UNCG CENTENNIAL ORAL HISTORY PROJECT COLLECTION

INTERVIWEE: Catherine M. Turner

INTERVIEWER: Linda Danford

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LD: Miss Turner, can you tell me when you came to UNCG [The University of North Carolina at Greensboro], and in what capacity?

CT: In 1971. And I came as an assistant professor. And, at the time, I taught in maternity nursing for one semester. And then the following year, I taught in psychiatric nursing, which is my major. In the area at that time of psychiatric nursing, we were involved in a research grant. I guess it wasn't really a research—it was a grant to enhance the teaching of psychiatric nursing. And we tried to integrate the concepts of psychiatric mental health nursing throughout the curriculum. And we were successful in getting that kind of a plan in operation within that year, in terms of changing, so that we weren't isolating out the mental health in trying to treat man as a whole being. [unclear] I taught in that capacity for about two years. And then I headed that area for—dates—I headed psychiatric nursing, that component of the curriculum—coordinated it for about a year and a half. And then in 1976—January of '76—I was appointed as assistant dean to Dr. [Eloise] Lewis [dean of the School of Nursing]. At which time then my responsibilities were primarily administrative, although I did have teaching responsibilities in the undergraduate program. And I taught the fundamentals course, which kept me abreast of what was going on from the basics within the program, as well as administratively.

LD: What kinds of things were the girls taught in the fundamentals course?

CT: Fundamentals course—

LD: I shouldn't say girls. It's not—young nurses.

CT: We taught the basic components of patient care—what it meant to give nursing care in terms of the physical components: baths, injections, catheterizations, irrigations, emphasizing always that that was the physical part and that you were doing more than just doing it for the person—that you had to consider that person as a whole being. And so that we had communications brought in in that fundamentals course. And then when they got—that was a prerequisite to the major at the time. And when they got into the major then, that was followed up with a course in communications, so that they had some beginnings for it, rather than just thrust them into it—into the major.

LD: Was that the course that they took in their sophomore year?

CT: Right.

LD: Prior to going into the junior year full time?

CT: Right. It was—and we used it as a screening measure, not necessarily to weed out poor students, but to see whether or not there was an understanding of what nursing was about and a commitment to it. I think we were fairly successful with that endeavor, particularly, in those years that we had more students than we could take. Not only to use a grade point average to cut them off, but to allow them to take that course and to see what they were able to do. And I think many times we discovered that students were not fit for nursing, but because it was a job they were going to be sure of a position afterwards, they sought it out. And I know—I followed up several of them that left nursing. Many, sometimes in tears with parents, but left it and have gone into pharmacy and have gone into medicine, have gone into math, literature and other fields that they're excited about today, so I think we accomplished what we were after at that time. [pause]

The curriculum then followed pretty much a traditional pattern of beginning with a medical-surgical nursing component, which was care of the adult, and then going into the specialized areas like maternity and pediatrics. And then in the senior year they had, at that time, community health and the psychiatric mental health component. And we would rotate them through the semesters with those two courses. Concurrently with those courses were theory courses that complemented the content for the specific nursing they were taking, which included pathophysiology, whatever we were—and the nursing care. And then a third part of that organization, we had the clinical and the theoretical courses. We also had a component that we called the dynamics, which was changing content, which kept us—. We had to keep abreast of what was going on in nursing, to bring that information current with the students learning—it covered such things as communications. It covered group work. It covered working with a team. As they moved on into the senior year, it covered leadership and the art of negotiation, so that we were preparing them, not only for bedside care, but giving them a generalistic approach to nursing.

LD: When you came, the program was already a four-year program.

CT: Right. In '71, it was already a four-year program.

LD: And was the building, the current building also there?

CT: Yes, the building was there.

LD: When—do you know when it was built?

CT: No.

LD: It must have been brand new.

CT: It was. They were only—psychology was still housed on the fourth floor of the building.

the psychology department. But I think it was completed in '70 because it was very—it was relatively new. I know Dr. Lewis had first class. I think it was about '69 or '70 that it was completed.

LD: And how large were the classes? How many nurses were you graduating in '71?

CT: In '71 we had in the area of about twenty-five to thirty. But then we increased pretty rapidly to where we were, by the time—let's see. '75, we were graduating classes over a hundred, hundred and twenty-five. [pause]

LD: How were your nursing classes affected by integration?

CT: We weren't. We had many, many black students in the nursing program. Many of those black students were students who, academically, were very astute and accomplished.

