

**Barbara W. Spradley, RN**  
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 20<sup>th</sup> 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**

Barbara Spradley was born and raised in China to missionary parents. She and her family returned to the United States during World War II after being detained as prisoners by the Japanese in 1943. Spradley received an associates degree in nursing in 1953 from University of California, Los Angeles. In 1956 she earned a bachelors in nursing from University of Southern California and an RN from the Huntington Memorial Hospital School of Nursing in Pasadena California. She was an instructor in public health nursing at the University of Washington in 1967 and a staff public health nurse at Seattle-King County Health Department from 1968 to 1969. In 1969 she began her Minnesota career as the assistant supervisor of public health nursing at the Minneapolis Combined Nursing Service. She has been an instructor, assistant professor, adjunct faculty member, and associate professor at the College of St. Catherine and the School of Public Health at the University of Minnesota. She became assistant director of the Program in Public Health Nursing in the School of Public Health at the University of Minnesota in 1983.

### **Interview Abstract**

Spradley begins by discussing her time in a Japanese internment camp during World War II. Spradley describes spending several years in Arkansas while her husband was stationed at Fort Chaffee. She goes on to describe her experiences working as a public health nurse in Washington State. Spradley discusses her husband's anthropological work and his recruitment to Macalester College, which led to their move to Minnesota. She discusses the tenure process at the University of Minnesota and fighting to have her work publishing textbooks considered as scholarly work by the committee. She discusses some of the politics of the School of Public Health during her time there, including interactions with Henry Blackburn, Barbara Leonard, and others. Spradley also talks about gender equality issues in the School.

**Interview with Barbara W. Spradley**

**Interviewed by Dominique Tobbell, Oral Historian**

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

**Interviewed at the home of Barbara Spradley  
in Mendota Heights, Minnesota**

**Interviewed on November 1, 2011**

Barbara Spradley                    - BS  
Dominique Tobbell                - DT

DT: This is Dominique Tobbell. I'm here with Barbara Spradley. It is November 1, 2011. We're at Barbara Spradley's home in Mendota Heights [Minnesota].

Thank you for meeting with me today.

BS: It's a pleasure.

DT: To get us started, could you tell me a little bit about where you were born and raised?

BS: My parents were missionaries to China, so I was born and raised in China, north China sort of opposite Korea. We came back during the war—World War II that is.

[chuckles]

BS: There've been a few since then... We were prisoners of the Japanese and in a concentration camp for a while but came back as exchange prisoners in 1943.

My mother's family was mostly on the West Coast in the Seattle [Washington] area, so that's where we headed. As missionaries, they were assigned to Los Angeles [L.A. California] to continue their work of recruiting new missionaries to serve in the Orient.

I did junior high, high school, and college level work all in the L.A. area. Then, I was married and did graduate study in Seattle. So that's really the background of my academic work.

My nursing training was connected with the Huntington Hospital in Pasadena, California. I did a Bachelor of Science in nursing through the University of Southern California [USC], took the boards, and got my R.N., was registered in California. Then, when we

moved to Seattle, my husband [James P. Spradley] was doing doctoral course work in anthropology at the University of Washington. So I took on a grad program for a master's in public health at the University of Washington. Nineteen sixty-seven was the completion. I can give you a copy of this.

DT: That would be great.

BS: It will be a little more up to date.

Education wise, I waited a few years because I was teaching full time and had young children, and we were busy. I started doctoral course work in 1976. The plan was to complete a degree in higher education, but because of my husband's death [September 21, 1982] and children needing to get through college, I had to put that on hold and it just didn't work out. Now, that's my educational background and, of course, I've been a lifelong learner and I continue to learn by classes and reading and that kind of thing.

DT: Are you still taking classes at the U of M [University of Minnesota]?

BS: I'm not taking classes right now, but I do a lot of reading, *a lot*.

[chuckles]

BS: I love to read.

DT: Another perk of retirement is that you get to read what you like.

BS: Exactly. That's one of the beauties of retirement.

DT: Can I ask you a little more about your time in China?

BS: Yes.

DT: How old were you when you were in the concentration camp?

BS: I was ten. I had my tenth birthday in the camp.

We were under house arrest for a year. When [the bombing of] Pearl Harbor happened all the Americans and British and French, anybody who was on the side of the Allies were immediately enemies of the Japanese, so they put all of us under some kind of arrest, house arrest or, sometimes, they put people into hotels and told them they had to stay there. Eventually, after a year of house arrest, we had a Japanese guard at the gate. It was big, lovely home that had been built by some wealthy Americans who donated it to the mission, so it housed, oh, maybe five or six families with servants' quarters. In China, they called them compounds where there would be a wall around the whole property. We had gardens and tennis courts and servants. The servants were allowed to come and go because they were Chinese and they were neutral. Out at the gate, the

entrance to the compound, there was always a Japanese guard with his rifle and bayonet. I was eight years old when it started. We kids weren't afraid of this man, and we'd sit down on the grass and play with him, and have him show us how his gun worked.

[chuckles]

BS: The poor man was a human being with kids at home and probably glad to meet some normal kids. One guard, later on, gave me a little doll.

They took away any transportation we had and any means of communication: no telephone, no radio, no car. So we had no way except through the Chinese servants to find out what was going on.

After a year, several of the Japanese soldiers showed up at the door and said, "You have three hours to take what you can carry and leave." My mother was pregnant and we kids were little. We took our favorite toys and a few clothes and our Bibles.

They took us to a hotel in the city. We were in the city of Tsingtao. Actually, it's grown quite a bit. It's spelled T-s-i-n-g-t-a-o. It's north of Shanghai and opposite South Korea on the coast. It still is, even more so now, a large seaport. Cruise ships go in there and that kind of thing. We were prisoners in this hotel. They just rounded up all the people who were—quote—enemies, and put us in the hotel. Our family had one room. My sister was born while we were in that camp. We had some German friends one of whom was a doctor so he arranged to have mother go to the hospital for delivery and took care of her. Then, she had to come back. The rooms were small and the food was terrible. People managed just fine. You know, you do what you have to do. A lot of Catholic nuns were included in our group. Many of them are teachers, so we formed a small school. People brought their instruments and we formed an orchestra. People brought their baseballs and bats and we had a ball team.

After six months of that, they put us all on a train and took us inland to a larger compound where they interned close to 2,000 prisoners. It had been a Christian conference center and training center. This is China fifty, sixty years ago. It had foreign houses and student housing. Student housing was these mud huts with dirt floors. They put all the prisoners in these huts. There was one set of two huts that were joined with a common room in the middle. My mother's brother, my uncle, and his family were with us. They took one room, my uncle and aunt and their four kids, and my mother and dad and us three kids had the other for sleeping. We had these separate rooms and then used the common room for our gathering place.

Food was limited and very poor, but we had enough to live on. There was no real mistreatment of prisoners. We were far away from fighting. There were guards stationed along the wall of the compound. The Chinese farmers were starving because they had lost everything. They had no money to buy their goods. So the people in the camp who had money or something to barter with at night would contact the Chinese and there was a black market trade that went on. It was quite interesting. That enabled us to

supplement our diet. We could buy eggs and some of the braver people bought chickens and even a pig or two. Sneaking it under or over the wall was the hard part before the guards caught you. One time, my dad got a whole basketful of eggs from a Chinese farmer but a guard had seen something going on and came to check it out. My dad held the basket and handed the eggs one at a time to the guard and while the guard was busy, handed one behind him to my uncle so that we got about half of them.

[laughter]

BS: There are a lot of fun stories. It wasn't pleasant but it was bearable. We all lost weight, but life went on. It was very interesting. We had a normal small society of very disparate groups, business people, teachers, Trappist monks—people who had taken a vow of silence for life and were living in Mongolia were rounded up; I don't know how they found them all—and, then, a lot of missionaries of different faiths. So we had to form a society out of that. If you have any sociology background, you can appreciate how interesting that would be.

DT: Yes. Once you moved to the larger compound, did you continue with having people teach the proto-school?

BS: Oh, yes. We had school. We had an orchestra. We had ball teams, theater. Then, governance was all volunteer. It wasn't formal elections, but people who had some leadership ability took charge and represented the camp to the guards. We had quite a few medical people, doctors and nurses and dentists and others. There was a building that we made into the hospital and used that for treating people who were sick. Many people brought things with them. Doctors would bring some of their favorite instruments or whatever, so we were able to pool resources enough to make it work. We were all grateful for that, otherwise, we would have really been stuck, because the guards didn't provide anything like that. They were simply there to make sure we didn't leave.

DT: Beyond their job to not let you leave, were, basically, people in the compound left to their own devices to a certain extent?

BS: Yes. They did give us the option at the beginning... Our group from that first hotel were the first ones to arrive. So we had an opportunity to set some of the rules that ended up being what governed the whole place as time went on. They let us choose whether they would take care of the food and the cooking or whether we could be in charge of that kind of thing. Our feeling was that we'd have more control if we could make those decisions. So the internees were a self-governing group. My dad was one of the leaders and so was my uncle. They were both very capable people. That made it a lot easier, so, then, they could be intermediaries between the internees and the guards.

