INTERVIEWEE: Ruby Wilson
INTERVIEWER: Jessica Roseberry
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PLACE: Multimedia Room, Duke Medical Center

WILSON INTERVIEW NO. 4
[*note on the transcript: Dr. Wilson responds at times to written discussion points previously sent to her by the oral historian*]

JESSICA ROSEBERRY: This is Jessica Roseberry. I'm here with Dr. Ruby Wilson. It's September 14, 2007, and we're here in the multimedia room in the Duke Medical Center Library. And I want to thank you so much, Dr. Wilson, for agreeing to be interviewed. It's a real pleasure to talk with you today.

RUBY WILSON: Thank you.

ROSEBERRY: First, we're going to be talking a little bit about the medical school today, and your relationship with the medical school—but obviously your influence was so much in the school of nursing, and I wanted to outline overlap between the two.

WILSON: As we just mentioned in our remarks before we started this interview, we really look at the medical center with its components being the school of nursing, the school of medicine, and the hospital more often than just the medical school. However, I don't believe there was or is overlap as much as they were/are three distinct entities with separate organizational structures with separate but congruent purposes. Since we are referencing my past participation, I will use the past tense of verbs. The administrative heads, of course, did have to work together, because we were all of one family, so to speak. I would say that where issues were discussed that affected either the totality of the medical center, or at times one of the distinct entities was in the vice president for health

affairs administrative policy committee. I served as dean from 1971 to 1984 for the school of nursing, and during that time I sat on that policy committee. There would be a number of issues that would come up that would very often affect just one entity, but the heads of the other components would have input into the discussion. Then there were areas, because we were separate entities serving under the vice president—who at that time was Bill Anlyan—that we discussed in individual conferences with him on a regular weekly basis. Issues and their attending details that really would be of noninterest for others in the remaining administrative structure would be dealt with at that time. I would say that collaboration for patient care occurred more through the clinical departments in the school of medicine and then also within the hospital, which included the Department of Nursing Services. When I first came to Duke in 1955, we really didn't refer to a medical center. That really—I'm not quite sure what year the term *medical center* came about, even though the school of nursing certainly was in existence, as were the school of medicine and the hospital. I was a new faculty member in 1955; I was not as attuned to what was going on at the upper echelons, as far as the administrators were concerned. However, I was aware that the dean of the school of nursing was not as involved within policymaking committees of the medical center as I ultimately became. I guess it was also remembering that situation when they talked with me about being dean that I indicated I wished to sit on policymaking and advisory types of committees I believed the school of nursing should be more vitally involved within the medical center and the university than what I perceived it to be when I was here as a young faculty member. Even when I came in 1955, Duke Medical Center was still young. It only came about as

a medical center but without that nomenclature, in 1930-31. Thus, there we were at twenty-five years, having a silver anniversary when I arrived.

You indicated you wanted me to speak a bit about working with Dr. Anlyan. One of our first ventures together was when I was here as a young faculty member in 1956. Bill had just finished his surgical residency and had come on the faculty. He was asked to head up what was called the MEND project, which was Medical Education for National Defense. I was identified to be the nursing component. At that time, we thought there was a possibility of an atomic bomb attack in the near vicinity because of all the cigarette factories in Durham. Even though it was after World War II, there were other wars going on; cigarettes were seen as a morale factor. Also at that time—Oak Ridge, Tennessee is not really that far from the borders of North Carolina. So it was thought Durham might be an attractive target as far as nuclear bombs were concerned. Anyway, Bill and I planned a disaster program for the medical center. To test the radiation fallout portion of it, we had an overnight experience of faculty and staff with their families coming together to mimic a drill in case there would be a nuclear disaster. We had canvassed the hospital for safe areas with the assistance of Conrad Knight who had recently been hired as the radiation officer. He had measured the thickness of the hospital's very thick walls of stone and had identified where were the safest areas. Thus, Bill and I knew that if there was a nuclear attack, we knew exactly where we would be found in the hospital, (*laughs*) because of that. But further, we became aware of the underground tunnel between East Campus and West Campus. Were you aware of that?

ROSEBERRY: I was not.

WILSON: This is where the pipes for heating, air conditioning, electricity, and so forth can be found; it's about a mile long. So we walked through it and decided it would be a great place for individuals to locate some sense of security if there would be a nuclear disaster.

ROSEBERRY: How big is it? Were you—is a person—?

WILSON: Oh, yes. You can stand up in it. There's a ground floor, of course. But there's also lighting. The space available was sufficient so that in addition to being able to take care of the Duke community—which meant the faculty, students, staff and their families—that we really could take care of all of Durham, if necessary, within that tunnel. I believe the Durham population at that time was about 65,000. We stocked the tunnel with all the disaster supplies that were perceived as necessities, such as water, crackers that were in metal tins, and toilets. I can't remember all the items we stocked, but, you know, there were certainly some medical first-aid types of supplies, too. Bill and I decided we should have at least one trial of testing a nuclear disaster situation. We used a large room in one of the buildings over on West Campus, I think it where the Department of Sociology used to be. We did not use the tunnel. We put out a call for volunteer from the administrative staff and faculty within the medical center, and we had around 100 physicians, nurses, and members of their families, which included children. We entered the room, which had an immediate outside door, about five o'clock on a Friday afternoon, and the drill was to last until noontime on Saturday. You might think that's not a very long time, but it was a very crowded situation with adults, teenagers, and young children of both genders. There were few chairs, so mot people sat on the floor. Once people came in, they were told they could not leave, because there was nuclear fallout outside,

and they would become contaminated with radiation if they left. Also, they were informed they really could not come back into the safe haven, as they would be contaminated with radiation. We had supplied food and water to each person when they came in. I am not one that drinks a lot of water ordinarily, but when you realize that it's going to be rationed, all of a sudden it's amazing how thirsty you get! I began to drink my water, and then I looked around and saw other people putting their water down and leaving it, not protecting it. If individuals desired, they could really go and pick up somebody else's water, confiscate it, and hide it. Those persons who missed their water would ask, "Have you seen my water?" and try to find it. Often to no avail. We had several volunteers to help us plant likely situations that would be a challenge. One was a child who developed measles. Then the child had to go into isolation. We had curtained off a corner of the room for an isolation place. Of course the child wanted company—the mother or other kids with whom to play. There was trouble trying to keep the child isolated so the other kids wouldn't get measles. We had an expectant mother who went into labor, and we had to isolate her and identify a nurse and doctor to deliver her. Another person was assigned to became very rambunctious and be very negative in their behavior to create another situation. Another person was assigned to say she wanted to leave, and, in fact, finally did leave, and then wanted to come back in. Of course we had to say "no" to that person. Time goes on, and it creeps up on to being midnight. It's time to go to bed and turn out the lights. Well, the only place to sleep is on the floor. Some people did bring blankets. You end up being beside each other, either head-to-head or toe-to-toe. It might be somebody who snores, and, if you are you going to turn yourself around, you're going to smell the other person's feet, because they've taken their shoes

off. So you have to make (*laughs*) that kind of decision. Then you find that some people don't sleep, they sleepwalk. Other people just couldn't sleep with being in a crowded area. So—the bottom line is we had all kinds of situations. Then the morning comes, and let me tell you, everybody was glad when noontime came and we could leave from being boxed into a small physical area and having to put up with various behaviors of human beings from being under stress. That's a long story just to answer Bill Anlyan's and my first working together. After that, we had disaster drills at least once a year. I remember the first one we planned on a large scale was, again, a nuclear attack but during a football game with thousands in the stadium. The medical and nursing students volunteered to be the victims, and so they were all lying on the ground near the Wallace Wade Stadium. Because of radiation, you develop nausea and vomiting as a side effect. We had made up this wonderful brew of vegetables, including canned, like corn and tomatoes with mushroom soup. We just ladled it out over the student victims. We also had some victims with broken arms and legs and some had open wounds, which were simulated with plastic wounds. Triage was utilized to separate those whose lives could not be saved from those who could be saved. It's the very opposite in a disaster of what we do ordinarily when we take care of patients: we usually take care of the most seriously ill or injured first. Where you have scarce supplies in a disaster situation, you have to decide how you're going to use those scarce supplies, so you try to save those whom you know believe will probably live. We had a 1-2-3 priority classification. The victims were put on stretchers and taken to our emergency room where another triage occurred. Some had to have surgery, others were admitted to the hospital and others had emergency room care. Today we still have disaster drills, but circumstances other than radiation are

used. Bill and I had to work closely together for this disaster program, so we got to know each other quite well in 1956-57. Then I left Duke for a couple years and was in California and Ohio, and then they enticed me back to Duke after I completed my masters degree. In 1959 Bill was doing general surgery and I was teaching nursing students in their senior year. At times they cared for his patients, and Bill and I would have interactions for that reason, but we didn't work closely together again until I became dean of the school of nursing in 1971.

I had a leave of absence from Duke University in 1968 and was in Thailand as a special consultant and visiting professor with the Rockefeller Foundation, New York City, to assist in developing a new research medical center in Bangkok. It was around the end of my first year there when I received a telephone call, halfway around the world, from Bill Anlyan, asking me to come back to be dean of the school of nursing. I said, "Bill, you know I have always eschewed administrative positions, and I have never, ever wanted to be a dean. Clinical nursing is my thing. In addition I am in an employment agreement with the Rockefeller Foundation here in Bangkok". He said, "Oh, we need you worse than they do." I responded, "Well, I don't know about that." What had occurred at Duke involved the dean of the school of nursing, and, actually, it was one of the reasons that I accepted the Rockefeller Foundation offer. The person who was serving as dean of the school of nursing was director of patient care. She—it was Myrtle Irene Brown. She had been appointed while I was on sabbatical and educational leave doing my doctorate, which I did here at Duke. However, I still had interactions with my faculty colleagues and knew about Brown's presence. I had known about her coming and had learned from the nursing faculty that none of them had interviewed her. Upon

learning this, I made an appointment with Barnes Woodhall, who at that time was vice president for health affairs.

ROSEBERRY: So the school of nursing faculty had not interviewed her?

