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[Tape 1, Side A]

RS: Today's date is November the 8th, 1995. This is Richard Steele, the Archivist of the Mount Sinai Medical Center. Today I will be interviewing Sylvia Barker of the Nursing Dept. here at Mount Sinai. Sylvia has been at Mount Sinai for approximately 60 years. She graduated in the Class of 1936 at the Mount Sinai Hospital School of Nursing and she has been not only a student, but a teacher and administrator and very influential in the Alumnae Association during that period. We will do a series of interviews with Sylvia, discussing her reflections and recollections of her time at Mount Sinai.

[Tape off then on]

RS: Sylvia, thank you for coming today. I really appreciate you taking the time to come down and spend some time with us.

SB: Well, thank you for asking me.

RS: It's our pleasure. I would like to do this a couple of times, if you don't mind, in the future.

SB: All right.

RS: And I would like to start with you giving us a little background about yourself. What your positions were here at Mount Sinai and aspects of your career.

SB: Well, that's a pretty tall order [laughs] in terms of 60 years at Sinai, with the exception of two years I was away.

Well, when I graduated, I graduated in 1936 from the School of Nursing and at that time there were choices, about two choices for graduates. They either could stay on and work in the institution, or decide to go into private duty. I chose not to do private duty and so I began my career at Mount Sinai upon graduation. Graduation itself, in those days, was held in February, because there were two sections to each class, and I was in the September section. So, on a very, very wintery, icy day in February, I got all dressed up in my white uniform, and wore the graduate cap and carried the traditional violets and we had our graduation exercises, at which time I was awarded a Guggenheim Medal. The outstanding thing about that day was that it was cold and icy and that my mother and my sister did travel down from upstate New York for the ceremony, at some great expense of energy because of the weather. The next day, of course, we had to go back into our student uniforms. We wore our student uniforms from that day in February until we finished our training. And at that time, unfortunately, they did use the word 'training', it should be, in modern language, we are using 'education'.

Another factor about finishing your education in those days was that if you had been sick any time during the course of your education, you had to make up that time. So, although I entered, I think it probably is the 6th of September in 1933, I didn't finish my experience as a student until the 2nd of November, because I did, unfortunately, have some sick time to make up.

Interestingly enough, that November day was a very important day in our national history because that's the day that Franklin Roosevelt was, the day after he was elected President. In those days student nurses couldn't be registered in New York City to vote. And so I went upstate. In Upstate New York you were allowed to be registered as a member of the family. And so my mother, who was an election board member, saw to it that my name was on the rolls in the local district -- election district. And so when I got home I was able to go and vote for my first time, just having finished training. I have always giggled about it because Upstate New York is very, very much Republican and I had made up my mind I was going to vote for Mr. Roosevelt, and I may very well have been the only vote he got in that district. [laughter] I am not sure, but I am pretty sure that I was one of the very few people who did vote for him.

RS: Why don't you tell us a little bit about growing up, what it was like growing up. Where are you from in Upstate New York?

SB: OK. My address in upstate New York is Schuylerville. It's named after General Philip Schuyler, whose family home was there and is there, it's a national historic site with all the trimmings of national historic sites. My house, the house in which I spent most of my life, until I came to New York, was in a little town called Clark's Mills, which the mills are paper mills. They're still there, it's one of the few places that still does have a paper mill. It's located on the Batten Kill, which flows out of Vermont and is located at the confluence of the Batten Kill and the Hudson River. My house is in Washington County; school and church were in Saratoga County because the river divides the two counties.

My grade school was in a district school in Washington County. It was one of the early combined districts between Clarks Mills and the neighboring little town of Thomson. It was an unusual school in that, instead of being the typical one room school of the time, it had three rooms, three teachers, and our classes were divided: Kindergarten, 1st and 2nd in one room; 3rd, 4th and 5th in another; and 6th, 7th and 8th in another.

My mother was a teacher and interestingly enough, on my first day of school, she was my teacher because my regular teacher was sick and my mother was the substitute teacher at the time. Another thing about my starting grade school was that I didn't start grade school until I was seven years old. My mother taught me all of the beginning stuff because she was a great believer that little children like five and six year olds did not belong in school. And so she knew the powers that be --[laughs] my mother is another whole story, but anyhow, she knew the powers that be and she saw to it that I did not start school. I started in April when I was seven and went from April to September and then I really went to school the following year as a 3rd grader. So that was school.

The other thing about school was that I was pretty bright and I was wasting my time and my mother didn't think much of that. And so she also managed to get me to take my Regents examinations early and so--

RS: How?

SB: I took them, I combined 7th and 8th grade [laughs] and so I went into high school a year earlier [laughs]. So actually, I only ever spent about 6 years in elementary school

because of the beginning and the end. I did go down to Schuylerville High School and graduated from there in 1932.

I guess we might as well digress. You're going to have time with me, but anyhow…

RS: Go ahead.

SB: This past July I was awarded a place in a newly created thing at that high school called the Wall of Fame --

RS: Congratulations.

SB: And there were eight of us who were inducted into the, that first time, into the Wall of Fame, and I was one of them. Interestingly enough, out of the eight, four were related to health professions.

RS: I'll be darned.

SB: Nurses, one nurse and three doctors. And, so anyhow that's just a little odd and end to think about, Schuylerville High School.

RS: Did you have brothers and sisters?

SB: I had one sister. She was 16 months younger than I. And that was another thing that my mother was very anxious for her not to have to live in my shadow. And that's another reason that she saw to it that I got out of grade school so that my sister had two years in grade school without me. And also, she had two years in high school without me. Which gave her an opportunity to shine on her own, and this was something that my mother was very concerned about.

RS: Sure, yeah. So what led to your decision to come to Mount Sinai?

SB: Well, there was lady who lived in our town who was a graduate of the School. She was a graduate of the Class of 1904. Her name was Esther Odenheimer Schmidt and she happened to attend my mother when I was born. Our doctor had his wife and his sister, were both graduates of Mount Sinai. His wife's name I've forgotten now [Anna Murtagh, Class of 1917]. His sister's name was Agnes Rogers [Class of 1919].

When I decided I wanted to be a nurse – and that was a new adventure as far as our family was concerned. Because my family -- the women in my family were all teachers. My mother was a teacher, my grandmother was a teacher, and my aunt was a teacher. There hadn't been any nurses. Interestingly enough, amongst my younger cousins now who are coming up, the generation who is coming up, we've got a lot of nurses. So maybe I've set the pace, I don't know. [laughs] But I was the first nurse, as far as the family is concerned.

RS: Now they have to follow in your shadow.

SB: Well, they are. I think that there was never much of any question in my mind, when I decided that I wanted to be a nurse, that I was going to go to school to study for nursing, Mount Sinai was really the only place. And it was primarily because of this lady that I called Aunt Esther. She had told a lot about it and indeed she was practicing as a private duty attendant down here in the City from time to time. And she also brought, this was pre-Depression, you know, and she also brought children up to the country to live with her. She brought up two or three different children that she got to know through the doctors here at Sinai that she had worked with.

It almost went off track, however, because our class, the class that came in 1932 was the first class to have a tuition requirement.

RS: Uh huh.

SB: Up to that time there had never been any charge to come to the School of Nursing.

RS: Was that because of the Depression?

SB: I expect so. They were having financial problems apparently, and they decided. As measured by today's tuition, that hundred dollars is minimal. However, it was a big hurdle as far as I was concerned. I had been accepted to the School when they sent us the note, the letter saying that it would cost $100. My folks did not have it. My mother and father did not have it.

RS: What did your father do?

SB: Well, at that particular time he was, I think, selling insurance. He had grown up on a farm. This is a farm community and he had grown up on a farm. But he didn't very much like farming. And so he pretty much, during my childhood days, was a salesman of one thing or another. He sold farm machinery. He was one of the -- one of his most successful selling ventures were electric lighting generators, because electricity had not come in widely into the countryside. And so people bought these generators so people could have their own electricity. And that was one of the things that he was selling early. As I say, I believe it was insurance that he was selling at the time that I was in high school.

RS: So that $100 was a hurdle for your folks.

SB: It was a big hurdle, a big hurdle. And really, we didn't know what it was going to be and we even began sending for catalogs from other schools of nursing nearby and things like that. However, my Aunt Marguerite was a teacher and she was employed at that time. And she made a deal. She would give me the $100 that I needed to go to Mount Sinai and rather than paying it back to her, I was to give it to my sister when she went to school. Because I would be earning by the time my sister got ready to go to college. And so that was the deal. And indeed, I fulfilled it with my first earnings at Sinai, sending my sister, who went to Plattsburg State College and graduated from there, and I helped her with that $100.

RS: What did she do?

SB: My sister was a teacher. She taught in elementary school. In fact, she taught in the one little district school that we had gone to as students. That was where she did most of her teaching.

RS: So you got the $100 and you came to Mount Sinai.

SB: I came to Mount Sinai.

RS: That must have been a, had you been to New York before?

SB: Only just -- it was traditional for the high school graduating class to take a trip to Washington, and our class elected to stay overnight one night in New York. So we came up from Washington and we stayed in New York that one night before we went home.

RS: Do you remember where it was? Where you stayed?

SB: Where we stayed?

RS: What was your impression?

SB: Well, the major impression I remember was the subway [laughs]. Our chaperones wanted to be sure that we got a chance to go on the subway and so if I remember correctly they took us on the [Time Square] Shuttle. At least I think that's what they took us on, in trying to recall back to what happened.

RS: How many in your group?

SB: Oh, there were about 36 of us that graduated from high school together.

RS: 36? Wow, OK. So, in other words, when you came to Mount Sinai it was your first real experience with the 'Big City'.

SB: It was my first real experience. My folks drove me down.

RS: It must have been a long drive in those days.

SB: It was a terribly long drive, but we didn't have money. I mean, in fact, it was a neighbor whose car brought me, but they all came together. We all drove down.

And that is my introduction to Mount Sinai. Because, obviously, we were late. [laughter]. You were supposed to have gotten here by 5 o'clock, but driving down… I well remember driving down Fifth Avenue through Harlem. It was quite, quite an experience. And we finally got to 5 East 98th Street and we came in the door and introduced ourselves. And we learned that the Director of Nursing, and she was then called Superintendent of Nursing, her name was Greener, Elizabeth A. Greener, well, she had gone to her room and they would have to call her to come back to see me.

RS: Hmmm… [laughs]

SB: So we sat there cooling our heels while Miss Greener made up her mind to come out and see this little Upstate New Yorker who was late. Obviously, this was not an auspicious beginning [laughter]. Furthermore, I do have a scar on my face, which you probably don't even notice and which most people don't notice. I have it because at the age of about 17 months I was burned in a fall on a little wood stove. And Miss Greener objected to my scar. And she indicated that, number 1, why hadn't my doctor written it down? Incidentally, I suspect that he didn't write it down because he probably knew that in those days that might be a mark against me. But at any rate, she also made it pretty clear that the private patients at Mount Sinai would be offended by this scar.

RS: I have to say, I don't see a scar anywhere.

SB: Oh, it's there.

RS: Yes, it's fairly unperceivable. OK. I understand that in those days there was a great deal of concern about appearance and going into private homes, but I mean, that sounds very much like a martinet.

SB: Well, it was, it was. She was that.

RS: OK.

SB: Anyhow, she immediately decided that I couldn't stay. Well, enter my mother.

RS: Oh, boy. [laughter]

SB: My father, who was a very wonderful, gentle kind of person would have taken me in his arms and taken me home. He wasn't having me stay in that situation. But my mother was intent upon making it clear to this lady that I could do the work, she knew I could do the work, and that I should be given that chance. And Mother practically refused to take me home. [laughter]

RS: So, did you go to a special room to meet with Miss Greener?

SB: No, this was in the auditorium, which is no longer here. The auditorium is where the elevators are…

RS: Yes, yes, I have seen the pictures, so I can imagine. So it's you in this situation with a lot of people around also?

SB: No, no not really, because I was late, there weren't too many people around.

RS: But there were some people who could overhear…

SB: There were still some people around.

RS: So you didn't have any privacy during this interview.

SB: Oh, no, no. So, anyhow, rather begrudgingly, [laughter] Miss Greener told my mother that, OK, if she wouldn't take her, if my mother wouldn't accept Miss Greener's decision, she would have to have me seen by the Board of Trustees. And, of course, the members of the Board were all in their summer homes out on Long Island and so it would be a little while before I -- a decision could be made. Well, my mother was, she thought she had made pretty good progress at that point. [laughter] She figured the longer they held it off, the better I would have a chance to prove I could do the work, that I was a capable young lady. So, anyhow, my parents left and I stayed at Mount Sinai.

Incidentally, I never did see the Board of Trustees.

One of the things that they had us do when we were coming into the School of Nursing was to buy orthopedic shoes because, you know, in those days you were on your feet a great deal. So, the man came to fit us for our shoes. And I said to the Principal of the School, 'Well, I don't know if I am going to be staying or not and I don't want to buy these ugly shoes if I am not going to need them.'

RS: You might have not the money to pay for them.

SB: Well, that was another whole big story --

RS: Yeah OK, We'll get to that.

SB: -- but I didn't want to even bother to be fitted. Well, the Principal had never heard this tale of woe. This Miss Greener apparently had, you know, she was mad, I think, because I was late and she had really…

RS: Who was the Principal? Do you remember?

SB: Miss Leeson, Lillian Leeson.

RS: And what did she do?

SB: Well, she said she would have to call over to the office and find out what I should do about these shoes. [laughter] So the next thing I knew was, I think it was the following day, I was summoned to Miss Leeson's office to go downstairs to meet with Mary P. Brown.

RS: Who was?

SB: Who was Miss Greener's assistant. She was another martinet. [laughter] Anyhow, I was to go downstairs and meet with Miss Brown. Well, the meeting with Miss Brown consisted of her asking me to walk back and forth in front of her a few times; down there on the first floor of the Nurses' Residence. And then she sent me back upstairs. She didn't say anything. Apparently she notified Miss Leeson that I should buy my shoes, because I was told to go and have my feet fitted. And so, that was how I finally was accepted in the School of Nursing.

RS: I see, I see. So what were you doing; how long of a period was this, a week, a few days?

SB: It was probably toward the end of September.

RS: Towards the end of September.

SB: I would suspect that it was around [then], as best as I can recall.

RS: Were you following the same introduction, orientation process -–

SB: Oh, yes, I was. As far as the people in my class were concerned, I was the same as everybody else. We were all struggling to try to get used to everything that was going on.

RS: You more so than anyone else, because you didn't even know if you were going to be staying.

SB: No, I didn't know. No.

RS: The people that you met during that period, did they become friends? Do you remember anyone you met during that time?

SB: Oh, yes. We became a very, very close knit class. There was something like 81 of us who came in in that September section.

RS: Was that a normal size class, or larger?

SB: Yes, yes. It was perhaps a little bit bigger.

RS: A little bit bigger, OK.

SB: We didn't graduate that many. I think we only graduated 55, but there were, I think, 81 of us.

RS: OK.

SB: We did get to be very good friends. One evening, we, of course, had to do a lot of studying, and one thing we had to learn how to do was to apply bandages and so we had to practice. So, one evening I was down in the practice room and there was a young, another student there, and she had with her a newspaper from Lake Placid. That caught my eye, first of all [laughs] that was Upstate New York. And second of all, I had been at college for a year before I came down here and I had met a young man from Lake Placid, so I was sort of interested to see if this girl knew my friend.