It was interesting, the communication, because hardly anybody spoke Japanese, but some of the guards had learned Chinese. Many of the people living in China had learned Chinese, so that gave us at least a chance to speak that language.

DT: Did you?

BS: I did as a young child. I was sent to a British boarding school for the missionary kids and we were not allowed to speak Chinese, which is very unfortunate and shortsighted, in my opinion. So I don't have it. I have a few words, but, unfortunately, no.

DT: Do you remember if you felt fearful or your family were afraid at any point during your internment?

BS: My parents, I think, probably were more than we children. I think they did a good job of assuring us that God would take care of us and that things would be okay. So we kids were relatively carefree. There were lots of unpleasant things: communal showers with no privacy, a communal toilet that was just a long trough, open cesspools and poor sanitation, and, yet, if you live around that, you learn to stay away from the unpleasant places and choose your own games to play. My parents were very helpful. They would tell stories. My dad was great at making them up. We didn't have many books. But a few people did bring books, and those were shared. People brought their musical instruments and formed an orchestra. When you can have some culture, it feeds the soul, you know. So there was lots of music and singing and church services. Also ball games. It wasn't bad.

Our exit from this camp was totally unexpected. We had been in the hotel prison camp for six months and in this camp for five months. Then, one day, the Japanese just announced that they were going to send some people home. They would post a list. If your name was on it, you went. Some families were split up for the rest of the war that way. The mother and the kids might be sent home and the father would be left in the camp. Anyway, our whole family was on this list. They told us that we would be exchanged for Japanese prisoners who were being interned or held in other countries and were being brought back to a common meeting place, which was going to be India. We would exchange transportation there. So that's what happened.

We had to go through body searches and they did not allow us to bring anything in writing out, because they did not want records of the war publicized anywhere.

My dad had a favorite Bible, a big, fat study Bible that had empty pages that he'd write his sermon notes in. He knew that he couldn't take that with him, so he wrapped it—we didn't have foil in those days—in oilcloth and spoke with one of the men, a friend of his, who was not going. He'd be staying in the camp. He buried it in the ground and told this man where it was and said, "If you ever get out of here, please, dig it up, and bring it with you"—and he did and I have it.

DT: That's amazing.

BS: Yes, it is, and it was in good shape. So that was very nice, but, otherwise, we really couldn't take very much with us. We were pretty much down to a few clothes and that was it.



They took us by train down to Shanghai and, then, we went by boat from Shanghai, if you can picture a map, past the Philippines and Malaysia and around to the west coast of India. There we changed ships with a Swedish luxury liner. The *Gripsholm* had been used for eleven of these mercy missions. They provided the ship and crew...the Swedes were neutral during the war. The ship we were on from Shanghai to India was a confiscated French vessel that the Japanese were sailing. People were just packed on like sardines. We sailed through mined waters, so it was very iffy whether we were going to make it, but we did. Once we got on the *Gripsholm*, the Red Cross was able to offer help to us. They had clothes and food. It was like heaven after eating so little. I can remember on the Japanese ship, we would sit with a bowl of rice that had little pink worms in it.

DT: Oh, gosh [whispered].

BS: Mother would say, "Eat it. That's protein."

[laughter]

BS: So you closed your eyes and did the best you could. Things were a lot nicer when we got on the other ship.

We sailed from India to the tip of South Africa to Rio de Janeiro in Brazil and, then, up to New York and sailed in past the Statue of Liberty. By the age of ten, I had gone around the world by ship. [chuckles]

DT: That's incredible.

BS: Yes.

DT: How long did the journey from Shanghai take?

BS: Well, actually, from the camp, that was a couple of days on the train, but the total journey to New York was three months.

DT: Goodness [whispered].

BS: Yes. My sister who was born in the first camp turned one and learned to walk while we were on board ship. It's not significant but kind of interesting that she had a sailor's walk.

DT: [laughter]

BS: My life has been one of many changes. I think that's been a very helpful thing in terms of learning to adapt.

DT: I was going to say, how would you say that experience shaped you?

BS: Well, partly because my father was a very optimistic person... His motto was "Not difficulty, but opportunity." So when anything difficult came along, he'd say, "This is an opportunity." Of course, we had a strong faith and an opportunity to trust that things would work out, that God would be there for us. I think that kind of an attitude of seeing things not as difficulties but as opportunities made challenges more interesting and that served me well, especially during my faculty years, because I had some difficulties with one of the deans. It wasn't Lee Stauffer. We're good friends.

DT: I can't imagine anyone having a difficult time...

BS: No, he's wonderful, and was. He was the dean when I started on the faculty in the School of Public Health. I never was in the School of Nursing.

I taught at the College of Saint Catherine for a couple years. I taught at the University of Washington in Seattle, right after I got my master's, for a year. I taught public health nursing. So public health had become my interest rather than nursing per se.

I did work as a staff public health nurse in Seattle with the Seattle-King County Health Department. My work, a large part of it, was acting as a liaison for patients between the hospital and home. I really was very involved in discharge planning and, then, follow up to make sure the patients were doing okay. Then, my staff nursing with the Seattle-King County Health Department was very interesting. I drove a city car and would go to visit people in their homes. You really learned how people take care of themselves or what their health issues are when you see them in context. I enjoyed that a lot. Plus, it gave me independence. Hospital nursing, I did enough of it early on, but I preferred to function independently and make more of my own decisions.

DT: And that was possible in public health?

BS: In public health, I had that kind of freedom and I liked that better. You'd have to exercise more judgment. It's a different kind of setting. It's not like working in emergency, where you have to have split second timing and understand symptoms. You still have to to some degree, but in a different kind of setting. I sometimes worked with healthy people, too, new moms who needed coaching on how to breast feed or bathe a baby or elderly people who were alone and needed some kind of monitoring of their health and advice on self care. Anyway, it was an interesting part of my career.

DT: What led you to a career in nursing and, then, consequently, public health?

BS: You can probably guess. My parents were missionaries and there were two things that women did: teaching and nursing and a third, lesser possibility, was being a librarian. [chuckles] Women didn't do anything else. I probably would have gone into medicine if I'd been in a different era, because I was always interested in that. I have a daughter [Deborah] who did become an M.D., graduated from U of M.

DT: Wonderful.

BS: Missionary nursing was held up to me as a desirable goal. That's what got me started.

I started at UCLA [University of California-Los Angeles] as an undergrad and did pre-nursing there. Actually, I started out as an English major. I was really more interested in literature, but I thought, well...

[chuckles]

BS: ...but thought it's probably not as worthy a career so I switched to nursing. UCLA had very good facilities. We worked on cadavers when I was an undergraduate, which I thought was an amazing experience and very helpful to me. I love science so I did well with the sciences. The nursing choice ended up being a good one.

I entered the Huntington [Memorial] Hospital School of Nursing program, which is based in Pasadena. That program was affiliated with USC, so that's why I ended up getting my last two years of college credit through USC and graduated from there.

I had met my husband right out of high school and we'd been engaged for three years. He had a stint in the Army after we were married. I spent some time in Arkansas and I was working in hospitals wherever I went. He was stationed at Fort Chaffee in Arkansas.

When he got out of the service, he enrolled at the University of Washington, so that took us both to Seattle. By the time we were both in grad school we had three kids [Sheryl, Deborah, and Laura]. I got a grant. I had a scholarship for undergrad and I got a... What do they call it? I think I've got it written in here. It was a national grant. Yes, the U.S. Public Health Service Training grant, it was called, for graduate study. So that enabled me to not work and just do my master's and get that done. But my husband was working part time and doing his Ph.D. work at the University of Washington. It was a busy time. The kids were kind of raised by the babysitter for a while. [chuckles]

DT: I was going to say how did you manage all that with three kids?

BS: When you're younger you can juggle a lot of things. When you look back, you think how in the world did we do that? But you do. It was a very egalitarian marriage. He was a good partner and we shared the work. Yes, we didn't have much money, so we'd go camping for holidays. That was fun. Washington is a beautiful state, lots of places to hike and beaches, so that was nice.

What track were we on here?

DT: I'd love to hear more about your experiences working as a hospital nurse. How would you characterize the work that you were doing and the kind of challenges or experiences that you encountered?

BS: Well, my first hospital nursing was in a children's hospital, so I did a little bit of everything. It was a small hospital in Fresno, California. My husband and I had affiliated with a Christian organization called the Navigators. One of their locations was in Fresno. It was really an organization that was reaching out to college-age people and service people, the military. We were staying with people from that organization and I was working full time at Valley Children's Hospital. At that time, there were still leftovers from the polio epidemic and we had kids in iron lungs. Some of the diseases that we saw then are really less of a problem now, the communicable diseases. I worked in a number of different units in that hospital. I had one little boy named Barry who was in an iron lung. We got to be really good friends. Working with kids is really heartbreaking in a lot of ways, because they're so trusting and, sometimes, they're so sick and so helpless. I worked in the neonatal nursery. I can remember holding an infant that was as big as my hand. We had these little isolettes and you could put your hands through the holes to take care of them. Then, I had to take her out for some reason with all the little tubes sticking in her. She did all right. She made it. Then, I worked in emergency.

