Barbara Leonard, R.N., Ph.D.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

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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

Barbara Leonard attended Gustavus Adolphus College in Northfield, Minnesota, where she earned her Bachelor of Science degree in nursing in 1963. She earned her Master of Science in public health at the University of Minnesota's School of Public Health in 1965. Continuing with her work at the University, she served as an instructor in the Division of Public Health Nursing in the School of Public Health and as project director for the Pediatric Nursing Practitioner Program. During this same period, she pursued her Ph.D. in healthcare administration at the University, which she earned in 1983. In 1984, she became a professor in the Division of Maternal and Child Health in the School and served as division head from 1986 to 1991. When the Division was moved to the School of Nursing in 1991, Dr. Leonard became a professor within the School. In 1993, she founded the Center for Children with Special Health Care needs. She retired in 2010.

Interview Abstract

Dr. Barbara Leonard begins her interview by discussing her education and her interest in public health nursing. In particular, she describes her early experiences with vaccination and her clinical rotations in college. She then reflects on her work toward a master's degree in public health at the University of Minnesota, including her coursework, mentors, the creation of the Public Health Nurse Practitioner Program, and the changes to and restructuring of nursing programs in the School of Public Health. She also discusses the following: the impact of the Rajender Consent Decree, relations between the School of Public Health and the School of Nursing; curriculum reform within the School of Nursing; the positioning of nursing programs within the School of Public Health; the favorable economic position of the health sciences in the 1960s and 1970s; and knowledge and skills-based competition among healthcare professionals. The interview then turns toward the following topics: Lee Stauffer as dean of the School of Public Health; transitions in the scope of public health regarding prevention and healthcare delivery; relations among divisions within the School of Public Health; the leadership of Alma Sparrow; her pursuit of a Ph.D. in Healthcare Administration; and her interests in maternal and child health and particularly children with chronic disease.

Interview with Barbara Leonard, R.N., Ph.D.

Interviewed by Dominique A. Tobbell, Oral Historian

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

Interviewed at the Office of Dominique Tobbell

Interviewed on October 20, 2011

Barbara Leonard - BL
Dominique Tobbell - DT

DT: This is Dominique Tobbell, and I'm here with Doctor Barbara Leonard. It's October 20, 2011. We're meeting in my office at 510A Diehl Hall [University of Minnesota campus]. Thank you, Doctor Leonard, for joining me today.

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

BL: I had a relative that had been a public health nurse, so there was some interest generated by that. I think it was, you know, family. My mom didn't do it, but had wanted to do nursing. The University [of Minnesota] was always in high esteem in my household, so that was sort of where I got started, with some family interest and encouragement.

DT: You got your bachelor's at Gustavus Adolphus [College, Northfield, Minnesota], is that right?

BL: Yes, I did.

DT: Was that a Bachelor of Science in Nursing?

BL: Yes, it was a Bachelor of Science.

DT: What led you to go to Gustavus to do that?

BL: Friends. [laughter] But it did have a good reputation, too, for the medical area. It had a four-year program in nursing and that was just starting. Well, it wasn't just starting, but it was new enough, and it had public health in it.

DT: Why this particular interest in public health?

BL: I don't know for sure, but I've always been interested in people keeping healthy and in health promotion, thinking people could do a lot to stay healthy. I don't know if it's more than that. It was working directly with people along those lines rather than along the illness route; although, I wasn't opposed to doing that or working with that. But, I like the public health piece because of its prevention of disease.

DT: Is that an interest you acquired while you were taking classes at Gustavus?

BL: No. I think it had been there before that, but, you know, certainly, I really liked my public health section.

DT: I know you mentioned the influence of family and family support to do this. I wonder given your interest in the prevention and the public health campaigns that you mentioned, are there any that were noticeable from your childhood, public health campaigns, that you think may have guided you in your interest in public health nursing?

BL: Do you mean the campaign itself?

DT: I'm wondering how you even became aware that public health nursing was an option, if it was through seeing it play out.

BL: It was actually through this relative who did it, yes. My mother taught school and there were always health issues. There was nursing in the schools at that time. I had encountered nursing in the schools, as well, although, it wasn't the greatest experience.

There was that whole aspect. It was the era when people got quarantined for diseases and so on. I think your awareness is because there's a placard over here for measles or whatever.

DT: Right. This is the early years when companies were looking to develop vaccines for measles. The polio [poliomyelitis] vaccine had just been recently become available, so, yes, I was wondering if that had framed your experience.

BL: That's a good question. Yes, I think it did have and before the polio vaccine, there was a lot of restriction on children, what you could do and what you couldn't do because of the fear of polio. So I lived through all of that. Then, there was the vaccine.

DT: Do you remember what kind of things you weren't allowed to do?

BL: Oh, yes, go to the movies, go into crowds, particularly in the summertime. We couldn't go to the State Fair, things like that, so it was restrictive. It wasn't the greatest, was it? There was a great deal of fear of it around, because people got the lung involved type of bulbar polio and that left them paralyzed for the rest of their life.

DT: Did you have any friends who ended up in an iron lung?

BL: My mother pointed them out. There were some. I can remember driving past this house where this woman had it and always was in the iron lung.

DT: I can only begin to imagine how scary that was for the children.

BL: It was scary, yes.

DT: Did you have the injection vaccine, the [Jonas] Salk vaccine, or did you take it on the sugar cube? Do you remember?

BL: I think it was the sugar cube when I finally got it, which was long past the time when I probably would have gotten it anyway.

I had all the childhood illnesses, the measles, the mumps. I didn't have whooping cough because we had immunizations for diphtheria and tetanus and whooping cough. I had all the other things that then weren't protected by vaccines.

DT: It's interesting that at the time you were getting your training, this was a real transformative period in public health, because of the new vaccines that then became available.

BL: Yes.

DT: What was your experience like at Gustavus? How would you characterize the training that you got there or the education?

