

Sandra Edwardson, RN, Ph.D.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

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

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

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

Biographical Sketch

Sandra Edwardson was born in New Ulm, Minnesota and raised on a farm in Fairfax, Minnesota. She attended Saint Olaf College and earned her bachelors of science in nursing in 1963. Dr. Edwardson then went directly on to the University of Washington and earned her masters of nursing in maternal-child nursing in 1964. Following her husband, Dr. Phillip Edwardson, on an assignment to rural Mississippi with the Indian Health Service from 1964 to 1965 and then to New York from 1969-1970, Edwardson worked as a substitute nurse before eventually returning to Minnesota where she began teaching in the Department of Nursing at Saint Olaf College. Her experiences at Saint Olaf College brought major financial and policy issues in the health care field to her attention, which prompted her to attend the University of Minnesota School of Public Health to pursue a Ph.D. in hospital and healthcare administration. After completing her Ph.D., Edwardson became an instructor in the Independent Study Program in Hospital and Healthcare Administration, after which she was appointed to an assistant professorship in 1979 in the Nursing Administration Program within the School of Nursing, which she took over one year later. She became an assistant dean in the School of Nursing under Ellen Fahy from 1981 to 1983. In 1992 she was named dean of the School of Nursing and resigned from the position in 2004. She continues to serve on the nursing faculty.

Interview Abstract

Sandra Edwardson begins by describing her upbringing and education in Minnesota, followed by her pursuit of a graduate degree in nursing, and her reasons for entering the nursing field, particularly maternal and child nursing. She then discusses nursing shortages, working as a nurse for the Indian Health Service in Mississippi during the Civil Rights era, and contrasts the treatment of Native Americans in Mississippi and Minnesota. Edwardson goes on to describe moving back to Minnesota where she taught at Saint Olaf College for a number of years and then decided to pursue her Ph.D. at the University of Minnesota in Hospital and Healthcare Administration. As part of her recollections surrounding her experience as a Ph.D. student, she describes the environment for women, her work with Dr. Vernon Weckworth as her advisor, and her dissertation research on Homecare for the Dying Child. She then covers the following topics: becoming an instructor in the Independent Study Program, becoming an assistant professor in the School of Nursing, the creation of a doctoral program in nursing at the University and doctoral education in nursing at large, teaching in the Nursing Administration program, working with the Institutional Review Board, and obtaining both research and building funding. She discusses the deanships of Inez Hinzvark and Ellen Fahy, her experience as assistant dean under Fahy, conflicting attitudes regarding nursing philosophies within the School of Nursing, regional planning for nursing, retrenchment and planning strategies at the University, the creation of the Master of Nursing degree at the University of Minnesota, the creation of the National Institute for Nursing Research, the transfer of the public health nursing program from the School of Public Health to the School of Nursing, her transition to interim dean and later to dean, the Rajender Consent Decree, and then her move from associate to full professor. She

goes on to describe the tenures of some of the vice presidents of the Academic Health Center and particularly Frank Cerra's creation of the Dean's Council, collaboration within the health sciences, community research projects, the recruitment of minority students, the creation of a nurse practitioner program in the School of Nursing, the relationship between the School of Nursing and the University hospitals, the development of the Doctor of Nursing Practice degree, and her relationship with the Regents, the University president, and the State Legislature.

Interview with Doctor Sandra R. Edwardson

Interviewed by Dominique Tobbell, Oral Historian

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

**Interviewed in Doctor Edwardson's Office
in Weaver-Densford Hall, University of Minnesota Campus**

Interviewed on May 30, 2012

Sandra Edwardson -SE
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Sandra [R.] Edwardson. It is May 30, 2012. We're in Doctor Edwardson's office in Weaver-Densford Hall.

Thank you for meeting with me today.

SE: Yes.

DT: To get us started, can you tell me a little about your background, where you were born and raised and your education?

SE: I was born in Minnesota in New Ulm. Most of my childhood was in Fairfax, Minnesota, or near Fairfax. My father was a farmer. After high school, I went on to Saint Olaf College [Northfield, Minnesota] where I completed the Bachelor of Science in Nursing degree. Then, immediately after that, I did something that was pretty unusual at that time. I went directly on to graduate school at the University of Washington where I completed the Master of Nursing degree, which was a professional degree except that it was really like a graduate school degree. The only thing that was different was that I didn't take the language requirement.

[chuckles]

Then, from there, my husband [Doctor Phillip Edwardson] was sent to rural Mississippi in a town where the three Civil Rights workers were murdered in 1964, 1965. He was in the uniformed U.S. Public Health Service with the Indian Health Division. I tagged

along there and did work in the Indian Hospital for a period of time while we were there. Then, from there, we went to New York where my husband did his psychiatry training and from there to Minnesota, and we've been here ever since.

[chuckles]

DT: What led you to go into nursing?

SE: That's a good question. I don't know. I was of the era where girls either went into nursing or into teaching. I joke that I couldn't make up my mind, so I did both.

[laughter]

It just felt right, I guess. I applied at Saint Olaf, and, at that time, we could go directly into the nursing program. There were times when I considered doing medicine, but then thought, no, I really needed more direct contact with patients than I'd foresee myself having in particularly a primary care role.

DT: When you made your decision to go to Saint Olaf, was it just a natural assumption that you would do the baccalaureate? Was there any kind of decision about whether to do a diploma first?

SE: No. No. I knew I was going to college... I was high school valedictorian and so on, so the idea of going directly on to college was sort of pounded into me.

[chuckles]

DT: Of course, the diploma schools, I guess, were kind of phasing out at that point.

SE: They were still going strong, but the handwriting was clearly on the wall; although, what did I know, at that time?

DT: Then, your decision to go straight on for the master's, you knew that you wanted to have an academic career?

SE: I knew that I wanted to go on. We knew that, Phil, my husband, was going to be in some small area for the two years after that. So it was sort of a case of do it now or wait for three years or so, so I decided to do it right away. It generally was a good experience; although, I discovered that the University of Washington, at that time, wasn't used to those of us who had come up directly through the baccalaureate route. So much of what we did as masters students, I had already done as a baccalaureate student.

DT: So they were more used to the diploma students?

SE: Yes.

DT: Did you specialize in maternal and child nursing?

SE: That's right.

DT: What was your reason for doing that path?

SE: I was always interested, I guess. It was just a natural interest. It was sort of the assumption that when you're working with young families like that, you can have a bigger impact over a period of time.

DT: As you said, you already knew you would be going somewhere rural, to a small town...

SE: Right.

DT: ...so that's something that would be a need.

SE: Yes.

DT: At that time, there was a lot of concern about shortages of nurses. Did that impact you, too? Were you aware of those concerns about nursing shortages?

SE: Not really. I was a little naive about that, although, I was able to benefit from the federal program that was trying to increase the number of nurses with graduate degrees. I had a traineeship that covered a stipend, tuition, books, and all. So I made about as much being a graduate student as if I had been working. That was interesting. [chuckles]

DT: Yes.

SE: No longer is that the case.

DT: Was that the Nurse Training Act that passed in 1964?

SE: Yes.

DT: That was good timing for you.

SE: Yes, it was.

[chuckles]

DT: Can you discuss what it was like when you worked as a staff nurse? You mentioned the Indian Hospital but also Pierce County Hospital in Tacoma.

SE: In New York. Not Pierce County Hospital but in Pierce County.

DT: Oh, in Pierce County. Okay.

SE: By that time, we had two young children, so I worked as a substitute nurse, because the residencies for my husband, at that time, were absolutely grueling. I wouldn't see him for days on end. It's a much more sane method of training doctors now than it was at that time.

DT: What was his specialty? Psychiatry?

SE: Psychiatry, yes. Then, he did a fellowship in child psychiatry, as well.

DT: What were your experiences working then as nurse? What were your interactions like with physicians, for example?

SR: At that time, nurses were really viewed as handmaidens. I'm naturally sort of reserved and didn't rock the boat too much. I wasn't in the positions for a long period of time. I really had relatively little clinical experience before I got into education.

When we came back to Minnesota, we settled in South Minneapolis, because I knew...I *knew* I was going to be teaching at Saint Olaf College. I don't know how I knew it, but I just knew it.

[chuckles]

SE: So this was a convenient location for that sort of thing. So I guess I knew I was an academic when I was an undergraduate.

DT: Did you find that you were encouraged to pursue that by...?

SE: Oh, definitely. Definitely.

DT: Because of all the nursing shortages, there were particular concerns about a lack of faculty, needing more nurse educators?

SE: Yes, I guess so.

DT: Can you talk at all about what you and your husband's experiences were like? Was it Philadelphia, Mississippi? Is that where you were?

SE: Yes.

DT: You mentioned that was during the height of the Civil Rights Movement. Can you comment on your experiences there?

SE: I'd spent some time in Africa, and I often say I had more culture shock going to rural Mississippi than I had going to Africa. The segregation was in full bloom in Mississippi.

There were three castes: the white people, the Indians, and the blacks. There was a gross discrimination against both the Indians and the blacks, although less against the Indians, which was true in that part of Mississippi, but not in other parts of the South. The Indians were treated like white people, but not in Neshoba County. So it was a culture shock.

