UNCG CENTENNIAL ORAL HISTORY PROJECT COLLECTION

INTERVIEWEE: Margaret G. Klemer

INTERVIEWER: Linda Danford

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[Begin Side A]

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

MK: Yes, be glad to. I came to be part of the founding faculty at UNCG, and I was teaching at the University of Washington [Seattle, Washington]. My husband was considering transferring to UNCG, Dr. [Richard] Klemer [chair of Department of Human Development and Family Relations], which was then the home economics department. And just during his interview he had said to Dean [Naomi] Albanese [School of Home Economics] at the time, "You know, we come as a team. My wife's teaching at the University of Washington in a baccalaureate program." "Oh," she said, "That's fine," and picked up the phone and called Eloise Lewis [dean of the School of Nursing] and said, "We have a dean on campus and have had for a year, and she is looking for faculty." So my husband chatted with her, Eloise Lewis, then called me. I came over for an interview, and when I left my initial interview with Dr. Lewis, I said, "Do I understand then that if my husband accepts his position in UNCG, that I will also be employed by UNCG?" And she said, "You can count on it." And that's how I got to the School of Nursing. During that interview, though, it was very exciting. She sparkles, she energizes, she's just terrific. And I thought if anybody can launch a new program, this is certainly the person who could and that I would feel good working with her.

LD: Eloise Lewis?

MK: Eloise Lewis, yes, for years in nursing. You have to know I was a student nurse '34 to '37, so I go back a long way. But all the years in which I was in nursing education, we always had to cut and paste and revise curriculum and limit, omit, add. Gets wearing after the years, and here was the first time in my life an opportunity to work with a small faculty, a terrific dean, to from scratch develop a curriculum for a baccalaureate School of Nursing. And I regarded that as a challenge, and I had just come, as I said, from University of Washington, where I'd been on their curriculum committee for five years. So I was really revved up.

LD: Can you tell what year this was?

MK: Yes. I came in 1967 as did the other five members of the faculty, and the dean came a year

earlier. But the opportunity here existed. We had a whole year to just plan the curriculum, to get acquainted across campus with what all of the other departments were offering, what departments we might need to cooperate with, to have cross communication for our students and that kind of thing, to get acquainted with the community, to know where all the health agencies were and the problems as well as the progress, and so we had that whole year. In the meantime there had been some young women on campus; there were no men at that time in the program. There'd been so many women on campus, knowing that there was going to be a School [of Nursing]. But we were then immediately assigned students for guidance, so we knew them, some of them, before they got to the major. And I hope I'm projecting my amazement that this could happen. It was just stimulating professionally for me, as well as being a good move for the family.

LD: I picked up three interesting—in every interview I've had with members of the nursing staff, nursing faculty, the same portrait of Dr. Lewis comes out.

MK: Oh, is that true?

LD: Yes. And I'm very impressed. I mean she obviously was an exceptional person to work for.

MK: And with.

LD: And with.

MK: Her leadership was just terrific. I have not encountered that kind of leadership anyplace else.

LD: Now your specialty is in—?

MK: Maternal newborn family nursing, with a strong lean toward community health and also psych[iatric] nursing. But you can't teach nursing without encompassing all phases, but yes, my area, women's health is what it's called now. That as a major or that as a program at the master's level or the undergraduate, women's health didn't exist. Now it's a common curriculum offering, but, yes. Maternal newborn.

LD: So then you were in charge of designing a course for—?

MK: Nobody was in charge, really. That was another stimulating thing. With six of us and the dean, we sat around the table, regardless of our special emphasis in nursing, and we talked about what we wanted, what the product should be, what was currently needed to prepare women for professional nursing. And we had then to design a conceptual framework of what professional nursing was and then a curriculum that would fit the framework to get the process and the product. So, no, we all had input when it came to our special area, but each area of nursing embodies either what the student has learned before she comes to your specialty, and you can use all of that, usually, and what she's going to need when she leaves your special interest. So, no, it was a community effort of all of us, and the dean sat back and watched us get acquainted with each other. The interaction was very exciting.

LD: What do you think the UNCG program did differently from other nursing schools that was—?