So we struck up a conversation, which has led to a long-term friendship. The fact of the matter is, I spent a few days with her two weeks ago in Lake Placid.

RS: Who is that person?

SB: Her name is Marion Kimball Daby. So, she was just one of many. There was a bunch of us, oh, perhaps eight or ten of us, who sort of banded together and did a lot of things together throughout our whole training.

RS: Looking at it demographically, where did a lot of these people come from? Who were they? Do you remember?

SB: Well, Sandy was from Harrisburg, Pennsylvania. Robin was from Sayville, Long Island.

RS: Can you give us their last names, if you remember?

SB: Yes, yes. Helen Sanderson and Agnes Robinson. Geraldine Lansinger was from Ohio. And, of course, Marion Kimball was from Lake Placid. Mildred Posey, from Valdusta, Georgia. Let's see. Those are the ones that immediately come to mind as being our closest people.

RS: We can add the other names later.

SB: Yes. The thing that, mentioning Posey reminds me of another thing. I was thinking during the interval since you asked me to do this, I was thinking about episodes, I don't want anyone to get the idea that I was the only one that Miss Greener chose to pick on. [laughter] She had, they had very, very strong rules and regulations at that time and one of them was a regulation against having an iron in your room. So, my friend, Mildred Posey, came to -- into the School of Nursing under the shadow of the fact that her sister, who had come in February, was in the February section, was on a suspension from the School because they had found an iron in her room.

RS: Wow.

SB: I've always thought, I thought I had it hard, coming, not being very well accepted. But I've always thought that, if you were coming to New York, and planning to be with your sister and to discover that she was on suspension, it must have been kind of tough for those two girls too.

Anyhow, Margaret, the sister, did come back from her suspension and both of the girls did finish with us. We all finished; they were in our class together – finished together in the school.

RS: Since that time your career has taken you to know a lot about what is happening in the field of nursing. Looking back, how would you compare the education and training you've had at Mount Sinai, compare that to other schools of nursing at the time? Can you do that?

SB: Well, I, of course, I probably am prejudiced, but I think that our education was tops. There's no question about it. It was rigorous.

And we were constantly wondering if we were going to make it. On the other hand, they did some pretty decent things.

One of the requirements was chemistry. But, they did, for one reason or the other, perhaps because the students had evidenced other traits that they were looking for, they did accept a few people who hadn't taken chemistry. And what they did was, that those

of us who had taken college chemistry were asked to tutor and that. You spoke about Big Sisters --

RS: Yes, yes.

SB: We didn't have Big Sisters, but those of us who had had any kind of advanced work in chemistry were selected to tutor these young ladies who had not had any chemistry. And so I was chosen, because I had taken chemistry in that year in college. I was chosen to help a young lady. My young lady didn't make it, not because of the chemistry; she stayed in the school for probably a year and a half or more, but she, for personal reasons decided to leave the School. But that was one of the rather sensitive things that they did do for people. So, it wasn't all being mean, but there was a lot of stress.

RS: Yes, I mean, this sort of relationship you had with some of the administrators, like Miss Greener, was that typical of the other schools of nursing?

SB: Oh, I think so, I think so, yes.

RS: I guess they were getting you also ready for what it was going to be like when you got out there working with the doctors.

SB: Yes, yes. Oh, yes. They felt that they had to be very, very strict with us. And we had to.

We could not leave the Residence without a hat. [laughter] Most of us bought little -- yes, and gloves. Most of us bought little tams or berets or something or other, that we could plop on our heads as we walked out the door, and put in our pockets when we got outside. But we were expected to wear a hat and gloves when we left the Residence.

RS: Sure. So, what did you and your new friends do for fun, to get away from the stress?

SB: Oh, we did all sorts of strange and wondrous things. In those days, nobody thought anything about walking down Fifth Avenue to 42nd Street.

RS: Right, it's a good walk, though.

SB: It's a big walk, but we were young and healthy and vigorous, and so we went. We would take walks, now, not necessarily always way down to 42nd Street, but we would walk a lot. And there was no real danger; I don't think I would recommend people walking to 42nd Street these days, but in those days there was no danger at all. And one of our favorite past times, once we got to 42nd Street, was to go to the Automat and get a table at the window. And we learned how to circumvent the Automat's rules by, they never would shoo you away if you had something on the table. So, we would take turns getting our food, so that we would always have something on the table. We would sit there at the Automat and watch the world go by.

RS: Now, the Automat must have been something very intriguing to you.

SB: Oh, it was. It was. You know, I think people really miss that Automat. It was a fun place to be.

RS: Sure.

SB: So, that was one of the things that we did.

There was a movie theater at about 102nd Street that we called the “Itch”. I don’t think there was any particular reason for it, other than that was what we called it. So we could go there for about 5 cents.

RS: That’s over here on the East Side.

SB: Yes, right on 102nd and Madison. Madison Avenue at that time was quite different than it is today. As far as the people who lived there, it was largely a Jewish community, and the store owners were mainly Jewish people. Whatever it might be: a little shoe shop, a candy store or a bakery or anything like that. It was primarily Jewish all around here. And there was no problem in our wandering around. At that time, what is now the Conservatory gardens, was a conservatory, a real honest injun conservatory, with the usual hot house kind of things. And we would walk up there without any question and spend time. It was a nice place to spend time in. And it was particularly nice for those of us who came from the country and were having problems with not being able to see green grass [laughs].

RS: Right, well, it was nice having Central Park right next door --

SB: Yes, that did help. And, of course, we spent a lot of time in Central Park. There were movie houses across the Park on Broadway, across town on Broadway, a good many of them. The only one that is left there now is Symphony Space, but there were a whole bunch of them up and down Broadway there, 96th to 100th something. That was not very expensive.

RS: Did you go to matinees?

SB: Yes, well, when we worked evenings so we went to the show that began in the morning. We could go down to the Palace Theater for a quarter. I think Radio City was not much more than that, in the mornings. So we would do that. And, of course, the trolley car went down on Madison Avenue and it cost only a nickel. The Fifth Avenue bus was fancy; it cost ten cents. [laughs] But we sometimes rode on it. They were double-decker and so it would be nice to ride down on the double-decker buses. So, we did things like that.

RS: Any particular movies you remember as having an impact on you at the time, that everyone talked about?

SB: No, I guess that somewhere in that time, but I don’t think it was quite that early, we did get to see Gone with the Wind. But, I don’t remember [crosstalk]. I am not much of a movie person, but I did go. You did it because it was something to do.

RS: It was an escape.

SB: Yeah. We also, this group of us had relatives and friends and so forth in and around New York City. We would be included like -- well, when my mother came down to see me, she would stay down in a hotel downtown and she, I would invite some of my friends to go with her. When Marion's mother came to see her, we all went down there. She always stayed at the Dixie because she came down on the bus from Lake Placid. We would go down there and she would treat us to breakfast in her room. As a special treat. My aunt was teaching in Middletown, New York at that time, and so when she came down with her teacher friends or on a date or something, she would take us out. We went with people when they came to town, and they were very kind and usually you took at least one of your buddies with you to enjoy the opportunity to get out.

RS: Certainly. What was it like in the classroom time versus the duty time on the wards?

SB: OK. We were capped. Well, the first uniform that we wore was what we called the "probie" [probationary] uniform. It was a dark royal blue dress and a white apron. Then we were capped and we went into the plaid. And, of course, we were one of the final classes to have the real Scotch Plaid. We were capped on the 20th of December.

Now, between coming in the first part of September and the 20th of September we had increasing opportunities to spend on the units. We frequently were assigned either to a Sunday morning or a Sunday afternoon, or a Saturday morning or a Saturday afternoon. And then as we progressed and learned a little bit more, we would go to the units from 7 to 9 and then have classes the rest of the day. And then a little later in our careers, we would go to the units from 5-7. The duty time for the nurses in those days was 7 am to 7 pm and 7 pm to 7 am.

So that, my first day on the unit was an interesting one. I was assigned to Ward M, which was the gastro-intestinal ward under the supervision of the rather famous Dr. A. A. Berg. And so, the first assignment that I got was typical of what we all got, everybody. We were given a basin of water and a dust rag and we were told to clean something. I was told to clean the linen closet. So I was up on top of the ladder cleaning the linen closet when one of the smart little doctors came and stuck his head in and said, "How do you like nursing?" I must tell you I was sorely tempted to dump the water on him. [laughter] I didn't, I tried to behave myself, but that was the first day. I still remember that very clearly.

RS: What do you remember about A. A. Berg?

SB: Oh, he was an interesting guy. Well, when he came on rounds, everybody followed him around. And you followed him around in the order of importance. Of course, that was the way you got in the elevator, too.

RS: Certainly.

SB: The most important person went in the elevator first and we little probies frequently didn't get in the elevators because it would get too full.

RS: What did he look like?

SB: He was a tall, imposing man. He had a goatee kind of beard and he always wore a red carnation in his button- hole. He had sort of salt and pepper hair. It wasn't really white or anything, but there was some gray in it. I would say that his face was, I think the word is craggy.

That's the thing that I recall about his face. I remember, and in one of the Alumni News there is an article that I wrote as a student -- it is unsigned because they didn't give me credit for it, but it was put in the Alumni News – of my experience of following him around on rounds. He, as I say, the chief resident, oh the attending people were first, and then the chief resident then the interns and then the nurses and then the probies. We followed him around when he made rounds. That I do remember very clearly about him.

That was my first contact with him. Later on, when I was working in the Private Pavilion, and by the way, I never worked in the Private Pavilion while Miss Greener was alive.

RS: OK. We'll get back to that.

SB: Yes, but, when I was working in the Private Pavilion, of course, he had a good many patients there. We all, all of us -- graduate nurses, private duty nurses, student nurses, everybody -- were on tether hooks every day until, when he came. Because if things weren't to his liking, he was pretty apt to carry on, rant and rave, which is sort of typical of Mount Sinai doctors. A lot of them do that. [laughter]

RS: Any other distinctive personalities that you remember? The physicians, we'll get back to Miss Greener in a minute.

SB: Well, later on when I became head nurse on the Gynecology unit, I worked for – at that time the Gynecology unit was divided into two, what they called services. One was the service of Dr. I. C. Rubin, who was famous for his insufflation test and one was the service of Dr. Samuel Geist. Dr. Geist was a red-haired gentleman, with the temperament to match the hair. [laughter] Dr. Rubin was a very gentle person. He was one of the gentlest people that you can imagine. He was Viennese, you know, and he had blue eyes like so many from Vienna had. I can remember his blue eyes.

They were interesting people to work for because they were quite different in their expectations.

RS: I see.

SB: Dr. Geist made his expectations very, very clear. He saw to it that I knew that the students were to do this, that, and the other thing and so forth. Dr. Rubin was much more of the opinion that if Miss Warman had put me in charge of that unit, she knew that I knew what I was doing. They were two, quite different personalities.

There was a man by the name of Myer, Meyer, Meyer, Meyer. What the heck was his first name?

RS: There were several.

SB: Yes, well, he was a gynecologist. His name may come to me. It seems to have departed from me.

RS: We'll find it.

SB: He was another one of those people who was given for tantrums and I remember a few encounters while I was Head nurse.

RS: How did you handle that, when they went into a tantrum?

SB: I usually just let them go. I mean, what can you do about that? I had been brought up that that was not a very good way to behave.

RS: I understand.

SB: But I figured, well, if that's the way you do it at Mount Sinai, well, that's the way you do it at Mount Sinai and I am not going to do anything about it. I'm sure not going to change those men's ways. No, I used to get hurt by some of their screaming and hollering, but I never did very much about it.

RS: Keep your poker face?

SB: Yeah, try, try just, let it pass over if you possibly could, it was about the only thing you could do.

RS: We've got to take brief break because we are getting near the end of the tape.

SB: OK.

[End of Tape 1, Side A]

RS: You mentioned some of the significant personalities that you had met. Now, soon after you came, Miss Greener died.

SB: Well, she died, I think in 1935, didn't she?

RS: I think it's 1934 or '35, I'm not sure.

SB: '34, maybe she's '34. She died in the summer, I know, and I happened to be on vacation when she did die. And then Miss Brown was in charge until Miss Warman came. Miss Warman came in the early part -- I guess it was the early part of 1935.

RS: Yes.

SB: I guess that's when she died -- in 1934.

RS: It was a search for the successor.

SB: Yes. It took a while before [Miss Warman] came. But she presided at our graduation. She was here, and in charge when we graduated in February of 1936.

RS: Now, when you say in charge, can you compare those two people?

SB: Well, of course I got to know Miss Warman much better, as years went by.

RS: Yes, of course.

SB: Which makes it hard to really make comparisons because I only knew Miss Greener as a very young student, and with this kind of -- this original meeting -- met her. And I really had -- if I ever had occasion to go into the nursing office, nearly always it was Miss Brown that you saw.

RS: Yes.

SB: You didn't see Miss Greener.

RS: Did Miss Warman have a Miss Brown?

SB: Well, yes. Miss Brown left shortly after Miss Warman came, and she -- her first assistant after that was a woman by the name of Claire Favreau, and then Claire Casey, who was a graduate of our school, was in the office. There's usually -- there got to be a time when there usually were two people, one who had a major responsibility for the School of Nursing and one who had a major responsibility for nursing service.

And I think Miss Favreau and Miss Casey -- Miss Casey did the nursing service and Miss Favreau did the School of Nursing. And then Miss Minnie Struthers became the one in charge of the School of Nursing. Miss Struthers was a graduate of our own school, and she and Miss Warman worked together until they retired. They retired together.

They were a very, very fine combination. Minnie Struthers was born and brought up in Pennsylvania -- West Virginia and Pennsylvania, and she had been a teacher before she came into nursing, so that she had a lot of maturity and a lot of experience. She was a very, very gentle, kind person.

Miss Warman, she was probably the best educated person that had ever been here at Sinai, up to that point.

RS: Tell us a little bit about her background, if you would.

SB: Well, she was a graduate of Presbyterian Hospital School of Nursing, and she had been Director of Nursing at what was called Nursery & Childs. Before she, that was what she was doing when she was picked up for here. She did serve in the Presbyterian Unit during the First World War.

RS: Right. It was Unit One, wasn't it?

SB: Yes. And she had done graduate work at Teachers College. She had what was known then as a graduates -- certificate of some kind. I've forgotten what the real title of it was. But it was the next thing you got after your Masters.

RS: Yes.

SB: She had her Masters, and then she got this certificate. She did not go on into doctoral study, which was not common at that time.

But she did have a very fine background in education. She was a very important person in the profession of nursing throughout the United States. During the Second World War, she was in charge of recruitment for the armed services at the level of organizational work. She taught -- I believe she taught at Teachers College, and Miss Struthers taught at Hunter. That was the beginning, I would say, that the two of them are beginning to be not just a hospital training school, but a school of nursing, where education was an important part of the what you were there for.

RS: It was during her tenure that the name of the school changed, was it not? [Ed. Note: Name changed in 1923, under Miss Greener.]

SB: I believe so. Yes.

RS: You got to work with her quite closely because –

SB: Oh, yes.

RS: Did you work with her staff?