I worked in Arkansas while my husband was in the Army. In that hospital, I did more medical/surgical nursing. Oh, my, the treatments in those days were so different than now. One of the things that we administered was nitrogen mustard, which was a *very* dangerous injection. It had to be given IV [intravenous]. If any of it got out of the blood vessel and into the tissue, it would just make it rot. It was extremely dangerous to administer it. I had to do that by myself and I really had had no training in starting IVs. I learned. I just had to. We were short staffed with medical personnel and the nurses would have to do a lot of the work that the doctors normally did. A lot of times, we'd have to work overtime and the hospital couldn't pay us for overtime. We'd go punch out and, then, come back onto the wards to keep working until the job was done. [chuckles] It was in that hospital that my first baby was born, my first daughter. I knew all the personnel and I knew the ropes. After she was born, I went back to work. I wasn't sure that I wanted to. They begged me to. I said, "Well, then, I'll do it under certain conditions." They said, "What is that?" I said, "I'll work days only, no weekends, no on-call, and private duty pay." So I was asking for a raise. I thought if they don't want to, that's okay. I just won't work. [chuckles] They accepted my terms. I think they must have been desperate. I continued to work there until we left Arkansas. In that hospital I enjoyed a variety of kinds of nursing. I worked in OR [operating room] and obstetrics. When we moved to Seattle, I worked as a float nurse, so I worked wherever I was needed. Again, not difficulty but opportunity, I learned to adapt.

[chuckles]

DT: Yes. It's incredible the range of positions that you held and the kinds of nursing practice that you were engaged in.

BS: Yes.

DT: I'm curious. What were they treating with nitrogen mustard?

BS: I think it was a treatment for cancer, but right now, I've forgotten. They don't use it anymore. It's extremely dangerous. I'd have to look that one up.

DT: I'm going to have to, as well.

BS: Yes. Isn't that interesting?

DT: It is.

Around that time that you were doing the IVs, as you mentioned, generally physicians did that. I know in some hospitals around the country that nurses wanted to be able to do the IVs but physicians put their foot down and said, "No, it should be physicians only." So it's interesting that you had a different experience.

BS: It was a necessity. I had had no training for it and they didn't give me any training. I learned by trial and error...the poor patients. I watched the lab techs; we had a few lab techs, but not like we do now. Really, now it's very compartmentalized with specific jobs that each of the staff in the hospital have, but, then, you did more crossover of roles. You did what you had to do. We had something called the autoclaves. I don't know if they call it that anymore, but sterilizing instrument packs. The diet kitchen...I didn't work in those very long, but I had opportunity to dabble. In a way, it was good, because then you knew the different workings of the hospital. Also, you knew who was where and you knew who to call if you needed something, especially in a small hospital.

DT: What were relations like between nurses and physicians in the various places that you worked?

BS: You know, I think a lot of that depended on how assertive the nurses were willing to be. Most physicians, there's a few that think they're God's gift and don't want anything to do with anybody else, but if you challenged them, it would very often end up being quite collegial. I always felt comfortable being myself, so I would just say, "I don't understand why we're doing this." I wouldn't be questioning, but just, "Can you help me understand?" Sometimes, we were able to go on rounds with the docs. That hospital wasn't a teaching hospital, but the Seattle-King County one was and other places where I've worked have been teaching hospitals.

In public health, I especially felt that I needed to be collaborating with a physician. They don't know as much as the nurses do about the patient. So, in a way, it's an obligation to provide that information and provide the context in order to help the physician give the best kind of treatment. A lot of times—I'm not saying that the physician wasn't good at what he was doing, he or she—I would write the orders and have them sign it, because I

knew what the patient needed. Or we'd work together and there were times where I would ask a physician to make a home visit with me, because I wanted him or her to see the situation and see the condition of the patient. Generally, they didn't make home visits. Of course, time was a limitation; it's understandable. I enjoyed public health a lot more because this notion of an interdisciplinary team was truly in practice. We could have psychologists and dietitians and social workers, physicians, nurses, dentists, whoever was appropriate to bring in. As a team, you'd confer with one another and, then, you'd serve the patient's best interest. I think that's a model that we need to practice more, especially with so much specialization.

DT: Did you feel when you were working in public health that it was entirely collaborative? Was there the same kinds of hierarchy that you would get in a hospital?

BS: There was some. The physician is always at the top of the totem pole. Again, if the nurses or other personnel are comfortable treating the other professionals as equals, then there's no need to feel so much of the hierarchy. You respect each person's contribution and each person's set of knowledge. They're specialized and the physician knows only one set of information. The nurse knows another. The social worker knows another. So when you pool that set of resources, you serve the patient better.

DT: Did you get a sense that physicians appreciated that nurses knew more in some areas?

BS: I think many of them did, probably not all, but I would say most did. I always had a good experience. It was partly because I wasn't afraid to say what I thought was going on, but say it in a tactful way that wasn't threatening, and I would make suggestions and say, "I wonder if you thought about such and such," or "This man is really limited in his range of motion. He's not able to feed himself. It looks like some help would be appropriate. Maybe that could be ordered." So there are ways to say it and make them still feel like they thought it out.

[chuckles]

BS: Most of the physicians were very happy to have that information.

DT: You've had such regional diversity in the work that you've done. I wonder, compared to California, Arkansas, and Washington, did you feel like there were any kind of regional differences in your experience?

BS: In the hospitals, it was very similar. It depended on the size of the hospital. A small hospital tends to be like a small town and everybody knows everybody's business. Smaller hospitals aren't as well equipped, because they can't afford to get the latest technology. Arkansas was a military town, so there was some influence on that where we were living. I think there was a little less sense of sophistication in Arkansas than there was in L.A. and Seattle, but it's hard to say.

DT: You were in Arkansas during the period of segregation, so I'm wondering...

BS: Oh, definitely.

DT: What was your experience with the racial dynamics and were you only treating white patients?

BS: In the hospital where I worked it was only white patients. The segregation, we were appalled at, because we hadn't really experienced that before. Blacks had to step down off the sidewalk if a white person was coming. There were black drinking fountains and white drinking fountains. The blacks had to sit in the balcony in a theater. The worst was on the Army base where my husband was stationed. In the base chapel and was had a baptistery where people of the Baptist faith could be baptized. They get baptized by being immersed under water. They would not allow any blacks to get in that same water with the whites. I was shocked.

DT: Were you still in the South during the Civil Rights Movement or were...?

BS: No, we were in Washington. We heard about the marches and the boycotts and Martin Luther King. We visited Atlanta since and have seen the Martin Luther King home and church and all the rest. Yes. They certainly had our sympathy.

DT: What led you to move to Minnesota?

BS: That was a recruitment. My husband was recruited to Macalester College.

He had published his doctoral thesis [*Guests Never Leave Hungry: the Autobiography of James Sewid, a Kwakiutl Indian*]. His research, actually, was the life history of a Canadian Indian Kwakiutl chief, who lived on Vancouver Island and had been a man who was able to straddle two cultures in a remarkable way. His name was Jimmy Sewid, S-e-w-i-d. My husband, Jim, interviewed him extensively, and wrote his life story, and wrote it as though it were his autobiography, as though he were writing it. He was very proud of that and very pleased. It was a way to shed light on that whole Kwakiutl culture. He published it through Yale University Press. That book is still in print, which is quite amazing. It's not selling a lot, but it's still available.

While we were living in Seattle—Jim was a cultural anthropologist—he somehow got interested in the skid row alcoholic population, so he would go down to skid row in downtown Seattle and interview some of these men who were really pretty much living on the street. Many of them were educated, had been in business and other professional roles. Some of them had gotten fed up with that and chosen this way of life. Many of them were alcoholic. The Seattle police would pick these men up on the weekend. I mean they'd find them laying in the street, in the doorways, and pick them up, put them through the delousing tank in the jail and, then, they'd have to lay around in these horrible cells with only a urinal and a tap, a water faucet. Then, they'd appear in court on Monday morning looking awful. Delousing is a terrible experience. Their clothes are

just a mess afterward. Any vestige of pride they might have had was totally gone. Jim was concerned about them. He had met these men. He had talked to them. He met them as human beings and, then, he found out how the police department was treating them. So he wrote this up. [chuckles] The long story short... He published a book on the treatment of alcoholics.

It's called, *You Owe yourself a Drunk* [: *an Ethnography of Urban Nomads*]*—*that was the title of the book—which was a quote from one of these men. He said, “Once you’ve been through that whole process and, then, you’re dumped back out on the street, you owe yourself another drunk just to get over it.” They had no detox [detoxification] programs or no rehabilitation for these people. It hit the *Seattle Post Intelligencer* front page, it was big news, for several days. We had to get out of town because we were being harassed. [laughter] The end of the story is that the jail had to change its whole practice. A detox center was opened to serve this population and things got a lot better for them. Alcoholism was a disease, an illness that needed treatment, rather than viewing them as social misfits that made bad choices.

DT: That would have been in the 1960s. Was alcoholism understood to be a disease at that point?