MK: Well, I would have to go back to what the conceptual framework and the philosophy. What we did differently was, first of all, to have the full year to plan was different in itself. To have the opportunity to know and guide students almost a year before they moved into the major was exciting because you could do a little counseling and academic advising along the way. The freedom to exchange ideas and not have to start with some preconceived idea of what a standard curriculum could be. The freedom to investigate the community was important because you could know what the community's needs were and how your student might eventually, as a professional nurse, fit in to help with those needs, as well as determining what the best learning experiences were for them. The freedom to work with other faculty, just talking with them about our program in other departments and schools on the campus was very exciting.

LD: I gather there was a good rapport between the nursing school faculty and the rest of the university. I've heard that from several people also.

MK: Yes, I think that was good too. I was fortunate. I came from an environment immediately where we had had that, so I kind of expected it. But, yes, we worked very well. The fact that psychology and part of sociology shared the Nursing Building with us was very helpful, too, because a lot of informal exchanges took place as well.

LD: Is there anything different in your concept of nursing in general that was different at UNCG?

MK: Oh, yes. Yes, yes.

LD: What did the school nurture as an ideal?

MK: It's just a matter of getting it out.

LD: Take your time.

MK: As we built the curriculum, we did not see the specialties that you started off asking me about. We saw nursing as a well-integrated body of knowledge, so we weren't going to divide the curriculum up into this, that and the other. I guess it was the patient, the client as a whole, total being with emotional, physical, religious, if you wish, a wide variety of needs. And that all of these be taken in consideration as we taught, prepared students to work with people. To see the student as a whole being. To recognize that we were not totally responsible for our education, but to certainly be responsible for using everything she'd learned before we got her and to prepare her to use as much as we thought she could possibly learn in the time that we had her. We didn't set aside a special course in ethics. They're back to teaching core ethics, I understand. This kind of thing was integrated throughout the curriculum as well as the client as an individual. I'm rambling a little.

LD: No, no you're not. You're being quite coherent. How long were you at—when did you retire?

MK: '81.

LD: '81. I wanted to ask you specifically about Lamaze [method of natural childbirth] and its—how it got started in Greensboro. When I had my first child in 1979 in Wesley Long [Hospital, Greensboro, North Carolina], Lamaze was very much part of the program. It was very—it was obviously not new. And I was impressed because although we were in the middle of a [unclear] between a number of big teaching hospitals, this is not a medical school town like Chapel Hill [North Carolina], for instance. And I had friends in other parts of the country who were battling with their doctors and their hospitals over trying to have some sort of Lamaze technique and not—. The hospitals in my home town in New Jersey, which were not permitting husbands in the—still, in 1979—in the delivery room. So I—and I know some of this must have been influenced by the program at UNCG because so many of the maternity nurses in Greensboro went through the program. Do you remember when it got started and how it came about?

MK: It was started when I got here. Let's see, who was the person that was teaching?

LD: That's pretty early.

MK: Well, I made it my point to find out. Mary, her husband is a judge here in town.

LD: Oh, I took my Lamaze class from her. Albright [1967 associate degree in nursing].

MK: Yes. Mary Albright was doing that when I got here in '67-'68, and there was already a La Leche League for the promotion of breast feeding. I found the hospitals somewhat restrictive, as you're saying about who could be in labor or who could be in delivery room. Natural childbirth was really not what Lamaze was all about. The preparation for childbirth was what Lamaze was all about and did include family preparation with the husbands. And then, of course, it was very hard to get to the hospital and find that husbands were not permitted, for the most part. I encountered this, too, because I came with a different set of principles in maternity nursing. For instance, I can well recall maternity was not taught until the senior year. So anyway, I had time to visit the hospitals and all of this. And I can well remember one day on the maternity wing at Wesley Long when I said something about the birth room. And they looked at me as if I had come from Mars. And I used terms like birthing and all of this, which hadn't come this far.

LD: Is that because of the influence of Seattle and the West Coast? Were they—

MK: It was the—

LD: —ahead of us?

MK: No. The idea just hadn't spread quite so much. So there were some, to answer your question,

there were some prepared childbirth classes and there were some support systems like La Leche League, but nothing like they are now. Another thing that I don't know influenced maternity care. It certainly changed, I think, a lot of young nursing students ideas about what maternity might be because one thing I did the first year, and I wasn't going to use the pronoun, "I." I'm sorry. I hope you'll take that out.