SB: Oh, yes. I worked with her -- well, as I say, I worked with her from the time she came until the time she left, except for the two years that I went to Chicago. She appointed me head nurse on to the GYN unit. That was what I did after -- well, immediately after graduating, we worked as staff nurses, and then I had a stint on nights that was not uncommon. And, in fact, Sandy and Kim and I were all on nights together. The title would today be called a night supervisor or a night administrator. In those days it was called the night head nurse. But we each had responsibility for a whole pavilion.

I had medicine and Sandy had surgery and Kim had pediatrics. I think I was on that stint for about a year-and-a-half, and then Miss Warman asked me to take the job of head nurse on Ward U. She was having some trouble. There had been a head nurse there who had been there for many years, and who had handled the unit and had handled these doctors very well. But she, that head nurse, decided to leave. So then, they appointed new people. Well, the new people couldn't seem to do very well, and the resident at that time was a fellow by the name of Newman. He was want to go down and see Miss Warman almost daily about what was going wrong on his unit.

He was displeased and he made his displeasure very well known. So, I guess in looking back at it -- of course, at the time, I didn't know how those things worked. But looking back at it, I think the ladies in the nursing office got their heads together and they decided they had to do something about this. [laughs] And so they chose me to see what I could do about keeping him under control.

And that was the idea. She made it pretty clear to me that I was there and that I was to run this unit, and I was to see to it that he didn't have any reason to come down and see her anymore.

She didn't want him down there. Well, we got along all right. He was satisfied with me, and we managed very well.

I had four years as head nurse on that unit before I was then picked to -- asked if I would like to teach in the School of Nursing. I taught for a year as an assistant in what was called Nursing Arts, which is the first course in nursing. It's where you teach the ladies how to make beds and how to do treatments and how to take care -- it's actually the hands-on business of how to be a nurse.

And then a vacancy occurred in pediatrics for an instructor. Here, again, this was a difficult time and the lady who was in the job was ready to leave. She didn't want to do it anymore. Again, I'm not sure what the machinations were. All I can tell you is that while I was home on vacation, I got a letter from Miss Warman, offering me the job as pediatric instructor. I've always figured that they had pretty much come to the end of their rope. [laughs] They knew that I had had this year of teaching, and so I took the job. I would not be accepted as a pediatric instructor with the knowledge that I had today. I mean, that's all there is to it. I learned that job by doing it.

And I kept about one class ahead of my students. But it was a wonderful experience, and I taught for -- well, let me see. How long did I teach? I don't know. I think I taught about three years. At that time I was studying for my Bachelors at Teachers College.

And they were very kind to me to make it possible for me to juggle my schedule so I could get up to school and still do the teaching. This, of course, was during the Second World War, and we had very few graduate nurses on the floor. My students were the ones that were taking care of the patients, and it was a big responsibility to see to it that those young ladies were able to carry on. I had a head nurse on each of my four units, and that was the only other graduate that I had.

RS: Wow.

SB: All the rest of them were students.

RS: Sure. Wow.

SB: But we did very well, and I made some very, very fine friends during that period of time. I had some wonderful head nurses.

RS: You stayed close over the years, then?

SB: Oh, yes. Yes.

RS: Real camaraderie, you felt.

SB: Yes.

RS: It's almost like going to war.

SB: Yes.

RS: Many of the things you've been saying – it's like being in the Army.

SB: Well, it was. And that's very true because the background of nursing. There are two very significant factors in the nursing [inaudible] group, and that was the religious orders and the military orders. So, there was a great deal of that background in the way nursing was taught and the way nursing evolved over the years.

RS: Sure. Right. Do you remember your first meeting with Miss Warman? Your first meeting with Miss Greener was quite memorable.

SB: Yes. I don't know that I do remember, particularly.

RS: She just recognized your ability?

SB: Yes. Of course, it was a part of the fact that when I did that one year as assistant instructor of Nursing Arts, I went to the faculty meetings, and I think maybe those were the most important contacts that we had with her. That was where we learned how she wanted us to do things, and so forth.

RS: What kind of woman was she?

SB: Well, she was a very striking kind of person. She was a tall, very well proportioned individual, dark hair. As years went on, the black was not natural. But she did have black hair, and a very, a very fine features.

RS: A commanding presence?

SB: A commanding presence -- yes. I would say that's the best way to describe her. You didn't play any [inaudible] with her.

RS: I see.

SB: But she could be very understanding and very kind. Very kind.

RS: You held several positions on her staff.

SB: Yes. I went from assistant instructor in Nursing Arts to instructor in Pediatrics, and then I became the number one instructor in Nursing Arts. And that job I held until I decided to go to Chicago. I think I had that job [Nursing Arts Instructor] for about four years, also.

RS: Why did you say you went to Chicago?

SB: Well, I decided I needed a change. [laughs] But I only stayed two years. I worked at Michael Reese, and I was the Nursing Arts instructor there.

RS: What year was that?

SB: I was at Michael Reese from 1948 until 1950.

RS: What was Chicago like back then?

SB: Well, that was very interesting. I met some very, very fine people in Chicago, and some of whom I still have contact with. They had some reservations -- other faculty members -- about having somebody from New York. They didn't know whether they wanted a New Yorker in their midst.

And they had some funny preconceived notions about New Yorkers.

RS: Sure, sure. You are from New York, right?

SB: Yes. I was from New York. So they -- but, they were very, very kind to me, and they decided that they were going to make me like Chicago.

That I was going to learn what a fine city Chicago was -- how really great it was. In those days, we had to work Saturday mornings. We only had Saturday afternoon and Sunday off. So in the morning at breakfast time, they'd tell me what to wear that afternoon, depending upon what it was that they were planning to do with me. They never told me where they were going to take me. They just told me, to wear either flats, or a suit, or a dress or what. And then they set about showing me New York – I mean Chicago.

RS: Who is they?

SB: The instructor in anatomy –

RS: Do you remember her name?

SB: Yes. Her name was Ruth Petersen. And a very good friend who was a librarian at the school, Charlotte Studer.

RS: Were they Chicagoans?

SB: Well, no. Charlotte was from Milwaukee.

RS: That's far away.

SB: And Ruth was from Southern Illinois. They were Midwesterners – let's put it that way. And Ruth had graduated from the University of – of.

RS: We can add it later.

SB: It'll come back to me. It's -- I thought I knew it right away [crosstalk] Madison, Wisconsin. Where she was.

RS: Okay. University of Wisconsin? Yes. Yes.

SB: University of Wisconsin. Yeah.

RS: Did you get to go there [crosstalk]?

SB: Oh Yes. Yes. Yes. We did. We not only traveled around Chicago and all the environments of Chicago and see all that Chicago had. But I would be invited to go to these homes. One of the other young ladies that worked with me was my assistant, who came from Iowa, she came from Tama.

And so, she, -- and she was on the farm, and she invited me to her farm and her home down there. I liked going down to Iowa because actually, they had a little bit of hills.

And that was one thing I missed about Chicago -- it was so flat. So, I enjoyed going down to Iowa. You can't call them mountains, but they were little hills.

RS: I've been to Iowa many times. I've been to Tama.

SB: That meant -- I felt good about going there.

RS: Didn't it remind you of your home?

[Inaudible to end of tape.]

[Tape 2, Side A]

RS: Today is November the 16th. This is Richard Steele the Archivist for the Mount Sinai Medical Center and today I will be conducting the second of a series of planned interviews with Sylvia Barker former administrator and teacher at the Mount Sinai School of Nursing and Department of Nursing.

Sylvia, it's nice to have you back here again.

SB: Hi! It's a beautiful day today. Did you notice?

RS: Yes. It's cool and crisp. Yes, it is. [laughs] We finished last time with getting your career up to the 1960s. Now, you may have reflected a bit after the talk, about some things you might want to add or comment on. Are there any thoughts you wanted to add to what you mentioned last time?

SB: Well, yes. I did think of some things as I was walking around my apartment, and I jotted them down.

RS: Great.

SB: One of the things that you had questioned me about the other day were any of the doctors that I remembered or that had a particular association with me. And it occurred to me that I should have mentioned Dr. Sidney Silverstone, who, at his time of retirement, was very important in the Division of Radiology. When I knew him [laughs], he was a resident or an intern -- I think, maybe, he was an intern -- and I was a student. One of the things that we never did when we were students was to start an intravenous infusion. That's something that nurses have taken on in more recent years. But as we were kids all together -- you know, the interns and the student nurses -- we tended to see what we could do about circumventing the rules. [laughter]

So, I very well remember that Dr. Silverstone was the one who helped me with my first IV. [laughter]

And it was fun to follow him all the years because, of course, his career really paralleled mine all the time that he was here and I was here. So, it was fun to think about that. And I just thought it was one of those things that happened with kids together in a learning situation.

I think that that -- and you spoke about the School of Nursing. And I think that that's one of the things that is particularly significant to the way that the graduates of the School of Nursing have evolved, and that is the closeness of their association. As student nurses, we lived in the Nurses Residence, and we didn't have much money. I think I mentioned the other day about going to the movies for ten cents.

I did forget to mention that after the end of our first year, we got a stipend, a monthly stipend, of eight dollars. [laughter] And that eight dollars was pretty important. You have to remember this was in the 1930s, and actually, it went pretty well. It took care of a good many of the things that you would want to do. In fact, one of the things that I spent one of my eight dollar checks for was a coat down at Kleins, on 14th Street. [laughter]

But anyhow, the closeness of our association -- both as student nurses and the nurses in relationship to the doctors -- was really something that is significant and is quite different from the method of educating nurses today. And I think also, although I'm not quite as cognizant of what goes on in medical school, but because it is a college kind of situation, and you live at home -- and, of course, we do have some of our medical students living here, but not all of them, by any means.

I think that the relationships that were created by our living together were very, very important and very significant.

Apropos of that, it would be interesting to make note of the fact that on November 2nd of this year, 1995, the graduates of our school who live in the Florida area, had a reunion. And we've just gotten a letter from the organizer of that reunion in the Alumnae Office -- they had ninety-two people there.

Which is -- heavens! That's many more than we get to our Alumnae Days. [laughs] Or about the same that we get to our Alumnae Days in New York City. We get around a hundred. They had a wonderful time, apparently, from this report. Then, of course, that spanned graduates going back into the 1930s. I think they said that the earliest graduate

was someone from the class of 1930, and the of course, the most recent graduate was the last class of the school. There was someone there from the 1971 class.

RS: Wow.

SB: So, they really had a great time. But it again emphasizes that kind of camaraderie and living together that was a part of our educational process. So, I think that's kind of an interesting thing.

In talking about my experience of being an instructor in the area of Nursing Arts, I mentioned that my first job as an instructor was as the assistant to the head instructor for Nursing Arts. But somehow or other, I don't know -- as I remember -- I did not mention the name of the lady who was the person with whom I worked, and that is a great oversight because she was Blanche Gubersky. She graduated in the Class of 1937. Before she came into the School of Nursing, she had been a teacher in the New Haven school system, so that she was a few years older than most of us. She was, perhaps, my senior by about five or six years. Blanche was a fantastic instructor. She became one of my very, very good friends, and in fact, she and I took our first apartment together here in New York City. And, interestingly enough, we moved into that apartment on December 7th [1941] of the infamous affair in Pearl Harbor. We had already made our plans, and we had rented it, and we had put down our down payment.

In those days, they were beginning, the Hospital was beginning to consider a subsidy for nurses for apartments, and they gave each of us twenty-five dollars a month for "living out." In other words, they wanted to get us out of the Nurses Residence because we were graduates, and they needed the Residence for the school, the students in the school. So, Blanche and I pooled our twenty-five dollars a month, and actually, the rent for that apartment was sixty-five dollars a month. So we did pretty well on that.

RS: Where was the apartment?

SB: It was at 24 West 96th Street, just in from Central Park West. And we quite often walked back and forth to work. In those days, you walked through the Park without any fear. So that we walked together, back and forth to work, a good deal.

We had some interesting experiences during that time. This was a walk-up, and it was on the fourth floor, and it had skylights. And, of course, we had to black out our skylights because of the wartime restrictions. We also had interesting experiences dealing with the ration coupons. [laughs]

Blanche has now died. She later on, after being a teacher in the School of Nursing, she became the person in charge of the Private Pavilion here, at Sinai, and a job that she held probably three or four years. And then she became the Director of Nurses at the Jewish Home and Hospital on 105th Street. She was perhaps the initiator of really modern geriatric nursing care there. Prior to that, that organization had been pretty much a custodial kind of place. And I remember when she went there and she took me around, I was horrified. It was so -- almost primitive in the way that it was put together and the things.

RS: Could you elaborate on that?

SB: Well, I found that the area was -- well, of course, it was old. The buildings were old, and they were dreary. And it seemed to me -- she took me to the dining room where the people ate, and it seemed to me that it was so depressing, and so very, just plain dreary.

She was supposed to live in that building, and they gave her an apartment. She was a very creative sort of person, and she did the best she could with the apartment. But as soon as they would give her "living out" privileges [laughs], she moved.

Because it just was not really very exciting. But she worked with Dr. [Frederick] Zeman, who was the medical director at the time, and who, if you -- I know you've done some reading on him, and he was one of the early geriatric people -- one of the people that recognized that there was a need for this whole field. And so, she worked with him. It was a relationship that she had with him here, in the Private Pavilion that really took her forward. She stayed in the field of geriatric nursing for as long as she practiced, until she finally retired. And she saw the building of new buildings up there at 105th and 106th Street, and she also oversaw the opening of the Kingsbridge facility, which they had opened during that time.

She became a very prominent person, as far as lecturing and so forth, in geriatric nursing. But I really overlooked mentioning her name when we were talking, and I felt that that was really an oversight.

RS: I appreciate your remembering.

SB: Yes. When I was the head nurse on Ward U -- now, obviously, we're going back and forth, but this is sort of catching up. When I was the head nurse on Ward U, this was the beginning of the people coming out of Germany -- the Jews coming out of Germany.

Because I was the head nurse on Ward U from 1937 to 1940. The thing that I was thinking about as I was thinking -- of course, I told you a little bit about Dr. [Sam] Geist and Dr. [I. C.] Rubin and so forth, but I didn't mention very much about patients. [laughter]

The patient population was primarily Jewish at that time. A few black people. But relatively little Spanish clientele at that time. I would say that primarily it was Jewish with a touch of Black patients. A lot of those Jewish people were women that had come over from Germany and were refugees.

That was an interesting experience, and they were, of course, working very hard to make a way for themselves in America, and it was an interesting experience to be with those ladies and to hear some of their stories.

I am not -- I don't want anybody to get the idea that I'm a proficient person in Yiddish, but I did get to learn a fair amount of Yiddish when I was working with those ladies. [laughs] And it held me in good stead many years later, when Blanche and I went to Israel.

Because I ran into some people who spoke only Yiddish. There was one lady -- particularly an older woman -- who, when she found out that I could understand her, was just absolutely thrilled because she was having trouble with her daughter-in-law, who only spoke Hebrew. [laughter] So it was an interesting kind of experience.

So, I thought that that was something to mention, particularly in terms of my head nurse-ship on Ward U.

Let me see. Back in the tap we talked about people -- a group of us who were student nurses together, and I mentioned different names, and somehow or other, I also forgot another very important name, and I guess maybe it came back to me because I had a telephone call from her this week. [laughter] She was Martha Clark, and she was a young woman about -- just exactly my age. Her birthday is about five days before mine. And so, we both had the experience of going to college for one year because we both were too young to get into the School of Nursing when we got out of high school. [laughter] Martha was from Iowa and she had gone for her year of college at Coe College in -- I don't know where that is, but anyhow –

RS: Which school did you go to?

