chuckles]

DT: Can we talk about the home care for the dying child?

IM: Okay.

DT: If you could, tell me about how you got into that research.

IM: That's quite a story. When I was a doctoral student at the University of Illinois, my husband had a call and they said his father had been admitted to the hospital here in

Bemidji. He had cancer of the pancreas, so had come back up here to Bemidji, actually in a cabin right here at this place. We drove all night; they said we should hurry. As Paul and I entered the hospital in the morning, his father said to me, "I want to go home to die." Home was this cabin. We had running water, but it was just a very terribly little cabin. I thought, oh, my word! At the same time, it was his last request.

I went to the physician first and the physician said, "That's where I would want to be if I were him. Of course, I'll help you if you need pain medication. Whatever you need, let me know, and I'll be a support to you." The nurse decided he was too sick to go home, but in the family we had his sister who was a nurse who lives right across here. Two of the daughter-in-laws were nurses. It seemed to me we could handle it. But I wanted to be sure. It was the youngest son who...I finally got his permission that, yes. When the youngest son had gone to see him, he said, "When can I go home?" to him. Then he was willing. So we took him home. As we carried him into the cabin—my husband and his brother carried him in—he said, "Home sweet home." During those days, our little kids would go out and pick wildflowers and bring it to him and he would smile. He got to the point he couldn't swallow, but he would chew beets. He loved fresh red beets and he'd chew beets and spit it out. Then, he really was kind of in and out of a coma. Then, he went into a coma.

I did call in a public health nurse because this was all new to me. I had not been involved in home care before. She said, "It's not going to be long." So, then, I moved into the cabin and my husband came in with me. I got up at about two o'clock in the morning and he was alert. He had not been alert. Both of his arms, both extremities were ice cold and his legs. I felt something really happening. I had my husband run around and get everybody to his bedside. Everyone was around, and he said "Goodbye" to everyone. This is a powerful story. His mother [meaning Paul's mother] said, "Do you see Jesus?" He said, "Yes," and died. [whispered]

We had to go call for the funeral guy to come, but I said, "Well, let's go into the living room so we went into the living room. We talked for about two hours about his life. It was just a *wonderful* family...as we told stories from his childhood to his adult years. It was just a powerful family event.

So, that's the background, because that's important to know what happened.

John Kersey, one night, my next door neighbor, looked sad. I said, "John, what is wrong?" He said, "Ida, I have to admit Eric [Kulenkamp] to the hospital tomorrow, because he's going to die." Then, I thought of my father-in-law and I said, "Why admit a child if you know he's going to die? Why not let the child be at home?" John replied, "It's medical practice at this time that you admit dying children to the hospital, but, you know, home care would be a possibility. I'd be willing to look at that with you." I said, "Okay. Well, let's do a random clinical trial and see if home care will pay for children dying of cancer." Well, he gave my name to Eric's mother the next day. He calls me, I think it was on Friday and he said, "Both the mother and father are waiting for you to come to their home tomorrow morning." This was before the Human Subjects

[Committee]. Now, what do I do? What kind of random clinical trial will I have here? I'll just have to do a case study.

So, I went over there at ten o'clock the next morning. I thought I'll ask the mother to keep track of what I do that's good and what I do that's bad, and I'll do a recording of what I do and what I don't do, you know, so we could have a real detailed discussion of this. She agreed to keep notes on this. That was the first visit. I think I made maybe ten visits before he died. He died at home [on 21 November 1972. He was age ten years and thirteen days.]

Then, I wondered should I go to the funeral? I'm afraid if I went to the funeral, would it make the mother and the father think of this difficult thing they had done? But I went anyway. The sister, I think of the husband [and thus Eric's father] who came up to me and said, "Ida? Oh, you're Doctor Martinson. I was going to call you. I thought you were making my brother and sister-in-law do something that just shouldn't happen. Eric was too sick to be at home. But," she said, "I learned how meaningful it was to them." So she thanked me.

DT: Wow. [whispered]

IM: The family went ahead and wrote even a letter, unbeknownst to me, to the President of the University...

DT: Oh, my goodness.

IM: ...because it had changed... They had said since their child had been under treatment, they felt they had had no control, no say, and, now, with the child at home, they could do the things the child wanted. Quite a powerful experience, that was.

So I thought, then, maybe I should study this then. [laughter] I was going to study physiology of dying. The family said for my father-in-law what I had done most was get all the family members there. So I thought that's what we should study. So I got wrapped up in this, and, over the next few years, several faculty members and myself cared for eight children and I think five of them died at home.

Then, that was the basis, and I wrote a grant to the National Cancer Institute, which was ultimately funded. It was funded for three years, but I ended it up getting four years of funding. The first two years, it was done directly through the University of Minnesota as a research study out of the School of Nursing. The last two years, I worked through the Children's Hospital in Saint Paul and the Children's Hospital in Minneapolis. I knew when it was apparent that eighty-five percent of the children died at home that this, then, needed to become part of the health care delivery system. I began the home care programming at the University of Minnesota—they hadn't had any home care—in order for them to pick up the dying children. So we had these three sites in the third and fourth year of the study. Again, about eight-five percent died at home. So that was a powerful experience.

This first child's mother, Eric's mother, Emily Kulenkamp was her name... When I went to the nurses in the hospital, one of the nurses said, "*Any* child but Eric. Emily Kulenkamp, the mother, is too up tight. It will *never* work at home." I think it was sort of the right idea. I felt, well, let's find out why it won't work at home, so, again, that research attitude. I think if I hadn't had that research base...so everything became research. I didn't know. I thought maybe one out of ten children could die at home. I didn't know, so I was open. It was just fascinating. I didn't know if we could find nurses. That was our biggest challenge in this study: how do you find a nurse four hundred miles away from you who would take on twenty-four seven call, twenty-four hours a day, seven days a week call for this family? Yet, we always found a nurse. Sometimes, it was pretty scary. Sometimes, the child was almost home before we found the nurse.

[laughter]

DT: These were children who were from around the state?

IM: That's right. We took everyone. These hospice groups that just work with a limited geographical area, they don't have any problems.

[chuckles]

IM: We covered Minnesota, North Dakota, a little bit in South Dakota, and Wisconsin. So it was a tremendous...certainly full time.

DT: This was the families themselves choosing whether or not their child would go home to die?

IM: Yes. That was a new learning experience, because these physicians would call me and say... During the trial study, all the physicians made the referral to John Kersey, and he became the acting physician. So I just worked with John Kersey. With the grant, John Kersey said, "Other physicians can do it, too. It doesn't have to be just me." So with the grant coming, then I worked directly with the pediatric oncologist that was working. I think we ended up with twenty-seven different physicians we worked with. Of course, it was much harder every time you had a new physician, because they weren't used to this, having a child die at home. But it worked out. It worked out *way* better. I think they didn't realize that families needed... The nurse became on call, and, frequently, questions would come up that could be answered. Not always, home visits were needed. I think we ended up with maybe an average of ten visits per family in home, but maybe like thirty-two, thirty-five phone calls. I'd have to see the articles I've written to give you the right numbers on that now.

What I learned most deeply is the parents know their child. I'd go into the home and if they wanted a popsicle, I would have to find out, do they want a red one, a green one, a white one? What is their favorite flavor? Well, parents already know those things. They

just intuitively are just able to care for their child. At this point, it's to keep the child comfortable, to let them do what they want. It gets to be a very precious time.

I'll tell this one story... It's one I used to do when I would always talk, because I learned so much from it. It was an adolescent boy. He had had real difficult times with his parents. I think there had even been some drugs involved with this kid. But he did not want to stay in the hospital. He went home, and, even at home, would not let his mother help him much, until he fell in the bathroom. I was able to bring in the portable X-ray machine and he had two fractured hips. I thought, ah! two fractured hips. Any child with two fractured hips goes in the hospital. That was my nursing; that was me thinking. We bring in the orthopedic surgeon and the pediatric oncologist to the home. I had the funds. I said, "What will you do in the hospital? Will you operate?" The orthopedic surgeon said, "No. We would not operate." "Well, what would you do in the hospital?" "We would sandbag." "Can't we do that at home?" So the next thing I know is I get this phone call, and the child is *not* going to be admitted to the hospital. I think I woke up with night sweats that whole time. I think that child lived about six weeks. Every night, I'd wake up just in a panic over this child.

