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Barbara Scheffer, Oral History Interview, 2019

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Oral History with Barbara Scheffer (BS)

Conducted by Historic Preservation Graduate Student Matt Jones (MJ) and Historic Preservation Graduate Student Rachel Burns (RB).

Transcribed by Matt Jones

Recorded 2019, April 11 at Halle Library, Eastern Michigan University, Ypsilanti, Michigan

MJ: It is Thursday, April 11th, 2019, this is Historic Preservation graduate student Matt Jones along with fellow Historic Preservation graduate student Rachel Burns and today we are in Halle Library speaking with Emeritus faculty member and administrator Dr. Barbara Scheffer. Since her arrival at EMU in 1976, Scheffer has prepared and mentored students to give exemplary nursing care to the community and to people with psychiatric and mental illness. Progressing to full professor and then Associate Dean of the College of Health and Human Services, Dr. Scheffer received Emeritus status when she retired in 2013.

We like to start all the way at the beginning. Can you tell us about your upbringing? Who your parents are? Where you are from originally?

BS: Ok. I was born in Detroit on, I think the street was Lakepoint. When I was three, we moved to the Chicago area to, I think, Lake Forest first, and then another place and then Skokie, and then Des Plaines. My mother was educated as a secretary; she went to business school somewhere in Detroit I assume. My dad did a variety of things but he was mainly a manufacturer's rep. I think my mother was also born in as was my Dad. His name is Wesley, same as my Dad's. We were in Des Plaines for the longest time, in Illinois. I went to three different schools there. Let me back up. I went to two kindergartens- I always tell people I flunked kindergarten. It had to do with the age difference. I lived in Des Plaines until I was fourteen at which point was what I call "The Accident." My cousin had come to visit for the summer and we were- it was REALLY hot. My Dad insisted that we go up to some property that we had up in the Upper Peninsula. He flew at that point. It was the second small, prop airplane that he had. At the time, the weather was fine but it wasn't when we got up there. The plane crashed. Both my parents were killed, my cousin had a severe head injury and died a couple days later. My brother and I were in the hospital up there, Phelps, Wisconsin, for about a couple of weeks. He had a concussion but was doing ok. My injuries included both broken legs, broken collarbone and a big gash on my arm. My folks had previously prepared a guardianship situation so my Dad's brother and his wife were our legal guardians and they came up to Phelps from New Jersey and they decided at that point that the cast on my legs was not adequate. So they flew me to New Jersey and I had surgery there on both legs. The plane crash was in August of '59. I had surgery probably September. I went to their house in October, did homeschooling there through December and then started regular school in January. I was first in a wheelchair and then on crutches for a

while and did physical therapy. My uncle, who was my Dad's youngest brother, was an engineer for Bell Labs and he was transferred from the Detroit office to New Jersey. He and my aunt and their two adopted kids (ages 3 and 6) were renting a house at that time and then they built the house so we had a different house there. In the end of my junior year, my uncle transferred back to Michigan, so my brother and I came back and lived in Birmingham for my senior year at Groves High School. Then, I came up to the University of Michigan because everybody in my high school went to U of M or Michigan State. There was no other option. I was going to consider interior design as a career but decided that job prospects probably weren't great. My aunt talked me into doing nursing and I was OK with going into nursing. It wouldn't have been an ideal choice but in the sixties, there were not a lot of women going into anything but nursing or teaching. In the 50s it was even worse- it was still unusual. Baccalaureate programs in nursing were still rare at that time. I went in 1963 for my undergrad at University of Michigan. And that was an interesting experience. Luckily I passed chemistry or I wouldn't have gone on. It was a challenge. I loved organic chemistry but inorganic chemistry was not my cup of tea.

MJ: Do you remember how she talked you into it?

BS: I had to do a career paper in my junior year in high school. I couldn't figure out what to do it on. My mother, years earlier, had said no- don't be a nurse. All they do is change bedpans. She wanted me to be a secretary. But my aunt said, "Well, yeah, nursing is a pretty good profession- she should give it a try." So what the heck? I wrote a paper on it and figured that's what I'd do. I don't know if they still do them, but the tests to tell you what your talents are- aptitude tests. That one I did in my senior year in high school. And it came up that I should be a medical technologist. I thought, well that'll be interesting for about six months. And then I'll get bored. So I said "no- I think I'll try nursing instead, which has been a very wise decision, in the things that I've been able to do other than just hospital nursing which drove me crazy.

MJ: I have some questions about that, but do you remember that plane crash?

BS: No. I have what they call retrograde amnesia. At this point, I can't even remember much of it other than I remember we were at a museum that morning and that my Dad wanted to go, but my mother didn't want to go. He talked her into it. I vaguely remember taking off from the airport. I think it would have been O'Hare. It wasn't a small airport. But I don't remember anything past that. My brother does. We landed in Rhinelander in Wisconsin to refuel. Then took off from there.

MJ: Did you expect, from an early age, to go on to college?

BS: Oh yes. That was automatic.

MJ: Tell me again who your guardians were?

BS: My Dad's younger brother, Robert Miner and his wife, Ellen.

MJ; Were they also educated?