WILSON: That's correct. So I went in to see Barnes, and I knew Barnes from his being a neurosurgeon, and, with students, I would take care of his patients. Also his daughter, Betsy, had been one of my students when she was a senior. I went in to see Barnes and told him that I was extremely upset to learn that Dr. Myrtle Irene Brown was coming into the deanship position, and the nursing faculty had not interviewed her. He said, "Oh." "Oh," he said, "Well, we'll take care of that. We'll have her come back, have them interview her." I said, "Not after you have already offered her an appointment and she has accepted it. That's like closing the barn door after the cow is gone. How would you feel if the dean of the school of medicine was brought on and the school of nursing faculty rather than the school of medicine faculty had the person interviewed for the deanship?" "Oh, oh, I—yes, I understand what you're saying." That is an example of how physicians in administrative positions frequently made decisions without always including individuals who should be included. To return to Dr. Brown, I have to admit I didn't know firsthand, because I was not working with her, but I did hear reports from my colleagues as far as Dr. Brown's service in her role as dean and did not think that I could probably work well with her. I went to see her and to inform her that I was going to resign because of my decision to accept an appointment with the Rockefeller Foundation. She said, "Oh, we'd be very pleased to have a faculty member serve with the RF, so why don't you just, you know, apply for extended leave?" I decided that would be acceptable as I could always make a decision to resign. Thus I just asked for an extension of my

leave. Dr. Brown had brought on an ex-military nurse, Evelyn Bedard, to serve in the role of director of nursing service. In fact, I have found among my papers her title as "acting director of nursing service," Things were not going well in nursing services during the latter part of 1969. There was a shortage of nurses, and they were having difficulty keeping patient care units open. Nurses were working extended hours—I know they're working twelve-hour shifts now, but that was an unheard-of thing back in the 1960s. Nurses were working ten hours and more, trying to cover—

ROSEBERRY: In the hospital—

WILSON: In the hospital, right. Two nursing supervisors decided to close a couple of the private patient units. This was, as I understand, and I—again, it's secondhand—was not discussed with the physicians. The nurses did it for safety of the patients because they felt that if they closed two units and didn't have to staff two units, then they'd have nurses to assign elsewhere. As you can imagine, this really was very disconcerting to the physicians, and, I have to admit, I don't quite know why they did not discuss it with the physicians and the administrators—I have no idea. I wasn't there. But that occurred. Some other things happened, too, and so Dr. Brown was given the privilege of resigning or being fired, and she resigned. There was then pandemonium in the school of nursing and also in nursing services. This was one of the reasons—well, I guess *the* reason—for Dr. Anlyan's long-distance phone call to me in Bangkok saying they needed me to come back to Duke to be dean. Anyway, I refused; because, of course, I was obliged to continue with the Rockefeller Foundation. But Ann Jacobansky, who had been the previous dean of the school of nursing, was appointed as acting dean. Previous to this incident that I'm now telling you about—earlier in 1969, I mentioned some things were

going on in nursing services that were being questioned. I had had a phone call from Dr. Anlyan asking when was I going to be back in the States the next time, because I had gone to Bangkok in the fall of 1968. I said I planned to be back for a national meeting of the American Nurse's Association that summer, which was being held in Florida. He asked if I would please come by Duke. He said, "We need to talk with you, and we'll be glad to pay your expenses for that." So I came to Duke on a Saturday morning, Dr. Stuart Sessoms, who was the hospital administrator then, spent at least three hours talking with me. He recounted situations that were going on in nursing service, and he asked me if I would return to Duke be director of nursing service. This was certainly a surprise to me. I have always believed that nursing education and nursing services should work very closely together, and I have always made arrangements as a nursing instructor for my being involved to know what's going on in nursing services. Because I was teaching senior students, and we gave them experiences in being in charge of patient care units, it was necessary that I attend the head nurses' meetings, especially on the surgical division, since I was teaching primarily surgical nursing. I never, ever expected to be offered the directorship of nursing services, especially of such a large one as here at Duke Hospital. Stu said my being offered this position had come about because of some previous experiences that I had at Duke in 1961-62. I earlier indicated I was here '55 to '57, I was gone '57 to '59, came back in 1959, and in 1961, a large group of the seniors graduating that year got together and then communicated to the dean that they would like to work at Duke as graduate nurses, but they did not want to provide patient care the way they saw many of the registered nurses giving it. They wanted to be able to give patient care as they had been taught as nursing students; they said, We don't want to become like all the

rest of the RNs. Thelma Ingles was chairman of the Department of Medical/Surgical Nursing at the time, and as I've said several times, I taught the senior nursing students in advanced medical-surgical nursing, and Thelma and I talked about their idea and came up with the possibility of maybe being able to concentrate them on one clinical unit so as to increase the ratio of nurse per patient. With that in mind, we conferred with Dr. [Eugene] Stead, because—something that I haven't mentioned in this interview, but earlier—when I was here '55 to '57—Thelma Ingles and I had developed, together, the first ever clinical master's program in nursing. Dr. Stead had been very supportive of that challenging venture and helped it come to fruition. Perhaps I need to say a few words about that program later. Because of that support from Dr. Stead, we went to him again, and he said he thought a special unit experience might be a possibility. We brought several of the senior nursing students in to talk with him so they could interact with him, and he could see their excitement and their sense of commitment to their proposed idea. To make a long story short, it did come about despite objections from the director of nursing services, and yours truly got identified to be the coordinator of the project—for a number of reasons. Again, I was familiar with the organization and personnel in nursing service, medical service, and the hospital; I had taught these students as seniors, and the powers that be in the School of Nursing decided I should do it. For that year of 1961-62, I was responsible for these sixteen newly graduated nurses on Hanes unit, where we focused on improving patient care through focus on the patient-nurse-doctor relationship, as well as providing advanced learning experiences for these novitiate graduate nurses. Even though they had a commitment to this project, I knew them as students and was aware of their varying competencies in nursing, which ranged from, I wouldn't say *A* to *Z*, but they

were not all the best students. There were certainly gradations, but there were also excellent students in the group. They were all committed to this project, and that was the important thing. So I arranged informal and course (graduate level) learning experiences for them as they were admitted as special students to the graduate nursing program. What we did was to take the clinical medical services—there were six of them at that time—to which the staff physicians were assigned. Cardiology was assigned to one, and there were many patients on Cardiology. Other services included pulmonary, neurology, et cetera. The interns and the residents were individually assigned to these services, and I did the same for the graduate nurses. I decided they would then be interacting with those physicians and their patients as a focused entity. Communications should be better, and, hopefully, patient care would be improved. There were assigned times for physicians on these six services to make rounds with their resident, the intern, and the nurse present. In addition I brought on a dietician on a part-time basis to be a consultant to the nurses, physicians, and their families for specialty diets. We also needed "on the spot" consultation from a pharmacist, so I requested that one be available on the unit during the rounding time of eight to ten a.m., I knew that physicians and nurses didn't know everything they should know about drugs and interactions, and such a resource was valuable. The sixteen nurses were assigned to three shifts of 7:00 a.m. to 3:00 p.m.; 3:00 p.m. to 11:00 p.m.; and 11:00 p.m. to 7:00 a.m. with similar numbers on the day and evening shifts. This was in contrast to five graduate nurses usually covering the three shifts, including their days off. In this instance, the graduate nurse had to give the medications with possibly only one on each shift, and the patient care was given by practical nurses. With sixteen graduate nurses now available, there was sufficient staff

for them to give medications and also provide some physical care to patients on their assigned (one of six) service. We did have some practical nurses on each shift to assist with patient care. Patients were assigned to one of three care levels, according to the severity of their physical/emotional needs, and were charged a daily nursing fee. The care level was reviewed daily by the primary nurse. If additional nursing staff was needed, especially patients on care level three (the highest), a graduate nurse would be called in from her time off, thus, no private duty nurses from the district registry were used; all the professional nursing care was provided by the sixteen graduate nurses. The charge for nursing care for each patient helped to offset the salary cost for the sixteen nurses, which was significant in comparison to the remaining patient units in the hospital. With nurses assigned to patients according to a medical clinical service rather than by geographical location of the patients' rooms, the nurses had to exert more physical activity to be in contact with their patients, as they were spread out on this thirty-nine-bed unit. However, the resultant communication and interactions of the nurses, the physicians, and the patients and their families were certainly of an increased quality and worth the nurses' extended physical fatigue, which subsided in a short time. As time went on throughout that year, the physicians were very well pleased with the improved patient care and wanted to transfer their other patients to this unit. They also gave increased responsibility for patient care divisions to the nurses, which resulted in jealousy with the interns.

One objective of the project was to indicate to the physicians what realm of patient care we believed fell within the province of the nurse, in contrast to that of the physician. Thus, I took the order sheet for the patient and separated it down the middle;

on the left was space for the physician's orders, and on the right was space for nursing directives. Patients were admitted to a specific physician and to the specific nurse assigned to his clinical service. This nurse was the primary nurse, and she would do a patient assessment on admission of what she saw to be the needs of the patients from the nursing point of view and then write her nursing directives. She would subsequently meet with the physician and talk about the patient together. The understanding was that they were to read each other's orders and directives. If the physician wrote orders that fell within the nursing province and the nurse had already written them under the nursing directives, she was privileged, through me, to cross them out and write her initials, because they had already been written by her. So when a doctor saw his order crossed out, he knew he had not taken time to read the nursing directives. It pushed the doctors to really read the nursing directives before they would write their own orders. Also, we had chronological notes that the physician wrote in the back of a chart as to the progress of the patient—not daily, but when it was felt necessary, maybe every few days, or, if the patient was seriously ill, maybe even several notes within one day. I gave the privilege to the nurses to write their chronological summations of the patient in the same area of the patients' chart so they would be in a chronological order with those of the physician, and, again, for the physician to also see them. That was new territory, too, for the nurses. We did a number of different things. We changed the times when we gave medications, especially daily ones to be spread throughout the day and not so many at breakfast time. We always put the patients to bed with a backrub at night, whether they were ambulatory or not, because we found that was a time—when the nurse was rubbing a back—that she could ask the open-ended question of, Well, how did things go today? It was intriguing

that with the patient not facing a person, they felt more comfortable, if they had something negative to say about what may not have gone well, or if something was worrying them. Concerns about a diagnostic test or forthcoming surgery or what they would have to do when they went home would be verbalized and the nurse would handle them. We did a retroactive study on the experimental unit and similar private ward in reference to the number of sedatives given at bedtime to patients for the same month. On the non-experimental ward, almost every patient received a sedative. Because there was only one graduate nurse on duty there, as she would pass the evening medications she could ask the patients if they wanted their sedative, which was available to them thorough their doctor's p.m. order, and invariably they responded affirmatively. On Hanes, we didn't do that. We really wanted the patient to go to sleep normally, and it was true that the backrub did help with their relaxation and their going to sleep. Rarely did a patient receive a sedative on Hanes, so there was a significant difference.

ROSEBERRY: How long did this experiment go on?

WILSON: It went on for a year. I was asked constantly by doctors for their patients on other hospital units to be transferred to Hanes, because the doctors were very well pleased with the nursing care given there and wanted their other patients to experience it. I would go visit those patients elsewhere in the hospital and evaluate whether or not I felt we could handle them, or whether I felt it was necessary for them to be transferred.

ROSEBERRY: And you're a faculty member at this time?