BL: [pause] I think it was a very well put together comprehensive look at nursing practice. They had just moved out of a diploma program, so I think it was a little bit of the apprentice model; although, they were very careful not to… They didn't want to be there, but it was in transition, because I was in the fourth class that they'd ever had. There was some ambivalence about that. There was a group of nurses. We went two years and had all the academic stuff, but we were kind of isolated from the rest of the campus for two years. They did some good things and some not so good things, I think. We missed out on some of the college life, which I think would have been very important to have. I think it made us grow up fast, really fast, because of what we were seeing in the hospitals and in the community. We became very close as a group. There were eighteen of us. We still get together. It was good in that way. There were some things missing, but just in terms of that later part of college life…

DT: Were you all living in the same dorms?

BL: No, we weren't. We were sixty miles away. We went back to graduate, basically, after two years. It was continuous from the end of our sophomore year. We started that summer, and we went around the calendar year, which was the academic year. So we were different that way.

We did see lots of things. It was the era when the state hospitals, the mental hospitals… We had clinical experiences in those. They were in a big transition, too. They had not very long before that gotten rid of their restraints and things like that, because they had gotten the psychotropic drugs. It was an interesting period that way.

DT: During the second two years of your bachelor's, were you then placed in different hospitals in different communities?

BL: Yes.

DT: You spent a certain amount of time in each?

BL: Yes. We were on different services in one hospital. We were out to the children's hospitals for our pediatric experience, and we were in the mental hospital for our psych experience, and we were in the community for public health nursing. We were in Minneapolis with the Combined Nursing Service.

DT: Yes. I saw that you had worked at the Minneapolis Health Department.

BL: Yes.

DT: That was after you graduated?

BL: Yes.

DT: Was that an extension of what you had done there during your clinical rotation?

BL: Yes, I think… it was built on that anyway and more responsibility.

DT: What kind of things were you doing in that role?

BL: We were doing a lot of maternal and child health, trying to help new moms establish good feeding practices and healthy interactions with their new babies or visiting pregnant women and making sure that they were getting appropriate prenatal care, talking about helping them get ready for babies. We were also doing some tuberculosis checks. We had some people who were homebound, and we did actual direct nursing care with them, wound care, or helped them with bathing, a lot of trying to sort out medication, just kind of really basically take care of themselves.

DT: For the tuberculosis screening, were you going to different sites to screen or were people coming to you?

BL: No, not screening. Actual following up with people who were on drugs.

DT: Oh, okay.

BL: There was a large group of people with tuberculosis, in active tuberculosis, in downtown. I was in the in the downtown area, actually, doing my public health—it isn't there anymore; the freeway is there—you know, in tenements really trying to convince them to take their meds or help them get meds. You'd have to go to the bars and meet people wherever.

DT: Would you say that you were mostly seeing kind of low-income patients then?

BL: Yes, yes.

DT: Was there much like ethnic and racial diversity in the early 1960s in Minneapolis?

BL: There was a huge American Indian population. I don't know what it is today, but it was third in the nation or something like that. Yes.

DT: Did working with different ethnic cultural groups present any particular challenges for public health nurses?

BL: Not really then. We had carte blanche pretty much. We were really accepted. That started to change over in the 1970s, I think, as Civil Rights came in more and started to influence that. We were white nurses; we didn't know a lot. We didn't, of course, know very much. [laughter] We were pretty much accepted. I would say there was definitely the cultural thing. They may have been more on an economic basis, except for the American Indian population. It was pretty much a white population at that point. I worked very well on the Northside, which had more African American people. Yes.

DT: What would you say were kind of the biggest either health challenges or other kind of challenges that you confronted as a public health nurse then?

BL: I think it probably was the poverty and trying to get people what they needed or help them get what they needed and all the many challenges that they faced, of course. A lot was daunting to them. Of course, that influenced what we could achieve.

DT: Do you have a sense of how much state support there was for low-income people for these health kinds of services?

BL: There were some private programs. There was Washburn [Foundation]. There was Wilder [Foundation] in Saint Paul that did a good job of trying to take care of kids in both cities, different organizations, different foundations. To tell you the truth, I'm pretty

ignorant about this, but I think all of us were probably were funded out of tax dollars at that point. I would assume that those tax dollars came from both city and state—but it wasn't abundant.

DT: Yes.

BL: There was much more available in the 1970s than there was in the 1960s, early 1960s.

DT: Who was in charge of you, basically?

BL: A supervisor.

DT: Nursing supervisor?

BL: Yes, a nursing supervisor.

DT: Did you have much interaction with physicians through the public health nurses?

BL: No, not so much. No.

DT: One of the things that I've read and heard about from people who've worked in public health nursing is that one of the benefits of doing public health nursing is that you get a lot more autonomy and you're not relying on what the physician says. Was that your experience?

BL: We needed to be in touch with them, especially if we were dealing with someone who had a medical condition to take care of, really communicating back to them. But, no, otherwise, it was really independent—which I liked.

DT: Yes. Going into public health nursing seems quite a contrast from the kinds of nursing work that would be done if you'd gone into a hospital right after graduation.

BL: Yes.

DT: How well prepared do you think your program was for preparing you for a career as a nurse? Not to single out Gustavus necessarily, but that's your only experience, but I'm wondering how well prepared you felt going out into the world of practice.

BL: Mmm… I think I felt more prepared to go the direction of public health than I did in the hospital. It's something that if I would rewrite it, maybe I would do something differently. Maybe I would do that first. I don't know.

DT: It's funny. Other people that I've spoken with… A lot of nurses have commented that as much as you do in nursing school that when you get out onto the wards, the nurse is not necessarily fully prepared for what confronts you.

BL: No. There's a real stiff learning curve with that, yes.

DT: How long did you work for the Minneapolis Health Department?

BL: I worked for them for a summer, and, then, I went to graduate school.

DT: Oh, you went straight into…

BL: I did. I went to the MPH [Master of Public Health] program—well, it was an MS [Master of Science] public health program here at the University [of Minnesota] in the School of Public Health.

DT: What led you to do that?

BL: [pause] Encouragement from the people that I was with at Gustavus. There were quite a few of us that were encouraged to go on and we did and got master's degrees. Yes, it was that, and it was a desire to learn more. I like to learn, so I did it.

DT: You went to the School of Public Health. That's where Public Health Nursing was located. It wasn't in the School of Nursing at that time.

BL: Right. Yes, it was in the School of Public Health.

DT: What kind of classes were you taking as part of the MPH program?