BS: My uncle was. He had a degree from Lawrence Tech. But my aunt probably just had business school.

MJ: And they were fully supportive of you going to U of M?

BS: Well, not necessarily. My aunt was. My uncle thought that being a girl, I should probably go into community college because then you find somebody, you get married, you don't have to waste all that money. But then it was my money- it was a trust. But he's been very supportive and he's always been- he died several years ago, but he's always been very very kind and caring and when I think about the fact that he was 39 when this happened and he had to all of the sudden absorb two kids when they already had adopted two kids recently because they couldn't have kids; they had a three year old and a six year old. He was always very kind and like I said, he was like, 39 when this happened and when my son turned 39 a couple years ago, I thought "wow." It kind of hits home.

MJ: What was their reaction to choice of career?

BS: They thought it was fine. My aunt in particular thought it was a good one because I'd always have an income and have a job.

MJ: You were supported in grad school how? Were you teaching?

BS: No- it was very interesting. My son was born in December of 73 and I had been working for the health department prior to his birth and I really liked the Health Department job versus the hospital because of the kinds of things I could do that I couldn't do at the hospital. After I graduated with my BSN, I said "Never again I'm not going to do this again." But after working a few years, I realized that in the Health Department I was doing a lot of counselling- there was a lot of need for counselling. That it wasn't just, you know, talking to people about how to take their pills and how to get their immunization and how to give their babies a bath and stuff. They had a lot of needs- food, housing, clothing, finances, family relationships, coping stuff. So I thought, well I'll go back to school and I'll get a degree in psychiatric nursing so that I can do a better job as a public health nurse. So I went to the University of Michigan and I talked to the counselors there, and they convinced me that I really ought to do this full-time. They said "That's not that hard to do- take a class here and a class there. Then you get through faster." And so I went home and I told my husband, well, I decided I'm going full time. He said, "oooooooook." I had a nine month old at the time -Daniel Christopher- but I managed to find some really good sitters for him eventually. So I went full time in psychiatric nursing and within probably a month of starting classes I got this check in the mail. \$2800, and I'm thinking where's this coming from? It turns out that the feds at that point were concerned that there weren't enough psychiatric nurses so they had grants and stipends available. They covered your full tuition as well as a stipend. So my husband's going "yayyyyy! Don't send it back!"

RB: For clarification, was the Health Department at U of M?

BS: No- it was, let me back track a minute. Got married between my junior and senior year at U of M. That, by the way, was the equivalent of a five and a half year BSN program for undergrad for nurses at that time. And then I lived with my husband in Hawaii for a year while he was in the navy. Came back and I worked at the University of Michigan Hospital. I think from January to March, 1969. That was disastrous because I wasn't assigned to a unit; I floated from one floor to the other. The day they put me in the pediatric ICU recovery by myself, I said "This is it- I'm going to accidentally kill

somebody. I have to leave before I do it.” At that point, my husband got hooked into this pyramid scheme- something called Holiday Magic, which was cosmetics. So I said “Ok I’ll do that with you.” Of course, I didn’t wear anything but lipstick so it was hard to sell cosmetics to people. It worked out fine because the job at the Health Department, which is what I really wanted, came through in June of that year- that would’ve been 69. The Health Department job was in the Ypsilanti office, Washtenaw County Health Department. At that time it was a combined agency of both health department and visiting nurses association.

MJ: How did you get interested in psychiatric nursing more than any other form?

BS: Because of the patients I was dealing with in public health. All of their different need and their challenges with just coping with life and relationships. It’s always been kind of something I’ve been interested in over the years, even younger. I don’t know if you call it a gift or a talent or what, but I have an ability to sometimes have enough empathy with people that I can communicate effectively, so when I thought I could definitely do a better job is when I considered a Master’s in the Psychiatric Nursing Program at the University of Michigan.

MJ: Have you had a lot of experiences with nurses, maybe in your own health care, where you thought why there isn’t more empathy in this?

BS: Oh yes. And doctors.

MJ: It has to pop into the minds of patients since the beginning of time, just why can’t doctors talk to me? Why can’t nurses just talk to me? We’re going to get into that more as we go.

BS: I have some answers for that but I’ll wait until you ask the questions.

MJ: Do you have any prior associations with EMU before you came here? The nursing program had only been here for three years before you arrived and I know your grandmother went here but did you have any other associations? Did you know anything about Eastern’s place in the community at all?

BS: It did not have a very great reputation at that time. Late 60s, early 70s. I got here in 76. Because I graduated in May and I started in August. It had a, how can I describe it? It had a lot of difficulty being next door to U of M and being sort of like, the stepchild. IT did not have a great reputation for academics that I recall at the time. It was considered...”if you can’t get in here, you can go to Eastern” type of thing.

MJ: How did you choose to come work here? How did you find out about the position?

BS: Well, we lived just down the road, so convenience-wise, it was a big issue. I don’t know how I found out about it. I may have just called them. I just got a degree- you want me?

MJ: that’s a great thing about EMU I think- you can just call them up.