WILSON: Oh, yes. I'm a school of nursing faculty member, and I'm also special assistant to the director of nursing service. She was not in favor of this project, I might say. And I also had a faculty appointment in the school of medicine. Dr. Stead gave me

a faculty appointment through the Department of Medicine, so I think I'm the only nurse to ever have a triad appointment here at Duke. Patient care satisfaction was high on this unit, and retuning patients would ask to be admitted again to Hanes. The nurses were gratified with the care they were able to give and with their increased knowledge, competence, and confidence gained throughout the year. The physicians said their patients had never had such excellent care and wanted the experimental unit to continue. However, I was worn out, as I had long hours the entire year and was also on call most of the time. This, the unit returned to its former status, and I returned to teaching in the senior year until 1963, when I became the first clinical nurse specialist at Duke in the Division of Nephrology, retaining my faculty appointments in the school of nursing and the school of medicine. It was a number of these medical staff physicians who had patients on the experimental Hanes unit that went to Dr. Sessoms and Dr. Anlyan and recommended that I be offered the position of director of nursing services at Duke Hospital. They believed I could provide the leadership for providing improved patient care all over the hospital to the extent I did on Hanes, which was just one unit. I pointed out in my conversation with Stu how difficult it was to bring about changes working with so many physicians as well as other service components of the hospital for a thirty-nine bed unit, let along the 660 beds of Duke Hospital—or whatever the count was then. In addition, there would not be available money for the ratio of nurses to patients I had on Hanes. Neither would the nurses be available, as there was a shortage of nurses—the reason the two supervisors closed two patient units and got intro trouble with the physicians and administrators later on that year. I reminded Sty there were not head nurses willing (or prepared) to put forth the heavy effort of work and time I had given

directly to Hanes. Thus, I refused his offer but gave him a suggestion. "What you should do," I said, "talk to Wilma Minniear. She is on the nursing faculty." In fact, she was teaching in the senior year the courses that I had taught. I said, "When she was at Western Reserve University—Frances Payne Bolton School of Nursing—she taught nursing service administration to the graduate students. She is much more familiar with nursing service, management aspects, and so forth than I. I would suggest that you talk with Wilma." Well, that wasn't done immediately, but because of what did eventuate—as I told you, with the units being closed and so forth—there was a committee that came together in terms of looking at nursing service, and Wilma was asked to be on a subcommittee to examine the structure of nursing service. There was another nurse, Verna Stitch, who was brought on as acting nursing service director when Dr. Brown and Ms. Bedard were let go, so to speak. She assisted in developing a job description for the director of nursing service. That report was made in, I think it was January of 1970. Wilma Minniear finally was offered the position of director of nursing service as of July 1970. So—not quite sure how—what point I was making when I got started into this.

ROSEBERRY: You were talking about your deanship.

WILSON: Oh, my deanship.

ROSEBERRY: You were being interviewed—Dr. Anlyan had called you and asked about being dean.

WILSON: Oh, yes. The detour involved the pressure from Drs. Anlyan and Sessoms for me to return from Bangkok to assume the directorship of nursing services. I finished being in Bangkok, at Ramathbodi where my consultantship and professorship was related to developing this new research medical center, which included school of nursing and

department of nursing services, which organizationally were both under one head, which was my philosophy. It also included a school of medicine and of course the hospital. It was brand new buildings, with my helping to develop brand new policies, brand new curricula for nursing and medicine, brand new teaching methods. The Thais were used to lecture, taking copious notes, memorizing, and spitting the information back on tests. The two physicians working with me and I were requested to introduce methods of debate and discussion, and more independent learning for the students. That's another story of—at that time over there, but it was certainly very challenging, I will say, also enjoyable, and I did work hard. I still have my relationship with the Thai nurses at Ramathibodi, which has always been very special. I returned from Thailand in early 1971. Again, the top Duke administrators are talking to me about the school of nursing deanship, and I still am saying, "No." In fact, while I was in Thailand, the chair of the school of nursing dean's search committee was Dr. Frank DeVyver, vice president of Duke University. I responded to his first two letters saying no, and this was even after I said no to Bill Anlyan on the telephone. Dr. DeVyvers' third letter came, and I remember writing back and saying, "You apparently don't understand *no* in English. Maybe you would if I said it in Thai," (*laughs*) just as a joke, as I knew Frank well. I decided I would have to resign from Duke, since I had refused their offer of the deanship four times and thought they would probably not desire me to be a faculty member under the circumstances. So I did resign. But they asked me to (*laughs*) retract, so I did.

ROSEBERRY: So they continued to ask you about the deanship?

WILSON: Yes. They had appointed Ann Jacobansky, who had previously been dean before Ann, as acting dean, but once I was back on campus, it was a live issue with me

again. I had been trying to help find a dean, but, because things were in such a disarray at that point, it was very difficult to find somebody who was willing to assume the deanship from outside Duke. I identified some individuals who had been previous faculty members and who knew Duke when the school of nursing was great and—like Faye Spring, who was at University of Colorado at that time. She did come for a visit, but she said, "Ruby, I'm a psychiatric nurse. Psychiatric people don't make good administrators." So it was back to Bill Anlyan calling me down to his office to repeatedly talk about the deanship. Part of the disarray related to Ken[neth] Pye when he was the chancellor for the university. At the end of 1970, he unilaterally discontinued the graduate nursing program. In fact, there were some federal grants that were supporting that program, and those monies had to be returned. Dr. Virginia Stone was the director of the graduate nursing program at that time, and she was livid, as she had a right to be. Ken did it with no consultation with the faculty or anybody. It shows that often in the university or the medical center, decisions got made not the way they certainly should have been made. (Another one was the appointment of Dr. Brown as dean of the school of nursing, to which I have already referred.) Being back on campus, I was hearing from, again, colleagues in the school of nursing of discontent and poor morale. At the same time, there was a new baccalaureate curriculum that had been developed and was waiting to be implemented. This was difficult, because of the existing situation of the school being without a leader, and it's very difficult to attract faculty to a school when they don't know who the dean is going to be. So Henry Raugh was chair of the medical center committee, which was a separate committee but under the trustees of Duke University that looked at the issues within the medical center. Alex McMahon was chairman of the trustees at that

time, and I knew Alex through his previous association with Blue Shield and Blue Cross in North Carolina and the American Hospital Association. Ken Pye had left the chancellorship and had gone back to being dean of the school of law. Jack Blackburn had moved up from being provost to being chancellor of the university. Jack started calling me in to talk with me, too, about the deanship of the school of nursing. A number of the faculty within the school of nursing, especially the nurses who were on the search committee for the dean, Gwen Fortune and Sue Norville, urged me to please consider being dean. However, there was a faculty member who really wanted to be dean. There were about four people—out of the thirty-some faculty members—who were supportive of her, but the vast majority did not want her to be dean. Jack Blackburn documented this by requesting each faculty member to write him indicating their choice for dean. After putting forth my concerns and areas for negotiation, the chancellor, President Sanford, and Vice President Anlyan promised me they would be met and supported. One of them was the reopening of the graduate program within the immediate future; another was that an endowment fund be created for the school of nursing based on every outside dollar I brought in, that the university would put in a dollar. Monies in a private university are always a concern. Again, as I mentioned earlier, I requested to serve on policy committees in the university as well as the medical center. I then agreed to become a candidate for the deanship, and I requested to be interviewed as anybody else would have been, and the central administrators understood and agreed to my request. So I remember the day when the chancellor called me over—Jack Blackburn—and he said, "Well, Ruby, you asked to have letters written individually from the faculty in support or nonsupport of you to be dean. Here are five letters, and they are from the person who

wants to be dean and the four faculty members supporting her. Here's the very thick pile of those who want *you* to be dean. It is of interest to me that the small stack all are the same letter. Somebody wrote the letter, and it was just copied and the other persons signed it. As far as I'm concerned, it's one opinion. These other letters are all different opinions, and they have all been individually written in terms of support for you. I think there's no question that not only do they support you, but they're very desirous of having you as their leader." So when the president, who was Terry Sanford at that time, met with the school of nursing faculty to announce my appointment, he said, "Well, it reminds me of the young lady that when she was asked by the young gentleman to marry him, she didn't say yes and she didn't say no, but they got married." (*laughs*) So he was saying that I didn't say yes, (*laughs*) and I didn't say no, but I became dean. So I've always said I slipped on a banana peel and became dean. From that time, I did serve on the medical center Vice President's Administrative Policy Committee, the Undergraduate Study Council of Deans, and a number of other policy-making/advisory committees in both the university and in the medical center. I wanted the school of nursing to be involved in central decision-making, as it had not previously been so. As I was going through some of my papers recently, I counted up—and between the medical center and the university, we were represented on twenty-six different committees. Now, that's amazing, it really is. It really even surprised me. That did include some in nursing service as well as general medical center and university. The university ones were primarily concerned with the undergraduate program, because, see, the university's academic organization reflects the professional schools, the undergraduate, and the graduate program of the arts and sciences. At the time I was dean, the three

undergraduate programs were within Trinity College of Arts and Sciences, the school of nursing, and the school of engineering. In 1971 Woman's College was recommended by Juanuita Kreps, who was its dean, to become a part of Trinity College, the men's undergraduate program, and be known as Trinity College. Woman's College was really just an organizational structure for female students to be admitted to arts and science curriculum through their own administrative structure. Woman's College's female students and Trinity College's male students were in the same classes together, as were the undergraduate students in the professional schools of nursing and engineering for the liberal arts courses. The academic departments were common to both Woman's College and Trinity College. When Woman's College was dissolved, it then meant that all the applications, whether they were female or male, came into Trinity College of Arts and Sciences to be admitted. It also meant that as far as student affairs was concerned, it was all under one head for the undergraduate students in Trinity. Prior to this time, the living accommodations for Woman's College were on East Campus. The living accommodations for Trinity were on West Campus. The living accommodations for the undergraduate nursing students were in Hanes House, which was the school of nursing building—a combination dormitory, faculty offices, classrooms, recreational facilities, and social facilities. Across from it was the Graduate Men's Center. The male graduate students, those in medicine, law, engineering, arts and sciences, lived there. If you've followed this, you see that the only women students living on West Campus were the nursing students, and they were right across the street from the graduate center. These two entities had first divvies on each other, you might say, in terms of dating. This made the Woman's College students very, very jealous, because they were way over on East

Campus, which was a mile away. Back in the 1950s and 1960s, the university had buses that took the students back and forth to the East and West Campuses—and there were some bicycles—but the communication back and forth between the two campuses wasn't near what it has been within the seventies, eighties and nineties and since 2000. Many marriages resulted between nursing students and the male graduate students. In terms of the graduate nursing program, the original one developed by Thelma Ingles and me in the mid-1950s was within the school of nursing, but Virginia Stone, who became director of the MSN [master of science in nursing] program in 1965, had it transformed to the Graduate School of Arts and Sciences. When it reopened in 1973 it was again within the school of nursing as a professional program. One great thing about Duke is that the schools have always been willing to collaborate for courses and degrees. Our academic programs have been on essentially one campus, even though there is a mile (*laughs*) between East and West, and it includes the medical center, which has not been separated like it is in many places like, for example, the University of Maryland. Their medical center is in downtown Baltimore, but the rest of the university is at College Park, which is quite a distance away. This type of separation is true for a number of medical centers. We have one board of trustees, which is also a unifying factor. Our proximity of disciplines also affords interdisciplinary research. May we take a break?

