Florence Marks, RN, MA
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

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

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

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

Biographical Sketch

Florence Marks was born in Louisville, Kentucky, in 1928. She received her BS from the University of Cincinnati in 1949, her BS in Nursing from the University of Minnesota in 1953, and her MA in Nursing Administration also from the University of Minnesota in 1956. Before coming to the University of Minnesota, she worked as a chemist. From 1953-54, she worked as a general staff nurse and assistant head nurse at the University of Minnesota Hospital. In 1955, she spent about six months working as a general staff nurse in Marselisborg Hospital in Aarhus, Denmark. From 1956-1961, she worked as a nursing supervisor at the Variety Club Heart Hospital at the University of Minnesota. In 1962, she was the special assistant to the director of Nursing Services at the University Hospital. She then stopped working as a nurse to have and raise her children but continued to be involved with nursing.

Interview Abstract

Florence Marks begins by describing her background, including her education and why she went into nursing. She describes traveling to Denmark to temporarily work as a nurse; her experiences as a staff nurse and then assistant head nurse at the University Hospital; getting her master's in nursing administration; working as nursing supervisor at Variety Club Hospital; her experiences as an instructor in the School of Nursing; and some of the other work she did after she had children. She discusses in detail her experiences as a nursing student at the University of Minnesota, including the School of Nursing curriculum when she was a student, clinical instruction and her experiences worked at different affiliated hospitals, her rural nursing experience, and living in Powell Hall.

She describes working as a woman chemist in the early 1950s; the perceived and real differences between RNs, LPNs, and nursing assistants; the technologies she worked with; curriculum changes in the School of Nursing; and the different ways women physicians were treated from the 1950s through the 1970s. She discusses the different relationship between nurses and physicians in private hospital settings and teaching hospitals; minority nursing students; nursing shortages; nursing students failing the state boards in the 1960s; the reorganization of the health sciences in 1970 and the impact on the School of Nursing. She compares her experiences as a nurse in Denmark and at the University Hospital. She talks about Katherine Densford, Florence Brennan, Ray Amberg, and Edna Fritz.

Interview with Florence Marks

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at Florence Marks' Home

Interviewed on April 13, 2010

Florence Marks - FM
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Florence Marks at 3424 Silver Lake Road, Saint Anthony Village, Minnesota. It is April 13, 2010.

Thank you for agreeing to be interviewed today. To get us started, could you tell me where you grew up and a little bit of your background and how you got into medicine?

FM: That's an interesting story. I was actually born in Louisville, Kentucky. My father was a physician and, at that time, he had just bought a nice new home and was in a specialty, ear, eye, nose, throat [EENT]. That was 1928. Then, in 1929, there was this thing called the Depression. He hung on for another year or two, but couldn't make it.

So he then joined the Public Health Service. I have a sister who is four years older than I. The family moved to Cleveland, Ohio when I was about three. He had some initial orientation to the public health service there in Cleveland. When I was four, we moved to Key West, Florida. My Kindergarten was taught by Calvert School System. My mother and a couple other friends put together, with several families, their own school for teaching—Calvert School—because the schools there were not to their liking. Then, we moved from there to New Orleans [Louisiana] for a couple years. Then, we went to Alexandria, Virginia, for part of a year. Then, we went to Hagerstown, Maryland, for a year where my father was a county health officer, which was kind of interesting. From there, we moved to Springfield, Illinois.

Someplace between Maryland and Illinois, my father got interested in doing chest X-rays for tuberculosis, and he built, with the help of my uncle, who was an electrical engineer, a device to put in the back of a big Lincoln Zephyr, which was a twelve-cylinder car that can haul around heavy radiological kinds of equipment. So he took this X-ray unit out into the countryside to check on tuberculosis in children in grade schools. I always was fascinated by that. I remember I spent a day or two when we were in Maryland—I must

have been in third grade—visiting these places. He showed me what lice looked like in heads and a few other things. That always interested me and health, so I was always sort of geared toward the health field.

Then we went to Chicago, Illinois. We actually lived in Oak Park. Then World War II broke out, which was sort of traumatic to us all. My father ended up being transferred back down to New Orleans. About the second year there, I was a sophomore or junior in high school. I skipped a year in here because of the way the schools were set up. I had skipped a half grade, and they didn't have it so I went ahead. At any rate, the sophomore/junior years were in New Orleans and the freshman year in Oak Park. Then, he was asked to go overseas to do some of the work with refugees. At this point, we moved to Cincinnati [Ohio], so my senior year in high school was in Cincinnati, and my dad was overseas. I graduated and he was still overseas.

I started at the University of Cincinnati. I thought I'd do pre-med. So I had a double major of chemistry and zoology. My competition was fierce. The war was over in 1945, and I was sixteen. I sort of majored in extra curricular activities, so my grades were not straight A's. I was maybe a B, B+ student. [chuckles] I had a good time. I enjoyed campus life. I did not get in the medical school. In my junior year, when I applied the second time, I was interviewed and the interviewing committee asked me did I plan on getting married? I said I hadn't planned *not* to get married. Well, they couldn't afford to give a space in medical school to someone who wasn't going practice full time. They couldn't do that now. [laughter]

DT: Yes.

And not having, you know, a fantastic grade point average, that sort of… So I floundered around. I turned twenty in October, and I actually finished my college in three and a half years. I did go to summer school.

So I started work as a chemist in January that year, 1949. I was doing analytical chemistry in a research laboratory at National Distilleries. Now, we come from a very prim and proper family. My grandmother *insisted* that I not tell anyone that I was working for National Distilleries. That was in Carthage, Ohio; it's still there. So I would tell them I worked in a research laboratory. That was all right.

[laughter]

FM: Someplace along the line, I had my own little lab, and I was doing spectrophotometry and biological assays, and I had all the reagents up there. I was starting to name the bottles, you know, Sarah, Henry, and Louise, and I thought I'm in the wrong field.

[laughter]

FM: I need to be out working with people.

That fall my folks had moved up here. My dad had transferred to the V.A. [Veteran Administration] and he was out at Fort Snelling. He said, "Dopey"—he always called me Dopey—"come on up here. They've got a good school at the University of Minnesota." I came up here and was an adult special. One of my favorite courses that first fall was called ecology. Nobody knew what it was.

[chuckles]

FM: Fascinating. I *loved* it. I liked zoology. At one point, I thought I'd major in zoology, but then I remembered the reagent bottles. I interviewed at the Social Worker School and was not at all impressed. My mother was a nurse, and she managed to gather information about schools of nursing that she sent to me. She got them and gave them to me. I got those brochures.

Oh, I forgot to mention… That spring when I was floundering around (the first year in Minnesota), my folks transferred to Harrisburg, Pennsylvania, so they were moving out. I had to decide where I was going to go. I happened to wander into the School of Nursing and came down the hall and I saw this conference room. The offices were here and the conference room at the juncture of the corner. There was this very interesting woman sitting at the head of the table—I could see through the door—with lovely white hair. She looked over and she looked at me, and I was sort of looking at the offices where to go. She said, "May I help you?" I said, "Yes, I want to get information about going into nursing." There was a bench. She said, "Would you wait there, and I'll come and talk…" It was Katherine Densford

That was a faculty meeting, I found out, years later, in that room. [chuckles]

She had me in her office and we chatted. Then, I found out she had grown up in Ohio, and I had just graduated from the University of Cincinnati and that's where she had her nurse's training. She would be very glad to consider my application for the School of Nursing. She felt sure there would be a lot that I could contribute, etcetera, etcetera. That was it. Okay, sign me up.

I did apply, to placate the family… My father wanted me to go to Yale and my mother had gone to school in Cleveland and she thought I should go to [Case] Western Reserve [University]. So I applied to all three schools, Western Reserve, Yale, and the University of Minnesota. [I was accepted to all three]

Oh, I didn't tell you this. The day I announced that I was going to go into nursing, my father was horrified. He felt I had too many brains to go into nursing. That should never have happened. He didn't talk to me for three days. I was shunned. [laughter]

DT: Even though your mother was a nurse.

FM: Yes. Yes. Yes. The result of that was that there was to be no financial assistance from him for me to go to nursing, but he would loan me $1,000. That was it. I was going to have a loan of $1,000. That did influence, to some degree, I don't know a lot, about my stay in Minnesota. It was thirty-three dollars a quarter.

DT: A little different from today.

[laughter]

FM: Thirty-three dollars a quarter, and I could make it through nursing on $1,000, I was pretty sure. So I stayed in Minnesota and they went off to Pennsylvania, and, later on, went to the Philippines and all over. But I stayed here and I've never left.

I went to Nursing School, graduated in March 1953. I stayed on as staff nurse at the University Hospital and became assistant head nurse. About this time, I got some inheritance money and managed to pay back my father the $1,000. I also got a Sigma Theta Tau Scholarships for two years, which paid tuition, so I just had expenses of taking the train back to various places to see the family. I had no relatives around here at all. My closest relative was my sister in Indianapolis, Indiana. I was pretty much on my own.

About 1954…yes, it was in 1954, that summer, a friend of mine that I knew from Cincinnati said, "Okay, let's go to Europe for a month." She was out in California, and I said, "Sure." That spring, we were planning this trip. We were going to leave in August. She said, "Oh, there's this fellow is getting pretty serious with me. I think I better stay here and won't go." I said, "Well, I'm going to go."

[laughter]

FM: So it was all kind of a change of plans at the last minute. Katherine Densford…I talked with her. She said, "If you're going to be going abroad, the best place…" I said I wanted to work and make it worthwhile and spend some time abroad. "You should really work in Denmark." She was, at that time, vice president of the ICN second vice president. Anyway, she was up there, one of the officers of the International Council of Nurses. She said, "Denmark is one of the few countries that will take non-Danish speaking nurses, English-speaking nurses specifically, or German or Swedish, as part of the exchange program." At that time, if Danish nurses wanted to come to the United States, then Denmark had to accept as many nurses from the United States. It had to be a fair exchange. So, consequently, they would take non-Danish speaking nurses from the United States. That was one of the few countries that did that. I had taken Spanish, French, and German, none of which I knew.

So I went to Denmark. But to get there, she gave me about a dozen letters of recommendation. She said, "You'll need these." I said, "Okay," and I packed those up. When I got to London—I did not have my assignment beforehand because this was all kind of changed at the last minute when I was in London. I walked into the ICN office in September, and gave the secretary my letter of recommendation. It was sort of all kind of

hoity, and I was sort of feeling like a pea, a very small little speck. I handed in my letter and, all of a sudden, the double door opened up, and this woman walked out. [chuckles] I was *queen*, all of a sudden, all because of the letter from Katherine Densford.

DT: Where in London was this?

FM: Where, I don't remember…the ICN, the International Council of Nurses headquarters, wherever that was.

I was staying with some relatives in Bexhill-on Sea in England, so I had an address.

In the meantime, I had a classmate who was living with her husband at an Air Force base near there. I went up and we toured around with them and toured Scotland and did some of these thing waiting to find out and then that finally came back and I did have a letter from the ICM saying that I could start in Aarhus at Marselisborg Hospital as a staff nurse the first of November. I would be there for six months. I had a six-month work permit. I had a friend in Norway and visited there in October for three weeks or so, and then went down to Copenhagen and toured Copenhagen for about a week. I was living on two dollars a day, staying at youth hostels and walking a lot and not eating much. Then I ended up in Aarhus on the first of November, and had one of the most wonderful experiences of my life. I wrote an article about my experiences that was published here in the *Minnesota Registered Nurse*, "Danish Nursing is Fascinating" [vol. 25, no. 1, January 1955].

DT: Oh, excellent. I'll have to look that up.

FM: That was a remarkable thing. I enjoyed my experience very much. I had a mentor who was a senior nursing student who spoke very good English, Inga. Inga and I are still friends. I email Inga. We've been over to visit several times, and she and her husband have come here, so we made lifelong friendships, very meaningful.

One of the things I realized is that some of their nursing duties were different. We swept floors. We made up sandwiches. We did a lot of things that are—quote—not considered nursing here. But, you read Florence Nightingale, and the environment is… Somebody has to do it. [laughter] On the other hand, they had some techniques that were amazingly good. They had a respirator that was a positive/negative respirator, the likes of which we did not have back at the University of Minnesota. We were still on iron lungs. I thought why in the world don't we have…? They piped in oxygen; we did not have that. They had piped in suction; we did not have that at that time. So, in some ways, they were very much ahead. I did make some other comments in that article about differences that were interesting. I was working by myself on nights after about two months of learning the ropes. It was like taking care of infants in a way because I didn't know the language. I knew the records, what the various diagnoses were, and what the nursing problems were. I could tell by what was going on with them as to what I needed to do to help them, so it worked out fairly well. The worst part was answering the phone…

DT: [laughter]

FM: …as you may know.