BS: Nursing was a really small department at the time. I think there were only like thirteen nursing faculty in King Hall, which was a dorm originally. It was in the west wing of the hall on the second floor. I interviewed twice- once and got turned down because I hadn’t graduated yet. Then after I graduated, there was a different Department Head. So they

offered me two options. One as a psych nurse faculty, and one as the home visit coordinator. They shared with me that they had a much more experienced PhD prepared psyche nurse who was applying for the psyche position. I said, "Well, he knows more than I do because I just have a degree in it." Plus I knew a lot about home visits, so I said I'd take that position. They brought me in as a tenure-track instructor.

MJ: That became a staple of the way you taught- the home visits, going out into the community. So you had an interest in that already?

BS: Yes. Absolutely. The right place at the right time. It was lucky.

MJ: Was EMU already doing that?

BS: They had tried to do it, and weren't being very successful with it. The faculty that were managing it were not public health prepared. They were medical/surgical faculty.

MJ: OK. What drove you toward the classroom as opposed to a hospital?

BS: Convenience and having kids. The timing of the schedule with teaching- it fit better with the school calendar and young children.

MJ: I read that one of the main draws was that you got spend summer with your kids. What did people who were getting home visits do during the summer?

BS: Luckily, it wasn't that long before they switched from the year-round curriculum to a regular two-semester curriculum so they didn't have class in the summer.

MJ: OK. Were any of the nursing students still going out into the community during the summer?

BS: They better not have. WE would have some legal issues there.

MJ: OK. Well, so you said you were in King? That's where the program was? When did the Department move? Did it go right from King to Marshall?

BS: Yes.

MJ: What year was Marshall built? What year did you switch locations?

BS: It would have been in the early 2000s or late 1990s.

RB: I think it was finished in 98. That's when Goodison Hall came down.

BS: Yes that would make sense. That was interesting- when they built Marshall.

MJ: What were the working conditions like in King?

BS: Depends on which office you had.

MJ: Did you have an OK office?

BS: Yeah. I had three different offices in King. Remember- it was an old fashioned dorm. If you wanted heat, at this end of the hallway, the guys closer to the mail hall had to have the radiators on a little bit. But if you had too much, you got blasted out so you had to have your windows open all the time, including in the dead of winter. It was functional though, and the rooms had character.

MJ: I don't think it's changed.

BS: Probably not. When we moved out, the radio station moved in, I think.

MJ: WEMU moved in to where the nursing was?

BS: Yes. The day I retired, I thought it'd be fun to walk down that hallway in King to see where my office had been but it was locked up and I couldn't get down there. But I had very very vivid memories of that first day I waked down to my office.

MJ: Can you tell us about it?

BS: It was just like it was meant to be; that this was where I was supposed to be. I felt really at peace.

MJ: Did you have pressure to do research at all? I know you have published things but was there departmental pressure to do so or was it more about teaching here?

BS: In the beginning it was a big challenges because Eastern was not considered a research university by any means and the majority of faculty that came here did it to teach. Most resisted research. They figured it was a waste of time and energy, that they really wanted to focus on the students. Unfortunately it's probably that way up until maybe a decade ago. Part of it is, I think, the preparation of the faculty and most of them come with a really solid clinical background, but not necessarily a teaching or research background or skill set. A recognition that to be a good teacher you really have to understand the research process and what goes on in order to get the evidence base to teach, which was not part of our "nursing" mindset.

MJ: You encouraged students to really dig into the context of who they were taking care of?

BS: Absolutely.

MJ: That's definitely unusual in my experience in doctors' offices.

BS: This chair- I keep shrinking.

MJ: Yeah there's a lever there- you can stand up and press the lever. I do it every day.

BS: There we go. OK.

MJ: So, did that surprise students ever? When you wanted them to know why someone was having a problems they were having in addition to what problem they were having.

BS: It depended on the student but yes it was a challenge for most of them because, I don't know how much you know about nursing education, but most folks that come into

nursing have a perception of, "Ok- I need to know how to do blood pressures, I need to know how to run these machines, I need to know how to write what I need to write in the chart." It's a task oriented and a lot of the skills they learn initially are task oriented and they have to be checked off to know they are doing it properly. They can kill people if not. So when you work with somebody whose mindset is "I have to learn all these tasks," it's sometimes difficult to make the transition to "There's a person that we are taking care of." To help students who are anxious to learn the procedures properly, to help them also capture in their mind the fact that there's more to it than just doing the task, that they really need to look at the big picture of what's going on with the patient, what's going on with the family, what's going on in the environment that has an impact on whatever the medical disease process is that's going on with them. It's a challenge but luckily I have a fantastic research/writing partner. We worked on stuff together. We wrote five nursing textbooks. Some have won several national awards.

MJ: I think I have the title of something you published here. There was a title, "Snapshots of Nurse's Personal and..." What was it? I know it was you. Maybe I'll remember it as we go along.

BS: I didn't bring my CV but it's probably in there.

MJ: "Snapshots of the Personal and Professional Lives of Nurses and their Mental Health."

