

Marie Manthey, MS, Ph.D. (hon.)

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

Marie Manthey was born and raised in Chicago Illinois. In 1956, she earned her nursing diploma from Saint Elizabeth's Hospital in Chicago. Manthey went on to receive her B.S. in nursing (1961) and M.S. in nursing (1964) from the University of Minnesota. She served as associate director of nursing at the University of Minnesota Hospital (1964-1971), as assistant administrator and director of nursing at United Hospitals of St. Paul (during the 1970s), and the vice president of patient services at Yale New Haven Hospital. During her tenure at the University of Minnesota Hospital, Manthey led the development of primary nursing and is recognized, nationally and internationally, as the founder of primary nursing. In 1979, Manthey founded Creative Health Care Management, a consulting firm specializing in the organization and delivery of health care services.

Interview Abstract

In the first interview, Manthey begins by discussing her childhood and her decision to become a nurse. She describes her initial nursing training and work at Saint Elizabeth's Hospital and the University of Chicago Hospital in Chicago, Illinois. She discusses her decision to come to the University of Minnesota to continue her education in the early 1960s, and describes her experiences with individuals such as Katherine Densford, Edna Fritz, and John Westerman. She describes working on Station 32 with Dr. Owen Wangenstein, the shifting roles of Registered Nurses [RN] and Licensed Practical Nurses [LPN], and relationships between nurses with different levels of education. She discusses her time as Associate Director of Nursing at the University Hospital and the work that led to the establishment of primary nursing. Manthey describes the changes in accounting systems in the hospital as well as the restructuring of the University's Academic Health Center.

In the second interview, Manthey continues to discuss her time at the University Hospital. She also describes her experiences serving as assistant administrator and director of nursing at Miller Hospital in St. Paul (later renamed United Hospital). She discusses her experiences with Ray Amberg, various hospital administrations, and nursing unions. She discusses the culture of the University of Minnesota's School of Nursing, and the relationships between the faculty and the Hospital's nursing service during the 1960s and 1970s. Manthey also discusses the changes in undergraduate and graduate nursing education introduced at the University of Minnesota during these decades. She discusses her tenure on the Hospital Board of Governors and explains her decision to leave Minnesota and move to Yale New Haven Hospital in the late 1970s. She describes the differences she sees between nursing and medical care in Minnesota compared to other locations in the United States and abroad. She discusses her company, Creative Health Care Management and developing the Leadership for Empowered Organizations (LEO) program.

Interview with Marie Manthey

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at the Office of Dominique Tobbell

Interviewed on October 12, 2010

Marie Manthey - MM

Dominique Tobbell - DT

DT: I'll introduce us. This is Dominique Tobbell, and I'm here with Marie Manthey. It's October 12, 2010. We're meeting in my office at 510-A Diehl Hall [University of Minnesota campus]. Thank you, Marie, for joining me today.

To get us started, can you tell me a bit about your background, such as where you were born and raised and how you got into nursing?

MM: I was born and raised in Chicago, Illinois. I was born in a middle class neighborhood. My father is one hundred percent German. My mother is one hundred percent Irish. Nobody had ever gone to college nor had any kind of higher education.

When I was five years old, I was sick in the hospital. It was a negative experience for many different reasons, one of them being that my parents knew nothing about hospitals, so they really couldn't tell me what was going to happen. They just told me I was going to a big building. They didn't tell me that I'd stay there, because they didn't know I was going to be admitted. So I couldn't understand why they left me there and, then, according to the rules for visiting children in hospitals in those years, only one parent could come for one hour twice a week. I didn't understand why they didn't come and see me and, then, when they did come, a very painful procedure was done. Those things I know to be true. Now, what else was happening and so on, what other feelings I may have had, I don't know, but those things I know.

In the midst of that, the other thing I know is that there was a nurse by the name of Florence Marie Fisher, and she colored in my coloring book. Now, I have no idea what else she did or didn't do and whether she was a good nurse or a bad nurse, but the fact that she colored in my coloring book meant that she really cared for me, in my mind, the way it felt, because it was an act of extremely precious caring. I just very quickly decided that's what I wanted my life to be about. From practically then on, as early as I can ever remember, anytime anybody said to me, "What are you going to be when you grow up, Marie?" "I'm going to be a nurse like Florence Marie Fisher." "I'm going to be a nurse like Florence Marie Fisher." It was a mantra. Florence Marie Fisher was in here. I never saw her again, and we never had any more contacts.

I became a nurse like Florence Marie Fisher and, as I look at my career, I can see that feeling of being cared for was really a driving force throughout my whole career. It's why I stayed with primary nursing. It's why I built the company that I built. It really accounts, in my own mind, for so much of what I've been able to accomplish. She colored in my coloring book.

I had the pleasure of finding her son. The rest of the story goes like this. In 1980 when my book was published, the publisher, [unclear] Scientific, decided to try and find her because I dedicated the book to her, *The Practice of Primary Nursing*. So they wrote a letter to the Illinois State Board of Nursing and found out she got married and lived in Indiana. They wrote a letter to the Indiana State Board of Nursing, and they couldn't find her.

A couple of years ago, when I was getting my papers ready for the archives, I came across those two onion skin copies of the letters that the publishers wrote to the boards. I looked at my home computer, and I looked at the letters, and I said, "Humph! I'm going to google her." So I googled "Florence Marie Fisher." I felt very outrageous in doing that. I just thought, oh, my god, this is just crazy to google Florence. She's always been right here. She's always been a big part of my life, and, yet, it's been on the inside, and to think about googling her brought her out in way that I felt was totally outrageous. Anyway, I got her obituary, which was both the good news and the bad news. I mean, oh, my gosh, there she is. Oh, my gosh, she's dead.

It had a survivor. So, I paid \$7.95 and got the phone number for the survivor, and I started calling him. He didn't answer all afternoon and a couple times in the... At seven o'clock, he answered. I said, "Is this so and so?" He said, "Yes, it is." I said, "Well, I don't know how to tell you why I'm calling you, but let me start off with my name is Marie Manthey. Before I get into anything, I've got to ask you, did you have a relative named Florence Marie Fisher?" He said, "That was my mother." I'll tell you, Dominique, it was like an electric current went through me. I thought, oh, my god, I'm talking to her son. I'm talking to Florence Marie Fisher's son. I can't stand it. Oh, my god! I'm talking to my Florence Marie Fisher's son. Rrrrrrrrr. I was just unbelievably exciting.

I started telling him about what she did and what it meant in my life and where I am now and

looking back on all that my company's managed to do and so on. He started his mantra, which was, "She never knew." "My mother never knew." "Mom never knew." "My mother never knew." I talked to his son and daughter, her granddaughter and grandson, and they said, "Grandma never knew." "Grandma never knew."

The lesson for me in that sort of capsule experience of Florence Marie Fisher in my life is to remind nurses how something like coloring in a coloring book can make such an incredible difference in the life of someone's own life. We may never know, but if we don't do those things, then they don't happen.

DT: That's amazing.

MM: That's how I became a nurse. I always wanted to be a nurse. No matter what job I had, I felt like I was right for it and it was right for me, even in jobs where I had some troubles later on with my personal problems. Still, every day I went to work, I felt like it was right for me and I was right for it. I filled every level of position within hospitals from staff nurse to vice president twice and always felt that way every day. I just consider it such a blessing when I see how other people struggle with why they're here, and what am I supposed to do?

DT: That's also amazing.

MM: Yes.

DT: Where did you do your education and training?

MM: I went to Saint Elizabeth's Hospital in Chicago. I entered in 1953 and graduated in 1956. The reason I chose that hospital is because that's where my father's doctor practiced. I, subsequently, found out that my father's doctor was considered one of the biggest quacks on the medical staff. I had to, eventually, counsel my father to use another doctor, because this guy was killing him, literally. It was Catholic school; I was raised Catholic. There was no evaluation of schools or hospitals. It was just like, "That's what Doctor [sounds like Mackery] said." "Well should I do that?" "Sure, I'll do that." I'm amazed, sometimes, in retrospect how unconsciously my career went, when I see people today and the conscious, deliberate steps they plan. I went to school there...uneventful. Loved everything—practically. All the clinical stuff, I just adored. I went to work there for a while until I got the state board results.

Then, in another bizarre kind of non-career planning move, my mother's cousin came over for a family affair. She was working in the HR [Human Resources] Department at University of Chicago. She said, "You know, Marie, you ought to think of working at the University of Chicago. Now, it's not a Catholic hospital, but it's a very good resort. They have very good personnel policies. I think you could find something." Now, I lived on the north side of Chicago and the University of Chicago was on south side, so it meant about a twenty-minute ride on the outer drive to and from work, but that wasn't so bad in those days, and it wasn't enough to deter me, to make me not go there. So I went and applied, and, of course, in those days, if you wrote your application, you got the job. I worked there for the next three and a half, four years. I went from staff nurse to assistant head nurse to head nurse. I finished that part running a twenty-bed surgical floor called Goldblatt Four.

Then, I came here. There was something of an anti-education bias. In those years, there weren't many people around with educations, nursing baccalaureate education. Ninety-five percent of the people I worked with were diploma grads. But we all heard this, "You should get your degree." Everybody was saying at work, "You should get your degree," especially if you had a couple of brain cells operating they would tell you to go to college. But I didn't want to. I had this *terrible* attitude when I look back on some of the non-thought processes that drove me. I looked around at the few people that had bachelor's degrees, and they were all older, and they weren't married. So I put two and two together, and said, "I don't know if getting a bachelor's degree means you don't get married or if you don't get married because you've got a bachelor's degree."

[laughter]

MM: It didn't look right. So, then, when they promoted me from staff nurse to assistant head nurse, they asked me to take a class in the night school on ward management. I took that and I just loved it. They had a good teacher and it just opened up things. I always had like a hunger for a broader education, but nurse's training was pretty tight, pretty controlled. Then, I started taking another class, another class, another class. By the time I left, I was taking nine semester credits and working full time as a head nurse.

Yes, just an absolutely crazy schedule, but I was loving the education. There was something *so* special in those days about going to night school in a city like Chicago, and taking something like philosophy or social and economic history of the United States before 1823, those were some of the classes. The students in the class would be so interesting. We'd have a lawyer, and a milkman, and a school teacher, and people who were housewives and truck drivers. The class was just full of these people doing all different kinds of life work and engaging the instructor in discussions about the topics.

When I came here to finish up my education in 1960, I was just *dismayed*—by this time, I think I was twenty-six—at the kids who weren't paying attention in class, whose eyes were glazed over. They were sleeping. They were doing anything but listening to the professor.

What are they here for? This didn't make any sense.

I came back here and got my bachelor's degree using my federal trainingship, which helped with the finances.

DT: Why did you pick Minnesota?

MM: Oh, this is such a long story.

DT: That's great.

MM: It's simple but not very easy. The director of nursing at the University of Chicago was a woman named Margaret Filson Sheehan, S-h-e-e-h-a-n. She was a feisty little dynamic woman, very nice, tough. She wanted me to go back to school. She said, "You're accumulating all these credits. You've got to put it together and get a degree," blah, blah, blah. I had broke up with a guy I'd been engaged to, and I thought, maybe I should do it now.

So, I started looking around. I was looking at three different schools for various reasons. She really encouraged me to come here because she knew they had trainingship money, but, even more importantly, she knew the school because she had been the director of nursing here at the University of Minnesota Hospitals before she went to the University of Chicago. Her name then was Margaret Filson.

DT: Yes.

MM: She must have been the assistant to K.J. [Katherine J. Densford]; although, I've got to get that straightened out if I go into the archives, because I don't see her name as often as I should, I think, looking at old stuff. K.J. left in 1959, and I knew Margaret Filson in the 1950s. Yes, it had to be when K.J. was here. That's just one of my little [history] projects. So I came here.

Then, the only interesting part about my decision to come here is that I was going to school taking nine credits, and I was working fulltime as a head nurse on a very busy surgical floor, and the idea of coming here to take the ACT [American College Testing Program] or whatever was pretty much out of the question. But, because Filson Sheehan had an honorary position at the University of Chicago, adjunct because of her department status, she was qualified faculty to administer the exam to me. So in *my* conference room on *my* floor at the University of Chicago, Mrs. Sheehan administered the ACT to me so that I could get admitted to the school. And I did and I came here.

[chuckles]

DT: What was it like? What were the faculty like? What was K.J. Densford like? I guess

she had retired by then?

MM: I started here in September 1960 and she left the previous year.

So Edna Fritz was the new dean. I had no opinions about her one way or the other. The courses... We had a little smattering of stuff in my diploma program that I hated it. History, Trends, and Professional Judgments. That was sort of like what they were going to give us now in great big doses. I had Edna for Trends. That was eyes rolling, total boredom and I couldn't hardly stand it. I just didn't care about the things she was trying to get into our heads. She wasn't a very dynamic instructor either.

There was one sort of critical course that I was taking, and, of course, I was so interested in the clinical side of things. This must be September 1960. I graduated in March 1961. The curriculum was in transition. The faculty was divided. I don't think they really knew how to manage the transition without pretty much destroying each other. There was one class I took... I didn't know these people at all. It is only in retrospect that I know now who at least some of them were. This one clinical class had team teachers, three of them. One was Myrtle Coe. Now, as you look the history of the School of Nursing, Myrtle Coe, is phenomenal. She was brought in early by K.J. in the 1930s. She was an extraordinary clinician, well authored, expert clinician, married to the coroner for Hennepin County for many, many years, a prestigious place in society, blah, blah, blah, blah, blah. She was an extremely brilliant clinician with a lot of understanding of the medical sciences and the nursing clinicals with it. But, the school was moving away from teaching clinical content. So what I saw as a student was these teachers standing up in front of us, two of them humiliating the third one, and the third one was the only one talking about anything I was interested in, which had to do with dealing with patients who are sick. The two of them, I don't remember their behavior specifically. All I remember is their trying to make us not like this woman, trying to denigrate her in our eyes. What *is* this nonsense going on? Again, I didn't know until years later about the transition that was going on at that time.

My degree, at that time, was a bachelor's in nursing administration. I was the last of that class. That's another reason Margaret Sheehan suggested I come here, that if I hurried up, I could still get a bachelor's degree in nursing administration, which she felt would position me better for the kind of career in practice and service that I was interested in. I got it in March of 1961.

In September 1961... In September 1961, I got married. So I got it in March 1962. No. September 1961 is when I started. In September 1962 is when I got married. So it was March 1963 that I got my bachelor's degree. I was pregnant by March. I worked private duty that summer. Is [Isabel] Harris called me up in late summer, like August, and said, "I think you should come back and get your master's in nursing administration." I said, "But I just got trainingship money for a year of bachelor's and I haven't done anything with it yet." It wasn't a requirement, but was suggested you pay it back by working in the field and I hadn't

been working in the field. She said, “That’s okay. We have trainingship money available. If we don’t use it, we’ll lose it. You can get your master’s in nursing administration in nine months if you go now. It’s the last time we’re going to offer this program.” So I got the MNA [Master’s of Nursing Administration] in the last program that was offered during the time that most of the graduate programs were functional: education, psych, or administration. Is Harris was really, I thought, very generous and very good to me in plucking me out that way.

When I was ready to graduate from that program, her housemate, Florence Julian, took me to lunch at the Campus Club and said, “I want to offer you one of a couple of different positions. You have a choice here.” That’s why I say, my career just kept happening. I didn’t *think* about what I was going to do next, and, all of a sudden, somebody said, “Oh, this might...” “Oh, okay.’

[chuckles]

MM: It was kind of like that being handed off thing. I thought it was just wonderful.

DT: Do you remember the names of the two faculty that were teaching?

MM: No. I think one was Dorothy Titt, but I’m not sure. I shouldn’t say that, because I really don’t know.

DT: She certainly was one of the faculty who came through in the archives who was quite antagonistic to Edna Fritz. She was pushing the scientific model of nursing.

MM: I don’t know that this was Fritz’s baby. I think they were antagonistic to the Densford Era. They were trying to root out the people like Myrtle Coe, who in many ways had a cement seat and should not have been... the only way to get rid of her would have been to make her feel uncomfortable. She had so much prestige.

DT: So she did stick it out?

MM: No. I don’t know how long. No.

DT: Were you working while you were doing your bachelor’s here, while you were finishing up courses?

MM: Yes. My bachelor’s... In the beginning, I didn’t have a trainingship for the first six months. You could only have a trainingship for a calendar year. So the first six months, I lived in Powell Hall. The deal was a board and room deal they had had for years where if you worked twelve hours a week, you could have your board and room free, as an RN

[Registered Nurse]. So I worked as an RN those six months.

I was stationed on [Station] 42, which was [Doctor Owen] Wangensteen's floor. Now, I had been a head nurse of a very busy surgical unit at the University of Chicago where, without an ICU [Intensive Care Unit]—they didn't have ICUs yet; you went right from the recovery room to the post-op floors—we were doing adreno-hypophysectomies. We were doing commando procedures when the lower half of the face was completely removed. We were doing nephrectomies. We were doing all kinds of major, major, major surgeries with no ICU. I was a very competent clinician and competent manager.

So I'm a staff nurse on Wangensteen's floor as a student, and, all of a sudden, there's that Wangensteen Suction. It was sort of like my first enormous hurdle that I didn't get over ever, because as a staff nurse in those days, we would work either as a team, one of two teams with sixteen or twenty patients that we were responsible for, and couple of support staff. Honest to god, Dominique, I would work eight-hour shifts that lasted eleven hours, but it was run from minute to end and I can remember not knowing what I was doing! Absolutely not be able to grasp the totality of what's being required of me and responding to it from one situation to the next, to the next, to the next, to the next, to the next. It was about CCs in and CCs out. We had so many infected wounds, it was just unbelievable, ward isolation up and down the corridor. Half the patients in ward isolation because Wangensteen's technique was not very good, tie in the sterile dressing tray and so on. Patients with wound drainage on split mattresses to drain puerile material in basins under the bed. People suffereing so much, and not having a minute, not even a second to look in on them even. I remember one night I went home to my dorm room, and I had to get up and go to work the next morning. It was one team, three to eleven. Sometimes, I would come home at three a.m. The next team, seven to three... a whole new bunch of patients. Oh! man. [whispered]. One night, as I said, I came home and I just started crying. I lay on my bed by myself sobbing my heart out because I realized that I had to work in there all night, and I did not know the name or the diagnosis of a single patient. That's not okay. That was not okay with me.