Well, we always interviewed the families a month later. I, then, would read these transcripts afterwards. I read this and, here, the day before that child died, the boy said to his mother, "I never used to like you, but I love you now."

DT: [sigh]

IM: I thought, wow. That hit between the eyes. See, what we were doing and what nursing was making possible here was a reestablishing of relationships in children and families. I mean, it didn't have to be establishing with *us*. The most important was for family, so it opened that *whole* marvelous thing. What a challenge. See? This is just like the greatest gift nursing can do is for the children and families to be united. That one still gives me chills.

DT: It's incredibly powerful.

IM: Very powerful. I think we have to realize that, that it's that family unit.

DT: I would imagine that giving the mother that, for her to have heard her son say that...

IM: Oh!

Then, we did interview all these families two years later, and even ten years later.

DT: Wow, so follow up.

IM: Yes. With that family, especially, it was very meaningful. I was so surprised. I had expected a lot more complaints about the heavy laundry, the on call, worrying. They said, "It's so much harder to come to the University and find parking and be away with

all your other responsibilities to be in the hospital.” Being at home just was *nothing* compared to the work that was involved, and I never realized that.

DT: Was there any way that you were able to assess how the kids themselves felt about it?

IM: [pause] We probably did some assessing of it. Like this one adolescent... It was more about the behaviors that they would do. The one had all these things brought to her, and she would give them away to her brothers and sisters, who were to have [them]. I don't think that would have been possible in the hospital. That just would be one of the things. They all wanted to go home if they were in the hospital. That was the one thing they wanted to do; they wanted to be home. There was only one boy who wanted to be in the hospital, and the reason for that is that his parents were divorced, and he felt the hospital ground was neutral. I always felt we had to keep the hospital available. We must always keep the hospital available.

With the child that was dying, we worked very hard on symptom management to be sure that pain was controlled and that they would sleep. We felt if they don't sleep at night, the parents would get exhausted. Our goal was always to keep the parents sleeping at night so they wouldn't get worn out. Actually, we just observed the child each time.

The father had carried Eric outside, propped him to a tree, as he was doing something in the yard, and he fell down. So he said, “I don't think I should have him outside again.” I worked with him that that would be okay. It didn't hurt him. Then, getting near the end, he said, “I carry Eric down to the breakfast table, but I see my hand prints on his body.”

DT: Mmmm [softly]

IM: That, I could reassure. I said, “That's okay. If he wants to be down, your handprints on his body aren't going to matter.” So there were a lot of these sorts of things. I think we worked a great deal with the parents, more than we did with the child, because this is something they hadn't done. They had a lot of fears. I always met with them separately besides when they were with the child to get at what they were concerned about. If they would have a symptom...like one was the upper leg was cold, cooler, they felt than the lower, I said, “You keep track of that. Now, if that whole leg gets cold or if you see any color change, then call me.” There was always this range. Then, I would always tell them, “What could be causing this coolness is that there are some blood cells that are clogged and right now is stopping the flow in the vein. It may well disappear. It may be gone, but it may get worse, and if it gets worse, call me.” I always gave the range of it totally disappearing to what would happen and, then, at what specific time they should call me. That was one of the things I called “limiting the uncertainty.” There were so many things that occurred during a dying process that if you could limit the uncertainty and be specific...you could take any of those. Dying, if it's a brain tumor, you can have any signs and symptoms that could come up, you know. It could be a hemorrhage. We had very few hemorrhaging. I said, “Have red towels. You don't want the child to keep seeing blood. You don't want to use white towels. If the child does hemorrhage, use red

towels.” I don’t think we really even had a single bad hemorrhage. These were the fears that parents would have. Whatever fears there were, we would try to limit when they should call us and when they shouldn’t.

DT: So, in addition to giving families more control, it also sounds like the child had more control, that they were making the decision whether to go home or whether to stay in the hospital. That must have been empowering for the child.

IM: I think so. The one most outspoken... This patient knew that there was this meeting down the hall. [laughter] It was a physician meeting with his parents. He had been bedridden, and he walked down the hall, opened up the door, and said, “When can I go home?” Well, we’d just been discussing him and the physician said, “The nurse in the hospital said he was too sick to go home.” But when he came and made this plea... I was told it wasn’t long, so we were able to get—can you believe it?—the President of University of Minnesota’s private plane...

DT: Oh, my goodness.

IM: ...and we flew him up to Fargo [North Dakota], I think it was or Grand Forks. I forget which. That was the only time we sent a nurse with. That night, the parents had all his friends in, and he died before morning. So it was one of those things. Yet, ten years later, this family was...”How did you ever manage that?” When I look back, I don’t know how we did either.

DT: That’s just incredible.

IM: It is incredible. It was just powerful. Every one of them was. We just could see that if our health care delivery system can be responsive, it can be a positive thing.

DT: Yes. This is now part of the health care delivery?

IM: Pediatric hospices have been pretty well established. I’m now called the Grandmother.

[laughter]

IM: I just got an award in March now from the Hospice Physicians and Nurses for my work. [2010 HPNA Leading the Way Award winner, Ida Martinson, in recognition of her work as a pioneering researcher in the areas of palliative care for the dying child, family care giving, and bereavement. She is lovingly known as the "Grandmother of Pediatric Palliative Care – from the *Journal of Hospice and Palliative Nurses Association*]

DT: That sounds very well deserved.

In doing the research and translation into a delivery health care model, did you have any interaction with state legislators in order to get state funding?

IM: My most interaction was with the insurance companies. At that time, I had a secretary whose husband was a lobbyist for Blue Cross Blue Shield, John Tracy Anderson. He has now died. He was with Blue Cross Blue Shield. So, he was *extremely* helpful in letting me know what type of data did we have to have. It gets down to how long were you on that phone with the family, all of the very nitty gritty. So we really had a very detailed analysis, all of this. Then, he also had me speak to claims adjustors. They had a yearly meeting and I went to that and I presented the project. Those claims adjustors were really interested. They all, basically, agreed to cover home care. This is where we're getting near the end of the grant, federal grants, and who then would cover it? They were really quite amazed at all the data we had on it. That was because of the husband of my secretary. [laughter] It was mainly the insurance companies. That was really what we were working on. The last child involved in the Home Care Project... As soon as they knew that the child was dying, she contacted her insurance company and, then, I think they contacted us. So, we were able to get the last child in the project funded. That was in the second year. Then, the third and fourth years, where we were going through these already institutions, we had that that they could go on and say, "This was funded by Blue Cross Blue Shield. This was funded by...so why can't you fund this?" That type of thing. We had documented again, even with an add-on, even if it looked like the kids were living longer—to me, it makes some sense—it was still far cheaper than the hospital. The three hospitals really didn't have a great deal of trouble getting insurance coverage for it without going to the legislature.

DT: That makes sense.

To me, this sounds a lot like health services research that you...

IM: That's what it would be called now.

DT: Right.

IM: Absolutely. This would be health services. We just didn't have health [services] research then.

DT: The health services research department or program...

IM: Wasn't even in existence.

DT: No, but it came in the late 1970s, early 1980s, I think.

IM: Yes, and see, I was funded... Let's see. I came to Minnesota in 1963. I was funded from 1976 to 1980. Then, I think health service came like in 1982, something like that.

DT: Yes.

You also were working very closely with pediatric oncology?

IM: Yes, absolutely.

DT: Were there any other practitioners that you were working closely with?

IM: When we were in the hospital, most of the time there would be like a social worker involved. That was fine but, once we took the child home two hundred and fifty miles away, there aren't social workers out there. Some of our families then, like after the child died, they might go back down to see the social worker. Actually, during this... We were in only an average of the last thirty days, and I don't think we had any visits by social workers. That was more because there weren't any in these home areas. We did allow physicians to make home visits. We had the funds to pay them.

There was one... I was always so grateful for it. This one physician, he made seventeen home visits. He was a psychiatrist. [laughter] On the whole, the physicians in the study really felt their role was one of consulting. The nurse would go in the home and call him up and, then, he would change the medication or would say, "The child needs more pain med." Then, he would order the prescription. When you're dealing with rural areas, they'd call the rural pharmacy and, normally, the nurse would go pick it up and bring it to the family.