BS: Oh that was my master's thesis. Yes. That was an interesting project. Turns out I was doing qualitative research and didn't realize it. I was in the psychiatric nursing program at U of M, and the research component is really heavy. Most people end up with a doctorate after that, but back then it was just a nursing degree. I don't know if they've change it now. Because I was a nurse, in psyche mental health component of it, I worked a lot with schizophrenic patients and the thinking back then which has been debunked now, is that the schizophrenic patients are not able to think into the future. That they can't recognize that they have these problems that they have. So I designed a study in which I had a group of patients draw a picture of themselves at that moment. And then I had them draw a picture of what they would like to look like in five years. There wasn't a statistically significant difference but my analyzing their drawings there were finite differences in the drawings, showing a more positive affect or appearance. Somehow I managed to crunch numbers in there somewhere. I can't remember what I did. The School of Nursing was not into qualitative research back then, which is where my preferences are, which is what you're doing.

MJ: The title of that, of your thesis, made me wonder about- do you teach nurses how to take care of their own mental health?

BS: Yes. It doesn't get considered often. It depends a lot on the program they are in, the preparation of the faculty that are teaching, the priorities that the faculty take. Much of the literature that came out in the 70s, focused on nursing faculty were very punitive in relation to students. It was sometimes referred to as "Eating our Young." Nursing staff were very punitive to new staff people and nursing students and that kind of thing. I think Friere did this stuff on oppressive group behavior. His theory is that when you've been oppressed for so long, you tend to take over that role when you've got somebody to oppress. That happens a lot in nursing. The thing that I think is helpful is, do you know about all the different ways to become a nurse?

MJ: I don't, but I'd like to.

BS: Ok. The original way to do it was to go to a diploma school. That's what Florence Nightingale did. It was usually two years in a hospital where you had a few classes but most of the time you worked like an apprentice on a unit, taking care of people. You had to do things like stoke the stove with coal, make sure that your uniforms were the right length and color. You couldn't date and you couldn't get pregnant- that meant it was all over. You couldn't get married sometimes. You'd learn through the work process. Then in the 50s, shortly after World War II when the real shortage of nurses was coming into being, they started the community college programs- the associate degree programs. They are about two and half years but they are very task-oriented. They're not into the humanities and some of the other general studies courses that we take in the baccalaureate level program. The baccalaureate nursing programs I think started in the late 1940s and that's a four-year baccalaureate university degree in which you have at least half of your classes are general studies, like English, history, Sociology so that you get that broader perspective of people and society. Then you also have the clinical and the tasks and the stuff that you have to do. Now all three of those people are able to sit for the registered nurse exam that is required after graduation if you want to be legally licensed to practice nursing. They all get the same credentials- RN, after their name after they pass the exam. But what they are finding is, and they have done some extensive research on this, is that the more baccalaureate prepared nurses you have on a unit, the lower the mortality rate of patients. BSN prepared nurses are better able to see that bigger picture of the patient. They can recognize when patients are going sour. What happens sometimes is they have "failed rescue." That's the terminology they use when the nursing staff is not prepared adequately to recognize when patients under their care are deteriorating.

MJ: Is there a way to track nurses that come from a particular school and their progress, their performances?

BS: Some hospitals do that. I have heard anecdotally that the hospitals around here prefer EMU students to U of M students.

MJ: Do they explain why?

BS: Yes. Because many U of M nursing students don't want to do anything. They don't want to take care of patients. They just want to sit and be administrators. At least that is the feedback I have been given.

MJ: No empathy over at U of M.

BS: It's a very interesting dynamic and I've got two degrees from them so I can complain. They are rather elitist in their approach to healthcare. I think I have seen our students- I don't know if it's a different demographic that comes in, but it's a different work ethic in the sense that our students jump in, do anything, are delighted to work with patients. I think it's possibly because of the program. U of M-type, big universities like U of M, they have so many resources for clinical sites that the students are not exposed to a variety of different clinical sites, different staff, different resources, etc. Eastern does not have a hospital so we had to go out to many local hospitals, such as Garden City. We have to send them all over the place to get their adequate clinical experiences so EMU students

have a much broader background in experience, problem solving, administrative policies, and interactions with different staff.

MJ: Do you think that Eastern students have less of an idea who they'll be treating when they get out of school? When you said there's more of an elitist attitude at U of M, I thought well maybe, do students go into a program thinking, "When I get out of here, I'll be treating people that are just like me?"

BS: That's an interesting question. I think that the hospitals that they have gone to...most of our students come from this area so they're familiar with the demographics and the populations so they probably have a sense that these are "just like me people." U of M gets a broader base that they draw from, including more international. But nowadays, international patients are also in smaller hospitals.

MJ: Do you remember your first impressions of the first Head of the Nursing Department? Janet Boyd?

BS: Actually she was not the first director. It was Gertrude Burtz. German or Norwegian. She was the one that worked with the biology faculty and other folks to create the program. She was very futuristic-sighted in the sense that she wanted the program not to be hospital-based at all. She wanted it to be engaged in the community because she saw where healthcare was going. Unfortunately she was probably about 30 years ahead of her time because it didn't move as fast as she thought it would. That was why we had the home visit component built into the program. She didn't last very long, and I don't know where she went. Janet Boyd was the one that hired me and she was from...she had a long distance relationship the whole time she was here. Her husband was at the University of Wisconsin. She was here for quite a while. She left and we had an interim for two years and then Regina Williams was here. Then I was here, and Marcy Sue Mars was here, and then I was here again. I was Department Head I think three times. They decided that when Dr. Williams left, or was asked to leave, we were sort of in a flux. We had to have a director who was a nurse because of the state legislation laws. So we were at a faculty meeting and one of my colleagues said "well why don't we have Barb be the Department Head," and I went "what?!" I had just gotten my doctorate and was thinking "You've got to be kidding guys." I said "Ok I'll do it for a little while as long as you keep hunting for someone else." That's when we got Naomi Erwin.