DT: Yes.

FM: The one phrase I learned was *Øje blik*, which means just a minute. *Øje* is eye, and *blik* is blink…in the blink of an eye. *Øje blik* I'd answer the phone, and someone would say something. Of course, if it was one of the doctors, they all spoke English. That wouldn't be a problem. I'd wait until they finished their statement, and then I'd say, "*Øje blik*," and I'd go to the other phone, and I'd call the operator and have it transferred to the supervisor who was on duty and spoke and English, and she would take the call. That was how that was handled…my most traumatic experiences. I really enjoyed that.

By the time I left…

Oh, one other thing. The head of the department was Professor [sounds like Nird-berg]… They had a medical school there in Aarhus at the University of Aarhus. They would go on rounds just we did with one very interesting note. The secretary would come along and she had a roller cart and a typewriter on it. The patient's records were in a notebook, so you could take pages out and they'd go in the typewriter. He would dictate comments with the patient and all the medical students there for her transcribe immediately into the patient record.

DT: Wow.

FM: The patient was included, and it was immediately transcribed, which was far faster than we did back before we had computers at the bedside. I thought that was a good way to do it. The patients' charts were always at the foot of the bed, so there wasn't any necessity of transcribing twice. If you did vital signs, they were right there. You didn't have to write on another piece of paper and then take them someplace else. So there were many efficiencies that I thought were good.

One embarrassing thing, though, was as usual in this country, you would have a nurse go with the rounds, with the doctor's rounds, and when I was assigned to accompany Professor [sounds like Nird-berg] and the medical students, he would always do the entire conferencing at the bedside in English and ask questions of the medical students in English, and they had to respond in English. I always felt very sorry for them because he only did that when I was there.

[laughter]

DT: That's great, though, that he did it to include you.

FM: Yes. I thought, oh, those poor guys. If I weren't there, he wouldn't be doing that.

When I left, they had a little tea party for me, a little reception. He gave a little speech, and he said he was very proud that I had learned so much and that my manners and my behavior had improved and I was doing so well that I could *easily* be mistaken for a Dane or a Norwegian, but not a Swede.

[laughter]

FM: That was a compliment. I really enjoyed my work in Denmark.

Before I left there that spring, I applied to do graduate work at the University when I came back. I applied for joining the new Master's of Nursing Administration Program at the University coming in that fall. Then, for the next six months or so, I managed to save enough money to travel, and I traveled over all Europe. I got back here about three days before the fall quarter started in September. [chuckles]

DT: You maximized your time.

FM: Yes, I did. I spent as much as I could over there. That was one of my more interesting years. I traveled alone. It was all right. I found out I could do that and have some very interesting stories to tell the grandchildren when they say, "Grandma, tell us a time when…."

DT: I bet, and it explains why you still like to travel now.

FM: Oh, yes. Fortunately, my husband likes to travel, too. He grew up the son of a Methodist minister, so they got moved around every few years, too, so he's used to pulling up roots and going places.

DT: Your father just kept getting different appointments in different parts of the country?

FM: Yes. He was in the Philippines for a few years, too.

DT: I'm curious about his time when he and your uncle built this portable chest X-ray. Do you know if this was something that he had seen other physicians working in the health service doing or he, basically, just came up with the idea?

FM: I have no idea. He was somewhat inventive. When he was overseas and during the Battle of the Bulge—he managed to get in for that part of the war—he came across a boiler. Somehow, he packed up and created a system of hot water and a shower. So he had a portable hot shower. Officers got wind of this, a few of them, and he made money…

DT: Oh, I'm sure, and very good friends, I'm sure. [laughter]

FM: …by providing a hot shower. At one time, he was going to be an engineer, so he would do things like that.

DT: Did you ever think about reapplying to medical school after those…?

FM: Actually, I was accepted. I got a letter when I had just started nursing, that spring of my first quarter in the hospital clinical experiences. I did get accepted at the University of Cincinnati, and I very nobly in my Powell Hall room said "okay" to Joan Carstater [my roommate] 'put it in the wastebasket.' [laughter] There are two reasons. I knew it would be a fight to be a woman in medical school, and I, frankly, didn't have what it took to be that kind of a feminist. I knew it would be difficult, because I had seen… In the few months I had been in the clinical area, there was one woman who was an intern and I kind of got the drift of how she was treated. I thought I'd rather be in a field where I could really contribute to the fullest and I wouldn't be having to fight to work my way into the domain just for standing straight rather than trying to contribute something always.

DT: Did other nurses, do you think, have that feeling, too? Were there others that you knew that had thought about medical school, but opted against it?

FM: Not in nursing, but I remember knowing a woman who was a couple years ahead of me who had gone into medical school. That's her choice, but it wasn't for me.

DT: When you were working at National Distilleries, did you experience any problems there as a woman or was that quite a welcoming environment for you to be?

FM: [laughter] In one of the first couple months…I forget the guys' names that were in the organic lab, but they kept sending me specimens for weight analysis. About the third time I got this sample, I thought, you know, this looks just like the one I've done before. So I did the analysis and I compared it to the other two, and it was *exactly* to the third decimal point the same thing. So I took it down to them and I said, "Isn't this the third time you've given this to me?" They laughed and said, "Yes, we were just checking on you."

DT: Oh!

FM: To see that my work was consistent.

DT: Right.

FM: I don't know if that was just because I was new or if I was a woman. My problem was my age because I was not yet twenty-one. There was a time when they wanted a group to go from Ohio to a plant in either Indiana or Illinois…two guys, and they wanted me to go along for analysis. I was ready to go when they realized I wasn't twenty-one. It was against the law to take a minor across state lines, so I couldn't go, and they took the dish wash boy, who was a chemistry major and was about a senior in chemistry, so he could do some of the analytical work, the flunky work, really. So it was more my age at that time.

DT: Were there other women chemists?

FM: No. No, I was the only woman there.

I also had the keys to the liquor cabinet. The director and I were the only ones, but, then, I was the only one who was a teetotaler. I don't know if that's why I had the keys or not, but I had keys to the liquor cabinet and he did.

An aside… [Laughter] They were trying to develop a chemical test for analyzing good bourbon from not so good bourbon, because they went under two different labels. They had a table of liquor testers who would determine each batch, because they had no scientific way of grading it chemically. They were trying to figure out what made the good liquor different from the bad—or not bad but not so good. They said, "You know, most people can't tell the difference." So they ran everybody to the lab to do a test with three goblets, A, B, and C. One goblet had an odd sample and two were the same and you were supposed to pick out which one was different. We all went through. Well, I got it right and the dish wash boy, John, got it right. Then we went through again. There were about four, five of us that got it. We ended up the second time around where the dish wash boy got it right and I got it right and we were the only ones. Then, the third time around, I got it right and the dish wash boy didn't. They all came around to me one day at lunch and said, "Why are you here? You ought to be a liquor taster. You could make twice as much money being a liquor taster than working in the lab."

[laughter]

FM: No, I did not feel uncomfortable being a woman.

DT: When you made the decision to go to nursing school and your father was unhappy about it, did you think he had any merit in what he was saying? Did you feel that you weren't living up to your potential, as he had indicated?

FM: I didn't feel that way. No.

DT: That's good.

FM: I realized that nursing could cover a large territory, that there are many areas where nursing can fit and not just in one place or another. I thought of all of that. I knew about public health nursing and other fields, and I knew you could be very much on your own. So, no, I didn't.

DT: I was thinking about public health nursing and I was wondering how much interaction your father had had with nurses in his…?

FM: Oh, probably quite a bit.

DT: But, do you think he had much interaction with public health nurses…the fact that they were so independent?

FM: I really can't answer that. I just knew him in his office and on the little trips I went as a child when we'd go see the kids and he'd point out…. I remember getting stuck in the roads because they didn't have paved roads, and they were mud, and that frightened me more than anything.

[laughter]

DT: It sounds like an incredible experience growing up and seeing the health work that your father was doing.

FM: Yes.

DT: Was your mother a practicing nurse?

FM: No, she had severe cardiac problems. She died the year I graduated, in 1953. That summer, she had open heart surgery. She had a mitral value replacement, which was very experimental, at Cleveland Clinic, by Doctor Flough. I took care of her at night time for the surgeon, but she died the third day post op from a huge clot at the base of her brain. She was not healthy. She had rheumatic heart disease.

DT: When you started the nursing program at the University, you started in 1949. Is that right?

FM: That was not nursing. I was an adult special student for a year when I was trying to figure out what to do with my life.

DT: Okay. I know in 1949, the School of Nursing implemented, for the first time, its four-year baccalaureate program.

FM: We'd be the second group through….

DT: Yes. So you did participate in that?

FM: Yes.

DT: It's hard, because that was your only experience of nursing school, but did you have any sense that this was a new program, that this was something different that the School of Nursing was doing?

FM: Not initially. Eventually, it dawned on me that there were other people who'd gone on and gotten their degree and education in public health. That's not what I'm doing. So, no. It was later on that I realized there'd been other programs.

DT: You've really answered why you picked the University of Minnesota. I wonder when you were thinking about schools of nursing, did you ever weigh the possibility of doing hospital-based training, doing the diploma rather than the…?

FM: No, quite the contrary. I had seriously considered Yale because you would end up with a master's. You were going with a baccalaureate. That was a pre-req [prerequisite] at that time. So I would be with a lot of other students who had bachelor's degrees in something or other, and you'd end up with a master's degree. That appealed to me, but it was so horribly expensive, and I was on my own—and I liked Katherine Densford.

[chuckles]

DT: I think in that situation, I don't know who wouldn't have said yes to Minnesota at that point.

You were aware then of the distinction between diploma nurses and the baccalaureate nurses? That was pretty clear to you?

FM: Yes. I was also thinking of getting my master's in chemistry. I did go interview with…—oh, he's got a building named after him now; it begins with K—for analytical chemistry. He wrote the book. [correctly, Izaak Kolthoff, who wrote *Quantitative Inorganic Analysis*] He looked at me and said, "Are you going to get your doctorate?" I said, "I don't know." He said, "I won't consider you for graduate work unless you're going to get your doctorate." I thought about my reagent bottle experience, I think I'll just forget that. My father had encouraged me to go and see if I could do graduate work.

DT: I would have asked if the Ph.D. came to mind, but, yes, if you knew you wanted to work with people, you don't get that experience in the lab.

FM: Right.

DT: If we can talk a little bit more about what that experience in Nursing School was like… Obviously, Katherine Densford was a really big figure in your time there.

FM: Right.

DT: Could you elaborate and talk a bit more about her and the influence that she had on the students?

FM: One of the things that I thought was interesting is that she gave a dinner for every class in our freshman year. We were all invited to her house for supper, and, at that time, TV dinners had come out, so she had this great idea that we would all have TV dinners. Well, unfortunately, she'd forgotten that she could get only so many in the oven at time, and it would take a half hour or more. So it was quite an interesting experience…

[laughter]

FM: …because we all were waiting, you know, for these, and we couldn't all eat at the same time. Anyway, it was kind of fun. So, she was very human, and we got to see her at her home, and I thought that was really remarkable, egalitarian, shall I say. I was so used to having people of authority as a professor or a director and, yet, we were in her house and I was really impressed by that. She was always so grand in her manner of speaking and poise, posture. She always had this look of a duchess, but not the severity. She was very gentle, very charming, a first lady kind of thing. So that was interesting.