About that time, I went down to somebody in the nursing office at the University Hospital named [given name?] McIntyre, Miss Mac. We all loved her. She was a good ear to listen to us. I said, "I can't do it. I've got to be reassigned. This floor is absolutely killing me." She looked at me and she said, "I'm so surprised because Mrs. Sheehan said we could have you go anyplace, that you're *that* kind of nurse that you can work anywhere." I said, "Okaaay."

DT: [chuckles]

MM: I went back and put in my next three months, and, then, I was out of trainingship and out of there.

Later on, I worked as assistant director, and I did some really intensive studies of that floor, and I ended up dividing it in half, which nobody thought they could do until I kind of drew out how we could change some of the way the space was being used and give everyone the support space they needed. We had two different staff [unclear] and continued on that way until they got the building.

DT: Was it just Wangenstein's floor, or was it...?

MM: No, there were other doctors, but it was predominantly Wangenstein.

DT: That ward was particularly bad for how busy the nurses were and how...?

MM: It was the biggest one. It was the biggest ward and the size adds so much complexity. He didn't believe in wall suction and I had had wall suction in Chicago. I just couldn't believe we had to be futzing around with that three-bottle suction. That took *so* much time. It was *such* a messy...such a persnickety requirement.

One of the other memories I have of those years is I was going into an isolation room and I was getting garbed up and had to put gown, and gloves, and mask on. A resident asked if he could tie my gown. I remember thinking, I'm going to start crying. Somebody is being nice to me.

[laughter]

DT: That's not something you expect, for a resident to tie a nurse's gown.

MM: Oh, my god, somebody is being nice. The tension was just unbearable. People were just on edge and yelling at each other all the time.

DT: Was that just the product of everyone being so busy or was it the result of Wangenstein's personality?

MM: Hard to tell. He beat up the residents, so they would beat up anyone they could. I wasn't directly involved with him very much. I'd see him and see other people bowing to him. Well... I don't mean to be disrespectful of people who've done great things, but when their behavior begins to create tension and toxicity in the system, then I have to be critical.

DT: Yes. You're not the first person I've had who has criticized Wangenstein's technique and identified that as an issue.

MM: Oh, yes. He had this other quirky thing. He wouldn't do operations for cancer of the stomach unless the patient would agree to a second look. So you kind of had to agree ahead of time to a second look, which was a year after the first operation. He would open them up again and look with his own eyes to see if the cancer had returned. Well, even by that time, there were so many better ways of knowing if cancer had returned. Some of these people would develop infections and the second look would cause death from infections! It just seemed like such an immoral thing to do, to require a patient to agree to another surgery, so the surgeon could lay his eyes on the internal organs? It could've been on the wall of the stomach and he wouldn't be able to see it. Do you know what I'm saying? It was like how can they let this guy do this?

DT: This was at a time when they weren't the same kind of ethical oversight?

MM: Right. Well, there were still ethics. Ethics hasn't changed, you know. The requirement, regulations, the documentation, blah, blah, blah, blah, blah was never okay, and we all knew it was not okay to do a second operation.

DT: But he was the chief, so...

MM: He was the chief and he brought in a lot of money.

DT: What were your responsibilities then when you were working on the hospital ward? What was a day in the life like?

MM: As a team leader on that unit, you'd get a report, and it was mostly a lot of numbers because the fluid balance was really extraordinarily important, and we handled everything. There weren't all the beepers and buzzers going on and off. We were measuring drops of IV [intravenous] fluid and measuring urine and weighing dressings before and after in order to know the amount of drainage on it. We'd be getting just tons and tons of numbers at shift report and very little about who was the person who was the patient. Every shift report, you'd make out assignments for however many LPNs [Licensed Practical Nurse] and nursing assistants you had. The assistants would do the temperatures and the LPNs would do the blood pressures and the team leader would pass the meds. Treatments...some things could be done by LPNs, but a lot of them were too complicated so most of the treatments required an RN. IV handling required an RN. Intramuscular injections required an RN. So the busyness and the amount of tasks to do was just unbelievable, and there was no time for anything. No time for breaks. If you didn't have something, if a hospital system failed, we had to go get it. We had to figure out how to fix it; we had to run and get it. It was just an extraordinarily busy and hectic, disorganized time.

This is a period of reflection on my part right now. I look back and connect a lot of dots that I couldn't see at the time. I think what that did is it really set me up to have the courage and the nerve to really work with that Project 32 and get the alternative established and, then, figure out how to help the alternative spread around the country and around the world. I think that the horrors of Station 42, at that time, really, for me was just the antagonistic motivation I needed to have later on to go ahead and know that what we were doing was wrong.

DT: Do you feel like there was a shortage of nursing staff? Was that part of the problem?

MM: A terrible shortage of nurses and there was, also, a very high turnover. In 1964, when I became assistant director, one of my jobs was doing turnovers statistics and I got to work with crazy Vernon Weckwerth, whom I'm sure you know something about.

DT: Yes.

MM: At that time, he was a young statistics person. He gave me a good formula that was I able to use for computing turnover rates. I know that on one of our floors, one of the most startling numbers was that... We had a small respiratory floor and everybody was on a respirator. It was only about ten or twelve-bed or something like that. One year, we had three hundred percent turnover rate, meaning that every single position changed hands three times in one year. So we knew we were running a revolving door. People would come to the school, work for a year, and, then, go someplace else. They had an incredible experience and go someplace else. We had a very high turnover rate. When I was working the floor and going to school, I didn't see much of that. It's so interesting to me how as you move from one job to the next, how you see different things.

Part of that undergraduate experience, I should tell you about. We did have a field work experience of some kind. Actually, my preceptor was a little Oriental nurse named Cile [Cecile] Kume. Other people may speak of Cile Kume. She was around for a very long time. She had a master's degree and that's why she was the one to be my supervisor. Anyway, she wrote my evaluation at the end of that field work experience. She predicted that I had the capability of being a director of nursing, something like that. At the time, the director of nursing was a title you used for the CNO [chief nursing officer] or vice president. I said, "Oh, my gosh! This is so silly! There's actually no way that I ever want to do anything like that!" She said, "I think you could." I didn't know where she got it from. I couldn't see it in myself at all, but it kind of became part of another thing that had already happened. When I went through my diploma program at the end of each rotation, you get evaluated. Almost every one of them would say, "Has leadership potential," "Has leadership potential." I remember my last one the OR, I think, and I said to the person, "What the heck does this mean? Everybody is saying it."

DT: [chuckles]

MM: "I don't know what it means." My lack of awareness of what later would become the main course of my career at that age was absolutely profound. My lack of awareness was profound.

DT: How were relations on the wards between diploma nurses and baccalaureate nurses?

MM: I didn't experience a lot of negative discrimination. Again, prior to that, the bulk of my clinical experience was at the University of Chicago, and we only had a few people with bachelor's degrees, and they were in the position of educator or always in supervisory positions, so they weren't one of us. At Station 42, 43, I don't know how many people around there were bachelor-degreed nurses or how many of us were diploma. The work was so overwhelming that there wasn't time to have any attitudes about that. My whole experience with attitudes about that came later on when I was in the assistant director position at the hospital.

DT: You got your master's in education before you became assistant director?

MM: Master of nursing administration.

DT: Administration, yes.

MM: Yes. I was just finishing that up when Florence Julian called me up and asked me to be assistant director. The MNA program was really not a good education at all. I really didn't learn anything that I can identify as being useful for my future career, except that it put me in a position to get that, metaphorically, union card that put me in a position for Miss Julian to say, "I want to offer you one of these positions."

One was to be the assistant director in charge of hiring and the other was to be a supervisor in charge of special projects. She described the special projects and the recruitment jobs. The recruitment job was to sit in the nursing office and interview people for jobs, be a full time high-level person who did nothing all day but interview the grads.

Oh, talking about shortages at that time...a little bit later on, I guess. We're still back here. When I was assistant director, we used to have what was called the warm body syndrome. About September every year, whoever that person who was doing the hiring was would say at morning coffee, "Well, we're into the warm body syndrome." What that meant was that all the June graduates had been placed, and from now on, any new hires were going to be the warm bodies who walked in the door and said, "Can I have a job?" and we said, "Yes." Put them on the floor as fast as we could, that's the way the shortage went.

My MNA was a sorry excuse, in my opinion, for what I think now leadership development should be about when they're in school. We spent endless meetings talking to each other as a

class of eleven about are leaders born or made? We had to read everybody's research on it and, then, report for the class about it. It was like nine credits. It was just unreal. They ran out of enough administration credits to justify some criteria of the University, so we had to take a course on public administration, How to Assess a City's Taxes. [whispered].

DT: [chuckles]

MM: So *nine* nurses, four of them nuns, took this class on the West Bank on "How to Assess a City's Taxes," in order to have enough administration content to get that ninth [credit]. Oh, my god! It was just incredible.

DT: Didn't Public Health have hospital administration classes at that time? They didn't want you over there?

MM: No, no. I have no idea. I didn't get any sense of that. I don't know why they did what they did. I know I was completely unconscious about anything going on [unclear] in the school.

DT: You kind of implied in what you said that this was when the graduate programs were being revamped, as well, so you were the last lot in for nine months and, then, they revamped the master's program.

MM: Yes. They used to have a really good program. The MNA used to be a very good program for just a lot of people who went throughout the United States were effective leaders, well-known people who have done a lot of writing and have led a lot of important functions. By the time I got there, it was on its dying breath. Nobody on the faculty had any interest in it. They were doing this whole new thing with the baccalaureate unique body of knowledge stuff. This was absolutely functionally distasteful. It was just get them in; get them out of here.

DT: When you took the position as assistant director of nursing... Oh, you were going to tell me, I think, what your role as supervisor of special projects was.

MM: Yes, it really morphed into... After the first year, she promoted me to assistant director. When I said, "I would do the supervisor job," she said, "Well, you know, the assistant director job interviewing people is at a higher level. It's a higher salary and you have a family to support." I said, "I know, but I just really think we can make it." The money sounded so much better than what I had.

DT: [laughter]

MM: You know what that first job is like.

DT: Yes.

MM: I thought I know we'll get along just fine.

[Extraneous conversation]

MM: So I took the supervisor job. The interesting thing about that job in the beginning was that the University Hospital nursing part... It was officially an 850-bed hospital at that time. We probably had about 700 patients. Now, I think it's about 250 in the hospital. But, in those days, it was a very big complex organization. It partly was divided into clinical areas that were somewhat based on geography and somewhat on conditions, types of treatments and medical specialties. They were always trying to get away from... We're not divided by medical specialties because we're nurses. So there was a head of the Psychiatric Department for nurses, a head of Medicine, Pediatrics, OBGYN [Obstetrics and Gynecology], and, then, there were surgical specialties and general surgery. I think those are the major departments within the Nursing Department. Each of them had a supervisor.

There was incredible turf-ism, so one supervisor would not go on another supervisor's unit. If she did, one of the head nurses would call their supervisor and say, "I just want to let you know Miss Kume was here a little while ago." "What was she doing in there? [spoken very loudly] It was like, what was she doing on my floor? It was like, bur-bur-bur-bur! So my job now is to go all over the place and make changes at a department-wide level working with the departments, the other departments of the hospital, to improve the delivery of services to the units. I had to be able to walk on every unit and not have people reacting to somebody from the nursing office being there. I was part of that nursing office. I think I was successful at it, because, early on, I just made the decision that in order for this to work, I had to have on the inside of my forehead where only I could see it, the phrase, "I'm not going to hurt you." I kind of approached every unit that way. It really worked well because I was able to be all over the place. I was able to do a lot of different things, to work with the departments and to really get successful at making change, especially after the new administrators came.

There's a note for the history, though, that I want to make about the supervisors of those floors. They were called supervisors and the head nurses reported to them. There might be three, there might be as many as six reporting to a supervisor. I was told, I'm pretty sure it was by Miss Julian, that when the faculty and hospital nurses split, which occurred some time in the late 1950s, people had to make a choice as to whether they were going to be on the hospital staff or part of the school faculty. *But*, there was one criterion that the only ones who could go to the faculty were people with master's degrees. So supervisors, by the time I got there in 1964, were very much second-class citizens because before they had been colleagues of the same people. The way it was when they were connected and integrated, the supervisor of medicine taught medical nursing. The supervisor of surgery taught surgical medicine. With the split then these people were here because they didn't have master's degrees, not because they weren't good teachers or whatever, and these people were here

because they did. It was really painful. The nursing school by 1964, when I began to be in a position where I could see what was going on, no longer a student but, now, an outside observer connected but outside...

Miss Julian was very close to the faculty. She never criticized the school. She always supported it. She felt she had a moral obligation to support the school no matter what. Part of that, undoubtedly, was because her life partner was Is [Isabel] Harris. They shared a home in Kenwood [Minneapolis]. There was a very supportive relationship there. The way that manifested is that Miss Julian would tell us things about what went on, and we thought, oh, my god! this is ridiculous. But, then, she'd end up always with, "Nevertheless, we have to support the school." Sometimes, she would ask me to sit in on a faculty meeting if she couldn't go. She was nominally on the faculty but just never allowed to teach anything. She didn't want to anyway. We had a position on different committees or on I don't know what committee we'd call it. I can remember going to some of these meetings and thinking oh, god! I'm so glad I'm not here. I can't even stand it. Someone would say something on... "Now, item four on the agenda is about the committee structure." Then, all of a sudden, nobody is saying anything, but I can feel...just feel the communication going around the room. Bing, bing, bing!

[laughter]

MM: [unclear]. Oh, my god! What's happening here? This is really *huge*! I never knew what it was, but knew it was really bad stuff. [laughter] It was just kind of like that. There was this incredible tension and stressful relationships within the school. It continued to get worse and worse and worse as the curriculum changed.

What happened in those early years was it went from a heavy clinical five-year program, and they were Cracker Jack nurses when they got out with the separate experience of liberalized education. The movement to the new curriculum was, theoretically, to integrate liberal arts with the nursing practice, but, also, based on theoretical understandings of nursing that sort of were justified at a level of higher understanding. I'm not saying this very well. So our program, by the time we left that five-year program was being somewhat criticized around the country because it really wasn't the integrated baccalaureate. It really was like a diploma plus two years of liberal arts.

So coming into this new approach, they really tried to develop a theoretical framework that would be recognized and accepted by higher education, by non-nursing academics. In doing so—there's a lot in the archives that's really interesting about this period of time—they developed a theory of equilibrium. Part of the theoretical framework was that the nurses' unique role was to put the patient in a condition of stasis, of equilibrium, so that the medical treatment could work most effectively. In adhering to that, they also hung onto that particular theory a lot of notions about power, male dominance, and the need to push the medical

profession *away* from nursing practice so that we could have our independence. Ultimately, the goal, I think, of even these faculty way back in the 1960s, was to have acceptance at the University level for doctoral research, to have a Ph.D. program that would enable us to really develop the research that was needed in order to improve patient care. The way it spun out in those years was in deep, deep, deep conflicts about how to teach that concept. During that period of time, the curriculum swung so far over to a non-clinical side that it was *absolutely* frightening. People were coming out of the school with an RN, if they passed their boards—that became another issue—came out not having ever given an injection, never having seen a delivery. There was a period of time when a lot of—my belief, and I can't believe it's true—what I thought was happening was that throughout their entire education right up to graduation time, they were discouraged from doing physical care for the patients. So they were interviewing patients. They would come back and they would do these process interview reports. They were supposed to write down every single word that was said by the patient and by them in an hour interview, and analyze and, then, decide whether to admit or not, I guess. People told me that if they so much as gave a patient a drink of water, they would be marked down by the faculty for engaging in a nursing care activity. But this was not activity [unclear] activities. There was a great effort to force segregation from medicine and from anything clinical and to teach something else that would be unique.

Miss Julian supported these new grads. Miss Julian had me do an interview of the head nurses of the new grads, the first class that came out. It was in 1964, maybe. So I interviewed about, maybe, a dozen head nurses at the University Hospitals about how they were doing. Some of the verbal information I got was absolutely frightening. If it ever hit the newspapers, I swear we would have been sued up the kazoo. In order to achieve a level equilibrium if a patient was sleeping, the nurse wouldn't do the monitoring of blood pressure and so on. Actually, one patient stroked out in the middle of the night and nobody knew it, because the nurse decided he was sleeping, so she didn't bother to check the blood pressure. They didn't have anyone, when the nurses came he was cold. It was like, well, I'm not supposed to. He was asleep. Oh, my god! you'd just hold your head in shame.

What happened as that was all just hitting a fever pitch is that the kids started failing state boards in large numbers. I don't know...I've heard variously, a fourth, a third, a half. I don't think it was ever a half, but I think it may have been up to a third. The Medical School got in an uproar. Now, everybody is seeing things that were scaring them, but when half of the University School of Nursing fails state boards, that's a scandal. Absolutely. With our prestige, with our history we'd had....

I do know that the doctors, at one time, the chiefs of the various services, decided to interview the faculty...oh, the faculty developer, our Public Relations Committee. This was their way to address the problem. They've got to improve their image. Dorothy Geis was one of the people on the Public Relations Committee. What they did—I don't know who initiated it, whether the chiefs did or the Public Relations Committee—is each one of them was supposed to go interview and use a tape recorder. So I saw Dorothy Geis in the lobby. Do you know that the Mayo Lobby was where...? It's still there, the Mayo Lobby. It's like a

cross section. That was really the throbbing point of connectivity within the hospital. I had been walking through from place A to place B and Dorothy was there with her old tape recorder. I remember we both were leaning on a counter there at the information desk. "Dorothy, how are you doing?" "Well, I was just interviewing Doctor A.B. Baker." He was the chief of Neurology.