DT: This is really dependent, as you say, on this infrastructure of public health and rural nursing that was already there.

IM: Yes. Many times, we couldn't find the public health nurse and we got people that I paid from my grant. I had the money. I paid them a couple, maybe it was two to five, hours extra because of the need to write this up and to be interviewed. I tried to be generous in that. Of course, back then, salaries were like ten dollars an hour.

[chuckles]

IM: So it wasn't a huge amount of money.

DT: You mentioned the one pediatric oncologist who was reluctant to refer or that didn't refer. Did you encounter any other resistance in getting this program up?

IM: Well, not really.

I do remember a Doctor [given name] Singer from Children's [Hospital, Minneapolis or Saint Paul?]. When our nurse went to see the child and the physician in the hospital, that child was on IV morphine. Okay? Our nurse at that time... We really had to be careful; we couldn't believe it. That child was sent home without pain medication. Can you believe what happened? The nurse had given the family the phone number but the nurse had to go for a PTA [Parent Teacher Association] meeting. The mother called the home

and, then, of course, nobody in the home told the mother. The next morning, this nurse went to the home and, of course, the mother was upset. That child was in pain all night. From then on, we, no matter what, any child would go home with pain medication. That was terrible for that child to suffer that night. I do think it wasn't just the nurse's responsibility. It was also the physician's. When I speak to physicians, I tell these stories. I say, "This is why it's so important to communicate between the two. Nurses have to be free to ask you and you need to be free to tell them. There's got to be good communication or the patient and family suffer." I've spoken to many physician groups and it's all right.

[laughter]

DT: It seems there's so much collaboration and communication and teamwork.

IM: There has to be, yes.

DT: It's interesting. The program, you started it, it sounds like, in 1976, and it seems to fill one of the themes for the Academic Health Center, why it was reorganized, to promote teamwork and disciplinarity and things like home care for the dying child.

IM: It really did.

DT: It really does that, manifests that.

IM: Yes, yes, I think it really did. I felt if we don't have good communication with physicians, it's the patient and their family that suffers; therefore, we've both got to work hard at this.

Then, to be realistic, we need physicians to be really good at diagnosing and the planning of the treatment, the care, and, then, these nurses need to be very good in carrying it out and knowing when to contact them.

Actually, the physicians in the study, many of them said... We interviewed all the physicians, too, the twenty-seven of them. Now, that really would be interesting. That's part of my data set that could go down to the University of Minnesota Archives. There's so much. When you think about it, even every phone call to the family that was made had been written down. I have to have a lot of data, I guess. Many of the physicians said they felt they knew more about this child at home than they did in the hospital because we did report in. We wanted to keep communication going. I had good relations with physicians.

DT: This is the material, the data that...?

IM: I think the physician stuff may be here. The Home Care for the Dying Child Project, Sigma Theta Tau, the nursing honor...they got the whole set of that. But what I've got down here, I've got a whole file full. [chuckles] One drawer is full of articles. I don't

know if they [the University Archives] would want all of them. Then, two drawers are full of data. I started to pull it out, and I thought, oh, dear, would they really want this?

DT: I'll take it. If there are transcripts and other information, this is the kind of... I can imagine a fantastic project by a doctoral student studying this.

IM: Oh, yes. You could make many different ways on it. What about the family, interfamily communication?

DT: Right, and not just for history students. There is so much fantastic material, I would imagine here that this... Well, I'm not the archivist.

[laughter]

DT: But from my perspective as an historian, this is absolutely wonderful.

IM: A lot of it is from the studies in Hong Kong and in Taiwan. But the main data set on home care for the dying child is down in Indianapolis, Indiana. Other than that, I've been tossing things away, so it's probably good you came now rather than later, because I have been thinking of emptying out that file.

[laughter]

DT: Let us take a look at it first. Well, we need someone to write about this history.

IM: I had so much fun.

DT: Did you have a role in distributing this form of health care delivery?

IM: I would say nationally. I think I've spoken in every state in the United States. That was one of my goals; I wanted to be sure at least someone in the state had... It was fun to hear people who, later... The one in Wisconsin said she heard me speak and she went home and did it, and she had me come and speak after the program was established. That was Mary Lohr who did it in Wisconsin. Then, I was down in I think it was Kentucky, and they had heard me speak. Then, I've been places where they wanted me to come and help them get started, you know.

Internationally, I first did the study in Taiwan. Let's see. Then, after Taiwan, I think I did the study in China when China heard about that. Now, for China, I've got the data. But they probably have more children dying unnecessarily from cancer than any other country in the world, just because there are so many people. In Taiwan, we got the Childhood Cancer Foundation going, and that was fine. In China, it just was too early for them. In South Korea, they also started a pediatric hospice after I did the study there. Then, in Hong Kong, I did the study there. They were doing some. I think I just gave them additional material that would help them. Then, I have spoken in Thailand, and like in Greece and so.

Of course, internationally, there are different problems. We had trouble. Let's just take pain. There were difficulties with pain management here, too. Some thought children didn't have pain, and, of course, there was pain. In overseas, like in Greece, I had the same talk with these two physicians. One wanted to just snow the patient, and the other wouldn't give anything. You know, there had to be a balance. That was very interesting that these two women... They were both women physicians and they both were outspoken, and here I was trying to say, "Well, that's too much," and "That's not enough!"...

[laughter]

IM: ...and still be polite, you know. I'd go back onto my stories and try to help them see that kids can be alert, but they can be free of pain, too.

DT: Why do you think it was too soon for China to adopt this model?

IM: I think they are just overwhelmed. Can you imagine? The head of the Cancer Center [Fuda Cancer Hospital] said to me in Guangzhou, which was the most advanced... Now, this is... Tiananmen [Square Massacre], when was that? Tiananmen was 1989?

DT: Yes, 1989.

IM: It was right before Tiananmen. So, it was 1988; I was there in 1988. He said, "Oh, there is no problem with families because they only have one child."

DT: Mmmm.

IM: Well, he was just totally wrong on that, and I publicly said that there was no problem in China. When I was starting the study, I had this group and three people came up, "Oh, that's not true." [whispered] "There's problems with money." [chuckles] So it was even, I think, kind of an unawareness of the money problems. We did write up the study, but then Tiananmen started. The key people from Taiwan with the Childhood Cancer, the top physicians and nurses and that, came to China with me to try to get them going, but China had said you had to have something like \$50,000 U.S. dollars to start a foundation. That just seemed overwhelming to the people, so we couldn't do it.

DT: It seems that culturally for China, how they deal with health care is that families play such an integral role of taking care of patients in the hospital.

IM: That's right. Also, think of it, even Confucius never talks about the stranger. So if they don't have what we have in the States and you help the stranger, the Good Samaritan story, they're missing that. They would do it for their family, but they wouldn't do it for a stranger. That really makes a difference in societal planning of this, you know, if you're concerned for a stranger.

DT: Yes, that's a really interesting point. That's the other side of the cultural story that is missing.

IM: Yes.

DT: That's fascinating.

Changing tack a little bit... I'd love to hear about your experience in trying to get a doctoral program started at Minnesota, because that was a very long effort from my understanding.

IM: Right. I felt to get a doctoral program going, you really need to have more research going. I'll tell you, even in the health sciences. it helped some, the home care for the dying child. Physicians could understand that. Other people in the University could understand that. They could see that, but it was hard for them to see what type of research. At this time when we were laying the groundwork for the doctoral program, I told the story of the child who had internal bleeding, that we really needed to know. I could get the responses of that and talk about that. I think they tend to think of nursing kind of as a mothering type of thing, without seeing that nursing is really complex. It should be nursing. If you get a sprain, do you put hot or cold on it? Which is the most effective? Well, we need to know that. I think the studies now are still kind of mixed. I think we need some *cellular* studies on what happens at the cellular level when you put hot and cold. I just see so much of nursing yet has to have a more solid science base to it than what they still have. You have to have a doctoral program to do that. So I was *very* much pushing for a doctoral program. [chuckles] In time, that's what we'll get. I do think we still need more of a science/biological base to nursing.

DT: It seemed that it was hard to convince the other health science faculty that there was legitimate nursing research to be done...

IM: Right.

DT: ...and that the School of Nursing had the ability to do that.