Another thing that I thought was interesting was when she interceded in our class. By the time we got to the point where we were going to have public health nursing experiences—we had a quarter where we spent doing public health nursing—the Minneapolis Visiting Nurses Association was undergoing reorganization, so they could not accept any students. Well, what are you going to do with all these students? You just had this window here where they had to have their public health nursing experience. Our class was asked—it only happened during this one or two quarters, I guess, in this year—to go outstate and to other states, to go away for your public health nursing experience. The class revolted. I was not one of the leaders of this. There were some other people agitating. They were having these standup meetings and crammed in the dorm rooms in Powell Hall and classmates said, "We can't afford it. It says here in the bulletin we're going to do this, this, this, and this. It says we're going to Saint Paul and Minneapolis, and we're not going to go to Duluth or Crookston or wherever, or Arizona or whatever." They were just jumping up and down, "No way. We're going to quit the School of Nursing." So they wrote up this big petition. I was against it. I said, "I don't think this is reasonable. The school has a situation. We need to help adjust to it." "But that's their problem. This says here that this is what's going to happen." [Mrs. Marks pounds the table several times for emphasis] I remember my dear friend Verna [Woodrich] and I were the only ones who opposed this great revolution. I remember going to Katherine Densford and telling her of the situation. I was president of the class, so I did that. She called a special meeting, and that evening; she and some of the faculty came in the Powell Hall amphitheater…called our class for a special meeting to try to deescalate the flames, and they did. Eventually, things calmed down. We didn't quit the school, and we did go to all these other places.

[laughter]

FM: I ended up going to Saint Paul, because I did not have the money to go outstate. At any rate, I remember that situation when she handled it deftly and defused all this.

DT: What about the other faculty? Were there any other notable faculty that stand out to you?

FM: My favorite, my mentor, was Florence Brennan. She was an amazing woman. She was extremely knowledgeable and quiet, calm, softly spoken. She would always say exactly what needed to be said at the right time. Isn't that amazing? I'm one of these people that sort of flies off at the mouth.

[laughter]

FM: You're supposed to think before you speak, that kind of thing. Stop, think; then talk. That never registered.

She always dealt calmly in tense situations and every one held her in great respect. She was a very softly dignified woman that was very, very smart. She knew her stuff. She could always handle my… I would always come up with questions. I would invariably have a question and she could always answer whatever it was I asked. Years later, when we were more on peer footing… In fact, it was after she retired. Dorothy Geis, up until recently, would have gatherings at her house of all former faculty members, and we would get around and do a lot of "remembering when" and have a good time. Florence Brennan would say, "Yes, I remember when"—she would invariably have student teachers with her following her. She said, "I had to coach student teachers to watch out for you." I said, "Why?" "Well, you would always ask questions and, most of them, nobody could answer."

DT: [laughter]

FM: Florence Brennan said, "So I would always have to coach the student teachers to be prepared to say that they didn't know and that they'd get back to you on whatever it was." [Laughter]

One of my questions I remember asking was… They had this thing in nursing, say before a patient was going to have surgery and what various prep you would do and, then, they would always say, "Then reassure the patient." "How do you reassure the patient?" What do you say to reassure a patient?" That was my favorite question.

DT: They couldn't answer…?

FM: They didn't all have the answer to that. I now see, subsequently, they put a lot more emphasis on skills and responding to patient's anxiety and they now have a lot more psychology preps and this sort of thing as part of their training. Now, they are given verbal skills for reassurance and anxiety, which they didn't have.

DT: Do you know when that change was…?

FM: Actually, it was part of the program that came in in the 1970s. I remember Dorothy Titt was the one I asked, "How do you reassure a patient?" I remember her fumbling all over that one. I thought she doesn't know. [laughter] She'd been a history major before she went into nursing. She was one of the leaders for the new curriculum that came in in the 1960s when Edna Fritz was there.

DT: I have some questions that I'll get to about that soon.

When you were going through the School of Nursing as a student, what was the balance between taking liberal arts classes, nursing theory, and clinical experience? How was your time kind of apportioned out?

FM: Basically, we were… [sigh] I'm trying to remember, what did we have? Most of our classes were nursing classes, the actual formal lectures. I would say half of them were…well, more than half were by our nursing instructors and some of them were by doctors. We would have doctors' lectures on various clinical aspects. Then, we would have the follow up corollary nursing for whatever the clinical situation was. Of course, the first two years, we were not in Powell Hall and we were taking campus courses, and we did have nursing arts. We had pharmacology, physiology, this sort of thing, and, of course, I'd had a lot of that, so actually I took courses with the medical students. I took physical chemistry and physiological chemistry and met with the medical students because I had the pre-reqs. That was the kind of thing we had the first few quarters.

Then, once we got into the clinical areas and moved into Powell Hall, we worked forty hours a week. Sometimes, part of that forty hours would be clinical instruction by the nursing instructor. It seems to me, a few years down the road, that got reduced to thirty. We did a lot of work.

DT: Was this mostly at the University Hospital or was it…?

FM: We had some rotations. We were at the University Hospital. We had a quarter or two—I can't remember—at Miller Hospital. At Miller Hospital, it was supposed to be learning how to work in a private hospital setting and, also, we had experience in eye surgery, operating room, and I think we had ENT [ear, nose, throat] at the Miller Hospital.

I didn't do very well at Miller. I was called up by a head nurse. They used to write up anecdotal notes on your performance. One of the doctors was extremely irate because I had explained to a patient about the medication she was getting. One of them was for her heart, to increase her heart strength…and the other one was just vitamins and whatnot. The doctor said I should never have educated the patient about the pills. He had not written any orders to say that the patient should be instructed about her medications. I said, "I think the patients should know what they're getting and why they're getting it." Well, he hadn't ordered it. So I was informed by that head nurse that never would she hire me there. My end result of working at Miller was that I shouldn't work in that kind of a private hospital situation because I didn't follow the doctor's orders. I went ahead teaching the patients.

[laughter]

DT: That's interesting that the head nurse…that this is the scenario in a private hospital. Did you think that that was something different, that you had a different relationship with the physician or the physician had a different level of authority in the private setting?

FM: Yes. Yes.

DT: Why was that, do you think?

FM: Well, the University Hospital is a teaching hospital, and we were encouraged to teach, including the patients. Everyone was learning, so it was a different philosophy. At any rate, I remember that experience.

Then, we also spent time at the Glen Lake Sanatorium [Minnetonka, Minnesota]. Oh, there was an extra experience there. We spent a month there, I think, at Glen Lake for tuberculosis. At that time, the doctor who was the head of the Glen Lake Sanatorium happened to be a colleague that I knew when my parents had lived at Fort Snelling, and my dad had known him, and we had socialized. I knew him and his family and I knew his daughters and whatnot. I thought I'll look up Doctor…—I can't remember his name—while I was there. I did call and say, "I'm here for a rotation with the School of Nursing." He had been one of the people who wrote a letter of recommendation when I applied for the University of Minnesota Medical School that year when I was trying to figure out what I was going to do. We had supper one night when I was at Glen Lake. I remember he said, "Well, how do you like nursing?" I said, "Oh, I love it. I really like it." He said, "I really don't think women should be doctors," and he had written one of my letters of recommendation, so I thought, well… [chuckles]

DT: Yes.

FM: I don't know what he said in the letter. That was another feedback on a woman's role.

DT: That is surprising that he even said he'd write a letter. You don't know what was in it.

FM: No.

DT: But he had this attitude towards women as physicians.

FM: Yes. So he thought I was doing the right thing being in nursing.

Then they had rural nursing experience. Where did I go for rural nursing? It was in Glencoe [Minnesota]. Anyway, that was a month, and that was fun experience at the hospital there. I saw them do what they called a Wiener intravenous [IV] administration for a newborn for fluid intake. They didn't do IVs on a little baby, I guess, but they would take a long needle and go up along the back, the spine. The needle would go up and inject fluid so you left a little wiener of fluid, saline. I'd never seen that done except there. I thought this is interesting, like something from the Dark Ages, but that's what they did. I thought, oh, all right.

Then, they did an appendectomy and we all raced in to scrub in, but not scrub in but at least observe this appendectomy because they didn't do appendectomies at the University Hospital. We'd never seen one. We had this check list of surgeries and nobody had ever seen an appendectomy, so we had to go see this one.

[chuckles]

FM: They did Crile neck dissections and total mastectomies, big stuff at the U, but not appendectomies. I remember that.

While we were there, Muriel Ryden, who was one of my classmates… She was very nice to me. When I would ever write a paper, she'd correct the spelling on it for me. I can't spell. At any rate, Muriel said, "I think I'll sing in a choir." So we did, and we all joined the choir. I guess it was a Lutheran church. So for four weeks, we went to choir practice and sang in the church choir. One of the nurses there had a brother who was in wrestling, and they were having some competition, so we went to this wrestling match. And we had tea at the home of the woman who was of the first family of the community. That was interesting, fascinating history, a lovely old house.

Then, the public health nurse came and met with us and talked to us about the care of the patients in the community as they left and the impact of having hospitalization on the family, particularly if it was a wage earner or was a farmer. Who was going to take care of the crops and everything at home? So we had exposure to the impact of a rural situation when illness strikes. That was an eye opener, so that was worthwhile.

I think that's where I went: Miller, Glen Lake, and rural nursing.

DT: Did you get a sense of whether nursing practice in rural communities was different to in the cities or did you see what nurses were doing as…?

FM: I think what they were doing for the kinds of patients they had of various situations was comparable. It's just that things were a little more tight knit because everybody knew everybody. It was all in the family. At the University Hospital, these are all strangers that come in, but, there, we'd know it's somebody's cousin or you're related to so and so and everybody knows everybody else, so the networking in the community is much more obvious. It's a little different.

DT: When you were a student nurse, what were your responsibilities? What were you able to do with the patients? Were you practicing as if you were a full-fledged nurse or were there limits on what you were allowed to do, aside from like following doctors' orders?

FM: We started our clinical in March. The fall and winter quarter were outside of Powell Hall. We were in Powell Hall the spring quarter. By that fall, we were doing charge work, charge lists. At that point, we were doing pretty much what the nurses did. I was called to do a charge on Station 22 because the charge nurse was ill, and the faculty

had consulted and decided that I could do it. I was one of the first in my class to have to work charge, so everyone came rushing in, "Oh! you have to work charge!"

[chuckles]

FM: So I was there with thirty patients, and an LPN, and two nursing assistants. It was surgical, post op, it was pretty scary.

DT: And you survived it?

FM: Oh, yes, we survived. We were working doing pretty much what nurses did by the time we got into our second year, and working nights, rotating nights.

DT: As I understand it, you weren't paid for this. This was just part of the curriculum and in exchange…

FM: We were indentured *slaves* making profit for the hospital. We got room and board and our laundry. Our uniforms were provided.

DT: How did nursing students feel about that? How did you feel about…?

FM: It was normal. [laughter]

DT: It was just what you did.

FM: Well, you know, it was cheaper than paying dormitory rates. We didn't have the finances. We could get through school and not have a debt.

DT: Do you recall how big your class was?

FM: Thirty-six, I think…thirty-eight—we had some dropouts—someplace in that category, thirty-six to forty.

DT: When you were working at the University Hospital, did you get a sense of what the proportion of student nurses to charge nurses that weren't students was?

FM: Ummm… I would say more than half were students. Frequently, it would be the head nurse and six students and maybe one other nurse. Then, we'd race around, get all the morning cares done, and go off to lunch or class. Seven to eleven [AM] was very common and get all the morning work done. Go to lunch and have class in the afternoon from one to three, and, then, go back to work from four until seven [PM]. So seven to eleven, four to seven was…

DT: That's a lot of work during the day.

FM: Yes, and then do your homework after that.

DT: What was it like living in Powell Hall?

FM: I'd never lived in a dorm before, so I can't compare it to any other dorm life. We were assigned our roommates. They gave us an opportunity to…write down your preferences of people you want to room with. We were sort of clustered by our preferences. Joanie Carstater was my roommate. Her parents lived in Washington, D.C. and mine lived in… Where were they at that time? They were in Pennsylvania. So we were sort of put together, I think, because our families both were someplace else, and we weren't going to be going anyplace on weekends because we weren't that close to family. A lot of people took off when they had a weekend and disappeared. Since a lot of us worked on the weekends—everybody worked; we had one weekend off a month—there were people around most of the time, on shift and somebody would be sleeping because they were working nights and this sort of thing.

There was a little breakfast nook where we could make—it had a refrigerator and a hot plate—snacks. There was one phone in the hall. When it rang, somebody would answer and, then, they'd yell who it was for. That was different, wasn't it? We had different hours than other dorm students. We had to be in by midnight unless it was the night before your day off. If it was the night before day off, then you could be out until two a.m. I can't imagine why anyone would stay out until two a.m., but I did along with everybody else. You did that. We could be out till two a.m., so we did.