DT: Yes.

MM: I said, "Oh, how is A.B.? How was the interview?" She just looked at me and she said, "He is just terribly reality based."

[laughter]

MM: It was just a little later, I think, that she herself threw down the gauntlet and said, "If I can't teach pediatric nursing, I can't teach here." So, she left.

It was one year after that, like still in the late 1960s, when eight people on the faculty came down with cancer at one time.

DT: Oh, gosh.

MM: Yes. We over in nursing service were watching this. In a way, we were close and in a way, we weren't, but it was more close than not. It was just really distressing.

They would say things to us like, faculty would be sitting around at coffee one morning, they'd say things like, "Well, we can't talk to you about the new curriculum because you don't understand the language. I remember saying, "Well, try me out. What word don't I understand?" You see, right there... "These are concepts not just definition of words, so without going through the preparation that we've all gone through, we can't begin to explain it to you." It was like... hello?

DT: But you had a master's.

MM: Yes, I know. Yes, I wasn't dumb!

DT: [laughter] You still didn't qualify for that side of things.

MM: That's right.

DT: So the faculty who were teaching who had master's degrees, did that mean that they weren't in practice? Their focus was purely on the educational? That would make sense why they're not teaching the clinical but of course then how are the students getting the clinical

input?

MM: That's when they began to have the instructors actually spending time on the floor. So you had a nursing instructor, preceptor students. But these were like the second level people on floor of the clinical. There would be like clinical instructors. I think they called them tutors, the professors, if you like, former supervisors and heads. They didn't have control of the curriculum. They would be just supervising the students.

DT: And they would report back to the faculty on how the students were doing?

MM: Yes, right.

DT: You said Florence Julian was trying to be positive about the faculty. What about Ray Amberg? He was hospital director until 1964.

MM: I never engaged in any conversation or understanding of Ray Amberg's attitude toward the School of Nursing. That's really a blank to me. My interaction with him was as a person who wanted to make improvements and who wanted to change the way things were happening where we saw that people were suffering unnecessarily because of bad decisions and where everything we tried to do would be ground to a halt. It was just really hard. The way Miss Julian would tell Ray Amberg what we needed was an annual report every year. God, we spent so much time getting the annual report *absolutely* perfect, so that, hopefully, our recommendations would be met some time in the next year. It was just...

One of the things, for example... Right from the early days of my job there, Miss Julian read about the idea of unit managers. The idea of a unit manager was that they'd take a lay person who was well educated with maybe an MHA [Master of Health Administration] even and have them in charge of the unit, in charge of the supplies, transportation, equipment, communication, but not the clinical functions. To us, this looked like nirvana. Wow! Was that a wonderful idea? So Miss Julian went around and looked at some of these places. She talked to people and we really thought it was the greatest thing since ice cream. Every year, she'd put that in her annual report to Ray Amberg, and every year, no. He wouldn't say it, but just... She would come back and say, "No, we aren't going to get this year."

Then, John Westerman came, and he said, "Yes." He taught me one of the most valuable lessons in my whole administrative career. He taught me as an administrator to always say, "Yes," first. I remember him saying it to me. "You can always say, 'No' later on. There's plenty of time to say, 'No' later on. If you say "No" too soon, you have just lost a great opportunity, potentially."

That was Ray Amberg, and he left shortly after I came, probably in 1965, I think. It wasn't very long when Ray Amberg was in charge. He used to do this thing about looking at the

nurse's pin, and he'd get himself *really* up close to her breast.

Gertrude Gilman was his assistant, who became the administrator during the next couple years, I think, before John Westerman came.

DT: She passed away, didn't she?

MM: Yes. Not while she was on the job. She was a good person, a nice person.

DT: Was it unusual to have a woman in that high a position?

MM: I don't think she would have... Hmmm. I was thinking I don't think she would have if Ray Amberg hadn't retired. It was an interim always. But she was okay at it and she stayed at it for quite a while. Yes, I think it was unusual. By this time, my experience in the world was at two of these institutions.

DT: Yes, sure.

[chuckles] DT: An 'n' of two.

You mentioned that there were silos on the wards between the different nursing divisions. Why did these silos come up? Why was there so much turf-ism, as you described.

MM: I really don't know. To a certain extent, I suppose it's one of a natural consequences—I know it is—of hierarchical authoritarian bureaucratic structures. In order to have good control, you have to keep people from collaborating and connecting, because that amasses power at the lower levels. So I think it was just sort of a natural outgrowth of that kind of structure.

Miss Julian was a good-hearted person, but she had a really hard time making decisions. I used to have a banner in my office that said, "Not to decide is to decide." I just realized how much of the time our not making decisions resulted in consequences that were hard for us to live with. She must have talked to me three or four different periods of time in those five or six years that we worked together about the need to reorganize the department. She saw all different reasons why it was necessary to reorganize the department, including the beginning of the clinical nurse specialty programs. She would draw organization charts. She'd ask my opinion, and I'd tell her, "I think this is going to work." "This needs to change a little bit." Then, it would go into her middle drawer. She'd say, "Why do you think we ought to do this?" I'd say, "I don't know." I didn't have an experience with any of this. Because it was hard to talk to the people and she didn't know how to do it without hurting their feelings, she didn't do it.

When John came, one of the first things he did was to set up a three-person committee. It was Tom Smith, me, and somebody else, and our job was to look at what would be the best way to reorganize the Nursing Department. Under Tom Smith's leadership, we ended up with a preliminary paper on decentralizing the nursing program in which I learned, for the first time in my life, what decentralization meant. I had grown up in a Catholic structure, grown up as a real believer that there's sort of this mystical authority above up there, and that that's "God in His heaven, and all's right with the world" kind of thing. The idea that it was a good idea to empower people, that was absolutely exciting and a new kind of thinking for me. This is like 1967, 1968. Just think about what's going on in the world in those years. Everybody is thinking of 1968, it's the name of a book written by Mark Kurlansky all the changes that were going on throughout the world: civil unrest and various kinds of uprisings, people challenging authority, structure, history, traditions. So for me to be learning about this, it just seemed like the whole world was moving in this direction. I was very excited about it.

My husband, at the time, and I were both quite politically... We were against the war in Vietnam. We were very active in anti-war, anti-racism, anti-poverty, that whole package. I, personally, was involved in some community organizing work and community action. Some of it was fairly radical.

There were student uprisings on campus at the time. In 1968 through the 1970s, we had the SDS [Students for a Democratic Society] a couple of times come and commandeered Westerman's office and took it over for days.

There were all kinds of ways that the old structures were being challenged and torn down. That experience of learning about decentralization simultaneously with all of that was very, very important in my development.

DT: One of the things when you talk about silos within nursing, it also makes me think that, at that time, there were silos within medicine as well, between the specialties. wonder if there's a way in which the nurses were mapping onto the separatism that was in medicine.

MM: I think it was and we would play along with theirs, but I think ours were, also, somewhat unique to ourselves. Margaret Clipper was a great neurology nurse. She and A.B. Baker would take on the world. So there was a lot of identification with the docs. But there was, also, a real interest on the part of many of the nurses in carving out our piece and recognizing our differences and owning them. It, also, took a lot of courage.

DT: That brings to mind what the nursing faculty were trying to do with the curriculum and, then, what the nurse clinicians were trying to do with themselves is like...

MM: A very similar motivation, but very different ways of acting on it.

DT: All to increase the autonomy of the nurse and professionalism?

MM: Right.

[break in the interview]

MM: The office of my company is trying to collect the history of the company before I forget how I did everything.

DT: [chuckles] That's great. At least I don't have to cover that part.

MM: Right.

DT: I'm curious... You had how many children in the early 1960s?

MM: Two.

DT: Oftentimes, I hear people having kids and, then, they don't go back to work.

MM: That's another thing that's really important. Yes, right. At the time that I was in the nursing office, there were thirty-five people in positions above the head nurse level in the hierarchy of the Nursing Department. Two of us were married. What that means, Dominique, is that the people over the years before this who got promoted were people who didn't get married. So I was one with children. That was 1970.

DT: It strikes me that you're incredibly unusual in the workforce for that reason.

MM: Yes.

DT: So how were you able to make that choice? Was your husband particularly supportive to you going back to work?

MM: Yes and no. When we met, he was an undergraduate student in chem [chemical] engineering and had spent four years in the Air Force. We got married with no money. I finished up my bachelor's degree in the first six months we were married. He finished his last quarter in December. He was taking stoichiometry and he hated it. He finished and then he dropped out of college. He had three years of chem. engineering and quit going to college. He became a lab tech in Pine Bend [Refinery in Rosemount, Minnesota] and hated it, absolutely hated it. He already had sort of a negative outlook on life and this job just really persuaded him that not much had any meaning at all. I was pregnant and I had Claire in September of that year, worked part time while I was pregnant.

Somebody invited me to teach in the Peace Corps when Claire was just an infant—was it that fall already? I think it was that fall—for six weeks. It was the Pakistan [unclear] Project, and I was teaching nurses who were going to Pakistan. I knew nothing about Pakistan.

DT: [chuckles]

MM: I was an assistant teacher and the hours were very flexible, like ten or fifteen or twenty hours a week, and Dick was working evenings, so it worked out really fine. We didn't need a babysitter.

Right after that, then, Gene [Eugenia] Taylor, who was running the LPN program, asked me to be a clinical instructor on the floors on the neurology unit four days a week, four hours a day. Again, it was the morning and Dick was working evenings. I took it making her agree that I would never, ever, ever, ever, ever, ever, ever, ever, have to teach a class, because I was *not* a teacher and I didn't want to talk in front of these faces.

DT: [chuckles]

MM: I did that. Then they invited me back to graduate school.

It was either the same time I went back to graduate school or right after that that I was able to convince Dick that he could go school. He still had the G.I. Bill. I was on a trainingship. I was getting my training and books paid for. It was \$250 a month in my master's program. He was getting \$410 a month on the G.I. Bill and had to pay tuition out of that. So that's what we lived on for those nine months that I got the master's degree. We lived over near campus and we had the baby. We had group health insurance that cost \$35 a month. We paid that believing that we could always get care if we needed it. As long as we had health insurance, we would go on this tight budget and it was going to be okay." Then, he really got into school. That was it...he *chose* philosophy and political science and that's where his heart was. So he, then, became a full time student for the next six years. That was the only thing that made him happy was going to school and reading, and reading, and reading, and reading, and reading, and reading. So as long as that was what was making him happy, I figured if I was working full time that was still the best thing for the family.

Before the six years were up, I thought, hmmm, Claire is five years old. When Claire was five, I decided it was time to have a second child. So I did. I had Mark. Because I was still the sole support for family, I used two years worth of vacation time and took five weeks off to have him. I worked on a Friday, with an armrest [i.e. a very pregnant belly], and five weeks later, on a Monday, I was back to work full time. It was hard.

DT: Can you tell me then about the development of primary nursing, as this is such an important piece of your career?

MM: I need to back up and talk about the change in the culture of the hospital.

DT: Yes.

MM: When John [Westerman] came, it was like a breath of fresh air going through the hospital corridor. It was just so incredible. I couldn't believe what was happening. I kind of had an early special relationship with him. I knew they were interviewing somebody for heading up the clinic, being a clinic administrator. I guess I was introduced to him by somebody someplace sometime, and, then, we met in that intersection of Mayo where all these important things always happen. I can remember him saying to me, "I want to go upstairs for the interview now." He was hired to run the clinics; that was it. Then, he applied for the job of hospital administrator. He said, "I'm going to go up and be interviewed now. Tell me the major issues in the hospitals today, major problems." Well! Bup, bup, tuh, bup, bup-a-bup! The systems had been so inadequately developed. We didn't have a transportation system so nurses had to take every tube of blood to the lab before seven a.m. Two nurses on a floor trying to get all the work done. It was just... I could talk for hours about the absolute insanity of the failure of system development that we had to put up with to save money. They were making bad choices about where to spend the money. So that failure of systems... I just went, "bing-a-de-bing-a-bing-a-de-bing-a-bing." The transportation system was one. Our system for handling medications... Everything was floor-stock drugs but in order to count narcotics, three times a day, we had to have two nurses counting narcotics and signing an official documents, and so on. The way we to do it was pour them in our hand, because we didn't have what had been developed for everybody else to use by that time, narcotic counters that gave you a visible counting. You could just look at them and know how many you had. We couldn't persuade the pharmacy to do it. I tried for two years to persuade the pharmacy to do it. I couldn't get them to spend the money to do it. One objection after another that made no sense at all. So I just said, "bing-a-de-bing-a-bing-a-de-bing-a-bing," telling him about issues of the bad use of hospital beds and issues of all kinds of stuff. Afterwards, he said, "Thank you very much, because I think you helped me get the job."

He came in and, immediately, brought in three or four top young administrators. It was sort of like, oh, my god. First, everything is no, and, then, everything is yes. Miss Julian didn't like it. Whether she would have been different under different leadership over a long period of time, I don't know. But she bought into the system as it was and was really uncomfortable with the lack of structure, the lack of controls, the-let-people-try-different-things attitude. One of the first things that we did was we said, "We've tried for a long time to get the hospital to look at unit management." He said, "Well, let's do it. Let's get started. Let's see what happens." It was like that organization chart in her middle drawer...oh, my god! Now we're going to get it. What are we going to do?

He appointed Dave Preston to be my co-director. These guys, they didn't know any more than we did, but they would act like they did. What we did was we set up a bunch of committees and took a bunch of trips. That's what you did when you don't know what else to do. The committees were interesting.

One was a high-level university committee—this was John's thinking—with somebody from

the Department of Sociology, somebody from the Department of Industrial Relations, somebody from the Division of Hospital Administration, somebody from the School of Medicine. I don't remember what else. We had this committee of high-level university people, and it became not just about unit management to free the nurse-to-nurse, but it came to be about how do we look at all the [unclear] hospital systems to the point of use to improve efficiency and effectiveness? So our little unit management thing went to being a problem worthy of the attention of people who were well developed in the field.

The second committee was the department heads, all the department heads that delivered services to the units, so food service, housekeeping, all the different departments, pharmacy labs, et cetera.

Then, the third committee was the Nursing Department Committee. We made trips to Michigan. We made trips to places that were doing some breakthrough work in unit management, people we had been reading about, the articles we had been reading in literature, and we looked at the research and talked to them about what's happening. This, for me, was sort of a big breakthrough moment, too. I had really come from a lower middle class upbringing, wonderful people, but we didn't do much high living and, all of a sudden now, I'm out there with the big kids doing high living, staying at nice hotels, not the cheapest place. You know what I mean. This was my big step into a new level of social connection, I guess.

Anyway, to summarize those trips and that finding, I'll just say that we found that in the places where they did any study of nursing time and the impact their unit managing systems had on it, there was no statistical significant change in the amount of time nurses spent with the patients. That was the whole justification for it as far as my point of view. They were saving money in other ways so it was of interest to the hospital, but they weren't doing what we had to do to change nursing care of patients. I went back and looked at a study that had been done at the University of Iowa in 1960. I reviewed that finding, and in that study, they increased the RN staff by sixty percent, and collected data of time spent with patients before and after the increase, and found no statistically significant increase, even though there were sixty percent more time available. So this really made me question what is going on. Why is this happening?

I was learning about decentralization from organizational work. I was talking to people in Industrial Relations and Sociology and so on about the work, about the workplace culture and the organization of work and stuff like the Hawthorne Effect, some of the research that has been done on workplace culture and change. I didn't really see the delivery system component of it. As the trips were going on and as I was getting this advice from the outside experts, the Nursing Committee was working with the other department heads and looking at ways we can change what's going on in the nursing unit. Because this is a research place, I was supposed to head up the research component. What became clear, as I started learning more about that, is that research in an operating setting is extraordinarily challenging the

minute you start counting something you start changing what's happening. Before and after are always fraught with problems of variability and reliability. I mean everything is full of problems.

But with help from statisticians and so on, we did construct a series of studies. We did six studies on that unit before we made any changes. They were: patient satisfaction; physician satisfaction; nurse satisfaction; time activity analysis over a five-day period of time, three fifteen minutes; activity analysis at the unit desk over a seventy-two hour period of time where every single activity engaged in by every single person at the desk was recorded as to purpose and type of activity. There was a sixth one. I can't remember what the sixth was. These studies were being done over a long period of time and, of course, they did impact the work on the floor.

The floor had been picked because it was a good floor with good morale and a really good leader. Geographically, its location, also, had something to do with its success. It was a medical unit. If you were to walk on that floor now, there's a little plaque there that talks about this being Station 32. But, its location was...this is a corner and this is a corner, and Station 32 was right where that L meets. The cafeteria is off here and the administrative offices are down here. So everybody going to lunch or going to these luncheon meetings with the doctors in dining room 3 would have to go through Station 32. It was a heavily trafficked corridor, which always added to the chaos and confusion around the desk. The desk was *always* a mob scene, lots of people talking, blah, blah, blah, blah, blah. Then, we had these studies going on. In that fifteen minute activity analysis, I used department heads and I taught them how to do the study. They came up with four-hour stints and recorded what everybody was doing every fifteen minutes. All these activities were going on during this period of time adding turmoil.

We decided to try and improve what we were doing with team nursing. This was their version of that same turmoil thing going on in Station 42 where people are necessarily focusing on tasks, not on patients, unnecessarily caught up in this incredible, hectic kind of communication pattern. We decided to try and do that better, went back to those text books that taught us how to do team nursing in the first place and decided to try and improve the nursing care planning process. It was getting really frustrating for the nurses, because they were working as these team leaders, just very, very fast-paced work, and, then, we were asking them to write these care plans and then we were evaluating the care plans, nurse clinicians, and telling them what they were doing wrong with their care planning. We hit a wall. They said, "Stop. Everything has got to stop. We can't do this anymore."

