

Q: The story about Mary Wyche?

A: Sure, I think it's fascinating to think about that process, we're talking 1898 when Mary Louis Wyche had only recently come back to North Carolina having graduated from nursing in Philadelphia. Got on the train in Raleigh and went to Buffalo, New York to an International Council of Nurses meeting, and the major focus of that meeting was the state of nursing in that day, and their belief was the only way they could really move nursing into a professional status, was through a nurse practice act in each of the states, and the way to achieve that was to establish a nursing association in each state.

So Mary Louis came back to Raleigh filled with determination and identified 15 nurses in the Raleigh area and sent each of them a post card inviting them to a meeting in Raleigh. She was working at that time with a Dr. Knots[?], who was a pediatrician, so the meeting was to be at his office. None of them appeared, so she sent a second card to them saying that everyone who was there was excited about the possibilities and that the second meeting would be on a certain date 2 weeks later, and all 15 appeared just so see what they had missed at the first meeting. So from the beginning it was clear that Mary Louis would do anything to achieve her goals, and from that was first the Raleigh Nurses' Association, which is now District 13 of NCNA. And then within a year, NCNA was established, and only a year later the Nurse Practice Act was formed. So Mary Louis Wyche was clearly a good organizer, a good recruiter, and mover and shaker.

Q: ?

A: I think that today, going to another state doesn't seem all that remarkable, but if one realizes that women had no vote in those days, that Mary Louis Wyche did go to college, was teaching grade school and her father told her that he had bought a house in Chapel Hill and she was to move there and keep house while her 2 younger brothers attended the university, which she did for 6 years. So women didn't have much control over their lives, even when they weren't married, and yet she had the, I think determination and commitment are the words that fit in my mind, to not only go to Buffalo, New York, but come back and organize and promote a change in law, again when she had no vote, and all of the people that she was organizing to assist her had no vote, and they had not a lot of money. So how to you convince a politician to do something when votes and money aren't involved? So it has to be by the conviction of the cause. So I think she's truly a remarkable woman, and I think deserves as much respect in North Carolina as Florence Nightingale.

Q: Why did we need a law like that then?

A: During that period of time, there were increasing numbers of people working as nurses, and all you had to do was call yourself a nurse and solicit business, you didn't have to have any education, any knowledge, any skill, you just had to be willing to sell your skills. And consequently there was a need for some organization of what must you know, what must you be able to do to be a nurse. Secondly, hospitals were just popping up and the hospitals, one of the things that I've read frequently is that in the late 1800s, early 1900s, when 2 doctors opened practice in the same town, the first thing they did was buy a hospital and open it and the second thing they did was start a school of nursing. And the school of nursing then provided their labor for the hospital. So there were multiple, multiple schools of nursing popping up in every little hospital, some of them only 5 or 10 bed hospitals, some were schools of only 3 or 4 students. No curriculum, no requirements of anything. So it was a rather loose, almost chaotic kind of situation in my mind. And the cause was to create not just an employment opportunity for unmarried women, but a profession, and so there was a clear need for standardization, standardization of the education, of knowledge, of skill, and from the first Nurse Practice Act to the current one today, the essential cause of the Nurse Practice Act is to protect the public from unsafe nursing care. And I think they saw that even in those days, perhaps a lot better in those days than we do now because of the lack of knowledge and skills prevalent then.

Q: What's it say about NC that we were first with such a law?

A: Clearly there were state nurses associations formed prior to North Carolina's, so other states had a head start on that possibility. I'm not sure whether it was something unique about North Carolina or the uniqueness that Mary Louis Wyche, and perhaps a group of other women who joined her in that endeavor, a gentleman from Wake County was the person that they convinced to introduce the act, and whether his, whether they converted him to the cause and then he had the kind of skill, political acumen, whatever it took to move it further, I haven't been able to find anything in the history to say that. I know that they seem to not have trouble getting him to introduce the act, or getting it through the house. It went through the house almost happenstance, with no problems whatsoever, and passed quickly in a period of like 3 months. However, when it got to the senate, it hit a road block, and a group of people began to be concerned that it might become law and again tried to stop it and they were able to pretty much gut the bill in the senate so that it took about 10 years for them to reestablish amendments in each general assembly to get the bill back to the original form. But it looked like it was gonna sail right through.