DT: [chuckles]

FM: We had to be in. Those were our hours.

Of course, no men. It was all women. There was a male student who came in one of the classes either before or after us, I can't remember, but I remember he was in the wing where the interns were. On the further west wing of Powell Hall is where the interns stayed.

We had parties. We had a lot of social life.

I was involved in the Nursing College Board; I was president of that. That was interesting. I remember Verna was on the Curriculum Committee of the faculty. We had students on the faculty committees and, then, we'd get together as part of the College Board and rehash the reports from these different faculty committees for feedback.

Then I was working with the Powell Hall Government Association. Casey [surname?] was her name, the president of that. We were having fundraisers for many different things—noble causes, all of them, I'm sure. I remember one time Casey got a car and we got a speaker—see, I majored in extra curricular activities…

DT: [chuckles]

FM: Anyway, we got a speaker and had this thing on the car and we were going around, "Come to the Powell Hall Carnival." The Powell Hall Carnival was a big fundraiser, one of the biggest sideshows. We set up litters and we gave backrubs. These guys in Pioneer Hall and the dorms all around and Territorial [Hall]—I don't know if Territorial was there yet—would come and get their backrubs and that was considered a great thing. We'd go around campus with this, not a horn, speaker. I remember we were parking to come back to get some more supplies for something. Back at Powell Hall, we ran into our pediatric instructor. She looked at us because she had just given our class, which we had skipped.

DT: [laughter]

FM: She said, "Well! what do you know about…" something or other, some clinical thing in pediatrics. I said, "Obviously, not what you taught in class just now, but we know a lot about the Powell Hall Carnival."

[laughter]

FM: [Mrs. Marks makes a growling sound] She was Mighty Mouse. She was one of these short women. Everyone knew who was Beulah [sounds like Gol-uh-falt] was. That's what I did at Powell Hall.

[laughter]

FM: We were there when they had panty raids. There was a year when they decided to have panty raids and they hit Powell Hall. Some got real excited about it and I thought, oh, well. [chuckles] That's just a lark. One of my classmates, though, was so irate. She took a pot of boiling water on the hot plate and poured it down. They were climbing up from the courtyard where there were vines. She poured out boiling hot water at them.

DT: [chuckles]

FM: I guess somebody gave them panties. They considered it a great success. Some of the students were egging them on.

DT: This was male students you were…?

FM: Yes, oh, yes. They were trying to climb up and get underwear—a panty raid. That was considered a big prize. That was the only success they had was at Powell Hall. They tried to go over to either Sanford or Comstock, I guess. Both of those were women's dorms then. I guess they didn't have quite as much luck as at Powell Hall. There was sort of this aura around nursing students as being aware of all body functions and whatnot.

Excuse me.

[telephone rings – break in the interview]

DT: It's interesting that the male students were… That's a funny adventure that they would partake in it. How many relationships were there between nursing students and male students on campus? Was there a lot of socializing?

FM: Oh, heavens yes…oh, my yes. I said we had a lot of parties. They had formal dances. We would plan formals, evening gowns, that sort of thing. We had one or two a year in Powell Hall that we put on. Then, invariably, we had boyfriends and they would have frat parties. [sigh] Big things. I used to usher at Northrop [Auditorium] and the ushers at Northrop would always have parties. We'd have picnics and outings of all sorts.

DT: That was a fun time, it sounds like. [chuckles]

FM: Oh, yes. Occasionally, we studied.

[laughter]

DT: I like the majoring in extra curricular activities. I'll have to remember that one.

Were there many minority students among the nurses?

FM: No. One of my classmates was Jewish, which was unusual. One who graduated, Cecil [Cele] Kume, was Oriental, graduated a year ahead of us…Cele did. I worked with her a lot when I graduated at the U Hospital. She was also a supervisor. But no black students at that time.

DT: Do you have any other experiences from your time as a student that you would like to share?

FM: Oh, I'm sure there are many I'm forgetting.

[laughter]

FM: [pause] Let's see… I did mention ushering at Northrop for Minneapolis Symphony Orchestra concerts. Opera was always a big season. I always had a hard time getting time off work. The Metropolitan Opera would come for about a week. They'd have two weekends. Of course, we were expected to usher for most of that and tried to work around class. It was invariably during time when they would be having finals, and that was always stressful, to try to get to all the operas and work and get your finals. I didn't quite make it to all the operas, but I always made a great attempt to.

Interesting… [chuckles] One time, there was a tornado warning, early in my experience, one summer. I remember there weren't many in the dorm at that time. My only experience that I could recall with severe weather was in my childhood when we had

hurricanes in Key West [Florida]. At that time, you had to save all your water, your drinking water. We would fill up the bathtub with drinking water because all the water was brought in by [railroad] tank car. There was no bridge to Key West. It was just ferry boats and freight railroads. There wasn't passenger service. So we would always save water. So there was a tornado and I'd never experienced a tornado. That was new. So I went into the lavatory and started filling up the bathtub with water. Then, I started thinking why am I doing this?

[laughter]

FM: That was my own personal thing, and not anything to do with school.

Another interesting thing that was clinical was air conditioning which was not prevalent at all. We had fans in the rooms and, then, we would have big basins of ice, and we would put the ice in front of the fan to cool patients. Our job was to keep the ice in the pans. That was different.

Then, of course, Wangensteen's Suction, which was always interesting with all the bottles. Did you hear about what happened at our 100th Anniversary?

DT: No.

FM: During the School's Centennial last year at the luncheon, we [the Heritage Committee] mentioned that we put together Wangensteen's Suction. This was three gallon bottles. It's a closed siphon, essentially, and the patient in the middle of this system the water, siphoned to extract gastric fluids. It was always a pain in the neck because you had these big bottles draining. You usually had to refill them or replace them at least once a shift. The bottles were invariably on the side of the bed where you were working with the patient, and you'd be kicking these bottles all the time, so it was a headache for more than one reason. Then, you always had to make sure you got the right stoppers in the right bottles. Everyone would be concerned if they did it right. [chuckles] Anyway, we mentioned this this last fall at part of our [School of Nursing] Centennial celebration, that we had put together Wangensteen's Suction, and the room just went, "Ohhhh!" There was a big uproar. Everyone remembered Wangensteen's Suction.

[laughter]

FM: It made a hit. Everyone wanted to come and see this thing that was the bane of their existence. Yes, that was fun.

Dormitory life and clinical experiences… Another thing between private [hospitals] and University Hospital. In Miller Hospital when you happened to be at the desk or you were charting or doing something and a doctor came, you were expected to rise.

DT: Hmmm.

FM: Well, at the U, we never did that. If they wanted something, you'd do it, but at Miller, when a doctor appeared at the desk area and you were busy charting, you would invariably stand at attention, more or less. I always found that rather irritating.

DT: Was Miller the only private hospital that you had experience at?

FM: Yes…then the rural hospital, which was a private hospital.

DT: Was it like that in the rural hospitals?

FM: No, there, it was much more casual.

DT: And later in your career… Well, it wouldn't have been comparable, I guess, later?

FM: I felt I was incompatible with private hospitals. [laughter]

DT: Yes. I'm just curious. I hadn't appreciated the distinction between teaching hospitals and private hospitals for nurses before.

FM: I hadn't either. I learned the hard way. They didn't say anything about that when we were oriented.

DT: I'm curious whether Miller was particularly exceptional in this regard or…?

FM: Ummm… Well, I really don't know. I can't answer that question. The only other ones would have been religious hospitals, and I think there's probably a certain decorum that would have gone on there. It was very obvious to me that it was different.

We did a taping of the Fortieth Anniversary of our class that I still have. My classmates told "I remember when" horror stories. I could let you have that and listen, if you'd want to.

DT: Oh, I'd love to see it.

FM: One of the girls was giving an IM. We did a lot of intermusculars. We did not do IVs. We were not *supposed* to start IVs. We all did it at one time or another, but we weren't supposed to. There were a lot of intermusculars. She, one time, was giving one and the needle went right through her thumb.

DT: [gasp]

FM: She just kept going and gave the shot and then pulled it back out.

DT: Oh, my goodness.

FM: That's on the tape.

DT: Oh, I'd love to hear that.

[laughter]

FM: They told stories about sneaking food from the cafeteria. The head dietician—bless her heart—would sometimes stand outside the door and we'd take these little cartons. They gave us like a half a cup of milk. These little cartons were so small, and we'd stick them in our pockets, you know. She'd stop us and she said, "Let me see what you have in your pockets." We weren't supposed to do that. We'd go at great lengths to try to figure out how to get food out of the cafeteria for a snack or something at night. You'd think for all the work we did, we could have a little more food. They made money on us, but… That was always a favorite story.

Oh, and, then, wearing your cap… We all had nursing caps. Even after I graduated, when I worked nights, one of the first things I did was take my cap off because, a lot of times on night duty, you do twenty-four hour collections, urine collections, and your job is to go around under the bed and empty all the bottles, and your cap gets in the way when you're crawling around on the floor trying to get those bottles out. So one of the first things I'd do is take my cap off. I remember we had sort of an agreement along the hall. I worked on Station 30. The night supervisor would make rounds on 32, 31, and 30, and when she got to 32, after she left there, the nurse would call me and say, "Miss So and So is on her way." I'd say, "Oh! Okay." So, I'd go and put my cap on. You'd get caught if you didn't have your cap on.

You want mainly my student days, don't you?

DT: I was going to ask some questions about then your experiences as a staff nurse.

FM: Friday mornings, we would have coffee in this little lab on Station 30 that was used when they did urine testing and odds and ends of simple blood… Where we set up our bloods there was a little lab. That's where we had our coffee. Of course, one of the main things was—Mr. [Ray] Amberg was administrator—there was to be absolutely no coffee made on the stations, you know. We would be making coffee. Well, you could smell it all up and down the hall. We'd always take turns bringing in Friday morning rolls and buns, etcetera, homemade stuff usually. Mr. Amberg would come along and there'd be another phone call, "Mr. Amberg is on his way down the hall, so quick close the door." But you could smell the coffee.

[laughter]

FM: I remember one time he came along, and he looked at me and he said, "You know the policy here is to have no coffee made on the unit." I said, "Yes, I'm aware of that." I was assistant head nurse then. "So you know that?" "Yes, I know that, Mr. Amberg." "You're a smart woman. You know that." I said, "Yes." "All right." Then, he'd go on and he'd never say anything else.

[laughter]

FM: You could hear people laughing, carrying on in the room when the door was closed.

One of my favorite phrases was [one] I learned from one of the hospital administrators. I remember doing rounds, as I did usually, and I walked into this utility room and behind one of the counters was one of the orderlies, and he was squatting down there. He was a black fellow [unclear] on crutches, a great guy, and he was crouched down eating one of the unserved patient trays. I looked at him and he looked at me and his eyes open wide. I said the line, "Don't let me ever catch you doing this again."

[laughter]

FM: That was my reprimand.

DT: Maybe we could talk about what it was like once you were a staff nurse and, then, assistant head nurse at the University Hospital. What were your responsibilities in those roles?

FM: [pause] I think the staff nurse job… One of the things you learned that first few months you were out that was different than being a student is that you got to see the continuum of the patient care, and you learned a lot more about the application of the nursing and the effects of the nursing care and what you really had to be accountable for because you could see the consequences, which you didn't always see as a student because you were rotating around the whole hospital. We learned a lot in the respect. It was a large growth period, that first six months. It was a big growth spurt.

As assistant head nurse, the thing that was always frustrating was the staffing and making out hours, scheduling, making sure that you had the right people at the right time. Sometimes, you'd come down to where you realized you were going to be very short staffed. Well, then, you'd want your stronger people on. If you had somebody else on at that time, they'd fall apart. Also, you had to juggle this. We always were short, short staffed with the strengths and weaknesses of your staff. That was always problematic. Of course, if anyone called in ill, then you spent all your time trying to replace, cover for illness, which took, sometimes, hours of time to do that. You were sort of 24/7 when you were head nurse or assistant head nurse.

DT: Were you getting much opportunity to work with patients when you were the assistant head nurse or was it mostly more of administrative?

FM: It was practically all administrative. We did not have ward secretaries, and you had to do all the doctor order transcriptions, so you did a lot of desk work. We'd always do rounds a couple times during the shift. You definitely had to do that. But, mostly, we were so tied up at the desk. The phones were going off the hook half the time, and, as I say, we didn't have ward secretaries.