SB: I went to Green Mountain. It was, at that time, called Junior College. I was in the second class of the school. Green Mountain is located in Poultney, Vermont, and it is the outgrowth of an academy, which was called the Troy-Conference Academy. Both of these schools were sponsored by the Methodist Church and the only reason that I was able to go to that school was because I had received financial aid from the Methodist Church in order to go for that year up there, and I also worked, and that helped with my expenses.

Green Mountain College has had many changes in the years since that time. It is now, once again, co-educational. It was co-educational when I was there. Then, during the war, it became all girls. And then most recently, it has gone back to co-educational. It started out as a two-year program, and it is now a four-year program. It is a very good school. I'm in touch with the President of the school, and when he comes to New York to fundraise, he usually sees me -- stops in to see me. [laughter]

But anyhow, that's where I went. But going back to Martha. Martha and I have maintained our friendship over these many, many years. She now lives in California, and it is not unusual, as she did the other day, for her to pick up the phone. She had been seeing on the television about the big nor'easter, and she wanted to know how it had affected me, so we had a nice conversation, and I found out what she's going to do for Thanksgiving and so forth.

RS: Then, of course, the nor'easter never hits. [laughs]

SB: Not really. Not as much as we had expected it was going to -- certainly. It did rain.

It really rained very, very hard. But anyhow -- now, I think that brings me up to date for the moment. The other notation that I had down here had to do with the on-going activities -- chronological review that we started the other day.

I think that if I remember correctly, we had probably gotten to the point where I took the position as assistant director in in-service education.

RS: That's correct.

SB: And that position I did hold from 1966 to 1972. That was a very interesting experience. Somewhere in my past I read that during one's career, one could expect to have three different kinds of a job. And so although I didn't leave Sinai for any great period of time, I've always figured that I did indeed have the experience of three different kinds because I taught in the School of Nursing, I supervised, as you will see a little later, in the Department of Pediatrics, and I was an administrator. And this assistant director of in-service education, was kind of a combination of the administrative role, and being involved in education.

The Department grew under the time that I was there. At the time, finally, when I gave it up and took on the next job, I had twenty instructors in the Department. I'm not sure how that compares to the present time, but I would imagine it's similar. I would imagine they have somewhere between fifteen and twenty instructors there, in that Department today.

Some of the things that we did during that time were kind of innovative and kind of interesting. One of the things that we started was a refresher program for nurses who wanted to return to the field of nursing. You see in that period, from 1966 to 1972, it was one of our times of having a shortage of nurses. [laughs] So, we were constantly trying to figure out ways in which we could improve the supply of nurses. So that the refresher program was an idea that we felt would work for us. And indeed it did. Elizabeth Murphy, who has retired recently from this institution, became the Director, Nursing Director in the Out-patient Department, and she came back into the field of nursing via our refresher course. So that, she's one example. There were others, of course, who also joined the staff after they finished the refresher course. That was one of the things that was kind of exciting and very interesting.

Another thing -- during that time we were doing recruitment from foreign countries, and I mentioned Miss Venger, and she was one of the prime movers of this recruitment activity. And a lot of our recruits came from England, and in order for them to become registered in the New York State, they had to make-up certain courses. The men, for instance, had to have obstetrics, because in England, they were not taught anything about obstetrics. So, we had to provide a make-up course in obstetrics for all the men who came. Many of them had to have psychiatry, because in England -- at that time, and I do believe it's not too different now -- the basic program in England does not include psychiatry, and it does not include obstetrics. The women go on into the midwifery program, and if they want to do psychiatry, they have to take a whole extra-special course.

So, in order for them to become licensed and take the exams here in New York State, we had to provide them with these classes. They were called PCCL: Post-Graduate Clinical Course for Licensure. Yes, I think that's it. And, of course, those courses had to be -- they were pretty closely supervised by the State Education Department. We had to be approved for giving such courses. So that that was a big part of our program at that time.

We were looking at, at that time, the licensed practical nurse to see how her role would fit into the situation. We had very few licensed practical nurses. Probably twenty might be the most. But we wanted to make the very best use of them, so at that time -- and it's changed back and forth, and the role of the licensed practical nurse in New York State is still in a period of flux. But at that time, it was possible for you to allow a licensed practical nurse to be in charge of a unit if there was a registered nurse immediately available. We interpreted it here, at Sinai, to mean that if we had our supervisor on duty, the supervisor was the person who was responsible for the unit, delegating certain responsibilities of charge to the licensed practical nurse. Well, since we chose to go that route, which I don't believe they're doing now because I believe in subsequent years the State said they could not be in charge under any circumstances, and now I think they're going back again.

We decided that it was important to teach them some principles of management, and how to assign and how to watch over the people to whom they delegated jobs. So, we had such a program for these nurses. Well, graduate nurses -- the regular registered nurses also needed a program like that, so we expanded it to include a program for registered nurses to help them in their assumption of the role of charge person. And it was sort of a beginning program from which they could maybe aspire to be head nurses, if they had that experience.

The other program that we did, which was one of my very special programs, and I enjoyed it very, very much. Unfortunately, we had to give it up because it was too costly. But anyhow, we offered a six-month program -- I believe it was six months -- I guess it was a year -- a program for new graduates. It was an internship type of program, whereby the new graduate was given experiences on a variety of units under the leadership of the instructor, and she was able to move from one experience to another, so that she'd get some knowledge about different clinical fields. Our feeling was that the graduates of the two-year programs in particular were not very well prepared to take on the responsibilities of the registered nurse. And that they needed some more time. The two-year program was lacking in time for them to have a real hands-on experience as a nurse -- with the patients. And so, we had that program for about two years, and we were able to sustain it. However, as I say, it became somewhat burdensome from the point of the budget because these nurses were registered nurses, they were a member of the SNA unit. They therefore had to be paid the negotiated rate, and yet they were not giving full time to take care of the patients.

It was a period of time that was being devoted to education. And so, it became necessary for us to give it up. It was a very good program, and we did recruit a number of our leadership people from that program, they were able to go on. Ronnie Pia, for instance, was one of the young ladies who became the head nurse and the supervisor in the ICU before she married and retired.

RS: What time period would that have been?

SB: Well, all of this was during the period that I was in charge of in-service education, somewhere between 1966 and 1972. I think we probably had that program about -- maybe 1967 and 1968 might be sort of a guess. But I would think that it might have been at that time.

Those were some of the things. Then we did try to help people to understand that Sinai what in-service education was all about. [unclear] Some of my instructors and I were also called upon to function in panel presentations for different professional organizations to let people know how we were organized in our in-service program. Because it was really one of the good in-service programs.

Coming out of that, we've mentioned a little bit that I did some things with professional organizations.

RS: Yes.

SB: We'll talk more about that maybe later on. But coming out of that, I was influential in forming an in-service education section for District 13 of the New York State Nurses Association, and I was the first chairman of that group. It persists in a different orientation today, but the whole idea of having sections with the people of like interest, is a part of the way the New York State Nurses Organization is organized.

RS: So that would make them different than some of the other states?

SB: I don't know. I think some other states do -- New Jersey is rather like New York, in terms of the way they organize their association.

But anyhow, those were some of the things that I did during that time. At the end of that time, in 1972, was the point at which Mrs. Venger was leaving and -- no excuse me, Mrs. Kinsella was leaving. I failed to mention Mrs. Kinsella, and I guess I better just mention her a little bit. She was the Director of Nursing from the time that Miss Venger left, which was, I think, in 1968, until 1972. Mrs. Kinsella was here for a relatively short time. She was a graduate of Bellevue; she was the first Director of Nursing to have a doctorate. I believe she had her doctorate in -- I don't know what she had it in. Education, I think, she had her doctorate in.

The most significant thing, I guess, about Mrs. Kinsella's reign here, at Mount Sinai, was that it was she who did indeed organize and manage the closure of the School. It is my considered opinion that that was her intent when she took the job, that that was what she came to do. She had recently done the same thing at Bellevue. The Bellevue School had been closed just before she left Bellevue. I think that that was her goal. There were many schools of nursing in hospitals being closed at that time. I've mentioned the fact that Bellevue was closed at that time, and we got shut-down. There was a movement and there still is in the nursing profession, to identify that nurses need an education rather than a training. And there, therefore, was the belief that education of nurses should be under the aegis of the educational institutions not service institutions.

Hospitals are service institutions. And the nurses -- student nurses -- were, over the years, the force of giving of nursing care in these hospitals where they had schools of nursing. There was no doubt about it. That's how you ran a hospital.

With your student nurses. And, of course, some schools were better at seeing to it that the nurses got the proper kind of classes and education. And I think that Sinai and

Bellevue were worthy in that area. But some schools really misused -- some hospitals -- really misused the privilege of trying to get cheap labor.

So that was really the impetus to the idea of closing schools. If you have a chance someday to go back through some of the files that I have sent over to you, you'll see that when Mrs. Kinsella negotiated the closing of the School, she did indeed believe that she was setting it up as a part of CUNY and particularly CCNY [?]. So that her plan, as anyone can figure it out from looking at the records, was to develop a school at Sinai, with Sinai and CCNY similar to what is commonly known as the Hunter-Bellevue Program.

You see, the Bellevue School of Nursing name was retained in their joining up with Hunter. For about maybe two years, I think, such was the case -- the program up at CCNY was called the Mount Sinai School of Nursing at CCNY. As a part of her negotiations, she gave a great many of the assets of the School of Nursing to CCNY, including a very fine library, which would have been a wonderful nucleus for the library here, in the medical school. But you see, the medical school started in 1968. All of this was in process together, and yet not together, and talking, and yet not talking.

And so, unfortunately, as I say, this very, very fine nursing school library, which had been developing over the years, of the whole, ninety years of the School of Nursing, was given to CCNY. According to my reading of some of the documents that I have been privy to read over the years -- because we've had to figure out what happened and try to come up with some resolution to the problems -- it appears that the Mount Sinai and City University trustees and these [unclear] or CCNY – CUNY probably, mostly because I believe CUNY are the overall, in charge of all of the schools in the system -- could not come to an equitable and satisfactory agreement. And so over the course of the years of its life, the nursing program at CCNY became the nursing program at CCNY, period. It [CCNY] had nothing to do with Sinai. Now, of course, with the way it's cut, that is one of the programs that is being wiped out at CCNY. So that kind of brings an end to this whole saga.

When we transferred, some of the nurses who were in the School were given the opportunity to transfer into this program, and they did graduate from CCNY. They did not become alumnae of Mount Sinai Hospital School of Nursing. They did not become a part of our Association. At the same time, when that change was made, some of the instructors who were teaching in the School of Nursing here were accepted as instructors at CCNY. They had the qualifications, and they were able to move up there. So that there were probably a half a dozen or more of the instructors who went to CCNY for that period of time when the School was indeed called Mount Sinai. But that was a very brief period of time.

RS: Do you have any idea who those instructors might have been?

SB: Yes. Karen Ballard was one. Rosemary Murray was one. Dorothea Horstman was the instructor in nutrition. She was up there. There's another lady, and her name is alluding me at the moment.

RS: We'll come back later.

SB: It may come back to me. I can see her and I know her. [laughs] I know where she lives; [laughter] but I can't think of her name. Well, anyhow, those were some of the ones. I believe there may have been a couple of others that I didn't know too well, but they did transfer into that school, and stayed there for a while. But, I guess one can understand I've been trying to be very, very careful about my words, in terms of this program. [laughter] It's a sore subject for a good many people, particularly as far as nursing is concerned. Why it had closed, why it happened, and what happened to the books and things like that are unanswered questions which are not too pleasant to contemplate.

Anyhow, when Mrs. Kinsella decided to leave Mount Sinai, and she -- I was asked to take charge until Mrs. Weissman, who was then Gail Kuhn, came. So that for the summer from -- July and August -- until the first of September, when Gail came -- I was the Acting Director of Nursing. I think the other day when I was talking about how I had to get the job of instructor for Pediatrics, I said that I was there at the right time for the job. And I think this was pretty much how it happened, that I was asked to be the Acting Director of Nursing. Most of the people that had worked with Mrs. Kinsella, left at the same time she did.

So that I was one of the few who were remaining on. Dr. David Harris, who was the Associate Director of the Hospital at the time, asked me if I would take on this job, and if I would gather around me a group of people to be my assistants. Which I did. Some of those people -- well, almost all of them -- Gail did retain when she came, and they were sort of the nucleus, [unclear] with me, were sort of the nucleus of her administration. It was an interesting experience, and certainly one that I had not anticipated. [laughs] Because I had not really sought the top job. I find my personality and my wishes and my own personal way is such that I would prefer to work with somebody rather than to have to assume the whole responsibility. So, that period of time was interesting and that I was very happy to see Gail come. [laughter] Gail and I worked together for the next twenty years. I guess it's about twenty years.

I was first -- the title that I had was Associate Director of Nursing. Which meant that I was responsible for the daily operations of nursing in the Hospital with the Assistant Directors that we had appointed, who were responsible for in-service education, and the financial and purchasing of things and for – let's see. We had four units for general medicine and surgery. Then, later on, after about five years of being that, Gail reorganized the department, and she decided that she needed more than one Associate. We were getting pretty big, and we were doing a lot of things, and she and I were spending a great deal of time at night trying to keep the thing going. And so she decided that she needed another Associate. And so she divided the job of Associate into two parts. And the part that I accepted was what she called Nursing Affairs. I took on the responsibility for risk management, for labor management, and for the quality assurance and the maintenance of standards. And that was the job that I held until I retired.

RS: Let's go back to that. What was the other half of that job?

SB: Well, the other half was this daily operations kind of thing that I had been doing in addition to all of these other things. I did start the whole concept of having a special nursing division for risk management, for labor management. I didn't really start the

quality assurance, and the [unclear] of standards and the accreditation, although I guess one could say that I really did.

It had been subsumed under the role of the Associate Director prior to that, and so when we put it together in this one job, it became an interesting and very challenging job. I had a good time at it. Most of my publications that I had written on over the years had to do with risk management, mainly, although I had some work in publications. But most of it was that. Because it's a field that, at that particular time, was really beginning to be -- a pretty important field.

RS: I'm going to change the tape.

SB: Okay.

[Tape 2, Side B]

RS: Sylvia, you were mentioning that risk management became an important issue at that particular time. Can you explain to us why?

SB: Well, the lectures I've given over the years probably answers that and I can see what I can do about bringing it back to mind. There was a study done by the government about incidents that occurred in institutions, and an attempt made to try to determine why people were in the mood that they were, and why we were having as much emphasis on this. And some of the things that they said in that study was: number one, that there had been a breakdown in communication between the patients and the caregivers. That the doctors were not talking to the patients, and that they were not telling the patients what the outcome was, and what the right kind of outcome would be. Another factor that they felt had increased the nature of this risk management field was that Americans are a litigious society.

[laughter] And that it was not – it was just sort of a natural outcome that if you could sue the city because the sidewalk was broken and you fell and broke your leg, why shouldn't you sue the hospital and the doctors? This was the nature of our American society -- was to be litigious. And that there was, therefore -- the medical profession and the hospitals became fair game for this kind of action. Hand-in-hand with that became the development of a group of lawyers, who were particularly skillful in this field.