LD: That's fine. That's fine.

MK: One of the things that occurred as we planned the curriculum for maternity and newborn was the idea that I proposed at the time was that each of the students during her maternity nursing experience might have the opportunity to have some experience in an obstetrician's office. And further than that, it would be desirable if the student and the physician, the obstetrician, together could select a patient which she might follow for the whole semester and go right with that patient through her antepartum classes, through labor, through delivery with the woman's permission and the obstetrician's. Well we did that.

LD: And this was your idea?

MK: Well, I brought the idea from Washington State. I didn't originate it, no. But it worked so well for five years out there, and it was just terrific. It was great for the students and the families who wished to participate it was great also.

LD: I had a student assigned to me.

MK: Did you? Sometimes it works. Sometimes it doesn't, you know.

LD: I thought it was very—I think she probably got a lot out of it. And I think it was a real different perspective because these girls are not, for the most part not married, and don't have—

MK: That's exactly right. But don't you see that's a preparation for women and for them just as well as it was for the patients who did the learning in maternity nursing.

LD: I thought it was a brilliant idea.

MK: We did that for quite a few years, maybe four or five years. I don't know [unclear] the process now. But I got to meet all of the obstetricians because I had to visit their offices by appointment to explain this concept and what I thought it might [unclear]. And we had no difficulty at all. No difficulty at all. I remember one of the doctors said, "Well, yes, I think that's a great idea, Mrs. Klemer. But under no circumstances is that student ever to get between me and my patient." And I said, "You're absolutely right." So it was accepted, and we did that. But it was a good learning tool.

LD: Did you find the local obstetric community fairly receptive to change?

MK: Well, I suppose change that they were making. I didn't come to make any changes, so I can't

answer your question directly. I don't know whether they were or not. This was a change that they certainly did accept. You have to keep in mind now that there were many fewer obstetricians in Greensboro than there are now. Many fewer ones. And sociologically it's interesting to note that as—what do I want to say? Those folks who used public health clinics and other public support environments for their prenatal care, you have to realize, that those people over the years have moved up economically, and many of those people chose for their obstetricians the gentlemen or women obstetricians that they had met in their public health clinic. So that was sociologically a change because so many of those people, prior to their moving up a little in economics, would never have had private physicians, and I think this was—I think this surprised the obstetricians a little too, but I can't speak for them.

LD: Do you think many more people get prenatal care now or—?

MK: Not nearly enough.

LD: Well I know it's not nearly enough, but I mean was it common for people to get prenatal care back in the sixties?

MK: Oh, yes. We'd been preaching it. Been teaching, preaching prenatal care for years. But you see, never before had we had this vast number of young early teenagers having babies. And, of course, they're at risk. And they need the prenatal care just as much as we used to say, "The elderly woman, thirty five or over, who was having her first baby was at risk."

LD: Actually, mostly what you have nowadays are people in their thirties and teenagers. Women in their twenties are all doing other things.

MK: They're doing different things now. The times have just changed in the twenty-three years I have been in Greensboro. But I had fourteen years at the U, and they were good years.

LD: Do you keep in touch with any of your students? Do you remember any?

MK: Oh, I remember several particularly. You have to know that I had to do some changing myself somewhere along the way because there was not this informality between teacher and students even in '68 and '70 that there is now. Any student probably that I ever taught at the undergraduate level, if we were to meet, would still call me Mrs. Klemer. However, some of the graduate students that I had later on after we developed the master's program would always say, "Hey, Marge." I don't deliberately keep in touch with them. But I do hear from some at Christmastime, and there are a few here in Greensboro that have gone on to do very good, good things that I do see.

LD: Can you mention some of them?

MK: Well, first as an undergraduate, and then as a graduate student, Lavonne Troxler Beach [now Lavonne Fisher, Class of 1970, 1982 MSN]. You've heard of Lavonne. All right. They're opening a room at [Moses H.] Cone [Memorial] Hospital [Greensboro, North Carolina] in

November. Lavonne was the vice president for nursing there. Have you had a chance to interview her?

LD: I'm going to try. I have to do my list first, but—is her last name Beach or Beet?

MK: Beach. She's widowed, but she has a grown son.

LD: Eloise gave me her name.