DT: When you were a staff nurse, what was a typical day in the life of a staff nurse?

FM: Usually, you'd try to get there about fifteen minutes early so you could get your assignment. The charge nurse does the set up of the assignments for who is going to take care of which patients. You'd find out who your patients were for the day. You'd set out a worksheet and you'd write down your patients and, then, the hours across, and, then, you'd write down what you had to do each hour, who had meds, who had what kind of treatments, if they had clinic appointments or had to go see someplace. You had that all down on your worksheet. Usually, your assignment was six to eight patients—well, except when you were short staffed and you'd get something like ten or more. Oh, it was horrendous.

Then, we would proceed hour by hour to do the various things. The first thing you would usually do is go around and check temperatures and vital signs. Then, you'd see how the patients were. You'd make your early rounds before the breakfast trays came. Then, you'd try to do a little a.m. care, wash hands and face before breakfast. Then, the breakfast trays would come. They didn't have people passing out the trays, so you would have to pass out the trays. Then, you had a little more time to check the patient's chart to get a little more information about what you had to know to carry on the rest of the day or if you're off at eleven… or if you were staff nurse, it would be for the day. You were doing mainly hygiene care for the patients, changing sheets, washing them, brushing their teeth, that sort of thing, and, then, doing their treatments, changing IV bottles, medications, changing dressings, measuring things. This was pretty much typical for the evening shift, as well. You'd do the same, go around and check the rooms, and do pre-meal care.

One of the things the night nurses did was to set up bloods, because they didn't have phlebotomists. So the night nurse was responsible for going through all the patient doctors' orders and preparing all the test tubes that were needed and setting up a tray with all the syringes and all the test tubes and, then, waiting for the intern who would come at six to do blood draws. So you'd wake people up at six a.m. to have their blood work drawn, and be sure you got the right tube. In 1953, I think it was, or maybe 1954, when I was assistant head nurse, the Vac-U-Tubes were introduced. So we had classes on how to use [them]… and they're still used. That's when they came in. It was either the fall of 1953 or winter of 1954, someplace in that time frame that the Vac-U-Tubes came and, then, we didn't have to use those different tubes; otherwise, we had stoppers. Some of the tubes had petri in the bottom. You had to know what kind of tube to use for which test. So you had to learn all that stuff.

DT: So when the Vac-U-Tube came in, it was simplified then?

FM: Yes. They had different colored tops for the different tests. You still had to know which tube to use for what test. That was still there.

I remember when I was in nursing school as a student, they had medication cards. The medication cards were different colors for whether it was qid, tid, bid, qd, prn, hs. They had different colored cards and some of them had a corner cut. There were about, oh, eight or nine different kinds of cards that were used for reminders of when this patient got the medication, what time of day. So when you did your worksheet, the other thing you do is get your med card for that patient, and you had to set up your meds.

As a student nurse, I remember getting a class test and the back of the test had these cards laid out and had the name of the color, and we were supposed to identify whether it was tid, bid, qd, that sort of thing. Well, I didn't know, because when I was working, I always would read the card so I would know. I hadn't memorized the colors, so I wrote a long little sentence saying, "I have not learned the color of the cards, and I think I can read on the card what it says and, furthermore, when I get to using this more often, I think I probably will learn it, but now I don't know." I wrote that on…

[laughter]

FM: They didn't count that question, I guess. I was a problem student, I guess. They had that system for identifying meds, but I don't think they use it now.

And of course, we had the Kardex, which kept getting bigger and bigger as time went on. When we had it, it was about this big [4" x 6"]. Then, they started putting the cards up above and below and we just had one card down here.

Making out staff hours scheduling was a pain, I remember, every Tuesday night or Wednesday night. Every pay period, I'd take home hours and we'd put them out for two weeks at a time. They always would come out on Thursday for the following two weeks. That was always a pain, so I'd do it at home. That took a lot of time. So, I say it was like a 24/7 job.

DT: What were interactions like with the physicians that you worked with and the medical students, as well?

FM: Not very close. They all were rotating. The senior resident was probably the most stable figure for a year at a time, because we would have that same doctor for a year. The other residents and interns would be there for shorter periods of time. It varied.

DT: Was there a respect, though? Did the residents and interns respect the nurses?

FM: Well, particularly in July, August, and September when they didn't know anything.

[laughter]

FM: When they first started, there was a lot of coaching that went on, and we always expected it, so that worked well. It wasn't a problem.

DT: You had mentioned earlier about there being LPNs, licensed practical nurses. Did the University Hospital have nursing assistants, LPNs, and registered nurses, also? If so, how were the responsibilities divided up?

FM: Basically, the RN did everything. The RN students, depending on what year they were, did everything. From junior [year] on, they did just about everything. There might be some techniques they hadn't been supervised on. If they were rotating into an area that was new, then you had to you had to show them first situations that they hadn't had before.

The LPNs did patient care and most of the treatments, vital signs, this sort of thing, but they did not do medications. They didn't change IV bottles, that sort of thing.

And the nursing assistants were mainly to do the room cleaning, transporting patients, feeding patients, this sort of thing.

DT: Were there any problems between LPNs and RNs, and how aware were individuals of the different status within the hospital structure because they were LPNs or RNs? Or was it just that everyone was a nurse and you just did what you did?

FM: I think you learned… I remember Gerta. She was fantastic. She was an LPN and later became a graduate from college and went on to be a head nurse and supervisor. She was really good. Anyway, she was an LPN when I was there and she was strong. She was older and more mature. I would actually go to her for suggestions on coping with a difficult situation. So it depended a lot on the individual. You just knew that if an LPN was there, she would do all the patient care, the hygiene, and everything else, but you had to give the meds and you had to do the IV stuff. She wouldn't do that.

DT: What kinds of patients were you seeing?

FM: This was a medical ward. In those days, they would come to us sometimes for long periods of time, much different than now where all you have is intensive care in the whole hospital, practically. They would be there for diagnostic workups, frequently, so a lot of them had to be taken for various kinds of tests. Some of them would have severe lung problems or urinary tract problems or nervous problems. Doctor Cecil J. Watson was head of the Medical Department then and his specialty was porphyria. So we would be having patients in with porphyria, who, of course, would sometimes have severe nervous problems. There was a lot of testing. We would have patients with skin problems, dermatitis; although, Station 32 usually got most of the dermatitis problems.

DT: You had mentioned a little while ago about IVs and the nurses weren't supposed to do IVs. As far as I understand it, the 1950s was when responsibilities for IVs were under contest.

FM: Right.

DT: A lot of nurses were starting to be…

FM: By the 1960s, they were, right.

DT: So even though nurses weren't technically supposed to do IVs, were there experiences within the hospital when the physicians wanted the nurses to do it or was there any kind of negotiation?

FM: Not when I was there. In situations, such as at nighttime, an IV would stop, would be infiltrating, and you'd have to take it out, and you knew you were going to have to call somebody, call the on-call. Or if you found out the on-call was tied up with a new admission in emergency or something, we'd go ahead and restart it. [chuckles]

DT: Did the physicians know that?

FM: What I usually did is I would leave a message, "Would you come and check this? I restarted it," and they'd come and check it out.

DT: But the physicians didn't mind if you did?

FM: No. The interns were the ones that did all the IV starting. The residents didn't do that, it was the interns.

DT: I'm sure the intern was happy to not have to do it.

FM: Right, so they usually would appreciate it when you did that.

DT: What other technologies and instruments were you using regularly in your practice? Were there monitoring devices that stood out?

FM: No. We were the monitors. You'd have fifteen-minute blood pressure checks after a procedure, and you'd have to be in there and physically do it. It wasn't considered proper to leave the blood pressure cuff around a patient's arm; although, if it was ever fifteen minutes, we usually did. Then, it had to be four fifteens for the first hour, the second hour every half hour, and the third hour, it would be reduced to every hour for the next six hours or something. You'd have to be in there. That would be on your worksheet and you'd have to run and drop everything else and go in and do the blood pressure. No, we didn't have monitors.

DT: You would take this blood pressure and you would write it down, so you'd be tracking how the b.p. changed over time?

FM: Right. Then, you'd have to transcribe that. The charts were at the central location, and you'd have your little worksheet with all these chicken tracks all over it.

That is one thing I should mention, that, usually, when you were at the end of your shift, like seven to three-thirty, at sometime around two or two-thirty, you'd start charting and, then, you'd start transcribing all your notes onto the patient's chart and hope you got it right. It's possible to make an error all over the place, but usually not of great significance.

DT: If you, the nurse, detected any deviation in the blood pressure, you would then tell the intern or resident that this had happened, and they…

FM: You'd tell the charge nurse.

DT: Ah.

FM: One of the charge nurse's responsibilities was to call medical staff if needed.

DT: But it was, basically, the nurses then, as you say, for monitoring patients.

FM: Right. Right.

We'd have patients that were in oxygen tents. They didn't have a mask all the time. We had tents that would go all around the bed. Then, we'd have these tanks of oxygen and we'd have to change the tanks. Lo and behold, one time, I dropped one—well, I almost dropped it. Things like this happened. [laughter] It tipped a little too far and I thought, oh… So you had to change all these big tanks around and had to make sure there was enough oxygen there. You had to call an orderly to bring up oxygen tanks. So you monitored that. They were not piped in.

DT: You said you spent six months in Denmark. You commented earlier that it was a very different experience. Could you elaborate on that and what about your responsibilities in your day-to-day experience as a nurse in Denmark was different?

FM: One of the first things I learned that was different is that they didn't have charts, except for the ones at the foot of the bed where you would record the vital signs and notes and that. They were very brief, nothing like the charting I was used to. So that was a change.

Also, on the units at the University Hospital, we had big books that were procedure and policy books. The procedure manual would have a diagram for how to set up an oxygen tent, for example. They'd have pictures of it and everything thing you had to do, where you had to put things, a complete how-to. In Denmark they didn't have anything like that on the nurse's unit. I thought, well, that was interesting.

When I was working my first charge evening—I'd be the only nurse on that evening for the first time—Tante poured all the meds. Tante was the assistant head nurse. I was taught that one of the things you do for accuracy is that you are responsible for pouring your own meds. You take the bottle off the shelf. You count what you put in using these

clever medication cards. You'd have a tray and you'd put these little cups and the cards and have that all set up. You did your own. You don't trust anyone else to do that. You were responsible. Well, Tante did it for everybody, so I sort of balked. I said, "I was taught you were responsible. You do this. You don't pour things that other people have done. It might be wrong." She said, "Well, don't you trust me?" I thought no. Well, okay, I'm in Rome now, I'll have to do as the Romans do, so… [laughter] That was different.

Another thing that was different is that every evening after every afternoon, usually at the end of the shift before supper, the rooms were swept. If you were working a weekend and the maintenance staff, the housekeeping staff, was not there, then you swept before. So I was sweeping floors. I hadn't done that before.

The other thing is that outside the hospital they had racks, sort of like wooden frame structures, and when the patient was discharged, the mattress went outside, and it aired out there for at least three days before it was brought back in.

[break in the interview]

FM: That was different.

The other thing is that they bathed the patients on Thursdays. Everybody got a full bath on Thursday. I was used to giving a full bath about every other day at the U, so that was different.

The other thing as part of the a.m. care, there were two cloths by the patient in Denmark. One was a peri cloth, so after you did the hands and face, then they were given their peri cloth to wash their perineum. We didn't do that at the U. I thought that was pretty good.

DT: Yes.

FM: They used that towel for a week. On Thursdays, when they had a bath, then they'd get clean linen, so that was different.

I learned out to make *smørrebrød* Sunday evenings. They had their main meal during the day, but when you worked evenings, the kitchen would bring you a loaf of bread and the makings for making *smørrebrød*, which was an open faced sandwich. You would spend a half an hour or so putting together open faced sandwiches to serve the patients for the evening meal. So that was different. I learned how to cut cucumbers and other little garnishes.

I had a friend of mine send me some popcorn, un-popped, and they didn't have popcorn. I said, "I'm going to fix you some popcorn at night." I think it did it at shift time. I went in the kitchen and popped corn. One of the nurses…"Oh!" [spoken loudly] She took the lid off.

DT: [gasp]

[laughter]

FM: Quick, we put it back on. "Oh!" and then they were so excited. So popcorn made a big hit.