BL: Basically, the MPH courses, all of the ones that everybody took, which was really good. It was epidemiology and foundations in public health and environmental health, all of those courses, and a course in health education. Then, we had some nursing courses, as well. They had a federal grant at that time if you wanted to go on and learn more about mental health and I did. Then, they also had a federal grant—I kept going—in education so that gave me the basis to teach. I did the mental health thing first. Yes, it was a great program. We were all thrown in together, all the different disciplines. It was a small school at that point, so we knew people, and people were going into different careers, but all studying together getting their public health lens.

DT: Were there particularly notable faculty that you enjoyed studying with?

BL: Well, I really enjoyed the whole thing. I think Doctor Gaylord Anderson was truly a renaissance man. I don't know that he was such a great teacher, but he had such a broad view of public health and had so much respect for people in the field, nurses, everybody. I think it was kind of a time when… It was before women's liberation, let's put it that way, but we were being treated in a very respectful manner and encouraged to be as

much as we could be. Nobody was holding us back. That was what I liked about the school. There were times, but overall… We were there, and we were expected to learn and deliver on that.

I can't remember how many were in the school at that time…a much smaller school, very much smaller. I don't know how many in my class that year. I'd have to go look it up, but from all over the country, and it was diverse. That was also very interesting to me. There was an African American. There was an American Indian in the class. There were people from Iran. There were people from Vietnam. This was before the war in Vietnam. There were nurses from all over the United States, many states represented. I was one of the minorities being from Minnesota. A Japanese American from San Francisco—she was interned during World War II—all kind of folks with very interesting backgrounds.

DT: That really belies the great standing that the School of Public had internationally and nationally at that time, that it drew such a diverse bunch of students.

BL: Yes.

Every Thursday afternoon over in the Mayo Building, in Mayo 100, the entire faculty and student body got together. I don't know, I suppose it was three o'clock in the afternoon, something like that, and we had lectures, lectures from all over, world health, Russia, all over, very engaging as far as what was going on in the world of public health.

DT: It sounds like an exciting time.

BL: I liked it. Yes, I liked it a lot.

DT: As I understand it, Marion Murphy was head of Public Health Nursing.

BL: Yes.

DT: Did you have much interaction with her or much experience with her as a teacher, as a director?

BL: Not too much, no. Not too much. She certainly was a good leader for that period of time. I think both Gustavus and Doctor Murphy really had a sense of what nursing could do, and maybe it was different from what the public thought or what even the school thought or whatever. We were going to take nursing forward and get it out of maybe the more apprentice, under-the-thumb kind of…make it more of an independent practice.

DT: This was, as you already indicated, a time of change within nursing education, that you lose the apprenticeship model, the extensive amount of clinical hours that you… where nursing students provided free labor in the hospital.

BL: Right.

DT: It's interesting that you commented that you were so encouraged into graduate work by your teachers at Gustavus. That seemed to be the trend. There seemed to be a real urge to get nursing into graduate education.

BL: Right. Well, they didn't ???? it to happen. Graduate education in nursing was under other departments. Nurses were getting a Master of Education, or, like me, a Master of Science in Public Health.

DT: It's interesting. As I understand from the archival material that I've read, the School of Public Health established a Public Health Nurse Practitioner Program in 1965 that you could get a master's in science but it would qualify you for nurse practitioner within Public Health.

BL: That didn't come until 1971.

DT: Oh, okay.

BL: Oh, yes, I was in on the ground floor. That was very exciting stuff to me. When that happened, our director Alma Sparrow had a vision about that and we wrote a grant to the Division of Nursing. We had had several kind of mock-up programs before that and then we got the pediatric nurse practitioner grant in 1971.

DT: That was through the Federal Government Public Health Service?

BL: Yes, $750,000. That was a lot of money in 1971. [laughter] We had a very wonderful program, a very elegant program.

DT: I've been curious about the establishment of the Nurse Practitioner Programs, because I know it's such an important part of nursing history, let alone the history of this institution. I'm glad that you are able to shed light on it. Can you talk more about the context of nursing at that time and why there was this need for the nurse practitioners?

BL: I think that the medical community was saying, "Look, there is a great big piece of what healthcare is that medicine really doesn't have to do. Besides, we don't have enough people to do that well-child care, developmental concerns, immunizations, childhood illnesses that are not life threatening. Nurses can really handle this."

That had started in Denver [Colorado] with Doctor [Loretta] Ford and Doctor [Henry Silver. Alma Sparrow had come knowing that. She had been in Seattle [Washington], and she came back to Minnesota to be faculty in the program in Minnesota. She knew those folks and she knew what their thinking was. She believed that. Actually, the pediatric community here at the University and within the Twin Cities couldn't have been more helpful. It just sailed and so did the Minnesota Nurses Association. At that time, it wasn't a union. It was a professional organization, and it supported it. When I think about it, it was really too easy. Yes. We just did it by really…we were one step ahead of

the students at all times. I had to learn it myself. I was faculty, but I had to learn all of the nurse practitioner skills, etcetera.

There was also a young person, a pediatric resident, who absolutely got it, and he worked with us and taught us many skills. So did many of the staff in the pediatric clinics throughout the Twin Cities area.

DT: Do you remember the name of the resident?

BL: Peter Boelens.

DT: Was there any opposition to the program from, like say, other nurses or…?

BL: There was a lot of opposition nationally. It didn't really affect us very much. I think there was some concern that doctors shouldn't dictate this kind of program. We kept saying, "Hey, this is nursing. This is something we want to do. It isn't medicine. We're not trying to do medicine. But we are trying to extend what we already know we can do with patients and families." There wasn't much here, but nationally, there was. It was in the School of Public Health that that was all created. I know that we tried to engage the School of Nursing, but they were in a very different place of how they viewed nursing, at that point. I think they were really concerned about autonomy. I think they saw this as kind of back to something that they had worked very hard to get away from. They also wanted to do more graduate education and doctoral education. It just wasn't good timing for them.

DT: Was it that they were fearful that doing the Nurse Practitioner Program nurses would be somehow more oriented to physicians again?

BL: Yes. Yes. They were very concerned about being controlled.

DT: It's interesting, because as a nurse practitioner one has more autonomy to a degree. You're doing more in practice, but, I guess, at least as it was initially set up, a physician always has to kind of be there or at least be somewhat in contact to supervise. Can you talk more about what that relationship was for the nurse practitioner and the physician?