LD: And you remember black students in the classes from the very beginning?

CT: I wasn't here for the first class, but when I was here—when I came in '71, yes. Yes.

LD: Not the first nursing classes, but your first?

CT: My first—the first years I came. Yes.

LD: What about placing them in the hospitals for—?

CT: We had no problem.

LD: That was not a problem. And what are the hospitals that they did their practical training in?

CT: We did them at Moses Cone [Memorial Hospital, Greensboro, North Carolina], Wesley Long [Hospital, Greensboro, North Carolina], North Carolina Baptist [Hospital, Winston-Salem, North Carolina], Forsyth [Medical Center, Winston-Salem, North Carolina]. Those were the major hospitals that we used. And then we used those for maternity—the care of the adult and the care of the child, and for maternity. And if it was possible, many times we would plan to rotate the students so that they'd have the opportunity to be in a small community hospital, like Wesley Long, which it was then. And then to function in a teaching hospital like Cone or North Carolina Baptist, so that they had the opportunity to see more. In addition to those experiences and the acute care settings, we also planned for the student to be within the community. For example, in pediatric nursing, at the time pediatrics took—there was a trend to keep children out of the hospitals much, and so we saw a lower census in the acute care setting for pediatrics and—we then went into the physicians' offices and into the schools, where we found the children. And sometimes it was on a selective basis into the home because the actual experience in the home didn't come until the senior year, but some students that were more capable than others to take that unstructured environment. We—it was on a selective basis. That happened also in

maternity. The students went into the physicians' offices to learn prenatal care. And I know that year that I taught, that first year, maternity nursing. We followed it through for about four years afterwards. They would work with the obstetrician and the nurse in the obstetrician's office to pick up a family—a mother—who was going to deliver while they were close to their experience. And those students went and followed the mother through labor and through delivery, and they made a contract with the mother and the father to be that they be called, no matter what hour of the night it was, and the students were always excited about that experience.

LD: I had a student assigned to me when I had my first.

CT: Did you?

LD: Yes.

CT: From here?

LD: 1979. My eleven year old. I had all my babies during the day. I was very cooperative. So she didn't have to get up out of bed, but I—in fact, it wasn't until I was talking to Margaret Landon [nursing faculty] that I remembered that and remembered the girl. I had forgotten, actually, that she was there for the delivery and everything.

CT: It was an exciting experience for students.

LD: I'm sure it was fun. And it was our first baby, so I'm sure she perceived that it was exciting for us as well.

CT: Oftentimes it would always amuse me, but oftentimes that was the experience that kind of sold them on nursing. Also they were going to be that nurse in maternity. And they were going to take care of mothers and babies. And it was interesting to watch them grow as they moved through their curriculum. That was fine for some, but not for others. But that had a great impact on the psyche of a young person at the time.

LD: I think Greensboro has sensational maternity nurses in the hospitals. They were wonderful. In fact, some of them I remember seeing for all three children. And because I had my children all about the same time of day, I caught people from the same shift, so—. And I just thought they were fabulous.

CT: I think another thing that happened with us. It was a commitment made by the faculty that I think strengthened our program and held it where we had a program of high quality, and that is the students were always under the supervision of a faculty member in that clinical area, even if they were out taking care of a mother, that student was reporting back to a faculty member at all times. We didn't—never relied on the hospital nurse or the nurse in the doctor's office. Yes, they learned a lot there, but the tying together to be sure they were getting the right kinds of concepts, that was always brought back to the faculty. And I think that was an important part of our program that we just didn't let them

loose on their own to kind of stumble.

LD: When did you start training nurses to do Lamaze [childbirth technique focusing on breathing, movement and massage named after French physician, Dr. Fernand Lamaze]? It seemed to me that that got started in Greensboro earlier than it did in a lot of other places.

CT: I would imagine—we had it in '71, '72—in the early years.

LD: That is early. Because a lot of other parts of the country—friends of mine were still having babies in very traditional hospitals—wouldn't allow the husbands in the room and there wasn't the availability of a Lamaze class. And it seemed that in Greensboro it was already a very established thing in '79, and the doctors were all supporting it and the nurses were all very knowledgeable.

CT: I think that was pushed by nurses.

LD: Really?