MJ: You came after someone named Dr. Williams? I have to ask- why did they ask her to leave?

BS: I'm trying to remember exactly. She didn't exactly like to play the game with the big boys.

MJ: The big boys being administration?

BS: Yes.

MJ: What was difficult about it?

BS: A lot of the same things that are difficult now. They had ideas about what it should be, how many students we should admit, how we should run things in the nursing program, and how many credit hours. She said "that's not good. You can't admit more students than we have clinical space for."

MJ: I don't want to jump too far ahead but was it called the School of Nursing in the 1990s?

BS: No. It was the Nursing Program in the College of Health. Originally when I started it was the Department of Nursing Education. And then they changed the name to the Department of Nursing. Then, when we were in Marshall, it was probably somewhere before 2010, would be my guess, that we were looking at the issue with grants and with research money and stuff. The faculty believe that if we were a "school," we would have a better chance in seeking funding, external funding. Of course then all the other departments decided it was a good idea too. Now they are all schools in the College of Health and Human Services.

MJ: I read about administration wanting faculty to take on more work hours for no more compensation. It seems like in all the interviews we've done, there's always a component of every interview that is faculty tension with administration. Obviously that doesn't seem to change. I looked at the faculty directory and I think the entire program was female. Do you think that had anything to do with not considering compensation while raising your work hours?

BS: Yes. I think so. There was a big lawsuit, class action lawsuit that would have been 1980s would be my guess. It wasn't just nursing, it was female faculty throughout the University, that were through the union at that time, trying to make a case for the fact that female professors, associate professors, were doing the same work level and the male professors but did not have the same pay scales. I don't think it's unique to universities; I think it's across the board. I think it's improving, but I really don't pay that much attention to it because money was never a driving force for me. I was part of that lawsuit just because I came in at a certain time and was one of the female faculty but I never paid a whole lot of attention to that. And we didn't win.

MJ: I was wondering about the outcome. A judge said there was no evidence of irreparable harm but adding all those hours.

BS: The thing with credit hour production, and I'm sure you guys have seen this, is nursing has out of necessity, just like doctors do, a certain amount of clinical time that you have to have. You have classroom time, you have in-house lab time, and then you have clinical time. Now, classroom time is easy to calculate: you have a two hour class, you get credit for teaching two hours even though it takes you sixteen to prepare for it. The laboratory time is kind of fuzzy at times because if you have four hours of lab, it varies from department to department of how much credit you get for being there four hours with students. Sometimes you get two hours, sometimes you get one hour. You don't get all four. The clinicals are six to eight hours and the most credit you get is usually two. So you've got not only six to eight hours with your students in the hospital making sure they're not killing people, plus doing all the prep for that and all the follow up with paperwork that students have to do. So that eight hours is easily sixteen and you get two hours of credit. So what they were trying to do is at least increase the amount of time, and it may not have been two, it may have been four or eight or something like that. They were trying to recognize that in professional programs, when you've got a clinical experience, you've got to recognize that faculty is not just lollygagging around= they are doing some serious work. You have, for that six to eight hours, and you have ten students, and they have two patients apiece, you have some responsibility for twenty patients.

MJ: And that all comes back on you as the instructor right? Those patients are your responsibility.

BS: To a certain degree. The hospital staff ultimately has responsibility, liability but you don't want you students killing people.

MJ: Did that ever happen?

BS: Students make mistakes, but to my knowledge we've never killed anyone.

MJ: I'm glad we got that on the record.

BS: The typical student mistakes are mess ups on medications. I did it as a student. I had two patients and I gave them the opposite medications. I talked to the doctor about it, was very upset, and the doctor said "Hmmm well it will probably do them some good."

MJ: We'll treat this as an experiment. I wanted to ask you about sending students into the community. What spectrum of activity were they doing? Were they going into homes? Were they going to clinics?

BS: They were doing all of that. WE would go into patients' homes, we would go to outpatient clinics. It was a time when we could go to schools but they don't have that many school nurses anymore so that doesn't work very well. We could go to industry. We would go to health fairs in the malls and stuff. Lately they started going into prisons. Senior centers. The whole gamut of ages and wherever they might be in a cluster.

MJ: I know that you did it, and the program was a five-week program?

BS: IN the beginning, it was all intermixed within their course. So for instance, the course that they would have in medical/surgical nursing, the patient they saw in the hospital gets discharged and then followed home. They help them with whatever teaching or adjusting back at home.

MJ: How would they get placed? A student nurse with a patient?

BS: because they worked with them in the hospital. The student would be taking care of the patient in the hospital and then followed up at home. But they would only do one or two home visits. They didn't do a whole gamut like you would if you were a public health nurse.