ROSEBERRY: Of course.

(*pause in recording*)

WILSON: And I have to really get myself back on track of where I'm supposed to be. Let me go back and say a couple things about some earlier experiences before we continue on with my deanship. After the Hanes Project in 1961-62, I returned to teaching

senior students again. There were nursing positions that were being posted, and I noticed one in the Division of Nephrology. I contacted one of the graduate nurses, Gayle Porter who had participated in the Hanes Project and told her to go interview for this position. She came back to me saying, "Oh, Miss Wilson, what they want that nurse to do—they need somebody like you, not me." I said, "Oh, Gayle, come on. I don't think that is true. Your last year of experience was great." But I thought, Before I send more nurses down there to interview, maybe I'd better go and find out what this position does entail. So I went and talked with Ike Robinson—his name was really Roscoe, but he was always known as Ike. They had just created a new Division of Nephrology within the Department of Medicine, because they were going to start doing kidney transplants. Dr. Starzl had started doing them out in Colorado. Ike was the first chair of the division, and Caulie Gunnells was his assistant. As I spoke with them, I decided Gayle indeed was correct. They really did need a nurse with a lot more experience and savvy in a lot of areas than she had in order to get this program off the ground. They wanted a nurse who would be able to make clinical assessments of the patients and be a real member of the patient-care team with the physicians. So I thought about it, and I've—I went into nursing because of my clinical interest, and that's always been foremost with me. So I thought, Hmm, I might like to do this. So I went over and talked with the school of nursing dean, Ann Jacobansky. She said, "Well, if you think it's something you want to do, I'll support you, and, of course, you would still have your faculty appointment, too." Then I went and talked with Miss Clark about it—Lelia Clark was the director of nursing service then—and she was not in favor at all. Lelia had been a military nurse, and she thought all nurses should do the same thing. We, of course, had run into loggerheads

with the earlier Hanes Project where my nursing staff practiced nursing at an advanced level over the other nurses on other patient care units. I even had my senior nursing students performing procedures regular staff nurses did not perform, but with the knowledge of the surgeons. I worked closely with the surgeons, since I taught and supervised senior students on the surgical units. What I'm saying is that I was always a bit assertive in terms of doing the things that weren't always according to usual procedure, but the welfare of the patient was always paramount. Thus, I was not surprised when Miss Clark was not in favor of this new nursing position. I said, "Miss Clark, the doctors really want a nurse to work with them, and the patients really do need a nurse. You should be supportive of this." I want you to know that in order for me to assume those responsibilities, there was a meeting of Charlie Frenzel, who was the hospital administrator at that time and under whom Miss Clark served as director of nursing service—and she was there, too—Gene Stead, as chair of the Department of Medicine; Ike Robinson as chair of the Division of Nephrology; and his colleague, Caulie Gunnells; Ann Jacobansky as dean of the school of nursing; and me. There were what, 1-2-3-4-5-6-7 people sitting in this office to make a decision about my assuming these responsibilities. As I saw it, nursing was beginning to define an expanded role for nurses to be clinical nurse specialists, but we didn't have one at Duke. Everyone was in favor of this new role except Miss Clark, and she finally had to acquiesce. I became the first clinical nurse specialist at Duke in 1963. I had my school of nursing faculty appointment, and I had the school of medicine appointment. And now I was having an appointment in the Nursing Service Division, as special assistant to Miss Clark, for patients with nephrology conditions. Soon thereafter, we began to choose patients for

kidney transplants. Of course, we had to put them on kidney dialysis first. These patients were carefully chosen because they had to follow special procedures for the rest of their life following kidney transplant in order to not reject the organ—kidney—that was being transplanted into them.

While I was clinical nurse specialist (for three years), I decided that if I was going to stay in academic nursing, I was probably going to have to have a doctoral degree. I really wanted to be more knowledgeable about physiology and pathophysiology, as far as giving patient care and teaching nursing students, so I began to look at programs. There weren't that many nursing programs offering doctorates at this time, and those what were focused on theoretical concepts of nursing, which were not of interest to me. I did look at programs from Seattle to New York City and was not turned on by them. So I came back to Duke and went to the Department of Physiology in the school of medicine. What they would have me do would be "gun barrel vision"—you know, cellular transport—which was not what I wanted. I wanted more gross physiology, which was not available at that level. So I thought, What else supports nursing? The social sciences. So I went to Tom Kinney, who was chair of Sociology, as he had helped Thelma and me with the first clinical masters program I mentioned earlier. He said, "I know what you're looking for, Ruby, but doctoral programs are gun barrel vision," he said, "and that's not what you want." So I thought, I can't get anything there. What else would I be interested in as far as the faculty and the school of nursing? I decided on faculty development. I went over to the school of education and talked with the dean and the chair of the graduate program, Dr. Allan Hurlburt. They said, We realize that you're interested in exploring a doctorate outside your discipline, but we know nothing about nursing. However, you've identified

factors you would like to examine and apply to nursing. Dr. Hurlburt said, "It looks like you have really investigated other doctoral study, and if we can help you, I'd be willing to be your advisor, but you'll have to tell me what courses you want and how I can assist you." I indicated I had already looked at some courses over at UNC-CH [University of North Carolina, Chapel Hill], and Duke has an inter-institutional agreement with them, so I could take some courses there, too. I was delighted I finally had a plan coming to fruition. In the meantime, Dr. Stead was aware of my considering doctoral study and he knew about my interest in learning more physiology and pathophysiology with related interventions for patients. He came down to my office where I'm clinical nurse specialist one evening at five o'clock. Dr. Stead was tall, gangly. He really never really stood up straight with his shoulders back. Sometimes—often he looked like he'd just crawled out of bed; his white coat was not really always the neatest. Anyway, he drapes himself in the doorway into my office and said, "Well, Ruby, I've come to tell you that I've had you admitted to the school of medicine." I exclaimed, "You what?" He said, "Well, you know, you've talked with me about your wanting to go on and get a doctorate, and I just think you'd make a great doctor." He said, "What with your nursing background and what you know and what you say you would like to do to expand your knowledge in patient care, there you are." I have to admit I really called him down, and I told him it was not his prerogative to make such a decision for me without even discussing it with me. I said, "I'm extremely upset that you would do such a thing." So he turns around and leaves. Ike Robinson was in his office, which was behind mine. He came out and says, "Ruby, I never heard *anybody* talk to Dr. Stead the way you did, and you called him 'Gene.'" I said, "He calls me 'Ruby.'" (*laughs*) Ike said, "He had you admitted to the

school of medicine with nothing—no application or anything!" I said, "Don't say 'nothing.' He worked with me for a full year on the Hanes Project with my being in residents' conference five times a week with him. He knows me. He knows what I know." So anyway, next day goes on, five o'clock comes again, and who appears in my doorway but Dr. Stead again? He said, "Well, Ruby, I've been thinking about what I said to you last evening, and I have come to apologize. It was not my prerogative to do what I did without discussing it with you. I have come to say that you are correct and I was wrong, and I hope you'll accept my apology. But regardless, you're still admitted to the school of medicine, and it's up to you whether you appear in September or not." So I told him, "I'm glad you see my perspective, and I accept your apology. I'm glad that you think well enough of me that you think that not only can I be admitted to the school of medicine but that I might be able to do the work. But I'm still making my own decision as to what I'm going to do. Yes, I'd like to have some courses that are offered in the school of medicine, but I've already told you that I still want to be a nurse. I do not want to be a doctor. I am afraid that if I would go to medical school—if you have that knowledge and you're taking care of patient and you don't exercise the knowledge, even if I'm registered as a nurse, I could be held accountable for the medical knowledge." The bottom line is that I did not go to the school of medicine. I did go to the school of education. But the summer before I started classes, I received a call from one of the vice presidents of the university who was on the admissions committee of the Graduate School of Arts and Sciences, and he said, "Ruby, please don't come near the graduate school this summer." I questioned, "Why?" He responded, "It's not your fault, but we have just discovered that we have illegally admitted you to graduate study here at the

university." I said, "What do you mean illegally?" He said, "Well, you are at a professorship rank (assistant professor), and we have a policy that faculty don't examine other colleagues as students within the university. It's not your fault. Everybody knows you've been several places inquiring about doctoral programs, it's been no secret. However, after you apparently indicated apparently to some of your nursing colleagues that you were admitted to the school of education, we've had an application from one of them. We've also had an application from a faculty member in physical therapy to physiology. When their applications came up, somebody on the admissions committee, remembered the policy I just mentioned to you. Then it became evident that we had illegally admitted you. But we're not going to unadmit you! It was our fault, not yours. We still expect you in the fall." So I illegally have a doctorate from Duke University! I guess the medical doctorate would have been illegal, too.

Now, going back even further as far as Dr. Stead is concerned, I mentioned in 1955, when I first came to Duke that Thelma Ingles, being the chair of Medical-Surgical Nursing, and I began to have some conversation about a graduate program in nursing. Nurses usually go into nursing because of desiring to give clinical care. However, all the graduate programs in nursing up to that point had been to prepare nurses for a functional role in nursing, like being an educator, a supervisor, or an administrator in nursing. We discussed that and said, Why is there not opportunity for a nurse to focus on clinical nursing at an advanced level? Thus, many Sunday afternoons I spent at her apartment—and her later home—talking about this, and discussing how we would implement such a program. And so finally we decided that she could be a guinea pig. The article Thelma wrote that you brought me about the 'Learning Year,' she had discussed with Dr. Stead.