BL: I think the physicians actually knew that nurses could do this. They were less concerned about what we were doing. They didn't think we'd make mistakes. There was a good team spirit about this kind of practice. But that's my local experience. I don't think it went so well in other parts of the country.

DT: Yes. I have a colleague who has written a book [Julie Fairman, *Making Room in the Clinic: Nurse Practitioner and the Evolution of Modern Health Care* (New Brunswick: Rutgers University Press, 2008] on the nurse practitioner movement in the U.S. One of the conclusions that she draws is that it was very much dependent on the local situation and the local personalities involved whether there was good cooperation…

BL: Oh, really?

DT: …between the physicians and the nurses. Yes, that really speaks to what your experience was here, I think.

BL: It just went. It was too easy.

DT: You say that like it came back to…

BL: No, it never came back to being anything. There were a few practices that realized that, okay, the nurse has way too many patients. We need those patients. She goes. We had incidents of that. Yes, I know people who had that happen. But it wasn't on the basis of competence.

DT: It was more the competition, the money.

BL: It was about the income, yes.

DT: The students that you were training to be nurse practitioners, were they working outstate, like in rural areas, or were they working in the cities as well?

BL: I would say they were mostly here in the Twin Cities.

I was with the Nurse Practitioner Program until about 1979 when I went to the nurse faculty in the Maternal and Child Health [MCH] Program. I was with them until 1991. The Nurse Practitioner Program was invited to leave the University.

DT: Mmm…

BL: Yes. The School of Nursing didn't take it. That was because of the Milbank Report that said schools of public health had gotten a *little bit* off of their focus. Things like nurse practitioner programs are off their focus and they need to get back to core public health. Nursing didn't take it. There were two programs, at that time, an adult nurse practitioner program and, then, there was peds [pediatrics], and they both went to the College of Saint Catherine. They were there, and they're still there.

But when I went to the School of Nursing in 1991, the plea was from the students, "We need a nurse practitioner program." So we began that again in 1993.

DT: Hmmm. That's a complicated history for the program.

BL: Oh, yes, it is, isn't it? [laughter]

DT: When did the Nurse Practitioner Program move to Saint Cate's? Was it in the 1980s at some point?

BL: It must have been about 1983, something like that. Yes, both programs, both peds and adult.

DT: I assume that must have been difficult for the Public Health Nursing faculty to lose those programs.

BL: Public Health Nursing faculty went away. Public Health Nursing faculty got back to its primary mission.

I can't remember precisely when they hired Robert Kane.

DT: I think it was 1985.

BL: That's about right. He reorganized the school. He put a nurse faculty in all the various divisions of the school. I was in Maternal and Child Health. I had already left Public Health Nursing. He really wanted nursing out of there, out of the School of Public Health. There were really quite a few faculty that remained, but they were scattered throughout the school during his administration. I don't know all the politics of this, because I wasn't directly involved in it. But Public Health Nursing, because of community support, not because of internal support, moved to the School of Nursing. It happened about 1990, 1991. Yes. Without the community support, it wouldn't have happened. It became a very good program there for a while. I hope it maintains its stature, because it kind of revived within the School of Nursing.

DT: When you say there was community support, was that like alumni from the School of Public Health?

BL: Yes.

DT: This was specifically Public Health Nursing alumni?

BL: Mmm…nursing and others, you know, saw the value and opposed its demise. It's been a fight!

[laughter]

DT: This is why I'm so glad to talk to you, because I've been trying to get my head wrapped around what happened to Public Health Nursing. A lot of the people that I've spoken to from Public Health either didn't have insights into really what happened with [Public Health] Nursing or if they were Public Health nurses, they left before the move happened.

BL: Okay. I think at the time that I left Public Health Nursing, which was probably 1979—I think I went over to Maternal and Child Health Program about that time—I think there were twenty faculty. They had grants. But I think when Bob Kane came, he was really trying to emphasize research, and I think trying to move the school forward

academically. I don't think he looked at nursing as having that capacity, which I think was wrong. But, on the other hand, he had a mission to move the faculty forward. I don't know that he really understood what Public Health Nursing could do. So that happened. I can tell you that twenty faculty did not go to the School of Nursing.

DT: How many would you say ended up moving with you to the School of Nursing?

BL: [pause] Four, plus some staff… a couple of staff.

DT: Yes, that's very few.

BL: I went because there was another dean and I wanted to move…

[laughter]

[At this time, Doctor Leonard requested the recorder be turned off.]

[break in the interview]

DT: During the 1970s, the [Shyamala] Rajender [Consent] Decree was enacted. I'm wondering if you could talk about how that impacted female faculty in general and faculty more generally in the School of Public Health or in the University more general.

BL: The University had been found guilty of sexual discrimination against women faculty. Then, for ten years—I don't know which year it began and which year it ended—every hiring was reviewed by the [Minnesota] State Attorney General. How did it affect…? I think Rajender helped women move forward in the medical sciences, in the Academic Health Center—I think we called it health sciences at that point—in the School of Public Health and in the Medical School and in the School of Nursing. There's much history that I don't know about this in the School of Nursing. But women tended to be hired on rolling contracts, if you will. They were temporary contracts, and they would be renewed for decades.

They weren't able to move into faculty positions where they would have more influence and power and things like that. The Rajender Decree came in and the School of Public Health, I think, was caught… At least it was explained to me by one of the deans that there was a lot of soft money around, but there wasn't a lot of tenure money, state money they considered more permanent. So for faculty, it was hard to get on a tenure track. They had to do it. Eventually, that all worked itself through. The days of repeating contracts and people doing work and not being allowed to move up and have more full careers… It was a positive thing, but there was a lot of storm and stress during that period of time as the schools reconfigured.

DT: I can imagine that. I've heard that from I think pretty much every faculty member I've interviewed from the School of Public Health, the fact that so many faculty were on soft money that it meant that it made it difficult to hire permanent faculty.

BL: Right. Yes. It's a good part and a bad part of the school. But, you know, in my later years, in the early part of the 2000s, I was on a Second Level Review Committee for the Academic Health Center, so I was privileged to see the people coming through for tenure and promotion from the School of Public Health and there were many, many woman. So it has really shifted.