BS: There were some who thought that. My husband was also involved with the National Institutes of Health studying different models for the cause and treatment of alcoholism. There were behavioral models, physiological models, medical and genetic models—many, a lot of different theories on what was going on. Alcoholism was, and still is, a problem with the Native American population. I don’t know that they’ve ever really clarified the cause, but there are some things that predispose people more than others. A lot of it is social and psychological factors that influence people’s behavior patterns.

Having kind of made a name for himself, both with the Native American study that he did and, then, the alcoholism—that was known all over the country—the Macalester College Anthro [Anthropology] Department made Jim an offer and asked if he would come and join the faculty here. So he decided that he would. He was teaching at Seattle Pacific College then and this sounded like a chance for him to branch out and maybe do more with his research. So that’s what brought us to Minnesota.

At the same time, I was offered a position with the Minneapolis Health Department. I had a job first with Saint Kate’s [College of Saint Catherine] on their faculty teaching public health nursing. I was there for a little while, and, then, I went to the Minneapolis Health Department, which was combined with the visiting nurse service. We called it the VNA [Visiting Nurse Association]. I was a supervisor there, and, then, was recruited to the U. Really, I have hardly ever had to seek a job. I’ve been recruited to almost every job that I’ve had, which was just lucky for me. [chuckles]

DT: Clearly, you brought with you to Minnesota such an important range of skills and experiences. It seems like a lot of nurses, for example, would have just been a hospital



nurse and maybe just stayed in one location. Because you had that diverse experience and, then, you had time and practice in public health nursing, too, it's not surprising that you were sought after.

BS: Well, I was lucky that way.

I enjoyed teaching at Saint Kate's and helped to enhance their public health nursing emphasis in their nursing program. Then, when I went to the U, I was in the School of Public Health right from the start. That really felt like a good fit for me.

The Nursing Department in the School of Public Health was located up on the thirteenth floor [in the Mayo Building] when I started. There were changes over time. It, eventually, ended up on the third floor of the Mayo [Building]. That's in your Archives someplace, the dates and all that. I don't suppose you need that from me and I'm not sure that I could tell you.

DT: [laughter] I'd be happy to take the information if you know, but if you don't, I'll be able to find it in the Archives.

BS: I don't remember what year we ended up down on the third floor, but that was a much more convenient space. When we were on the thirteenth floor, the School was occupying thirteen and twelve and eleven and other places. We were scattered. Now, the School of Public Health is more centralized, except for Epidemiology, which is across the way, and I suppose there's some branches other places, because it's grown so much.

DT: It seems like the School of Public Health has always been split up and separated.

BS: Yes, and still is to some degree.

The Nursing Department was intact until it finally got moved over to the School of Nursing. I fought with the dean for how to handle that. He did not want the nurses in the School of Public Health, Dean [Robert] Kane. He and I tangled quite often. [chuckles] I think that it was good, because I wasn't afraid of him. He tended to intimidate people, so people didn't fight back and I wasn't afraid to. We ended up being colleagues as a result, because I think he appreciated that.

But he tried to get me out of there. I did not have tenure. I was an assistant professor. He said that all I was doing was teaching and that he needed faculty that were doing research. I said, "I'm doing scholarly work. It's just not research," because I was publishing textbooks. He didn't think that was adequate. I said I thought it was. Eventually, after many discussions, he decided to have my work reviewed by outside reviewers to see if I would be worthy of staying on the faculty. [chuckles] I said I would agree to having that done, but, then, he chose the reviewers, and he picked two M.D.s. Well, that's not appropriate. You pick people in the field that's being reviewed. So, I thought he's already made the decision. If they come back negative, then I will appeal, because it's inappropriate to be reviewed by people outside of your field. But as it turned

out, they both thought my work was great, that I should stay on. [laughter] So I didn't have to fight it, but I was prepared to. I had consulted with the University attorney and had another professor who had gone through something similar as my coach. I got my tenure. At the end of that, he wrote me a memo and said, "Congratulations and thank you for conducting yourself the way you did through this whole process." I felt diplomacy won the day. It was a tough experience, but as my dad said, "Not difficulty but opportunity." So I hung in there and kept my position and was associate professor.

Not long after that, I was chair of the Faculty Consultative Committee [FCC] for School. People in the School were not happy. I would say a *large* portion of the faculty were unhappy with the way that this particular dean operated. He was a brilliant man and he's made a huge contribution to the field of geriatric medicine and public health. Still, I admire him very much. But he did some things that were not favorable to the School and was making some of our constituents in the community unhappy. So it fell to me as chair of the FCC to call him in and tell him that people weren't happy and that something had to change. I remember Henry Blackburn meeting with me ahead of time all concerned saying, "I don't know if this is a good thing to do." Do you know who he is?

DT: Yes.

BS: I said, "Henry, I'll be just fine. Thank you for your concern." About half the committee didn't show up on that day. They were scared, too. When the dean came, he looked pretty concerned. I offered him a chair and said, "We just need to talk about the way the faculty are perceiving you. This is not acceptable in the eyes of many of the people here in the School. We need to have some changes." He did try. He hired a consultant who did some things that were supposed to help his administrative skills. We didn't see a lot of change.

Things got bad enough that there was a rumbling of a vote of no confidence. Before that happened, as chair of this committee, it fell to me to do something about it. At that time, Cherie Perlmutter was the V.P. [vice president] for health sciences. I made an appointment with her and told her the situation and said that rather than having this kind of thing hit the newspapers, we needed to consider other actions that would avoid that kind of publicity.

To end that story, he was moved into this endowed chair position in geriatric public health. He's really done a fine job with that. I have no complaints.

He and I had a number of conferences where he paced the floor and was not pleasant, and I stood my ground and, at one point, asked him to, please, sit down. He was not acting like an adult. [chuckles] He sat and we talked. He wanted me to be in charge of the nursing piece. This is when I was still in Public Health Nursing. I said I would consider it—this was early on, because, later on, I did chair that department—but I decided I didn't want to, and he wanted to know why. I said, "Because I have to work too closely with you and I just don't want to do that." He got upset about it. It was interesting. He wanted to know more. It wasn't as though I had offended him so much. It was like it

was a revelation. So, I think in many ways—you know about these geniuses whose heads are in the clouds—I don't think he was aware a lot of times of how his behavior was viewed by other people. So we ended up having some good discussions. I can remember sitting in his office, in the dean's office, and, oh, we talked about public health nursing. He said, "I've never understood why we have public health nursing." So I gave him my explanation, and he looked very thoughtful, and he said, "That's the first time I've ever heard something that really made sense. Now, I can see it differently." [chuckles] Well, it wasn't that complicated. He had one model in his mind of nurses as being the handmaiden of the physician, I think. He'd come from a research position. He was in the RAND Laboratories in California. Whatever nurses he worked with were probably just assistants to him. I don't think he had a vision of nurses as independently functioning professionals.

So that part went well, but the atmosphere for nursing was never friendly during his tenure as dean. He had gotten rid of a number of faculty. Barb [Barbara] Leonard probably gave you some of that history. Ellen Egan [correctly, Ellen Fahy] was the dean of the School of Nursing, so I, as chair of Public Health Nursing in the School of Public Health, had a number of meetings with her and with the graduate faculty in the School of Nursing to discuss the possibility of just moving the whole nursing unit from Public Health over to the School of Nursing, which would be, hopefully, a more friendly environment. There were arguments for it at either location, but, given the circumstances, it made a lot of sense to consider the move, and that's what ended up happening, as you know.

DT: Did you begin these conversations with Ellen Fahy...would that be in the late 1980s or was it earlier than that?

BS: It might have been mid. We had early conversations before any decisions were made, and, then, she asked me to meet with all of the graduate faculty, because this was a graduate program, and talk about that possibility. So I had two or three of those meetings. Not all the faculty there were receptive, but I think over time... I ended up doing kind of a shuttle diplomacy between the two schools for a while. [laughter]

LaVohn Josten, who you may know; Have you interviewed her?

DT: No, I haven't.

BS: She's wintering in Arizona now, but she would be a very interesting person, because she knows the bridge between the two schools. She did her doctorate in the School of Public Health through Health Services Administration. So she knows that setting. LaVohn was, I think at that time, with the Minneapolis Health Department—no Minnesota Health Department, the State Health Department. Later, she went on the faculty in the School of Nursing. I can remember meeting with LaVohn for lunch and figuring out strategies and talking about ways to win over the School of Nursing graduate faculty, the ones that were resisting.

It ended up that LaVohn and some others nominated me for the Ruth [B.] Freeman [Public Health Nursing] Award, which is a prestigious one in public health nursing, given through the American Public Health Association, the national organization. I received that. Let's see if I have the date on that. Nineteen ninety-nine. That's the Ruth Freeman Distinguished Career Award. And I got the Public Health Achievement Award from the Minnesota Public Health Association in 1997.

So there were some people who really felt that that shuttle diplomacy paid off, because we could still preserve that academic unit, just finding it a new home, and, then, the students wouldn't suffer from that kind of tension going on all the time.

For the last few years in the School of Public Health, that unit became submerged under the Health Administration umbrella. So some of us decided to just stay in that setting rather than move with the program. So my last years in the School were in Health Administration. It was called Public Health Administration in the Division of Health Management Policy.