Now, this was a big project. There was a lot of prestige going on other than... It was called Project 32. We were sending out a newsletter on a regular basis of monthly updates to the *whole* hospital family. *All* the medical staff, *all* departments, *all* the nursing staff got this update on Project 32 every month on what was then the in-color paper, mustard, with charcoal ink. Do you know what I'm saying?

DT: [chuckles]

MM: We had an artist do the logo for Project 32 and the artistically worded Project 32 crap, what kind of lettering sort of thing. This thing has got big cigars and motor cars behind it, and, now, I've got the nurses saying, "Whoa! Stop! We can't do this anymore. You've got to quit the project. We can't do this anymore."

I said to the supervisor who was my friend, Pat Robertson, "What are we going to do?" She said, "When I was a head nurse on the isolation floor five years ago, we had a big problem, and I had the nurses come to my house and talk it over, and we figured out what to do." I said, "Let's do it." So that night, we had a meeting at my house. I called up Dick—Mark must have been born by then—and I said, "I'm going to have a meeting in our house

tonight.”

[laughter] MM: “Clean things up. Put the paper away.”

We had that meeting. That, in and of itself, was a story that I don't know if you want the legends that go along with the history, but we tell stories about that night, which we can always back to, if you want. That night, they ended up asking Pat and I if they could not be team leaders the next day. We looked at each other, and we swallowed hard, and we said, “Yes. We can do that.” Now, we did not have permission to do that. Team nursing was the end all, be all in nursing throughout the United States. It was the standard. Every decent nursing department had to be doing team nursing if you were worth your salt at all. I had implemented it at the University of Chicago, and I was one of the avant-garde people there who did it. The NLN [National League of Nursing] required it for accreditation of a school of nursing. They had to be practicing in a hospital that did team nursing. I mean it was it! For us to say, “You don't have to be team leaders,” meant there was no team nursing. So we were actually stepping *way, way, way*, out of any boundary that we had any legitimacy to do—and we didn't know what was going to happen. By this time, we knew that what we had done was created the role for the RN where she's a checker-upper for the cheaper-doers, but, most of the time, she's running around doing things for patients, checking up to make sure everybody else is doing what they're supposed to be doing, if they were getting coffee and back on time, lunch on time and back on time, charting done on time, reports done on time. It was all about being a supervisor, and they never had a chance to talk to patients. We called them the checker-uppers and for the cheaper-doers. When we gave them permission to not do it, we didn't know if everything would get done or not, because so much time was spent checking up on making sure everything was done. Did you check the TPR board? Did you check the blood pressure board? Did you check this and check that? What if they don't have a checker-upper? Anyway we said, “Yes.”

We had been doing some work around remembering what comprehensive nursing meant in our schools of nursing when we were students and how the essence of nursing was really understanding a human being who was sick, his environment in his home, understanding him in his place in his life, understanding how the illness and, subsequent, hospitalization was affecting this person in all dimensions of their being, and what's going to happen after hospitalization when they reenter. That whole picture of the nurse's responsibility, we just sort of gave the catch term, Comprehensive Nursing 101, which is what it used to be called in some of the school programs. We had been talking about that with the nurses and Diane Bartels, the head nurse, had been talking about it with them. Those discussions had given them a focus that they were able to turn to immediately when they weren't working as team leaders.

You know, I prayed that first day that we weren't going to forget to care for a patient, because I knew that Miss Julian didn't know what we were doing, and I knew I didn't have permission to do that. We didn't talk to any doctors; that was the other thing, we didn't tell

any doctors. At that time I made a conscious decision to not—these were generally the good guys, the medical guys, generally easier to get along with—to say anything about it, because I didn't know how to say it without asking for approval. I didn't know how to talk to a physician about saying, "May I?" I was in my mid thirties by this time with a master's degree. I look back and go, "Oh my god."

By day three, we knew that something pretty exciting had gone on. Everything was clicking. The LPNs were being supervised appropriately. The aides were doing their right work *and* the remarkable thing was the desk began to quiet down.

So we started getting questions like "Did you hire more nurses on 32?" "No." "Well, you must have a shortage of patients. It's so quiet there." "It's so quiet." Then, the docs started saying, "I don't know what they're doing on 32. We want our patients there." It began to build up. I'm telling the story now of what we're doing. By this time, I'd watched the nurses long enough to figure out what they'd done to safeguard things, to make sure that limits of a job description are being met appropriately with appropriate coverage and so on. I was able to tell her [Miss Julian] what we were doing there. Her answer every time was "Who is supervises the LPNs?" "Who supervises the LPNs?" I said, "Whatever RN is cross assigned to check." "Who supervises the LPNs?" [sigh]

I think it was 1969 that Miss Julian went on a sabbatical. She got six months off with pay because of her faculty position to study the new clinical nurse specialist role that had popped up in the country, throughout the country, in the mid 1960s. So she went to a few places where she had friends who were chief nurses and, then, she did some other phone calls, and she did a survey and wrote a report to justify the sabbatical. And apparently what happened as she did that, as she talked to people and traveled to places where they would say things like, "Well, what is this primary nursing that I'm hearing about?" So she came back loaded for bear from her sabbatical, got me the first day, and said, "Come into my office! I want to talk to you!" She said, "You've *got* to tell me what's going on with this primary nursing because I can't answer anybody's questions. Everybody's talking to me about it, and I'm so embarrassed!"

DT: [chuckles]

MM: I said, "Miss Julian, I don't know what to tell you anymore. I told you everything I can. I just don't know how to explain it in a way that doesn't confuse you more." She said, "I'm going to go sit on 32." So she went to Station 32 her first day back, sat at the desk for about three hours. She came back and she said, "It's okay. I understand it now." She was fine.

DT: [laughter]

But all that time, I had the support of the boys. Dave Preston locked stepped along with me. I never did anything that wasn't something we hadn't agreed to. He had a direct road to John. Every day, they'd talk several times a day, so I knew I had John. John was one of the best believers in the philosophy of decentralization, and he was just *delighted* that somebody was actually paying attention to it. He'd been there for a couple years now, and the departments were still running the same rigid lines, still squelching people, still not encouraging creativity, which he was all for. So, he was just delighted that I was doing it. I felt bad that Miss Julian didn't really support it, but I never felt like my neck was on the chopping block because of it. I knew I had the boys' support.

DT: If I understand this right, at that meeting at your house when Pat Robertson was there, the nurses on Station 32 who had been team leaders, you said "you don't need to be team leaders," the next day, they just went to work and just...

MM: They divided the patients up...

DT: By themselves?

MM: Yes. They figured out how they could incorporate the evening and nights into a plan that would provide for every patient to have somebody really be in charge of their care, this Comprehensive Nursing 101 idea, and to utilize LPNs and nursing assistants in ways that would be appropriate to their abilities.

DT: It sounds so much like it's you freeing them up to be creative and put into practice what makes sense to them, based on what they've learned.

MM: Right.

But the interesting question is why did this go organic and become a worldwide movement that is now coming back again and again and again? We've done thousands of changes on units. I've been in charge of many, many projects myself at the unit level to change something. It works fine, stays there, dies. What made this different? There are a couple things I think of.

One is that it was within a context of societal values that were very dominant and consistent with the direction a lot of society was moving. So there was a congruity that was perceived and felt within the culture of the University of Minnesota hospital leadership staff, within the culture of the University of Minnesota structure, the State of Minnesota. I don't think it would have happened in New York City. I don't think it would have gone anyplace if it had happened in a different environment. I might be wrong, but I just think that there was a convergence of values and an openness at that time that really supported it.

The second factor is the learning that I had, the opportunities I had to learn things. I didn't have a clue what a delivery system was. I never learned that in my graduate school. Stan [Stanley] Williams was on the project, and he was wonderful, bombastic, brilliant. He was, then, a hospital administration resident. He's since become a statistician. He's the head of the Cancer Research Center here.

DT: Oh.

MM: Just an unbelievably talented guy who taught me so much, *so* much. Today, he doesn't understand what I'm saying when I try to give him credit ...

DT: [chuckles]

MM: ...but I have no question in my mind. I learned about delivery systems, and I was able to analyze everything that had been before in the context of principles of delivery systems so that I can differentiate them and explain them to other people so everybody gets it.

The second thing I learned how to do was to describe it using terms that are at an abstract enough level that they are applicable to all settings. I think one of things we normally would do is just talk about we did on Project 32 as it being appropriate for that particular unit, but with the help of people that were around the project, I was able to use language in describing it that works across the board.

Then the third thing was we didn't write a formulaic book. The easiest thing in the world would have been to do that. Everybody wanted to know the formula—even today. When I work with people today to implement primary nursing, they're asking formula questions. How many patients should we assign to a nurse? Tuh, duh, tuh, duh. How many kinds of shifts should the nurse work? Tuh, duh, tuh, duh. All of these formulated kinds of questions really represent decisions that people need to make for themselves based on the principles that they are going to operationalize and should not be made by somebody else who doesn't understand the work as well as the people who do it.

DT: Right.

MM: So it's so fundamental and clear to me and, yet, it's so foreign even today to the way most decisions are made to implement any kind of change, including transformational change.

DT: To have that decision-making power on the ground?

MM: Right. If you're going to give power to people you have to empower them. Let's do it! You decide. I know I'm going to have that question when I go someplace in two weeks again. How should we do this?

DT: It's interesting that you bring up the societal changes, because the old way was very much a hierarchical way, military oriented, and this is in the heyday of the anti-war movement. Simplistically, it is this backlash against that hierarchical model.

MM: Against the 1950s the big return to normalcy which had.... Look at *Mad Men* [television show set in the late 1950s] even.

[laughter]

MM: I remember that time so well. When I was a senior in high school, I was a 120 [pound] skinny five-foot-eight person wearing a girdle...

DT: [laughter]

MM: ...because that's what you were supposed to do.

DT: At the hospital, was this primary nursing adopted by every station?

MM: No. That began the next ten-year study period for me.

[break in the interview]

MM: ...where I started to learn about leadership and cultures. A traditional nurse manager could not implement primary nursing successfully, because a traditional nurse manager needs to control what's going on on the floor with patient care. That control would restrict the nurse's ability to be professional. It took me a long time.

One of the things we used to do throughout the 1970s was use very careful criteria for selecting the stations. I would use...if people were asking my advice. I wasn't consulting at the time. I was a chief nurse at United [Hospital, Saint Paul, Minnesota] by this time and at Yale [University]. If I was involved in advising people, I would always say, "Pick your best unit, the one with the best morale and the strongest leader." Those were the units that first started implementing primary nursing, because that was the conditions that I knew would lend themselves to successful implementation. I twice unimplemented it when patient care really began to suffer because those managers could not give up control, could not let the staff go.

In 1982, I created the first development program for teaching nurse managers how to be

effective leaders. So, then, we began to learn how to correct some of the managerial problems that would impede the development. That was only one of the factors that would determine who did and who didn't implement it. A lot of places are run by CEOs [chief executive officer] and even CNOs [chief nursing officer] who, fundamentally, don't believe that staff nurses *should* have the final authority to make decisions about the nursing care of patients. That continues to blow me away. There are even nurses who believe that, despite the fact that we have the only license society awards for that function. We even have nurses who don't feel that they should be making those decisions. There's a lot of stuff that gets in the way of implementing primary nursing.

DT: How much overlap...that's not really the right word. Primary nursing where the nurse is given primary responsibility for the patient...

MM: For the nursing care of the patient.

DT: It resonates, somewhat, with what Public Health nurses were doing out in the community.

MM: Right. The setting of the practice has so much to say about how much autonomy a nurse has, because in the setting, the hierarchical authoritarian bureaucratic structure, we don't see the nurses having very much, But, in home care, my god, that setting requires absolutely autonomy. In some of my history study, I learned that from 1873 when the first three schools of nursing opened in the United States, a la Florence Nightingale, until the end of the Depression, nurses didn't work in hospitals at all. Students did. So private duty nursing in those days, the original, those nurses had more autonomy than our nurses today do in salaried positions in the bureaucratic structure. The setting has a huge... As we move to a professional where less and less of us are working in hospitals and more and more are working in other settings, I think the opportunities for autonomous practice are just going to grow.

DT: It's fascinating. From this story, it strikes me, and you said yourself, that John Westerman's support was crucial.

MM: Oh, yes.

DT: What's so interesting is several people I've interviewed have been less supportive of Westerman. I wonder if you have any perspective on why you had such good relations with him but yet...?.

MM: Doctors?

DT: Yes, doctors didn't.

[chuckles]

DT: John did not have a whole lot of respect for doctors. He was always polite and everything, but he did no bowing down. He once said to me, "Doctors are the most well educated narrow-minded people in the world." He would just say things like that. He would say things that were pretty outrageous at times in public to doctors. Administrators and doctors always have had a tenuous relationship, because, basically, the doctors feel they should be able to do whatever they want, and administrators feel they shouldn't. It just gets into...

[laughter]

MM: Normal male head knocking.

DT: And I guess because John Westerman was so blunt about not bowing down to doctors then, it brought that tension more to the fore and made it more noticeable?

MM: From our point of view in the hospital, we didn't see a lot of that. I happened to hear some of it because I was, eventually, into the inner circle pretty much. But, I don't think that it played out very much in terms of the way physicians were in their physician role with patients. I don't think it played very much into any trouble that we experienced.

For the last couple of years, I was associate director under Miss Julian, eventually, and then I became acting director. When I was recruited to go to Miller Hospital in Saint Paul, I wasn't really looking to make a move. I was pretty happy in my job, always challenged by what was going on in a really good way. But I began to realize that it was quite an honor to be picked by Miss [Thelma] Dodds to replace her. She was a compatriot of K.J. Densford's, and they were both extraordinary leaders. Thelma was definitely ready to retire. She'd been in the job for thirty-nine years and lived in the dormitory, still. At first I went over there with a why-should-I-do-this attitude. The second or third time I went over there for interviews, it was like, hmmm, this might be kind of fun. So I did decide to take the job.

John Westerman was disappointed. He wouldn't ever stop me. He said, "I was just really counting on you," because Miss Julian had been talking about retiring for years. "I was counting on you to replace Miss Julian." That was too late. "It didn't happen. I've got to do it, John." "I understand." At that point though, he realized that he had to do something or he was going to have Miss Julian there for the next biennium. So, he moved her up to an administrative position and asked me take over as acting director. So the last four or five months, I was acting director and I implemented a phenomenal decentralization of the Nursing Department that just... A lot more attention should be paid to it because we did a reorganization that I've never seen done by anybody before.

The Monday after I left, thirty-five people in top positions changed their jobs, offices, job descriptions, roles and responsibilities in one fell swoop

DT: After you left?

MM: Yes, but it was all planned.

DT: Okay. You planned it.

MM: Yes, it was all set up. *They* planned it, we did it together. An incredible consensus and decision making. An incredible story. Really a heartbreak to leave by that time.

DT: So who replaced you?

MM: That was so interesting because there was a big search committee, a national search going on. As this work we were involved in with reorganizing the Nursing Department was evolving and people were investing so much of themselves into this incredible experience, we had a small group of the total group called the Committee on Reorganization, CORE. The CORE started saying to me, "We don't want an outsider." Everybody was accepting the fact that I was leaving, but they don't want an outsider. "We don't want an outsider." There was an administrative assistant named Donna Nehls, N-e-h-l-s, who had been Miss Julian's assistant and now was my assistant. She was a Cracker Jack. She was a wonderful leader, a good politician. She understood nursing. She knew what she didn't know. She wasn't a nurse. We ended up, as a department, sending our recommendation to the search committee that a non-nurse be appointed, and she was. It really upset the faculty. Oh, my god!

DT: That's amazing.

MM: She did an excellent job for a number of years.

DT: She was in that position for a while?

MM: Yes. Yes.

DT: Is she still alive?

MM: No, she died.

DT: That's too bad.

MM: So did her replacement, Barbara Tebbitt.

DT: That's too bad.

When you were assistant or associate director, that's when Medicare and Medicaid were passed. I'm wondering what impact, from your perspective, Medicare and Medicaid had on the hospital.

MM: I remember more clearly, I think, the change in accounting systems. When I first came to the hospital, about a third of the patients were coded in such a way that we knew that they were county patients and the government was paying. The government paid about a third of our budget, state and county and city together. Again, we had a way of coding them so we all knew who they were. What we would do, a lot of times, is charge meds to them and give them to other patients. We played Robin Hood. All that changed and, all of a sudden, new systems came in order to be ready for Medicare, I guess, that were much more highly developed accounting systems. So I remember more about the change to computerization and accounting systems specifically than Medicare. I didn't see anything that was having a big impact and I don't know a lot of discussions about it.

DT: So the change in the financial system, was that related, though?

MM: I think it was getting ready for Medicare. Yes.

DT: What about the reorganization of the Health Sciences then in 1970? How did that affect the hospital?

MM: When, did you say?

DT: Nineteen seventy.

MM: [pause] Was that when the Academic Health Center was started?

DT: Yes, that's right.

MM: Lyle French became the vice president and Dave Preston became his associate.

DT: Yes.

MM: I don't know a lot about what went on there. The School of Nursing came out from under the School of Medicine, I think, at that time. So that was a big, important step for us. I don't think we ever could have gotten to the Ph.D. if that hadn't happened.

Interestingly enough, one of the pieces that I discovered in my history study is that Richard Olding Beard, who founded the School of Nursing, in the 1920s was talking about...

[break in the interview as Mrs. Manthey takes a telephone call]

DT: You were talking about the reorganization of the Health Sciences and Lyle French...

MM: I don't know a lot about what all was happening. I paid a little bit of attention to the PR stuff and that, but by 1971, I'm out of there. Dave and I would get together periodically after I left, but it was just chit-chatty stuff that really wasn't experiences I hung on to.

DT: In the archives it looked like—I mentioned this to you before—you were nominated when the University Hospital was appointed a Board of Governors. This is in 1974 and you were nominated to the board, but there was a lot of opposition to your appointment from the nursing faculty.

MM: Yes.

DT: Can you talk about that?