IM: Right. So we had to get our faculty doctorally prepared. Now, it's no problem, but it was a long haul. We had to get them doctorally prepared. Then, they had to get going on their research. When you get a doctoral program, well, then, you get doctoral students; otherwise, how else do you get your doctoral faculty? When you get enough doctoral programs going in nursing now, you don't have to hire all your own graduates. You can have that diversity. I found that really helpful in Hong Kong when I became head of the School of Nursing in Hong Kong there. I was recruited to do that near the end of my career. I really had felt that we need to have our nursing faculty get their doctorates at *many* different institutions so there's a richness. That's what you want is a climate where intellectual discussion is possible. You want that and you find that that's your stimulation for the day and that researchers would talk. [laughter] That type of climate isn't easy to establish.

DT: Yes, I'm sure.

When you began working for the doctoral program, do you recall how many of the Nursing School's faculty had doctorates?

IM: Oh, it was very few. I think it was maybe under five.

DT: There was [A.] Marilyn Sime. Isabel Harris.

IM: Yes. Ellen Egan. Then, we kept trying to get more doctorally prepared. Mitzi Duxbury, she was really good. She had energy. She worked, I think, with the March of Dimes. So, she was good. She was able to be assertive. Okay? She just wanted equality, and I know I wanted equality, too. I think sometimes nurses tend to think, well, we have to wait a while before we get equality, but I felt that in academia, we have to have equality. I think Mitzi and myself were two really assertive people in that time. We felt the School of Nursing had a right as well as they had. I know I spoke at the Institute of Medicine, the Academy of Science once on nursing needs a doctoral program, too. You guys should let us have it. We let you have it. [laughter] You've got one; we need one, too. But it took a while. It wasn't only the health sciences. It was parts of the University, too. It was not understanding nursing or really the need for the scientific base.

DT: Did you find any resistance among nurses or nursing faculty?

IM: Oh, yes. Some felt that nursing was getting too far away from the bedside, away from the clinical. I always would argue that, because I said, "Just look at this..."

[break in the interview]

IM: ...how much more clinical can it be, and look what it led to and that. So, with nurses, I had an easier time to convince, but, they were too afraid that nursing would get too theoretical and not clinical enough. Today, I'm really delighted that the U of M is now starting another clinical doctorate, so that you have your Ph.D. research where it can study cellular level or whatever level they want, integration level. Then, you can have the clinical, which is taking some of our clinical problems.

DT: How about discussion in the 1970s about whether it should be research based or clinical?

IM: Oh, I think so. I think we did. I think there are much more sophisticated arguments than what we were way back then, you know.

DT: Did you find that you had the support of other nursing schools and hospitals in the state?

IM: I think so. I was director of research at the time. We'd have, those of us who were wanting doctoral programs or were trying to become research established, our meetings once a year. It would always be, "Are you sure the University of Minnesota is ready?" I said, "Well, we have to keep moving. If we don't, we never will be ready." I think on the whole, they were supportive, but they were concerned that nursing would get too many doctoral programs and not have enough doctorate prepared faculty. I don't think that really happened. The greatest difficulty is getting the time and researchers or time and the funds for research at the university schools of nursing. It's a whole mindset that has to change, because, on the whole, nursing faculty tend to be so very busy. They're really marvelous to students. They spend all their time with students and teaching, so how do you have time for research? When you do research, honestly, your research has to come first or it never will get any place. Then, you still have to teach and you still have to be nice to students. You do your research first, and, then, you do your teaching along with it. You've got to change it, and that's hard for some nursing faculty members. It was hard. I think, now, it's changed, but it was hard to get that change.

DT: It goes back to your earlier point about the reorganization and that it helped nursing realize that the things that it deserved and what it was to be an academic institution.

IM: That's right.

DT: This is another example of that, it seems.

IM: Yes. Research is part of an academic... You *have* to do research. [laughter]

DT: But it does sound like that you had that challenge of getting enough doctorally prepared faculty while having enough there to do the teaching and while having enough nurses staying in clinical practice.

IM: Clinical, yes. It's always a tension. We keep needing more and more nurses, because nurses are very capable people in many different arenas. I think the strength of nursing...you have this biological science background and, then, you've also got the psycho and the social and all of that, so that they can fit into many ways in the health care delivery system.

DT: Yes. There was the nurse practitioner movement in the 1960s and 1970s, too, and that's another kind of advanced training.

IM: Right.

DT: How were those conversations taking place at the school?

IM: I just felt they should be *in* the School of Nursing, because they were, at the time, in the School of Public Health. I think that was *not* healthy for nursing. In my own mindset, I've always felt the beginning nurse should be a nurse practitioner. That's the type of education and preparation you need because today's people are sicker. They're

much more highly educated. It's really complex diseases we're dealing with. The bedside nurse needs to be a nurse practitioner. I still feel that way.

DT: Yes.

IM: We're a ways away. There are more and more movements, but we do need master's level people at the clinical bedside. Absolutely, we do, but it will be a while yet.

DT: It seems that your position as director of research was integral to getting the doctoral program, because you were there to show people that, as you've already said, this is what nursing research is. This is why it's valuable. This is what it looks like when it's done. Do you see yourself as having had an integral role, at the time?

IM: The three things most important to the doctoral program probably were getting the research going and, then, that has to be ongoing and that whole attitude on change. I think I helped there. I think...oh! what is her name? [Dr. Barbara Redman] She was the one, I think, who really kept pushing it. I think I also helped with those conferences we had on doctoral education in nursing, and, then, I was the one who wrote the grant. I think it went under the dean's name, but I did that whole write up of what got the \$300,000 to sponsor these things that led to the doctoral program. I wouldn't say I was the key by *any* means, but I think it might have been harder if I hadn't been there. I think my study, also, was useful to use at that time. It takes a lot of people. It was everyone working for it. The more united we were, the easier it was. That's where Mitzi Duxbury was great.

DT: I'll look through my notes and figure that out.

IM: There are two missing names to me.

I think I helped it along. I didn't dare leave. I did *not* leave. I did not dare leave until I heard that we could have the doctoral program. Then, I felt safe to go. I'd really put in a lot of behind the scenes... Mitzi and I worked behind the scenes that no one knew about. We would certainly wine and dine these other guys.

[laughter]

IM: You know, there's a *lot* of stuff that went on there. I know when we finally heard, then, I felt that it was all right for me to go.

DT: So you were wine and dining other...

IM: Other people, yes. No one in the School of Nursing would ever know that. That's what I learned from Mitzi. I had to learn that from Mitzi. Mitzi was the one who knew you had to work behind the scenes to get things.

DT: So, John Kersey, for example, whom you had such a positive experience with...

IM: He would have been supportive.

DT: Yes. So the people who had seen your program...

IM: They were *very* supportive, yes, and Dean [Neal] Gault. I remember Dean Gault—he was academic health science—said to me, “Ida, just think. If we, as physicians, would have encouraged nurses thirty years ago to get their doctorates in physiology and anatomy...” He saw that I had come through that program. He kind of wished that he had been part of encouraging nurses to get their doctorates sooner. Up until then, nurses just got their doctorates in education. It was the only field that would take them. That was insightful of Dean Gault.

DT: Yes.

IM: I always remember that. Mead Cavert, I think, felt the same.

DT: Did you have much interaction with Lyle French.

IM: Oh, Lyle French... No, not as much. The guy who worked with Lyle was this David.

DT: Dave Preston?

IM: Yes! That’s it. Dave Preston. I enjoyed him. I could be very free with him. I can remember that night at our table. He was just kind of shocked that I didn’t think I was eligible for a sabbatical. They were, also, the ones who internally said, “Go for your professorship.” Nursing tended, always, to...no, you’re not ready yet and all of this. I did get my professorship before I left Minnesota, but that was *not* from encouragement in Nursing but from outside of Nursing.

[laughter]

DT: So even the deans in the School of Nursing didn’t...

IM: They were a little bit more conservative, you know. Irene Ramey, I was real close to. She was really close, a wonderful gal. She died of cancer. She wanted me to come with my husband to her home one night. That was very interesting. She said, “Your husband can’t talk about the church.” She was formerly Lutheran. So he talked about Buddhism and Taoism and all these sorts of things. Then, she turned on and we watched the whole two-hour funeral of Hubert Humphrey. The next Monday, she called me down and thanked me for what we had done. Irene Ramey, I was very close to.