We were adopted by a small Episcopal mission while we were there. My husband is a musician, so he played an organ for them. Those were the only folks in the town who had really spent much time outside of the county, to say nothing of the state. So it was a pretty inbred, isolated kind of locale. That, too, was a bit of a shock.

I remember one of our neighbors, a lawyer, took my husband to see their new hospital and was very proud of the hospital. He said, "You see everything is the same in the white section as in the black section, except for the smell," that kind of blatant crap. We found a poster on the bulletin board in the courthouse that was recruiting for the Ku Klux Klan. If I walked down the street, black people who would be approaching me would get off the sidewalk until I had passed. These sidewalks were built up like two to three feet off the road.

I remember one instance particularly. After our first son was born, I was out in the front yard with him. We lived right on the edge of town where the government houses... The pavement ended at the end of the government houses and it was a dirt road from there. Black people would walk into town to do work as maids and that sort of thing. This woman, whom I'd seen many times, stopped. Having little kids and dogs is a great way of starting conversation.

[chuckles]

SE: We were chatting for a while and, then, she suddenly stopped and began apologizing. She said, "I lived in Missouri for a while, so I learned how to talk to white folks." I said, "You don't have to apologize." I was embarrassed, and I was *grieved* by the whole experience. That stuck with me for a long time.

DT: Yes. What were health conditions like for the different populations?

SE: We saw a lot of endemic infections. Parasites were common. About half of the Indians had outhouses; the others had nothing. So the parasites kept circulating. Some of the healthiest, best-nourished kids were the ones who were hospitalized, because they got good food while they were hospitalized. The only milk that they had, because they had no refrigeration as a rule, was powdered government milk. If you've tasted that when it's not cold... So the kids were drinking coke. There was malnutrition. Parasites. I remember these big institutional size jars of round worms that had come out of a little kid. It was pretty disgusting.

OB [Obstetrics] was just a nightmare. So many of these women would bleed after delivery. We never could figure out, was this a nutritional thing? Was it a genetic issue? Or what was it? They'd had prenatal care...not a lot, but they had some prenatal care.

Yet, we were always on pins and needles when there was a delivery coming, because of the tendency to bleed. And there was no blood bank. When they needed blood, they'd send a taxi driver to Jackson, which is about ninety miles away, to get blood. Fortunately, most of the Indians were the same blood type so they kept one unit or so on hand at the hospital, but that was about it.

DT: The public health service that I guess both of you were working for, were they making particular efforts to kind of change things or was it just more kind of maintaining things the best you could?

SE: It was part of the Indian Health Service. We did some rural clinics, but mostly it was primary care kind of service and then a hospital, which was pretty low-level hospital work. There was no surgery.

DT: If they needed surgery, they had to go to Jackson?

SE: Jackson.

DT: The Civil Rights Act was passed when you were there. Did you notice any change once the Civil Rights Act had been passed?

SE: No. Not, really. There's been a big change now, we understand. We've not been back. I'd be terribly curious to go back. Now, the Indians have a casino, and they also have some kind of manufacturing, so, now, the Indians are hiring white people. So it's quite a reversal of the old pattern.

DT: That must have been quite an experience to be down there.

SE: Oh, yes, it really was. I'd go into a store and they'd notice my age and my accent and *assume* that I was one of those Yankee agitators. I'd never thought of myself as a Yankee. I always thought of people from New York as being Yankees, but not people from Minnesota. When we'd go in, and they heard my accent, they'd say, "You just passing through?" [chuckles] But when they found out that we were with the Indian Health Service... That was one of the biggest payrolls in the town. It was a *very* poor county, that area.

DT: That improved people's attitude toward you?

SE: Oh, absolutely. Then we were okay.

DT: Did you see any civil rights protests while you were there?

SE: Martin Luther King Jr. came to the march through Philadelphia when we were there, but other than that, no. It was too dangerous. Voting activities were going on, trying to get people registered to vote, and that's why the three Civil Rights workers were

murdered. We weren't involved in that. There were church burnings and crosses on lawns and that sort of stuff.

DT: That's quite a contrast to Minnesota.

SE: It certainly is.

DT: I realize that the time you'd spent in Minnesota until that point had been as a student, but I wonder if you had any sense, and certainly when you returned to Minnesota, of how differently Indians were treated in Minnesota to Mississippi.

SE: Well, there's still a good bit of prejudice against Indians here. We've done some projects in the schools trying to help Indians become nurses and, then, progress in the graduate programs. So we've become much more aware of what their needs and so on are. But there's still a lot of subtle prejudice against the Indians. Some of the same issues of malnutrition and infectious disease are true here, not to the same extent. We don't have the parasites. It's too darn cold for parasites.

DT: Yes, they're sensible; they go elsewhere.

[chuckles]

DT: When you moved back to Minnesota, what was it like teaching? You taught at Saint Olaf then for a number of years?

SE: Yes. Right. It was like going home to my alma mater. The director of the program, at that time, was interested in having young, married women on the faculty to be a role model for the students, to encourage them to continue with their education and that sort of thing. So that was good. I enjoyed my time there a lot. I really did. Also, in doing the clinical practice, I worked with students in the OB area and realized that there were major policy and financial issues that needed to be fixed in order for us to actually give the kind of care that I thought we needed to give.

So that's when I began looking around for doctoral programs. I left Saint Olaf and went into the program here. It was called Hospital and Healthcare Administration with a big emphasis on health policy, health economics, and so on.

DT: What were those major issues that you identified? What were those financial and policy issues that you saw?

SE: The whole prenatal care system, but mainly the post delivery system of providing parents with learning how to *be* parents and some of the issues that came up around that were what concerned me. There were no ways of paying for that.

DT: Before we go on to your experiences in graduate school, I'm curious about that comment that you made that the Saint Olaf Department of Nursing wanted young,

married nurses to come back and teach. Were there particular expectations of women at that time? This was, what, the early 1970s? There was still that expectation that once a woman married, they would leave the workforce, leave the field?

SE: Oh, wow, yes. There was a lot of that that went on. At that time at Saint Olaf, women were considered secondary breadwinners and pension benefits and that sort of thing went only to the primary breadwinner until one of my colleagues and I pointed this out to our program director. She, then, brought this to the attention of the president and they changed that policy. But, then, it was about time for me to leave.

[laughter]

DT: That's significant that the system was set up in that way.

What led you then to come to the program at Minnesota to do your doctoral work?

SE: I looked around. There wasn't a Ph.D. program in nursing. We were sort of place bound at that point. This one seemed to meet my needs for looking at some of those policy and economic issues that I was interested in. My goal was that I would spend the rest of my career doing health services kind of research.

DT: That Hospital and Healthcare Administration program here had a very good reputation at that time, as I understand it.

SE: It still does.

DT: Well, yes. [chuckles] I'm wondering, what other students were in the program with you? Were there other nurses? Who else was there with you?

SE: I had one classmate who started at the same time that I did. He never finished the degree. I was one of the first nurses. There were several who followed me in the next several years, but if I wasn't the first, I was certainly one of the first nurses in that program. I remember a comment such as one of the program directors saying to one of the masters student men that, basically, I didn't *have* to work. I didn't *have to have* a career because I had this husband to support me. It was just...uhhh!

[laughter]

DT: Not necessarily in Hospital and Healthcare Administration, but within the School of Public Health, at that time, there were a number of female faculty.

SE: Oh, yes. Yes, particularly in Maternal and Child Health and in what's now the Division of Community Based Services. I'm not sure exactly what they call it.

DT: Epidemiology and Community Health or something. I'll get the full name.
[correct]

SE: There weren't too many in Epidemiology at that time; there are now.

DT: Yes.

SE: In fact, we have several here who finished the Epi [Epidemiology] Ph.D. and, then, we hired them here.

DT: Even though they weren't in Hospital and Healthcare Administration, was it encouraging to see other female faculty in the school and to see them as potential...

SE: We didn't really see them. We were pretty isolated as a program.

DT: Can you comment on some of the notable faculty that you worked with in that program?

SE: Well, Vernon Weckworth was my advisor. You've probably heard about Vern.

DT: I interviewed him, in fact.

SE: Did you?

DT: Yes.

SE: Ohhh, that must have been a treat.

[chuckles]

SE: A lot of people thought I was a little crazy selecting him as my advisor, but an absolutely brilliant guy, a little rough around the edges, but... He gave a lot of students a lot of grief, but he didn't give me grief, and I could never figure out exactly why. Was it that he thought as a psychiatrist's wife that I would analyze him, or if it was that we were both from the Evangelical Lutheran Church in America, if we had that kind of a common background, or if it was my rural roots, or what it was. He would be brutal with some students in class. He never was with me. I was always puzzled by that.

DT: Were there other faculty that stood out to you?

SE: The other principal faculty member was Ted [Theodor] Litman. I don't know if you've interviewed him?

DT: No, but I should. He's still around?

SE: Yes. He did a lot of the medical sociology policy courses; that's his specialty. We always joked that Ted never culled his reading list. He just added to it, so that in

preparing for preliminary examinations, we had these *mountains* of literature to go through.

DT: What was your dissertation on?

SE: I worked with the project here in the School of Nursing that was a radical idea at the time of caring for children who were dying of cancer at home, the Home Care [for the Dying Child], Ida [Martinson's] project.