MM: Here's the story Dave told me. They were sitting around trying to decide who they were going to ask to be on the board, and they had a bunch of recommendations from the Third District, Fourth District, the MNA [Minnesota Nursing Association], and from the faculty, and from different associations. If they knew the person, they said, "Oh, god, she's flaky." "Oh, no, she talks too much." You know how guys are talking. My name wasn't there, but Dave said, "Well, we all know somebody who is less flaky than the rest." [laughter] I just love that.

DT: [chuckles]

MM: There are certain things that have stayed with me as gems. So, they asked me to be on it, and I said, "Yes." Then, I heard afterwards—I think Dave told me—that two carloads of faculty went up to Duluth to protest my appointment. I don't know why they did. I actually don't know. It may say in the documents.

DT: Yes. Isabel Harris, who I guess at that point was dean, said you were not qualified to serve because—quote—you did not have the background in nursing education.

MM: Okay. Do you know what's kind of interesting about that? She really did like me and respected me. At one point, before she died, she was interviewed, and it was published, I think in a Johns Hopkins nurse magazine. She was looking back on her career. Her experience with the graduate students was her greatest satisfaction, and she mentioned me in particular as someone who fit that. Oh, that's a surprise. Yes. She was in charge of that MNA [Masters in Nursing Administration] program. But, I realized afterwards that, god! she was sweet woman, but she hadn't been inside a hospital for thirty years and she was teaching us...

DT: So do you think, then, the faculty's opposition to you was probably part of that second-class conflict?

MM: Well, here's the thing... That's an important topic we'll maybe...

DT: Have to come back to.

MM: Yes, it's a big one. We could all see the same problems with patient care that was going on in the hospital. Their solution, I learned subsequently—I had no idea about this in the beginning of the development of the graduate program—the clinical practice, which we called originally the Nurse Clinician Program... It is now called the Clinical Nurse Specialist Program. Some of the original designers of that really saw it as a way to solve the problems of fragmentation and discontinuity, etcetera, etcetera. Then, I came along at almost the same time that was being developed with, oh, no, here's a different way to do that. Let's reorganize ourselves right now. We weren't waiting to get the new practitioners from education. We went ahead and did something. I think, in those days, there was a very strong belief—even *I* had it, so I think it was really strong—that the real change that was going to revolutionize nursing care was going to come because of the change in education. I believed for a long time, because Miss Julian said and therefore I believed, that our job was to find a role for the new practitioners that the educators were preparing. Even when we started primary nursing, four years after I started working there as assistant director, I felt like, oh, this is not coming from education. It's a big change, and it's not coming from education. I don't know. Is this going to be okay? Well, no, it wasn't. It just wasn't okay.

I've heard from another really good change agent, the woman who started the nurse practitioner program in another state, Loretta Ford, talked about all she thought she was doing was implementing the rhetoric of the profession, but she was so shunned by her colleagues that, for two years, no one spoke to her in her job. None of her colleagues spoke to her.

So, the fact that we had a top leader from the School of Nursing on the original Nursing Committee, the fact that we asked the educators to participate in the first seminar, and they said, "No"... When they did finally participate because we kind of said, "You have to," their participation in one hour of that seminar was to have students who were on Station 32 tell what *might* go wrong in the future with primary nursing. That was their contribution to the educational implications, which was the assignment I gave them. I asked them to do it. There was an absolutely consistent disregard throughout the 1970s with most educators in the United States.

I've heard people say to me about me to others, "She speaks primarily to staff nurses," as if I don't have the legitimacy to speak to other nurses. It's a long, long, long history starting with you can't talk about it because you don't understand the words all the way up, until the big change came here with Joanne Disch and Mary Jo Kreitzler and Connie Delaney and recognition of my work that goes very deep and is very well respected.

DT: Yes. It's kind of ironic that, then, how many years later you are awarded an honorary doctorate degree.

MM: I know. I know. Some of them must turn over in their grave.

DT: [laughter] I think it's a great ending.

MM: I do, too. I can't say it anymore, because Dean Delaney is tired of hearing me say it, but there's been a lot of healing that's gone on. In fact, she's done that with a lot of people. A lot of what Connie's been doing is healing some of the pain of those years when the school was trying so hard to do something, but they were doing it in such a stupid way. Look at what Connie is doing now and we've got better relationships within the Academic Health Center that any other school has ever had—than our school has ever had; that's for sure. It's not by closing in on yourselves and saying, "We have secrets. You can't know because you're not a nurse."

[chuckles]

DT: I'll have to take this up with you when you come back from your travels and talk about what happened then after the 1970s from your perspective. Even though you weren't based at the University, you have a valuable perspective on what was happening here and at the other schools. I look forward to picking that up with you at a later date.

DT: Sure. There are a couple of things that I think I may have some particular interest in talking about: the DSN [Director of Science in Nursing] program and what happened with that.

DT: Yes. That would be great.

I'm conscious of the time now.

MM: Yes, right. I have to go.

[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

Interview with Marie Manthey, Part 2

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at the Office of Dominique Tobbell

Interviewed on February 23, 2011

Marie Manthey - MM
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Marie Manthey for Marie's second interview. My research assistant, Eli Vitulli, is also sitting in. It's February 23, 2011, and we're in my office at 510A Diehl Hall [University of Minnesota Campus].

Marie, thanks for coming back.

MM: You're welcome.

DT: We left things off at our last interview talking about the early 1970s. Before me do that, I have a couple of questions to follow up on from when you were at University Hospitals.

MM: Good.

DT: One of the things I was curious about is what were relations like between the nurses at the hospitals and the Minnesota Nurses Association [MNA]? Was there much relationship there?

MM: Yes. In explaining this, I need to do a little bit of history. Until 1974, Taft-Hartley laws did not apply to charitable institutions. So, none of the labor laws that governed behavior between unions and employers were in place. The MNA was strongly supported by K.J. [Katherine] Densford. It was also the first collective bargaining agency in nursing in the United States. In post World War II, Minnesota had the first collective bargaining action. I don't know specifically about K.J.'s role in it, but I do know that K.J. was very active in the MNA and that we were very much into collective bargaining early on. So, in those days, it was considered a real professional obligation to belong to the MNA, and, in my day, the

years we're talking about, it was part of what you did as a professional nurse. You belonged. You were active.

The collective bargaining part was really kind of bazaar. That's the only thing I can say. [chuckles] Looking at it today in terms of the way the adversarial relationship is defined by laws, that simply was not in place. There was a *little* antagonism between the HR [human resources] departments and union reps [representatives], but it was nothing like later became required relationships.

Those of us who were active and in leadership positions were members of the MNA. We were active on the committees. I'd go to Third and Fourth District meetings. There was a very comfortable relationship.

In 1974, when that changed, I was, by that time, chief nurse at Miller Hospital.

Maybe we'll just put this in the history... I suppose this might be valuable, although, not about the University. At Miller, I replaced a woman named Thelma Dodds, who had been quite a colleague of K.J. Densford. Miller was one of our affiliating hospitals of the University [unclear]. There, what I inherited, in 1971 when I became director of nursing, was a process whereby the MNA would tell us, based on how many members we had, what number of delegates we could send to the House of Delegates, which defined collective bargaining elements. Not only did they tell us how many—you have seven, you have six, five, whatever that number was—but the practice that I inherited was Miss Dodd's who would call a meeting after work hours, four o'clock in the afternoon, and all our staff would be invited to come to the conference room, and there would be an election of members from Miller Hospital to the House of Delegates. Miss Dodds would take nominees and, then, there would be vote. She would tally them on the board and that's how our representatives to the House of Delegates were selected. When Taft-Hartley came in place, this was *absolutely* forbidden. This was absolutely employer control of collective bargaining. It was against the law, illegal, immoral, and sinful. Just an example of what the relationship would have been like before and after Taft-Hartley.

People here in Minnesota in the MNA did not support the movement and the initiatives that the MNA had put forward in getting us under Taft-Hartley. It certainly strengthened the collective bargaining with the result today there is a union here that leadership does not belong to, that, unfortunately, is the voice in the Legislature. There are consequences to all of that that are very harmful.

DT: Can you elaborate on it?

MM: When legislators are going to be considering a bill that has to do with health care and they want expert opinions, they go to the MMA [Minnesota Medical Association] and the MNA. All the MNA consists of today are union members. The only issue that they have is protecting RN [registered nurse] jobs. What the legislators get from nursing is a very skewed, very narrow focus usually having to do with the goal the MNA has of imposing

staff/nurse/patient ratios by law. So everything sort of gets focused, funneled into that issue. We would be talking about accountable health care organizations and we would be talking about health homes. The MNA are not the most knowledgeable...., because they don't necessarily have people who are interested in that stuff. A lot of people are studying the issues. But for them, it's all collective bargaining. It's under a national union. It's really discouraging. And as we see what's going on in Madison [Wisconsin] right now, we need effective unions in this country. We need unions that people can support. It's really hard for a lot of people to support the behavior of some of the unions that are very strong today.

DT: It's interesting that the MNA is a professional association on the one hand, but also it's the voice for collective bargaining for nurses. Does that represent...?

MM: An absolute conflict, absolute conflict. We can now belong to the American Nurses Association [ANA] without belonging to the Minnesota Nurses. It used to be impossible to do that. That's changed, so, now, a lot of us belong to the ANA but not to the MNA.

At the time that that law became effective in 1974, I had just been elected to the Twin Cities Nursing Service Administrative Group, and I was chair of the Statewide Nursing Administration Conference, I think it was called. So I had this double role of leadership in the MNA, but I was an employer. So I was on the Board of Directors in two capacities. I'd been elected to both of those positions. They couldn't keep me on the Board because that was a violation of the Taft-Hartley, but nobody came to me and said, "Sorry, you have to get off the Board now." They just stopped talking to me. They just isolated me. They just stopped telling me when the meetings were. [laughter] Some people I've known for a long time became awful.

DT: I know when it comes to labor relations, historically, there's often conflict between the leadership of the labor groups and the rank and file, those in non-leadership positions. But, within nursing then you're a nurse, primarily, but, then, to have your role be perceived as employer rather than worker, it seems you're occupying these dual roles and that's, obviously, shaping your interaction with the union and with your own employer. It puts nurse leaders in an awkward position.

MM: Yes, it does. There's issues of professional leadership and, then, issues of the kinds of things unions negotiate about, work issues. It's a very difficult situation for the people right now who are in professional leadership positions, because of the antagonism that occurs in times when the negotiations are hung up. It results in a break in relationships and confidence and trust. It's very devastating.

DT: Were LPNs [licensed practical nurse] represented by MNA, too?

MM: No. They have their own union. I'm going to be speaking at their union meeting sometime in the next month.

DT: What's their union?

MM: I don't know. It's a bunch of letters [MLPA - Minnesota Licensed Practical Nurses Association].

[laughter]

MM: They might be ASME[?]. I just don't know.

DT: I'm sure it could have changed over the years.

During the 1960s, what were the main issues around which collective bargaining...?

MM: Salary was the number one issue. The hospital associations were pretty adamant at holding back nurses' salaries. They really made the connection deeply about how increasing nurse's salary increased cost of care, and.... we can't afford any more cost.

Ray Amberg used to be the administrator. I remember being at a meeting where he was talking to the leaders. I think I may have been a student at this time. He was talking to the nursing leadership group. I think he plunked like four pennies down on the table and said something like, "If we increase nurse's salaries this much per hour, we're going to drive health care costs out of control." At that time, we were very much torn about vocation versus job and should we do this for money or for love of work. There were all kinds of values that carried over from the deep religious genesis of nursing that were still very prevalent. We felt *extreme* loyalty to the hospital in those days, and were willing to do anything, work extraordinary hours, all that stuff, out of a sense of commitment to the profession. When he said that, it was deeply disturbing.

DT: That's a powerful strategy for, say, hospital administrators to use. We even saw it in the strike action in the summer that the MNA took, that if nurses walk out, then the implication is they're doing harm to their patients.

MM: Oh, yes.

DT: That's a very powerful emotive rhetoric there. Did you think that Amberg's perception was accurate, that it would increase hospital costs?

MM: Oh, yes. We're talking about attitudes like fifty years ago, forty, fifty years ago. That was a compelling argument to us, to just sort of accept where we were, because we weren't horribly underpaid. We were just sort of moderately underpaid.

[chuckles]

MM: There was one period of time when I was at the U [University of Minnesota] that I was very pro-union. I was pro-MNA and pro-collective bargaining. Philosophically I always was pro-collective bargaining. I can't remember what the issue was...maybe going from working two out of three to every other weekend. It was some issue that we felt very strong about, that now is the time, and I think maybe the University was maybe lagging behind the other hospitals. A couple of us decided that, really, we should get a union at the University. We should get represented at the University...knowing nothing about civil service, nothing about the issues of unions vs. civil service, etc. I was just absolutely ignorant about everything, but we started rabble-rousing. We started getting people signed up. I was really supportive. Now, I was assistant director in the midst of all of this, and *way*, way, way out of line in terms of the normal relationships on those issues.

The only central place where leadership sort of hung out was a coffee shop in the Mayo [Building] lobby. It's not a coffee shop anymore, but it used to be a very popular spot. There was a cash register right inside the door, so we would take a medication card, turn it over so it's blank and write a number on it and tape it to the front of the cash register. Now, nobody knew what that card meant except a handful of us. It was the total number of people who were willing to sign the card. So we had this little quiet campaign going on.

[laughter]

MM: Nothing ever came of it. I don't even remember where it went, but somewhere along the line, somebody said, "Hey, you know what? With civil service, you really can't have a union." We sort of [unclear].

DT: Where did Florence Julian stand on the issue?

MM: She knew nothing about what we were doing. [laughter] No, no, no.

DT: Did you ever have any conversations with the nursing faculty about these issues?

MM: Later on, I did. [pause] I didn't have any conversations then, but after MNA became a union, I did. I can't remember the various conversations, but probably just sort of community meetings and stuff. I came to understand from what people were telling me that faculty were advising students to join the union in order to have rights. As time wore on, this became sort of a problem in the community, because the union was already moving away from interest in patient care, solely towards membership, closed shop, all the different things that made the union strong. Those of us who were in leadership positions felt this was really an unprofessional way for faculty to be. It was unprofessional for nurses to be in unions in the first place, and, then, for the faculty to be advising them, it seemed like it was a totally stupid thing. At that time, the faculty was sort of anti-administration, in general. They felt that the powers that be would never support nursing. So nurses had to be strong and organized and the union was willing to do that. So that was the only kind of dialog that went on with the union and the faculty. Nowadays, that's completely not a part of the mind set of the faculty. Periodically, I found myself reminding them the way it used to be, because

vestiges of that are still around here. If you don't get what you want from administration, get it from the union.

DT: The issue around nursing fees or nursing salaries and hospital costs...was there ever any kind of dialogue about a comparison with physicians' fees?

MM: Oh, yes. All those comparisons went on.

DT: How did nurses feel regarding their salaries versus what physicians' fees were in that period? Was there any kind of resentment?

MM: Oh, yes, sure.

[chuckles]

MM: We could go on and on. That's year's worth.

[laughter]

DT: [unclear]

MM: Right.

DT: Did physicians jump on that rhetoric, though? Where did physicians stand on the issue of nurses' salaries?

MM: I don't remember them having anything to say about it. Maybe they did, but we didn't talk that much about stuff like that. I don't really remember anything. Most of them were anti-union. But, then, a bunch of them joined the union. So that changed, too.

DT: Did the passage of Taft-Hartley laws... The 1974 law was permitting Taft-Hartley...

MM: Requiring charitable institutions to join the Taft-Hartley labor laws. That defines an adversarial relationship. I mean, it says that. "This relationship *will be* adversarial."

DT: That's interesting. So the ANA had a role in getting that passed?

MM: Yes.

DT: You said Minnesota was kind of at the forefront of collective bargaining for nurses. Then, you have the national association that's kind of changing the parameters around labor relations for nurses. Do you feel like Minnesota was unduly influenced by the national picture?

MM: I can't really say who said this or when, but my understanding at the time, though, was that the MNA did not support ANA's position, but were overwhelmed.

DT: Also, during the 1960s, another significant change was the introduction of Medicare and Medicaid. Did you feel that that influenced nursing practice at the University Hospitals?

MM: You know, I can't say that it was influencing, except that the accounting system had to change [unclear]. Prior to that, the accounting system was very loose. [chuckles] The joke was that the CFO [chief financial officer] gives the CEO [chief executive officer] a paper once a year. Is it red or black? There were all kinds of things that had to change, and I think it was at that time.

For example, a lot of stuff wasn't charged for. It was assigned to a floor, and it was simply distributed. I don't know how those costs were paid for. I don't really know, probably some flat room charge. But medications, supplies, and things would just be there. You'd have a certain number of trays, for example, catheterization trays, and we'd just grab one and use it. We didn't have to send a slip. All of a sudden then, we had to get [unclear] that and start sending our charts with everything that we did. The floor stocked drugs. We used to get most of our medications up in large bottles, and we would pour from the bottle for the different patients without it being individually charged. So, when this change came, everything became individually charged, and we ended up with [unclear].

Before that happened, our systems was very much like they are now in the countries that have universal health care where you're not creating this mountain of paperwork and data on computer somewhere, but a much simpler way of distributing things that are needed and used.

DT: It seems like it would have added so much more paperwork.

MM: Oh, unbelievable. Yes.

I had this fantastic job of assistant director in charge of special projects, too. I got to play with a lot of people around the University who were real interesting and innovative thinkers, industrial engineering people or systems people and stuff. Somebody was always talking to me about this stuff. For example, I don't think we ever really did it, but it's like placing a red dot on an item to be charged, like a catheterization charge, and, then, just follow it through the system to see how much it would cost in order to process charges for a piece of equipment that probably costs like eight dollars and fifty cents. They were coming up with these fantastic sums of money. Charges vs. Costs.....Things like two aspirin, and charge twelve dollars on you bill for two aspirin. It's crazy and it doesn't get any better.

DT: Did Medicare and Medicaid change the kind of patients that you were seeing in the hospital?