Isabel Harris... I think I used to cause her a few headaches. She knew me as an undergraduate student, but she was good to me, too. Yes.

[Ellen] Fahy was fine. She was the one why I left Minnesota. [laughter] Not from any...it was just that she took away my secretary! I was serving on the National Institute on Aging [National] Advisory [Committee]. I was the first nurse ever to be appointed to the NIA National Advisory Committee. I had several different roles in national and international. Because of budget cutbacks, she cut away. The day I got the notice from her that I no longer have a secretary was the same day I got this phone call from the University of California-San Francisco that said would I come look to be department chair?

[laughter]

IM: If I had not lost my secretary, chances are I would have said, "No," to be honest. Oh, this is recording this.

[chuckles]

IM: Actually, to be honest, it was a very good move that I did, so I have to be grateful for Ellen Fahy for sending me that note.

[laughter]

DT: I can imagine with all the things that you were juggling and managing that the loss of secretarial support was not insignificant.

IM: Oh, it was not insignificant. I thought how can I do all this? It wasn't a cut in half; it was gone. I thought how do I manage this? I went out there and one of my first questions was, "Do I have a secretary?" I still remember that.

[laughter]

DT: Chances are a physician in your position would have had a secretary.

IM: Of course. Of course, he would get a secretary.

[laughter]

DT: That's funny.

The School of Nursing...the funding was being reduced at that time, then?

IM: That, I don't remember even. I just know that my secretary was cut, and that was what kind of stimulated my being serious about looking. I think, looking back, probably the funding was very good. We had a lot of state funding.

DT: I think around that time, well, in the late 1970s, President [Jimmy] Carter was vetoing the Nurse Training Act. That was going to cut away an enormous amount of federal funding from the U.

IM: That could be, yes. I left in 1982. I went to the University of California-San Francisco.

DT: Going back to the early 1970s...

IM: Okay.

DT: In 1972, when you first arrived as faculty, the School had just developed a Nurse Midwifery Program.

IM: That was after, I think.

DT: Oh, it was after. Do you remember anything about this?

IM: Oh, yes. It seemed to me that was really important, and I was all for it. I think Sharon Rising was the first Nurse Midwifery person. I was really glad that she came. I was very much for that. I know I learned from the Nurse Midwifery Program at Minnesota when I got to San Francisco, because, there, we were just kind of getting our nurse midwifery program at the master's level, and I was very grateful for the fact that Sharon Rising I knew and Minnesota people I knew were doing that.

DT: Do you know what the impetus was for developing the program?

IM: No, I don't.

DT: Do you have a sense of how physicians and nurses felt about the development of the program?

IM: I know I was thrilled about it. I think, on the whole, we were pleased. I don't think physicians were really opposed to it. But, I've got to be careful, because in San Francisco, the physicians came over to see me and said, "You've got to have this." [laughter] So, you know, I'm trying to keep track. Sharon Rising...see, that was early.

DT: I think I've seen some material in the archives. Now, I can't remember who it was, but a couple of letters were exchanged between various physicians. Maybe it was even Ed Ciriacy who may have been one of the ones in Family Practice. Someone was resistant. You shouldn't have midwives. This is what obstetricians should be doing or this is what private practitioners do.

IM: Yes, outside. Yes, that was him, but I did not go along with that.

DT: Also, early, in that 1970s period, there was the establishment of the program in human sexuality. Did you have any experience with that?

IM: Yes, yes. We had to go. It was so interesting. My husband was at Luther Sem, and all the seminary professors had to attend that weekend, the human sexuality. So, I was attending, too, because this was a new thing. I think it's right at that that I met John Kersey. I knew John Kersey was my neighbor, but I think it was at that that I got to know him even better. [laughter] I think we were just sitting in the same row as he. Yes, we did attend that.

DT: What happened that weekend?

IM: Well, my husband had a rough time. He got so mad there.

DT: [chuckles]

IM: My group wasn't like his. I didn't have the pressure to conform. I don't know, maybe I just [unclear] different. But, he had a group where they were going around and everybody had to do a swear word. This one gal just couldn't do it. They were just forcing her. He, finally, spoke up in defense of her, that that's no way...that she shouldn't have to say that she didn't want to. Anyway, they called and they were really concerned about him, thinking that he was rigid. I was really laughing about this. For me, I had a different response to the weekend. I had no trouble with it. I found it helpful, because I had always wondered about people who were paralyzed from the waist down, what type of sexual satisfaction they could have. There were very explicit films and in talking about it, I found, as a nurse, that I could give better advice and counseling from that. So I was just in a different group. When anybody asks, I think of my husband's response. That was really something. they said they'd been up all night worrying about him.

[laughter]

IM: He's fine. For me, I found it useful.

DT: My understanding of the program it was in order to help health care providers, social workers, counselors, any religious counselors to better help the people who were coming to them for counseling or to help their patients. So it sounds like for you, that definitely...

IM: Yes, it was fine for me. Yes.

DT: Did you have a sense of what the impetus was behind the program?

IM: No, I don't know what that was. It was so interesting. He's at a seminary, a different institution, and I was at the University, and we both had to go.

DT: One of things I've been curious about the program is I think it was the American Lutheran society [Synod] who were very supportive of the program.

IM: Yes.

DT: Yes.

IM: Well, if the funding came from them...

DT: I think some of it was.

IM: Ohhh.

DT: I think at least some of it did in the early days. There's a lot of correspondence between the Lutheran society and the program folks saying this is a very good thing. I've been curious why the Lutheran society was so supportive of it. What was their thinking?

IM: What was going on? My husband came from the sem, so, yes, he was required to go.

DT: But he didn't know why?

IM: No. No. No.

DT: Interesting. I know that, later in the 1970s, the program got a lot of public attention because a couple of Regents were really opposed to the program. But you don't recall any of that?

IM: No.

DT: That was in several [*Minneapolis Star Tribune*...

IM: Articles?

DT: Yes.

IM: It was quite blatant. For me, it was helpful as a nurse and I wasn't a shock, but probably people would be shocked [laughter].

DT: From what I've read about the weekend seminar...

IM: If you did get into a group... See, my group person was much more laid back and didn't try to force. I think my husband just got into the wrong group. I think it was fine that he defended her. I think that was probably appropriate.

DT: So within your groups, what were you discussing?

IM: I don't know what I shared, but, it seems to me, people were sharing from their own experiences and their own things that they'd had clinically. I don't think I had a lot to share, because I was pretty young at that time. I hadn't done my research yet. It was before home care for the dying child project began. After that study, I could have shared some things, because it was for many families difficult for sexual relations to occur if the child was dying and after. That came later. I don't remember sharing much at all.

DT: It's exciting to, finally, meet someone who participated in the program.

IM: Yes.

DT: That's neat.

I really am curious... You had said that with your master's in nursing administration, you'd taken labor relations courses.

IM: Yes.

DT: It looked like there were efforts to establish the health sciences bargaining unit in 1973, to have a single bargaining unit rather than in all the health science units. Do you have any recollection of that?

IM: No, I don't think I could have been on that. No, I don't remember. Was that for faculty to get...?

DT: Yes.

IM: Oh, yes. I do remember a little. I think my stand was that we're professionals and don't need it, don't need a bargaining unit or something. I think I was probably in that camp, but I did not become active in that much.

DT: In the archives, again, I saw some correspondence from other nursing faculty who were claiming nurses shouldn't be with the health sciences, because you don't have private practice, so you're not like the other health sciences. You're much more like the rest of the University in that some of the nurses wanted to be in a bargaining unit with the rest of the University.

IM: Oh, I see. Oh. Oh. Okay. That would be. See, some of us felt... I would have felt, even at that time, well, sure, we don't have private practice now, but, maybe, some day, we will. That's what happened at the University of California before I retired. We did have opportunity for private practice, so what that means is when you get a grant and you get part of your salary on that grant, that can go over almost like private practice, which, ultimately, then, leads... Well, all it means is that when you retire, you have a bigger salary.

[laughter]

IM: That just occurred at the end so that my time in Hong Kong. When I was head of the school over there, the last two years, I was able not to take any money. I just sent it back to UC-SF and that went straight into my retirement fund, so, now, every month when I get my check, I get extra money because of that time in Hong Kong.

DT: Right.