DT: It's interesting what a significant impact Rajender had on the University, and, yet, there's… My experience is if you ask female faculty from the health sciences who were at the University in the 1970s, I think most of the people I've interviewed from that period have talked about Rajender, but, then, it doesn't have that same kind of institutional memory for the leadership in the University, I think.

BL: Yes. A watershed event for women, I guess.

DT: It's interesting that it happened here—there was a lot of activism around women's equal rights in the workplace and women's liberation and the Equal Rights Amendment in the 1970s—that this happened at Minnesota and it was such a state watershed.

BL: Yes.

DT: Going back to the 1960s for a bit… Were there any kind of relationships between the School of Public Health and the School of Nursing in that period, particularly around the education of public health nurses?

BL: Yes. Public Health Nursing was taught in the School of Nursing by Public Health Nursing faculty and I actually did that. I probably did it two years and, then, in about 1967, I didn't do that anymore, but it still happened for a while after that. I'm not sure when that ended, when they hired their own faculty.

DT: Then, the School of Public Health retained the graduate programs in Public Health?

BL: Right. The undergraduate was picked up by the School of Nursing. Yes. The graduate program in Public Health remained until 1991 or something like that.

DT: What was your sense of the School of Nursing at that time? You talked about it earlier. It was going through some transitions in terms of curriculum reform.

BL: When I first came to the University, it was a very highly respected program, basically, five years, really good clinical, really tough program, very, very well respected. Then, as they went to a four-year program and got the apprenticeship stuff out, things were lost. The faculty that had to do that changed and I think probably took a lot of heat. I think they, in the end, produced a good program, but there was a lot of reaction to it. People didn't think it would be as good. I think it actually is a very good program from what I can tell from my experience with the school from 1991 on…a really good undergraduate education.

DT: My understanding was that, as you said, there were a lot of problems, tensions, within the school around the curriculum reform and that Edna Fritz, as director, had some real challenges.

BL: Oh, yes.

DT: Did you have much experience with her?

BL: Not too much. No, I really didn't. I did go to faculty meetings. I was required to go to faculty meetings there for a couple years. I really didn't know… I was not really part of that at all, but from the periphery I could see that. I knew people who had gone through the four-year program. A lot of people had come from three-year programs that were strong programs, but they had to make up the academics and they had to go through the nursing program, part of it anyway, to get their MS degree. For some of them that was redundant. They were practicing nurses. There's always going to be that kind of lag. But I think overall, it was a tough time and it was necessary.

DT: As I understand it, there was a year or two when many of the students failed their boards.

BL: Did they?

DT: Yes. I think it was in the mid 1960s and that raised all kinds of issues and accreditation issues, concerns.

BL: I did know that. I didn't remember that, but I did know it at the time.

DT: My understanding of public health nursing and the schools of nursing in other areas of the country is that, oftentimes, public health nursing was within the school of nursing and not in the school of public health. I'm wondering if you have any perspective on why Public Health Nursing was within the School of Public Health [at the University of Minnesota] for as long as it was.

BL: I think there were some philosophical differences between nursing and…just like public health was outside the School of Medicine, too. I think philosophical differences. The educational approach is different. The goal is different…some of that, definitely.

DT: And would it be fair to say that the kind of practice that a public health nurse does is quite different from the practice of a hospital nurse?

BL: [pause] It shouldn't be.

[laughter]

BL: The focus in a hospital… Well, today, people are in and out of hospitals pretty quickly, so the time to really do education and things like that is lacking. But I think public health nursing would be more, "Okay, this has happened. Now, let's get a regime going that you can work with," taking into the context of where that individual came from and is going back to. I think public health probably had more understanding of diversity, economically and racially and ethnically. But I don't know. This hospital situation here has always been pretty diverse. But when you're really dealing with life and death—this is like a tertiary care hospital—the focus is on getting people well the best you can, and they don't have the luxury of maybe doing some of the same things that public health nurses could do.

DT: In that sense, a major responsibility of public health nurses is then to educate the patient on how to take care of themselves.

BL: It's a nursing responsibility. It plays out better in a home setting or a school setting, something like that.

DT: This makes me think of the Home Care for the Dying Child Program that Ida Martinson set up in 1972.

BL: Oh, yes.

DT: That seemed to rely a great deal on the work that public health nurses were doing out in the community.

BL: Yes.

DT: Public health nurses would be the ones that would be helping the families take care of the dying child.

BL: Right. Yes.

DT: Did the public health nursing program have much involvement with setting up that program?

BL: No. No. That was Doctor Martinson. But there were quite a few nurses who… She was on my dissertation committee. I got patients through. I worked with her a bit. It was a really good program.

DT: Yes, it sounds like it was really amazing.

BL: Yes. Hospice was coming in in the mid 1960s. Care of the dying was much more in the focus… and it didn't have to be in a hospital. She caught that and brought it along for children. Its time had come. She was the first one to really move forward with that…very good.

DT: Yes. That's one of the things that has always amazed me about the history of medicine here be it in Public Health or in the School of Nursing, because there have been so many crucial nursing innovations that have taken place here, especially in the 1960s and the 1970s.

BL: Yes.

DT: It just is exciting to me.

BL: Yes.

DT: When we were talking about the setting up of the Nurse Practitioner Programs, you mentioned that, in part, it was a response to there being a shortage of, say, physicians to do some of that work that the nurse practitioners could take on. Do you think that the development of the Nurse Practitioner Programs helped resolve some of the shortages that there were in healthcare personnel? Did it kind of fix the problem that it was partly set up to resolve?

BL: It probably helped. You've got to remember, there was a lot of money being pumped into the academic health programs at that time, so physician programs expanded, nursing programs. There was a lot of resource that came in in the 1970s. I'm not sure… There's some talk right now about utilization of nurses and physician assistants in the healthcare reform. We were telling them that forty-five years ago. So… Okay. [laughter] Some day, they'll get it.

It's an economic thing. There are shortages now that exist but there's not the will, political will, to take care of those things. The way we pay docs is moving against that. That hasn't changed. [laughter] A rational system would say, "Yes, use more nurse practitioners. Use some physician assistants. Use nurse midwives." They are being utilized. We graduate people and they get jobs. Set up a system where there's more triage and make it more rational.