And so, they were out to make money, too. And that was alleged to be another factor. What could institutions do about this? Well, one of the things that we did here was to develop this very busy risk management department that you are aware of. And one of the things that the risk management department is responsible for doing is supposed to be -- to try to teach people how to be responsive to patients' concerns. This was one of the things that I tried to do in the nursing department, was to teach nurses how to respond to patients in such a way that they would accept whatever you had to say to them. But not to turn them off, not to run away from them, and to make sure that if they had questions, that they were answered. Hand-in-hand with that, one of the things that many institutions did at about the same time was the development of the patient representative program.

In some institutions, the patient representative program and the risk [management] program don't get along very well, because the purposes are a little bit crossed purposes. But in some institutions, it can be the patient representative program or the ombudsman program -- can be a very, very valuable program in helping the risk manager in allaying some of these problems. Because risk management, if you look it up in the book for a definition, the idea is to manage the risk of loss. It is an insurance term that came into the medical world at about this time. It had been adopted by such big business places as Goodyear and the airlines, and so forth and so on. And so, it had shown that having some kind of an anticipation of this risk of loss was a good business deal. And so, health fields took it on.

RS: It was a business.

SB: It was a business. Yes. The health field became a business. And that, I think, is one of the big changes that I've seen in the sixty years that I've been in nursing. We never knew anything about the business aspect of this until about the time that Miss Venger came. She was the first one who taught us supervisors how to do a budget. Up to that time, the budget for the nursing department had come out of the main nursing office, and none of us out in the trenches had any idea of anything. We were given this, and we were given that, and if you wanted a nurse, you went to the main nursing office and you said, "I need another nurse", and they looked at something and decided maybe you did or maybe you didn't. You got it or you didn't.

RS: What was your reaction when you started doing budgets?

SB: [laughs] I didn't mind it because I found it kind of fascinating. And I'm being -- one of my friends is always talking about the various signs, you know, and I'm a Virgo. And being a Virgo, I'm kind of organized, so they say. So, I didn't mind making up these pieces of paper with lines and spaces and so forth, because it kind of fits into my personality, I guess. [laughter]

I also felt that in doing it -- and that was the principal that Miss Venger taught us to do -- in doing it, we became responsible. We knew what we had to work with, and we could make some decisions based upon that knowledge. So that I didn't mind it.

RS: Did your colleagues?

SB: Well, some of them didn't like it.

SB: And, of course, it was pretty tedious sometimes. It can be a very tedious thing.I mentioned a few minutes ago about how Gail and I spent hours and hours -- after hours -- doing things. And one thing would be that, after the supervisors and the assistant directors made out the budget, it was Gail's and my responsibility to go over it and make sure that all the numbers were right, and that everything was right before we turned it into the financial division.

It could be tedious. We spent -- well, we'd go home at midnight -- after a long day at work, we would spend the evening straightening out these numbers.

RS: Those were the days of the real spreadsheets. [laughs]

SB: Yes. Real spreadsheets. [laughs] You had none of these computer kinds of things that they have today. So that some people who are not very able to deal with that kind of thing, found it very, very distressing. They couldn't really see much advantage. It's kind of like not being able to see the forest for the trees.

RS: Right.

SB: You get so wound up in these pesky numbers that you lose sight of what it is that really you're going to be able to do with those numbers, and what it means. And I think that's what happened.

RS: Well, they want to be caregivers, not administrators.

SB: Yes. That's right. That was the other thing.

Anyhow, going back to risk management, I found that this whole field was fascinating. I think when you asked about me as a person -- the first day -- we talked about the fact that I had decided to be a nurse. And I also talked about the fact that my family had very -- no money. Truth to tell, if I had come from a wealthy family, I would have probably been a lawyer, because that is really what I wanted to be. But I -- there was absolutely no way at all that I could go to college and get to be a lawyer, and so my next choice was nursing, which was -- they were sort of equal in choice. I was never angry about not being able to be a lawyer, but when I got into this risk management stuff –

RS: [laughs] There you go.

SB: [laughs] I was right back in my element. I really did enjoy being able to work with the lawyers, and I didn't even mind too much having to go to court and being questioned.

SB: It's always been kind of fascinating -- when I'd have to have a deposition. It was sort of like me against that lawyer, and sort of who could win this questioning session. [laughs] So I did not -- I found it interesting and did get involved in it a great deal.

RS: There was a life lesson there, isn't there?

SB: Yes.

RS: That you did eventually get to do what you wanted to do. [crosstalk].

SB: Yes. I did.

RS: Good. You just had to wait long enough.

SB: That's right.

Labor management was another field that was developing into an important need. When Gail came she, early on, identified that we needed to have better control over what was

happening in terms of labor management. Prior to her coming, the labor division or the personnel division [unclear] -- those people who were responsible -- were really pretty much running this union. That's something we should talk about. I went through this whole business of unionization at Mount Sinai.

RS: We can come back to that.

SB: I forgot it.

RS: That's okay.

SB: But anyhow, we, as nurses, didn't really have very much to say about what was going on in the interpretation of the contracts and what would happen to people when they did something wrong, and when there was a disciplinary action. And it was Gail's opinion that we needed to have a better relationship and a better control, and one of the things that she identified was -- and it's, I think, a truism as far as labor management is concerned: you must have consistency.

You cannot have one supervisor doing one thing and another supervisor doing another. And for that reason, it was Gail's decision that we would appoint me - and this was even before I became Associate Director for Nursing Affairs. It was when I was still doing other things. But I was the person who had the ultimate decision. The supervisors could make up their minds what they wanted to do. They could take it up with their assistant directors. But before it was implemented, it had to come back to me. So that we could make sure that if a nurse did a certain thing wrong in one department, and another one did the same thing wrong in another department, that the same kind of action was taken.

This was an important change in the relationship between the personnel department and the nursing department. And it was not necessarily an easy change. It became -- it did work itself out. I think because Gail and I worked very hard at it, and because they soon discovered that I knew what I was talking about that I had a knowledge of what was going on, and that we needed to. I well remember a grievance hearing early on in the beginning of this thing, and –

RS: Which would be what time period? Would this be 1972 again?

SB: No. I think this particular episode occurred before Gail came.

I kind of think that this occurred -- no, let me think. It probably was after Gail came. I guess it would be in 1972. But anyway, we went over there for a grievance hearing, and Mrs. Brand, who was the lady in charge of our auxiliary staff, and this grievance hearing was reference to auxiliaries. We went over there and the Personnel man, who we will leave nameless, was being particularly abusive to Mrs. Brand and me. And so,x I looked at her and I said, "Let's go". She looked at me and I said, "There is no need for us to sit here and listen to this, and to take this abuse. We will go back to our offices." So, we got up and we walked out.

I'm telling you, we didn't get to our offices before that man was on the phone with Gail. [laughs] What business did I have? [laughs] Well, Gail supported it. She ultimately

supported it because she did not think that it was necessary for us to take that kind of abuse.

RS: Exactly.

SB: Well, things did change after that.

RS: [laughs]

SB: We got up and walked out with those people. [laughter]

They realized that we were not playing games anymore, and that we were going to approach this business of interpreting the contract in a fair, equitable manner, that would be to the benefit of the institution and nursing department.

So that was a big change. Gail's position was that she was in charge of the nursing department, and that the personnel department was a resource to her. And that was a very different point of view.

RS: Sure. You'll have to tell us a little bit about Gail. Gail was here for about twenty years.

SB: Yes.

RS: She left in 1993.

SB: Yes.

RS: Can you tell us a little bit about Gail?

SB: Oh, she was a very, very fine lady. She's a -- her basic nursing education was obtained at Vanderbilt. She got her Masters Degree at Teachers College, and then during the time that she was here, she obtained her doctorate at Teachers College. She was quite young when she came here, and a very different kind of image than had been in the past.

RS: That means exactly what?

SB: Well, she was -- the first day that she came to work, she wore white kid boots, and a rather short skirt.

RS: [laughs] This was 1972?

SB: Yes.

RS: [laughs]

SB: One other day she came to work and she was wearing clogs.

RS: [laughs]

SB: Now, we had a rule here at Sinai, that you couldn't wear clogs. So, one of the first things that Sidney had to do was to go to the Director, me, go to the Director of Nursing and tell her that she couldn't wear clogs!

RS: What did she say?

SB: Well, she always was very willing to hear what had to be. She was not angry. And, in fact, she was always appreciative that I didn't allow her to get into any kind of a jam, as far as the rest of the institution was concerned. Because that was my intent; I was going to orient her and I was very proud of her. I liked her, I liked her right from the very beginning, and I wasn't about to let her get in trouble with this crazy institution. [laughter]

So, my theory of orientation was pretty important, in terms of really becoming oriented to what it meant to work here, at Mount Sinai. She'd had good experiences before she came here. She came here from Montefiore, and prior to that she had worked at Columbia Presbyterian, so that she had a good background in her business. Very bright woman, and very, very personable. Very understanding. She has an excellent mind. She's right on the ball all the time, and she's right up-to-date with everything that's going on. This is being shown -- some of the things she's doing -- right now in Boston. She's busy as a bee, doing all kinds of creative kinds of things, and she was very creative in her work here in Sinai. Under her aegis, the Nursing Department became a very, very important department, a very strong department, and in a way, I think that was her downfall. I think that's the reason why it became apparent that the time had come for her to go somewhere else.

RS: Do you want to elaborate on that a little more?

SB: Well, under the direction of Mrs. [Wendy] Goldstein, [Director of the Mount Sinai Hospital] she, I think -- well, in fact, I've heard her say -- that the Nursing Department was not a learning institution anymore. That's all there was to it. And in truth, the Nursing Department had always run Mount Sinai. The School of Nursing, before it became two separate entities -- the School of Nursing ran the Nursing Department, and pretty much ran the institution, right from the very beginning, back in 1891.

And it had been like that all the years. The procedure manual that was used by the nurses in this hospital was developed by the School of Nursing. It wasn't until a good many years later, when the first editions that I was responsible for, was deemed [a product of the Department of Nursing]-- as you look at all the manuals, from 1948 on -- they have my name on them.

But anyhow, there was a change there, from it being a manual of the School of Nursing to a manual of the Department of Nursing. And this was an example of this kind of change.

The Department of Nursing has always been a strong department to reckon with, and maybe the time had come when there needed to be a different approach to management. I don't know. Some of the things I hear and see at the present time I have questions about. But anyhow, that seems to be the way it's going, and that's the whole thing. I think that because the Nursing Department was so strong and that was not in the

cards as far -- particularly as far as Mrs. Goldstein was concerned -- that it became apparent to Gail that she would be better off if she -- she didn't want to be asked to leave, and nobody wants to be asked to leave. And if you have sense enough, if you're smart, you'll know when its time for you to make moves. And I think that that's what she did. She made her move. She was invited -- she didn't even ask -- she didn't go to Boston to seek a job. She was asked by Boston to come.

RS: Yes.

SB: And that really is the way to do it.

RS: Yes.

SB: I think that from her point of view, I think she made a very, very good move. I think that one of the things that -- as far as that's concerned -- that impressed me very much. It seems that Boston -- that Mass General has a practice there of following up on their graduates. This is particularly their medical graduates, but if there are nursing people that they can find, right, they do that. And they send a team of people from the institution to a country to spend some time meeting with the graduates, and within the year after Gail was there, she was invited to go with the team that went to Japan, to check on their graduates and to talk to the people there. And they also went down to Hong Kong, I believe, while they were over there. I thought that was really a significant indication of the way in which she was seen and was perceived, and the kinds of things that she can do.

I guess you get the idea that I'm one of her fans.

RS: I can see that. I appreciate your candor.

SB: We had a very, very fine relationship, and when she decided to leave, that was when I decided to stop being Consultant. You see, after I finished -- after I retired as Associate Director of Nursing Affairs in 1986, I stayed on as the consultant to the Department of Nursing, and I left that job when Gail left it. Well, she left in January, and I didn't leave until June, but I made the announcement that I was leaving at that time because I felt that it was good. It was good for my own personal well being, but it was also a break. It was time to leave.

RS: Were you still actively involved with the Alumnae Association?

SB: Oh, yes. Yes. I do stay in touch with things, and I stay in touch with people here, and so forth and so on. The fact of the matter is, I'm frequently invited to nursing department affairs whenever they have something they think I would enjoy. I get an invitation.

So, I haven't lost all the contacts, but I don't have an official role any longer with the Department of Nursing.

RS: Right. To go just a step back a bit and go to the reorganization that Gail instituted that started that.

SB: Well, she –

RS: This is when she divided the department and you –

SB: Yes, she divided the department. That was one of the reorganizations that she did. She did also some reorganization, as far as the role of the supervisors and the head nurses. She did away with the head nurse job and created the job that was called senior clinical nurse, which was the nurse in charge of the unit. The supervisor was in charge of the division –- yes the division. There would be a supervisor for –- there was a supervisor on each floor. She had twenty-four-hour responsibility. The senior clinical nurses -- there were three of them on each floor -- they were in charge for a shift.

The supervisor, of course, held many more responsibilities, and that's when they became more deeply involved in the budgets than ever before, and a lot of other administrative functions.

This was an interesting change, in terms of the relationship between the [New York] State Nurses Association and the Department of Nursing. In 1970, this was another one of the things that Mrs. Kinsella achieved. We had our first nurses contract with the State Nurses Association. This was another one of -- I would say it was probably another one of Mrs. Kinsella's goals. She had been active in Bellevue, where they had had State Nurses Association representation for many years, and so she recognized that that was a way to go. So in 1970, the first contract with the State Nurses Association was formed, and following that, after Gail came -- the fact of the matter is, Gail and I did the 1972 contract while she was still up at Montefiore.

Because what they did in those days -- what was called the League hospitals negotiated their contracts together, and so she was negotiating for Montefiore, and so she also negotiated for Sinai. But, of course, I had to do the groundwork because she wasn't too familiar with all the things that were going on at Sinai. So, we did that in the 1972 contract together, and then from there on, every time a contract came up, I was a part of the negotiating team. That was a part of this labor management business.

Well, when she decided that she wanted to change the role of the supervisor and so forth, and she wanted to take supervisors out of the bargaining unit, they were in the bargaining unit from the beginning, and she wanted to get them out. So we had some very, very interesting meetings with the State Nurses Association. We were able to prevail. Mainly because Gail and I came up with some strategies that we thought would work, and we were able to sell it to the State Nurses Association, and to this day, as far as I know, the supervisors have what is known as the Council of Clinical Supervisors. This is an independent group, independent of the State Nurses Association. But it's an outcome that was negotiated when we took the supervisors out of the bargaining unit, in order to get them -- the supervisors -- an opportunity to have some say in their own destinies. But it is independent. There is Mount Sinai only, and it doesn't have any relationship with the State Nurses Association. And that's how we were able to get the State Nurses Association to let us take the supervisors out of the bargaining unit, by agreeing that they would have an alternate system.

RS: Did you work that out between the two of you? Or whose idea was it? Do you remember?

SB: I don't know. I think we came up with it together.

RS: Both of you together?

SB: Yes. I think we just came up with it together. I think that Mr. [Norman] Metzger [Director of Personnel] always thought that I had most to do with it, but I don't believe so. I think we did it together.

RS: Did you know Gail before she arrived? I mean, obviously, you were working with her before she came here. [crosstalk].