DT: I feel so interested in the location of public health nursing and how in some institutions it's within the school of nursing and here for so long, it was in the School of Public Health. What can you tell me about where Public Health Nursing sat in the University of Minnesota and why there was some resistance on the part of the School of Nursing graduate faculty to have Public Health Nursing more over?

BS: Well, I think the ones who resisted were some of the long-time, long-tenured faculty who had gone through earlier years where there had been some tensions between the two units. When I started, which was, actually, 1978, I can remember having joint sessions in the Campus Club with the School of Nursing graduate faculty and the School of Public Health Nursing faculty. Bob Veninga was our consultant at the time to deal with conflict resolution. I don't know all of the reasons for the conflict, but I think that the disagreement on the part of some of that School of Nursing faculty was the curriculum was so public health focused. I think they wanted it to be more nursing focused. Really, undergrad, I could see that, but, graduate level, when you're specializing in something, it makes a lot of sense to emphasize that. I don't know what their problem was. [chuckles] But there was conflict and Bob Veninga was doing sessions between the two faculty on conflict resolution. I think it helped, maybe, a little. I don't know. It would be interesting to know. You're already talked to him?

DT: Yes.

BS: I don't know if that came out in your interview?

DT: I believe it did, but I'll have to go back and have a look.

BS: It would be interesting to know whether he thought it made a difference. I don't know, because I was new to the situation, didn't know the history of it. Anyway, I think there might have been some personality conflicts, as well, clashes.

But having it stay in the School of Public Health made the most sense, because it was a graduate program, specializing in that field and all the resources were there. The Epidemiology Lab, Bio Statistics, Public Health Administration, all of the faculty and the interdisciplinary mix was available through that school. It made so much more sense, I thought. But when the environment wasn't receptive and friendly, it made sense to move it to the School of Nursing. I think the School of Nursing faculty had to do some adjusting to accept this maverick group that kind of liked to work independently and didn't fit the mold. Barb Leonard focused on kids and her interest in pediatrics really spans both schools, so that was fine. But people who wanted to do epidemiologic studies of one sort or another that was kind of new and hard to understand for some people.

DT: Historically, there's always been the fact that public health nursing is so different. In your own career, you experienced you were more autonomous as a public health nurse than as a hospital nurse. But, also, public health nursing is focused on population and the hospital nurse on the individual.

BS: Absolutely, and that's a huge difference, because there's a *much* different mind set. Even in a hospital setting, a public health nurse has a different view. I think a four-year nurse who's gone through a good program will have had a public health piece as a part of that curriculum and would, hopefully, give some of that perspective, but it depends on who is teaching it, how well it's taught. So I would say many, if not most, RNs do not get that mindset of the population. If your focus is on individuals, which it often has to be, if you can think of an individual in the context of the larger group and, then, the impact of the larger group on that for the environmental setting, it's so important. I really felt strongly about that in terms of my own philosophy of health. I think a lot of doctors could benefit from that same perspective. You can't treat people in isolation. They're not islands. They are part of the bigger group and that has such an impact on their wellbeing, even on how well a medical regimen will work. That's my bias.

[break in the interview]

BS: Where do we go from here now?

DT: I'd love to follow up with you a bit more about what you were telling me about Bob Kane's deanship.

BS: Yes.

DT: Well, maybe we should start with what the School of Public Health was like when Lee Stauffer was dean. As I understand it, it went from Stauffer to Edith Leyasmeyer and, then, to Bob Kane. What was the School of Public Health like when you arrived?

BS: When I arrived, lets see, that was in the 1970s and there was a lot of government money available. It was a different era financially. There wasn't the pressure to get outside money nearly as much as there was later and certainly is now. So there was more freedom in terms of the kinds of academic programs that you could develop. I'm trying to think of the one that Judith Garrard headed up early on...something Community Services. I'm forgetting the title of it. Anyway, it was an outreach practice kind of orientation. Psychology was worked into that, public health psychology. That was an example. Then, public health dentistry was Les [Lester] Block's thing. He was the only man in that department. I sensed a feeling of greater camaraderie. I'm trying to think of the right word. We'd have luncheon seminars and share ideas and talk about various people's research and practice experiences and courses they were developing. It was very collegial and this was between departments. It was a mix of departments, interdisciplinary. For me, that was a nice model for the way public health should be practiced, interdisciplinary. We've talked about that already. I felt that Lee Stauffer had that vision of the interdisciplinary mix, so there was a sense of collegiality across the whole school. But, then, the economic factor helped to influence that, because there wasn't the pressure [to raise money].

Bob Kane came and brought his more narrow view of public health. At least in my opinion it was more narrow. I think he learned on the job. He alienated a lot of people, because he didn't learn fast enough or well enough, they thought. I think his moving out of that position was a good thing for him and for everybody.

Edith was a good bridge, and she had a tough time, too, because, then, things started getting tighter financially. In the 1980s, things started tightening up and the 1990s was really where faculty were beginning to raise their own salaries. That meant going into funding sources that they might not ordinarily choose, and, then, funding sources to some degree dictate the kinds of things that get done, because they have their pet things that they want to fund. So if you don't go along with that, you're out of luck getting your money. In a way, the funding sources end up dictating the direction of the research in the school. I strongly object to that. I don't think that's ethically or morally right, but it's the way it is. The element of public health practice became much less valued because research was the only way to get the money, to bring money into the School.

So public health practice, was what the public health nursing faculty were emphasizing. Some of the nursing faculty were doing some good research, but the nurses ended up scattering. The ones that stayed in the School, some of them went ahead and got their doctorates and went into environmental health, for example, or epidemiology or biostatistics. I don't know if any of the nurses went into public health nutrition. The nurses were gone in terms of the core professional group that could really keep that program...so it was really important to move it into a more favorable location. That splintering I think was directly affected by the economic issues. It's not the only thing, but I think it was a large factor.

DT: Yes, I understand that through the 1960s and 1970s, and probably before that, too, the School of Public Health got a lot of money from federal funds, because, as you

mentioned earlier, when you went to the University of Washington, you had a public health service trainee grant.

BS: Right.

DT: There was a lot of government money available. But, then, there were retrenchments in the late 1970s, early 1980s...that's the economic piece you're talking about.

BS: Yes, and that's big. The influence of that was big in shaping the direction of the School. Soft research, behavioral kinds of efforts were not valued as much unless you could find a good funding source. The hard number crunching kinds of research is what was valued the most. So, then, new faculty were recruited and as new faculty came in, they were the number crunchers and there was much less of the qualitative stuff. Qualitative anything became devalued in comparison to the quantitative. It's changed the culture of the School. I think it's changed the culture of the University in many respects, the economic situation. Well, that's partly the way it is.

DT: I've heard from several people, actually pretty much everyone I've spoken to in the in the School of Public Health who were at the School in the 1950s, 1960s, 1970s, 1980s, somewhere in that period, and they've all commented that there was this shift in attitude and orientation away from training practitioners or being engaged in practice, so to say, and towards research. I've seen that shift happening in other schools like the School of Nursing, that it was more of a general shift in the health sciences. It's really interesting to see how it had such an effect in the School of Public Health.

BS: Yes. It's been a dramatic effect, I think.

DT: You told us about your own experience in terms of having your contributions being undervalued, because they weren't clinical-research based. Did you get a sense that there were others in the School of Public Health who ascribed to kind of the older model priorities within public health that were being influenced by the shift?

BS: The ones who hung on to that model had a harder time maintaining that. If they were well established—I'm just trying to think of an example—in their field and in their research, it probably didn't affect them as much, the older, closer to retirement faculty. But the younger ones really had to make a shift to fit into the culture.

DT: As I understand it, when you arrived in the 1970s, Alma Sparrow was head of Public Health Nursing?

BS: Yes.

DT: Did she retire at some point or did she step down?

BS: When did she leave? I'm pretty sure she retired, but I can't remember when that happened. I might be able to tell by when I moved into health management. It must have been the early 1980s, mid 1980s maybe.

DT: What are your recollections of Alma Sparrow and how she shaped Public Health Nursing in the School?

BS: Alma was a very interesting person. She had some good leadership ability and I think in many ways, she did a good job, but in other ways, I was quite disappointed. The thing that comes to mind that was especially disappointing is that when I had my first book [*Readings in Community Health Nursing*] published, it was an edited book, but, then, I wrote all the interstitial stuff. It was published and, of course, it says, "University of Minnesota." It gives recognition to the School and the program and I thought she would be delighted for that, you know. She complained that I was never in my office when I needed to be, which wasn't true. I was spending a lot of time in my office, but I was spending a lot of time in the library. We didn't have computers then and I had to look everything up and do all of my research, you know, through the library system. So I had spent hours in the library. I was working a hundred hours a week. You don't write a book without spending a lot of time on it. Then, when I did my textbook [*Community Health Nursing: Concepts and Practice*], that was tremendously time consuming. All she could do was complain that I wasn't visible enough. I said, "Well, Alma, what do you expect me to do? If I'm going to do this kind of work, I can't be in my office to do all of this." You could now, because you could do it all on the computer. You'd be gone mentally...