CT: We have a graduate, and I did not teach her, but she was in the first class—her name is LaVonne Troxler [Editor's Note: LaVonne Fisher, Class of 1970, 1982 master of science in nursing]—who was very instrumental in working with the physicians to get that kind of a program going, and she's currently now Lavonne Beach, and she's a current vice president of Greensboro Hospital, which is going to be the Woman's Hospital for Greensboro. But she was very instrumental in—

LD: She'd be an interesting person to interview.

CT: She would.

LD: I'll have to write her name down too. Thank you. As many people as I can find, you know, who are available locally.

CT: Right. She would be very good. [pause] I was here for the accreditation of the program and reaccreditation in—what year was that? I think it was '73 or '70—I think it was about '76, '75. I can't remember those exact dates that we set time aside to evaluate the curriculum, which took us about a year and a half. We didn't make any major changes because we felt—the faculty were satisfied with what we were doing, and we were on top of things and the trends that were going on and probably a very conservative approach, but it was an approach that kept us very strong. I was responsible for the coordination of the accreditation of the program in terms of getting the committees together and organizing for what we were going to look at. I had that role because I was also a visitor for the National League for Nursing and had the expertise that I could bring to help the faculty pull together what we had to have and get that report done.

LD: Was that a very stressful time? Do people get very nervous when they are going to be

accredited?

CT: Well, not really. I think that we were able, between Dr. Lewis and myself—she also, at the time, was a National League visitor—that we could calm the faculty, that they were human beings just like the two of us. And if you could work with us, you could work with these people. And I think that kind of squelched a lot of anxieties that made it otherwise have—having gone on visits, other—and experienced among other faculty and the trauma that was waiting for visitors to come. We didn't find that. And I think that the faculty had so much input into the process of getting that report ready that they felt pretty comfortable with it. And we kind of mock-reviewed what would happen when the visitors would come and play the devil's advocate, the kinds of questions they may be asked. And assured them that they may not be asked that way or in that sequence, but you could rest assured that some areas of the five parts of the process would be—they would be involved in answering, sometimes on a one to one. And we would prepare the students. I think that what was most exciting that first time that I was here—the program was reaccredited at that time. I think what was most exciting for me to experience was, we had opened up the reading of a report which the National League still does of their findings of the school and the program. They never make any decisions, but—the visitors never make a decision. But the reading of what factual information was gained and many times they would identify strengths and weaknesses during that report. And we opened that up to all of the students and to all of the faculty and to faculty in other disciplines that were involved with our students in the sciences, the social sciences. I was in administration for the university, and I was really excited when in Room 130 there was hardly any—there was standing room. And the—

LD: The big auditorium?

CT: Yes. Then the students listened, and the faculty listened with great intention. You could tell the pride with which this was—and I think you could almost sense that that in itself gave the visitors something to look at because that doesn't always happen in other schools. Sometimes only the faculty listens. That report sometimes only the dean wants it read to her or him, and that was a very—I think—a very exciting time.

LD: I'm sure it was a flattering report.

CT: Yes. It was.

LD: What kinds of things do you look for when you go—when you went as a visitor to other nursing programs? What were the crucial things that you were looking to see?

CT: Well, look at—in the report, there's a section on the organization and administration of a program, and people come to look from what you've written, is that in operation? And, indeed, it was in operation for not only what was in the school itself, but the relationships and the interaction that we had with other faculty and with other disciplines on campus was very evident. And in that report it became very evident to the visitors as they moved about. There was a section on curriculum, and they questioned students. They questioned

faculty in terms of the implementation of that curriculum, both in the theory and the clinical classes that were outside of the major—Did they have them? Who was with them? Were they all nurses? And that was something that we didn't have. They were mixed in with other students, and that was important because we didn't want this person to have visors on when she or he finished the program. The area of students was another component that was looked at—the admission, the progression. Did we have criteria? We wrote we did, and they would question students on how they got into the program, would question faculty on what input did they have in the development of these criteria. The section on resources—what resources we used, in terms of where we said we were going to Moses Cone and Wesley Long, how were they used? When they would investigate that part, they would indeed go out to the areas that they could reach within a limited period of time. I—another was a course, a section, on evaluation in terms of the overall evaluation of the program. What did we do in terms of students? How did we grade? What did we do in terms of evaluating our resources? So there was—in looking at the criterion that were presented by the National League, one could find overlaps, and the key that we helped the faculty look at was when we answered one, we had to be sure we answered the other one the same way, even though we might have used the same words again. And they began to see that as a very—it was organized that way. Not necessarily to trip a person up, but I guess to see whether or not we were indeed doing what we said and getting it back that way.