MM: I'm a little confused by exactly when Medicare and Medicaid came in and what some of these changes were occurring. One of the things that was occurring in the 1960s is that the ratio of state patients to pay patients changed dramatically. Prior to that time, about one third of the patients were state and the different counties all had budgets to contribute to pay for their people when they required care at the University of Minnesota Hospital. Now, the only people who would be admitted at that time under those circumstances were people who couldn't be cared for in their own... You couldn't walk in to the University of Minnesota Hospital and be a patient. You had to be referred by your physician somewhere in the state. So it was a tertiary care hospital and about one third of those were actually financed by state...really county monies

MM: All that changed. They were no longer so designated. There was no categories of patients who were state or county paid. Everybody was private pay of some form or another. I think that was all happening at the same time.

DT: Yes, I think so as well. That's what I've heard from other people, too.

We talked briefly, last time, about the reorganization of the health sciences that happened in 1970, and you said you hadn't been too aware of what the implications of that were, say, within the School of Nursing. But, I was curious whether it seemed to have an effect on the University Hospitals at all.

MM: Lyle French became the vice president.

DT: Yes.

MM: The Board of Directors of the Hospital didn't start until 1974. [pause] All I'm remembering are conversations that I had with the boys, Dave [Preston], Peter Sammond and John [Westerman]. The sense with the profession of nursing was that we were now out from under Medicine meaning the School, and beginning our identification as a distinct profession. Otherwise, I can't think of anything that particularly was happening within the hospital about that reorganization.

DT: I guess your interaction was always mediated through Westerman rather than to Lyle French.

MM: Yes. He was just a figure that would smile at us.

DT: [chuckles]

MM: I knew Dave Preston pretty well. We had worked together for so much, and he always spoke about Lyle French in such a warm and friendly way.

DT: You had said before that Dave Preston doesn't like to think about that. Do you know why?

MM: I think he feels that they didn't do what they should have done, and, as a result of that, the Medical School budget was never really brought into any kind of control... I think he just has a feeling that they were never successful in really bringing the Medical School to where it needed to be—I don't mean down at all. I just mean in a more fiscally appropriate position with the rest of the Health Sciences.

DT: It gives me some context. Hopefully, I'll have a chance to talk to him and ask him directly.

[laughter]

I think this is where we left off at our last conversation. You were talking about some of the tensions within the School of Nursing, the tensions between the faculty and clinical nurses, those who were actually doing nursing practice. I wondered if you had any more to say about the kind of second class the status the nurses perceived they had with regards to those in faculty.

MM: First of all, in the 1960s, that decade was feeling the impact of what had happened in the 1950s, which is there was a separation between faculty and leadership staff in the hospital. So prior to that time, the person who taught medical nursing was also responsible for the patients on the medical floors. When that split occurred, the ones who were invited to be faculty were the ones with master's degrees and the ones who didn't have master's degrees were not invited to be faculty. So the pain of that... Then, again, this is a profession at this time that...people didn't talk about this stuff openly. There was no healing going on. It was just bitter resentments, bad feelings. That's sort of what I walked into in 1964 and began to understand why people were behaving the way they were.

In the 1970s, we had the impact of the new curriculum—let's see now, that was actually during the 1960s—whereby, they completely changed what they were teaching students, teaching them no clinical complex functions but really a lot of psyche social, a lot of anti-male stuff, not the strength of women feminism, but bad men feminism, you know. During that period of time, the 1960s, it was a period of time when the faculty would say to people like me, "Well, we really can't explain the curriculum to you because you don't understand what these words mean." [chuckles] It was almost like, okay, big words. Can't understand. It was really bad. In the 1970s, I was kind of out of it. I left in 1971. So when we talk about the 1970s, I'm in Saint Paul. In the 1960s, that's what I remember. It was a very difficult time. There were a lot of tensions within the School of Nursing. Faculty members were not getting along with each other. The School of Medicine was up in arms because so many nurses were failing the State Boards and we were hiring graduate students who did not know how to do anything. Today, we are hiring graduates who don't know how to do a lot of complex functions, and there's a real acceptance of the fact that that's not going to be taught the way it used to be in the old former programs. There's not enough clinical and hospitals understand that and accept it. But hospitals didn't understand that in the 1970s and were not

prepared, *not at all* prepared to take a new graduate and do the skill training. They were still expecting them to get that in school. So we didn't have any resources. We did have any education departments. We didn't just didn't have the capacity to do the training.

DT: You left in 1971 to be director of nursing services. Was that at Miller or United Hospital?

MM: It was Miller first, and, then, United...a merger.

DT: Oh, okay. All the hospitals changed their names...

MM: I know, fast and crazy, still.

DT: In your capacity to hire new nurses, did you then prefer to take on new graduates rather than take established RNs?

MM: No, we'd always take some new graduates. We usually had some balance with that. In those days, if you got an experienced graduate... We used to have this thing called the warm body syndrome. That was something that would sort of go into effect some time after the bulk of June graduates had been hired. The nursing office would say, "Warm body syndrome is now in effect." That really meant that anybody who walked in the door practically got a job. The shortage was so severe that if an experienced nurse moved to Minneapolis, walked in the nursing office and said, "I'd like to work here," it was, "Fine. Here's the paper."

DT: [chuckles]

MM: "What area do you want to work in?" Experienced nurses were really scarce.

DT: What did you see, then, as the biggest challenges confronting nursing once you got to Miller Hospital?

MM: Biggest challenge confronting nurses...

DT: I guess the shortage of nurses was one thing. Was there anything else that you felt needed to be resolved even within practices within the hospital?

MM: My interest has always been, and was very keenly so by that time, in empowering nurses. My own development throughout this period, in the 1960s and 1970s, was coming to understand the value of an empowered employee and the necessity of creating an environment that allowed people to become empowered personally and professionally. So I was worrying about how to create those environments, learning how to create an organizational structure, roles, and relationships that would facilitate people's professional and personal growth and development. That also carried with it learning on my part and

experimenting and developing and teaching leadership skills, as well as teamwork in interpersonal relationships. We were dramatically changing the culture of the hospitals both here at the U. and, then, over at Miller/United, and, then later, at Yale, from places where there are enclaves of un happy employees, but a lot of dysfunctionality, and instead of that, just really sort of revamping things.

I used to do a reorganization that changed everybody's role from the unit level up in terms of their own individual skills and abilities creating positions that would match those skills and abilities[unclear] institution. it was a very innovative approach that we used, totally, *totally* unbelievably innovative. I think maybe I should explain that a little bit for the sake of the history.

DT: Yes.

MM: At the end of my time here at the U, Miss Dodds recruited me, I think in May 1970. I made the decision to go there to start in September. In June—I think I've got these dates right—John Westerman realized that as long as Julie [Florence Julian] was in place... He had lost me and he was going to continue to have the same problems with nursing. So he did a 'lateral arabesque' and pulled her into administration and asked me to be acting director. Did I tell you any of this last time?

DT: I think you told a little bit of it last time, yes.

MM: So I was acting director for the next three months until I left. During that time, thirty-five people above the head nurse level changed positions in a very innovative process that, first of all, created positions based on a clear understanding of responsibility, ability, and accountability. These were brand new concepts that had not been used before in the organizational structure. We developed a theory of decentralization. We had a core committee. That core committee went through an incredible intellectual process of applying those principles to the organization as we knew it and to the needs and strengths of the our institution. We created a whole different administrative structure. We identified the clinical resource needs that were present in the department. We asked nurses, "If you could have any kind of clinical resource support or [unclear] of information that we don't have now, what would that be?" We created clinical resource positions and administrative positions more than we had people for. We had thirty-five people who had jobs that were going to be changed.

Did I tell you about the cards and the bulletin board?

DT: I don't think so.

MM: We divided the hospital into logical administrative departments, created an administrative title, the head person, and the support positions, educational and clinical.

We then developed a cards on this big, probably five by three or four bulletin board, and put the job title on it and put these thirty-five or forty positions on a great big bulletin board that was in one of the outer offices of the nursing administrators suite. So it was a relatively public place. Each person whose job was going to be involved in this had three yellow tags, and they could put their name on that yellow tag and put that yellow tag in any position that they were interested in. There was a box of little green tags and anybody could put a green tag up on any position and put the name of the person they would like to see in that position with the requirement that they put their initials there, and they'd tell that person why they felt they'd be good for that position. This went on for two weeks. There was this *incredible* interest in who is where, who wants what position, what are we talking about here and why. It was *such* an open process.

The boys from administration began wandering over there and looking at this thing, because they knew we were doing reorganization. I'm going to be leaving in about three weeks now, and they still don't have an organization chart and there was a little bit of anxiety going on, but everything is going to be okay.

As a matter of fact, that board was up for two weeks. People changed. All kinds of amazing things happened. Nurses were talking to their husbands about changing their position and why they wanted to move from this to that. It was just an *incredible* time. The deal was that the last week that board was in my office and I would make the final decisions. Everybody understood that these were recommendations and everybody knew that this was not a popularity contest and that it wasn't going to necessarily be that everybody was going to get what they wanted, and that, ultimately, I was going to make the final decision. Of course, the final decisions were in effect, it all worked out at the end so that people had the right positions, and there was nobody left over, and nobody felt that they'd been shortchanged in any way. Some people were really angry and resistant early on. They felt that they shouldn't have to think about what they wanted to do. They were much more comfortable with someone telling them what to do. It's what they were used to. Some people really resented the process and other people would work on them then. By the time the final decisions were announced, the entire administrative staff was in agreement with what had happened and how it had happened. It was just an *incredible* time for the department.

That process or some variation of it is what I actually ended up using the next two times I was a chief nurse, doing reorganization that was fundamentally based on the interest, abilities, and skills of individuals and the needs of the organization and bringing that together as an organizational structure based on a philosophy of decentralization that made sense. The experience was just truly phenomenal. We did write about it, but it has never really caught on. A lot of people have never read the article. ["Planned Change:] A Quest for [Nursing] Autonomy" [by Donna Nehls, Verona Nelsen, Patricia Robertson, and Marie Manthey, *Journal of Nursing Administration*, January/February 1974] is the name of it. Yet, I think even today, it's such a transformational process for really getting an organization to sort of get out of the doldrums and get energized to move forward using a creative process that is based on appropriate skills and ability of people.

DT: So was it you and John Westerman who came up with this?

MM: I had a consultant that he hired. Her name was Cokie [Colleen] Kiebert who was actually both an art therapist and an organizational development consultant. She and I have remained friends. I learned *so* much from her. This process was one that was being created while we were doing it. We'd have a meeting of the committee on reorganization and things would go awry. Uhhh! We'd get together afterward and say, "What are we going to do now?" Then the next thing we'd develop something based on the principles, always based on the principles of empowerment, responsibility, authority and accountability being matched and used to solve the problem

DT: Where did you get this commitment to empowerment from?

MM: Well, we're talking about 1968. We're talking about civil rights. We're talking about the Vietnam War, ERA [Equal Rights Amendment], abortion rights, you name it. I'm out on the streets. I'm campaigning to be the Phillips Neighborhood Improvement Association representative in Model Cities Policy and Planning Board, pregnant with my second child, working full time as assistant director. It was crazy. So I was very active in the community affairs at that time. Everything that was being said at these community meetings reflects things like "Power to the people." "Down with authority."

I read Paul Goodman's *other* book. He's most famous one called *Growing up Absurd*. He wrote another one called *People or Personnel* where he laid out in the first ten pages of that book the rationale for when functions should be organized around a centralized decision making structure and when they should be organized around a *decentralized* decision making structure, and it made *so* much sense to me that I never had another question about whether we should hold control in a central place or distribute it.... once I was understanding what nursing is the way I do.

DT: It's incredible. It's important to understand how influenced you were by the changes going on around you and the activism at that time.

MM: Yes.

DT: Did you consider yourself kind of part of the feminist movement?

MM: Probably. I never thought bra burning was necessarily a good thing, but I certainly thought the rights issue should be solved. Again, I came from a really traditional Catholic background, was very compliant and obedient as a young woman. I didn't have any burning desire to change the world. So this kind of just really grew in my thirties more so than... When I was a kid, I certainly didn't think that I was going to do anything exciting. I thought I was going to wear housedresses, be a housewife.

DT: How wrong you were.

[laughter]

DT: When you instituted this kind of organizational philosophy then at Miller and United and elsewhere in your career, did you encounter any resistance?

MM: Oh, my, yes, all over the place, inside and outside. Yes. There are a lot of people, even today, in top positions in healthcare institutions who don't feel basically that an RN *should* be able to make decisions about what is done for patients. There's just an awful lot of lack of recognition within the system, people in positions of power. The thing that I don't understand about it is, to me, it's so clear that when you empower people, you generate additional resources. I just don't understand why people can't see that. If you have these two employees... One is an empowered person who's thinking and has the ability to make decisions based on the knowledge that they have in the situation that they're applying it to versus someone who is going to *not* think, who's going to go by some rote guideline or policy and not go beyond that, that they can't see that there's additional resources available here, that you're going to get more work done, that you're going to have more staff, going to have more accomplished. I don't understand it.

DT: I wonder if what they're worrying about then—and this relates to our early discussion about labor relations—is that when you see an empowered individual and you think that person got more power and could be more activist...

MM: Here's the really bad thing, though, is that the unions see me as a union breaker, because of the empowerment issue. Their concern is that if I had my way, nurses wouldn't go into collective bargaining, that they'd feel like they had enough power to take care of what they needed in their lives. So my reputation is as a union buster; although, I've never, *ever*, *ever* done anything to stop a union. In fact, our policy as a company [Creative Health Care Management] in every place we consult... Our consultation changes organizations. We don't go and study things and write a book and put it on a shelf someplace. We get right in and we change roles and relationships at the point of care across the board, across all the different parts. When we're doing that kind of work, we know we're touching very hot-button union issues. So our policy is to invite the highest level union representatives, as many as they want, into those fundamental committees where we design the process, the actions that will be taken, where everything is being designed, so we're anything but union busters...

DT: You're trying to create a situation in which unions aren't so necessary because everyone is empowered.

MM: I'm not trying to say anything about unions. I'm trying to empower people. Their interpretation is that it's anti-union. We'd have better unions if they would facilitate

empowerment rather than destroy it. Rather than keep people depending on them, if they allowed people to grow and be more, we'd have better union activities. We desperately need better union activities.

DT: It's good that you're going to be talking to the LPN union soon.

[chuckles]

MM: That's about the weakest link in the whole thing.

DT: When you were at Miller and United, did you have any sense of whether there was a different culture within those hospitals compared to University Hospitals?

MM: Oh, yes. Yes. It was a community hospital. The first two years, I was just Miller. The last two years, I was United. Then, I went from there to Yale-New Haven [Hospital]. I came from the mighty U with *all* of those attitudes about University Nursing, University Hospitals into this little community hospital of 350 beds, about half the size and replacing somebody who'd been there for thirty-nine years, still living in the dorm! She took me around and introduced me to the head nurses, by that title they still carried. I was being told those first two weeks how *wonderful* the nurses at Miller were. This is the best nursing department in the *country*! These nurses are the *best* nurses in the Twin Cities. This hospital is *the* best and on and on and on. And I've still got this thing about the University.... Now, wait a minute. Wait a minute. Wait a minute. This is not the University. After a couple of weeks, it sort of occurred to me that what was happening was that because they believed they were the best..., they gave extraordinary care. They really gave extraordinary care. They went the extra mile. They did the extra things. They were there for patients in a very special way. So I came to understand the value of simply community and the expectation of excellence. People are generally going to try to fulfill that expectation. It was very interesting.

Change for me... You know, the community hospital world is a lot different than the world of academic medicine. The relationships that most play out in nursing are the relationships with the medical staff. Because community docs are much less open to questioning, much less open to partnering, much less open to collaborating, the tendency was to have a nurse come on rounds so she could write down what he said and that kind of thing rather than to say, "What do you think should be happening with this patient? It was "My order is rah, dah, rah, dah, rah, dah." If she wrote it legibly, he was happy. It was that kind of thing.

However, even in that environment, we were really able to do some truly remarkable things.

A physician on our staff got a grant to implement something called "Problem-Oriented Charting," which was being pioneered by a physician named Larry [Lawrence] Weed nationally as a way to organize the medical record much more logically than according to the departmental sections. It was organized around the problems of the patient rather than department structure. This guy got a small grant, \$10,000 grant, from Northland Regional

Medical Center. He asked his colleagues to join him in his project, and they said, "No. No, thank you. We're not interested in changing the way we chart. We're not interested in changing the way we think." So he came to me and said, "What do you think about P O M R...?" I said, "I love it! I think it's wonderful, but it's supposed to start with the doctors." However, we were able to make an adaptation to it that we could implement within the nursing documentation. He and one of my top nurses went around to each unit and facilitated the change in thinking that was required in order for nurses to realign the organization of their narrative for this adaptation. It was just a phenomenal experience. It was one of those changes where the only thing that was a problem was that they could only do one unit at a time. Once people heard what was happening and saw how logical it was, they all wanted it. We had a list of who was going to be next. It was a big change. All of sudden, you know, instead of saying, "I don't want do this change," it was "How come we have to wait three months before they come?" It was really kind of nice. We also did the implementation in primary nursing hospital-wide there. I had an assistant director that I assigned to innovation. She was just a remarkable person who had been staff and Head Nurse at the U of M. She and this doctor worked together. We did other innovative things. We did a *lot* of very innovative things way back then. She went through the School of Public Health Nursing program to become a nurse practitioner.

I don't know if you've caught on to the nurse practitioner genesis in this institution?

DT: I was going to ask you about that.

MM: It started in the School of Public Health Nursing, and it started without a requirement for a bachelor's degree. It was a certificate program.