[laughter]

BS: ...and emotionally, but you'd be there physically. She just wanted a physical body, I guess.

Then, another time, she complained about something and I was really upset. I went to Lee Stauffer and said that I was going to resign. He said, "Don't do that. Please, don't do that." He might have told you this, too, but he talked to Alma and Alma came into his office and stamped her feet. He said she acted like she was having a little temper tantrum. So there's that side of her, too.

But she did a good job in lots of ways. She held the program together. We went through changes and had to move off the thirteenth floor. There were a lot of adjustments: changes in the curriculum, introducing the Nurse Practitioner programs that Barb probably told you about. Alma was good at getting money and developing good relations in the community and sites for our students to practice in, so I think, in many ways, she did a good job.

I could never appreciate her point of view about my scholarly work. [chuckles] She was fine with my teaching.



CT: How much teaching were you doing?

BS: Uhhh... It depended on when you're talking about. I would have at least two or three courses and, then, lots of advisees and committee work. I had pretty much a normal teaching load compared to everybody else.

DT: It strikes me that some divisions within Public Health were not doing very much teaching at all.

BS: Yes.

DT: But Public Health Nursing because you had the graduate programs, there was a lot to be done.

BS: Right. Yes, we had a lot to teach. When you do clinical courses, that's very time consuming. The student to faculty ratio was very low because you've got intense amounts of time that need to be spent individually with students. That added to the workload. And, then, to do scholarly work on top of that, I thought I was knocking myself out. [chuckles] I couldn't understand why she didn't seem to appreciate it. But that's the way she was. In some ways, it was easier after she had retired.

DT: Who took over from her?

BS: Marla Salmon was Public Health Nursing director for a while, S-a-l-m-o-n. She did a lot of other things. She was dean at [the University of] North Carolina in Chapel Hill and I think she's in Seattle or maybe it's Oregon, somewhere on the West Coast now. She was director for a little while, two, three, four years, something like that. She did a good job, a very bright woman.

DT: I'm curious how you ended up on the Faculty Consultative Committee. How did that...?

BS: That was an elected position and I was elected. I guess somebody thought I should do it. [chuckles] Committees are a pain in the you know what. I guess I felt at that time that maybe it was a way I could make a contribution.

DT: How long were you on the committee before you became chair of it?

BS: Not too long, maybe a year or two. I don't remember.

DT: I've heard from other people about the faculty uprising around Bob Kane. Your perspective on it is completely valuable, because it's from more on the inside and seeing how that worked.

So I'm curious about the power of the Faculty Consultative Committee. What kind of power did you have on the FCC?

BS: Well, you know, power is a relative thing. Your power is directly related to how much power you want to take. I think people who were timid were powerless. I felt that as representatives of the whole faculty group, and there were a couple hundred faculty... We didn't do any formal survey per se, but we did lots of talking informally with people, and really had a pretty strong sense of how people felt. So representing the faculty, we felt that something had to be done. I, as chair, had felt the need to do it. I don't know how I got into that spot, but I don't remember feeling upset about it or intimidated. I just felt very confident. I'd already tangled with him over my own tenure and that was history for me, and I knew how to work with him. I knew that he—forgive me for saying this—essentially bullied people. Unless you bully back, you don't win, so I learned to stand up to him, and I think he appreciated it. I think he appreciated somebody not being afraid of him.

When we talked to him at that time that we called him in, it was a little bit tense, but it was an okay meeting. It went well. He was receptive and said he would try to improve his performance. But, then, when I had to go to Cherie Perlmutter, by then, some of the people in the School were calling it charm school. He went to charm school and it didn't take. [laughter] Maybe that's just not what he was cut out to do. I think what he's doing now is what he's cut out to do and that's where his skills are. I think he's making a huge contribution in that way. But, as dean, he really didn't seem to pull it off.

Back to your question about power... Part of our power was the threat of public exposure. I knew that would work, so I used it.

DT: I'm on a University committee myself, so I'm only beginning to understand the structure of the committee. The FCC, this was specifically for the School of Public Health. You were responsible to your constituents, the faculty in the School of Public Health, but, then, was that chain of command up to the vice president for health sciences office?

BS: I don't know. That's a good question. I don't know. I don't remember any chain of command, but, apparently, that was the next level, the vice president of the health sciences, that I felt I needed to go to. So, apparently, that was it. It wouldn't be one of the other academic units, and it couldn't be the dean, and an associate dean wouldn't have any power. So it had to be somebody above the dean and that would be the next person that the dean would be reporting to. So I guess that would make sense.

DT: You mentioned earlier about Edith Leyasmeyer, that she was interim dean for a couple of years between Stauffer and Kane. You mentioned that she had somewhat of a difficult time. I wonder if you'd be able to elaborate on that.

BS: Interim anything is a difficult position, because you can't really initiate your own programs and move forward. You have to kind of hold the status quo and keep the peace and hope that things are going to be okay. She, eventually, was instated as the dean, but she didn't have that position initially. I think she was more free to move ahead once she

had that freedom, that position. Interim is temporary. I think she did a fine job. She is not a charismatic leader, but she held the School together well. I think she did a nice job in lots of ways.

DT: It's striking that she held the interim position a couple times between other deans.

BS: Yes.

DT: Then, as you say, she was finally given the full appointment.

BS: Right.

DT: It's interesting. I did speak to her for a short while earlier this year. She did not elaborate too much on her experience.

BS: Well, she probably was being discreet.

DT: Yes.

BS: This is *totally* a guess on my part because I have *no* evidence to support this. But, the *old boy* network—this is true in medicine, too, I think—is hesitant to allow women to have power. For her to be in that role, especially at a time when leadership was needed, really put her in an awkward spot. I think she was working with a handicap just because she was a woman, a very capable woman, but nonetheless... There was a whole bunch of... People like—I hate to have this on the record—Henry Blackburn and some of the others who'd been around for a long time who appeared to be male chauvinists. I think they had a hard time with a woman leader. That's just a guess.

DT: That was something that I wanted to ask you about...your experiences, particularly as the chair of the FCC. It ended up it was a powerful position and I wonder not just about the FCC but like during your experiences, what role did gender play, do you think?

BS: I think once you've dispelled the myths through your own performance, then, you can move on, but it takes a little while to do that. I think once I set people at ease and let them know that I was going to be fine and doing all right and did my job, I had the respect that I needed in order to move ahead. There's a breaking-in period.

DT: Around the time that you first arrived in the School, this was around the Shyamala Rajender case and the Rajender Consent Decree.

BS: Yes.

DT: Can you reflect at all on whether that had any influence on your career or the culture at the School?

BS: Oh, yes. Faculty salaries were not equitable and we were able to get not just an increase but a retroactive pay settlement for the women faculty whose salaries had not been commensurate with the men of equal standing. But that took a lot of work. I wasn't directly involved with that, but I was there when it happened.

DT: Did the Rajender Consent Decree have any bearing on your tenure case at all?

BS: I think it cast a shadow on it, but the tenure case, as far as Bob Kane was concerned, was specifically research versus teaching and me not making the right kind of contribution to what was needed for the School. I could point out a number of other people on the faculty who were doing a lot less than I had done. I didn't go into that, but I just felt that I was justified in fighting for my rights, because I felt that I was making a contribution. My students were happy and I enjoyed the classes and I was doing scholarly work and I had good community ties. Just because I wasn't doing hardcore research didn't mean I wasn't making a contribution. The Rajender thing raised that whole awareness of the inequity between men and women at the University. So I think it raised consciousness of that and at least had some bearing on my situation.

Bob Kane...mostly he was getting rid of women faculty by trying to get rid of the Public Health Nursing people, and he did. He did fire some of them. We lost quite a few people who didn't try to fight back. The strong ones survived. [chuckles] It was unfortunate for the others.

DT: Not just in Public Health Nursing, but it seems that across the board in the School of Public Health because so many people were on soft money, there was the shortage of tenure lines in the School of Public Health.

BS: There was.

DT: Then, you add that extra vulnerability of being women...

BS: Exactly.

DT: ...at least in that situation, it makes...

BS: Most of us in that unit were on soft money. But I stayed on soft money the whole time. I was lucky because I left at the right time before things got tough.

[laughter]

BS: I can remember, even when I was still there, Bob Veninga and I would talk a lot. He and my first husband were very close friends. I'd say, "Bob, you've just got to be like an anthropologist and pretend that you're observing this culture. Then, get in your corner and do your own thing and just let the rest of the world go by."

DT: [chuckles]

BS: “You can’t let it get to you or you’re done.” That’s kind of the little game that we practiced. We’d remind each other, “Let’s just play the anthropologist.”

[laughter]

BS: “Do a little observing of this culture.”

DT: It sounds like your first husband had a big influence on you.

BS: He did. Yes. I appreciated his anthropological perspective. Well, it fit so well with public health values and philosophy, to respect another culture, learn how they think and try to understand. That’s partly what you have to do to practice good health. Practices in public health, good medicine, good nursing, whatever it is, you’ve got to understand the context that you’re dealing with.

DT: As you were alluding to, the different cultures within the health sciences, too, that you have to negotiate.

BS: Yes, exactly. Lots of negotiating.