DT: Yes.

SE: What I was interested in is, how was that decision made? So I interviewed and worked with the parents of the children who had died and with their physicians to look at what were the decision-making processes that they used to come to those decisions. It was a very rich experience. I was trucking all over the state to meet with these parents. I think my interviews were as much therapy as they were investigation, because some of them commented, "This is the first time anybody has really talked to us about that experience." It was interesting.

DT: Do you recall how, generally, the parents and then the physicians felt about the program and about their decision to put their children in that program?

SE: They were all very pleased with the results. The kids wanted to be home. They wanted to have the kids at home. Ida had set up systems so that there was support from local public health nurses or clinic nurses who would come in, so we had people in *Alaska*. I didn't go there to interview; although, that would have been fun. [chuckles] The arrangements with local nurses who could go in and help... We really saw the parents as being the primary caregivers and doctors and nurses and therapists and so on as being consultants to the parents in helping them manage some of the symptoms and problems that arose during the dying process.

Then, issues arose such as a child dies at home and, then, you have to call the police. That was just not the time to be having police coming and investigating this death. So they began making arrangements with the police department. We anticipate this death coming. It's going to be at home, all of that sort of thing.

DT: Were the police responsive to that?

SE: Oh, yes, generally.

DT: In all the interviews you conducted, did you talk to families who chose not to put their children in the program, chose to have them die in the hospital?

SE: No. I just used those who had been in the program. There were a few children who actually did die in the hospital, because the parents weren't able to continue to manage them at home. But that was rare.

DT: The physicians that you spoke with, they were supportive of the program, too?

SE: Yes. It was just a relatively small cadre.

DT: When I interviewed Ida about it, I was blown away hearing the details of the program and how valuable it seemed to be for all of those involved...

SE: Oh, absolutely, yes.

DT: ...for the children in particular.

SE: Yes. She's one of these individuals who is an idea a minute...less effective with the follow through...

DT: [laughter]

SE: ...but very good with the initial ideas.

DT: Did you then publish the results of...?

SE: Yes.

DT: Homecare for the Dying Child seems to be incorporated elsewhere.

SE: Oh, yes. It's sort of standard practice now.

DT: Do you feel like the work that you were doing was...? It sounds like it would have been really helpful to pushing the program forward, and getting it talked about, and incorporated elsewhere.

SE: I don't know to what extent it had a big impact, but it was good.

I do remember, though, that I had done most all the data collection and I was working on the final paper and in about April, Ida said, "I'm going to China for a year in July. If you're not done with your dissertation by then, you'll have to wait a year 'til I get back." So talk about motivation!

[chuckles]

SE: I got that baby done before she left.

DT: Now that I'm several years out of my doctorate and on the other side of it now advising students, you do realize that so much is about setting, purposely or not, those deadlines.

SE: Yes.

DT: Sometimes, that's all you need to get it done and out of the way.

SE: That's right.

DT: You were also an instructor then in what's the Independent Study Program [ISP]. Is that right?

SE: That's right.

DT: That was another recent innovation, it seems like.

SE: Yes.

DT: Can you talk about that program?

SE: Vernon said it was for the smart peasants, those people out there who had been hospital administrators, but didn't have the training for it. So there were a series of courses that were done by distance. It was a paper and pencil kind of distance strategy. Then, they would come to campus a couple times a year. A lot of it was the basic kind of management stuff. Then, the final year was one where he enlisted us as doctoral students to be the faculty. So we did units on social policy, on health economics, on...oh, golly, I can't remember all the areas, but there were about four areas. We were each required to do that. Many of my colleagues objected to that. It was *slave* labor, blah, blah, blah. I had more teaching experience than anyone else in the program and, yet, I thought it was very valuable to do that. So I did my year.

Then, Vernon asked me to stay and be the coordinator for another year, so I did that another year. Then, one of the other doctoral students sort of lost out of the program and he brought me in to do that unit, to finish up for him. So I did three years in that program.

[chuckles]

SE: It was a good experience. I'd get phone calls at seven o'clock in the morning from Grand Cayman Island, "Tell me again, what is a p-value?"

[laughter]

SE: It was an interesting experience.

DT: So for most of that year then, it was this paper/pencil correspondence at a distance, and, then, they would come to campus. Now, we think of distance learning all online and it's not without its difficulties also, but I'm curious, how does one manage that kind of distance learning with just paper and mail service?

SE: Well, it worked. There was the telephone; we did use the telephone. Then, we made good use of the time when they did come on campus. They were here for a week or a little more, I think, during that time.

DT: How common were these distance-learning programs.

SE: It was very new, very new. Vernon was a real pioneer in this area.

DT: I know I asked Vernon these questions... Actually, I was looking over the interview with him yesterday in preparation for this. But I can't quite remember now where the funding came for the ISP.

SE: It was basically self-funded, tuition income.

DT: He had said he faced some kind of resistance to the program from other faculty members.

SE: Oh, yes, forever.

DT: Are you able to elaborate on why some of the faculty were, maybe, opposed to it?

SE: I wasn't that intimately involved with the faculty, so it's hard to sort out how much of it was irritation with Vernon as person or with the concept of the program. But, clearly, they've phased it out completely now. It's a real source of pain for him, I think, to see that happen. I think there was some suspicion about the quality of the program. In fact, I did have a question about the quality of some of the work that I saw students doing, especially compared to nursing students. But, it filled a very important social need at the time, I think.

DT: I guess there's always that overhanging concern that if a program is entirely tuition dependent and dependant on you getting the students in and, then, being satisfied...

SE: Yes, yes.

DT: I initially thought it was just with residents of Minnesota, like outstate residents, but it was an international program, too.

SE: One year, I had a student in Grand Cayman and one in Vancouver, Canada. We did use the telephone for some of those p-value questions.

[chuckles]

DT: Then, you were appointed as assistant professor in the School of Nursing in 1979. This seems, maybe, like an obvious question, but what led you, then, to transition to the School of Nursing?

SE: I was recruited. I was recruited for the Nursing Administration Program. I said, “I don’t know anything about nursing administration. I’ve never been a nurse administrator.” They said, ‘Well, you’re getting a degree in it!’ They said, “Besides, Isabel Harris”—who was one of the former deans of the school—“runs the program and she can be your guide and help you get started with it.” Well, I was not here eight months, and she announced her retirement. Welcome to the University of Minnesota.

[laughter]

DT: You had eight months to learn on the job.

SE: Right. I did work in that area pretty much solo after Isabel left, pretty much solo for four years, I guess, four or five years.

DT: When you joined the faculty that was in the midst of the graduate faculty trying to establish the doctoral program in nursing.

SE: That’s right.

DT: Given that you had a doctorate...

SE: That’s why they wanted me.

DT: Yes. Were you involved...or what was your sense of... It took them six years to get the doctoral program established. Can you reflect on that at all?

SE: I was really not involved with it. I was a real sideline kind of person, supportive, but skeptical about... The questions that kept coming up during that six-year period were, is there sufficient knowledge to warrant a doctoral degree, do you have faculty with the right kind of preparation, and so on? Marilyn [A. Marilyn Sime] probably told you about the strategies that were used in order to overcome some of those questions. So it was interesting to watch.

DT: It is interesting, given the order of the faculty with Ph.D.s, that none of them were in nursing, because there were so few nursing doctoral programs.

SE: That’s right.

DT: Yet, each one of you potentially brought together a different body of knowledge depending on what you got your training in. So it does present the boundary issue, kind of what are the boundaries of nursing knowledge.

SE: That was less of an issue, I think. It certainly was for me. Yes, I’m not sure that that was a big issue.

DT: I think I remember seeing that Vernon Weckworth was quite supportive of the...

SE: He was. Yes. We were the peasants he was helping.

[laughter]

SE: He and Doug [Douglas] Wangenstein and Bob [Robert] Veninga all had appointments in our graduate program, which helped to move it over the top in terms of adequate faculty.

DT: I saw that the school had gotten a good amount of funding from...

SE: It did, federal.

DT: ...the federal government to enact or to at least look into doing the doctorate.

SE: Yes.

DT: You said you were on the sidelines of it, but I wonder if there was any discussion at that time about whether it should be a Ph.D. or a professional doctorate.

SE: The only thing was Ph.D. at that time.

DT: Once it was established, can you talk about those early years of the doctoral program? You were involved in teaching presumably within the doctoral program once it got enacted?

SE: Yes. I'm not sure how much of this should go into a permanent record, but there were some real philosophical differences within the faculty about what constitutes doctoral education, Ph.D. education in particular. My sense was that most of the faculty thought of it as the master's degree, only more so. So the notion of having faculty with research programs that could then be a source for supporting graduate students or helping them or getting them involved in their research activities was really foreign. There were just a couple of people who had any kind of external funding, so students were sent out and developed their own projects like a master's thesis, only more so. I think there were some good papers that were done, but it was not the model of doctoral education that I had in my head—not that I'd had that model myself.

DT: [chuckles]

SE: But it was what I thought it needed to be, that the best model of Ph.D. education was to have faculty with their own programs of research that students could then work in and learn along with their faculty member. So there were those kinds of philosophical differences.