MK: Another one is [Elizabeth] Libby [Kuykendall] Dickson [1977 MSN]. Libby came through our master's program, but I've also taught beside her as a colleague. Libby went on to become certified registered nurse midwife at the University of South Carolina [Columbia, South Carolina]. And Libby working and changing attitudes like crazy about maternal care, has an affiliation of her own in High Point [North Carolina] with an OB. You always have to have an obstetrician, but they do deliveries and everything. And Libby is exciting in nursing too. Yes I hear from Libby. If they do something special I get an invitation—that kind of thing.

LD: Does she do her deliveries in the hospital? Do they—?

MK: They are adjacent to the hospital in case of emergency, but no.

LD: It's an auxiliary building?

MK: Exactly. It's their own building.

LD: I did know that there were midwives practicing in High Point.

MK: Now Lavonne would be great to talk about all this kind of thing, too, because she was very influential, I personally think, in opening the eyes and minds of some of the local obstetricians. And she worked at Cone Hospital for a while before she transcended to be the vice president for nursing over there. But casually, I hear from some of them. I have not pursued it because I came up when there was really, not an autocratic approach in nursing, but you didn't fraternize with students at that time like you do now.

LD: You must have seen some big changes in the neonatal care area.

MK: That's not really something I could talk as positively with you about as I would like to because I have been away from maternity nursing. More than the eight years I have been retired. Three years prior to retiring I was the director of continuing ed[ucation] at school and two to three years before that I was director of the master's program and before that I chaired the committee to develop the master's program. So I came in out of a clinical field. So personally, I would not go into an intensive neonatal nursery at this point. I would be like a fish out of water.

LD: Tell me something about continuing ed. How often does a nurse need to go back to school to

refresh her knowledge?

MK: My simple answer, oversimplified, would be as often as she can.

LD: What are the—are there—there must be some state requirements.

MK: I'm lost.

LD: You don't know what those requirements are?

MK: No. I haven't kept up with this. I have not kept up with this. Dr. Lewis put me on sort of what you'd call release time to chair the committee to develop the graduate program, and that probably was what I would consider in my career professionally here as really, probably the highest point. That was very exciting because there was only one program at the graduate level in the state of North Carolina, and they only prepared for clinical expertise, and we could see that a lot more needed to be done.

LD: When was the master's program developed?

MK: Let me look right here. [pause] It went to the graduate curriculum committee in 1975. And we admitted our—when did we admit our first students?

LD: '76.

MK: '76. We went through all of the channels that you do to develop any graduate program on UNCG campus as well as administration.

LD: And you were in charge of that committee?

MK: Yes. I chaired the committee to develop the program for a master of science in nursing. And that was very exciting.

LD: Was that a general program or were there specialties within that that you could pursue?

MK: Well, in order to even develop a proposal, you need to know what it is the state needs or what it is, and what it is that nursing needs and what can your environment educationally provide. And we did a study of need for a program, and the greatest needs in North Carolina at the time were teachers of nursing and administrators of nursing service or administrators of nursing practice, both of which needed current, clinical nursing skills, bedside, etc., skills where ever nursing is practiced. And this was our focus. North Carolina at that time had two-year programs in nursing as some of the technical colleges and the community colleges had. Diploma nursing and then they were starting to have the baccalaureate programs in nursing. And since the baccalaureate program had gone so well here, it was determined that it was sound and logical after we defined the need to propose that we offer a master of science program because of the strength of the baccalaureate program to build on the strength of the faculty. Again Eloise Lewis guides, and a campus that was ready for it. They

were accustomed to having nursing. We weren't somebody that just sat down there on the hill. We were an integral part of the university, and so we did. And we had to go through the graduate administrative board on the UNCG campus, and then we had to present to the Board of Governors [of the University System], and we did it.

LD: How many students in the first five years of the program did you—?

MK: I don't have that information anywhere. I don't have that information anymore.

LD: You don't remember the average class?

MK: Well, I was trying to think how many we took in the first class. You have to be patient. Figures are not my—. [pause] First class of master's students, full time and part time, and you might ask me about that full time, part time business if you'd like to because that's vital to this program that we had. They were admitted in '76. Let's see. In '77 master of science in nursing was conferred on each of the nine students who had successfully completed all requirements for the degree. So there were nine in the first class, and we even defined what they—they even wrote back and told us where they were working. They admitted the second class in '77 and the third class in '78, and that was when I moved over. See, I did not have a doctorate, and it was determined pretty much by the profession and the trend that if you're going to be a director of a master's program as well as faculty on a university campus, you really need a doctorate. And by that time I was getting on in years and been widowed and had a daughter to educate, and I did not have a doctorate, and so I moved over into continuing ed. Am I wandering?