MJ: There's no school nurses anymore?

BS: Very few and the ones that out there are covering more than one school. It's a lot of paperwork. You don't have the nurse's office there. It's too much paperwork and they have to follow up on immunizations and issues of abuse. An uncomfortable thing.

MJ: In the early to late 70s, I was surprised to see so many people applying to the nursing school but so few being admitted. I think I saw a number like 200 applications and 60 admittances. Why were so many people applying?

BS: It's a good job. No matter where you go you can get a job. It was a challenge in the sense of, how can I say this tactfully, nowadays because it was and is a good job and the economy is as it is sometimes, people that are applying are not as well-qualified as they used to be back when I went to school. You automatically had certain GPAs. We have the same problem today. I don't know the exact numbers but up until when I was retiring it would not be unusual to have 200-250 applicants for 80 positions because there's a shortage but it also is a good job. The pay has improved significantly over the years. Starting pay for baccalaureate nurses probably, depending on the region and the facilities, somewhere between \$60-80,000.

MJ: Looking at the numbers, the program also grew a lot. Was the program hiring more instructors? How did it grow and how large did it grow by 1980, 1985? What did that number of new acceptances rise to?

BS: We originally, back in the 70s, I think they only admitted 60 people, and then they rose it to 80- and in order to do that they negotiated with administration to make sure we had a couple of extra faculty to manage the loads. The problem is, let me back up. In order to run a nursing program, you have to be approved by the state. The state has certain requirements that you have no more than ten students per one faculty member in the clinical site. You also, if you know what you're doing, you also need another level of approval which is called accreditation. That's through the National League for Nursing or the AACN, which is American Association of Colleges of Nursing. That is not mandatory but if you don't have it, good luck trying to go to grad school. They have certain requirements as well. Theirs are more focused on the curriculum that you have, how much clinical time you have, what are the credentials of the faculty, what kinds of match you have between your program objectives and your outcomes and whether or not your students pass the NCLEX which is the state licensure examination for registered nurses to be allowed to practice nursing in the state. So, in order to manage the volume of students, you have to have at least a certain number of faculty and most of the time administration will recognize that and they gave us more faculty over the years. So now, not only do they admit 80, what are called "generic" students- the ones that don't have any nursing background, The School admits a group of about forty second-degree students. In other words these students have a bachelor's degree in something but they want to be a nurse. We also admit the RN to be BSN students, which are the ones who completed an associate degree program. They have become an RN but they now realize that the baccalaureate degree is going to help them advance in their practice. We had the RN to BSN program in at least five different sites off campus. They are now offering online programs so that I have no idea how many people they have registered, but it is growing significantly. Then there's the master's program and they admit 40 into that program. Admission to all programs is confined by the number of faculty you have and the number of sites that are willing to take your students for clinical experiences. Because of the current nursing shortage, the need for new nurses exceeds the capacity of programs to teach new students.

MJ: You mentioned the master's program here. It started in 1993, and how differently were nurses treated that didn't have master's degrees?

BS: It depends on your setting. You could not teach at a university without a master's degree. In the hospital setting there were very few Master's-prepared nurses. Most folks with a master's degree were probably going into teaching or to some level of administration.

RB: There's no nurse practitioner program?

BS: Yes we do have that now. That's another interview.

MJ: When were you appointed Dean of the College of Health and Human Services?

BS: Associate Dean. That was another one of those flukey things. Dr. Murali came into my office one time and said 'I need an Associate Dean.' I said "Good for you!" he explained what it entailed and I said, "well, never even considered this but I suppose if you think I can do it, I'll give it a try." And so I was Interim Dean for probably a year and a half before they converted it into a real position.

RB: Who was it that approached you?

BS: Dr. Murali Nair, he's the current Dean of CHHS.

RB: Thank you.

BS: We've had a rotating Dean at that College for a long time. \

MJ: Why is that?

BS: That's a good question. I think we had...who was the first guy...Bob Boisenau. And then we had some woman and then there was Betty King and Betty King who was asked to leave. Then there was Jeanni Thomas I think. Then Jean Thomas left and then Dr. Murali came in and then Deb DeLaski Smith was in, and then Murali came back, and he's been there for at least ten years now. It's a difficult role because there's such diversity in the different schools and it's hard to develop systems that work for the whole when these are so different. Now, they're all professional programs and that makes it a challenge at the University level because most of the other colleges don't have the same kind of accreditations and clinical stuff like professional programs. So it makes us kind of unique at the University and until recently the College of Human Services was the only one who was producing enough credit hours to do well. More than the other colleges.

MJ: Did your perspective on a place like EMU change when you go from faculty to administration?

BS: Yeah I think it has to. Whenever you move from a worker position to a leader position, you've got to think broader. You've got to look at it from the economic as well as the practice perspective. Just because as a faculty member, we say "Oh we're working all these hours, we really need more faculty, w4e need more of this and that." You get to the administrator role and you say "Yeah, you do but if we give you this, we can't do this other thing." So it's a balancing act. A different kind of balancing act. The other thing that I shouldn't tell you, but I will, when I moved from faculty to Department Head, my biggest shock was that I thought I was working with adults and I was really working with two year olds.