DT: Now that you bring that up, I remember in reading the documents, some of the Nursing School archival material but, also, some of the discussions of some of the other committees outside the School of Nursing, that that was something that kept being asked of the doctoral committee, the people who were putting together the doctoral program: does the faculty have a strong enough research program? So that speaks to a concern that had been raised all along.

SE: Yes. Yes. Right.

This was the era of the grand theories in nursing. I never could figure them out.

[laughter]

DT: I've heard of that before, but can you elaborate on...?

SE: Ohhh. In my mind, they were more philosophical statements than they were theories. I was looking for, okay, how can you reason from this theory down to get a proposition or a hypothesis or whatever it was? I thought I was talking French or something. It just didn't resonate with a lot of the other faculty members, so we had some disagreements about things like that; although, here I was a lowly assistant professor and couldn't mouth off too much about those things.

DT: Are you comfortable saying who you saw as kind of intellectual allies then on the faculty at that time, who kind of shared your view of graduate education?

SE: There weren't very many.

[chuckles]

SE: There really weren't.

DT: How did those tensions get resolved or were they ever resolved?

SE: They weren't, I don't think. Some strategic resignations and retirements helped *a lot*. Most of those occurred after I became dean. I don't know if they just knew that we had those philosophical differences and they were going to take the exit or if it was just time for them. They were of an age where they...they were in their middle to late sixties, so it was a natural time for retirement. It sure made a difference. [chuckles]

DT: These kind of philosophical, intellectual differences and kind of attitudes towards what nursing doctoral work should be was that something that was unique to Minnesota or was this something that you saw happening in the field more generally?

SE: It was probably a little more general in the field.

After I became dean, I was asked to chair a task force at the American Association of Colleges of Nursing on the quality indicators of doctoral education. That came up because there were a number of us from major research universities like this who were a little bit alarmed at the number of Ph.D. programs that were growing up where they had very few faculty members who were prepared to teach in those programs, little research going on, just real quality concerns. So these quality indicators were intended to provide support for people who were trying to develop high quality programs. We hoped that they would help people decide whether or not they were ready for doctoral education in their universities. I don't know to what extent that happened, but the document was successful and has been used a lot, probably updated again. We did things such as: is there a central body for receiving and managing grants within the university? Are there library resources that are needed? Those kinds of structural things in addition to the intellectual work within the unit...

DT: Why do you think there were an increasing number of doctoral programs but a question of quality? Do you have any sense of why that was?

SE: It was sort of Ph.D. creep. Schools thought that they needed to do that for prestige reasons, to be competitive. All of those sorts of things were going on.

DT: In the 1980s and also during your tenure as dean, who did you see as the school's peer institutions? Who were the peers that you thought were doing a good job?

SE: The Big Ten [Indiana-Bloomington, Michigan State, Northwestern, Ohio State, Pennsylvania State, Purdue, Illinois-Urbana Champaign, Iowa, Michigan, Minnesota, Nebraska, and Wisconsin-Madison], obviously, were. At this time, the University of Washington had become very strong and was developing the kind of research programs that I thought we needed to develop and the University of California-San Francisco. Those were sort of the models. The University of Pennsylvania a little bit later, probably.

DT: It's interesting. One of the things that's easily noticeable about your tenure is that in those thirteen or fourteen years that you were dean, there were a number of research centers that were started in the school. Is this what the impetus was for setting up those centers?

SE: It was partly that, yes. But there were also faculty who were growing up around particular areas of study, gerontology being one of the first and, then, maternal/child kinds of issues, children with special healthcare needs and adolescent services. It was sort of a joint... The faculty was coming up with the ideas and I was, *yes*, right there with them, in terms of supporting them.

DT: It strikes me that those were areas that had long been a strength of the school.

SE: No, they weren't.

DT: Oh, they weren't? Okay.

SE: There was one incident. A request came out for an exploratory research center and Sue [K.] Donaldson, who was here at that time, brought us all together. This is long before I was dean—not long before, but it was before I became dean. She brought us together and said that she'd been looking around and she thought that the major area of strength that would make this a winning proposal was gerontology.

Cynthia Gross, who has a joint appointment between Pharmacy and here, had this wonderful analogy. She said, "There were those who had blue chips and I've *always* worked with blue chips and they said, 'You *cannot* force me to work with a red chip.' [chuckles] 'It's my academic freedom.' Then, there were those with their red chips who said, 'I always worked with red chips but maybe if I worked with a blue chip, I could get a purple chip and we could be...'" It was just a perfect analogy.

There were some people who decided they couldn't be a part of that. Then, there was a whole bunch of people who did come to together to make a winning proposal.

DT: Going back to when you first joined the faculty in Nursing and you were, essentially, put in charge of the Nursing Administration Program, what did you see as kind of the major challenges there or some of the issues you had to contend with?

SE: [pause] I'm not sure that there were major challenges. It was sort of what I would expect from an academic position. I was trying to get some research going, so that was probably the major challenge, trying to figure out how to get this. So much of the work we do requires use of human subjects and, then, by definition, that gets to be real expensive fast, so you need extra moral support for that. So I was working on that, as well. That was probably the biggest challenge.

I did a lot of work trying to introduce things. I remember trying to introduce spreadsheets as a way of doing analyses for administrators. The students in the class *moaned* and *groaned*. When the first group graduated, I got one of the thank you teacher cards. They had one of the students write the message in Chinese and it said that was *my* program.

[chuckles]

SE: It wasn't Excel at the time. It was another spreadsheet program that I was using. So they got their point across.

[laughter]

DT: When you first started working in the nursing administration, in that program, were you looking at other programs nationally to get ideas about how to teach nursing administration?

SE: Yes. There was and still is an organization, Council on Graduate Education for Nursing Administration, and I was quite active in that for a while.

DT: You mentioned human subject research and kind of the expense of that. I think about when you were doing your doctoral work, too, that this was in the early years of the Institutional Review Board [IRB].

SE: Absolutely, yes.

DT: So the IRB was already in place when you started your doctoral work?

SE: I think so. To tell you the truth, I don't remember.

DT: Do you remember what it meant to put your work before IRB? Can you reflect on that process at all?

SE: Do you mean later on?

DT: Yes.

SE: It just made good sense to me that we would do that kind of approval process. In working with students, the issue always was, to what extent is this review a protection of human subjects or the scientific merit of the program? Trying to keep that sorted out was sometimes difficult. But I have no problems with that process.

DT: I guess it would be interesting to ask someone who had done human subject research before IRB and then afterwards to see what the difference was.

SE: Yes.

DT: You were there right at the beginning of the IRB process one way or the other.

SE: I think I probably came in under Ida's project.

DT: Yes.

SE: I don't remember having to do anything really special.

DT: You've talked, obviously, about the need to get research funding. Where were you applying for funding, for research funds? What was your source of funding for your work?

SE: My background was, of course, in maternal/child nursing, but when you're looking at hospital services, by default you're looking at old folks in a hospital.

[chuckles]

SE: I applied for some funding from the Retirement Research Foundation, which was a private group that supported much of the work that I did. Then, one of my doctoral student colleagues had been doing some work in self-care of the elderly, community-dwelling elderly, and she asked me if I would work with her. So we did that. We created our own project working with community-dwelling elders in the Twin Cities area.

DT: Was that the Block Grant, the Block Project?

SE: Block Nurse? No.

DT: That was something else. Okay.

SE: This was self-care... What did we call it? Self-care of symptoms among the...community-dwelling elders... I've forgotten exactly the title that we used. The Retirement Research Foundation, I think, was the one that sponsored that work.

DT: Did you continue to have interaction with the Hospital and Healthcare Administration Program?

SE: Not really.

DT: I'm just thinking of Ruth Stryker Gordon's and I guess Ken [Kenneth] Gordon's... I guess those were more about...

SE: Nursing homes.

DT: Nursing homes, yes. They set up that program, but that's a little different.

SE: Yes.

DT: When you joined the faculty here, that was also in the midst of securing funding to build Unit F or this Weaver-Densford Hall. I wonder if you had any insight into the process because, again, there were efforts to get that money.

SE: That had happened before I joined the faculty. I was hired by Irene [G.] Ramey in the spring of the year. She was the one who had gotten that funding. She and Larry [Lawrence] Weaver were instrumental in that. By the time I joined the faculty, she had died [Irene Ramey died on June 28, 1979].

DT: Inez Hinsvark was the interim dean when you got there?

SE: Yes.

DT: What was she like as interim dean?

SE: I was pretty green and pretty naïve. She seemed to be fine as far as I was concerned. I remember there were others who...really?...because of her experience at [University of] Wisconsin [Madison] and other places. I had no difficulty with her.

Then, she was succeeded by Ellen Fahy, who was a character, a real character. She brought me into her administration as an assistant dean while I was still an assistant professor. Looking back on it, that was a stupid thing for me to do. I just didn't have the background and I didn't have the credibility with the rest of the faculty that I should have had. I did that for two years. Ellen was sort of peripatetic. She was an actress. If you'd get her on a stage with a bunch of other deans, she'd absolutely steal the show.

[chuckles]

It was fun to watch her.

DT: I realize she was actually an actress, but it's funny that's what everyone says.

SE: Yes.

[laughter]

DT: I think I've heard from others, that she could be quite harsh, too, that she could tell people off.