Oh, the nurses would do Benzene urine testing samples routinely. I thought, good Lord, I haven't done that—where you had a Benzene ring—since I had been sometime in my pre-nursing. We did that routinely. I said, "Oh, goodness, I haven't done this for a while." "Well, what do you do?" "We send it to the lab." "Ohhh, don't the nurses know how?" "I suppose they could." "Why don't the nurses do that?" That was an interesting experience.

They had one patient who had multiple sclerosis, I guess. Anyway, it was a severe case…Sven. He was on one of these respirators that was hooked up to his tracheal tube and it was positive/negative pressure. He had a special nurse around the clock. I remember one time, I had to spell off the nurse. He had a lot of secretions he had to have suctioned, so they had [sounds like ike-ten] suction and piped-in oxygen at the U. We used to have these suction machines and everything else around the bed for this kind of patient. I was always impressed that came out so well.

I remember I was working one time in the evening—the patients had visitors come in—and one of the visitors came up and tugged me and said, "Come." They said it in Danish. They would ask me, and I learned to say, "I am from Minn-e-so-ta," so I'd try to talk Danish, which I couldn't do. They would laugh and laugh. So I was entertainment…

[laughter]

FM: …in my broken Danish. That was different.

The bedpans were shaped differently, which I thought was interesting. Anyway, I did write some of the differences in that article.

DT: Good, I will look that up.

When you returned from Denmark, you said you began your master's degree. What led you to decide to go ahead and do the master's? I know you said you'd been thinking about it from the beginning.

FM: Ummm… I like organizing. I never felt very strong in teaching. I thought I would be either in administrative things or in teaching. I wasn't strong in teaching, and public health just never reared its head at this point for some reason. At any rate, I chose a route to go on to administration.

DT: What was your graduate school experience like? Was it noticeably different from when you were doing your baccalaureate?

FM: Oh, my yes. No clinical. I did private duty nursing to help get some money. Part of my inheritance, I used to go to Europe and the other part, I used for getting my master's degree. I was working as counselor at Sanford Hall and that paid my room and board.

I thought the master's degree was too easy. I wanted more of a challenge. I should have gone into graduate school and gotten my master's instead of a master's in nursing administration. A lot of the classes I thought were organized common sense, so it was somewhat of a disappointment. I expected more of an academic challenge.

DT: My understanding is that they changed the graduate program in the 1960s.

FM: Yes, it didn't last more than ten years, I don't think.

DT: Do you remember the faculty who were…?

FM: Yes. I had Isabel Harris and Doris Miller. Isabel Harris was a good influence in my life, too. I liked her very much.

DT: How so?

FM: Well, she was smart. She could answer my questions.

[laughter]

FM: I could go to her with situations that bothered me, and she would always be open to them.

DT: How long did it take to complete the master's?

FM: Just a year, a full year, summer included, and we did a major paper, and that was a breeze.

DT: Did you know people who were doing master's in the graduate school, to know that master's programs through the graduate school were tougher?

FM: Yes, I probably did. The thing that scared me about that was language requirements. I am so bad at languages, and I thought I'll never get through that language requirement. That really put me off. That's one of the reasons I probably went into whatever you call the technical rather than an academic master's was the language requirement.

DT: They still have them today.

FM: Yes, but now it's different.

DT: Yes, it is.

FM: You can take the course, and you don't have to have a separate language test. Well, I've taken courses. I can get through a course. [laughter] I'm taking Spanish, German and French. I can't speak any of them. In fact, when I took my German class, I'd had Spanish and before German in college and Herr—what was his name?—would have us read in German, so I'd get up and he'd want us to really work on our accent, so I'd give it everything I had, and then I'd sit down. He'd shake his head and he said, "Fraulein, you read German with a Spanish accent."

[laughter]

FM: "How do you do that?" I said, "Well, I had Spanish in high school."

DT: Similarly, language is not my forte.

FM: It was one of the reasons I avoided the graduate school program was because of the language requirement.

DT: Once you had your master's, I found somewhere that you, then, were nursing supervisor at Variety Club Hospital [University of Minnesota].

FM: Yes.

DT: What were your responsibilities then as a nursing supervisor?

FM: Okay. I finished my MA, my master's degree, in the summer of 1956, and I started as supervisor at the heart hospital in September. I was there for five years.

I was responsible for all the nursing care at the heart hospital, which was a forty bed pediatric unit [Station 301] and a forty-two bed adult unit [Station 201], med/surg unit, and the heart clinic and the heart catheterization lab.

DT: Were you then seeing patients or were you doing administration?

FM: No, I was doing administrative work of managing the nursing staff… It was like a little hospital, an eighty-some bed hospital and clinic.

DT: This was…

FM: The exciting part.

DT: Yes, this was an exciting time to be in the heart program because of the open heart surgeries.

FM: Right. A *huge*, huge amount of things going on, yes.

DT: What was your experience with that at that time?

FM: Trying to keep up with what the doctors were doing, because we were not always included in the operating room end of it. I had spent time in the OR to try to figure out what they were doing. I'd go on rounds as much as possible to hear them say what they were doing, because there was no other way really good formal communications of what the surgeons were doing. Now, the medical staff was quite different. Doctor Watson would have weekly meetings with all the medical residents, and include myself and Miss Brennan, who still had that adult medicine area. We would go and listen to the latest updates from there. But the surgeons didn't do that. They were all their own. They had their own little fields, so just by hook or by crook, you'd try to keep up with what they were doing.

Then, of course, on the fourth floor—it was 201, 301—were the research laboratories. We got—what was the name of it?—the electron microscope, and that was a big advance at that time. Doctor [Robert] Good was doing work in rheumatic fever and the effects on the heart. That was very interesting, too. So there were very interesting things.

One of the things we did there with the nursing students that came through is that we had patient classes every Friday afternoon at one o'clock. We would have the patients who were getting ready to go home come to the class, before they went home but when they were well enough to attend the class. Some of the clinic patients would come. We'd talk about the heart and what it did and how it functions and what went wrong with it sometimes, and various things you could do at home. At that time, a lot of people had congestive heart failure and they couldn't do things, so a lot of it was on simplification of homemaking activities in some of these classes.

DT: So really geared to patient education to help them rehabilitate once they've gone home?

FM: Right. Usually, if we could swing it, we'd have a student do this, so I spent a lot of time with the student. I, also, was still an instructor. I had the rank of supervisor and instructor in the School of Nursing, so I also went to faculty meetings. We'd work with a student and develop a plan of what she wanted to teach that particular Friday and coach her.

DT: That was totally up to a nurse's responsibility? There was no influence from the physicians in this education?

FM: Well, they knew what we were doing. This was usually medical. It wasn't all medical, because, a lot of times, we had parents there who had children who'd had open

heart surgery. A lot were heart defects, and they had patched up some part of their heart, the atrial atrium, ventricular septal defects of various kinds. So we'd go through what happened, where it was, that sort of thing. The doctors knew we did it.

DT: They were supportive then?

FM: Yes.

They didn't need an order to come or anything. We just went around and we would recommend, "You might want to come." The clinic nurse was typically good at getting people there.

DT: It seems like a really important function, but it was something that you, the nursing staff, initiated yourselves?

FM: Miss Brennan [and Mary Ann MacIntyre—the previous Heart Hospital supervisor] initiated it. [chuckles]

DT: Without that initiation, the implication is then that the clinicians would have just sent the patients home without that education.

FM: Well, they might possibly if the staffers had time to do it while they were still in the hospital as part of the bedside care, but that rarely happened or very well. In the class, we usually had a heart model, and we had diagrams. We had the teaching tools there to do it.

DT: I can imagine this was such a valuable contribution to the heart program because so much of the long-term success would have depended on patients knowing how to take care of themselves…

FM: And parents knowing how to care for their child, right. I think a lot of it was just anxiety of the unknown and trying to figure out why their child's fingernails were blue and things like that.

DT: You mentioned that the medical staff, those who were in medicine, had, basically, a good relationship with nurses and had this open communication, but the surgeons did not.

FM: Well, a lot of it depended on the surgeon, but a lot of them did not.

DT: Were there particular surgeons that were, say, more difficult than…?

FM: There's always…even in medicine, there are some doctors who are very particular, and they'll just go to the desk and blow off if a certain urine hadn't been collected for twenty-four hours or something hadn't been done that they were *relying* on to get this work done and could follow through. They'd just raise a ruckus. If you knew it was

Doctor [Richard] Varco's patient, for example, you jolly well better get everything lined up for sure.

Also, Doctor [Walton C.] Lillehei would come. I remember I stayed late one night doing some work… No, I had come in on the weekend, I guess it was. I did that often, would come in on Saturday mornings. I remember when I went up in the unit, here was Doctor Lillehei standing next to the bed, just standing there, watching this child. He was there for an hour or two just watching the child.

DT: That's a very human side….

FM: Yes.

DT: I've heard from several other people that Doctor Varco could say his piece to other physicians, too…

FM: Oh, yes.

[laughter]

DT: …that he was a character.

One of the things that you had noted earlier was that there seemed to be a perennial shortage of nurses.

FM: Yes.

DT: I'm wondering then, given that there was so much cardiac surgery taking place in the late 1950s, that this must have increased the workload and demand on nurses. How did you deal with nursing shortages then in that environment?

FM: With difficulty. [chuckles] If she walks and breathes and walks in the door, we'll take her—or him; we did have a few male nurses, not many. Intensive care units were not yet there. What they did is after surgery, they would have what they called a private duty nurse, so you would have an agency outside the hospital that would provide a private duty nurse for the immediate post op area. Of course, some of them specialized in any open heart patients, so you had a list of those who had experience in taking care of the open heart surgery patients. If it hadn't been for those private duty nurses coming in and covering, it would have been *extremely* difficult. We couldn't have handled it.

DT: Did the University or the School of Nursing…? Were there conversations about how you might increase the supply of nurses?

FM: They were always having campaigns on how to do that. [chuckles] I spent two whole days going around with a photographer putting together a booklet about nurses and what wonderful things nurses could do and live with at the University Hospital, so it was

a whole brochure. We have a copy of it in our Heritage Committee. I'm on the back of it sitting on up on top of the hospital looking at the Mississippi River. [laughter] Part of our effort was this recruitment brochure to send out to try to recruit more nurses. There was an effort was in broadcasting advertising and trying to improve the salary structures and the hours, listening very closely to the complaints of what bothered them *most* when they were short. Periodically, they would have a special little tea party or something for the nurses to try show appreciation for what they did and things like that.

DT: Were there also efforts targeted at recruiting high school kids and college kids to enter nursing as a profession as well as trying to get RNs and LPNs to work…?

FM: I wasn't in on that end of it. That would be the School of Nursing doing that sort of thing. I never got involved in that end. I'm sure they did.

One thing we did as alumni, I remember, is we started—what did we call it?—some sort of a tea where we invited all the graduating senior nurses and all the hospitals to send representatives for hiring. So they would set up tables around in the Powell Hall lounge with the representatives from all these different hospitals. Then, the seniors would come to this tea party and go around and talk to people from all these different hospitals. Everyone was so anxious to get nurses.

DT: I know, also, in 1964, the Nurse Training Act was passed federally, so, obviously, by the 1960s, this concerted effort, not just at the University but the state and national.

FM: All over, right.

DT: It was a shortage that you had felt profoundly?

FM: Oh, my yes. Yes.

DT: You mentioned earlier about Ray Amberg as the director of the University Hospital. What was your experience with him?

FM: I enjoyed Ray Amberg. We got along very well. I was a student nurse on neurology, Station 50, and working evenings or weekends or some time, and Ray Amberg, at that time, had had sort of a blow up and he was in for care and sedation. It was when they were doing the designs for the Mayo [Building]. He wanted to tell me all about the Mayo, I remember. My objective was to get him in the tub for a hot bath to calm him down and relax him, and all he wanted was to tell me all about the hospital. Well, it took a little bit, buy I finally got him in the bath tub for a warm bath to quiet him down and take his medication. Ever after that, he always looked at me as if…okay, I've met my match. You could get me in the tub when I didn't want to go.

[laughter]

We always got along very well. I liked him very much, and Mrs. Amberg, too. I can't remember where she came in, but, later, when I got married and had a baby, we still kept in contact. My first baby was Mary Ellen, and the Ambergs sent me this little gift and they were so excited because their first daughter was named Mary Ellen, and I didn't know that. They thought, oh! we've got babies with the same name. Yes, I enjoyed them very much.