Q: What was the opposition?

A: I doubt that people understood, I don't think the general public had any understanding of what a nurse practice act would do or mean to them. So I don't think it was a general citizen issue. But I think it was one of the medical establishment. Physicians were only beginning their own profession, so it wasn't 100 years ago that physicians were not required to be able to read or write, and their own profession was somewhat chaotic, and they were trying to gain better control over their own. And many of them owned hospitals, many of them were in it for money because that was their livelihood, and I

think they were the ones that felt threatened that another group of healthcare providers was gonna have legal status. Because most of the opposition as I've seen it came from physicians and from businessmen who might have had some concerns about a women's profession having that kind of authority and control.

Q: How did the board handle licensing then?

A: Because there were no registered nurses when the law was established, the first thing they had to do was figure out a way to license the initial group of nurses, and they set up criteria and the adopted the criteria first for that. And it basically required that the individual had to have worked as a nurse for a period of at least 5 years, or have graduated from a school of nursing, and have a letter of recommendation from 2 physicians. So the first 35 nurses that were licensed, some of them had actually graduated from a formal school of nursing, like Mary Louis Wyche had. Others were people who had been practicing working as nurses, but had not gone to school. And I think it's noteworthy that in that first group of 35 licensed was an African American nurse, Annie Lou Rutherford, who had graduated from Freedman Hospital in Washington, DC, and went to work in Fayetteville after she was licensed. Then they began the process, after having the first 35 registered nurses, those who were members of the board then were obligated to write examinations, and future applicants, as students graduated from nursing school, they applied and took the licensing examination, and each nurse member of the board wrote one examination a year and conducted it for whoever applied during that period of time. So that they began then to establish a knowledge base that a person who held a license in North Carolina had at least met that minimum standard of passing that test.

Q: Major disadvantages of the early education?

A: They were small, knowledge was meager, physicians were clearly in control and did whatever, they wrote the orders. The students received education only after all of the care was provided, so that if you read some of the early work, classes were held in patient rooms, so there had to be an empty room. Secondly, they were held after all of the patient care had been given, so it would have been at the end of the work day, or when there were no patients to care for, and if there was a physician available to teach the class. So with those 3 requirements you can guess that a lot of days went by without formal classes. Most of nursing education in those days was training and was called nurses training, and it was on the job training. They came to the hospital, they were assigned to work, they worked 12-hour days, 6.5 days a week, and they learned by doing. Now the disadvantage to the patient is that you have people taking care of you who don't necessarily know what they're doing. But it was better than no care at all.

Q: UNC-Greensboro?

A: Greensboro had limited schools of nursing in the period. There were several diploma programs in Greensboro, but they were sort of phasing out. Moses Cone was the largest hospital in Greensboro and did not have a diploma program affiliated with it, because it

started in the late '50s as a hospital, so by then they simple did not establish a school of nursing there. So they felt the need for additional schools in Greensboro, and had given a million dollars to UNCG to establish the 2-year associate degree program there, and it operated there for a number of years. However, Patti and others were able to convince the university system to move that from an associate degree to a baccalaureate, and I'm still not sure how she did that. In my mind that's a little bit similar to Mary Louis Wyche's feat, because the hospital was not supportive of that move. They believed that they had funded the establishment of the school at the 2-year level so that it could turn out new graduates quickly, and the philosophy at Cone at that time was they wanted nurses, not necessarily well educated ones. But Patti and others were able to convince the university and the community to move it forward. And if you ever sat with Patti, and tried to oppose her, you would come to understand it's sorta like stopping a freight train. She was absolutely certain of her beliefs and opinions and anyone who had a contrary one had to be wrong, and would do anything in the world to convince you, and if she couldn't convince you, she would do anything in the world she had to do limit your ability to stop her. So she clearly moved that program forward.

Q: Again?

A: Patti was always convinced and believed strongly and completely that she was right. I never heard her hesitate and say, "Well, maybe that's not right." She was always certain of her beliefs. And certain that you had to believe with her, and if you chose not to, if you had a contrary opinion, then she would do everything she could to convince you of how you were wrong, and if she was unable to do that, she would then work at stopping you or limiting your ability to convince others so that she made sure that she had the majority opinion, and if she couldn't do anything else, she would just keep the floor so that people that who opposed her had difficulty speaking.