There was a big push here in the late 1980s and 1990s to have physicians be family care people. They don't want nurses who practically know more. The nurses know more in pediatric care. A pediatric nurse practitioner with a graduate degree probably has more content than the doc. But that's competition. I mean no disrespect for my colleagues in medicine. They're wonderful, but that's the story.

DT: It's interesting that you bring up the Affordable Care Act and the recent healthcare reform, because I've been working on the history of family practice, family medicine, and I'm familiar with the history of nurse practitioners. As you say, we had shortages in the 1970s which the nurse practitioners and the growth of family medicine was supposed to resolve, and we still have the shortages today and it's not resolved. Again, your nurse practitioners are a potential solution to the problem, but there are still those economic issues, the competition.

BL: Exactly.

DT: It will be interesting to see if the mandatory insurance provision of the reform act gets enacted and whether that will force a change in priority given to primary care, however it's delivered, be it nurse practitioners, physician assistants, or primary care physicians. People need to learn from history.

BL: When I heard that yesterday morning, I was taking my shower, and I thought.... [laughter] Okay, here we go again.

DT: Yes.

BL: It isn't about whether the nurse practitioner can or can't. Thirty plus years has proven they can. However, it's the political will.

DT: Can you talk a bit about what Lee Stauffer was like as Dean of the School of Public Health during the 1970s?

BL: He was a huge change from Gaylord Anderson. I don't know that I've reflected on that before. He was, I think, a good person. I think he really had a good idea of what public health could do. I think he was supportive of Public Health Nursing to an extent. He encountered Alma Sparrow quite a few times. That was the time of huge expansion of programs. So I think just trying to keep… I mean, it must have been a very difficult job to keep track of what was going on. The school changed to become dramatically large…many programs, many more. I don't know if it was programs so much or the expansion of existing things that were there. Yes, I didn't have much focus there. I was really focusing on getting my degree and doing my job.   He was always very supportive of nurse practitioners, things like that. But, in the end, I think before Doctor Kane came, he was trying to maybe refocus the school. I'm not totally sure. I think he might have been, because of the Milbank Report that came out in the early 1980s that said, "Schools in public health need to get back to their core." So he might have been trying to curtail some of that.

DT: I haven't read the Milbank Report, but I'm going to have to, because it sounds quite important. What did they identify? What would be understood as the core of public health?

BL: Well, public health is really to protect the people. It's part regulation. It's a very broad scope, but its focus is different than medicine, and to keep the population healthy, I would say the core of that is research, and epidemiology, and environmental health. It's population based. It is not individually focused. I think maybe that's where the rub came, because a lot of these nurse practitioner programs… When they're in a school of public health, they have a more population based approach; however, it is individual and I think that's probably what Milbank was trying to say was get back to this, what society wants you to do, and it's to look at things with population strategy.

DT: That's really interesting. One of the things that I've seen commented on about the School of Public Health was that during the 1970s, there was a shift from emphasis, perhaps, away from prevention to healthcare delivery.

BL: Yes, I guess that's what I've been trying to say.

DT: That really fits with what you're saying, because nurse practitioners are about delivery of care.

BL: Right.

DT: That's the focus. The comment I've seen in terms of this shift wasn't just related to public health nursing. It was broader than that.

BL: Oh, yes, definitely broader, very much broader. It's just that it impacted nursing.

DT: Yes. Your observation that that could explain why that tension was there around nurse practitioners within the School of Public Health, that really does resonate.

BL: I don't know if there were other comparable programs in the School, let's say in sanitary engineering. I don't know if there were some other things that also were impacted as much. The view from my window was very narrow at that point. I don't remember. I don't think I was involved.

DT: One of the other programs that I guess was started in the 1970s was Long Term Healthcare Administration that Ruth Stryker Gordon and Kenneth Gordon were directing.

BL: That's right. Yes.

DT: I wonder if that fit within that more care delivery model than the prevention model. But, then again, it fits within hospital and healthcare administration.

BL: Right. Remember, they were in the School of Public Health.

DT: Yes, yes.

BL: In fact, I got my degree from the MHA [Masters in Hospital Administration] program. It was called Hospital and Healthcare Administration in those days, a very strong emphasis on healthcare delivery, but it was also healthcare delivery to keep the population healthy; although, the MHA program was very hospital focused. So it was quite different than the Ph.D. program.

DT: In a moment, I want to ask you more about your experience doing the Ph.D.

Before getting to that, I'm curious what you saw the relations were like, in the 1970s and I guess afterwards, too, between the various divisions within the School of Public Health. Was there a hierarchy of divisions at all?

BL: Oh, definitely. Yes, there was a hierarchy. When you think about the large research refunding that we were awarded—Epidemiology in particular, Health Services Research maybe later. Yes. [sigh] I don't know what more to say about it actually. There was much more of a team feeling, although, that could have just been my misunderstanding of the whole thing in the 1960s because the School was smaller and because Gaylord Anderson had a view of how people should be educated but also how it should be delivered and believed in teams; although, his name was on every grant. You've probably heard that from Lee Stauffer. [laughter] So there was a great deal of control.

BL: Yes. I can't remember exactly… There was a relationship of laboratory medicine.

DT: The Physiological Hygiene Lab?

BL: That's right.

DT: Ancel Keys?

BL: Yes, that's right, that whole piece. I don't know where they were located, if they were in the School of Public Health or not.

DT: They were, yes.

BL: Were they? Okay. All that would have been very prominently placed, too, and certainly Epidemiology stuff. Yes, I would say they would be the biggest and, then, Health Services Research later.

DT: So the hierarchy was really defined by the extent of research funding?

BL: I would say, yes. The MHA program had a lot of prestige, a lot of prestige. I don't know how they were funded. They might have been foundation funded or privately funded. I don't know, but they had a big program and lots of graduates, and they were very separate.

DT: That's a lot of what I've been hearing about the School of Public Health, that the individual divisions were fairly separate and that, perhaps, there wasn't so much interaction between them…

BL: No.

DT: You were physically disparate, too.

BL: Yes, exactly. That, I think, made a big difference, just the location. It was all over the place.