SE: Oh! No doubt she could. Yes, she could.

DT: It's interesting to have an assistant professor appointed assistant dean. Do you have any sense of why she put you in that role?

SE: She and I were of a similar philosophical stripe. We, frankly, had struggles with some of the faculty. They tried to get her fired, tried to get a vote of no confidence. It never went anywhere, but they tried that. I think she saw me as an ally.

DT: Did you, then, encounter some resistance from your colleagues for being in that position? You mentioned not having the kind of credibility, because of being an assistant professor.

SE: Well, the director of graduate studies, at that time, controlled the data. I was the assistant dean for graduate studies. The director of graduate studies controlled the data, and I could never get my hands on data, which frustrated me to no end. I would have these anticipatory headaches on Monday when we'd have these meetings of the faculty around graduates. It was terrible. It was really a grueling experience.

DT: I'm trying to remember... Who was director of graduate studies at that time?

SE: Marilyn Sime.

DT: I knew it was one of them. Okay.

SE: She really kept it like this.

[chuckles]

DT: I didn't go back and reread her interview. I think she was probably one of the people who commented on Ellen Fahy. She wanted to keep control of the data because she was concerned about... Did she have tensions with Fahy?

SE: Oh, yes, of course. Yes.

DT: As you say, you were one of the few...

SE: Yes.

DT: It sounds like, then, she was really keen to get the faculty research-oriented?

SE: She was the one who was in charge, was dean, when the doctoral program was finally approved. She saw folks like Sue Donaldson, who was a born and bred experimental researcher, very much of that ilk... Then there was...what's her name...who was also well-known, has her own theory of nursing, which I never did understand. I still do not understand it.

[chuckles]

SE: Anyway, the two of them were at sixes and sevens all of the time. Ellen rationalized the appointment as a balancing act between those two opposing views. Well, it was pretty disruptive.

Margaret Newman was the...

DT: Okay.

SE: Sue took after Margaret at a national meeting.

DT: Wow.

SE: It was something about her data or something. It was a very embarrassing kind of thing for everyone who was there, but she did it.

DT: That sounds tense.

SE: Ohhh...yes.

DT: It's always, obviously, valuable to get multiple perspectives on any situation, but, also, on individuals, too. I have spoken to Floris King on the phone, but she decided not to go ahead with an interview, but she had commented that when Ellen Fahy came in as dean, she kind of took over the committee to get the doctoral program started. Floris King had previously been chair, so had felt kind of pushed out. Hearing your perspective on things, I wonder if that was less about a control issue...that others may have perceived it as more about trying to get her philosophical view implemented and get the research agenda pushed in.

SE: Well, I think there were some personality issues between the two of them, to tell you the truth.

DT: The efforts by some of the faculty to kind of have a no confidence vote on Ellen Fahy and to get her fired... At what point in her tenure was that?

SE: Probably about midway through. I don't remember exactly what the dates were.

DT: I understand you may not be comfortable elaborating. But I'll ask the question anyway and you can elaborate as much as you care to. What were their reasons for trying to get her out?

SE: I never was really clear.

DT: It's interesting. This is the issue where there's no archival material to kind of give perspective on this.

SE: Would that go in the Archives?

DT: That is always the question. What's interesting about the school's history is in the 1960s, Edna Fritz, who was the director then, had encountered similar strong opposition from within the faculty and they succeeded in getting her fired.

SE: Would you believe we bought her house?

DT: Oh, you did?

SE: Yes. When we came back to Minnesota, we bought her house.

[chuckles]

DT: I hope it wasn't jinxed. Well, clearly, it wasn't.

SE: I walked in and we'd been gone for seven years and I said, "Aren't you the dean of the School of Nursing?" "*Former dean.*" I thought, oh, well, we'll just move on to another topic.

[chuckles]

DT: There's a good amount of archival material about it, but no clear sense of why, why there was opposition. Then, talking to people, a lot of the faculty who had been most vehemently opposed to Fritz have since passed away, so it's been hard to get at that perspective. Hearing about the efforts to oust Fahy resonates.

SE: That didn't go very far.

DT: Something that's been clear to me from the Archives is that in the 1970s, increasingly throughout the 1970s, there was a push towards regional planning in terms of the nursing workforce and about meeting the state health needs, particularly in terms of Montana and the Dakotas, as well. Do you have any perspective on those efforts to do regional planning?

SE: Not the planning so much, but when I was the assistant dean, we had an arrangement with North Dakota. We took some of our core courses up to them through distance strategy. Then, we also had some of their faculty. At that time, the National League for Nursing was requiring that faculty have a master's degree in nursing. It didn't matter if they had a master's degree in education or anything else. It had to be in nursing. So there was a group of them who came down here in the summertime to work on getting that master's degree in nursing. So I worked with them. A lot of them took my courses that summer. That program went on for a number of years.

DT: Was the collaboration with North Dakota the Midwest Alliance in Nursing?

SE: Ummm... No. That was a regional organization. I was quite active in that in Maine, but this was an arrangement between the University of Minnesota and the North Dakota Legislature.

DT: It seems like there were similar policies between the Medical School here and I think both North Dakota and South Dakota about the quotas allowing the North and South Dakota students to transfer in, so it seems like there was a model for that.

SE: Yes. We had outreach programs to Rochester, as well. Ellen asked me to look at that from a financial point of view when I was the assistant dean. It became clear that it was just incredibly expensive to do that, because we were transporting faculty up to Moorhead or down to Rochester. It usually meant overnight stays. Not only was it expensive in terms of out-of-pocket costs, but the time that was eaten up by having people drive those distances and so on. My analysis was one of the reasons for the demise of that program. [chuckles]

DT: As I understand it then... I think Ruth Weise had said that in the late 1970s, beginning then, she was doing a lot of outreach for the undergraduate...

SE: No, for the graduate...

DT: Oh, this was for the graduate.

SE: The master's program.

DT: So she was kind of part of this.

SE: She was it. She was really the mainstay. Good old Ruth. I first met her at the University of Washington.

DT: Oh, really?

SE: She was a student there at the same time I was.

DT: Oh, okay. I had a great time interviewing her.

SE: Yes, she's a character, another character.

[chuckles]

DT: She was fun.

With the demise of that kind of outreach and distance learning effort, did anything replace it?

SE: Not for a while.

DT: The impetus for that program in the first place was to increase the supply of nurses out of state?

SE: Yes. We just did those core courses that we took out. Some of those students did come here to finish their master's degrees.

Then, along somewhere in the 1990s, we got a federal grant to develop a program for public health nurses, to get together leadership people in public health. That was done in Duluth and Rochester.

DT: These efforts, these kind of more regional or statewide efforts to increase education... I've seen this happening in the West, too. California was part of the Western Interstate...

SE: WICHE [Western Interstate Commission for Higher Education].

DT: WICHE, yes. [chuckles] There were so many different names in Minnesota. I have here the Committee on Institutional Cooperation and the Agassiz Region Nursing Education Consortium.

SE: Agassiz was the one that was related to the North Dakota effort.

DT: Okay. At one point, I had all these names. I don't know who it was that I asked... Ida may have been one of the people and Marilyn, too. What do all these things mean? I've seen them in the Archives. There's a lot out there. The Area Health Education Center [AHEC], too, which I think was federally funded. Do you have any sense of what AHEC's role was?

SE: By the time I came on the faculty, that had disappeared for Minnesota. But, my first job at the University was as a research assistant [R.A.] for the director of the AHEC at the time. That was when I was a doctoral student.

DT: Was that Edith Leyasmeyer?

SE: Yes. I was her R.A.

[chuckles]

DT: Then, you were both deans at the same time.

SE: That's right.

DT: She was interim.

SE: We called her the intermittent dean. She kept coming back.

DT: I know. Three different times.

This began in the late 1970s, but it seems that there were growing concerns nationally about the costs of healthcare, at that time, and President [Jimmy] Carter was planning to veto, or maybe he did veto it, the extension of the Nurse Training Act. I saw discussion in the Archives that, obviously, that was a big concern to the school. In the early 1980s, there was lots of retrenchment and kind of budget cuts from the state, as well. Can you talk about that at all, what the impact was?

SE: The major program that ended at that time was... There had been—I've forgotten what it was called—direct funding to schools of nursing to increase the enrollment. There wasn't any kind of a plan for when that funding... Capitation funds. So the schools were awarded money based on the number of students that they added. Ellen knew from the beginning that that was going to go away, and it was a dangerous thing to rely on those funds. So she was prescient about that. That did go away about that time. It meant some reconfiguring of programs here and elsewhere.

DT: I don't know if this is exactly the same but in 1983, the school was asked by Neal Vanselow to develop a plan to reduce 0-100 spending by nine percent for the 1983-1985 biennium.

SE: Probably. It kept coming, you know. Sounds like the same song forty-third verse.

DT: Yes.

[laughter]

DT: It just happened that I had one file on this, but my sense of things is that throughout much of the 1980s, there was pressure to always cut the budget.

Another thing that you would have arrived in the midst of, and I assume it still continues today in one form or another, is this idea of the University getting interested in long-range planning and expecting each of the schools to be engaged in long-range planning projecting ten years out for what's going to happen. I know that the long-range planning that the school first did in the late 1970s provoked some kind of reaction or resistance from Central Administration.