So this woman, Vivian Smith, on my staff went into the program with this physician, the charting guy named Larry [Laurence] Savett, as her mentor. She started seeing his patients as a nurse practitioner being guided and mentored by him, while they were also implementing problem-oriented charting. She became a *phenomenal* nurse practitioner. His patients loved her. He loved her. It was such a wonderful team. Everybody would just remark when those two went on rounds together. It was just incredible. One of the things I remember is that Vivian was an attractive person on the outside physically and inside, and had a real nice way about her. She was a Canadian nurse. She would do the history and physical for Savett on a newly admitted patient. As part of that, the topic would come up about their sexuality, or their sexual problems, or whatever, and men would tell her all kinds of things, you know. Larry would be just stunned, because they'd never say boo to him about a problem. [laughter] She would have chapter and verse. It was just that they were so much more comfortable talking to her about their sexual problems rather than talking to the doctor.

We did other things, though. My boss was a real innovative guy. We were looking around at what was happening, and we were both very inclined to try things out and not to worry about special funding, but just see if we could afford to try things out. We did things like we had Vivian go to Wilder Nursing Home [Saint Paul, Minnesota] and have an afternoon clinic

where a nurse practitioner would see patients in the nursing home—I think it was assisted living—to find out what their questions were and which ones had to be referred. We were doing things in the 1970s that came to be part of the system now.

We did it on a small scale basis.

We used to have primary nurses go to the patient's home after they were discharged from the hospital on duty time. Other nurses would cover for her. She'd go and see how the patient was doing at home, and maybe meet the public health nurse there. [We did] all kinds of innovative things. I had, generally, good support from administration to take some risks and do some things that weren't necessarily standard operating procedure, at the time.

DT: It sounds incredible that you were able to do that.

MM: We set up a peer review system for nurses to review the documentation of their colleagues on discharged patients. This was just a phenomenal learning experience for everybody. The Joint Commission [on Accreditation of Healthcare Organizations] came and their processor at that time was to have a medical records technician review the charts and identify where things hadn't been noted [unclear]. We were having the nurses do this peer review where they were actually analyzing the judgment of the nurses and learning from it in a *positive* environment where there was no recrimination. It was just phenomenal. We got cited by the Joint Commission because we weren't having this objective medical records technician checking to see if everything was correctly documented. My administrator knew about the program and that it was true peer review, although not the process recommended by Joint Commission. I said, "We're going to get cited on this." He said, "Well, are they right?" I said, "No. These are the reasons why our way of doing it is so much more professional and appropriate. It's a real peer review system." He said, "Well, if it is better than the process they recommend. I don't care. I'll support you. It's okay. Don't change."

[chuckles]

DT: That's great.

What can you tell me about the development of the nurse practitioners in Minnesota?

MM: Like I said, it started in the School of Public Health Nursing. The School of Nursing had just started the CNS [Clinical Nurse Specialist] program. I think Grace Sarosi...

Grace Sarosi, by the way, is somebody you might want to interview. She's back in town.

DT: Good.

MM: She's the one who started the medical surgical CNS program.

I don't know for sure... My understanding at the time was that the School of Nursing just wasn't interested in it, because it involved having doctors teaching nurses. There was a pretty antagonistic attitude. Nursing is unique. We don't need doctors teaching nurses. So the School of Public Health Nursing ran this nurse practitioner program for several years. It was a certificate program. There were some remarkable results, like my friend Vivan... I don't know when the SON came around and created it as a graduate program, which is what it should have been.

Alice Sparrow was sort of the thorn in the side of the ivory tower, the School of Nursing, at the time. She was very practical, very dominant, very connected to the community, listened to people, and responded to what was needed.

DT: I've wondered about that separation between Public Health Nursing and the School of Nursing.

MM: Yes.

DT: Could you say anything more about that?

MM: As part of the 100th Anniversary of the School of Nursing, I really spent a fair amount of time looking at the history and helping gather the information that Laurie Glass used in the writing of her book [*Leading the Way: the University of Minnesota School of Nursing, 1909-2009*] and that we displayed in the Wangensteen Library.

One of the big pieces, because it's still a political hot potato, is the relationship between the School of Nursing and the School of Public Health. The School of Nursing started teaching public health long before the School of Public Health was a dream in anybody's eye. Over the years, there's been this sort of backing and forthing of different kinds of programs from individual classes to whole courses to post graduate programs. There's been just a very complicated history. Somebody could spend, probably, a couple of years just really getting the facts about what started when, how long did that last, what did they do next. It's really confusing. That's the one piece that I never did get a real clear picture of, could never explain it simply to anybody. I'm not sure when the School of Public Health started. I knew it last year, and now I can't remember.

DT: Was that 1947?

MM: Probably.

Richard Olding Beard, the real brains behind the School of Nursing, really saw a strong role for the nurse in public health. He was a great believer that nursing was the mechanism for social justice in societies through public health, through improving the health of people. He always was a proponent of the nurse being involved in public health.

It started in 1947, as you say. Then, at some point, Public Health Nursing was part of the School of Nursing and, then, it went away into the School of Public Health. I don't know when that happened. I don't know why it happened. There was a separation then that was pretty painful, and the reconnection has not even been easy. So there's still some *stuff*.

DT: The people in public health who I've spoken to about it have all characterized it as what the public health nurse does is something quite different from what a hospital nurse does, so it requires a different body of knowledge, a different philosophy. That's why it made sense from their perspective for public health nursing to be in Public Health. Public health nursing was the primary vehicle through which public health was achieved and practiced. Yes, it's not clear that that's what nursing faculty thought.

MM: Yes. Right. In fact, to say, today, that the School of Nursing prepares people to work in a hospital is hugely erroneous.

DT: I don't want to...

MM: Yes, I know, but that probably is exactly what the original thought was.

DT: Yes.

You weren't associated, really, with the School of Nursing then from 1971 onwards, but you, presumably, had some perspective on what was happening. I wonder what your thoughts were on the different deans of the School of Nursing. Isabel Harris, we talked about a little bit last time and Irene Ramey, for example.

MM: I don't have much thought about Irene Ramey. I didn't know her, wasn't around much in the community when she was here.

Ellen Fahy, I think, struggled a lot with the faculty. By this time, the faculty's strength was pretty strong. There wasn't a lot of cohesiveness within the faculty, a lot of battles. The faculty, for a long time, really lacked the leadership of a unifying vision that people could support and say, "This is the direction we're going." There would be a lot of unhealthy interpersonal relationships within the faculty that the deans would always be dealing with. Ellen Fahy was an actress. I think she struggled with the faculty.

DT: Yes.

[chuckles]

MM: She liked to perform. I was pretty close to her associate dean named Eleanor Sullivan. It would probably be a good idea for you to talk to her. She left here and went to Kansas. She was dean of the University [of Kansas] School of Nursing in Kansas City, Kansas, where she retired. She's still around and active in some various areas. I think she's active in Sigma

[Theta Tau International]. She's become a mystery writer, wrote a couple of mystery books, a nice person. She was inside there and saw a lot of the dysfunctionality.

DT: I'd definitely like to talk to her. Is she local or...?

MM: No, she's in Kansas. Eleanor Sullivan. She was associate Dean under Ellen Fahy.

I just know that it was very dysfunctional.....many students struggled with personality issues within the faculty.

One of my friends, Susan Lampe, who has been a colleague of mine for years and years and years, went into the graduate program when I was at Yale, so this was in the mid 1970s. She'd call me up sometimes. Susan is the salt of the earth, strong person. She would be just beside herself, just absolutely beside herself, because of the way faculty were treating her. It's just hard to explain. I gave her some advice about who to get for her faculty advisor. I think I suggested Ida Martinson as somebody who had common sense, and she's been so eternally grateful to me.

[laughter]

MM: It was just really an unhealthy group of people. You never felt like you were getting a straight conversation.

DT: It did seem, for whatever personal conflicts there might have been, that pragmatically there was separation from the graduate faculty and baccalaureate faculty in the 1970s.

MM: Yes.

DT: Do you have any perspective on the school's efforts to get a Ph.D. in nursing?

MM: Yes, I was around and, then, when I was plowing through some of the archives over at the [Elmer L.] Andersen [Library, University of Minnesota], I pulled up some of the minutes of meetings around that time and I helped remember some of this stuff.

What I remember about that period is the whole issue of... We were trying, as a profession, to get out from under the subordinate to the medical staff role, that we aren't anything on our own, only doing what the doctors tell us to do. Part of that meant having an identifiable body of knowledge that is discreet and different from all medicine. So trying to define that body of knowledge was incredibly difficult and...[pause]...probably an impossible thing to do. Now, it seems so silly almost, with the diffusion of knowledge. But they were trying so hard to get that discreet body of knowledge. That was what led to the curriculum changes. That's what led to the whole theoretical framework change to create that separation that made nursing different.

So having created this new body of knowledge with new jargon., they would go to the medical staff and say, “Now, can we can have a Ph.D.?” And they would say, “No.” [laughter] “No, you don’t have a body of knowledge to do research on, so, therefore, you can’t have a Ph.D.” I just remember that as being an *extremely* frustrating time for the faculty. I was sort of like...oh, well, you know, we can do fine without a Ph.D. I was not very educationally evolved at that time. I remember the effort, the feeling that it was just incredibly important, and the total frustration trying to accomplish it. As I read some of the minutes, some of my buddies on the medical staff... You said that? That’s not nice. [laughter]

DT: The wealth of information in the archives about the doctoral program is quite overwhelming.

MM: That’s a whole history right there.

DT: Oh, yes, for sure.

MM: And it’s a whole history of the women’s movement, in many ways. It was so male/female differentiated at that time. There were few women doctors and there were very few male nurses, pretty much, in leadership positions, so it really did smack a lot of sexism.

DT: Yes, it’s hard not to see it as sexism, for sure.

MM: Yes.

DT: We started talking about your tenure on the Hospital Board of Governors starting in 1974, but we didn’t really talk about what your tenure was like on the Board.

MM: Oh, it was exciting. I really enjoyed it. I felt I learned a lot. I learned things that had never been clear to me before about the political structure of the organizational structures, and, then, a great deal about liability, which has just stood me in such good standing, because it was all coming out at that time.

There was a case—I think it was called the the Darling Case; I think it’s 1967—when for the first time in the history of hospitals a board of directors was held liable for the medical malpractice of a physician on their staff. It had to do with a boy in Illinois, who had a sports injury, I think, and broke his leg. It was casted, and he was in the hospital, the nurse could see that the cast was cutting off circulation, and she kept reporting it and reporting it, telling the doctor and telling the doctor and telling the doctor, but nothing happened and the boy lost his leg. They had to amputate it. In that case, the court held, for the first time, that the hospital board of directors were liable for the quality of medical practice. I’m not sure, but 1967 sort of pops in my mind. That was like an oh-my-God moment.

That also was part of why the University Board of Regents started to say, "Wait a minute now. We've been acting like a board of directors here, and that's not going to be okay anymore." [chuckles] They weren't looking at the qualifications of the medical staff. The whole issue of credentialing and the controls over the quality were being brought into play. We would have attorneys coming and talking to us about various cases and helping us understand what that liability meant. So it was a tremendous learning experience.

DT: What other members were on the board? It doesn't have to be names so much, but what were their backgrounds? Was it all health care people?

MM: I think it was a couple community people. I think maybe Sally Lawrence might have been on it—she's a community person today—I'm not sure.

DT: Was there a lot of contention on the board?

MM: No.

DT: Things ran smoothly?

MM: We got along well. Yes. It was a good board.

DT: How long were you on it?

MM: Just one year and, then, I moved to Yale.

DT: One of the things I noted in the archives was that the AHA [American Hospital Association] had threatened non-accreditation of the hospital in November 1974. Do you recollect that?

MM: Probably because we were not complying with the Joint Commission. John's attitude toward the Joint Commission was not supportive. Let them go away. We were an academic health center. We've got the best. I'm not sure if that was it. You're sure it was AHA accreditation?

DT: Yes, I think so. That's what my notes say, at least.

MM: I'm wondering if it was because the Joint Commission gave us those bad citations..

DT: But you don't have any reflection on that?

MM: No.

DT: What led you to leave Minnesota and go to Yale?

MM: Just about the time I left the U, my husband said he didn't want to be married and have two kids anymore. So I went to Miller after a really fresh divorce.

What was that book? It was published in 1970 something. There was a very popular book out at that time that said if you make three major changes in your life at one time, you're likely to get sick. It was about a change in in a major relationship, change in living, change in a job. So here I've got two out of three. So I thought I better stay in this house. This was the house that we moved into as married family. We picked up furniture together. It was the house that I'd been married in and, now, I'm divorced and still living in that house. That was part of it.

Then, the other part of it was... For the first two years, I had just the one the hospital and the last two years I was there, it was a fresh merger. You can't imagine...nobody can imagine the administrative nightmares of trying to merge two competing cultures. I mean it was just unbelievable the kinds of situations that you'd find yourself in. These were really difficult issues. People felt them at the core of their being! And they were irreconcilable differences. I could go on and on about some of the situations that would come up.

Just in terms of the politics of it, for the first two years, they decided that because nursing was so big, they'd do nursing last. So for these two years, there were two directors of nursing, one at Saint Luke's [Hospital] and one at Miller. Then, all the other departments had been done, so nursing was left. We have to do nursing now. Well, the CEO at Miller and the CEO at Luke's were entirely different people. The CEO at Miller was a guy who believed in empowerment, decentralization. He believed in hiring the best department heads you could, highly qualified people and letting them run their departments. The guy at Luke's was a pharmacist who believed you save money by hiring people who are inadequately prepared and you control them carefully. [laughter] So we had these two philosophies going. Of course, as it came to the departmental integrations, we'd compare this person and this person. Well, this person kept getting it..... the Miller department heads people kept getting appointed. Luke's is having a fit! Half the board are Luke's people, and they're just *outraged* that this was going on! The Luke's guy is the assistant CEO. It was just awful!

Then, I come along with a master's degree in nurse administration, I'm published. I'm being asked to speak nationally. I've got this incredible reputation and people love me. The doctors all like me. I've got all these things going and the other one is this... Joy is her name, and she's un-joyful.

[chuckles]

MM: She wears this little organdy cap and she's not a happy person. She's just really a rigid person, unhappy person. Nobody likes her. She's punitive and controlling. So it comes time for the Board meeting where a decision was going to be made. What happened that day—I wasn't there; I learned about it the next day—was I got the position and, the number two

person (COO) to whom I had been reporting, Ken Kelly, was fired. It was like...the tension was so bad that some head had to roll in order to satisfy . He was person, and his head rolled.

Then, came the challenges of bringing those two departments together. It was kind of nightmarish. It really was. The issues were so...

[break in the interview]

MM: It took a lot of negotiation. It took a lot of finesse. It took a lot of trying out different ways of doing it and learning new things. It was a tremendous learning time for me.

There was a woman, a nun, [Sister Madeline] who I had read about. Maybe this is too much detail. She wrote an article in 1966 entitled, "Existentialism: A Philosophy of Commitment in Nursing." It was a real mind blower for me, because she explained existential philosophy and how it applied to nursing and how if you weren't engaged in that kind of an approach to patient care, you'd end up being a problem solver, but not really being able to interact and become a part of the healing process. In that article, she has a sentence where she said, "Professional nursing occurs when the nurse enters into a therapeutic relationship with the patient." It was about giving yourself in the therapeutic relationship with the patient. It just was a real important article for me. It was one of the things that opened the door for primary nursing in my own mind. Then, I got to know her. She had me come out to the East Coast to talk to her faculty. She was Dean of a School of Nursing at the time. So, by now, we've been back and forth a few times.

It's the mid 1970s and I'm struggling with this incredible merger stuff. It was really difficult. Here at Miller, going back to these two CEOs where the philosophy of management is so clearly impacted in the way people think and feel. This is what I learned in that merger: that *leadership* has a *profound* impact on what happens to the organization.

I can give you a couple real world examples first. For one: policy...care of the body after death. Care of the body after death is always a policy. The Miller policy was bup, bup, bup, bup, bup, bup. When you've done all that, call the supervisor to inform her. The nurse does everything, and takes the body to morgue. Saint Luke's policy: step one: call the nursing supervisor immediately. The supervisor would come up and do what was needed to be done, make all the notifications, call the undertaker, etc. The nurse was not expected to be able to handle this issue....it became a 'problem' for the supervisor to deal with So that is just one small example...and this went on and on and on.

Miller had always bought the most expensive equipment, sent the staff off to the highest quality training programs, always had the best. Luke's always had the cheapest, least expensive equipment, didn't get the preparation for their people, didn't have the policies in place that really made sure that the best was done.

Now, my job was to bring these two practices to one because they're going to be working together eventually in one building. My direct reports at Miller, the people that were my closest colleagues, were on my tail. They were saying, "Manthey, are you saying we have to lower our standards in order to support the merger?" "No, that's not what I'm saying."

Anyway, Sister Madeline came to visit, and I had a tea for her with the leadership staff in the Red Lounge of the old Nurses Dorm. That day, nobody from Luke's could come. They had some kind of an emergency. Everybody was tied up. So it was only the Miller people there. I said, "Sister Madeline, I've got to ask you this question." She had been involved in some merger stuff in Massachusetts, and they had decided not to merge. I said, "Now, here's the situation, Sister. This is Miller. We've always had these high, high standards. You know the problems we've had here with Luke's. Now, where would your loyalty be? Where would your values...? If you were here, would you support the merger or would you support the standards of Miller Hospital?" "Achh!" She had a very heavy French accent. "Achh." She said, "Marie, you didn't prepare me for this question. Then she said, "I am a French woman and, therefore, I am a pragmatist. I would look at the name on my paycheck, and if it said 'United Hospitals,' I would be loyal to the merger. If it said, 'Miller,' I would be loyal to Miller's standards." That was like, oh, my gosh, that is the answer.

DT: [chuckles]

MM: Like it or not, that is the answer. I can't tell you how many thousands of times I've used that example when people are resistant to something that has to be done, whether they think it's right or not. It's so helpful to say, "Look at the name on your paycheck."

That was a great time but much, much, much stress and struggle.

DT: Yes. So after that, you decided to go to Yale given...?