Those other divisions, like Epi [Epidemiology] and Health Services Research, Physiological Hygiene, those people, they were mainly research. They didn't educate that much. I'm sure they had students. I'm sure, but it wasn't the same focus really.

DT: Whereas, Public Health Nursing, Hospital and Healthcare Administration, that's really about training practitioners.

BL: Yes. Health Education, too.

DT: Yes.

BL: And to some degree Environmental Health. Yes.

DT: One of the other things that's so interesting about public health is that, particularly in terms of the hierarchy question, public health was composed of nurses, M.D.s, Ph.D.s, engineers, administrators. It was the whole gamut. It's interesting that the hierarchy was not contingent upon the degree that you had, but rather about the nature of the funding, the degree of funding that you were getting.

BL: I think that was the slant.

DT: You mentioned Alma Sparrow a couple of times. I'm curious what she was like as the leader of the Division of Public Health Nursing and what her personality was like.

BL: She had a lot of respect for what nursing could do. She'd been educated in the School of Nursing during World War II and was in the Cadet Corps. She had a background, I think, in physiology or educational physiology, something like that. She really admired the director of the School of Nursing during that period of time. That person retired before Alma came back to the University of Minnesota and [the School of] Public Health. I think she believed very much that nurses could be much more autonomous, contribute in a much more full way than they were being used. Like I said before, she really got this nurse practitioner bit. It was her leadership and persistence in that that I think brought it about. I don't know that it would have happened without her there. She worked pretty tirelessly to get that to happen. Because she didn't have a doctorate, I think that maybe her emphasis was more on delivery of care than on research; although, she knew that that was the trend that was coming. She knew that and encouraged people to get their Ph.D.s. Again, she really urged me to get my Ph.D. Another push! There you go.

[laughter]

DT: You had some good mentors.

BL: Yes, I have.

DT: Aside from the encouragement from Alma Sparrow, what led you to decide to pursue a Ph.D. and why healthcare administration?

BL: Well, nursing wasn't available. I did explore other programs around the country and I didn't really want to move for a lot of reasons. Healthcare administration was very interesting to me because of the focus it took on the political and economic aspects of things. So, I got a good education in that, for sure. I think that was part of the incentive for me. I probably would have gone to nursing had there been a degree in nursing, but I'm not sorry for going to the other program. I learned a great deal. I actually learned a great deal about how the healthcare system in the Unites States works and where nursing was in that hierarchy of things—or wasn't, mostly wasn't. It was an awakening of that, but, also it had a really good background in health economics. I just see it being played out every single day. [laughter]

Plus, I could pick a minor of my choosing, so I picked child development in this wonderful school over in Psychology, and it was really good.

DT: Were you working full time on your Ph.D.?

BL: Yes.

DT: So you left your faculty position then to pursue the Ph.D.?

BL: No. I worked full time and pursued

DT: It had to be convenient. Wow. That's a lot of work.

BL: Yes, it was. It took a long time.

DT: When did you start your Ph.D.?

BL: Oh, I started in 1971. I just took like a course every quarter. We were on quarters at that time. I finished in 1983. It just took a long time to get the paper written. The course work was done, but it took a long time—way too long. I don't advise that.

DT: This was before the Hospital and Healthcare Administration moved to the Carlson School?

BL: Oh, yes, way before.

DT: You began working in maternal and child health. Was that after you got you doctorate or during that time?

BL: It was during.

DT: I know you talked a little bit about this, but why did you move into maternal and child health?

BL: Because I'm always optimistic about being able to influence families and help them find ways to maximize their health, optimum health for kids and moms—and dads. But the focus in that program—it's federally funded—is mostly on women and children. There's a huge need. Also, I knew from my doctoral studies that if you educate and influence women, you influence the whole family. That has an astonishing amount of impact. In fact, we had a speaker from World Health [Organization] one time. He was located in Geneva [Switzerland], I think. He said, "If I could do anything at all, I would take my entire budget to educate women." So those are some of the reasons behind it. Plus, it was a good program and great students.

Then, I started a sub program within that on chronic illness and childhood, because there seemed to be a gap, again, about really caring for kids long term. As kids were now having advanced medical care and surviving…and then what? There they were with their families. We were moving kids out of institutions. They were moved into communities. It was just a really natural place. That's what I contributed when I went from Public Health over to Nursing. We had a grant—it's still there; it's probably into its seventeenth or eighteenth year—from MCH to create a program for nurses focused on kids with chronic illness. Nurse practitioners take that program. I'm very proud of what happened with that, because it's really needed.

DT: It's so interesting. I'm curious. Your appreciation that…if you can target women, you can impact the entire family. Did you get that sense from your time working as a public health nurse in Minneapolis?

BL: Not so much. I think I got that from the program, my Ph.D. program. Plus, my graduate education in child health, too…child psychology.

DT: That's so interesting.

[laughter]

BL: I've got about five minute, and I have to go to a public health award for one of my former colleagues.

DT: Great. Excellent.

Well, then, let me focus on… [Doctor] Robert [L.] Ten Bensel was head of Maternal and Child Health?

BL: Yes.

DT: As I understand it, his emphasis was on child abuse and neglect?

BL: Well, I think he was basically a public health doctor. He did kind of have that sideline, yes. Again, that was an emerging thing that he wanted to make sure that residents… He also was a physician and had been at Hennepin County [General Hospital] a long time and saw lots of child abuse. He didn't want the residents going out without knowing about how to deal with that. He was very instrumental in getting laws passed and moving the whole system.

DT: I was going to ask you about your focus on children with chronic disease. This is a time when the Medical School was doing a lot of transplantations with kids. So kids were surviving with organ transplants. Presumably, that had chronic implications. I'm wondering if those children factored in at all in the development of your program.

BL: Not so much. Kids with leukemia who were surviving, actually kids with diabetes. It's a very tough disease, and it gets really dicey with kids having to take it on themselves and deal with it as teenagers. There's lots of family stuff that goes on. It's a very big deal. How do you help kids take care of themselves in a good way and not be a helicopter parent? Families can be terrified. It's really dicey. So you really want to help kids do that. That could be repeated with all of those conditions, anything that's chronic. There are 200 syndromes kids are born with. It's so much more complex than adults.

DT: I've done some research on thalassemia and the way that patients have had to grow up with and deal with thalassemia and treatment. It's got parallels with diabetes, as well.