Q: What was Patti Lewis's message to the administration at UNCG for the need for a nursing program?

A: I think one of the things that worked to Patti's favor at UNCG, Patti was a very elegant southern lady, always well dressed, always had her hair well fixed, was always charming and courtly. And the chancellor at the time, Dr. Ferguson, was an equal southern gentleman, and I think Patti wrapped him around her little finger and I don't think she ever really had to justify much, she told him what she needed and he provided it, and I think he was afraid not to. So I'm not sure that she ever spent a lot of time trying to justify, she just told him what she needed and went out and spent it, and expected that he'd provide it. She also worked hard to convince the community, though. She was very active within various segments of the community, and used that community influence as well to, any time anybody might think that she didn't need something, then she would organize a group to help them understand better, and get money from wherever she could. Moses Cone Hospital supported that program rather heavily over the years.

Q: ?

A: I think hospice is sort of the culmination of her career. I think first and foremost, Patti was an educator. I can't imagine thinking of Patti Lewis and not thinking of nursing first and nursing education, but after her retirement and she also had cancer herself, and after that her understanding of the need for care at end of life became much clearer and she became much more committed to it, and in her retirement had time to do that. And in the late '70s, when the hospice movement was just really getting re-started well, end of life care was pretty grim. Families and physicians often conspired to withhold the information from the person who was dying. Care, as technology grew, we were able to keep people alive longer, but their life wasn't full of good things, but tended to be bad things. They were taken away from their home, their possessions, put in a sterile hospital environment, hooked up to machines, and pretty much any sense of who they were and what they had been was removed. So hospice developed as a way not to prolong life but to improve whatever life left. And I think Patti came to understand that intensely, and then joined. She was not early in the hospice movement in Greensboro. But when she came in, she came in full force, and took over and became a strong, dynamic mover during that period, and worked hard to make sure that patients were in charge of their care, and that we could provide as close to home-like care as possible for people in the end stage of their life.

Q: Why did you work so hard together to get in-patient care, and any favorite stories?

A: I would take it a step back and say that first we worked to convince the hospital to become a partner with hospice, and they did in fact merge. One of the dilemmas that a social venture like hospice has is, the people who get in to it, are what I call in a positive way, social do-gooders. They know what they want to happen, but they aren't necessarily good at making it happen, have the vision but not the ability to create it. And that was where hospice was, we were struggling, we had money but the people in charge were afraid to spend it, no one wanted to make the bold move to start care. So kept, "Well, let's think about this again, let's study this a little further." And so when the hospital came in, doubled the assets, but it provided a group of decision-makers who were then quick at moving the care forward. Then the next step was the in-patient unit. But the dilemma that happened is that people who elect hospice toward the end of their life want to die at home, by and large, but the family may not be comfortable with that, and the person themselves sometimes loses their confidence at the end. So the alternative was, if they got near the end, and had problems, lost their confidence, family lost their confidence, then the only alternative was the hospital bed. And then we went right back to square one, and the care that was being provided was suddenly cut off. So by creating an in-patient hospice unit, we could staff it with staff who understood that we were there not to prolong life but to allow the person to live their life. We were able to create as home-like an environment as you could ever have in a hospital, and I think provided a home away from home concept for hospice patients. And it proved to be very successful. And I think Patti was able to understand that dilemma between wanting to die at home and not being able to, and providing a safe alternative.

Tape 33

Q: An overview of Patti's stature?

A: From the state level, one of the things that Patti took a lot of pride in was that she simultaneously was president of the North Carolina Nurses Association, chairman of the North Carolina Board of Nursing and then dean of the School of Nursing at UNCG. And there was a member of the general assembly during that time who ran a hospital and a school of nursing in this state and had some differences of opinions, both with the board of nursing and with Patti Lewis, and introduced over 100 different bills in one session of the general assembly, regarding nursing. Everything from abolishing the Nurse Practice Act to replacing all of the members with physicians. But the one that Patti took pride in was the bill that passed, that said, 'No single individual could simultaneously serve as president of the NCNA, chair of the Board of Nursing and dean of the School of Nursing,' so we all call this the Patti Lewis bill. So I think that says something about her status and stature within North Carolina. At the national level, probably the best example is that she's a charter member of the American Academy of Nursing, and was one of the first fellows introduced into that charter status. She also served as chair of the American Association of Colleges of Nursing, ran for office in ANA but wasn't successful in that, and I think was truly, for one of the few times in her life was not able to succeed at what she wanted, and so it was probably good for her character, but was not good for her,

Q: The 1981 NPA?