We decided we could get more knowledge about pathophysiology through the physicians, And so he said, "Yes," he said, "you can come study. And you can attend rounds—physician rounds—and conferences and, you know, certainly do library study, and we'll have at least one or two conferences a week to discuss what you're learning, what you want to know, and so forth." So she did. She took a leave of absence and obtained some outside support for that, that year of studying, with Dr. Stead being her mentor. We took ideas was from that year and developed our first master's program in nursing at Duke—indeed the first-ever clinical master's program in nursing. It was approved in January of 1957, and we admitted five students to the program—four of them being our own graduate alumni, and the remaining one—she came here from Florida, her husband was being either an intern or resident that year. The National League for Nursing [NLN] was the national accrediting body for collegiate programs in nursing (as well as diploma), came to visit us, and they wanted to know what this "animal" was that we had here at Duke. It was a program entirely new to them, the first ever, so there were no criteria to evaluate it. Of course this was not a surprise to us. They also learned that we hoped that the graduates of the program would be employed by nursing services, but nursing services didn't have available positions yet for them since it was a new program. Thus, the majority of the initial graduates were hired to be nursing faculty members. Anyway, the new clinical masters program was not accredited by the NLN. We also had another situation that the NLN didn't like. Duke had started its first generic baccalaureate program in 1953 with collegiate transfer students, and those students graduated in 1956. The faculty believed it would be advantageous to the students to have a clinical internship following their academic program, and they could choose the clinical area in which to

have it—obstetrics, pediatrics, medicine, surgery, psychiatry, or public health. A faculty member in each clinical area had a clinical conference with the students on a weekly basis, but they were assigned to forty hours a week under the preceptorship of nursing services. The NLN didn't like that. They indicated we were making an academic requirement after the students had received their diplomas from Duke University. We said, Yes, that is correct, medicine does the same thing. Their students graduate from medical school, and then they do a required internship. We offered an alternative to the NLN—give the students a certificate recognizing this internship. The NLN did not approve this experience, and they cautioned us that if we continued it, they would take away the accreditation we had for the BSN program. In the meantime—of course, you talk with your colleagues about what you're doing at your school of nursing as you go to national meetings, and so forth. Thus, other schools of nursing—collegiate programs—had started introducing an internship following (*laughs*) their programs, as they approved of our idea at Duke. Then these schools started receiving letters from the NLN threatening their accreditation! Even though we didn't agree with the NLN philosophically, we did discontinue the internship for the BSN program. But with the MSN program, Thelma and I decided to continue to be proactive despite the NLN's disapproval of it. We started visiting deans of nationally recognized schools of nursing across the country and talking about the program. They thought the clinical masters program was an excellent idea and they started to develop similar programs, using our curriculum as a model. After a number of schools developed clinical programs, the NLN was forced to accredit them in the mid 1960s. However, I want to recognize Dr. Stead's initial and continuing support for that program, because the graduate nursing students had

rotations within the areas of gastroenterology, cardiology, dermatology, pulmonary, and neurology, making patient rounds with the division chiefs, interns, and residents, and all learned from one another and contributed to the care of the patients. Thelma and I were always grateful to Dr. Stead for his support of several innovative nursing programs and projects at Duke that brought us national recognition, despite the conservative stand of some nurses nationally, as well as at Duke.

All right, now let's go back to the deanship. I keep being distracted as collaborative experiences with the physicians come to me. So I become dean in 1971. And as I have indicated, the faculty morale was very low, with all that had been occurring, and I didn't know what kind of leadership I could provide, but we began to move on. It was important and necessary to help the faculty regain self-confidence, trust in each other, and to begin to get the new baccalaureate curriculum implemented, which was an unusual one. It provided required core courses for clinical nursing, but it also had an option for students to take around seven or eight elective courses, which was one fourth of the courses (thirty-two) required for graduation. We developed nursing elective courses, which was a first nationally. Duke was always on the cutting edge and being innovative. The students could either take nursing electives, or they could take electives in arts and sciences. They could use nursing electives to develop a concentration area in nursing, i.e. oncology, or could develop a second major, a major other than nursing but not a science major requiring laboratory courses. Or the third option was to use elective courses in choosing what I called a *taster's choice* of courses in the arts and sciences as well as nursing electives. We did require an independent study for graduation, because, as we told students, There's no way we can teach you everything, and knowledge is

always coming forth within the field of health. If you can identify what you don't know and know how to find that out, then you will always be educated. We decided that in order for students to show us they could meet that goal, it required independent study. Students could do two independent studies, and, if they obtained an A grade in each, they graduated "with distinction." One elective, Patient Assessment, was similar to the Physical Diagnosis course of the medical student, but we called it *Patient Assessment* because we were assessing more than just physical observations. We included emotional, educational, spiritual, and cultural needs as well as some of the family's needs for support of continuing the patient's healthcare at home. That course was taught by physicians and nurses as an elective, but we also incorporated it into and integrated it throughout the required nursing courses. This meant the faculty also had to have similar competence, too, so I offered the course to faculty and had the medical internists and teachers and preceptors. It was "cutting edge" to teach physical assessment knowledge and skills to undergraduate nursing students in 1971.

Another nursing elective was The Child with Diabetes. A nursing faculty member taught the course but the students were precepted clinically by both a nurse and physician (endocrinologist). After completion of this course, one student opted to develop and independent study that involved her participation in a summer camp in western North Carolina and physicians children with diabetes. Registered nurses were responsible for children's health care, but under supervision. The nursing student was responsible for monitoring the insulin needs of a group of children, which changed according to the increasing activity and food intake levels of the children at camp. It also involved teaching the children how to monitor their own urine and blood testing and food

intake in identifying their insulin needs. This was an excellent learning experience for the nursing student—and the camp children.

Other nursing electives were offered in care of the terminally ill, cardiology, oncology, poverty and health, and others I can't recall. We also offered two electives that were open to Trinity students but registration numbers were limited—Parenting and Human Sexuality—two areas of adult responsibility for which formal preparation is not readily available. These courses were always composed of half makes and half females, and there were always waiting lists due to their popularity. In the parenting course a couple (male and female students) could have an infant (a baby doll was used) to care for while managing their student course schedules and learning how to handle the diapering, feeding, and sleeping needs of their child between them. The practical aspects of this course made the young students really respect the parenting role and its heavy responsibilities. Nursing faculty taught electives from their own area of interest or expertise, areas in which they might be doing research. Faculty provided clinical supervision for their electives, but often they needed additional preceptoring assistance, so we would identify interested registered nursing services to precept the students. It was my philosophy that bringing nursing service and nursing education should work together to share and assist each other in patient care and colleague development. We began to look at what kind of recognition we could give these clinical preceptors and decided to identify them as clinical faculty with an appointment of clinical associate, which did not involve any exchange of money with nursing services. In my discussions of this with Wilma Minniear, director of nursing services, she was willing for the clinical staff to provide preceptorship to the nursing students, just as part of their responsibilities, up to

10 to 15 percent of their time. In like fashion, our faculty gave presentations to the continuing education in-service programs of nursing services without exchange of money. It was a collaborative type of situation. We did the same thing with the Durham VA Hospital across the street and some of their nursing staff were interested in doing research. I remember Dr. Carol Hogue was our faculty member who assisted them with developing their research question, their hypothesis, and their methods of investigation. As time went on, Duke also had responsibility oversight responsibility for the VA hospital in Asheville. There was what was called the Dean's Committee that met at fairly frequent intervals, both at the Duke VA and the Asheville VA to discuss issues of concern to them, what issues they had, how we at Duke could help them. So I served on that committee, too.

ROSEBERRY: The Dean's Committee would be you as dean or dean of the—

WILSON: No, it was called the Dean—but it was really referring to the dean of the school of medicine.

ROSEBERRY: Okay.

WILSON: Bill Anlyan kept the title dean of the school of medicine, in addition to—ultimately becoming vice president for health affairs. According to the VA's organizational structure, the committee was always called the Dean's Committee. The chairs of the clinical departments on the Duke side were on that committee, too, with the corollaries at their VA hospital. The first time I went to a meeting, the chief of VA nursing service wasn't there for the Durham VA, and I asked where she was. "Well, she doesn't serve on this committee" was the response of the VA medical director. I said, "She has to serve on this committee, because I am not serving without a counterpart."

When I returned to my office, I called her and told her of the interaction. "Oh, I've been wanting to be on that committee, Ruby. Thank you for getting me on it." Then from Duke we would fly down to VAH Asheville maybe every other month to meet with them. Usually it was on a chartered plane, and we would fly, have the meeting, and the majority of them would come back. I would usually stay over, because the chief of nursing service would ask me to meet with her nursing staff the next day to help them with nursing issues. A friendship with her also developed out of that. Ultimately, we developed, for our undergraduate students, a semester of study at Asheville—because I was interested in the students—at least some of them—having some experiences outside a tertiary (quadrutionary, as I called it) medical center. I wanted the students to realize that there were patients that didn't have all these esoteric conditions and diseases that we saw here at the Duke Medical Center. Thus, a group of senior students went to Asheville with a faculty member for a semester. They did their—what was called their episodic nursing courses (required) there, with their clinical experiences being in the hospital on the adult medical and surgical units. We videotaped the lectures back here at Duke and sent them down there. The students could view them on the video there at their convenience. The librarian down there asked us for a list of books that we would like for them to add to their library for the students. So we did that. The students also did an independent study when they were in Asheville, and very often the focus of it was in the community. Housing during this time was provided by the VA hospital. The VAH had a house right beside the hospital—a lovely house—for the administrator. However, the administrator during this time had his own private home in Asheville, so they made this house available for our students. We had eight students and a faculty member for the five

bedrooms. They had their kitchen downstairs, and the living room was made into a classroom, so it really worked out great. The VAH nursing staff valued the rotation highly, as the students' questions kept them on their toes, and as seniors the students were advanced in their care of patients.

We also developed a study abroad program for this undergraduate program, which ended up being in England. Students would make application for it, and there were some criteria that the faculty developed, which had to be met for acceptance. They did receive Duke University credit for it, and we had a faculty member who accompanied them. However, there was the additional cost of the students' travel to England, which the school could not absorb; the student and their parents had to assume that. The England experience turned out to be a great one, too. The students were able to experience our health system through another country's eyes, and England had the national health system. England was ahead of us at that time, in terms of midwives delivering babies in the community, and also their approach to care of the aging—they were doing a lot more of in that the community than nurses in the USA were at that particular time. Now we have branched out much more, but this experience gave the students an early introduction to that.