MJ: Do you mean the other people in the Department?

BS: Yes. The faculty that I used to be.

- MJ: What kind of challenges did you find yourself dealing with that were new when you became Department Head and when you became Associate Dean?
- BS: Budgets, a lot more reports, computers, paperwork, a lot more meetings, helping people be comfortable in sharing concerns without telling them they're stupid. When you're a faculty member, you've got thirty students in your classroom and you've gotten in a clinical. You're balancing forty, fifty things at the same time. When you're an administrator, it goes up exponentially. You're looking at a hundred different things at a time and you're attempting to solve small problems and big problems and we go in in the morning, we've got a list of twenty things you have to do and when you go home there are twenty-five things. I did notice, particularly in the Dean's office, I had a lot more towards the end a lot more eye strain. From being in front of a computer a good portion of the day.
- MJ: I know that you had a hand in creating the study abroad program for nurses?
- BS: No- I facilitated the PhD program. It was Educational Studies and it was a collaboration between the College of Education and the School of Nursing in CHHS. Basically what we designed was a program for educators and nurses working together to get a PhD in Educational Studies.
- MJ: Working together from countries abroad?
- BS: No- it didn't have anything to do with countries abroad.
- MJ: Hmm. I wonder where I got this. A nurse exchange program.
- BS: I know where that is coming from. It evolved from the work in the PhD program, but I wasn't that directly involved with it. But there is a group there now that is working with folks in, I think it is Taiwan, and they are doing an exchange with the Taiwanese nursing students to come here and four nursing students to go there.
- MJ: Would you be an administrator again? Was it a good choice for you do you think? A good fit?
- BS: It actually was better than I thought it would be. It was a great way to do something different before I retired because I was getting bored. It was a nice new challenge. I had originally said when I came to Eastern that I would be here for two years because I knew I'd get bored. So thirty-eight years later, I finally decided it was time to retire.
- MJ: For some it might seem hard to imagine something like nursing getting boring because it seems like it has to change so often. Technology changes and that must change everything else. When do you think you started to lose a little steam and get bored with it?
- BS: Probably after about, I don't know, thirty five years. There was enough variation over the years and initially the kind of content you teach- if you are teaching something that doesn't change, that gets really boring. But in addition to the focus of the content, I was able to do a variety of different things. I worked with the students initially for the home visits, but then I taught in the entry level course that had a lot to do with what we call the

“nursing process,” which is a problem solving process. I’d had some of that in my master’s program because it was just coming into vogue then. I didn’t know much about it so I had to learn in order to teach it, and managed to stay a week or two ahead of the students. It allowed me to move into that which developed into my interest in diagnostic reasoning which developed in interest in critical thinking, which developed into our writing of the books and research with my colleague, Gail Rubenfeld. We did numerous local, regional, national, and even international presentations about our work as well as writing textbooks.

MJ: Was that one of the main reasons you retired when you did?

BS: I was 68 at the time, I figured it was about time I retired. Most of the reason. I may have stayed another year or so, but the technology, the computer stuff, the reporting stuff was getting to be too much. I decided this is for younger people.

RB: How many textbooks did you write?

BS: Altogether, five. The first one had two editions, along with some instructor manuals. The second one we had three editions. All this was in collaboration with my colleague, Gail Rubenfeld.

MJ: What do you think are some of the weaknesses of the institution? And also the strengths?

BS: Of Eastern?

MJ: Yeah.

BS: I think the weaknesses are primarily leadership or lack thereof. I’ve always been concerned over the years that the Regents are not in tune with the University itself. They are not academicians. They are business people, which is fine on certain levels but there needs to be a balance in there. I don’t think the decisions that are currently being made are very smart but I’m not in higher administration so I can’t be sure. Where they’re contracting out the parking, contracting the housing, which is one of the stupider moves. It just is mind boggling that when you think of us as a commuter campus, why do we need more housing? I don’t know all of the ins and outs so I’m just basically an outsider on that. I think the strengths of the University are the faculty. I think they have been dedicated to students from day one. There are always exceptions but the majority of faculty are so committed to helping students succeed. I’m not sure the University is as committed to that because what they’re doing- they’re admitting everybody under the sun but they’re not providing the support systems to help them succeed. One of the big areas that is growing at the University and is trying to have an impact is the writing center, which is downstairs here. They have no idea- the University has no idea what a treasure they have in Professor Ann Blakeslee- the energy she brings to her field. We worked a lot with her in developing some of the writing stuff for nursing.

MJ: I love the writing center. It’s my go-to when I’m desperate. And I’m glad to have a go-to.

BS: She has struggled over the years for resources. We went to a conference together several years ago when we could present a paper of how nursing and writing centers could work together as we had done. To hear what the others were doing around the

country in their writing centers, not with nursing but with other things- it was pathetic compared to what we have here. Without Anne, I don't think we would have had anything.

MJ: That's all the questions I have. Do you have anything else you'd like to say on the record?

BS: Hmmmmm. Well, I don't think so. Although the teacher in me wants to say, do you know the difference between nursing and medicine?

MJ: No. I don't. Please explain.