DT: So you think he did a good job of taking care of the nursing staff as much as he could?

FM: He was very supportive. I never felt that he was anything other than concerned.

[break in the interview]

DT: You said at the same that you were nursing supervisor, you were also an instructor in the School of Nursing. What can you tell me about your experience, basically, as a faculty member?

FM: The students had a two-week rotation to the heart hospital, so I had all students for two weeks in the heart hospital. [chuckles] After two weeks, I had to have an evaluation conference with each one of them with all the various anecdotal notes. That was my main job. I also had to, in their clinical hours, make sure that they got time to observe a heart catheterization while they were there and that they had an experience to work a few hours in the clinic to interview the patients there and do the admitting process in the clinic. I didn't rotate them necessarily between peds and adults. That usually depended on where they were in their clinical. Then, usually, we tried to get them up to the OR to see an open heart surgery while they were there. So, in the two weeks, that's all, I guess.

DT: That was a lot.

FM: Yes. We'd usually get about six at a time.

DT: You said you were attending faculty meetings?

FM: Yes.

DT: Would you go to every faculty meeting?

FM: They had an all faculty meeting on Monday afternoons—I think it was Monday afternoons.

DT: Are there any things that were particularly notable about those meetings, any particular issues that you remember being discussed?

FM: No. [chuckles] It was frequently clinical content, trying to get the courses arranged, and the clinical experience correlating with courses as much as possible, this sort of thing.

DT: While you were an instructor, then Katherine Densford retired.

FM: Yes.

DT: And Edna Fritz assumed the directorship. Obviously, you've spoken very highly of Katherine Densford and her influence on the school. How was Edna Fritz as a director? How was she received?

FM: Oh, I think everyone was excited, as I was, because she was very bright, very articulate, a very charming person, quite different in her demeanor. I liked her very much; I liked her very much. I thought she did a good job. As far as I was concerned, I got along with her very well. When I wrote that bit for the Master's of Medicine, that part, I had her go over all my writing. She was concerned about *one* thing. She said, "It's not erudite." I said, "No, I don't write erudite. I write plain English."

[chuckles]

That was her one complaint. I do not like the kind of obtuse—or not even obtuse—heady language that goes into some papers I see. The College of Education, for example, loves to put in great big words in sentence after sentence after sentence, and they don't say anything. I don't work that way. That was her one criticism of my writing; it was not sufficiently erudite. I thought, oh, all right. [chuckles]

DT: One of her big achievements was introducing the curriculum changes.

FM: Well, she did not do that as much as this powerful group of faculty led by Dorothy Titt. They were the driving force.

DT: Okay. Who else was in that group?

FM: They're all listed in the book [Laurie K. Glass, *Leading the Way: The University of Minnesota School of Nursing: 1909-2009*, Tasora Books, 2010]. I can't remember all their names right now. Nancy [Cook].

DT: I can see it in the book.

FM: Yes, they're listed there.

I do remember in 1960… See, I left. I had babies. Mary Ellen was born in November 1961 and I left as supervisor and came back and did some staff assisting for a few months until the babysitting situation was unacceptable, and I quit altogether. But I still was

involved at the School Nursing Foundation. I had helped Bob Provost write the bylaws and set it up. K.J. [Densford] had me working on the foundation of the Foundation.

[chuckles]

FM: I was still secretary when Edna Fritz came. I remember going to a meeting. They had the meetings in the [Coffman Memorial] Union in the faculty dining room or one of those conference rooms. Edna Fritz grabbed me by the arm as we went in, and she said, "Flossie, I don't know what I'm going to do. I only have three faculty left." They had all resigned. I can't remember which effort this was at, but I felt so sorry for her. [spoken softly] I thought, oh…

At any rate, I, at that time, was also president of the Alumni—no, that was later. That was in 1966 or 1967, some time around then. The students from this program began flunking state boards and the alumni were up in arms. It must have been 1967. [sigh] [pause] I was asked to go to meet with President [Malcolm] Moos, and it was the woman who had been president of the Alumni before, myself, and the alumni who was president coming in after me. And the three of us went to see President Moos. The alum who was ahead of me, the older one, was irate! "Edna Fritz must go. This is intolerable." When we were in school, no one ever flunked state boards. That was great pride. Nobody had ever state boards, and, now, we had practically the whole class had failed. I said that I thought Edna Fritz was good. I liked her very much as a director, but I thought it would be difficult for her to re-grow the school because everybody had left. I said, "If I were a nursing educator and was looking for a job and I was applying at the school to the director and knew that everybody had left, I'd sort of have second thoughts about becoming a member of that faculty." I thought it would be very difficult for her to do. Then the gal that was after me said, "No." She thought Edna Fritz should stay and put together what had come apart. So I don't know what help we were. [laughter] But she was eventually dismissed, of course. I know Bob Howard, Dean Howard, was very supportive of her all the way through.

DT: Yes.

I've looked at the archival materials, and it seemed that…

FM: And then he left the next year.

DT: It seems that Edna Fritz was facing criticism for a good year or two, and that Dean Howard and the vice president, William "Gerry" Shepherd also stood behind her for long time.

FM: Right.

DT: The nursing faculty who resigned, do you know why they resigned, what they were opposing?

FM: I was not part of that group then. As I say, at these teas that we've had in the last ten, twenty years before these people died—they're dead now—I never brought up the subject because Dorothy Titt was at these, and I knew she was one of the strongholds behind it.

DT: She was one of the ones who was opposed?

FM: Oh, no, she was one of the faculty who resigned…

DT: Oh, yes.

FM: …rather than give up the changes they had develop so that the students would pass state boards. Her view was that state boards should have changed.

DT: Hmmm… Interesting. But the state boards never were changed?

FM: No.

Subsequently—in fact, just yesterday—I was with one of the gals who graduated about 1970, I think, and she had flunked state boards, and she's irate. She is still irate. She will have *absolutely nothing* to do with School of Nursing, which is too bad. She's kind of a wealthy woman right now. She married a rich man. She said, "I spent all that time and money going through nursing school. I got out. I couldn't pass state boards. I could not get a job, so that was worthless! That was a complete waste of time and money, and I couldn't get a job as a nurse." That's the attitude she has.

DT: Was it ever clear why the students were failing? Was it because of the new curriculum then?

FM: They were not teaching the didactic things, what you do with this medical situation, this clinical situation. All those things were not there. They were supposed to know enough theory that they could figure these out for each patient. It was not something that they learned, you know, as A, B, or C.

DT: It makes sense why, then, Dorothy Titt wanted the exams changed because the exams weren't keeping up with the way that nursing education was changing?

FM: Although, that particular mode has not been accepted. They still teach the clinical aspects along with the other. I don't think state boards have changed that much.

DT: I'm sure the medical boards are probably equivalent in their emphasis on didactic.

FM: You have to know the clinical information, right.

DT: Presumably—maybe not presumably—other nursing schools elsewhere in the country were making changes in the curriculum around this time.

FM: I think the changes they made were good, except they let go of too much of the didactic clinical stuff. They should have incorporated that and included these other factors. The fact that they started the nursing earlier… The two-year liberal arts education as an independent block was no longer there. They started introducing nursing, I think, in the first or second year, and, then, incorporated more of the liberal arts later on. When I was in school, you couldn't really take an elective, because you were so busy; although, I did have one classmate that did when she was in school. She took courses in philosophy and sociology. She ended up getting her Ph.D. in sociology and taught at a college in Virginia. I forget the name of the school. She didn't stay in nursing. She went into sociology.

[chuckles]

FM: At any rate, we didn't take electives, but, now, they can take many more of the liberal arts courses as they go along. That, I thought was good, but they should have kept the clinical content. They still have to know what to do for the patient who has an insulin reaction or something.

DT: I'm aware that you were less involved with the School of Nursing at this point, but after Edna Fritz was fired, do you know if a lot of the faculty who had resigned returned?

FM: I don't think so. I think there were a few that stayed. Florence Brenna was still there. I have a friend in pediatrics, Dorothy Geis, who stayed on. There were a few who stayed on, but I know Dorothy Titt never came back. Nancy Cook went out to California.

DT: I interviewed Bob Howard, actually around this time last year. He had talked about…

FM: How is he?

DT: He was good.

FM: Well, good.

DT: He was in good shape. He and his wife, they were in their lovely home in Walnut Creek, California.

FM: Oh, that's where they are?

DT: Yes.

FM: I was wondering where they were.

DT: He talked about Edna Fritz, that he had had to let her go because of the…

FM: He got orders from President Moos, right.

DT: Yes.

FM: He didn't want to do that.

DT: That was my impression based on what he said, but, then, clearly, from the archival record that he stood by her till the very end. He had said that he had to let her go because of the students failing the state exams. What's interesting then is it seemed that Bob Howard received a good number of letters from nursing faculty at other institutions around the country and also in the Upper Midwest, basically, haranguing him for having fired Edna Fritz. So he took a lot of flak for that.

FM: Yes. Yes. I think where her Achilles heel was is that she didn't reign in the faculty when it should have been done. That's the only thing I can think of. As I said, I wasn't a part of it at that point. Looking back on it, I think that she had to just say, "Okay, you have to have enough in there that they can pass state boards," and that didn't happen. So that was a fatal error, you might say.

DT: You had said that Dorothy Titt was really the leader of this…

FM: I always had that impression. I don't know… I think that's true, though.

DT: And she was on the faculty when Katherine Densford was?

FM: Yes, I had her as an instructor.

DT: Okay. I'm wondering was it only after Densford retired that Dorothy Titt and the cohort of people looking to revise the curriculum, that they…?

FM: Yes, I think they had an opportunity when Edna Fritz came. Edna Fritz had wanted everyone to go in the clinical areas. One of the reasons Myrtle Coe left was that she was forced to doll up in a uniform and a white cap and go back into the clinical areas. She hadn't done that for decades. That was terribly hard on her. She was doing classroom teaching in physiology and this sort of thing. So she left, but that was because of that experience, I think.

DT: The change in leadership created an opportunity…

FM: Yes.

DT: …and then Edna Fritz came in and wanted to push the clinical side. You think if she had more control over the faculty at that point… I'm pushing this because I saw the letters of criticism that were written to Edna Fritz and to Gerry Shepherd and President Moos criticizing Edna Fritz's leadership, but it's interesting because a lot of the faculty

accused her of being autocratic and not listening to the faculty and just making these decisions on her own.

FM: Maybe that was one of her decisions they didn't like. I don't know. I was busy having babies.

DT: Yes.

[laughter]

DT: This is one of the great mysteries that I am hoping to uncover if I talk to enough people. Even though you weren't centrally involved, you still have, obviously, a perspective.

FM: That's my sense of what happened.

DT: Just knowing also that you speak positively of Edna Fritz…

FM: Yes, I liked her very much.

DT: So then, you were having children. When did you return from nursing practice?

FM: I never really got back in the clinical area. I was in more administrative types of things. I was very interested in research. There was a new thing I got very excited about. Pat Price came along and she'd gotten her doctorate in education at Columbia [University]. She had gotten a five-year grant to study staffing and staffing patterns at five different hospitals, I believe. I managed to get a part time job, so, once a week, I would go and work, or twice a week, and find someone to take care of my three babies. Actually, I had my third baby on the job [unclear]. I had my first baby on the job, too [meaning, while I was employed]. That was exciting and that was my first job then…or no. I'd been on another one. I'd done some work with Ida Martinson in here someplace or other. [Mrs. Marks looks at her papers.] Here's the project on staffing. Yes, I guess I did that and, then, I did writing curriculum development at home. I had stacks and stacks of books. Dorothy Geis was working, and she'd gotten this. She said, "I can't do it. You can do that." So I got that job. I did that at home.

DT: This was in 1976.

FM: February 1976.

This one was with Ida Martinson. Mainly what I did is I wrote an index for her book. [Ida Marie Martinson, *Home Care for the Dying Child: Professional and Family Perspectives* (Appleton & Lange, 1977).]

I actually didn't go back working half time until 1978.

DT: And that was at Hennepin County.

FM: Hennepin County, all due thanks to Jane Philips who called me in to help them set up patient classification.