DT: You’ve talked about the relationship between Public Health Nursing and the School of Nursing. I’m wondering if you can say anything about what relations were like between the School of Public Health and the Medical School, and Dentistry perhaps.

BS: And Pharmacy. We mixed on committees, examining committees. We’d have a mix of health sciences faculty. Well, of course, it depended on the students’ research and interests. I had students in my classes from almost all the other schools at one time or another. I taught a course called Healthcare Leadership and I had a lot of students from other schools. I had doctors and nurses and dentists and pharmacists and lawyers. It was very interesting and fun to have that kind of a mix in your classes. I prefer to do a seminar type of class when I can, because I think the students learn a lot from each other. So to have those different perspectives from the different schools really, I thought, was a learning, enriching for everybody, including myself. So that was one way that we mixed.

We had some crossover like I’d serve on a search committee that would involve collaborating with Medicine or Pharmacy or Nursing or somebody depending on the position. I served on the search committee for the dean in the School of Nursing and at least several others where we had a mix from the various schools. In that sense, there was crossover.

I don’t know if I’m answering your question.

DT: You are. A lot of people have responded and, said, “Sometimes, in an odd case, here or there with respect to research but, generally, the schools were somewhat separate.”

BS: Well, they were, but there were the opportunities for crossover. Then, there were times when the health sciences people would be thrown together for colloquia or whatever or someone was presenting research on a topic that might include a pharmacy emphasis or dentistry or pacemakers, something that would bring in the cardiologists. I think there's been a lot of mix that a lot of people aren't aware of. Students in your classes, you don't advertise to rest of the faculty.

DT: It speaks to your philosophical orientation, as well as optimism and seeing the best, the best in things that you are indentifying crossovers that other people probably experienced but just...

BS: It didn't register.

DT: Yes. [chuckles]

Obviously, when you were dealing with the Bob Kane situation, you were interacting with Cherie Perlmutter. But I wonder, before that, did you have much experience with the senior vice presidents, Lyle French and Neal Vanselow?

BS: I didn't personally. I know Lee Stauffer talked to Lyle all the time. Bob did, too, when he was associate dean. I think there was more collegiality at that level with the dean and the associate deans of the schools, more interaction with the vice president because there was, obviously, more reason to. But, I personally didn't, but we'd hear about them and they would speak at meetings and whatever, faculty meetings, or give reports on something that was going on in the University.

DT: Do you have a sense of whether there was a hierarchy within the health sciences between the different schools?

BS: I didn't really feel that anymore than... Medicine has always been held up as *the* most important science, but that's not true. [laughter] I didn't buy that. I didn't personally see it that way. The Medical School has a lot of prestige, probably more so than the School of Nursing. I think we have a lot of doctors, a lot of M.D.s, in the School of Public Health, so there was more equality there, somewhat. [chuckles] But, overall, I didn't see a huge hierarchy. If you had to put them in a hierarchy, if you had to rank them, Medicine would be first and, maybe, Public Health second. Pharmacy and Dentistry and Nursing in that order.

[chuckles]

BS: That's my guess.

DT: In the late 1970s and early 1980s in the School of Nursing, the graduate faculty put a lot of work in to get a doctoral program established. Did you have any involvement or

engagement with that process or any point of reflection about the effort to get a doctoral program established?

BS: I did not have any involvement in it. I did hear about it and talked with people during that process. I strongly supported it. I thought it was a good thing to do, for one thing, just to raise the level of prestige for the School and preparation for people to practice in the field. To hold equal status with other professional peers, I think it was important. Typically, nurses who went on for doctorates would get them in non-health related fields, which was unfortunate in some ways, because, then, we'd sometimes lose them. They'd go into education or they'd go into psychology or something else. For the status of nursing as a professional group, I thought it was a good thing and I was glad to see it happen, but I didn't have any involvement in it.

DT: Did you hear any opposition to it?

BS: I don't remember any. I think they ran into some, but I don't specifically know about it.

DT: I saw in the Archives, and I've spoken to some of the graduate faculty who were involved in setting up the doctoral program, and the opposition they confronted was, I think, usually at that higher administration levels where questions were being raised: counts as nursing research? Is it really rigorous enough? Things you can probably well imagine.

BS: I've noticed it's almost over compensating. The School of Nursing puts out a periodical. It's very nicely done, glossy, pictures, and everything. That hardcore research, the quantitative stuff, gets *really* emphasized in there. It's almost like they're trying to prove something. But, in a way, they are, because they've had to overcome that stigma.

DT: I don't suppose you were involved in the Pilot City Health Project.

BS: I worked there for a while.

DT: I have no idea what it is, so could you talk about...?

BS: Ohhh, I hardly remember anything about it. It was right when we moved here. No, it wasn't; I was at Saint Kate's first—or am I getting it mixed up? Where did I work first?

DT: You were at Saint Kate's first.

BS: I was at Saint Kate's, yes, because we moved here in 1969, and I started at Saint Kate's. You know, I must have left this out of my résumé. My CV [curriculum vitae] doesn't include it. Ha! I'm going to have to correct that.

When I was with the Minneapolis Health Department, I started out at Pilot City. That was in Northeast Minneapolis. Is it still there? I'm not sure. How did you hear about it?

DT: I found it in the Archives, just a couple of references to it. I've been asking everyone in Public Health, "What was it?" I think it was Lee Stauffer who said, "Barbara Spradley will know." [laughter]

BS: Oh, dear.

Well, it was a community health center and it was serviced, at least partly, by the Minneapolis Visiting Nurse Association and the Minneapolis Health Department [MHD]. It was a combined MHD and MVNA, Minneapolis Visiting Nurse Association, so we had nurses working in that clinic and, then, going out from there to serve people in their homes. It was a very rough neighborhood, mostly ethnic people of color and a poorer neighborhood, so there was a high crime potential. It was not safe and the nurses were asked to go in pairs sometimes and didn't make any after dark visits and that kind of thing. We had a steady stream of people. It was kind of like an urgent care would be now, but, at that time, it served that purpose. So people would come in with whatever their immediate problems were: colds, flu, baby sick, knife wounds, whatever. Then, we did a lot of immunizations and some health counseling, health teaching. I don't know if the doctors were paid through the Health Department or if they were volunteers. I'm not certain about the funding of it. It served a very useful purpose for quite a few years. It was an interesting experience for me to work there, too. I was glad to have that.

DT: It was called Pilot City. Was that because it was supposed to be a pilot project, which would be moved around?

BS: I'm guessing that's probably right. I don't know. Who else would know? LaVohn Josten might know. She knew some of the people that worked there. LaVohn Josten's area is maternal/child health and she had some connections with the Minneapolis Health Department. Who else would know? Well, I can always call you and give you a name if I think of somebody else.

DT: Yes, sure, if you think of anything.

When did you become chair of Public Health Nursing?

BS: This is what my CV says, "Nineteen eighty-eight, Public Health Nursing." Then, I was in that position for about a year.

Then, that's when Public Health Nursing moved. We, who stayed in the School, were, then, just in Health Services Administration. Then, that name got changed to Health Management and Policy.

[chuckles]



BS: So, I became chair of the Public Health Administration piece, that unit within Health Management and Policy, in 1991 and it was that way for three years, 1991 to 1994. That's on here.

DT: You already talked a little bit about that decision, that process of moving Public Health Nursing to the School of Nursing.

BS: Yes.

DT: I wonder if we could just talk a little bit more about it. You mentioned that you had to convince the graduate faculty in the School of Nursing, some of them, to come over. Was there any resistance on the side of Public Health that didn't want to go?

BS: Yes, but not as strongly. There was strong loyalty to maintain it in the School of Public Health and the people who felt strongly about it stayed. So there weren't too many faculty that went, but the program went. Then, new people were brought in. LaVohn Josten was one who had been head of the Minnesota Health Department Public Health Nursing and she came on the faculty. And, oh, shoot...Resnick. Linda [H.] Bearinger, I don't know if she was fulltime faculty, but she had a public health background and she was in the School of Nursing by then. Judy...what's her last name? I don't know; I can't think of it. [Benike]

DT: Maybe you'll remember when we get the transcript back.

BS: Yes. Anyway, there were some people who were brought in to replace those of us who stayed in the School of Public Health. Barbara Leonard made the shift. You got her story. Sharon Ostwald stayed in the School of Public Health and she's now in Texas. Mila Aroskar, whose field is ethics stayed, but, now she's retired, and she lives in Tucson [Arizona]. Who else? Pat [Patricia M.] McGovern, Sue [Susan G.] Gerberich, and... Oh! I'm blanking on her name. She's now an assistant or associate dean in the School. I know it so well, but I've lost it. [Deb Olson] Those three went into Environmental Health. Those were all nurses that were in our program.

When I was chair of Public Health Administration, It included Mila Aroskar and Sharon Ostwald, Lee Stauffer, Bob Veninga, and Les Block and me. There were six of us.

DT: It sounds like a nice group.

BS: It was a great group. We had a good time, a very good time. Yes.

[chuckles]

BS: I think that answers your question. When the program moved, the resistance, if you want to call it that, was that the faculty stayed.