SB: That's when I first knew her. I had never met her before. No, the fist time I ever met her was across the bargaining table. [laughs]

RS: Yes, right. [laughs]

SB: That was it. I think we were meeting at the Roosevelt at that time. We almost always did negotiate at different hotels, and I think that we went to Roosevelt that year. [laughs]

RS: What did you think of her when you first met her across the bargaining table?

SB: Well, I was impressed with her knowledge, and I was impressed with her skill. You see, I had never had anything to do with this bargaining business because the first contract, Mrs. Kinsella had done on her own, and I just inherited that contract, and I didn't know from beans about it. So, I had to learn a great deal, and then I was impressed with the NYSNA. But of course, I had worked with Mr. Metzger.

Maybe this is a good time to talk a little bit about the beginning of this unionization at Sinai.

I was supervisor in Pediatrics when is it that 1199 came in here, and I was supervisor in Pediatrics from 1951 to 1966, and I think that the 1199 people came in here in –

RS: I'd have to look it up. I don't remember.

SB: 1955? 1950 something. Anyhow, when it became apparent that 1199 was going to make this leap toward trying to organize the hospitals, Mr. Metzger conducted a training program for those of us here at Sinai in the whole field of labor relations. The fact of the matter is, I guess it was probably his course that he gave at whatever college he was teaching in.

But he gave it to those of us who were supervisors and so forth. And taught us some of the basic rudiments of how you handle the approach of the union toward unionizing, and what you, as management, can do and what you can't do, and all that kind of stuff. So I had learned -- had worked with him in the 1199 arena -- from the time that it had started,

and I was here during the big strike when they did come in and when we did have the big strike [1959]. So that labor management stuff was not unknown to me.

But I didn't -- I had never worked with the State Nurses Association. So that was a little different, because while the principles are essentially the same, the approach is quite different. The State Nurses Association sees their labor relations from a professional point of view.

And 1199 is not exactly a professional organization. It's a pure and simple labor management situations.

So that we learned from doing. We had a variety of experiences. We had some very, very active delegates and they were being taught well. I think that's the interesting thing about this whole business of labor management. You really have to give some credit to the opposition, as it were. [laughs]

Because they really know what they're doing, and we had some really very, very good delegates, who went to school and who learned, and so forth. And you could learn from them many times.

I guess maybe that's one of the reasons that I got along with as many of them as well as I did, was because I would listen to them, and I did give them credit for having [unclear]. So, we managed pretty well. But that strike, that first strike was quite an experience.

RS: I bet.

SB: And then we went through, of course, two or three others -- strikes or sit-downs or sit-ins. [laughs]

RS: So, what was it like when Mount Sinai went on strike?

SB: Well, in the very first one, everybody did whatever had to be done. There was not very much of a -- well, you know. [unclear] In pediatrics -- I can only speak mainly for pediatrics.

But if the floor needed to be cleaned, some of my residents and interns would clean the floors. And if the dishes had to be washed, some of my nurses would do it. It was really -- everybody pitched in to try to see to it that the hospital kept going, and that the patients received the kind of care that they wanted to. That was in that very first one.

RS: Which lasted how long? I can't remember.

SB: Oh, I don't know, some many days. It was -- I don't know, 37 days or such and such thing. It's in the records, but I don't remember. It was long enough.

It was a wearing experience. Later on, after the State Nurses Association came in, the position of the State Nurses Association was that when 1199 struck, that the nurses were not to do the jobs that 1199 wasn't doing. And that they have a whole statement that they publish every time themselves.

And they say what you can do and what you can't do. The nurses were not to be called upon to do anything that was not being done because of the absence of the 1199 person. So that made your whole picture quite different from the very first strike to the subsequent strikes. Because the subsequent strikes -- the management people were the ones who had to take over the tasks.

So, you managers did all of the things that nobody else would do. Of course, some of the nurses would defy their union leaders because they would see that something had to be done, and they would just do it.

RS: Not so much defy, but have to kind of help as they could.

SB: That's right. They could go just as far as they could get away with it and not get called up on the carpet.

Usually, the strike situations were not too bad. We had a few incidents out on the streets, some eggs and some tomatoes and some problems. But on the whole, from my point of view, when I would have to walk in past the people -- in the first place, I always came in very early. So that's one of the ploys that you learn after a while. There aren't so many people on the picket line at six o'clock in the morning as there are at nine. [laughs] So, you come in at six. Those are little deals that you learn to work through when you're in these situations.

For the most part, I never suffered any kind of problem because generally speaking, most of the 1199 people that were out here had a fair degree of regard for me. They wouldn't -- they might yell a little bit, but nothing, nothing that was intolerable. And as I say, we were always very happy to have the police around because I do think that that does curb the behavior a little bit and folks behave themselves a little bit better.

RS: So, how many strikes did you go through?

SB: I don't know. I think it must be about four, I think.

RS: And work stoppages?

SB: And work stoppages and things like that -- yes. But we tried very hard. That was one of Gail's ideas. We tried very hard to make life for the people who were working very hard under these circumstances as comfortable as we could. Our management people, who were having to take over big tasks -- we almost always provided them with lunch. You know, we saw to it that they had some something special, like great long heroes and things like that, for them to eat. Then, afterwards, Gail would always send a memorandum thanking people.

She and I would make rounds a lot on the units, so that the people would see us, and that we would know –- that they would know that we were with them and thinking about them. And concerned about them.

I think that this is one of the principles of management that Gail was very, very on to, and that was making sure that people understood that they were appreciated, and that they recognized what they were going through.

RS: It sounds like she brought modern management in here –

SB: She really did. She very much did. We had some introductions to some of those things, under Miss Venger. She worked very closely with Mr. Metzger, and Mr. Metzger had many contacts with different people who were leaders in the field of management. And so we had, during her time, we had some introduction to the modern management theories. But when Gail came, she was more into it I think even than Mary Jane [Venger]. I have always told Gail that if she had been able to follow Mary Jane, her life would have been a heck of a lot easier.

RS: Wow.

SB: Having to deal with some of the unrest that had resulted during the period of time that Mrs. Kinsella was here, made it more difficult for Gail. Gail's style was more reminiscent of the kinds of things that Mary Jane had tried to do. And I frequently told her that it was just -- if she could have just come in right after Mary Jane left, that it would have made a lot of difference.

RS: Wow. I think on that note, I'll close for the day, and we'll start again next time.

SB: All right.

[Tape 3, Side A]

RS: This is Richard Steele at the Mount Sinai Medical Center Archives, and today [November 28, 1995] we're having the third of a series of interviews with Sylvia Barker. Sylvia, thank you very much for coming back. I appreciate it.

SB: You're very welcome.

RS: We spoke last time about your career here, as it overlapped with that of Gail Kuhn Weissman. I wonder if you had thought about that since we spoke -- if you had any other things you'd like to add to that.

SB: Well, yes. I have been thinking about the time that Gail and I worked together, and I particularly thought that it might be important for me to mention some of the accomplishments of her tenure here, as I perceived them. Perhaps when you speak with her, you'll find that she has other ideas. But there were certain things that I thought were impressive.

We did talk the other day about the introduction of the position that I took as Associate Director for Nursing Affairs, where I worked with labor management and risk management, and the quality assurance activities. I found that that was a very exciting time of my career, and I think that she felt that it was very worthwhile and exciting.

I think I better stop because I seem to have a cough.

[Tape off/on]

Sorry for the interruption.

The thing that -- other things that Gail accomplished while she was here that I thought were very significant -- number one, she identified early on that her membership on the Medical Board was a very important way of bringing nursing into the forefront here, at Mount Sinai. Up to that point, it had not been the way it was. Nursing was not represented. One of the things that I learned from Gail was how to be politically astute.

And how to plan for the changes that you wanted to make. So it occurred to her that Social Service was also not represented on the Medical Board, and that if the two major departments of Social Service and Nursing got together and petitioned for membership, that it might be a more successful strategy. And indeed, it was. So that she worked very closely with Helen Rehr, who was the Director of Social Service at that time, and the two of them were admitted to membership on the Medical Board. And it was not just for them only, but for posterity that this would be the way the Medical Board would be organized.

One of the advantages to this was that those of us of Gail's assistants, who were members of Medical Board Committee, now had a vote on those committees. Just as she had a vote on the Medical Board, we had the power and the right to vote on those committees.

One of the committees, for instance, that I was a member of, and which was an important factor, was the Pharmacy and Therapeutics Committee. We were -- Nursing had been, over the years, represented on those committees, but we had always been without votes. So that this whole change was very important. It was a change that was national in nature, in that other institutions were beginning to look at the way nursing was represented. And while I think perhaps Mount Sinai was one of the first here, in New York City, before long, the Nursing Departments were recognized as integral parts of Medical Boards, not only in New York City, but elsewhere.

RS: What time period was this?

SB: This was fairly early in her career. I would say -- she came in 1972, and I would say that she started this toward the end of the 1970s, and certainly by the 1980s it was well established. I don't know the exact date for that achievement. [By Medical Board action on Jan. 15, 1974.] But it occurred to me that that was an important accomplishment.

She was also -- as I mentioned before, I learned a great deal about being politically astute, and it was not just being politically astute as far as interaction with other departments in the hospital but also in her way of managing her own staff.

She was very, very sensitive to the need for the staff to be kept informed. She established while she was here things that were called speak-outs. And these were an opportunity for each of the divisions to meet directly with her. The division was represented not just by the appointed leaders, like the supervisor and the assistant

director, who generally did have access to Gail. But when a meeting of the division was planned for a speak-out, representatives from the auxiliary staff, from the unit clerks, from the staff nurses and from the head nurses, were all included in this opportunity to speak-out.

And, indeed, the staff took advantage of this, and they did speak out, and they did bring to her attention things that were troubling them about the way they had to deliver care. And they brought things such as delays in response of such departments as the T&I or delays in response to laboratory work, or problems with the X-ray department. They were a voice for what was going on in their unit, and they brought these to her attention, directly.

And it wasn't just an opportunity for them to talk. [laughs] But she had one of her assistants present there to keep track of what it was that they brought, and then she arranged her follow-up on the questions, for further investigation, and very often, at the next meeting of that particular group, she brought a representative from one of the departments that had been a subject of their discussion of the previous meeting.

These were organized so that each division had about four times a year, that they would get to meet with her. Because she wanted to keep them in small intimate groups in order to encourage the conversation. And therefore, she didn't -- she kept it small, like the medical division, the surgical division, pediatrics, the operating room, and so forth. Each of those divisions had their opportunity to meet with her. These speak- outs I consider to have been very, very successful and a very important part of the staff feeling that she really cared about them, and that there was somebody there that was willing to listen to what happened. It also was a very good way of improving her delivery of care here in the hospital, because by bringing out the problems that the staff was meeting, we were able to bring about some very nice changes.

In terms of delivery of nursing care, during this period of her being here, we introduced what was known as primary nursing. Primary nursing was espoused by a woman by the name of Marie Manthey, and she wrote about it. She was invited by Gail to meet with the staff and to introduce her theories and her ideas about how this would be. Gail hired a person to be responsible for inaugurating primary nursing. We did it floor by floor, and that was, I think, one of the really successful strategies that we were able to bring about this change.

The idea of primary nursing was that each patient would have a registered nurse who was their nurse. And that the patient and the doctors and other nurses and everybody would know who that person was. So that there was a board -- a main board -- put on each unit, which identified the patient's name and the nurse who was his primary nurse. I think the doctors liked this.

Earlier on, we spoke about the fact that we had eliminated the head nurse, and this was a hard thing for the doctors to accept. Head nurses were kind of traditional in nursing. I remember when I was a supervisor, Dr. Hodes frequently said to his counterpart in psychiatry, Dr. Kaufman, "Well, what does your head nurse say?" [laughter]

He used the word head nurse at that time, rather easily because we usually used it to represent the unit level manager. But he always -- and I felt that it was a compliment. I felt that in his words, using the term head nurse to apply to me, was really a compliment. It was that I was "his" head nurse…. [laughter] He and Dr. Kaufman used to talk a great deal about what 'their' head nurses had to say. Well, that just gives you an example of the important role that head nurses have played here at Mount Sinai.

The reason that Gail thought that it was time for a change was because it had gotten to be almost a road- block, in that if anybody wanted information on the phone, they wouldn't talk to anybody else. They would just demand to speak to the head nurse. And if they couldn't talk to the head nurse, then that particular problem didn't get solved. The head nurse had a lot of power, and it was very important for her to be in on what was going on, but we recognized that flattening out the service was an important thing in order that we could get more done. You can't have a road-block in the form of a head nurse. By doing this primary nursing, although we still had a person on each unit who was a charge nurse, the identification of the primary nurse on this board, and the knowledge that the doctors or the x-ray technician --. When the x-ray person came, if he needed the patient Mr. Jones, who was in such-and-such a room, he would look at the board and he would know who the primary nurse was that day, and he could go find that primary nurse himself. This smoothed things out and it worked a great deal better.

The patients also, of course, during this time, from the 1980s, maybe even some in the 1970s, patients were beginning to be much more savvy. They are even more so today. But there was a beginning, I think, of patients accepting the fact that the doctor was not exactly God, that he could be talked to and he could be asked questions, and that they -- the patient himself -- had a role in what was happening to him in the hospital.

Over the years, I had observed this phenomenon in my own mother. When she called up during the time she was bringing us up -- my sister and me -- she called the doctor on the phone to get some advice, and even though she might disagree with him, if he told her that that was what to do, she would do it. I remember that I had scarlet fever as a child, and I was really quite sick. And in those days, they put us on quarantine. So I was quarantined in my room and my father had to leave the house. My sister couldn't come near me, and my mother had to scrub her hands every time she came in the house, and so forth. And in those days, they had a rather unusual theory that the germs from scarlet fever were transmitted by the flakes of skin that came off when you peeled. Therefore, she had to rub me with olive oil, and to this day, I detest olive oil.

But at any rate, I had a very, very sore throat. Now we know that that was a streptococcus sore throat. Streptococcus is the organism that causes scarlet fever. My mother looked at my throat, and in spite of all of these scientists of the day, she said, "That's where the organisms are." [laughter]

And this is the kind of example of the forward thinking of my mother. She represents a group of people that were beginning to say, 'Just because the doctor said so, isn't necessarily the way it's going to be.'

RS: What did your mom do for your sore throat?

SB: Well, they irrigated it. They used saline solution in a bottle and irrigated it, and then, in those days, [unclear] was a big deal, and so she was supposed to paint my tonsils with a swab with [unclear]. And that was what they did for me.

RS: Okay.

SB: That experience was kind of an interesting experience all the way around. But I use it as an example of the beginning of patients beginning to be a lot more responsible for themselves in hospitals.

When we introduced primary nursing, the patients got into the act. We even had a little folder that was published for the patients. And there was a place for the nurse to write her name -- her name or his name -- on that folder, so that the patient would always have, at his hands, the name of his primary nurse while he was in the hospital.

Primary nursing got a bad rap because people thought that Manthey was saying that you had to have an all registered nurse staff. And that, of course, was expensive. According to Manthey, she did not say that. There was a role for other people to be responsible for and to deliver care. What she was trying to say was that the registered nurse should be the person who was responsible for that primary patient.