A: The issue that was the driving force in rewriting the act, was the clause in the previous act that allowed individuals without a license to do routine, repetitive tasks. And you can break almost any task down into a component that is routine and repetitive. Consequently, non-registered people were performing rather complex nursing tasks, it also allows a person to remain employed without a license as long as they call themselves a graduate nurse, rather than a registered nurse. I went to Pinehurst in 1972 and discovered that a head nurse there on a busy surgical unit had graduated 25 years previously but never passed the boards, and so there were instances like that all over the state, where there were people who were unsuccessful at getting license who were allowed to remain in positions of authority, but also people who may never have gone to school a day who were doing things like administering medication. So there was a belief among the nursing community that we had to improve the safeguards for patients, because healthcare was becoming increasingly complex and potentially deadly, moreso than it had been in the past. From the nursing community, there was also a desire to replace the non-nurse members of the board. There were 2 hospital administrators on the board at that time, one served 19 years consecutively, the other 17 years. So the 2 of them, by their tenure alone, knew how the system worked. The nurses came and went, so they pretty much knew how to get things done. And there was a desire among the nursing community to take that over. I think that was what we wanted, what we wanted for patients was safety.

Q: There'd never been such an overhaul of the act?

A: There had been at least one previous major rewrite, but, and each of them had attempted to do what we wanted to do, but had never succeeded. What we recognized first was that we had to educate ourselves, meaning all of the nurses in North Carolina, to the need, and to agree to what we were about to do, that if nursing wasn't unified, it wouldn't happen. So, [name, Becky?] Taylor, who was president of NCNA at that time, convened a group, appointed me as president elect, as chair of the task force, and Ernestine Small, who was the next president-elect following me, became co-chair when she was elected. Becky also then established an invitation to other nursing organization leaders, to meet together in a common cause if you will and asked me as president-elect to be the chair at the first meeting of that. And so from that came the North Carolina Federation of Nursing Organizations, 35 different nursing organizations came together in the Federation and joined with NCNA in the cause to get the Practice Act changed. So we educated ourselves, we unified ourselves on that issue and then we had a very large group of distinguished nurses, including members of the Board of Nursing and staff, look at the Practice Act and dream how we wanted it to be. and then went to the Institute of Government and happened to get Tru Solberg, who was there at the time, to translate it into legal language for us. So that before we went to the general assembly, we had nurses unified behind it, we had lawyers writing it in language that the general assembly could understand, so we were in good shape when we started the lobby. And I remember well the first time we went to the general assembly, it was a very large group of nurses and time after time after time I heard the legislators say, "Doesn't matter what nurses want, physicians are gonna stay on that board and you might as well get over it." And in the end, it was 100% positive vote, adopting the act, eliminating both physicians and hospital administrators from the board, and appointing in their stead an all-RN/LPN board with 2 public members, and the public members could not be healthcare providers, spouses of healthcare providers, or owners of a healthcare facility. So we wanted it to be truly public representation there.

Q: How'd you convert the legislators?

A: I think it started with the unification of nursing, there's nothing that confuses general assembly like having 2 different groups, or 5 different groups of nurses saying 5 different things about a law when they don't understand it themselves. So because we were unified behind it, that was our major first step. Second thing we did was, we provided each member of the general assembly with a number of registered nurses and licensed practical nurses who were registered voters in their district. And the understanding that those individuals were committed to this change and would vote for or against whoever helped or hindered us in the process. And I think that was educational, I don't think a lot of the general assembly understood how many of us there really were, and how dispersed we were. We're in every voting district in the state, in almost equal numbers compared to the rest of the population. So I think that impressed them. We didn't have money, but we had unity, we had numbers and we had commitment, and I think that's what won the day.