As far as some other areas having need when I became dean, we were weak in pediatric nursing. Prior to my becoming dean, I had appointments with all of the medical department heads—clinical heads of Family Medicine, Medicine, Surgery, Pediatrics, Ob-Gyn, and Psychiatry. They and many of their staff of Family Medicine had known me in the clinical area when I taught senior students prior to my obtaining a doctorate and being in Thailand. They were ecstatic over having a dean of the school of nursing who

was also clinically competent. In my appointments with them, each one offered to assist me in whatever needs I had as dean. Immediately I went to Sam Katz, who was chair of Pediatrics, and said, "Sam, I need help in terms of teaching pediatric nursing." He said, "I have the perfect person for you, Ruby—Lois Pounds, who was first prepared as a nurse and then went to medical school." So Lois helped us for a couple of years, and was just great. We happen to share a common alma mater, University of Pittsburgh. There were also other areas of—where, again, going back to your initial question of—not overlap, but collaboration with the clinical medical departments. The department—I believe it was called Family Medicine [Department of Community Health Science] in the early seventies, and then I think it changed its title to Department of Community Medicine and Community Health [Department of Community and Family Medicine]—maybe you can look that up and get those titles straightened out. But we needed to have—we wanted statistics in our program, and Harvey Estes was chair at that time, and they taught a course, but we were willing to have, you know, graduate students and medical students in it, too, so they took the responsibility for that. They really wanted—as far as their clinic was concerned, they wanted to have a nurse practitioner in it. So we brought on a nurse practitioner who then had a faculty appointment between the school of nursing and the Department of Family Medicine. Dr. Estes had given me a faculty appointment in his department when I became dean as we identified areas of working together. A neighborhood clinic in a black residential area of Durham was developed by the nursing and medical students for those with no health insurance. The students provided free health care under the supervision of nursing and Family Medicine faculty. So those were some collaborative activities.

As time went on, Bill Anlyan thought we might move into national healthcare, and he planned for a two-week program—one week in England and one week in Scotland—for deans—several deans—from schools of medicine, and asked me to identify some from schools of nursing. I remember Alex McMahon also going as president of the American Hospital Association. We spent a week in England with their giving us conferences regarding their health system—how it worked—and then we went to Scotland and spent a week there. As it eventuated, we never did get national health insurance in this country. But, again, that was another interactive approach between medicine and nursing. We had a medical center board of visitors. I earlier mentioned Henry Raugh being the chair of it when they were trying to get me to be dean. The nursing representatives were Drs. Loretta Ford and Shirley Chater, whom I requested. That group came, I think, twice a year to consider issues wanted to bring to their attention for discussion and ideas for strengthening medicine and nursing.

We had need of a library. The library for the school of medicine had been in the basement of the school of medicine for a very long time, over forty years. A lot of its holdings just couldn't be there. They were in storage. We were also overcrowded, as far as our library in Hanes House for nursing. I remember Bill bringing to the weekly policy meeting knowledge of some funds that would be available for a building of unusual architecture, but the monies had to be spent from this estate of Seeley Mudd within—I think it was a ten-year period. He, if I remember correctly, lived in California. We were looking at what we were going to call a communications building, because in addition to books, TV was coming on line as far as students learning with videos. Also, we didn't know what the future might bring, as far as computers. Thus, we were referring to it as a

communications building. Anyway, we were seriously considering these available funds, but all of a sudden Bill said, “One condition is it has to be called after that gentleman. We can't have a building that's going to be called the Mudd Building.” I said, “Bill, once this building is built, it's going to be referred to as the medical center library. No matter what we call it, students and faculty aren't going to call it by that name.” So finally I convinced him that it would be okay to take these monies, because it would not be forever known as the Mudd Building. There had to be a portrait of him in the foyer. We are sitting in the Mudd Building. If you go upstairs, you'll see a portrait. Do you remember ever seeing it when you walk in?

ROSEBERRY: Where is it located?

WILSON: When you first come in.

ROSEBERRY: Oh, very good. I think I do.

WILSON: Some people don't even see it. Of course, there is the name outside—the Seeley Mudd Building. But do you ever hear it referred to as the Mudd Building?

ROSEBERRY: Seeley Mudd is what I hear.

WILSON: But do people say, I'm going to the Mudd Building?

ROSEBERRY: No.

WILSON: What do they say?

ROSEBERRY: I think “the library” and “the Searle Center.”

WILSON: The library, yes. Then the basement area—it was not finished to begin with, and so we looked at it as a continuing education area. Bill was able—he was serving on the board of the Searle Foundation at that time to get some Searle funds, so that's why it's

called the Searle Center. We avoided stationary seats so flexibility of seating could be maintained for multiple use of the facility, which it has not.

There were a number of other programs that we got involved in as a medical center, one being AHEC, the Area Health Education Center. And that was to provide continuing education for health professionals across the one hundred counties of North Carolina—and UNC-Chapel Hill was designated from North Carolina legislature to be responsible for this state-aid program. They did come to us for help, and we volunteered to take a ten-county area that became known as the Fayetteville Area Health Education Center, so we refer to it as FAHEC, for which we still have responsibility. We had faculty members from the school of nursing going down there, and people from down there coming up here. Barbara Jo McGrath became the nurse educator employed by FAHEC, and she qualified for a faculty appointment with us. In addition to continuing education, e considered how nurses in FAHEC could obtain BSN degrees.

We also had some responsibilities for Highland Hospital, which was the psychiatric hospital in Asheville. That was given as a gift to the Duke Medical Center by Dr. Carole in—I think maybe it was like 1960—oh, maybe it was even earlier. They used it for adolescents who had mental health problems, and they had a high school there that they attended. Over time it really became a liability, and we did get a new hospital administrator in the 1970s. We tried to get nursing going there—and Bill looked to me for that, but the agency just didn't fly, and we finally were able to rid ourselves of that albatross around our neck. Then there was another project. That was Snug Harbor. Snug Harbor was originally in Staten Island, and it was a healthcare facility for merchant mariners. Mr. Taylor, who lived in Sea Level, North Carolina, was playing golf in

Florida with a person who was associated with Snug Harbor, and he said their buildings were being condemned on Staten Island. Thus, they were looking for another place to put this healthcare center. Mr. Taylor said, "Oh, I have the perfect place out at Sea Level, North Carolina—right on the water." The other fellow stopped at Sea Level on his return trip to Staten Island, New York and decided that yes, it looked like it would be a good place. Sea Level Hospital, with 100 beds, had been given to Duke, but it was in a very sparsely populated area and was operated in the red. Bill Anlyan thought the merchant mariners might provide a population base to improve hospital operations. Thus, Bill Anlyan got me involved in this, too, to go up to Staten Island, and to review the patient care situation up there and see if I thought a move to Sea Level would be operative. Then I had to go to court and swear that the air that the merchant mariners would be breathing would be healthier in Sea Level, North Carolina, than at Staten Island, New York. The legal papers were signed by Alexander Hamilton, and the legal charter said that this Snug Harbor healthcare facility would always be in New York. Consequently, that legal agreement had to be broken to bring Snug Harbor outside of New York and down here. Sailors Snug Harbor's administrator and I diagrammed a beginning model of a new building on the back of a paper placemat in a restaurant—a one-floor design—and a new facility was built in Sea Level. I was responsible for obtaining the nursing supervision. I was able to obtain Amie Modigh, who became the geriatric nurse practitioner for the merchant mariners, and also a colleague of hers, Sandy Venegoni, who became the medical/surgical nurse for the patient care there, too. And Sea Level was not very happy—that is the little village—with the inroad of these merchant mariners from New York. Number one, they were New Yorkers, number two, Sea Level was a very small

community—like, numbering in the low hundreds—and it thought the mariners would move in—they were older and they would die and fill up their cemetery. And lo and behold, on the day of transfer of the mariners from Staten Island to Sea Level, not all of them came, some decided not to come, but of those who did come, there was one death the first day, and the Sea Level villager said, See, we said that would happen. Dr. Del [Delford] Stickel and I became Bill's designees to make monthly trips to Sea Level there to see how things were going, because there was one physician, and he did everything. I mean, he delivered the babies, he did the appendectomies, he did whatever needed to be done. At times several of us as central administrators of the medical center would again fly down there to oversee operations. One of those collaborative activities that I never, ever anticipated happening (*laughs*) when I became dean. Finally we made half the hospital nursing care—nursing home—beds, and that helped, because there was no way we could keep that hospital full with such as small population base. Finally, we were able to get rid of Sea Level Hospital, too, but not before it gave us a lot of headaches; we spent a lot of time with it. There was another project—the maternal child health project that the school of nursing supported with Dr. Tom Frothingham, who was a pediatrician, and this involved Warren and Vance counties—as far as maternal and child health was concerned.

We reopened the master's program in 1974 and—oh, prior to that, we broke ground for and opened the school of nursing addition. It opened in 1973. I think Mudd opened in 1975.

Another collaborative activity was the smoking policy. I went to the med center policy committee meeting one day and commented on a situation involving a nursing

faculty member who was working on a pulmonary unit during her summer break. She came to me and said that physicians were making rounds on the pulmonary unit with lit cigarettes in their hands, and the patients were gasping for breath. So I said to the group, "We need to do something about no smoking." At this time, Bill Anlyan smoked cigarettes, a pipe, and cigars. At the first policy committee meeting I attended after I became dean, Bill, being a gentleman, asked me if I minded if he smoked, and I said, "Yes, I do." So, being a gentleman, he didn't smoke during the meeting, and never did in any meeting I was in with him. Thus, my no-smoking stance was not new to him, but I said, "We have to do something for patient care. I realize that some monies for Duke came from tobacco, but we still need to be proactive for health." It was discussed: What could we do? The first thing we decided to do was not to renew the contracts for the cigarette machines in the hospital. They said, Well, where are people going to buy their cigarettes? I said, "If we're not going to support smoking, we're not going to care much." People ended up going across the street to the VA Hospital, where they could get them even cheaper. But anyway—we moved on from there. On one of our trips to Asheville VAH, I said to Bill—because the surgeon general's, you know, report had come out about smoking, and the federal hospitals were concerned about smoking. "Here is something we can use that's a positive approach. A notice on the outside door of the VA Hospital indicated smoking only in designated areas. It doesn't say 'no smoking.'" So that was then we began to identify outdoor areas for smoking. We used that notice on doors as people came into the hospital. Then there was the question, What about patients who feel they have to smoke? I said, "Then the doctor writes an order for that, just like he does for medication. You write how many cigarettes they may have a day, or at what intervals,

after talking it over with the patient and determine what their desire is." I said, "As far as staff and faculty are concerned, we really have to come down hard on no smoking." I introduced that issue in the summer of '74 and it took us to December of '75 to have a policy approved; that was the fifth draft. Anyway, as you know, it has gone on from there, but it has taken us until 2007 to be a smoke-free entity.