Today, an outgrowth of that is the campaign that the New York State Nurses Association and the ANA is running to bring to the public the fact that every patient deserves a registered nurse. Now, this is different times than Gail was working in, but it is the same idea, that registered nurses should be the people that are delivering primary care to the patients. Or who are responsible for seeing that the patients get the primary care. Anyhow, primary nursing, I think, was introduced -- I understand that at the present time, the whole concept is being revisited, and I hear that there is a person that's been hired to -- probably the best word to use would be to upgrade, and to bring into the 1990s this same concept of primary nursing or professional nursing or care of patients by professionals.

Those were the things that I thought -- in addition, of course, to the whole organization of the Department of Nursing, that were particularly outstanding during Gail's tenure here.

There is, however, another factor, and that was the awareness that Gail had of the importance of people being recognized for what they did. And she worked very closely with the Board of Trustees to develop a program of the Trustees' Nurse of the Year being selected, and a whole program of this Board of Trustees honoree was initiated during the time that she was here. Over on the -- well, on the fifth floor of the Annenberg Building, as you come off the elevator, is a plaque which was installed, which has a space for the addition of each nurse who becomes the Nurse of the Year, and her name, and the year that she was identified for that. We were very careful to be sure that we had good criteria to follow in the selection of the nurses who would be the representative of the department for the year.

Along the same time that Gail was doing it here in the hospital, the different nursing organizations had begun to identify the importance of recognizing the achievements of nurses. And so that our District 13, which is our local county association, and we'll talk

about that a little bit more, and our New York State Nurses Association and the ANA, all have programs of recognition. During the time that Gail was here, Gail and Carol Nicol and I each received the nursing administration award from New York State Nurses Association. Gail and I received the Jane Delano Award from our district association, as well as one of Gail's programs, the mentor program with the high school students, received an award from the district association. Gail and I both received awards from the Alumnae Association of the Nursing Division of Teachers College, as well.

Now, I mention this as one of her achievements because she set the stage for us to do this kind of thing. She encouraged getting the names sent down to the various committees. Presently, I am serving on the local committee for this coming year for the awards, and this is one of the things that is kind of a fun thing to do. In addition to the trustees' recognition, there was program under Gail's aegis, which I know is continuing. I have some question about whether the Trustees program is continuing, because it's been traditional that the award be made in November, and today is the 28th day of November, and I have not heard of such an award. So I don't know where that's at the present time.

However, one program that was started and is continuing is the recognition of a person from each of the divisions. And that person can be a nurse or an aide or a unit clerk. It doesn't have to be nurse, in other words. And that goes around the year -- over the years the divisions are assigned a month in which they have an opportunity to select an employee of the month. This goes along with a similar program in other departments. The T&I people have a T&I worker of the month, x-ray has somebody of the month, and so forth.

So that this is something that I wouldn't want to say necessarily that Gail was the beginning of it, but I do think that she had something to do with getting it a hospital-wide opportunity to recognize the contribution that people make to the management of this institution and the care of the patients. So, I think that those programs are very important, and something that is worth mentioning.

Another program that Gail was very active with, which had its origination in the -- what is the Ellen Fuller Award. The Ellen Fuller Award is given by the Association of Attendings, in recognition of the very important role that Ellen Fuller, who was a graduate of our school in the Class of 1939, made to this institution. She was the evening assistant director, that was the final title that she held. There were many other titles that led up to that, but it was always the same job.

She was a very strong individual who really saw her role to see to it that the patient got what they wanted -- needed. She was not about to let any red tape get in her way, and she was fabulous for her being able to manipulate the system so that she got what she needed for the patient. The doctors were enamored of this because when they would have a problem on a unit, sometimes they would purposely hold it off until she came on duty at four o'clock because they knew that "Ma Fuller" would get it taken care of.

Unfortunately, Ellen died, and really at the prime of her life. So, the doctors initiated this Ellen Fuller Award, which is given annually, and we just had the celebration a few weeks ago, to two people who carry out the same "it can be done" notion that Ellen had. So,

we've been very, very excited about that. It not only was important for the persons who are named to get this award, but again, it was an entre to one of the other programs that Gail was excited about, and that was collaboration with the medical staff.

And she did a lot of things to improve the collaboration of the medical staff. I know I'm talking a lot about Gail, but you have to recognize that I was her associate and almost all of these things that she was espousing, I had something to do with. [laughs] If it was a staff work or whatever it was -- that we did together, in most of these things.

There was another award here in Mount Sinai, which is a long, old traditional award, given again by the doctors, called the Jacobi Medal. Up to this point, only two non-doctors have received it. Nurses, that is. Ellen was the first recipient of the Jacobi Medal. That was before she died, which was very great that she had that opportunity. And Gail was the second nurse to receive the Jacobi Award. So, I think that those are important milestones in the progress of nursing, and the recognition that the doctors had for the leadership of nursing. I think it's been said about Mount Sinai, and I suppose it's true of other hospitals, but not having too much experience with others, I can't speak for them. The doctor has always been the main person in these medical institutions. They always have run things and been -- what the doctors wanted was pretty much what the doctors got. So that the various opportunities for recognition of contributions of others than doctors, I think, are significant in the way nursing has evolved over the years.

I think maybe those are the outstanding things that I had thought of the past week or so, as being some of the accomplishments that we were involved in during the twenty years that Gail was here as Vice President.

RS: You had mentioned that when Gail left, that you ended a lot of your active involvement with the nurses. However, you have been very involved with the Alumnae Association. Perhaps you can recap your association and give us some background about the institution itself.

SB: Well, yes. I can talk about the Alumnae Association. I think there's a couple things in the background of the Alumnae Association that I'd like to make sure to mention.

Our Alumnae Association was one of the founders of the New York County's Registered Nurses Association, that I had mentioned. One needs to have a little bit of a review of the way things happened, in terms of organizations in nursing. Back in 1894, there was a group formed that was called the Registered Nurses of the County of New York, and this was a forerunner -- these local units were a forerunner of what ultimately became the ANA. The ANA was founded in 1897, as the Nurses Association of Alumnae of the United States. That was the beginning of the national association that is known today as the ANA. An outgrowth of the national organization that then became the state organization, which here, in New York State, is called New York State Nurses Association, fondly called NYSNA. And then there were these local, county organizations, which -- the one here is the New York County's Registered Nurses Association, District 13 of the State Association.

The interesting thing about this is as far as the Alumnae Association is that it was alumnae associations that began to recognize the need for organizing nurses. It didn't

start at the top. It started down with your alumnae associations. And being as this School had been founded in 1881, and had developed into a pretty important school, we were one of the first alumnae associations to be a member of the New York County Nurse's -- Registered Nurse's Association. In fact, in 1903, we joined that group and the first treasurer of that group was one of our own graduates, Jenny Greenthal.

So, it is interesting to remember that at the beginning, in order to become a member of your district association and your state association, you had to be a member of your alumnae association. And indeed, that's how I got into being active in each of these different levels of the organization. Because when you graduated, you became a member of your alumnae association, and that made you a member of your district association. You had to pay dues, of course, but you automatically got into it. Frequently people ask me -- I am a more than fifty year member of the state association and of the district association, and frequently people ask me how I got involved. Well, I got involved through the Alumnae Association. It was just accepted that that was the way it was going to be.

Our Alumnae Association, of course, has not had any new graduates to come to it since 1971, when the School was closed. Some alumnae associations like our's have been pretty successful in continuing to be an entity. Bellevue has an active alumnae association, although their original School of Nursing has been closed. Columbia Presbyterian has an active alumnae association although their School of Nursing has been changed to the collegiate program.

The purposes of an alumnae association are usually to provide for the needs of the nurses in terms of socialization and any other activities that they may choose to engage in. Our association, from its very beginning, has been very interested in the welfare of nurses, and we continue to have a thing that's called a friendship fund, which is one of our wealthiest funds. We do have a lot of money in the Association. Friendship Fund, which we use to meet the special needs of nurses. Maybe they are nurses in nursing homes who need something nice or something special. Or maybe they have been burned out, and they need money to help them re-establishing their homes. Whatever it is that we begin to know about, the Friendship Fund takes care of those things. In addition, the Friendship Fund sends checks to needy nurses at Easter, at Christmas, and one time during the middle of the year. Not magnificent funds, but some money that will maybe buy some little extra thing that a needy nurse might have.

The Pension Fund of the Alumnae Association is another important activity, and it was started in 1894, very soon after the Alumnae Association was formed. And it is one of our best buys, really. The nurses must be a member of the Alumnae Association -- must have been a member of the Alumnae Association for thirty [?] years before they receive a payment, and a member of the Pension Fund for thirty years. The dues to the Pension Fund started out at ten dollars, and in doing a little research for this, we are still only charging ten dollars. Still ten dollars.

Of course, the money that is paid out in pensions is a result of big donations of interested people, and the money that the people pay in, and from good investments. The total amount of money that a nurse would pay into the pension fund over her lifetime would be three hundred dollars. I think it's important to know that now, nurses who were

members of the Pension Fund, are receiving over five hundred dollars twice a year. A pretty good investment, I would say, for three hundred dollars. [laughs]

We continue to maintain the Pension Fund. We have a committee that oversees the investments, and that makes sure that the nurses are getting their checks when we send them out. We make sure that they deposit them because many people who are on pensions are getting along in years, and they don't always take care of their business as well as they should. So, we watch over that very carefully, and if the check hasn't cleared, we set about finding out why that check hasn't cleared. The alumnae associations have always been -- and the District Association -- have always been very involved in the other types of welfare of nurses.

In running through some things that I thought were kind of important for us to remember was the role of the alumnae association in the introduction of registration for nurses. Nurses were not always registered. Nurses way back before our schools of nursing began, you got to be a nurse mainly because you thought wanted to be, and you might learn from doing. It was the Nightingale era that brought about the development of schools of nursing and nurses who were prepared in an educational setting to know how to give care.

So, in 1901, the New York State decided that it was important for us to have this function of registered -- registering each nurse who was going to practice. The idea of registration is to protect the public. So that people that they hire as nurses are properly qualified and have a document to identify that they are a registered nurse. There is, of course, has been over the years, some people who believe that registered nurses want to be registered for their own gain. And there is even, and has been on several other times, efforts by different organization s or governmental agencies to do away with the concept of registration on a state level and to have it be institutionally oriented. That sector seems to be again rising that some of the people presently in the delivery of nursing of healthcare, in general, but we trust that we will be able to see to it that throughout the United States nurses are continued to be registered. And that is a function of the state based upon the Constitution of the United States, which gives to the states the responsibility for the health and welfare of their citizens.

The here -- Alumnae Association here was very very active in making sure that its members became registered when the registration process was opened up. We do not pay so much attention to it now as nurses become eligible for registration, it generally is a function of the institution where they're working to see to it that they have the right credentials. But we did start -- the association was involved in that.

Another thing that the association has always been interested in, is education of nurses, that is furthering the education of nurses. In 1921, they established a scholarship loan fund which made it possible for, with proper backing, to borrow up to five hundred dollars to help nurses who wanted to further their education. I don't have the exact date when our current two scholarship funds were founded. One is called the Edith G. Ryan Scholarship Fund which is named for and in honor of a nurse who was a -- her title now would be the Assistant Director in charge of the Semi-Private Pavilion. She was a -- worked here at Mount Sinai all of her professional life. She started the concept of semi-private care prior to the development of the building which has now been torn down was

called Hausman. Prior to the development of that there were just really two kinds of patients, they were either private patients or ward patients. But then along about 1927, or '32, somewhere in that time, there was a movement toward identifying this other class of people who were semi-private and give them facilities. So Miss Ryan was in charge of that building all -- all of it's life practically. When she died the Alumnae Association created a scholarship fund in her name. Going on, when another very beloved nurse in our association died her friends and classmates and her husband formed another scholarship fund which is called the Joan Herman Bilder Fund.

As a result of these funds and the monies that we receive, not all the monies that have been put to good investments but also currently continue to receive, we are able to give approximately four or five scholarships each year to nurses who are working towards higher degrees. In the beginning when we started all of this scholarship business, obviously the goal was for nurses who were graduates of the diploma program to work towards their bachelors. Nowadays, most -- many of our people who apply for the scholarship funds are working towards their masters and indeed for their doctorate. Which is a -- shows that the change in the educational preparation of people. These scholarships are -- may range from five hundred to two –- two thousand dollars usually each year. Depends upon how the market is and how our monies are. How much money we have to give out. We do not keep it. If we have it, we give it out. And then, we expect to earn it again for the coming year. The scholarship fund then is another thing that is very important as far as the Alumnae Association is concerned.

We formed a foundation, along with most every other association that forms a foundation, a 5-0-1 3C.

I think it is. We formed that, at the time, when it was the appropriate thing to do, I don't have the exact dates, but those, the foundation is where we have our money for the Scholarship Fund and for the Friendship Fund because foundations according to the IRS rules are supposed to be concerned with education, philanthropy, social service, and research. And so, all those monies are organized under the foundation, so we do actually have two associations running side-by-side. The Foundation of the Alumnae Association of Mount Sinai Hospital School of Nursing, as well as, the Alumnae Association. The Alumnae Association per-say takes care of the more mundane things about keeping our membership records straight, keeping correspondence, collecting the dues, and we do hire two people in our office to help us with these things.

[Tape 3, Side B]

SB: Okay. Tell me about the bookkeeper. Alumnae associations are primarily volunteer organizations. The officers are volunteer; they do not get any pay. As we grew in membership and as we grew in activities, such as trying to keep the Pension Fund going and trying to keep all these other things going, it became abundantly clear that we could not really expect the volunteer officers to do all the work that had to be done. And so long back in the early -- middle 40s, I think it was, possibly after the Second World War, no, I guess it was before the Second World War, but somewhere in the 40s, we hired one person who was identified as the Executive Secretary. That worked out very well for a number of years, the one person to manage the affairs with the help of the officers. However, with our increasing investments and with the rules and regulations of the IRS

and all of the other agencies that we have to be responsible for, it became clear that we needed a bookkeeper, somebody who really knew something about managing the financial aspects of this.

So, that we did hire a bookkeeper. Generally speaking, that bookkeeper has always worked about two or three days a week. The job is detailed, as only bookkeeping jobs can be, and it does represent the management of a good deal of money, but it is manageable on a part-time basis. We've actually had three professional bookkeepers and one of our members who was able to carry out the work of bookkeeper for a period of time.

The first bookkeeper was a very fine, retired gentleman by the name of Henry Bultman. He really represented what you think about as good, old fashioned bookkeepers. He wore a cap over his eyes and the whole works. He was a gentleman worker and he was a delight to work with.

Following him one of our members took over the work for a few years and then we hired a part-time bookkeeper by the name of Laura Gilberty. She, too, was a retiree - this is a fine job for retirees. They want to get a little extra money and we don't want to pay a whole lot of money and we want somebody who knows the work and so this has worked out very well. We were very, very happy with Laura for a period of about nine years, she worked for us. I had the privilege of hiring her. Unfortunately, Laura died very suddenly this past spring, Easter week. She was found dead in her apartment. It was a great loss to us.

And so, once again we reverted to volunteer work. Judy Scher, who was the Secretary and I took over the management of this whole bookkeeping business from the beginning of April until the end of May. We were able to hire another part-time bookkeeper. That experience that Judy and I had of managing the books was made easier by the very fine work that Laura had done. I mean the books were in perfect order and it was just, we just had to kind of go back and see 'what did Laura do with this' and you knew what to do. So we did pretty well. Although neither of us had had any particular training in bookkeeping. And we were very happy to be able to find another part-time bookkeeper. Her name is Ann Taberna and she is a jewel. She is just absolutely one of the best people I've ever seen to work with.