IM: At that time, though, I would have even been for that. We don't have private practice now, but, someday, it should be equality.

DT: It's almost like we should be part of that unit.

IM: Yes.

DT: We should argue for what's good for private practice, because that will be here soon enough.

IM: Right.

DT: What happened with the building of Unit F?

IM: Oh! [laughter]

DT: You said there were three or four things you were involved in that were important.

IM: Oh, yes, I ended up with a great deal of time on that. That's, again, where David Preston and some of my contacts outside of the School of Nursing helped. I learned, for example, that if I would go for a lab in Building F, a nursing lab, there would, then, be funds to cover that lab, but if we didn't have labs, we wouldn't get it. We'd just get the building. See? I thought, well, why can't we have labs? This was in my mind constantly. So I did set up that that could be an animal lab, and we got two rooms. I'm telling you, we got even flasks. The whole thing was equipped, totally covered, and it was nursing. I pushed them. They had a little harder time with it, but I think they funded most of that. Like, I wanted a hyperbaric chamber, but it was for people to study hot flashes. They could control the temperature of the setting and marking. I was able to get that included. I mean, it was just some far off things. [chuckles] But I learned in building buildings, those things, all of that, basic science equipment is included! Well, if we just go in for our rooms with desks and tables, they probably won't give us the desk and tables. As a matter of fact, like exhaust hoods would be covered. Well, you know, all of that is expensive stuff. I just felt we had to have our share. [chuckles] So some of it was my desire for my commitment that we'd get some of these things.

DT: It sounds like it was from talking with Dave Preston and others.

IM: Outside of nursing.

DT: So, they were saying, “You need to ask for these things. You deserve these things.”

IM: Yes. “You can have these things if you can justify what they’re for.”

DT: Without those communications, you wouldn’t have gotten them?

IM: I would not have known. Again, Mitzi Duxbury was very powerful. She said, “You’ve just got to know this University that we’re in. We’re not always taking advantage of the University.” That was a real good insight.

DT: It seems that the arguments for research, for lab space, tied in with the doctoral work program.

IM: Right.

DT: You can’t have a doctoral program without research space.

IM: There is an article written by Karen Brand and myself about the building, about the research center. That would give you some of the details of that.

DT: Oh, good.

IM: Then, there’s something else about the equipment that was needed, and all of that came from working on Building F. Looking back now, I should have even thought of more, but, at the time, I was *maxing* out. [laughter]

DT: Yes, I’m sure.

It seems that there was some trouble getting the building built, because the state legislators, suddenly, stepped back and said, “We don’t want to fund this anymore.”

IM: Yes. I remember a little bit about that, but I didn’t seem to be involved. My biggest energy was spent on getting the research space in there and making sure that we had lab space and that. So I don’t remember that fight. Then, I, also, was somewhat involved in the naming of it, for Katherine [Densford] Dreves and [Lawrence] Weaver, who I knew. [chuckles]

DT: It seemed like Dean Ramey and President [C. Peter] Magrath did a lot of legislative and fundraising work to get the building built, because there were a few senators... Senator John Milton was arguing that the University health sciences already had all these big buildings. The University was large enough. There wasn’t a shortage of pharmacists. I think there was even some question about how much of a shortage of nurses there was. It was like time to turn of the tap, basically.

IM: Yes. Yes. Irene Ramey was a fighter. I learned from her, too. She wouldn't let anybody put her down.

[laughter]

IM: I really felt I worked under good deans.

DT: In the 1970s, there was a lot of emphasis on regional planning and ensuring that there was a sufficient nursing workforce for the region.

IM: I do remember somewhat of that, but I don't remember enough details about it. I know we worried about northern Minnesota, the Duluth area, and this area. This north/northwest area was pretty neglected. But, now, we have something in Crookston and in Bemidji here, so those were kind of the two responses. Before that, I don't think we had anything there. Also, it was Rochester. I don't know what that was. Now, I think we've got part of a U of M campus down there, don't we?

DT: That's right, just health sciences, I think.

IM: Yes. There was concern over that part of Minnesota, too. With Rochester there, there's marvelous resources.

DT: It seems like there were a few organizations involved. I haven't entirely figured out what these organizations were, so if you know them, you can maybe shed some light. One was the Committee on Institutional Cooperation.

IM: That wasn't the Big Ten?

DT: Yes, that's the Big Ten [Universities of Illinois-Urbana/Champaign, Indiana, Iowa, Michigan, Michigan State, Minnesota, Northwestern, Ohio, Purdue, and Wisconsin-Madison]

IM: Oh! Yes! Oh, yes, I was involved in that one. We started through that our Midwest Nursing. Is that down there anyplace?

DT: No, the Midwest...?

IM: Midwest Nursing Research Group. That's still ongoing today. It started out with the Big Ten. We were starting to get together as nurses. It was, again, this whole movement of starting of research in nursing. Actually, Minnesota, I think, this last year hosted it, the Midwest Alliance for Nursing or something, and there was one out in the western area, and there was one out east. I know I spoke at both of the others. I know I was involved in some of the committees on that. So, yes, it was the ten universities here in the Midwest. We got together as a nursing group from that, but, also, these universities got together. I don't know too much about the other. I do know more about the nursing.

DT: That committee was committed to ensuring sufficient nursing...?

IM: We were more concerned about the academics.

DT: And the research?

IM: Yes, and the research.

DT: Did you feel that the committee played any role in furthering research at the school?

IM: Oh, I think so. This was where people could present their papers, where they could meet other people in the research area, who were in the same potential research area. No, I think it was very good. You've got to get that collegueship outside of your own institution as well in research, and I think that Midwest [Nursing] helped a great deal.

DT: Yes, it's sharing the validity of nursing research that's beyond...

IM: Beyond your own institution.

DT: Yes. These other Big Ten schools of nursing were trying to build research there, too?

IM: Yes, and some of them were farther ahead. I think Michigan was farther ahead than we were. Probably Illinois was, too. We sort of felt we were trying to catch up.

[chuckles]

DT: Yet, so much in the Minnesota School of Nursing was the first.

IM: Yes.

DT: Do you remember the Agassiz Regional Nursing Education Consortium?

IM: Well, this is this northern thing.

DT: Oh.

IM: That's where Jean... [Kingen] We've got to get Jean's last name. Ohhh! She would be the good one to talk about that. Yes. I can see her. She lives at 1666 Coffman [Street, Saint Paul, Minnesota]. Ohhh, why can't I get her last name?

DT: I should be able to find her name.

IM: Yes. Yes.

DT: So that was ensuring that nursing schools or nursing education centers were built in northern Minnesota?

IM: Yes.

DT: Then, the Area Health Education Center?

IM: [pause] Area Health. [whispered] I've heard it, but I don't know. I think the only involvement I had was that I once mailed out to 3,000 nurses a questionnaire. I was trying to get at what they thought about home care for the dying children or dying adults. I think I had some contact with that, but I don't know any more than that.

What's the next one?

DT: The other one is Health Educational Welfare, WICHEN. I don't think I was ever clear what W-I-C-H-E-N...

IM: I don't know that.

DT: That was a national thing. I didn't know what the acronym stood for. [chuckles]

IM: Okay.

DT: I think from the late 1970s, the School of Nursing, or it seems that the entire health sciences, were trying to do long range planning in each of the schools. The School of Nursing was involved in that. Were you involved at all in that?

IM: I was mainly involved with the doctoral program and research. Those would be the two.

DT: I think so much of it is, obviously, related. It seems like so much of the School of Nursing's long range planning was tied to we're going to be doing this research. We're going to be this...

IM: Right, right. That way, I...but I don't remember being on any specific committee. Oh, I know we really worried about getting the doctoral program through. That was a real worry.

DT: I remember seeing that, in terms of the school's long range planning, some in Central Administration believed that the School of Nursing had a lack of realism about what the School of Nursing could achieve.

IM: Yes. Yes. And you'd get so mad at that, you know. Let us achieve. We knew. Part of it was, I felt, that we were women. I shouldn't use that as an excuse, but, that was, I know, at times, my feeling. I'd kind of upset over that. Give us a chance. We'll show you. [chuckles]

DT: You do remember that feeling?