LD: Isn't there also a teacher's exam—I mean, a nursing exam that they have to pass? Is that a state or a national?

CT: It's a national exam.

LD: A national exam. And who sets the passing grade for that?

CT: The National League for Nursing.

LD: The National League for Nursing. And is there—I'm sure you've never had any trouble having your students pass that exam, but is there a—?

CT: Yes, we did.

LD: Did you? When? You mean, in particular or just—?

CT: I think the first three years of the program there was 100% passing. And then we had 90% and 95. A couple of years there, with some of our large classes, I think the law of averages said that we were going to have not always the best students who could always put that down in writing or always answer those tests. They were not good test takers and we could identify them, so that we recognized that we were going to have a lower grade, and I think we had went down to 87% one year. Back up to the nineties. So it kind of fluctuated.

LD: Did the accreditors expect you to meet a certain percentage? Did they have guidelines in

order to have a worthwhile program? Was there a percentage below which you're not supposed to drop?

CT: No. Actually, accreditation didn't—

LD: They were not concerned with that?

CT: They were not concerned about that. They were concerned about what we were teaching, how we were implementing what we said we were doing. The ability—we presented those statistics to them, but it was not—there wasn't anything in the criterion for accreditation that addressed that issue.

LD: Did students who did not pass the exam get to take it again, or were they encouraged to—?

CT: At that time, they could take it over any number of times in the early '70s. We never had any student that took it more than once at that time that didn't pass the second time. Now, the law's been changed so that a student may take it three times and if, after the third time, does not pass, must go back to school again. And that's dictated by the state board here in North Carolina. Of course, in the state we had instances where students were taking it over and over and over again for ten years and not passing them; taking them until they could get—and it was watering down what we were—. So that was tightened in the law. I know right here—this doesn't connect, but the—it crossed my mind earlier when I was talking about psychiatric nursing. I'll just go back, and I sound like I'm not all put together, but I am.

LD: That's fine.

CT: When I first came, when we were teaching psychiatric nursing, that's why we had worked to get that grant money so that we could enhance that and get into the mental health component. Psychiatric nursing was still within the confines of acute care settings or chronic. Most of the care that we found was chronic care, so that we found ourselves traveling—at least, I did, when I—that first year that I taught psychiatric nursing here in the program. We took our students to Salisbury [North Carolina] and worked at the VA [Veterans Administration] Hospital with them. That was an hour's trip from here and an hour's trip home, many times on the highway, which we didn't like. And as we looked at that and kept abreast with what was going on, we felt that there were other ways to teach students psychiatric nursing besides taking them into a chronic setting where they never saw any movement or never saw a patient, by way of treatment, get well or even show any semblance of getting well. The experience was a good one, but not keeping up with what we knew we had to change. And so there were—at the time, the state released patients from Butner [psychiatric hospital, Butner, North Carolina] and just sent them out into the streets. What we discovered was many of these patients didn't have any place to go. They had no homes to go to. And Evergreens, which was a nursing home for many of these people, assumed responsibility to take them in. That was the old Evergreens, not the one that exists now on Wendover [Avenue, Greensboro, North Carolina] and in High

Point [North Carolina]. It was out on Huffine Mill Road. It was the old polio hospital, as I understand.

And we—when we found that out, a couple of us went and talked to the administration there to see whether or not we could bring students into that kind of environment to teach them part of the chronic, the chronicity. And also we felt that we were getting—even though we knew these people weren't getting well, we were getting them out of the institution, in the sense of the psychiatric institution. It was one of our early endeavors to move into the mental health component, and we functioned over at Evergreens and probably was the seed for what we do today in getting them into the community and to be able to see this into the home. The group work and Alcoholics Anonymous. There are a lot of people who are emotionally disturbed, but they don't need, for example, hospitalization. I found that exciting because I saw that movement and saw it grow. Is there anything else I can tell you about that program?

LD: What do you consider the strengths of the UNCG nursing program if you had to summarize or boil it down?

CT: When I was there, one of the strengths was the leadership given by the dean.

LD: Dr. Lewis?