SE: Oh, did it? Hmmm.

DT: It seemed to resonate a lot with some of the concerns that were raised about the doctoral program. There was one part where one of the administrators was saying the school had a lack of realism and there was defensiveness on the part of the nursing faculty.

SE: That was before my time.

DT: Yes. As assistant professor, you probably weren't involved in that.

Do you recall the University's "Commitment to Focus," which was started in 1985? Can you talk about that?

SE: That was a big planning strategy, of course. I think the school did some good work. I don't remember the details, but some good work at that time. Yes.

DT: I realize I had access to some of the minimal amount of archival material, so it's fine if...

SE: You had boned up in advance.

[laughter]

DT: I don't expect you to know everything I'm referring to but one of the documents that I saw from 1985 is that the "Commitment to Focus" suggested the school reduce its

undergraduate class size and focus on attracting graduate students. I think Fahy's response was, "We are already doing this. We're okay with that."

SE: In fact, we did, because of that reduction of Capitation Funds and so on. Yes, we had to reduce the undergraduate program.

DT: Was there a sense that the role of the main state university... Was there any kind of concern, if we're cutting undergraduate education, we're not doing what we should be?

SE: Yes. That continues to this day to be a concern.

DT: I guess part of what is interesting about the different kinds of nursing education is that the University was one of, well, maybe the only institution that was really doing graduate nursing education...

SE: Yes.

DT: ...whereas, there were other institutions in the state and regionally that were doing undergraduate nursing.

SE: Right. That was the rationale that was used a lot.

[chuckles]

DT: It sounds like you're saying that the school is still concerned, though, about not doing more undergraduate education.

SE: Yes. I think there are many of us who would like to really reduce the size of undergraduate program. It is very expensive. We have this new program, the Master of Nursing. The applications are way over the top. We could run the program just on that.

DT: Actually, I'm interested in this. I realize this is a fairly recent introduction, the Master of Nursing. As we're on the subject, can you explain what that Master of Nursing is and what the impetus was for introducing it?

SE: We started it while I was still a dean. We started it as a certificate program for those who had degrees in other fields who wanted to become nurses. We were getting a lot of inquiries about that. It didn't seem reasonable to put them through the whole baccalaureate program and come out with a bachelor's degree. So we experimented, basically, for about four years, I think, with the certificate. We could sort of test the market and test the viability of the program. It turned out that it was very popular. But the students also wanted a master's degree. They really didn't want another bachelor's degree. So I think it was after Connie [Delaney] came that we actually changed it to the Master of Nursing as an entry-level professional degree.

DT: How long is that Master of Nursing? Is it two years?

SE: No, it's about sixteen months, pretty intense.

DT: Not here, but I had a friend who had gone through—I think it was at Columbia University—I don't know if it was called Master of Nursing but the equivalent, kind of switching fields, and it sounded pretty intense.

SE: A lot of schools have done it as a second bachelor's degree.

DT: In 1985, the National Institute for Nursing Research was established at the NIH [National Institutes for Health]. What did you feel the impact was for nursing with that establishment?

SE: It was a recognition of nursing research at the federal level, and I think that was widely applauded all over. The funding has been...it looks like decimal dust compared to some of the other institutes, but it has done a great deal for the nursing research programs to get started and encourage faculty to look at other institutes, as well, that could potentially fund their work.

DT: Before the Nursing Research Institute, were the faculty applying to NIH, different institutes of the NIH?

SE: There was a center for nursing research within HRSA [Health Resources and Services Administration], so people would apply to that one. There was not very much money there. It was hard to get it.

DT: There was the sense that you could apply to, say, the National Cancer Institute?

SE: Oh, you certainly could, yes. A few nurses did who had that kind of credibility.

DT: It was based on their kind of research ability?

SE: Yes, absolutely.

DT: Given that nursing was at a disadvantage because it was working to establish itself and be seen as credible among other fields...

SE: Exactly.

DT: ...and make any applications to the NIH.

SE: People still say, "Nurses do research?" That continues today.

[laughter]

Well, yes, we've been doing it for forty years now, at least.

DT: I wonder if you could talk about the relationship between the School of Nursing and the public health nursing programs in the School of Public Health. This is something that I asked every nursing faculty member I've interviewed and anyone who is trained as a nurse but was Public Health faculty. I'm trying to understand why public health nursing was in the School of Public Health and what that meant for nursing education.

SE: Why it was in the School of Public Health, I don't know. I suspect it had to do with federal funding. There was federal funding to support public health nursing and the School of Public Health has always been eager to get that support. During Bob [Robert] Kane's tenure... Have you interviewed him?

DT: I haven't. He's on the list.

SE: During his tenure as dean, he, basically, organized public health nursing out of existence. There was a movement outside the school actually, among the public health nursing community, to oppose that and it became clear that that was not going to happen. He was determined. The year that I was the interim dean, Cherie Perlmutter was the interim vice president and Edith was an interim dean in Public Health. We worked out among us the transfer of the program of public health nursing over here to the School of Nursing. I don't know if we could have done it if there hadn't been so many interims. [chuckles]

DT: All interims, all female.

SE: Yes.

DT: Obviously, Bob Kane didn't want public health nursing in Public Health.

SE: He kept saying, "There's no such thing as public health nursing! There's no such thing as public health doctoring! Why would there be public health nursing?"

[chuckles]

SE: Sorry.

DT: No. That's difficult.

SE: Yes.

DT: I've heard that he is a personality, too.

SE: Definitely.

DT: The three of you worked on that transition together. Did you have support or any kind of opposition from the faculty in public health nursing or your faculty in Nursing or elsewhere, any kind of reticence about that move?

SE: I don't think there was much reticence within the School of Public Health, from the faculty there. But, there certainly was a lot in the public health nursing community who were afraid that we would turn into a nursing in the community kind of thing rather than an official public health nursing sort of model.

A good friend of mine, who happened to be the director of public health nursing at the [Minnesota] Health Department at that time, was one of the people who was sort of spearheading to save the public health nursing education program. So I recruited her to come here to start it. Her credibility won us *a lot* of support, because people knew that if LaVohn Josten was in charge, it will be a *real* public health nursing program.

DT: That was very strategic on your part.

SE: I'll tell you, I don't know what made me do it, but I did it. [chuckles]

DT: You mentioned that you didn't think it would have happened if all three of you hadn't been interim. What do you think about your interim status allowed you to make it possible?

SE: I got into that interim position sort of over my dead body. I did not want to be an administrator. I really did not. It wasn't until they threatened me with who would be appointed if I didn't take it that I said, "I give up. I'll do it."

I was intent on putting the school in the best position for a new dean to come in. There was the public health nursing issue, and there was an issue during that time following the Rajender [Consent Decree] decision when, across the Academic Health Center, people who had been in non-tenure track positions had the option of going onto the tenure track. We had a whole bunch of people here who were master's prepared who were teaching and they chose the option of going onto the tenure track but, then, coming off immediately, putting a hold while they completed their doctoral studies. This had been going on for *years*, and we weren't seeing any *progress* in terms of getting those degrees.

So another thing that I worked out with Cherie and the provost at that time was an arrangement so that we gave them a deadline, "You have to complete that degree within a certain number of years." I think it was five years that we gave them, or maybe it was fewer. Then, they'd go back on the tenure track. Maybe it was three years. I've forgotten exactly how many years we had given them. That really sped things up. A number of them left the University, but it was really tying us down in terms of developing the research program here to have all of those people who were, basically, not prepared to do the work.

DT: Yes.

You mentioned the Rajender Consent Decree. I wonder if there was any other impact that you felt from the Rajender decision.

SE: There were some modest adjustments in salary, but not that you'd take to the bank.

[laughter]

SE: Again, most of that controversy occurred before I came.

DT: What led to Ellen Fahy stepping down?

SE: She was just ready. I think she had sort of given herself ten years. Her husband [Paul Lett] had had a stroke. They wanted to do some other things.

DT: You were appointed as interim and you were interim for two years?

SE: For one year.

DT: Oh, for one year. Did you find your colleagues supportive of your appointment as interim?

SE: Ummm... They acquiesced, I think, would probably be the way to say it. I was an associate professor at the time. I was tenured, but I was still an associate professor, had just gotten a research project underway. It just didn't seem to fit with my goals, but, once I got into it, I decided that it really fit. I liked the work so I did that.

What was the question?

DT: I was curious about whether you had support among the faculty.

SE: I had to go up for promotion. I wouldn't have taken the permanent job without being a full professor, so I got a lot of support for that. Apparently, people liked enough of what I was doing. Maybe they thought they could manage me. I don't know.

[laughter]

SE: I was supported for full professor.

DT: Did the school have a national search?

SE: Yes. I put in my application at the eleventh-and-a-half hour.

[chuckles]

SE: I was really torn.

DT: You said that you had just started a major research project. Once you're a dean, I assume it's hard to get any research done.

SE: Yes, it is. Some people have been successful at doing it. I wasn't. I finished that project, but in terms of developing a new one, it was tough.

DT: Cherie Perlmutter was interim senior vice president and, then, was Shelley Chou the senior vice present after her?