Q: ?



A: I think it's good testimony that those of us who worked to perfect the previous act were able to project far enough ahead to keep it current for that period of time. I think even the first year after its adoption we began to start a list of, "The next time we write the act, let's change this, or let's do that," but they were very minor things. So I really do think that the individuals who wrote the act had vision and wrote it for the future, not the past. I think that is clearly the part of it that made that different.

Q: First male president, what's that mean for nursing?

A: Not only first but still the only, in 100 years. Other men have run but not been elected. I'm not sure that I had anything in mind about proving that a man could do it. I graduated from the school of nursing for men in a hospital for men, so I learned from the beginning that men were nurses and that wasn't an issue. My goal as a nurse was to make gender irrelevant, and because I had been active in, as a student I was president of the Student Nurses' Association of Illinois, I had been taught that it was my obligation to continue to be active in nursing organizations. So I saw it as my responsibility, not because I was a man but because I was a nurse. And perhaps that's why I was accepted. I'm not sure why I was elected. The first time I ran, I ran for the board of directors, and lost by 4 votes, interestingly enough to the dean who is my boss at the moment. And the second time I ran was for president, and was elected and by a good margin. So for some reason I was accepted by the nursing community in North Carolina. I wanted to be president because I felt the obligation to be, but also because I needed the leadership development, the skills that go with serving in an office at that level. So it was a need of mine as a nurse and as a person and I think perhaps when you're the first at something, people don't know what to expect, and so you have to some extent a free rein, you can do it any way you want to, you're not held to the previous pattern. And so there is a freedom to be yourself when you're that unique, and I think I realized that and was able to take advantage of that opportunity. Those 4 years were very, very good years in this state, with the Nurse Practice Act, the Federation of Nursing, all of those things happening, so I was in the right place at the right time for me, and I hope in turn that my being there made a difference for nursing, and we will see in time. A hundred years from now we'll know.

Q: What else about men in nursing?

A: I often don't remember that men in nursing go back more than 1000 years. I always tell my students, "Florence Nightingale was a little over 100, almost 150 years ago, so nursing in its current form has a history of 150 years. But men in nursing go back to 800-and-something, so we have about 1200 years of history. So whose history is richer?" Again, I think, I understand why Florence and others tried to eliminate men from nursing, because they had, they had to overcome the social beliefs at the time that women are to be in the home and not taking care of strangers in public for pay. Consequently for Florence to succeed in getting nursing as she wanted it, she had to demonstrate that men weren't able to do it, and she did her work well. In 1900, men were almost 50% of the nursing population in the United States. By 1930 it was less than 1%. So Florence succeeded. Now, I think our job is to say, "Nursing is not a women's occupation, it's an occupation for those individuals, male or female, who want to provide care to others, who want to be



responsible and accountable for their actions,” and nursing I think is a wonderful, wonderful profession. It’s the best decision I ever made for myself. I would do it again 100 times, because it’s meaningful. You get to share the intimate moments of stranger’s lives, birth, death, anything that happens to them, and you’re there as a supporter, you’re there to assist them, to guide them, I think it’s just wonderful. So I encourage any and all to consider it.

But there is nothing that requires one to be a particular gender, a particular race, a particular age. It’s for people who want to help others, regardless of their own characteristics. It requires intelligence, it requires a willingness to work hard, but beyond that, I think it’s open and I encourage and invite everyone in.

Q: Helen Miller?

A: I always think of Helen and Patti Lewis together, they were both very courtly, southern ladies, very bright, very committed to what they’re doing. One black, one white. Very different backgrounds but in the same place at the same time. Helen worked hard at providing an opportunity for registered nurses who didn’t have a baccalaureate degree to get one. And that was not the favored opinion among baccalaureate and higher degree-educated nurses at that time. There was a movement in the ‘60s and ‘70s to say that an associate degree in nursing was a terminal degree, a diploma in nursing was a terminal degree, and if you wanted a baccalaureate degree, you had to apply and start all over and go through the whole program again. And they believed that strongly and

most schools of nursing at baccalaureate and higher degree, wouldn’t give you any credit for any previous education or experience. Helen, on the other hand, thought that nurses had a strong clinical base and needed some additional education. So she created what I think was a premier national program for non-baccalaureate prepared registered nurses, and had a very successful program at North Carolina Central over the years. At the same time, Helen was a fierce advocate for integration of nursing. [audio break]