CT: Yes. The—a dean who would work with faculty and encourage faculty to keep abreast of what was going on, to be accountable for the—for self and to self, as well as to the public in terms of what we were doing. I think that we had a tremendous *esprit de corps* among the faculty, which was one of the key points that the National League for Nursing picked up when they came by for the visit. That was not something we could put in a book. But to experience that, I think, was exciting. And I haven't been a visitor—I used to tell the faculty that it doesn't always exist anyplace else. You may think it does, and it was a strong—we differed. We may not have appreciated by the time someone—without—that differed with my—I didn't, maybe, sometimes with my opinion, but you would come around to be able to see that there were some things that we needed to keep abreast on and keep going. And I think that spirit was so vital and so prevalent, and I experienced that. [pause] I saw a decrease in that the last years I was there.

LD: When did you retire?

CT: In '88.

LD: So, fairly recently.

CT: Yes.

LD: And when did Dr. Lewis leave?

CT: '85.

LD: Did you see a decrease after Dr. Lewis left?

CT: Yes.

LD: I've had the impression from speaking to other—

CT: The leadership was not the same. We had a weak leadership. Dr. [Patricia] Chamings didn't know how to get people to come together and how to get the most out of them. And I thought that that was a weakness for us. I think it's being pulled together now.

LD: That's encouraging.

CT: It makes me happy.

LD: The program also has a very—had, under Dr. Lewis, I believe, very good rapport with the rest of the university, which is not always true of some of the professional schools. And I gather that you agree and that you think that also is due to Dr. Lewis' leadership?

CT: That's part of the accountability. We can't just be here in this building doing our own little thing. We're a university faculty and therefore we need to move out, and as you begin to move out, you bring that back to your students. And I think we saw that. I think the students saw it too. They could experience it because we had students, then, function on university committees where sometimes I remember from Vice Chancellor [for Student Affairs] Jim Allen that he had a hard time sometimes getting commitments from students, but he would—when he searched among the nursing students, he found a commitment and even though sometimes their schedules were different and they couldn't always get there, he would look forward to when they could participate. So at one end we were hampered because of the clinical component to get students involved, but when they did they were strong leaders.

LD: Did the faculty also get involved in campus committees?

CT: Yes.

LD: Do you remember any ones that you were on?

CT: For example, I was on admissions on the Academic Cabinet. In fact, I served as chairman of the admissions committee. I've forgotten what years. I served a period of time on the committee. Academic appeals was one on which I was called for many times.

LD: What did academic appeals do?

CT: Students that didn't make the grades and—like would receive a lower grade point average than the university would allow them, and we would have to review the students' progress to determine whether or not they would have to sit out a semester or they could come back. Those were long and strenuous committees. That was a lot of committee work,

especially at the end of the semester when grades would come out. I served on so many odd-ball committees for the university. I chaired the faculty component for reaccreditation for the Southern Association [of Colleges and Schools]. We were doing a nontraditional study at the time, and I chaired that one. But there were faculty—I was just using that as an example—faculty on all committees of the university. I think that's it.

LD: That's about it. Okay, well, thank you very much. I appreciate it, and I enjoyed the interview.

[recording paused]

LD: —reconvene this interview for just a few minutes while Miss Turner tells me about some students. I asked if she had any students who went to Vietnam.

CT: One in particular—I can't remember what year he graduated. He was a junior at the time I was teaching him. His name was Mike Calder [Class of 1975]. And Mike had been in Vietnam, and I remember one day—it was a course in the dynamics, and I was teaching the first one. It was the communication component, and Mike all of a sudden stood up and looked very agitated and walked out of the room. And after class, I saw him and asked him what had happened and he said, "I had to go out and sit and meditate because—" I've forgotten what happened. What [United States] Congress had just done with regard to the Vietnam veterans or what had just happened in Vietnam, but it was something that was just surfaced with him—the torture and the misery that he had experienced in Vietnam and seeing the many people that died that didn't need to die, both his buddies and the Vietnam people, that he said, "I couldn't handle it." And he apologized. I assured him that wasn't necessary; it was just that he was all right. And he did—he learned to—he took some TM [transcendental meditation] at the time and got himself involved in that. That helped him relax enough to handle it. Mike, I'm proud to say, has gone on—I think he's studying for his doctorate now and has done real, real well in nursing. Real well.

LD: So he got involved in nursing after he came out?

CT: Yes. And I think he's still in the Armed Forces. He's back in the service now. So he was the only one that I knew that we had in the program that had been a Vietnam veteran.

LD: You didn't have any who graduated—nurses—who then went to Vietnam as nurses?

CT: Not that I know of.

LD: Not that you know of?

CT: Not that I know of.

LD: Okay. Thank you very much.

[End of Interview]