Part of our study with Doctor Price had been patient classification. We compared patient classification systems with an assessment by the charge nurse of what staffing they needed for a certain shift. The end result was pretty much that what the charge nurse said she needed was as good as any patient classification system. I think that's what they've ended up with now. I'm not quite sure what they're doing for patient classification. It's pretty much what do you need. You know, if you get too many people, work slacks off, and they socialize. You don't want less than that, and you don't want more. We learned that and I think all those studies are beginning to show that's probably just as good as anything.

So I never really got back to bedside nursing at all.

DT: In the late 1970s, were you actually on the faculty then at the University?

FM: No. I was in administration. I was in hospital things.

DT: Okay.

FM: I wasn't on faculty. [I was on as adjunct faculty at U of M S.O.V. while at Hennepin County Medical Center but only participated in one class.]

DT: So I have just a few more questions.

FM: Okay.

DT: These are more about University things, so I'm not sure if you'll be able to answer them, but I'm going to ask them anyway.

FM: [chuckles]

DT: Obviously, you were engaged in what was going on at the time. One of the significant things in the late 1960s, early 1970s was the reorganization of the health sciences and the creation of the Academic Health Center. For the nursing school, the big change was moving the School of Nursing out of the College of Medical Sciences and to its own school.

FM: And Isabel got to be the first dean.

DT: Yes. [chuckles] What was your take of that? How did nurses feel about that reorganization?

FM: It was about time is what I say. [chuckles] That's how I felt. The only drawback that I felt about the students and the Powell Hall business, the hospital… The hospital also had been accepting the students. When students applied to the School of Nursing, there was this shuffle of names and whatnot to the hospital because Powell Hall was hospital property. The indentured slaves had to be admitted as part of the staffing. [chuckles] I don't know where they kept the names; I really never did know that. So that ceased in, I think it was, 1962 or 1963, sometime in there when they removed them of the necessity of their having to exchange room and board for clinical experience.

I think the one thing that that my classmates to my knowledge, to some extent my own, was the feeling that we really need a fair amount of clinical experience to practice before you're let out on your own. We felt that there wasn't enough time of practice to come out feeling secure and safe. That was our concerns about the cutback. We thought what we had done was too much, but then we were concerned it might be too little.

DT: This, presumably, had a big effect on the hospital, because if it was losing their student nurses…

FM: On their budget…they had to spend more money paying nurses.

DT: Do you any knowledge of how the hospital coped with that and how they felt about it?

FM: No, I was away from that.

DT: You got out at the right time.

[chuckles]

FM: I was more concerned about toilet training my children or something like that.

[chuckles]

DT: When you were on faculty in the late 1950s, did you feel any influence because the School of Nursing was within the College of Medical Sciences? Did you think that organizational relationship influenced what the nursing faculty could do?

FM: I don't think it influenced them what to do, but I think there was always a struggle on budget and budget items and how you could get money… But I never was part of that. I just sensed it very indirectly. K. J. was the charmer there, and she was the one who tried to negotiate for a share. That always was an issue.

DT: From what you know of the situation, do you think that improved once the College of Medical Sciences was disbanded?

FM: I couldn't really say. I had no idea.

DT: But as far as you were concerned, it was definitely…

FM: The budget was always a problem and still is.

DT: Yes.

[laughter]

FM: So I don't know if there was any change or not.

DT: As far as you were concerned, having the School of Nursing established on an equal administrative footing as the other health sciences…?

FM: Yes. I thought that was good, and it put nursing in a better professional status. Nursing has always struggled with its semi-professional/professional status. What core knowledge is nursing and nobody else's? That sort of definition issue. So, in that respect, I thought it was appropriate that it be separate.

One of the issues with the clinical separation with the faculty no longer having one foot in the hospital as supervisor and another foot as an instructor, as we all were, and then that being severed, is that you had more of a gap between clinical and education. The instructors in the School of Nursing were not seeing what was going on in the clinical area day-by-day, week-by-week as you had been when you were dual positions. The medical staff still had dual positions, but not so in the School of Nursing. I always thought that was an issue. There is this gap here, and I think it's a problem today. You have an idealism in the educational part and, then, in the clinical part, you have reality and they don't always meet. So I think that's still an issue.

DT: You'd still have the student nurses doing rotations, *some* clinical rotations in…

FM: I think the instructors needed to have, the teachers.

DT: Right, they needed to be in the clinical setting.

FM: Yes, teachers needed to be in the clinical area.

DT: Because, now the staff nurses and nursing supervisors who were overseeing what the student nurses were doing didn't have a medium for reporting back to the School of Nursing about how those students…?

FM: I don't know how they do it now. I know the instructors go to the clinical areas when students are having learning experiences, and they go through the patient records, and they select the patients for those students to work with so they get certain experience. The instructors frequently are there in the clinical area with the students for some of their experiences.

DT: When this change happened, that was lost?

FM: I'm saying now.

DT: Now, they're there.

FM: Now, they're doing some of that, but not to the extent they were previously. I don't know the communications on the student… The clinical instructors are there—I think they are. Well, they work… I'm trying to remember my friend. She did nursing arts instruction fifteen years ago. Fifteen years ago, they were doing that. The instructor would go to the clinical area and pick out a patient, and they would be with the student. They might have three or four students in the area. They could see how they were doing for evaluation. To what extent they were left on their own with an experienced nurse and you had to get feedback, I don't know.

DT: But, at least, in 1970, and I guess in the 1960s, when…

FM: They had the change?

DT: Yes.

FM: I don't know.

DT: But your sense is that there was also this separation?

FM: I don't know. I'll have to ask Sandy [Craighead] the next time I see her. She doesn't want to talk about; she's still angry about it.

DT: Yes.

Do you have any other reflections that you'd like to share on your experience from…?

FM: I could write a book.

[chuckles]

DT: I haven't asked you about the 1980s because, for the moment at least, I want to focus on things in the 1950s, 1960s, and 1970s. So maybe we could talk again at a later date about the 1980s and thereafter.

FM: I'm just glad you talked to Bob Howard. His wife… What is her name? Marg? Was it Marjorie?

DT: She has since passed away.

His first wife?

FM: Yes.

DT: I don't know her name.

FM: She had become a deacon in the Methodist church and, of course, my husband being the son of a preacher, and I thought that was a very admirable thing for her to do. [sigh] We saw some of them.

Some of the medical staff were not on good relationship with nurses. They were somewhat aloof. Others were always very communicative and supporting. Doctor Paul Winchell was one of the internists at the heart hospital who was very supportive and would freely meet with the nurses. When they came upon an issue with a patient, he would be always glad to talk with them about the various problems they were having. In fact, he put his name on a paper that I wrote about catheterization, if I remember correctly. I wrote most of it, and then he put his name on it…

DT: [chuckles]

FM: …for some aspects of it, I felt I needed to have a medical name attached to. [Mrs. Marks looks through her papers] Here, this one. I think it was the angiocardiography I wasn't quite sure most of, so he went over some of that, so he got his name on that one.

So it varied person by person. Some of the doctors were much more communicative with the nursing staff than others, and I don't think that's probably changed. That's just human nature. You felt more of a camaraderie, in others you felt definitely subordinate.

DT: Yes, that's what I was going to say.

FM: Right.

DT: It was just personality rather than specialty?

FM: The surgeons always are a class to themselves. That's the way they are. Internists, as a rule, are analysts and it's more of a group sort of thing and surgeons have to work independently and make decisions in a moment. That's part of the nature of their work. If you do an MMPI [Minnesota Multiphasic Personality Inventory], I think you'd come up with two different kinds of personalities.

[laughter]

FM: That's just the way they are. Yes.

DT: Did you find, generally—again, it would depend on personalities—that the nurses worked well together irrespective of how they were trained or where they were trained?

FM: Pretty much. Once in a while, you'd find diploma nurses, I remember, who would say, "What's so great about the being a baccalaureate grad? What's the big deal?" Diploma nurses had a lot more clinical work than we did, and they could run circles around us a lot of the time. They were real good workhorses. You were always glad to get a diploma nurse because they knew how to work. I remember saying one time, "Well, the main difference is communication. When you go to college, you learn how to write and talk." [laughter] You would get this, you know. "What makes you better than me?" At this time, there was no salary difference. A diploma nurse would make the same salary as a baccalaureate. I don't know if that's still true or not. There aren't any diplomas out there now.

DT: Right.

FM: Whether an AA, an associate degree nurse, gets less than a baccalaureate, I don't know.

DT: I don't know.

The patients weren't aware of the different [types of nurses]?

FM: No.

DT: And the physicians didn't treat diploma nurses differently from RNs?

FM: No, and if she was real cute, she'd get treated a lot better, sometimes.

[laughter]

That depends pretty much on the individual.

DT: There was a lot of fraternizing between the nurses and the doctors?

FM: Oh, yes. There's always been that.

DT: Yes.

Given that your experience when you had initially wanted to go to medical school and the difficult experience you had with that, did you notice from the 1950s through the 1970s a change in how female physicians were treated?

FM: Yes, definitely. There was a *big* difference. I can remember one woman who was an intern; she was quite a loner. She wasn't included in on a lot. If there were rounds, she was usually shoved on the outside. You'd see that sort of thing. Later, in the 1970s, for instance when I needed care—I was with Health Partners—probably in the 1980s, I remember going to different doctors for my annual physical. I didn't like that one and I

didn't like that one. I even had one of the Mayo grandsons or somebody. So I finally found a woman. I could just see when she did my physical. She went system by system by system. Well, that's pretty good. So I still have her as my primary physician…a big difference.

I remember talking to Doctor Coe. Coe, I think graduated from Harvard. He goes to our church, John Coe. In fact, I was one of the people who spoke at Myrtle Coe's funeral. She was the first clinical instructor…in the world, I guess. I think he graduated from Harvard, and he mentioned that over half of the students at the medical school were women. That must have been in the 1980s.

The flip side of that is that there was concern that all these former nursing prospects went to the Medical School, so that the IQ, or whatever you want to call it, basically would go down in the School of Nursing, but that hasn't happened. So now a lot of nurse students, of course as you know, have baccalaureate degrees before they go on to nursing. I was the only one in my class that did, but there were others in my time that did, not very many.

DT: It's interesting. Do you think the introduction of nurse practitioners has changed things?

FM: Yes. I can never quite figure out the difference between a physician's assistant and where they fit in here with nurse practitioners. I haven't got that figured out yet.

DT: Do you know Julie Fairman, nursing historian at Penn [Pennsylvania School of nursing]?

FM: No.

DT: Her most recent book is called *Making Room in the Clinic*. It's a history of the nurse practitioner movement in the U.S. She contrasts it to physician assistants and the efforts at the same time in the 1960s and 1970s to build physician assistants as a profession. I think it's clear that there was a lot overlap. It was different people pushing different agendas.

FM: Right.

DT: I read the book; it's a great book, and I recommend it.

FM: To me, a physician's assistant is kind of a dead end job. If that's all you want to do, that's fine. I think in nursing, you have a much broader range of things you can do.

My daughter [Mary Ellen?] went to school at the University and graduated from the nursing school. She's a school nurse now. I look at what she does and it's phenomenal.

[pause]

DT: Do you have any suggestions for who else I should talk to?

FM: I wonder if you want to talk to Sandra Craighead, the one that [failed her boards]. [laughter]

DT: Do you think she would talk to me?

FM: I don't know. I'd have to look up her…

DT: How do you spell her last name?

FM: C-r-a-i-g-h-e-a-d. Sandra. I can get you her contact.

DT: That would be great. I appreciate that.

FM: I don't have it with me right now. I just saw her yesterday. She's been very active. She's president of boards and all this sort of thing. She's been president of Emma Norton Services. I've been on their board. She's very active there. She's active in Scouts. She's been president of the Saint Paul, Scouting Board of Directors, Girl Scouts. She's vice president of the board for the Boy Scout/Girl Scout Museum now in Maplewood, I guess it is. This was a Girl Scout bunch that were getting together yesterday. It was fun.

[chuckles]

FM: All these old… I think the average age was probably eight-six. [laughter] She was there doing a pitch for money for the Julie Gordon Low Fund.

DT: I would love to talk to someone who was a student at that time. So, hopefully, she'll be interested.

FM: I will let you know.

DT: Yes.

FM: And get you that information.

DT: That will be great. Thank you.

[End of the Interview]

Transcribed by Beverly Hermes
Hermes Transcribing & Research Service
12617 Fairgreen Avenue, St. Paul, Minnesota, 55124
952-953-0730 bhermes1@aol.com