There were other areas where we collaborated. We had international visitors. We would share the entertainment of them and have them speak to our nursing and medical faculty when they would be visiting. Whatever purposes they came for, we would try to meet them. Then they would ask us to go to their country and provide consultation and conferences. I know I went to Japan and—actually, Harvey Estes and I went together. We presented papers at the Center for Life Planning International Conference. I think that was somewhere around 1978, and then I provided some consultation at the request of Dr. Hinohara to St. Luke's College of Nursing in Tokyo when I was there. Dr. Hinohara's father had attended Duke Medical School, and he felt an association here, and he would come to us for assistance. He happened to be a Christian, even though there are other religions dominantly practiced in that country. We had some other faculty who went to Japan in subsequent years, after Harvey and I did. Then one day Bill asked me if I would go to Iran to provide some consultation for the Shah at the Imperial Institute of Health. Thus, Ike Robinson and John Shytle and I went. They had built hospitals in the rural areas, but they were empty of patients because of lack of staff. It was a very sad situation. I don't want to go into all the details, but they would get expensive equipment, however, nobody knew how to maintain it. As we visited, we found equipment sitting there not being used, even X-ray, because nobody knew how to do repairs, or, again, to

maintain it. Anyway, I was not impressed with what I saw and was unwilling for our school of nursing to develop any kind of a relationship with Iran. Also, I had met another nurse who had provided some consultation over there, and she had indicated that it was not really a positive situation. They did want some education in hospital administration for some of their staff. Ike and Bill did agree to that, and I told Bill, "I think you're going to be sorry." Well, nine months later, the Shah was deposed. They did honor, I think, a contract for one or two students, but then that fell apart.

You asked about interactions, as far as legislation was concerned. We met with the administrative echelon—higher echelon—in the medical centers in North Carolina—those being Duke University, Wake Forest—which was also known as Bowman Gray—and UNC at Chapel Hill. We met usually quarterly, and we would look at issues that would be before state legislature, or items that we knew might be coming up would demand action in terms of clinical practice, like the physician assistants, like the expanded role of the nurse with nurse practitioners, even the licensure for practical nurses. There would also be other issues, as far as funding was concerned, for healthcare programs. I served on governors' committees as well, in addition to other people from the medical center. And so we did interact, as far as the medical centers were concerned.

In addition, of course, I was also involved very much as far as the profession of nursing, and I was responsible for initiating and organizing what we called the North Carolina Council of Baccalaureate and Higher Degree Programs, with the deans of the baccalaureate and higher degree programs as the members. At that time, there were eight state schools of nursing—of the UNC system—that offered baccalaureate or higher degree programs, and there were three private schools. We at Duke were the largest.

There was also Lenoir-Rhyne, and there was—it became Barton—it was in Wilson, North Carolina. They were very small programs. Of course, I was also active as far as national legislature was concerned, too, and for nursing it was the Nurse Training Act. I was very much involved in helping Congressional staff to draft the various bills and to write regulations for them. In fact, I was responsible for the deans of the American Association of Colleges of Nursing, the national organization of deans, to get involved in visiting their legislators when we met in Washington. We wanted their support to pass nursing legislation, but we also wanted their support for funds to make the legislation productive. They were always wanting to have a balanced budget, so monies were always of, you know, real big concern. Professionally, I was active locally within our own medical center, within the community, state-wide, nationally, and internationally. So it really became a challenging proposition.

Back home again, one of the things I didn't mention—as time went on, in the seventies, was our need for a new hospital. I have to admit, I was very disappointed when I first came to Duke in 1955 and toured the hospital, because I had come from Allegheny General Hospital in Pittsburgh, which was built in 1933, just a very few years after this one. However, the differences were dramatic and significant. Ours was a skyscraper hospital with twenty-three floors. Even though it wasn't a medical center, it was associated with the medical center at the University of Pittsburgh, and we had interns and residents. We really had an outstanding hospital, as far as the design of it and the available treatment and support services, for patients as well as staff. When I came to Duke, I just couldn't get over all the equipment that was in the hallways. There was no place to put the stretchers or the wheelchairs or the surgical dressing carts. The

accommodations for patients were very meager. I kept asking on the private units, "Don't you have rooms that offer different levels of accommodations? For example, if Doris Duke would come, where would you put her?" "In the same room." The rooms had a dresser and a piece of carpeting that was probably twelve inches by eighteen inches in front of the bed. I was used to gradations of private rooms that went from the very low level Duke had to the high level of where we had carpeting all over the floor; a hospital bed, but it was a wooden bed, not a steel bed, a chaise lounge; a fireplace; a commodious bathroom; and there was a room beside it where private duty nurses could stay, or the family if the patient was sleeping. At Duke patients and garbage were on the same elevator at the same time! There were such significant differences in the two hospitals that it took me a very long time to accommodate. I had decided to come to Duke on an interview in Pittsburgh by Dean Jacobansky. I had not come to the campus. I had made an error, and I would never, ever make another change without visiting the place. I had thought, with a Duke Medical Center, it would certainly have a commodious hospital. Thus, I had an opportunity, when we were planning the new hospital, to put in some ideas, even though it was twenty years after my initial arrival. I made one suggestion on which I was unshakable. That was that the patient units in the new hospital would not be named for physicians—because in the old hospital, all the units were named for doctors—Welch, McDowell, Halsted, Minot, Cabell, Reed—and so forth. When a family member would come to visit, they would ask where Welch was. You had to walk through clinical units to get to other clinical units the way this hospital was organized. You were always giving turn left, turn right, so on, because there were absolutely no directional signs. It was the nurses who usually ended up giving directions, not the

physicians—they were either in the operating room or in clinics. So I said, "We are not going to use names, we're going to use floor numbers." I was used to 4 North, 4 South, 4 East, and 4 West at the Allegheny General Hospital. We had come up with the idea of there being three individual towers for the patient-care rooms, and they would be built on a fast-track basis. Jane Elchlepp from the Department of Pathology had joined the policy committee as she was assuming major responsibility for planning the new hospital. I was delighted to no longer be the token woman on the committee, as women and men think very differently on some issues. Jane agreed with me on no names for the individual patient units, and we came up with a numbering system delineating the first number for the tower (one, two, or three), the second for the floor (one through nine), and the remaining two numbers for the room. This four-digit number also was used for the last four digits of the telephone number. They system was so logical, the physicians on the committee could not counter it, so it was adopted, to my pleasure. Another concern I had was transportation of patients on the same elevators with visitors, equipment, garbage—and at the same time. This, I pushed for a separate bank of elevators for patients and was successful. These were other areas where I had input, but these are examples.

Another area of collaboration involved fundraising. We would go down to what we called the Gold Coast of Florida—and we would meet with nursing and medical alumni in different places.

ROSEBERRY: When you say we—?

WILSON: Bill Anlyan and I, usually, and Bud [Ewald] Busse or Tom Kinney—whoever was dean of the school of medicine at the time. A number of the Duke nursing alumni were married to physicians, too, you know, who were also Duke alumni. Once there was

a conference planned at Disney World—Disneyland's in California, right? Well, anyway—.

ROSEBERRY: I get them mixed up. (*laughter*)

WILSON: We had a private tour of Disney World, as one of the physicians for Disney World at that time was a Duke alum. I said to Bill, "I want you to observe a number of things that I think we could use in terms of this new hospital. Number one, you don't see any delivery trucks. You know they have restaurants here. There have to be many types of deliveries, and we have to find out how they do them. Also, this place is absolutely clean. There's always somebody who's sweeping up. We don't see dirty linen being taken out from restaurants. We learned that they had some core activities underneath where we were walking, for deliveries, disposal of garbage, et cetera. When we returned to Duke, we talked to Jane and we sent her down to Disney World where she spent some time and brought back additional answers to my questions of delivery, laundry, garbage, et cetera, and we incorporated them into the new Duke North Hospital.

I was not gung-ho about our putting carpeting in patient units in the new hospital, because from a nursing viewpoint, I thought it would keep a high count of bacteria for passing on infections and show soil from solutions that would spill on the floor or from body fluids. However, Jane Elchlepp was really high on carpeting, and she put it on the Cabell Unit to try it out experimentally. Everybody loved it, because it made the unit quiet. You didn't hear all the clacking of shoes and equipment going up and down the halls. So we had carpeting when the 1980 hospital opened. In 1986, I was a patient, and there was of course carpeting in my patient care room. On the carpet was a huge area of stain, of which I didn't know the origin. Housekeeping staff had been unable to remove

it. One of the things I was pleased we were able to do in the new hospital was to have what we called "private occupancy" rooms. We never referred to them as private rooms, because then Medicare wouldn't pay for them. However, we had to make them as small as possible but large enough to accommodate any equipment, like orthopedic equipment on a bed. Fortunately, each room had its own bathroom. Anyway, back to my hospitalization. The maid would come in to my room and would clean the bathroom with a wet mop. She used the same mop to also go over the carpeting in my room, apparently to clean it. Well, that was not aesthetically pleasing to me. I commented on this procedure when Bill Anlyan came to visit me while I was a patient, and I told him that I never did like our having carpeting in the patients' rooms. I said, "Look at this big stain. You don't know whether it came from blood or what it came from, and they can't remove the stain." Then I told him about the cleaning procedure of the maid. So he sent the infectious disease control nurse to see me, whom I knew, Jackie Robbins. I told Jackie about this, and she said, "Well, yes, but they have done tests for the bacteria count, and it was acceptable." I responded, "We still have this aesthetically unpleasing stain that nothing can be done about. I still don't think the same mop and the same solution should be used to clean the bathroom floor and the carpeting in the room. I sure don't want to get of bed out in my bare feet on it." Then they sent the facilities person who was in charge of facilities. After my discussion with him, he agreed to remove the carpeting from the rooms and the hallways. Eventually, I—my stance got implemented, but not for several years.

I know you're interested in the contributions from women, particularly within the medical center. I will comment that in the early seventies, there was concern for the

place of—or, the status—of women faculty in the university at large. The Women's Network of Duke University got organized, and Jean O'Barr was instrumental in that. She was also head of the new Women's Studies Program for the university that began to develop courses geared particularly to the contributions of women. For the network discussion women were invited from the medical center as well as the university, and we used to meet over lunch and discuss our concerns. There was concern about the ranks as well as the salaries of women, because it was felt that the upper ranks of associate professor and professor were not made available, and also that the salaries were downgraded for women. This was of concern in the arts and sciences, as well as in the medical center. Women in the school of medicine were concerned about the lack of women in medicine at that time. Of course, in the school of nursing, we were concerned about the lack of men, even though we were trying to recruit them. There was also concern for diversity, because we really didn't have as many blacks and people of other ethnic backgrounds. We started what was called the affirmative action program to really try to keep these issues in front of central administrators, particularly. At the same time, in the mid-seventies, the Women's Forum of North Carolina was developed, and they were supportive of the ERA. Juanita Kreps was one of the first members of that group, and I became a member shortly thereafter. That group is still ongoing, and, for example, I know these last several years we've been working hard to get more women elected to legislature, also to be CEOs of organizations, and just supporting women overall.