LD: No. No. Please talk about the part time, full time.

MK: This had to do with the need in the state. A lot of nurses saw the need for more education, and they [unclear]. And as I said to you, nobody was preparing teachers in nursing in the state, and nobody was preparing administration of nursing service—wherever, like a director of a public health service. Nobody was doing this for nursing. But one of the reasons nobody was preparing them was the program didn't exist. But some of the women in nursing had wanted—and there were some men—wanted degrees and additional education and additional personal growth and personal enrichment. We were getting master's of art and master's of sciences and other things which did not build on nursing, but, of course, it enriched the person herself and in turn anything else that she did. Well, there weren't any programs to do this in nursing so that was another reason. The other things we decided that they shouldn't teach, not just be full-time program was that so many of the people in nursing were married women and could not just stop cold and go back to school full time. A lot of the single women couldn't afford to just stop working and go back full time. So one of the things that we helped sell our program with was the idea that as we planned the curriculum, we would plan it so—and this was a little unusual in the mid '70s—so that you could go full time or part time, and we started right then with evening classes for the part- time girls and summer school classes, too, as part of the program. And you could complete the MSN (master of science in nursing) in one year. But we urged them only to do it if they had that kind of drive and time and could afford it. That to come part time and we would work with

them, and that we did. And it's still open to part-time students.

LD: Well, that's a trend that the whole university has had to develop because of the nature of the student demand.

MK: That's right. And there again, we can sit here and say this in 1990. We were glad to do it a little earlier than that to get it rolling. As I say, I'm not fudging. I just have not kept up with the master's program. When I resigned, I resigned. I did two years of volunteer work for Eloise Lewis at the school afterwards on the records and things like that. But again, it did not involve that kind of concentration on the master's program.

LD: When your students—when you were training your students in the early '70s, did you supervise their clinical practice in the hospitals?

MK: Are you talking about what I did as a faculty person when we were educating these young women to be nurses?

LD: You personally, yes.

MK: I say educating because "I had been trained in the thirties." I had not been educated three years at a hospital. Good, sound school, passed my state boards and all of that, but it was more of an apprenticeship nursing in those days. Yes, everybody who taught in the baccalaureate program had a clinical group—at least one group of students working in the environment, whether it was public health or the psych unit or in maternity or the nursery or pediatrics or medical/surgical. Everybody had a group of students to teach, and so we had to be up on our own clinical experience in order to do as well as show.

LD: Did you find students had good academic backgrounds but difficulty sometimes with getting into the practical aspects of nursing?

MK: I hear what your question is saying.

LD: Oh, how did you handle it? I'm sure that that did happen sometimes, but how did you—?

MK: Well, you're saying they might—you're asking me if they had the academic ability that perhaps the transferring, getting it out through the fingers and the heart and the head on the units was difficult. We did a lot of individual counseling early on with the students, academic counseling and this kind of thing, because we had small groups of students. And we were able. We had mid-term conferences with them. We were very sensitive to if a student was getting into difficulty or if she was backing off. My own personal theory is a student has a right to withdraw from any program that is not doing for her everything she had hoped it would do. And my own counseling one to one with them academically, after we had tried to find out what the problem was. (and sometimes it was just a simple little glitch of not understanding or getting into an agency before she was ready for it or having a hang up about some particular illness), that kind of thing. My own thought has always been to say to the student, "Is this causing you more pain than pleasure?" And I think a student

has a right to withdraw if it is not fulfilling or if she isn't really able to give it her best. They also have the right to fail. Everybody has the right to fail, you know, without being condemned for it. But by the time you got nursing students, again, into the major, they still knew where they wanted to go, but it was different to try it on in the clinical areas as your question indicates. One thing that made the transition easier from full-time academic student to practicing nursing student was the development of a 200-level course which was taught in the summer between the sophomore and the junior year in coming in. That helped in the transition. The students could be observed very closely for the kind of thing you're asking about. At the same time if they felt, "Uh, uh. This isn't what I thought it was going to be." Then some students withdrew at that.