BL: With the maternal and child health in this country, there has been an emphasis on chronic disease since 1935. It was, basically, find them and treat them. So each state has got their own program for doing that. That was part of the deal. Within MCH, which definitely influenced residency training and things like that and the government services are available, there's much more like comprehensive programming for kids and their families until they're twenty-one or eighteen. Then, they go into the abyss of adult medicine. Those training programs might have been on another planet, because they have no idea what it's like to have cystic fibrosis and be twenty-one years old. They're treating pulmonary disease and in MCH, the pediatric is much more holistic. You're looking at the family. You're looking at the kid's developmental trajectory and certainly their illness, in trying to manage it in a good way. But, I'll tell you, they're on their own once they drop out of pediatric services. There is some compensation now. We have pediatric/internal medicine degrees, things like that that compensate for some of it.

DT: During the period that you were setting this program up and running it, there's so much change in the treatment protocols and the life expectancy of kids with cystic fibrosis and thalassemia. They're actually living into their thirties and forties.

BL: Exactly!

DT: You're right in the middle of this transition…

BL: Yes.

DT: …where the patients for the first time are living into adulthood.

BL: Yes, exactly.

The one that was most seamless here at the University was hemophilia. There was kind of a seamless team, but that wasn't true for anything else that I worked with. Doctors, if they're adult focused or internal medicine focused, they think adults will do what they're telling them to do.

And they get nineteen- and twenty-year-olds who are really about something else in their life. There are a lot of kids that fall through tracks because of the way our system is. It should be better because we have HMOs [healthcare maintenance organizations] and that sort of thing. If we don't get healthcare reform that funds kids through twenty whatever, a lot of work is really for naught. It's terrible.

DT: As you say, who's picking up where your program, for example, leaves off? Who's picking up the other side of it?

BL: Yes. The individual has to. Because I had the Maternal and Child Health grant there, we had programs on transition. Every nurse practitioner knows about it and physicians know about it, too, because of Maternal and Child Health programs. We had a lot of MCH, not only in nursing when I went over there, but there were MCH programs in the School of Public Health that emphasized that. We did collaborative things. It's pretty good around here.

DT: Do you think that's a function that nurse practitioners or simply nurses can play in helping facilitate that transition for children into adulthood?

BL: Yes.

DT: It sounds like it.

BL: Oh, yes. Absolutely, it could be done. I think it's very important that kids begin to be educated about their condition, and what they can do, and work with them throughout adolescence, and, then, bless them, educate them so they can do it and support them. It's not only just about… They know—I've done research with them—perfectly well at thirteen or fourteen what they're supposed to do. Do they do it? No, it's not important to them as much as being part of a social group or achieving in something. Their disease is a problem and that will get neglected.

DT: It's so clear what the perspective of nursing and public health bring to this kind of issue. Or, actually, I'm wondering. Is it your perspective as a nurse or your perspective as a public health person that orients you to understand problems that these children face, or is it the training that you did in child development, or all of the above, I suppose?

BL: I think it's probably all of the above, and I think the emphasis in child development really, really spoke to early experience and doing that in a good way. Oh, yes. That's where healthcare can come in and be really important. If a young mom comes into a clinic and she's trying to breastfeed and she gets no help, it's not going to continue. The advantages of it are documented all over the place that women should be encouraged. Those that really want to do that should really be encouraged to do it and not make it difficult. That is like critical!

DT: That's potentially a low-cost intervention.

BL: Oh, by god, yes. It prevents allergies. It promotes cognitive development, socialization, etc.

I think it's a phenomenal thing in development, and we're not encouraging it. It makes me nuts.

DT: Yes.

BL: Midwives, nurse practitioners do, pediatricians do. I hope family practice does. I'm pretty sure they probably try also. But, again, that's not their specialty.

DT: Well, I'm conscious of the time. I could ask you a billion more questions because you have such an interesting perspective.

BL: Oh.

DT: I do want to thank you.

BL: Oh, you're welcome.

DT: This has been really enlightening for me.

BL: It's really a wonderful thing to work here at the University…an amazing time to live through. I'm sure there will be other amazing times.

Yes, really dedicated people.

DT: It sounds like you've had such an exciting intellectual and professional career.

BL: Yes.

DT: It really exciting to hear about.

BL: One thing about this Academic Health Center being located physically, geographically in this greater University, I always talked about in grants, because a lot of

them are not so located. I think that's very important. We have a lot of interactions with the College of Education, especially with the chronic disease stuff as kids were being mainstreamed in schools. They were being mainstreamed, and there wasn't any help. I could go on and on.

[laughter]

DT: We might have to reconvene at a later date.

BL: We can muddle our way through.

You've been talking to other people, like Bob [Robert] Veninga?

DT: Yes.

BL: And Lee [Stauffer]?

DT: Yes. Ruth Stryker Gordon.

BL: Oh, yes. She's fun, isn't she?

DT: Yes, she was great.

BL: That's good. That's good. Well, good luck with this.

DT: Thank you.

BL: It will be wonderful to see it. I think the School of Nursing has a history written.

DT: Yes, it does.

BL: Do they?

DT: Yes. You're mentioned in it.

BL: I am? Oh, dear.

DT: It tries to cover the history of Public Health Nursing, and it's complicated movement.

BL: Did what I said make any sense?

DT: It did. Yes, it did. It resonated before, but you had a bit more perspective on it. It's really a confusing history, I think.

BL: Yes. I think if Robert Kane hadn't come and divided the nurses up over all the divisions and said, "You're going to do research…" I really question… I think Public Health Nursing would still be in the School of Public Health, and I think it's probably better in the School of Nursing. Well, it definitely shaped the Pediatric Nurse Practitioner Program, because I don't think any other way. Since I started it, that's the way they have to think now. I don't know…they may be revising since I'm not there.

[laughter]

BL: It was their chance. Oh, get her out of here. But if they want MCH money or they want any Public Health money, they almost have to continue with a public health perspective. I think that's spilled over to some other areas, like gerontological nursing. It's great.

DT: This has been a real pleasure. Thank you, Doctor Leonard.

BL: Thank you.

DT: I'll be in touch when I have the transcript.

[End of the Interview]

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