SE: Shelley and Dick [Richard] Elzay shared the position for a year...the dean of Dentistry. In my first three or four years, I had like five...reported to all these different people, first Cherie, then Shelley and Dick and, then, [William] Brodie came and, then...

DT: There was [Robert] Anderson in between.

SE: Anderson, oh, yes, Andy Anderson.

DT: There was a lot of change and transition in the midst of this.

SE: Right. Then, Frank [Cerra] moved from being department chair to dean to vice president within like a year. It was just the most meteoric rise. All those experiences were good experiences for me. I got along well with all of those different folks.

DT: Before you were appointed dean, did you feel that there was much collaboration or conversation between the different units of the health sciences?

SE: No. There was rhetoric about interdisciplinary work, but not much action.

DT: Do you think that changed at all once you became dean? Did you see any change in the rhetoric or the action?

SE: Not really. One of the things that Frank developed that was just *so* valuable was the Dean's Council. It wasn't a data dump. He would bring issues that he was working on. We'd have discussions and, then, we'd actually come to some resolution and he implemented decisions. It was quite remarkable. So we developed quite a strong cadre of folks within the Academic Health Center and were really envied by deans in the other schools within the University. So there was a great deal of consensus about the need for interdisciplinary work within that group, but we kept running into all of these logistical roadblocks. We're not on the same calendars. We have different schedules. Our students are entering their professional program as undergraduates. Others already have degrees. There were all sorts of those kinds of logistical issues.

DT: Is your sense that those logistical issues can be surmounted or is it just that they're really hard to get beyond?

SE: They're hard to get beyond. We're doing some. I think the program that Barbara Brandt has started now with the first-year students through the first year... We're into the second phase of the project. Then, in the third phase, we'll get students together in clinical sites.

Frank and I, while he was dean of the Medical School, were PIs [principal investigator] on a project that was sponsored by the Kellogg Foundation for interdisciplinary work. We were looking at graduate medicine and nursing. We did that in the Phillips Neighborhood [Minneapolis, Minnesota]. Basically, I ran the project. [chuckles] Frank was too busy with other stuff.

[chuckles]

DT: It proved successful?

[break in the interview]

SE: ...so I was very disappointed that after the funding went away, they let the program go, which was exactly what the folks in the Phillips Neighborhood thought. There goes the University again. They come in and they do their work and then when the money runs out, they pull out. That was my concern and it's sort of what happened.

DT: Can you describe what that project was? It was graduate medicine, so they were in residency and then, the nurses, were they...?

SE: Graduate nursing. [pause] We had some joint kind of clinical experiences in the Phillips Neighborhood out of CUHCC [Community-University Health Care Center] that was a program for chronic inebriates in the Phillips Neighborhood. [pause] I'm sorry, I'm just drawing a blank.

DT: That's fine.

SE: It's one of the reasons I need to get this stuff pulled together and into the Archives.

DT: If you remember anything about it, you can always add it to the transcript when you review it.

The CUHCC Clinic is still ongoing?

SE: Yes. It preceded our project by a long time.

DT: You mentioned the neighborhood community being, it sounds like, ambivalent from the beginning, imagining the University would be there until money ran out. What is your sense of the attitudes of local communities towards the University, particularly in the health sciences?

SE: A lot of that persists, that sentiment, sort of a love/hate relationship with the University.

We hired an African American woman to be sort of the project director. Of course, being a Type A person, when we got the funding, I said, "We need to do this and this and this and this." She said, "Just a minute. First, we need to talk." She meant that literally. So she organized meetings with the community folks to talk about what this project was, what we were hoping to do. I remember one young man getting up saying, "We are no longer lab rats!"

DT: Mmmm.

SE: So that was the kind of sentiment that they had. We gradually built trust around that and did a lot of projects with the community members.

I remember we worked with the Andersen [United Community] School [on Andersen Lane between East 27th and 28th Streets, Minneapolis], for example, and sent students in there working with the parents and the teachers around health issues. One that I remember very vividly was the whole issue of warts. They were having kind of an epidemic of warts. So they brought together the parents and the teachers and all. It became clear that there were all of these folk remedies for treating warts that various groups were using. It was just fascinating to watch. Trying to respect those kinds of cultural beliefs and practices and integrate them into the education of our students was part of the strategy we were using.

DT: This isn't entirely related, but given that we're talking about community relations... The Phillips Neighborhood is predominantly African American?

SE: No. That neighborhood has been the place where immigrants tended to land, so, at first, it was the Scandinavians. Then, it was the Jews. Then, it was the African Americans. There are lots of American Indians in the community and, now, lots of East Africans, Somalis and so on. So these populations have been there and, then, moved on. As they become more acculturated and affluent, they go on to other neighborhoods. It's a very interesting community to work with.

DT: Does the school make efforts to try and recruit students from those neighborhoods, too? You talked about incorporating kind of an awareness among the students who are already here of kind of cultural differences. I wonder if you're trying, also, at the same time...

SE: We have a couple of faculty members right now who are doing a lot of work with the Somali community, particularly Somali women. We have had some Somali students, more in Rochester, actually, than here in the Twin Cities. It's tough, because there's the pipeline issue. So we've been moderately successful, I guess, in trying to take advantage of that.

DT: I think 1968 was when there was a conscious effort trying to recruit minority students to medicine, to nursing, and to the other health sciences. In addition to trying to recruit from, like, the Phillips Neighborhood and elsewhere, do you think that the school has had some success being able to recruit minority students more broadly?

SE: We did have a couple projects going related to American Indians. The University of North Dakota has a strong program for Indian nurses. So we had a partnership with them where their graduates would come here to do graduate studies, particularly doctoral studies. Two, three of them who were in that program graduated a couple weeks ago. The American Indians seem to be a good population for us, given our location and culture.

DT: Going back to something that you said a little while ago about when you were an interim dean and what a couple of the different challenges were and the issue of getting the faculty doctorally...making sure they were finishing their doctorates. I'm wondering about the comment you made even earlier about that kind of persistent tension, ideological tension within nursing education. Given that within your tenure then—maybe all the faculty were doctorally prepared at that point, at least those who were on tenure track—has there been any lessening in that ideological tension about...?

SE: Oh, definitely. Definitely. As I said, some retirements helped a lot.

DT: Yes.

[chuckles]

DT: Was it just a generational issue?

SE: I think so. I really do.

DT: It's interesting. That fits with what my sense of those kinds of ideological tensions around education and what the educational function of the schools are and what graduate education should be. It seems that was a tension experienced in Public Health, too, and maybe to a lesser extent in Veterinary Medicine that I've seen. In general, the University is becoming increasingly research oriented and because of the changes incorporated within the individual schools, then for those faculty who were working under the older model where it was about training practitioners and not about producing researchers, that's been a long tension in the other schools, too, and that it is generational.

SE: Of course, we have to do both.

DT: Yes. It's not even a switch just to research orientation. You still have an obligation to train the practitioners, as you say.

SE: Probably the biggest challenge that I faced was that this old guard within the school was very much opposed to nurse practitioner [NP] education. They thought midwifery

was fine. Nurse midwifery was fine. It had nurse in the title. But nurse practitioner was medicine. We shouldn't be doing that sort of thing. I knew, as I was entering the deanship, that if we didn't move in that direction, we were *dead* as a graduate program. So one of the faculty members, who had been doing a lot of work in gerontology, and I sort of collaborated, and she developed a proposal for a geriatric nurse practitioner [GNP] program. We counted votes. We made sure the right people got to the meeting and we got approval of that GNP program. Now, except for introduction of nurse anesthesia, it has been pretty smooth from there to add other specialty programs. We have a whole bunch now.

DT: Who was the faculty member you were collaborating with?

SE: Mariah Snyder.

DT: I left a message on her voicemail seeing if I could interview her.

SE: She's a great one to interview.

DT: You mentioned nurse anesthesia was, perhaps, not so smooth an introduction?

SE: Yes, and that's much more recent. In fact, one of the faculty members was reminiscing the other day about how she was attacked during the faculty meeting, and asked to sit down when she was talking about the nurse anesthesia. We sort of slipped that one in. We, first, worked with the V.A. [Veteran's Administration] certificate program in nurse anesthesia and built our master's degree on top of that, so that the nurse anesthetists were getting degrees in weird things. [chuckles] Yes, just to get a master's degree. We started with that and, then, gradually, we pulled the program over here and it's *all* within the School of Nursing now, but it took a while.

DT: Was that opposition, being told to sit down, from someone on the Nursing faculty or was that in the V.A.?

SE: It was here, the Nursing faculty.

DT: Any sense of why anesthesia in particular?

SE: Because it's so *medical*.

[chuckles]

DT: That's interesting.

SE: Maybe jealousy, too, of the salaries. The salaries are far greater than any other nurses.

DT: Yes. That's the same, I think, for anesthesiologists, too?

SE: The surgeons can compete very well.

DT: That's true. Certainly compared to the primary care field, anesthesiologists, I think, can do better.

Really, the fact that the school was relatively late in setting up these nurse practitioner programs... As you say, unless the school had NP programs, it was going to be behind, because the first nurse practitioner programs were, I guess, in the late 1960s, 1970s. It's a notable achievement.

SE: We just had to do it. I'm not sure, looking back, if those faculty who opposed it so are persuaded now or not. I'd be interested to know. They've all left.