LD: I know sometimes you get a doctor with no bedside manner, but it—frequently, in fact—but a nurse without bedside manner is a serious problem.

MK: That's right. Well, here again, we tried to integrate the emotional needs, the physical needs, all the health needs, the nursing needs, the nursing diagnosis of what this patient needs to help sensitize them to it.

LD: Is there anything else that you think you'd like to add?

MK: No.

LD: Any other faculty members you'd like to remember? You said quite a bit about Eloise Lewis, but what about some of the other—?

MK: Faculty that I worked with? Margaret Moore [Class of 1935], of course, is deceased. Margaret was the only faculty member who was a little bit older than I was. I came here as the oldest faculty member, and the only position I ever had where I was older than the dean. [laughs] But they accepted me. They never let me feel that old. You know what I'm saying. Margaret, of course, was a treasure. And she—Margaret Moore was medical-surgical person. She was also the dean's housemate. They had taught together, I believe, over at [University of North Carolina at] Chapel Hill. And Margaret was great, a humanist. A graduate of UNC Woman's College [Woman's College of the University of North Carolina] in phys[ical] ed[ucation] way back and then went on to nursing. [Dr. Sandra] Micqui Reed [nursing faculty] still teaches. She's Sandra Reed at the school. [Dr.] Ernestine Small [nursing faculty] still teaches.

LD: And you were telling me just before we started the tape, Ernestine Small was the first black faculty member—

MK: On the campus.

LD: —on campus.

MK: I just read that somewhere in my notes.

LD: Where you aware of it at the time?

MK: The dean was. Sure. Sure. But Ernestine was a pioneer. You need to talk with Ernestine. When all the civil rights mess was going on in the '60s, Ernestine was doing staff duty. I've watched Ernestine go from her master's to her doctorate. She's great. She's married and has two children and lives here. But when she was at Cone Hospital, I just, I don't know that this belongs on your tape.

LD: Oh, I think that this is appropriate.

MK: She might not like it.

LD: Well, I don't want to force you.

MK: No. All I was going to say was Ernestine was a needer. She didn't mind pioneering. Let's put it in that context, pioneering. Being the first black, Ernestine was employed for what Ernestine was and is. She's great, knowledgeable, works well with students and all that. But when Ernestine was working in the early '60s at Cone Hospital doing staff duty, and the time came to integrate the dining rooms for the first time, Ernestine was the person who was chosen and did.

LD: So she worked there before the dining rooms were integrated?

MK: Well, in the '60s not every place was integrated, you know. I had a little trouble in making myself [laughs] in the '50s during integration. We admitted black students for the first time. Yes, Ernestine was the first, and at one point we had five other people on our faculty and now, of course, we have lots of them on campus judged for their quality and their abilities, and that's nice. Now the others have left. Eleanor Brown is over at Chapel Hill. Shelly Jones is at the University of Oregon. Billie Boette is in South Carolina. Those are the originals.

LD: How large was the original staff?

MK: Six with a seventh person who came in January after we started in '67.

LD: And how large was the faculty when you left?

MK: I don't remember.

LD: But it must have been larger because you had a private program at that time. And you took over the whole building, did you not?

MK: Yes.

LD: And you no longer shared with anyone, I believe?

MK: Well, the rooms are for classes and things but no other offices are there, no. Psych didn't

have a building at that time. And then we had part of the soc[iology] faculty because I think they were crowded over in Graham [Building] or something. But that was very enjoyable having a mixed group like that. I'm sure I haven't said all of the things or conveyed to you the feelings I have about this School and this University and women's colleges, but I regard it professionally and personally as a rare treat to have been part of the original faculty, and I suppose, as I said to you earlier, the high point for me was being asked to chair the development of a master's program. That's something I hadn't really anticipated, but Eloise must have seen the spark. She has the ability to hone in on the special skills of the individual, and I didn't realize that she was going to ask me to do this. But she has this knack. If you've got it, she knows what it is and she will use it. [laughs]

LD: Well, I have certainly have gotten that impression from everyone that I've spoken to. Well, I have enjoyed the interview. Thank you very much.

MK: Thank you for asking me.

[End of Interview]