BS: OK. Well, physicians, and this goes back to your question earlier about they don't have more empathy. They're not trained that way. Some of them now are. Some of the PAs (Physician Assistants) are a little more. But most physicians are trained to know anatomy and physiology and all that good stuff. They usually do not have courses in nutrition, they usually do not have courses in communication. They usually do not have courses in human relationships. They have medical stuff and therefore, you know, we give them a little bit of a break because they have been socialized in one way and not necessarily the other ways. Some of the newer ones are coming out as private practice practitioners- they have a much better background in how to interact with people that have an illness. But physicians' primary job is to diagnose and treat an illness. So somebody comes in, they're not doing well, they all of a sudden have this unquenchable thirst, they're going to the bathroom a lot, they're not feeling good, they exhibit a cluster of symptoms. The physician goes through an algorithm and asks certain questions, and "yep- you probably have diabetes. We'll run these tests that only I or my PA or the Nurse Practitioner can order. So the physician says to the patient, "Based on your test results, you have diabetes. We want you to go and start eating right, exercise, come back and see me and we'll see if you need insulin." The nurse is going to see this same patient and is going to recognize the likely medical diagnosis, even though he can't diagnose the medical problem (unless he is a nurse practitioner), that it's probably diabetes. He's going to work with this patient and say "OK let's look at who you are. What kind of family you live in, who cooks the food, who buys the food, how you will manage this new diet and how are you going to fit it into your lifestyle. What are you going to do exercise-wise, sleep-wise, skin care, how you going to wash your feet and make sure they don't get problems because of the poor circulation from your diabetes. We also need to watch for any changes in your vision." That type of thing. And then he's going to maybe talk to the family members, how they're adjusting to this, whether or not this is so traumatic that they're going to go into a depression or whether you can handle this big change. So the nurse is going to make nursing diagnoses, and there are fancy labels for them but basically nurses are looking for alterations in activities of daily living, nutrition, exercise, skin care regime. He's going to deal with the big picture while the physician is focused on an accurate medical diagnosis and treatment for that diagnosis.

MJ: It sounds a lot like what I think of as social work.

BS: There is a fair amount of social work in there. There's physical therapy in there. There's occupational therapy in there. The nurse, basically, in the ideal world, would be the case manager and make sure that the doctors are communicating with the patient, the social worker and the physical therapist too. But there is a lot of blending of the professions but

the nurse is the one educated to look at the big picture and be sure all the professions are working together.

MJ: It's nice to know that there is a whole program here and people teaching that.

BS: it doesn't always get through to everybody but it's the goal.

MJ: I remember you saying that you cringed at the idea of being a pill pusher in a hospital.

BS: Oh yes.

MJ: I was wondering about students coming in and thinking that's what they're going to be. Are those students here?

BS: Oh yes. EMU has them, U of M has them, and the community colleges have them. We used to call them refrigerator nurses because they'd work long enough to pay off the bills, buy the fridge and then take off. Come back later. What we like to think of the professional nurse is when this is not just a job- this is a profession and you look at it from a different perspective than just a simple occupation. Not everybody does, and even the ones that graduate from baccalaureate programs don't. But if you have one of them taking care of you, you know the difference and you feel really cared for and safe.

MJ: Could you tell that about students coming into the program? Could you tell right away?

BS: Yes. Unfortunately, and you have to be careful that you don't stereotype folks but it's a mindset that you can see in students that are interested in learning, that have curiosity, that are not into ego trips, that are able to see things, see all the grey and not the black and white only.

MJ: You must have turned some around from one way to the other. That must have been gratifying.

BS: I think that's why you stay in teaching; it makes a difference. I had a student years ago in her first clinical rotation and she had "attitude." I pulled her aside and confronted, respectfully, her behavior. Years later I ran into her at the University Hospital when I was teaching another group of students. She recognized me and said "Hi," and then said "Do you remember what you said to me?" She reminded me of what had happened. I said "Yep- I have a general idea now that I remember your name." And she told me that I really turned her around and I congratulated her on her many successful years in practice. Today it's a whole different population coming into nursing. Some of it is the same as years ago, but "attitudes" are much more privileged. I don't know whether its kids in general, but the entitlement stuff is pervasive.

MJ: In students?

BS: Yes. Helicopter parents too. It's just mindboggling. We've had to tell parents that there are privacy laws and we can't talk to you because your kids are adults.

RB: Have you seen an increase in male students?

BS: A fair number. It's nowhere near 50/50, but it's moving in that direction. In the 70s, we had one or two, and now we average, I would guess probably between 5 to 10 per cohort. I think the stigma of going into a female-dominated profession is dissipating. Most of the males that come in are interested in the ER or moving on to become nurse anesthetists. Some are quite happy doing floor nursing and public health, and they're good. We have trouble with some clinical placements for students in settings where patients will only accept female nurses based on the patient's religion or custom. Because there is a large percentage of the Muslim population in Southeast Michigan, female patients prefer female nurses and physicians. And staff and nursing instructors make the necessary adjustments.

MJ: Anything else you'd like to add?

BS: I can't think of anything.

MJ: OK. Thank you so much for coming.

BS: You're very welcome.