[laughter]

DT: I have a few more questions if that's okay.

SE: Yes.

DT: I'm wondering if you can comment on the relationship before you were dean and then once you were dean between the school and the nursing services at the University Hospital.

SE: Well, my colleague Joanne Disch likes to tell this story. She, as the director of nursing at the Hospital, and Ellen Fahy, as dean of the school, resigned on the same day and neither side knew that this was happening. So that was the nature of the relationship. So Joanne and I, when she became the director of nursing, were determined that we were going to change that, to increase that relationship. It's been more or less successful, I think.

DT: Do you have any sense of why there was that separation?

SE: I don't know. I really don't. It was curious, I guess. In nursing education, we came out of an apprenticeship model and, then, in the 1960s and 1970s moved more toward an academic model. I think we've been moving back toward sort of a middle ground. So, we've been at the poles and, now, we're coming back to more of an integrated approach. So I think there was some tension on the service side of...are we really making nurses who are competent and on this side? Are we running nursing services so that our students can actually perform? There's some of that tension that remains.

DT: That's something that jives with what I saw in the 1960s and 1970s from the records that I saw.

Do you recall who was director of nursing before Joanne Disch?

SE: I think that was Barbara Tebbitt.

DT: Oh, that's right. She passed away [July 13, 2001].

SE: Yes.

DT: She was director of nursing for a while. I would have loved to have spoken with her.

SE: I think that she was the one immediately preceding...

DT: I think you're right now that you mention that.

I do want to interview Joanne, at some point. She wasn't in Minnesota before?

SE: No. She came from Penn [University of Pennsylvania].

DT: Can you, then, talk about the setting up of the doctor of nursing practice?

SE: When I was chairing that committee at the American Association of Colleges of Nursing, they had asked us to look at the research and the clinical programs. As we got into it, we thought, this whole area of clinical doctorates is so confused. We recommended to the board that they appoint a second group to study and make a proposal about that. So I was appointed to that task force, as well. One of the first things we said... We changed it from clinical to practice because the practice was more than clinical. It was public health and all the other fields that were in there.

I remember Frank—bless his heart—when I first started talking about this in one of our one-on-one meetings, “Yes! How soon can you do...?” He was on board immediately. The faculty here, too, there was really very little resistance. If there was resistance, I wasn't aware of it. They kept it from me.

[chuckles]

It went very smoothly in terms of developing the program model. Getting it approved was a yeoman's job. Frank was convinced that we had one shot at this, and it had to be perfect the first time around, or we wouldn't get another chance. After I started counting, I was on fourteen drafts of the proposal before it actually went to the Regents. It was approved without any hesitation. Frank was right, I think, about that.

Then, was about the time that I was transitioning out of this position and when Connie came in, she asked me to head up the implementation of it since...you-were-the-big-mouth-you-do-it kind of thing.

[chuckles]

So I did that. It was a good experience, I think. We started with a post-master's program. We assumed that people already had the qualifications to be expert practitioners. What we were doing was building on top of that. After the first two years, we started transitioning to a post-baccalaureate entry of doing both the specialty preparation and the additional DNP [Doctor in Nurse Practice] preparation in one program. That's where we are now and tweaking the curriculum as we're going along.

DT: What does one have to do to get the DNP? What's extra beyond the master's level?

SE: The post-master's program includes things such as economics, health policy, evidence-based practice, epidemiology... That set of courses that we identified as a task force were the things that were being asked of us from the field.

DT: The task force was trying to be responsive to what was needed outside.

SE: Absolutely.

DT: What was the push for the DNP? What needs does the DNP fill?

SE: Well, it's obviously an idea whose time had come, because the proposal was approved in October 2007 and at last count, there were 184 programs and another 100 or so on the drawing board. It just shot up. It was gratifying to see that.

DT: What does the DNP prepare nurses to do in practice? What positions are they then going out and filling?

SE: Our first graduates, of course, were the post-master's, and we've just graduated the first post-baccalaureate now this spring, so it will be interesting to watch them. Most of these students who were post-master's came out of very responsible positions, so they went back into those positions and were performing at another level. We've gotten good reports back from the employers about what they're able to do.

One reporter asked me if I am a patient in a clinic, how will I know if this person has a doctorate or not? I said, "You probably won't know, but her colleagues and the organization *ought* to know." So it's that broader perspective.

For example, one of the students I'm advising right now is an anesthetist in North Dakota. He was looking at the informed consent process for anesthesia in labor and delivery. He said, "We're asking for consent after the procedure has begun, basically." So he's working on, right now, developing sort of a prenatal introduction to what's involved in doing spinal anesthetics and that sort of thing. That's one example.

Another anesthetist—I've got all these anesthetists—student had been looking at the use of certain kinds of expensive blood replacement products in surgery [albumin as a much cheaper alternative]. He collected the evidence about, is this really necessary? Then, there are all those issues of, how do you work this within an organization? How do you

convince a bunch of anesthetists and anesthesiologists that you really don't need these colloidal things, that you can do it with Ringer's lactate instead? He's implementing that in Wisconsin.

It's those kinds of projects that the students are doing.

DT: It really is clinically and administratively oriented...

SE: Taking evidence that's out there and using it to improve practice.

DT: Yes.

SE: One of the biggest challenges we've had, I think, is helping Ph.D. prepared faculty understand that the project is not a classical research study.

DT: It's very much oriented to improving practice.

SE: In a specific time and place.

DT: Whereas, research, the kind of classical Ph.D. model, is about...

SE: Answering a question.

DT: Yes. It's great to have you delineate. I knew that they were different, but to have you delineate what those differences are, you can see very clearly that the goals are quite different.

SE: That's right.

DT: Was there or is there any concern now that the DNP is out there as a qualification that it somehow kind of minimizes what the master's level clinical specialty preparation gives people?

SE: Well, we did away with the master's level. The recommendation from our task force was that by 2015, the DNP would be the entry level for advanced practice. That's met a considerable amount of resistance nationally, in some cases because people don't think it's necessary, but in many cases because the universities are not chartered to do doctoral education. So, basically, they're afraid it will leave them out of the picture.

DT: With that in mind, that the DNP will be the qualification for advanced specialty, does that mean the nurse practitioner programs get eliminated or are...?

SE: We have a DNP program for family nurse practitioners, a DNP program for general nurse practitioners, nurse anesthetists, nurse midwives, so the education has simply moved to that doctoral level.

DT: In a way, I guess, there are parallels there with what some of the other health science professions are already doing. The Pharm-D is the kind of standard entry...

SE: It was sort of a hard sell on the whole notion of, do we really need a doctorate for these programs? Then, one day, I sat down, and I laid out all of the credits that our students would have taken from the time they graduated from high school until they got a master's degree. I did the same thing with Pharm-D students. The number of credits was the same. I thought, *oh*, my goodness, it's time that we recognize what we're doing with the appropriate degree.

DT: Physical therapy...now the primary entry is doctorate of physical therapy, so once you put it in those terms, of course, nursing should be at least at the same level, especially if you look at the credit level, but just in terms of the kinds of work that your graduates are going out to do and the level of sophistication with which they do it.

SE: Yes.

DT: When you put it in those terms, in that broader picture of the health sciences and the allied health fields, it seems pretty obvious.

SE: It begins to make sense, does it?

DT: It does.

[laughter]

SE: Good.

DT: You can't get this from... I guess one can read the task force reports, but I think it's invaluable to have it explained for people to really appreciate it.

The only other thing that I'm kind of curious about is when you were a dean—well it's not the only thing but it is the final question—what was your contact with the Regents, and with the president, and the State Legislature? Were you going before those entities?

SE: I knew the Regents and would visit with them when we would have gatherings. I didn't have to go and testify before them. I met with Nils Hasselmo when I was appointed dean. Then, we had some smaller group sessions with [Mark] Yudof when he was president. But not a lot of work with... Then, of course, Bob [Robert] Bruiniks and I had been deans together, so I knew him well before he took over. I don't know [President Eric] Kaler at all.

DT: What about the Legislature? Did you have to go before the Legislature?

SE: If we did, it wasn't for the University. It was more for professional issues.

DT: I guess the senior vice president, Frank, was the spokesperson for the health sciences.

SE: Yes, or the lobbyist or the communications people. There are some rules about what we can say on behalf of the University. Obviously, you don't want all kinds of folks going out there blabbing.

[chuckles]

DT: You've got to control the message.

SE: Absolutely.

DT: Is there anything else that you feel is important to get on the record about the history of the school?

SE: Boy, I'm sort of brain dead right now.

DT: I've pummeled you with questions.

[laughter]

SE: No, I really don't.

DT: Are there other people that you think I must speak to?

SE: Historically, you mean?

DT: Yes.

SE: My nemesis died. I was convinced that she had some kind of dementia and she died of Alzheimer's [on October 7, 2009].

DT: Oh, goodness. May I ask who that was?

SE: That was Ellen Egan. She was definitely my nemesis.

[pause] I think you've got the key people.

DT: If you happen to speak to Mariah Snyder... I left her a voicemail. I haven't phoned again. If you will, put in a good word so that she'll talk to me.

SE: Okay.

DT: Thank you so much for your time today.

SE: Yes.

[End of the Interview]

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