IM: Oh, yes, yes. It was scary. We didn't know if we'd get it or not, but we were determined. I suppose *they* thought they could stop it. That's probably why they thought we were unrealistic. We *had* to be optimistic and keep going for it. We couldn't buy into this when we knew long range, we had to be here or the school would always be second rate.

DT: Yes.

You were involved in developing the Block Nurse Program?

IM: Oh, yes. Ohhh, yes! Ohhh, that's quite a story. Remember, I'd done this home care, now. That was already under, so I was quite sold on home care.

Well, my mother-in-law called me. She said, "You've got to come with me. We've got to go see this woman." She was eighty-eight years old, I think. She had been taken to the hospital and they said, "It's an inoperable aneurism." They sewed her up and sent her home to a ninety-year-old husband and those two were in their home. I made this home visit. I gave her a bath. I talked to her, and I worked to get a nurse to come in. That experience was in my mind.

So, then, Thelma Schorr, who was the editor of *The American Journal of Nursing*, came for... This must have been the NLN [National League for Nursing] convention, and I was on a panel. She knew my work was with the children. She said, "You know, Ida, if you could design the health care system, what would you do for the elderly?" I said, "Well, I'd have the block nurse system." I told the story of this... I said, "We should have nurses who are looking after their neighbor, *their neighbors*, how cost effective it would be. They could do it fifteen minutes before they go to the hospital in the morning. They could do it wherever they worked. It wouldn't take them long. Just think, you'd have that care right there." That was one thing that happened.

Then, I was invited—I guess maybe I was a Republican at that time—to a National Institute in Aging, and they were having this national aging conference in Washington, D.C. I went to it. Then, when I came back, I was interviewed by the Saint Anthony Park newspaper. Again, I said, "We need this block nurse." I'd said it once and it sounded right. "We need this block nurse." This newspaper reporter, she said, "Well, how many do we need?" I said, "This is a guess now, but in Saint Anthony Park, we could use three or four." Anyway, when this hit the newspaper, I got a telephone call from Jane Prest Berg. She said, "I have my baccalaureate in nursing. I'm home with my little baby. I volunteer to be your first block nurse." So, I thought, wow!

I was having a meeting in Chicago. I think it was this Midwest Nursing. It was a Friday night or Saturday coming home. I was by the window, and there was an empty seat, and, here, is this man sitting on the aisle. We got onto the runway in Chicago and the plane

wouldn't move. It had to be de-iced and we were hours on that plane. Finally, I started talking to this guy. I said, "Where do you work?" He said, "Fuller." [H.B. Fuller Company] I was excited. I said, "Fuller!" That was the only business that I had identified that lived in Saint Anthony Park. I said, "I need funding for block nursing."

DT: [chuckles]

IM: See, Jean Prest Berg, now, had just finished a couple days before I went to Chicago offering, but I wanted to pay her. So I told him this whole story. I can remember, he looked at me so stern and he said, "I don't believe it. I just got out of a meeting in which we decided to set aside some funds." When he heard that Elmer [L] Andersen, who was the owner of Fuller, went to the same church [as I], he said, "You talk to him." I got home and Sunday. I went to church, and here was Elmer Andersen sitting two rows ahead of me. I go up to him. I mean, I couldn't get out of this Block Nurse Program. There was no way I could forget about it. Here, he was. I went up and told him, and he said, "You need to talk to this man." Well, by Friday that week, I had a meeting. I had coffee with that man. The next thing was if I could get a proposal to him by nine o'clock Saturday morning, the next day, there would be a potential for funding. So I wrote the proposal. My husband, I woke him up at three o'clock in the morning to type it. My husband typed the first proposal for the Block Nurse Program. We made it there and we were funded.

DT: Oh, my goodness.

IM: [laughter] I mean, it was crazy.

Then, I knew I was going to the University of California. I had accepted that call and what was going to happen? Before I left, we even got the first patient in the Block Nurse Program. Then, I looked around. Who could take my over? Who had that spirit? I came across Marge [Marjorie] Jamieson. She had been a missionary. You kind of have to have the right spirit, you know. You have to be willing to work more than eight hours a day. I talked to Marge. I would come back almost every other weekend, and we would have Block Nurse Program meetings. *Finally*, my husband said, "Ida, you're gone all week. You've got to have some time. You've got to not spend all your Saturdays on the Block Nurse Program." So I, finally, resigned. Of course, that's history. Marge took over, and did a great job with the Block Nurse Program. But it really was my idea, and it was my baby for that two years.

DT: Wow, that's incredible.

IM: But I am willing to let go. I don't need to hang on.

[laughter]

DT: Especially when you're on the other side of the country.

IM: Yes, you just have to. I think I'm the developer. Then, I probably get bored.

DT: Another thing you set up was the Nursing Exchange Program with China. Is that right?

IM: Well, I encouraged that. I didn't set it up so much as speak to the need for a nursing exchange program. That really developed, then, more after I left, but it certainly was the work in China. Now, of course, you know I met the dean [Connie White Delaney]... She, now, knows about our work in China. I might be in Zhengzhou at one of the Chinese universities in January, February, and March, and she'll probably come over during that time. I think it would be very good to have a tie-in with the University of Minnesota.

DT: Yes. How would you see such an exchange program?

IM: For them, for different students, depending on if they're wanting to look at cultural issues, certainly coming to China would be a good place. Zhengzhou is in the capital city of Henan province. They've got very, very bright students. I think one of their potential doctoral faculty should come here and get their doctorate degree. I think that would be a nice one to have. I want one to go to Hong Kong, too...my idea of different places to get their doctorate for the development of this doctoral program in Zhengzhou. Again, the development of the doctoral program in Zhengzhou is probably ten years away, but you've got to start planning. That's why they want me to come, to help them get ready for that. I see at the University of Minnesota that would be one way that they could have one of their doctoral students from Zhengzhou come here. I think any of the faculty who is interested in cultural issues with the Chinese, this would be a nice way to go over and exchange with them. Besides going over there, we are working two hours away in a very poor rural area in China, so for that rural health care need... That's really there without really any health care at all. I'll give you a couple articles to show that work.

DT: Yes.

IM: I'm now on the Board of Directors for the China Service Ventures. That will give you some idea. I just think the world is getting smaller. [chuckles] I think it could be very interesting for both the University of Minnesota and the Zhengzhou University. There were three Zhengzhou University members that came here and did spend time at the U of M and met the dean.

DT: The connection to China, you encouraged it. Is it because of yours and your husband's connection and experience in China? That's why China is the other end of the exchange?

IM: [laughter] Well, we had contacts in China, and Paul's grandfather moved there in 1902 and this is the area of China we know, so we have that contact. But I think the University of Minnesota had contacts with lots of universities around the country. I just don't think they had one really solid in China's rural area. I think China is an important

nation. We have so many ties with China because about twenty years ago, we helped start the Hospitality Center for Chinese. The University of Minnesota has approximately 3,000 scholars who come from China to the University of Minnesota. The largest number of students come here than any other university in the country.

DT: Really?

IM: So we started, about twenty years ago, the hospitality center for the Chinese. Now, the China Service Ventures and the Hospitality Center have a joint building on the Saint Paul Campus. My husband has always been interested in China and what can we do to have more Americans understand China. I can't take the credit for what Minnesota does with China, but I've been there. You know, when I was here before I left in 1982, I was trying to get some things going in China.

DT: I didn't realize the University had such a connection with China. Do you know why more students come here?

IM: Probably agricultural and, also, I think for our friendliness. People in Minnesota really love China. It's interesting. Going way back now into the early 1900s, many of our missionaries to China were from northern Minnesota. It's fascinating reading of their lives. I think that's historical, and I don't think we had like the East Coast McCarthyism, the fear of Communism. I think we didn't quite buy into the evilness. Minnesotans didn't like Communism, but I don't think we had this fear, so there's not been a rejection of China at all here.

DT: That's really interesting. That's fascinating. I want to look a bit more into it.

IM: It's just me. [chuckles]

DT: You've already talked a little bit being recruited to UC-SF and more about why you decided to leave. How did that go about? It makes sense to me why you were recruited, but, maybe, you could explain what they were thinking.