Helen was a fierce advocate for the integration of nursing, not just of African Americans but of men and other minorities as well. Helen was as strong a supporter of men in nursing as I ever met, and so I have great admiration and respect for Helen. and again, am amazed at how much she achieved and how different she was from Patti. Helen was a much softer-spoken, behind the scenes worker, while Patti was a very dynamic speaker in charge and in control. But they both accomplished great things for nursing and although both realized recognition for it, I don’t think either of them got the recognition that they really deserved from it. Without them, I don’t know where we would be.

Q: Helen’s contribution in summary?

A: Helen I think was a force for change. I think those are the words that I would use to describe her. She saw things as they were and wanted them to be as she wanted them to be, and moved toward that. Her first and primary emphasis at least in my experience was

in promoting the RN to BSN program, but that did evolve into a generic baccalaureate program at NCCU, and was again a positive state and a step up. The RN to BSN programs still exist, are still very heavily enrolled, but most of the schools that were running those programs as separate programs in the '50s, '60s and '70s, eventually closed them out, opened generic programs, and then integrated the RN students into that curriculum, at an advanced level, which is the way it is now throughout the state. So I think Helen was a visionary, and saw the initial need and then moved that into a long-term commitment, and I believe one that is still needed. I think there are still some, some reasons why a society is not as open to minorities as it might be, and when you're a visible minority, men, African American, whatever, there's some comfort in being around others like you. I've often said that most of the women I know are nurses, and most of the nurses I know are women, so when I have a different opinion, I have to go check it out with another man who is a nurse, because otherwise I don't know if it's just because I'm a man or if I'm wrong, or if I'm the only one that's right. and I think that holds true for other minorities as well, there is a comfort level in learning complex materials in an environment where you feel accepted and safe.

Q: What contribution did St. Agnes and Lincoln and the like make?

A: I think we need to remember that most of those were religious-based hospitals, so that many of them are Catholic, and they were the first and perhaps only access for African Americans to healthcare at that time. If there was no African American physician in the community, the white physicians might provide some care, but they might not, and most of the non-black hospitals would not admit black patients, or if they did they would admit only a few and only to one unit in the hospital. So I think first and foremost they provided access to care. Secondly, they provided an opportunity for African American, primarily women, although some men also, to enter nursing, and nurses in the African American community, in the early part of the century, were really social leaders, because they had an education, they had a skill and an occupation, so they not only provided them with good care, but they also were role models for the others to see the value of education.

Q: Mary Mills?

A: I really don't know enough about Mary to comment, I respect her but I don't know her.

Tape 34

Q: Why were midwives so prevalent in the first half of the century?

A: Remembering that North Carolina is a rural state, and that the population is very widely dispersed through the state, midwives and many of them were not nurse-midwives but granny midwives, were the only access to a trained child birth assistant for people in those days. People had little or no money, particularly during the depression, so they

couldn't afford to go to the physician or a hospital, if there was one available. So the midwives played that link between access to some care, when access to the best care wasn't possible. And so a state like ours was a perfect place for that kind of need, because we had so many rural and so much poverty, that without the midwives, childbirth would have been purely natural and not always safe.

Q: But by the '20s the public health nurse came in?

A: I think it would be not just midwives but care of people. Public health is far more important I think than just in the area of midwives, maybe because I know more about the other. But in that time, people went to the doctor if they were in severe pain or in an accident, broken arm, something like that. Otherwise,

Q: Again?

A: In that time period, people went to physicians only when they had severe pain, a broken arm or a leg, had some really necessary need, because they had no money and they didn't think of it as important or essential. So that public health nurses were the ones who came in when the family had typhoid fever or measles or chicken pox or mumps or any of the other diseases. So that public health nurses were the first real presence of health care in most homes and families. Now, when someone in the household was pregnant, then the need for someone to assist that person in the delivery of the child, became important. I was born at home, not by a midwife but by a physician, but up to about my time period, I was born in the late '30s, most people were still born at home, and it was the public health nurses who had the most on-going influence in the care of those families.

[end of interview]