Now, you asked what I would say would be my legacy. That's really hard to say, although you probably are aware I was presented the University Medal for Distinguished Meritorious Service last year (2006). I was very surprised when I received the president's

letter indicating that, and then I became pleased, and then I became humble, and I've been humble ever since. I am the first woman in the medical center to receive this award. In the citation that President Brodhead read, he did focus quite a bit on my being an innovator as far as nursing education was concerned. I guess that is true, in terms of working with Thelma Ingles on the first clinical master's program in nursing and then the innovative baccalaureate program that we had with electives, which—really, there has never been another curriculum in another school of nursing like it. It's not meant for all schools of nursing, because you have to have students who are willing to be independent learners in order for it to be successful, and to also incorporate study of nursing abroad, as well as off the campus. I think, secondarily, I hope that I—when I was in roles that I could—supported the patient-nurse-doctor relationship, not only in terms of teaching students, but certainly through the Hanes Project, which was also known as a primary care project. Also through being the first clinical nurse specialist in 1963 and paving the way for other nurses to come into that role, as well as the role of nurse clinician. Another hallmark was institution and developing collaborative relationships between the school of nursing and nursing services in not only Duke Hospital but the VA Hospitals of Durham with Asheville; providing their staff with clinical appointments, and working together to assist with whatever professional needs they had. This included, at times, offering together continuing education programs, workshops, and major national conferences. Sometimes major conferences were sponsored by our chapter of Duke Sigma Theta Tau, the international nursing honorary society. Also, I have commented on either my or school of nursing's collaborative relationship in many ways within the medical center, as well as the university. Also faculty development, because I really did focus a lot on that

when I first became dean, in terms of not only having faculty become better qualified for our curricular programs, but also to support them in their obtaining advanced degrees—including doctorates—and moving on with research, consultation, and other scholarship activities, so that the school of nursing would become locally and nationally known through more individuals than just the dean of the school of nursing. That has occurred because a number of our alumni and other faculty have gone on to be leaders, deans, and be recognized as fellows in the American Academy of Nursing. Also, we did have a retrenchment time of six areas being identified in the university when Ken Pye was back in the acting role of chancellor. I, together with the faculty and other colleagues—nursing and otherwise—and alumni were able to keep the school of nursing open, which was not the desire of Ken Pye. I have seen how, unfortunately, the person who followed me as dean took the school down after I had worked very hard to bring it up from the problems of 1970. Then Mary Champagne came in as dean, and she needs much recognition in terms of her work—re-developing the school of nursing, and now with its new building—and, of course, I'm pleased the patient assessment lab within it has been named for me. Even though it does not relate here to Duke School of Nursing or the medical center—I have to admit the work that I did in Thailand with the Rockefeller Foundation was significant—not only to them, but to me, in—and a relationship with nursing at Ramathibodi continues after thirty-six years that is pleasing to me. It also opened my eyes to examining healthcare in another culture. You look at your own healthcare system much more definitively and critically when you're working in another culture—everything goes through the culture of filter. I was also able to examine our own educational system. Overall, whatever my activities have been and whatever

contributions there may have been, it's really all toward improving patient care, whether it's through educating nurses, or working together with my various healthcare colleagues.

ROSEBERRY: Well, I think that shines through. Thank you very much, Dr. Wilson. I really appreciate it.

(*pause in recording*)

WILSON: Another major activity—I was elected to the Institute of Medicine in 1976, and this is an organization that was established in 1970 to be advisory to Congress on healthcare issues. Even though the majority of the members are physicians, in the charter, it does indicate that—I've forgotten the percentage, but there are to be other healthcare professionals as members. As a member I served on a number of major committees in the Institute of Medicine including their program committee, the International Health Committee, and others. I also participated in several study groups, but I think the most important one was the Study of Nursing and Nursing Education. The report came out in 1982. This was a group that worked very hard, and came forth with twenty-one recommendations for nursing. One of them was the basis for which finally became the Institute of Nursing Research and is a part of NIH. One can go back and look at that study if one desires to, to see all the details of that.

ROSEBERRY: Okay. Thank you.

(*pause in recording*)

WILSON: I was looking at—

ROSEBERRY: I'm sorry. Go ahead.

WILSON: During the time that I was developing the role of clinical nurse specialist in the Nephrology Division, there was the difficulty of the director of nursing service being

willing to support that position. Dr. Stead took issue with her and she finally agreed to it. But at one point, he said to me, "Ruby, how can we develop more people like you and Thelma Ingles?" I said, "You can't, because we're black sheep. We really just don't stay within the bounds that are normally set forth for nursing practice, and, perhaps, nursing thinking." Following my experience with him with the Hanes Project, and then in terms of his seeing the difficulty I had in convincing Miss Clark to agree to my being a clinical nurse specialist, he was interested in helping to developing a nursing education program for nurse practitioners. This was before—but around the time—that Loretta Ford and a medical colleague of hers in Colorado was developing the nurse practitioner program. So Dr. Stead's proposition was taken to the nursing faculty after having discussed it with Dean Ann Jacobansky. It did not get accepted by the majority of the faculty. Some of the faculty—not many, but there were a few—who thought I was practicing medicine more than nursing, because I had the privilege of writing medical orders on a patient's chart, which would subsequently be countersigned by a physician. But I was also making patient assessments that were really beyond the role of the usual practicing nurse. With the school of nursing turning down the program for a nurse practitioner, Dr. Stead came to me and said, "Ruby, we're having many individuals being discharged from the Korean War who have been medical technicians. I wonder if you'd be willing to take one of them and see what you can teach him, and what he can do in the dialysis procedure that you're using to prepare patients for kidney transplants." So I did. The first person was Charles Mitchell. Charlie was very open to being taught and following the parameters of his defined area of responsibility, not going beyond them; knowing when to call either me or Dr. Charles Hayes, who was one of the physicians working in Nephrology. After

about a year, Dr. Stead asked me, “Are you willing to try any more?” I said, “It depends. We can certainly use some help in building the artificial kidneys.” Thus, we brought three of the veterans on as what we called kidney lab technicians: Carl Fasser, Steve Joyner and Ron Purser. Ron didn't last long, but the other two continued learning and working with us. What eventuated from this experience in the Nephrology Division was Dr. Stead's development of the physician assistant program. I remember being in a meeting with him and about eight other physicians from his Department of Medicine, all male, and discussing this new program. Dr. Stead decided that he wanted only males admitted to the physician assistant program. I think it was primarily because of nursing turning down the nurse practitioner program and there being primarily females. I told him he couldn't do that. I said, “You have to leave it open to women as well as men.” But he was adamant that he was only going to take males, and there was no comment from his male colleagues. I was just as adamant and said, “If that's your stand, then I will no longer assist you, in terms of these individuals, and identifying what they might be able to do as a physician assistant.” Then I walked out of the room. He called me later and said, “Well, you won. We'll keep it open to women as well as men.” I really did not continue on with a lot of the development. Kathleen Andreoli, whose husband was in Stead’s department and who was on faculty at that time, did work with Dr. Stead. Whenever I see female PAs when I visit clinics, I tell them they owe their career to me, because I was successful in changing Gene Stead's mind to admit women, in addition to men. In the program here at Duke, there are now more women in it than men, and there's a woman who also heads it. Dr. Stead never appreciated my reminding him of the growth and importance of women in the PA program, up to his recent death.

ROSEBERRY: Can you kind of outline some of those—? You were talking about the nurses being, maybe, upset about you doing what a doctor would do. Can you outline some of those differences, or—?

WILSON: Rather than nurses being proactive in identifying procedures related to patient care they could do rather than physicians—and this goes back decades and decades, as to the role of nursing—many of the nurse's responsibilities came about through doctors' delegation of tasks to them. For example, at one time, nurses didn't even take temperatures—and so that was delegated. At one time they didn't take blood pressures—that was delegated by the physician. On the other hand, as time went on, nurses used to do procedures that physical therapists now do. I can remember when interns catheterized male patients, and this was then taught to orderlies to do. So there has been a constant delegation of responsibilities from physicians, but nursing faculty were questioning some. I was assuming the nursing faculty were on patient units with students several mornings of a week, and they observed me making rounds with the nephrology physicians participating in treatment decisions. They were also aware that often the nurses caring nephrology patients would page me with their questions or observations rather than calling the intern or resident first. I would decide if I could write an order for medication or request certain observations of the patient, or if a doctor needed notification. Within nephrology, it was a very specialized area, and you begin to get well informed and knowledgeable about what is going on with disease of the kidney when it's not functioning as it should, and this affects other systems, too, like the cardiovascular, the pulmonary, and the neurological systems. Thus, you're looking at the patient as a whole in terms of what is going on, and whether or not the patient is developing other

symptomatology, for which you may be able to do something to prevent further symptoms or to intervene on behalf of the patient. If we were performing dialysis, patients often develop various signs and symptoms in response to this procedure, like low blood pressure, or they may have retained some chemicals due to their malfunctioning kidney being removed by the artificial kidney too fast and have symptoms due to that. I knew what interventions needed to be done in these instances because of my specialty knowledge in nephrology, which the nursing faculty didn't have, so they saw this as "medicine" rather than "nursing." After patients would receive a kidney, you'd have another set of issues and problems that you have to counter. It was an intriguing situation, because the nurses on the units where the nephrology staff had patients knew I was practicing nursing even though I had some additional knowledge they didn't have, which often was knowledge doctors had. The practice of nursing has changed so dramatically from what it was in, I would say, the 1930s, to here we are in 2007. One of the reasons I went into nursing was because I knew that the knowledge base would be forever changing, and I was one of these people who don't like to do things repetitively. I always like new challenges, and want to be learning something new, but this was not true of many nurses in the 1960s at Duke, as the philosophy of the Department of Nursing Services was very traditional at the time and trying something new, and, like Eleanor Lambertsen, who served with the National League for Nursing accreditation used to say, "If you want to know what's going on new in nursing, look at Duke University School of Nursing. Now, they might be in trouble with the league, but at least they're on the cutting edge." Again, this was something that was the privilege of private universities, because you weren't using taxpayers' money, so you didn't have to stay in the tried and true ruts,

so to speak. You could move out on the cutting edge and try things. Duke has always been very supportive of that. It's, I guess, one of the—in fact, I know it is the reason that I have stayed at Duke as long as I have. If you had an idea, you could go and talk with somebody about it, and they would know that you'd thought it out. Now, it didn't mean that it was going to succeed. But they gave you the privilege of failing as well as it being successful. Along the way, as you saw things not working out maybe the way you had planned it, you could make changes. On the whole, all the new things that I have tried or was involved in were successful. It's not that everything was 100 percent, but they were projects that were able to influence the practice of nursing and nursing education, not locally just here at Duke, but beyond Duke, and primarily within the educational realm. I was not a researcher—that was not my bailiwick—clinical practice and education were. Nursing has always been challenging, but it has presented me with many challenging and been most rewarding to me.

ROSEBERRY: Good. Thank you.

(*end of interview*)