IM: Sure. They wanted me to head up family health care nursing. It's very interesting. The person who they were going to have was a faculty member, and she died in a fire in her home, so there's this the whole bereavement thing, and, then, here I come. I think, probably, in some background in their minds made it that I might be a good department chair for them, because I had somewhat of an understanding of bereavement. They could see how I could fit into a department who had suffered this. She opened up a closet door instead of the outside door and, then, smoke inhalation and she died. Eugenia Waechter was her name. That was part of the reason I went out, because I really had admired Eugenia Waechter, who had done a lot of work with dying children early on. I had learned from her work.

It was very interesting. In the department, I would have had the pediatrics. I would have had family. I would have had the elderly. Because of the Block Nurse Program, I was

interested in the elderly, the children because of my work with childhood cancer, and family because I see that as embracing the context for both of these. Then, they had an interest started in midwifery. Then, of course, again, they really wanted me to get going with research. So, when I started there, there was no research grant. These were all clinical. By the time I stepped down as department chair, all but one had a research-funded grant.

All of that gave me such great experience, at the University of Minnesota and, then, UC-SF. I had an endowed chair at Case Western [Reserve University, Cleveland, Ohio] part time for about five years, which was a private university. All of that really helped when I became head of the school in Hong Kong, different cultures, different situations. I could pull on the experience that I had gained over this variety of marvelous experiences.

DT: Given all the working experience you had the institutions, how distinctive do you think the School of Nursing at Minnesota was and is?

IM: I think the new dean is wonderful. I think she's got the spirit. I think that internationalization is what needed to come. Katherine Densford Dreves was very much involved internationally. I think she was here many years. It was hard on the school after she left, and I think it took a few deans to get back. I'd say Minnesota has risen very fast and will continue with the new dean. For a while there, we had lost some of our international focus, and I think that's back now. So I'm very proud of the University of Minnesota. I think a lot of graduates are rightly proud, too.

Last year the women had that banquet. Were you there at that banquet?

DT: I went to some of it. I actually got to some of the events.

IM: It was marvelous. They really did that up very well. I can contrast that to the University of California. [laughter] We had our 100th celebration, too, but it wasn't done with the class that Minnesota's was.

DT: [chuckles]

IM: I really feel fortunate. I've been at really three different schools in the states that were really good. The University of California-San Francisco, it's very solid in research, and I think Minnesota is almost as solid now. There was a real contrast, but California had to come that way, too, because when I entered, there was no research going in my department when I went in 1982. Yet, by the time I stepped down, eight years later, in 1990, they really had a lot of ongoing research. We *had* to out there have research publications. We had to average three data-based publications a year in California.

DT: They really had set the bar.

IM: They set the bar. You had to; there was just no choice. There were some of our doctorally prepared people who didn't make it and had to leave. You had no...no matter

what type, no matter how well they'd write... They would be gone because of that external criteria. It kind of goes between the University of California and Seattle [University of Washington] for the top school. But I see, lately now, California has been winning over Seattle. I think the reason for that is Seattle faculty have too heavy loads. [laughter] I looked at that. You've got to give people time and sort of a freedom to do research. It takes a lot of time.

DT: At these different institutions, did you see any difference between how the school of nursing and nursing faculty were viewed by, say, the medical school and medical school faculty? Did you see any difference there?

IM: Well, I think we all had to justify our existence. It wasn't just given. I think that's gotten better over the years now. There's a pride in nursing schools even by medical schools now. I think we're over that awful period—I hope. [laughter] I think so. I think they appreciate nurses in a more open way now than they did before.

Of course, Case Western was really interesting because it was a private school. So from the time beginning to do anything, they had to have a lot of private money. Maybe, they were a little bit ahead in being accepted, because they brought in their money.

I think California has gotten, finally, like seven or eight endowed chairs. It took a while. Endowed chairs help give you clout in universities. Minnesota, now, is getting their endowed chairs.

That's why in my will, I remember nursing schools. People need to remember nursing schools. I learned this... When I was in Duluth—very interesting—this one woman, a Jewish woman, she just loved me. She said, "Oh! Ida, you are so good. I'm going to give money." I said, "I don't think I can get money." She said, "Oh, no, I'm going to give you this bottle of perfume," but she gave something like \$100,000 to medicine. That stuck with me, that, here, it was because she really had liked me she wanted to do something. But I was a servant. I could get the perfume, but medicine had to get that \$100,000.

DT: Yes.

IM: I was always hurt by that at one level, but it stuck with me, so I work very hard to try to remind nurses that they should remember nursing. Many nurses marry physicians, and they remember the medical school and not nursing.

DT: That seems like a really important point.

Well, do you have any other things you want to share?

IM: No!.

[laughter]

DT: Well, do you have any other suggestions for who I might speak with?

IM: Ahhh. You've got to find this Jean [Kingen], because I forget her name. Her last name even starts with an H., but I'm not too sure. That would be good. You mean about Minnesota nursing?

DT: Yes.

IM: Well, Mitzi Duxbury. She lives in Madison, Wisconsin.

DT: Oh, good.

IM: She would be very good.

DT: It sounds like it.

IM: She's up front. We had a marvelous relationship. She could start a sentence and I could finish it.

DT: [chuckles]

IM: I could start a sentence; she could finish it. We were just so in tune. She was marvelous. She's a great one. She's in Madison. You should talk to her.

DT: Excellent. I have to.

IM: Flossie...

DT: Flossie Marks?

IM: I wonder. Not Florence Ruhland.

DT: Okay.

IM: She was the one I think who would feel she started the doctoral program, by the way. She probably wouldn't acknowledge me at all, but I played a real role there. To me, I never fought that; it wasn't worth it. [chuckles]

DT: She's still alive, also?

IM: I don't know.

DT: I'll look into that

IM: She's a tremendous piano player. She would play for you.

Let's see. I started the Katherine Densford Research Fund. You may have heard about that. A lot of the funds that came for that were from Irene Ramey's estate.

DT: Yes, I do recall that.

IM: Yes. But Mitzi would be great. Sharon Hoffman. She could talk about some of those things. She was more involved like in the education, outreach education. But Mitzi, I would say, absolutely first.

DT: Yes.

IM: You've probably talked to Marilyn Sime?

DT: Yes, I did.

IM: We got along good. I liked her very much.

DT: Yes, I had a very enjoyable interview with her.

IM: How is she doing? Okay?

DT: She's doing well.

IM: Are her hands okay, now?

DT: She didn't say. Her dogs are fantastic. One is a Great Dane...

IM: Oh, really?

DT: ...and a tiny Italian Greyhound that made the interview rather fun.

[laughter]

DT: I love dogs. She was wonderful.

IM: I should go see her.

Let's see. About the school, right?

DT: Yes.

IM: Those would probably be...for sure, Mitzi.

DT: Excellent. Do you have other people even beyond the school as well? If there are other people that might have something to contribute.

IM: It would be interesting. I wonder what David Preston would say. Is he still alive?

DT: Yes. Yes, he's on my list.

IM: He may not even remember me. He helped me get a bigger picture.

DT: That would be great. I have him on my list. I want to talk to people from as many of the different health sciences and I'm sure he was involved in every aspect.

IM: Yes. Oh, he's ninety years old, though...Benson.

DT: Oh, Ellis Benson?

IM: Ellis Benson.

DT: Yes, I've already interview him.

IM: Oh, you've interviewed him. Okay.

DT: He was born in China, too.

IM: Yes. Yes.

DT: He was great.

IM: Isn't he great? You know. Yes, Ellis Benson. Mead Cavert. You've got that down.

DT: I've interviewed him already, yes.

IM: And you've got John Kersey?

DT: Yes.

IM: Mark Nesbit. B.J. Kennedy died. You would have been interested if you would have... I'll probably think of people after you leave. If it's really important, I'll call you.

DT: Excellent.

IM: I think those are my key ones.

DT: That's great. Oh, I'm so excited that Mitzi Duxbury is in Madison.

IM: That would be doable?

DT: Yes, absolutely.

IM: She will just...you know.

[laughter]

DT: That sounds great.

IM: If you want more about the Block Nurse [Program], Marge Jamieson would be the one to talk to.

DT: Yes.

IM: It would be interesting to do John Kersey to see what he thinks back now in the Home Care Project. That would be very interesting. He's got so many other things, but he's just great.

I think that's about it.

DT: Great. Thank you so much, Mrs. Martinson. This has been fantastic and very informative. So, thank you.

IM: Oh, you're welcome.

[End of the Interview]

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