DT: But in a way, especially the people who'd been in the School of Public Health for their careers, that would be quite a shift to suddenly move.

BS: And to move to the School of Nursing when there had been a fair amount of resistance didn't make a lot of sense, you know. It was an understandable thing to stay put where we were already tenured and didn't have to go through that.

DT: Who was dean at that point? Was it Egan? The School of Nursing, that is.

BS: Oh, no. By then it was Sandy.

DT: Sandy [Sandra] Edwardson?

BS: Yes.

DT: What was your experience working with her to get the program moved over?

BS: Umm... She was new at that time. I think the decision might have already been made. I'm not certain about that. More of my dealings were with Ellen. I worked fine with Sandy. We described her... I don't like it being recorded.

DT: We can take it out.

BS: We described her as having an iron fist in a velvet glove. She didn't appear to be as strong as she really was, so it was disarming for some people. As far as I know, she did a good job. I knew her personally a little bit. We'd see each other at meetings, but I didn't have much dealing with her.

DT: One of the other things I want to talk about—I did discuss this with Barbara Leonard last week, but I'll be interested in your perspective—is the status of the Nurse Practitioner programs. Can you talk at all about what it was like when those nurse practitioner programs were first established? These are the ones that came up in the 1970s.

BS: We had two sets of students, because the students who were in the Nurse Practitioner Program were really more specialized in their field within Public Health. Their learning experiences were separate in many cases and they shared some core courses. But there wasn't as much of a mix, because they had their own clinical practice settings. The faculty who ran those programs were pretty much immersed in that. It was kind of like having a cousin living in the house with you. [chuckles] I remember it being a very positive thing and the feeling on the part of a lot of the nurses that it gave a little more status to the nursing field. I think it was already in place when I came on board.

DT: A couple of the other early nurse practitioner programs, I think, had been in pediatrics and the gerontology.

BS: Right, those two in particular. Marilee [A.] Miller... What's her maiden name? [Woehning] Barb must have mentioned her. Marilee was involved with the geriatric nurse practitioner program. She'd be an interesting one for you to talk to.

DT: Nationally, from the mid 1960s through the 1970s, nurse practitioner programs were being set up at various institutions. But, again, it was most typically in schools of nursing and not in public health.

BS: Right. Yes.

DT: It's curious that these innovations took place in the School of Public Health.

BS: See, that's another—back to my speculation—reason why there was conflict between the two schools. I think there might have been a little jealousy about who was doing what. But the graduate faculty in the School of Nursing were not being as innovative or as assertive about starting new things and the faculty in the School of Public Health were more innovative.

DT: The Nurse Practitioner programs were temporarily moved to the School of Nursing and, then, eventually, transferred to Saint Kate's, at some point?

BS: Yes, I think so. I don't know the history there, what happened at Saint Kate's. I wasn't there anymore at that time. They were transferred to the School of Nursing for a time. I'm not sure where they are now, if they exist at all.

DT: Barbara Leonard seemed to suggest that they were now all at Saint Kate's.

BS: Okay. Well, could be. She would know more than I.

DT: Again, it's curious.

BS: It is. It's like tracking down a mystery, isn't it? All of these clues.

DT: That's why I'm so glad to finally been able to speak to you and Barbara Leonard, because you're filling in some crucial pieces of the jigsaw puzzle.

BS: Oh, good. That's good. I'm glad to help

DT: We've covered a lot of ground. I'm curious if you have anything else that you think we should talk about in terms of the history.

BS: You asked for my thoughts on the recent history and I think we did talk about that.

The one thing that bothers me the most is the way that economics are driving the direction of research. That concerns me. As a whole health sciences unit with all the

schools, I'm not sure that we're addressing all of the problems that really need to be addressed. I think we're letting other people dictate.

DT: Actually, I'm glad you brought that up again. I was curious when you mentioned that earlier when you said faculty were having to get money from places that they might not typically have liked to go. Could you elaborate a bit more on what some of those places are?

BS: Well, I'm not privy to all of those. I'm just knowing that the Kellogg Foundation or federal grants or private foundations have their own agenda, their own ax to grind, or whatever you want to call it and their own concerns about certain needs that they see. It's sort of like people feeling the elephant, you know. Some people say, "Oh, an elephant is this big trunk," because that's the part they're feeling, or the side of the leg or whatever. I think we need somebody to stand back and say, "What does the whole elephant need and where should our priorities be?" I don't see that happening, because the faculty are scrambling just to keep their jobs and glad to get funding for their grants. When they write a grant, they hope they get funded. Sometimes, they have to rewrite it and reword it to focus on the thing that the grantee is willing to fund. That bothers me. That's the cart driving the horse. I don't like that. That's my thought on the recent history of the School.

I think the new University president [Eric Kaler] is an experienced and wise person from what I'm gathering. I think he will provide some good leadership. But I don't know how that filters down into this kind of a problem.

DT: When did you retire?

BS: Nineteen ninety-six. So, it's been a while. [chuckles]

DT: Yes. Frank Cerra was senior vice president when you retired.

BS: Yes. Have you seen him?

DT: I work relatively closely with him, because it was his vision, basically, that established the history project for the Academic Health Center.

BS: Good.

DT: The funding for the project comes from his endowed chair.

BS: Excellent.

DT: Now, that he's retired as senior v.p., he's looking at the history and planning to write a book.

BS: Very good.

DT: So he's reading all these oral histories for his own edification and interest.

BS: That's great. Oh, dear.

[laughter]

DT: He's learning a great deal, he says.

BS: I'm glad I get to see the transcript.

[laughter]

DT: He's been very hands off. He just wants an honest portrayal.

BS: He gives you a lot of latitude?

DT: Yes, I don't have to run anything by him. We have regular meetings every three months, but not to dictate who or where I go, just a how are things going.

BS: Good.

DT: As you say, when you have a patron that can really influence the nature of the research, but, in this case, I've been really fortunate that it's not been that way.

BS: Sometimes, there are philosophical differences, too, between individuals on the faculty. Obviously, there are. I was just thinking of John Kralewski, who used to be... I don't know if he's still there [in the Center for Health Services Research & Policy]. Is he?

DT: Yes.

BS: Oh, my goodness. He and I always differed on the need for a broader curriculum. He thought research should drive your teaching, that you should be teaching what you're researching. I pointed out, and he could not see it, that, sometimes, there are things that need to be taught, like leadership or organizational culture or some of the more nebulous stuff, that it's pretty hard to let your research drive what you teach in the class. He did not agree. What you teach is what you have researched and that's all you teach. That would leave some huge holes in the curriculum. There's always philosophical differences. He, or people like him with that kind of a view, would maybe not be so bothered about being narrowly focused in their research because of funding organizations saying, "This is what we want." There's lot of things to choose from, why not this as opposed to anything else? But, then, somebody still has to have a big picture.

DT: That speaks to that philosophical orientation of people who are more focused on research versus those who prioritize teaching...

BS: Right.

DT: ...and scholarly work around teaching. It seems, at least since I've been at the University, that there has been a renewed or a growing appreciation for pedagogical scholarship, doing research on teaching.

BS: Good.

DT: I don't know how that really gets evaluated vis-à-vis the more fundamental types of research, so to speak. It's an interesting philosophical orientation.

BS: It is. Yes. I think what happens when we have the cart driving the horse, the money driving the choice of research subjects, is that we end up having a lot of little splintered projects. It doesn't tend to create a cohesive whole as we had it under Lee Stauffer's leadership. That was partly his leadership and his style, but, also, because of the economic and environmental times. So there was a more cohesive whole for the school. I'm not just talking about the School of Public Health, but the health sciences generally. There was more reason to be interdisciplinary in our approaches to things and to give students that perspective. You can have a physician caring for a patient, but this patient may need certain medications that a pharmacist could be more helpful with or his dentist who is treating an infected tooth. There's all these reasons why the cohesiveness is important for good health in our country. I think we, at least now—this is just my perspective—have put the onus on the patient to try to pull that stuff together. Unless people are willing to stick their necks out and be assertive and ask the right questions and pool the information together that's needed to give themselves a holistic set of rules to go by, they're in a mess. People are not getting as good a quality of healthcare as they could. We have the technology. We have the ability to, but we're very splintered. We're so highly specialized.

We're members of Health Partners through the University and ever since they've gotten computerized, I have noticed a difference in better referrals and more interdisciplinary stuff through my primary physician and others. So communication is an important part of it.

DT: Primary care providers, be they nurse practitioners, family docs, or internists, they're supposed to be the coordinator of patient care and need to view the patient a bit more holistically in the kinds of needs that they have.

BS: Yes, and some do it better than others. But overall, we're very fortunate to have as good a system as we do.

Any other questions that you have for me?

DT: No, I think we've covered a great amount of ground. I've learned a lot from talking to you.

BS: Good.

DT: So thank you.

BS: You're welcome.

DT: And you were worried about not being able to remember much. This has been wonderful!

BS: You were right. It does come back, except names. I'm just terrible on names.

DT: You've done pretty well. I'll be able to fill in some of the gaps and you may be able to when you look over the transcript.

BS: Okay. Good enough.

DT: Thank you.

[End of the Interview]

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