MM: Yes. They recruited me. That was four years since the divorce, and I'm thinking I've got to get out of this house. I need to start building my own life. This is still our life, not my life. I thought I would just go look. I was getting recruited a lot. Yale was kind of the prestigious one at that time. I thought I'll just go take a look at it. I went and then they had me back a couple of times. I decided to take it. Really, part of it was to get out of that merger, to just stop having to deal with the merger and get back to developing practice improvements for better patient care.

DT: You have a good perspective because you went somewhere else. You were at Yale for several years, is that right?

MM: Yes.

DT: Did you get a sense of whether the issues and the culture of nursing and of health care in Minnesota were distinctive to the state? How different were things in New Haven?

MM: I've thought about that stuff a lot, not just in New Haven but, since then, I've traveled...

DT: Right. You've seen a lot...

MM: I've got a whole international perspective, yes. I think there is some thing different about Minnesota. [chuckles] I really do. I've thought about this a whole lot. [pause]

The state's culture, until fairly recently, has really been more aligned with the social welfare notions of the Scandinavian countries, and of Canada even, than the rest of the country. So there's been an openness and a sense of connectivity within the state's institutions, I think, that I certainly didn't see at Yale and don't very often see anyplace else. I'm trying to get these thoughts straightened out. I don't think it's an accident that primary nursing started here in my own world. There's an advanced thinking that partly is the Midwest. The East Coast has its own rigidity and the West Coast has its own rigidity. I have found in both of those cultures, for different reasons, there is a rigidity and a resistance to change based on different reasons but equally difficult when you're functioning as a change agent. The Midwest doesn't have that. Whether it's Iowa, Minnesota, Michigan, there is less reliance on tradition. On the West Coast, it's not so much tradition, but there's some other kind of rigidity on the West Coast that makes change really, really difficult. I don't think I've ever quite figured out what it is. The East Coast, it pretty much is the old vestiges of classism. For example, on the East Coast, in primary nursing, I always had trouble with people who believed that we should reserve primary nurse title for those with bachelor's degrees. My position was if you've got a license to practice nursing, it says you have the right to make your own kind of decisions in this field and that is all we need. We need to have clinical competence to do it.

[pause]

MM: I'm trying to collect my thoughts. I think the Midwest culture is part of it. I think, also, the Minnesota political environment, sense of commitment to education and health as strengths that make this a good place to live... The University's intense connection to the community... I remember in the 1960s when there was a lot of unrest in the community, professors at the University would be interviewed on television and talking to us about some of the issues and the principles. It just felt like the University was very much part of the community and had a sense of responsibility about what was happening here. I certainly never felt that Yale. Oh, my God, on the contrary.

[laughter]

MM: I don't think it's an accident that health care is where it is in Minnesota compared to the rest of the country. We are *much* more like Canada. If you look at Minneapolis as a city,

it is much more like a Canadian city than like any other city in the United States. We are not like Chicago, and we are not like San Diego, and we are not like New York as a community, as a city. I know this is pretty incoherent answer, but I have thought about it a lot. Why did things start here? Why is this such a hotbed of innovation?

DT: Yes. Actually, Eli and I were talking about this before you showed up: the number of innovations within nursing that took place at the U while you trained the nurses in the 1960s and then the 1970s, so you got primary nursing. Ruth Stryker-Gordon was talking about the innovation she helped introduce with ward clerks within nursing.

MM: Yes.

DT: I can't remember what hospital she was at at the time.

MM: Saint Barnabus Hospital. .

DT: Yes, Saint Barnabus. She had a lot of similarities, it seemed, with primary nursing; although, it was just more the outcomes of. Then, Ida Martinson's home care for the dying child.

MM: Yes.

DT: I've been wanting to ask you, was this unique to Minnesota or it was a coincidence that you were all here at the same time? Were these innovations happening elsewhere within nursing?

MM: I'm not sure. One of the things I noticed as a young nurse... Again, I was thoroughly educated and not particularly intellectually awake yet. I remember I used to read the *AJN*. This is what you were supposed to do, read the *American Journal of Nursing*. I can remember thinking—this is when I was working at the University of Chicago as a staff nurse and a head nurse—what is it about Minnesota? There were *so* many articles that were authored by people from Minneapolis, Minnesota. So, even in the 1950s, this was a hotbed of innovations in nursing.

I think if you look at the whole health care scene, we are way out in front, too. It's not just nursing. It's not medicine—I guess medicine in some respects—but I'm talking about health care. HMOs [health maintenance organization] started here. In Two Harbors was the very first HMO and the think tank that generated the recommendation of President Richard Nixon supporting HMO's.

DT: What's the think tank?

MM: Oh, I can't think of the name of it. I don't know.

So health care has always been... I think part of it is the MHA [Minnesota Hospital Association] program. I think that they prepared people to be pretty innovative leaders, and they went out right here in the Twin Cities. We've had some of those strong CEOs. I think it's not only nursing. I think it's also health care in general. Our statistics are good. Our quality is good. Our costs are low. Everybody agrees with those facts.

DT: When did you start your consulting company?

MM: In 1978.

DT: This is when you were at Yale still?

MM: No, I had just left. Remember, I was fired while I was in treatment for alcoholism. I told you this, didn't I?

DT: No.

MM: Oh, my God! It's a big piece in my personal experience. By the time I went to Yale, my drinking had advanced to an addiction. This is a public story..... In 1978, my boss said, "You need to get help." I said, "Outpatient." He said, "Inpatient." I said, "No." He said, "If you want to keep your job, you have to go as an inpatient treatment." So I went, and I was fired while I was in treatment. That was a very, very, *very* bad time. It's not a secret. This is just who I am, and I've made it a part of who I am. People forget about it now and sometimes seem surprised, but it's basically been out there. I've written about it, and I've talked about it, and I've made it very much a part of my life in every respect since then.

So in 1978, I was in New Haven, and I lost my job, and I had two kids, an eleven-year old and a sixteen-year old, and I was the sole support, and it was a very, very, very difficult time, to say the least.

One of the first things I did was I started writing a book. I wrote the book, *The Practice of Primary Nursing*, at that time, which I had not had time to do before.

And I began, reluctantly, becoming a consultant. I didn't want to. I didn't like being a business woman. I didn't like charging for what I knew. I liked to give it away. Yet, there was no other thing to do. I was too sick to move to another state or to look for a job. It just really wasn't something I could consider. In New Haven, there were only two hospitals and when you've been at one, you don't go to the other. It just isn't done. So I didn't know what else to do, except that people still wanted me to come and talk about things and they were willing to pay me. So that began my solo practice. For three years, I was a solo consultant and gradually learned about how to charge, and how to send a bill and write a report, and how to package what I knew, so I could actually go forward and help people make the changes.

Then, in 1982, I moved back here. My daughter was going to school by now at the U [University of Minnesota], and it just seemed like the right time to come here. So I came here in 1982.

One of the first things that happened was I created a coordinated curriculum to prepare a staff nurse to become a nurse manager. Up to this point in time, we had *absolutely* no training *anywhere* in the United States that taught a staff nurse how to become a nurse manager. It was just incredible. One of the things that was happening as I was traveling around the country a lot is I'd be on an airplane talking to my seatmate and it turned out that he would be a desk clerk for Holiday Inn going to Florida for a three-week training program to become a concierge. I'm thinking to myself, three weeks for a desk clerk to become a concierge. We take a staff nurse and put her in charge of the *lives* of all these patients on a twenty-four-hour-a-day, seven-day-a-week staffing basis, and we don't give them any training. What is wrong with this picture?

[chuckles]

DT: It really helps to get out of an organization to be able to sort of see what's crazy.

So I developed a five-day program that has been shortened to three days, has been renamed, Leadership for Empowered Organizations. (LEO) It's exactly the same as I created it. It's licensed all over the place. It's licensed in England. They've done a hundred train the trainer trainings over there and I don't know how many hundreds of thousands have gone through here. I started that in 1982. That gave me a way to begin to expand and hire some other people to do the work.

Do you know anything about Vern [Vernon] Weckwerth's program, the Independent Study Program?

DT: Yes.

MM: Well, I became the director of the PCA, Patient Care Administrators, part of...

[break in the interview]

MM: ...independent study program. I did that from 1982 to 1987.

DT: [unclear]

MM: Yes. That was very part time. It was like a half time faculty position. Essentially, it paid my mortgage. That was important security just to get that mortgage paid.

[laughter]

DT: I've always thought about people who go into business, it seems to me a scary [unclear].

MM: Oh, yes.

DT: You don't have that consistent flow of income.

MM: Right.

I don't know how much you want to go into about the history of the company. It's still going on. It's a very strong company. We grew and we've expanded. We stay true to the fundamental values of empowerment and inspiration, leadership development, nursing care delivery systems and structural reorganization that's based on a decentralized structure. We do things now on a hospital-wide basis. There's about fifteen full time consultants who work nationally and internationally. We publish a journal. We publish our own books now.

I found out that in terms of just the consultants' role that I'm sort of an anomaly. I was asked to speak to a group of independent consultants and they were just in awe of the fact that I went from a one-person consulting service to this, sold it, and retired, and still work with them.

[chuckles]

DT: How big is the company now? How many people do you have?

MM: There's fifteen full time consultants and about eight full time staff. We have about 200 or 300 clients a year.

DT: In those first three or four years when you were in New Haven when you were starting up the business, where did you get your information about how to be a consultant? Were you reading books? Did you just like trial by error? [chuckles]

MM: Trial by error. I didn't want it. I remember really stupid things. At first, I absolutely didn't know what to charge. I was being asked to give talks. I had been for years. Some professional journals would sponsor conferences and stuff like that, or professional associations. I had finally become a pretty decent speaker. I hated it at the beginning, but I had finally learned how to do it. I never used Power Point, always interacted with the audience.

So this one day, I had done a good job. It was the end of the conference. I was the last speaker. We all had planes to catch. Yet, there was about, oh, thirty people standing in front of me just asking question after question. Oh, I was so excited about what I was telling them and everything. I got on the plane and I thought, shit! I forgot to tell them I'm a consultant.

[laughter]

DT: Didn't hand out your business card.

MM: I didn't have any business cards. I didn't have a business card for the first two years, because it cost thirty-five dollars in those days to print 100 of them and that was a week's groceries that I couldn't justify. Oh, man, it was tough going. It took a long time for me to be able to think about business, to think about change from the organizational thinking that I had been doing to entrepreneurial thinking. It was a very challenging change in thinking. [chuckles] It was really incredible.

I never did take a lot of courses and study a lot about business management. Eventually, in 1992, I hired a really good business manager who was my tax accountant. He says now that I've got one of the best business minds he's ever worked with. It's just because I kind of keep going back to common sense.

DT: You have your guiding principles, too.

MM: Yes.

DT: You said to me back in October when we first talked that you were going to be speaking to some MBA students, that, at some point, you were going to be talking to business students. Based on that interview, too, but from what you talked about today, your knowledge of organizations and organizational practice, it makes sense that the Harvard Business School...that someone should do a case study of your development, not just the consulting but how primary nursing...and how you transformed experience in practice into organizational leadership. I think there's a lot of value and lessons to be learned.

MM: I do, too. I see what we've done right, what we've done as colleagues, and I see what's going on in the rest world. This experience of meeting with these other independent consultants—most of them are working in organizational dynamics—I realized that what we've done is special and the way in which we've done it is special. We've done it with consistency and values. We haven't always done what would be considered good business practices in the sense of... For example, we have a principle that we won't compete. We'll collaborate. We won't compete with anybody. So if other people are doing work that's similar to ours, we find a way to connect with them. We develop strategic partnerships and stuff like that. We've helped independent consultants up the kazoo to get themselves started as a new kind of consultant. They're all our friends now and we're colleagues. I'm not saying we don't sometimes go after the same dollars, because surely we do. Our attitude is that we're the best and going to get there, eventually, and, if we're not, we should become the best. We don't really accept some of the conventional wisdom.

DT: It's remarkable. The period when you began was still a difficult period for women in health care and business. Sure, you came from a traditionally female occupation and appreciate innovation in that realm, but you're not just talking about nursing. You're talking

about health care organizations. I wonder if you have any kind of final comments on how you negotiated the kind gendered workplace.

MM: I don't know that I negotiated that well. I think that I found the openings where I could and tried to stay away from the places where there wasn't any opening. My philosophy about change as a change agent has been... The analogy I always use is I'm like a flood of water rushing down a hospital corridor. If there's an open door, I rush in. Where there's a wall, I rush on. When there's resistance, I just sort of try to ignore it...not meet resistance. Because every time you try to fight resistance, you strengthen the resistance. So to move the people who want to go... There's always somebody.

My latest thing—this is really off track—is I've been starting this salon [Marie Manthey's Nursing Salon] and people are asking me to talk about that now more and more. I did some work today on Margaret Wheatley's stuff [her book, *Turning to One Another: Simple Conversations to Restore Hope to the Future*] about the value of conversations. One of the things that she says is that conversations among people have the capacity to change the world, because conversations change people. I guess I deeply believe, have always believed, that everybody is educable, so there's always hope for people. But I don't personally attack anybody in order to persuade them or fight against another direction. The thing about my work on Salon development..., I'm very excited about this because when you follow this line of thought through, it turns out that it is when people get together and talk about things that they really care about that they begin to figure out what they can do in terms of the next steps in their life to change that situation or to improve what they care about. It is those steps, those conversations that really begin to change the world like nothing else ever has.

In the book, *Blessed Unrest*, by [Paul] Hawken, he talks about the fact that there are discussion groups going on all over the world, people getting together in their homes to have conversations about the environment and about spirituality. He says, "There conversations are changing the world and nobody knows about it." It's under the radar screen. It always will be under the radar screen. They'll never be organized. It is those conversations that are changing the way people think and feel. Those changes in the way people think and feel are really what makes changes in this world.

I really went off track from what you asked.

DT: No, no, no. That's great.

MM: When you said that about Harvard...one other comment. Did I tell you about Seymour Sarason, a professor at Yale?

DT: No.

MM: As VP of Patient Services, I was running all the time, very busy. I was very, very, very busy v.p. I began getting messages that this one patient needed to see me. I didn't have

time to go see a patient. Well, finally, I was persuaded to run up there and see this guy. I walked into his room and I said, "My name is Marie Manthey and I'm vice president of nursing." He said, [Marie claps her hands] "I'm *so* glad to see you. Sit down. I need to talk to you." His name was Seymour Sarason, and he was a professor of social psychology at Yale. He had written a book called *The Creation of Settings [and Future Societies]* in which he posited the notion that when you create new settings, you change the functions of society. He was a patient on the first primary nursing at Yale, many times in the past.... it was urology.

Now he was there at this period of time when we had three days of a fierce blizzard. No patients were allowed to go home. No visitors were allowed in. Staff couldn't go home. No cars were allowed on the streets, except emergency vehicles. We ran out of food. We ran out of clothes. We ran out of everything in the hospital. It was like this incredibly difficult time. He was a patient during that time. He had experienced the change in nursing from his previous experiences and, during that period of time, he wanted to know if this was the function of his unique relationship with his nurse or was it a change in the setting.

So he took it upon himself to interview the patients during that snow storm because nobody could go anywhere anyway. So he went around in his bathrobe, with this clipboard and he did a sociological analysis of the unit and was *so excited* about what he had learned. The first thing he said was, "What are you doing to study this?"

DT: [chuckles]

MM: I said, "Well, to tell you the truth, I'm so tired of research in nursing that has to do with counting minutes that I am not really doing any research. He said, "Don't do that! That's not what's important! What you've done is you've created a system whereby the nurse can solve the patient's problems. Now, *that's* remarkable!"

He wanted to tell two examples that he had had. One, the doctors came and said, "How you feeling today?" He said, the tape on my dressing is pulling. It hurts when I move." They said, ""We'll probably take that off tomorrow." The nurse came in later, "What did the doctors say?" "I told him about the tape pulling and they said they'd leave it on till..." She said, "Oh, we take this off a lot of times after four days." So she took it off. Problem solved. The dressing was off; problem solved. The next day, the doctors came around and said, "How are your bowels?" He said, "Not very good. I'm constipated. I haven't had a bowel movement yet. I'm not feeling good. I've got a lot of cramps." They said, "Well, if you haven't had one by tomorrow, we'll order something for you." She was with him this time. As they're walking out of the room, she said to Seymour, "What do you like to take at home?" He said, "Milk of Mag [Magnesium]." She went out, snagged the resident, said to him, "Write a Milk of Mag order, would you, please?" He did. She came back with the Milk of Mag. Within five minutes, he had a laxative and he was feeling better. So he was convinced that this was a change in settings.

Then, he said to me, "Here's the way I want to explain this to you. If you were to ask the teachers at that grade school down the street and the professors at Yale the same question, 'What is the purpose of the institution, you would get two entirely different answers. The teachers in the school down there would tell you that the purpose of the school is to teach students. The faculty at Yale, if they were being honest with you, would tell you that the purpose of Yale is to provide them with an opportunity to learn, grow, and change. To the extent that there's a difference in those two purposes, that's the difference in the quality of the education.

So, for me, that has always been if you're creating an organization where the employees are going to learn, grow, and change in order to have a superior product. Just to deliver care, just to carry out the functions, that's not going to be high quality.

He got very excited about what I was doing. They were starting a school of business that year. He was also going to be the informal liaison to the president of Yale. But, he really wanted to work with me, and that was just the time when I left, and we lost complete contact. But there was that time when I thought, oh, gee, somebody *really* paying attention to his work.

DT: That's great. His experience as a patient.

This has been tremendous. Do you have any other insights you'd like to share about the School of Nursing or AHC [Academic Health Center] history?

MM: Just that today, I think that the School of Nursing is under leadership now that was very similar to the K.J. Densford leadership. I think [Connie] Delaney and Densford are very similar in the ability to broaden, to envision, to inspire, and help people. Yes. They're both really remarkable people, so it's a great time in the school. The faculty is overworked and wearisome, but the students are just having an incredible experience.

DT: I've heard several people say that about Delaney.

MM: Yes. She's special.

DT: Thank you so much, Marie.

MM: Okay.

[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