We have just gone through our audit - we do have an audit every year - and we have just gone through our audit with flying colors. Even with Laura's death, with Judy and me taking over and with Ann to put it all together, we did very well this year with our audit and our auditors are very pleased with what they found.

As far as an executive secretary is concerned, when we decided to hire the executive secretary, the first one was one of our own graduates, Elizabeth Rattigan. She served for a good many years. She was followed by a non nurse, a non-graduate, by the name of Donna Butler. Donna Butler was a very fine lady. Her background was with the Metropolitan Museum of Art [laughs]. She was a very, very smart woman and a very gentle kind of person.

When you are hiring an executive secretary for an organization like this, you really do have to be sure that you are finding somebody who has some good social skills and who can answer the phone and answer some pretty seemingly dumb questions with a degree of grace and to make the members feel that she is very, very interested. Donna worked for us for a number of years. I think maybe she worked for us the longest of any of our executive secretaries. But, she, of course, time came when she was unable to work any longer.

She was followed by Peggy Wolfe, who worked for us for about three or four years. And then she was followed by Mrs. Verdel Mann, who has just retired. Verdel reached her 65th birthday in April and she decided that it was time to retire. And so, she has just retired and presently our executive secretary is Marie Tatai. We are trying out for her to be a four day a week worker. We're not sure; we have to see whether we can manage. We need to be prudent in our use of money. And so, if we can manage this organization with two part-time workers, by scheduling their time so that there is full coverage, it makes sense. And so right now, we're doing that. I don't know how long that is going to last and whether it is going to be possible to do it that way. But we will try.

The Alumni News is another important activity of the Alumnae Association. It was first published in 1910 and in the beginning it was published monthly. And it has been published monthly until around the Second World War. Then it has been published since that time either three or four times a year. The editor of the Alumni News continues to be a member of our association. Presently Marjorie Lewis is that editor. She is greatly assisted by the executive secretary. All the typing, for instance, is now done by the executive secretary. And much of the putting together of the news items from the correspondence that we get, that's how the information is pulled together for the Alumni News.

This past year Marjorie came up with the idea of our publishing a supplement to the Alumni News, which would detail some of the activities of the Alumnae Association over the years. So, a committee of us, this is really -- to augment what is in the 4700 book, which we published at the time of the 100th anniversary. The contents of these supplements are derived from what has been published in the News over the years as well as going back to the minutes of the organization prior to the News. We could start with the 1910 News to get information, but prior to that we had to go back into the minutes. This supplement has been divided into currently, it's in three parts. The first part is called the "Overview," which related the time from 1894-1994. And it covered much of the things that I have talked about previously that the Association had done over the years. One of the things that I have forgot to mention is the Oaks, and I must go back to that, but I want to finish on this right now.

The second issue, part of this supplement was Part Two and Three. Part Two we called "Shining Stars". This is the one, the section that I wrote for this supplement, and what I did was to go through and try to find the names of people in our association who had been noteworthy in their various accomplishments. Now, it's important for people to recognize that the "Shining Stars" may not include every graduate from our school who has made a mark for herself. My source was what was published in the News. If somebody did something and didn't tell us about it, there is no way for it to get into this

supplement call “Shining Stars”. [laughs] But, at any rate, it was a very fascinating thing and people enjoyed it very much.

It not only included graduates of our school who were identified as “Shining Stars”, but also there was a section, which we called “Shining stars from another galaxy”, the non-alumnae. This honored: Mrs. Klingenstein, who willed us the Oaks; Mrs. Butler, whom I have mentioned; Mae Karon, who was a very fine lay woman who always took care of us a great deal; and then our Directors of Nursing, because, in the modern era, there has been no Director of Nursing who was a graduate of our school. Back in the beginning, there were two graduates of our school who were Directors of Nursing. But in what I call the modern era, in my lifetime [laughs], we’ve had Miss Warman, Mrs. Cutler, Mrs. Kinsella and Gail Weissman. So, we have always recognized them as a very important part of our association and indeed, Miss Warman and Gail Weissman were made honorary members of our Association.

The third part of this publication, and oh, along with the “Shining Stars”, in that supplement, we also detailed the development of the Pension Fund, the whole history of the Pension Fund.

The third section dealt with private duty and the battle for the eight hour day, and a section that we called “Mount Sinai Nurses Know how to Celebrate,” different kinds of parties that were recorded in the News. The next issue -- the last issue of the News we did not have a supplement in because it was the News that covered our annual meeting and all the annual reports and so it was kind of fat. The next issue is about to come out and it will have nurses in the service, the military service. And there’s one other section. I’ve forgotten. Anyhow, it is coming out soon and we will have that.

I think that anybody who ever listens to these tapes should be referred to the Alumni News in 1994 and 95 for information to augment some of the things that I have tried to tell about.

RS: You wanted to talk about “The Oaks”.

SB: Oh, yes, we must talk about “The Oaks”. “The Oaks” became ours in 1947 as a result of the will of Magdalene Klingenstein. Mrs. Magdalene Klingenstein was a fascinating woman. She and her husband were both, well, I think Mrs. Klingenstein was on the Auxiliary because I think in those early days, women did not get on the Board of Trustees. I think they do have a woman now and one of them is a graduate of our School, Catherine Vance Gaisman. But, Mrs. Klingenstein -- her husband was a Board of Trustees member. They are the people for whom the maternity building on Fifth Avenue is named and they gave a great deal of money for that. They were big benefactors to the Mount Sinai Hospital.

Mrs. Klingenstein was always very interested in nurses. When I was a student nurse I can remember that she came in and volunteered in the pediatric clinic. Now, Mrs. Klingenstein, true to the times, really paid more attention to the doctors than she did to the nurses. And every time that she came into the clinic – she came in once a week – and every time that she came into the clinic, she brought a huge cake for the doctors.

Now, if the doctors didn't eat it all up, we nurses were privileged to have, shall I say, the crumbs [laughter].

Anyhow, Mrs. Klingenstein did finally mend her ways a little bit toward nurses. She had this property up in New Rochelle, on Davenport Neck, which is called "The Oaks". In her will she willed it to the Alumnae Association, along with money in the amount of $300,000. Her will is pretty specific about what we were supposed to do with this. This is supposed to be a vacation and rest home. It was supposed to be made available to nurses and to the employees of the Mount Sinai Hospital. And also, because we were in New Rochelle and we were interested to get good tax abatement, we made it available to the nurses of the New Rochelle Hospital. Therefore, our taxes in New Rochelle are minimal.

The early days of this and the dream that Mrs. Klingenstein had for "The Oaks", was very sound. In 1947 people didn't go romping off to London for a week. If you had a week off, you needed a place to go that was cheap and pleasant and accessible. There's a bye [?]. Bye the bye, I never went to Europe until 1963. That really does indicate a little bit about the difference between today. Now kids are going to Europe on their high school junkets, but in those days when Mrs. Klingenstein dreamed of this place, she saw it as an available spot for people to take some time off. And, indeed, that is the way that it worked in the beginning. As the needs have changed, the use of it has diminished to some degree. We are presently looking at the usage in order to identify what to do.

The buildings are interesting buildings. They are typical mansion type buildings. The fact of the matter is, the two of them – they are called the Red House and the White House – the Red House was at one time a school for girls. And it is alleged that Katherine Cornell was one of the students at that school. At some point of time in their lives, the Klingensteins acquired this property and they used it as their own vacation spot. And they rented out the White House to other people, mainly to doctors.

We have run it ever since we got it. And a committee, as identified in her will – she was pretty specific about how this was to be used and how it was to be maintained. And she made provisions in her will for this operating committee that would be responsible for making it run. The committee is made up of members of the Association, non-members who are interested in us and who want to do something with us, and the Vice President for Nursing is on the committee. The Vice President for Nursing at New Rochelle is on the committee. It's made up people who have an interest in the committee –- in the property.

The usage in the beginning was primarily given to nurses and to professional employees of the Hospital. By that I mean clerical staff and social workers. As time has gone on and as time has changed -- times have changed, society has changed, we now identified that anyone who has an ID card from the institution is welcome. Their entry to use it must be their ID card. And this means that that's anyone. It doesn't matter who it is; there is no distinction as to who can come.

"The Oaks" can accommodate approximately 25 overnight guests. Over the years we have had to change - again, because of the demands, what people want - we started out

with full-fledged, well, you could almost call it, in today's world, a bed and breakfast. We started out with a full-fledged institution whereby people could come, get three meals a day and stay as long as they want to, so long as they are willing to pay. Nowadays, we have cut back a great deal on the food service, because we do not have the overnight guests to support our spending money to keep a cook on hand who is cooking for nobody.

But we have had to make many, many changes over the years, based upon the needs. And I don't think it has anything to do with the fact that "The Oaks" is not nice and that, but it is just the fact the people can spend their money with the new cars and the new transportation systems, they can go to much more exotic places. They don't really feel the need to go to New Rochelle.

One of the things that "The Oaks" does serve as a very good resource to the Mount Sinai family. Some of the doctors, when they have their divisional picnics in the summertime for their whole departments, they come to "The Oaks" for those picnics. And we also have nice facilities for weddings. People like to have weddings there. It's a pretty nice expanse of land, and even if the wedding is too big for the -- to be accommodated in the two houses, you can put up a tent and so people use it for that purpose. And then the weekend usage by nurses and employees is pretty good. They go up for the day, it's what we call day guests. And they pay a small fee. That was part of the will. We are not supposed to try to make money on this; you just pay a small fee. Primarily, that helps, of course, but it's also important for people to feel that they are paying for something. What they get, if they pay for it, they're a little more appreciative and careful about what they are being offered.

The money, the $300,000, has been invested and it has grown under our aegis. It's more than double that amount now. It's my understanding, from a reading of the will, that if we ever give up running "The Oaks," Mount Sinai becomes the recipient of that money. We keep the property, the money is ours. If we were to sell it, say, for instance, the income from that sale would be ours. This money, $300,000 is not ours. It is only ours to use the income from as long as we maintain "The Oaks".

What we're going to do with "The Oaks" in years to come is a question. If, as I've indicated by just even mentioning Katherine Cornell, gives an idea that these are not new buildings. And anybody who owns old buildings knows, the maintenance of old buildings is a very, very expensive proposition and it is an ongoing proposition.

In addition to that, we are on the [Long Island] Sound, and these wonderful nor'easters that we have along the Sound do us in. And do a great deal of damage. The big northeaster in what, 1992 or 3, the water came up and ran through the basements of both houses. It did horrible damage, not only to the underpinnings of the houses, that we had to have redone, but also to the lawns. I mean, salt water on nice green lawns is not recommended. So that we are constantly struggling to maintain these buildings in any kind of usable condition.

So, I'm sure that the decision of forthcoming Boards of Directors of our Alumnae Association are going to have to be what to do with "The Oaks". In fact of the matter is, we presently have formed a committee to evaluate and to come up with some

recommendations. I have been appointed as the person to convene that committee. It will meet after the first of the year [laughs].

We spoke about Alumnae Association relationships to the New York County's Registered Nurses Association and to the State association, and I think it is kind of important for us to recognize that two members of our association have been presidents of the New York State Nurses Association. Clare Casey and Elaine Belitz were both presidents of the New York State Nurses Association. To the best of my knowledge, following the -- having Miss Greenthal as the treasurer of the New York County's registered nurses association, I am not aware of anyone in our alumnae who have held leadership roles. Many of us have been members of the board of Directors, and committee chairpersons of the New York County's Registered Nurse Association, but to the best of my knowledge, nobody's been president, and nobody's been treasurer or anything like that. But I do think that is an important thing for us to keep in mind that the relationship between the alumnae association and the District association and State associations continue to be maintained.

One of the things that this opportunity to talk, in terms of history, is linked to, is the work that we have done in our Association in maintaining archives. Over the years the Association had collected a great many things and each time that we had to move our office because - the Hospital has always been very generous about giving us office space. However, it is contingent on the many changes that take place in the institution itself. So, we are frequently moved from one place to another. Last year I think perhaps was the banner year for moves. I think we had to move three times. But, we hope and pray that we are settled down for a little while in our present location. But for many times when we had to move, we had to be responsible for moving all these archival things. So, while I was president I made some suggestions to the Board of Directors that we needed to look at how we were storing these archives and were we doing it in the best possible way. We had tried. We had an active archival committee. We bought all kinds of file folders and things, advised by the Archivist at the Hospital. But the rooms that we were given to live in were certainly not conducive to the best storage of this material.

So, I asked that the Board of Directors give some thought as to what we could do with our archives. And I gave them some ideas. I suggested that they could be turned over to nursing archival -- archivists. There are two collections that I knew of that were pretty good, one in Boston and one in Philadelphia. And I suggested that that was a possibility. The Teachers College has an excellent archival collection and I mentioned that as being a possibility. New York State Nurses Association, the Foundation of the New York State Nurses Association, has a fine archival collection; I mentioned this. And I knew, because I had been working with Barbara Niss, I knew that we had the facilities here at Mount Sinai for that.

The Board took all of this under deliberation and invited Barbara Niss to come talk to us about what her dreams were and what she was trying to do. I mentioned her because she was the first archivist that Sinai ever had, as a real archivist. Dr. [Albert] Lyons had done a great deal of work in this field, but he was not a professional archivist. So, anyhow, the Board decided that they would be happy to accept the invitation of the Mount Sinai Archivist to take care of our 'stuff'.

So, since that time, each time we moved [laughs] we divested ourselves of some more 'stuff', and I think that we have a pretty good working relationship with the Archivist. We were interested in making sure that access to the stuff would be available at any time and that proper recognition would be given to our materials if they were used in displays and so forth, so that we would not just die out, but be recognized. And, I think that the decision that the Board made was a good one and I am delighted that we've been able to get these archives under some kind of professional care. Which, I must admit, try as hard as we would as an alumnae association of volunteers, we were not terribly professional in the way we were doing it.

So, I think the Archives are an important legacy that the Association has made to the institution. It seems to me like it is a good -- a good move.

RS: Well, we appreciate your continuing support.

SB: We will continue to try to see to it that you get things. I don't know if there comes a time when you feel like you are not getting something, the Archivist ought to have the privilege of saying, 'Hey, whatcha got lately?' [laughs] People do continue to send us some things. And when they come, at the present time, we do not have an archives committee. We are redoing our policies and procedures and we are recommending to the Board that we just name one individual as the Association's Archivist who would have an liaison with the Medical Center Archivist, rather than trying to deal with a committee. This does mean a bylaws change, but that is something that will probably come about. And there will be one person, beside the Executive Director, who is the one who gets the mail in, as to look up the stuff and decide what needs to be done.

I think that those are the things that I had jotted down as being important for us to mention in terms of the Alumnae Association.

RS: OK. Perhaps the next time you can talk about your observations of how nursing has changed over the last few years.

SB: All right. I will think about that.

RS: We'll appreciate that.

SB: There'll be many memories.

RS: Okay good. We'll look forward to that. Thanks very much.

SB: That'll be fun; I will think about that.

RS: [unclear].

SB: Yes. That's next!

[Tape 4, Side A]

RS: This is Richard Steele, Archivist for the Mount Sinai Medical Center in New York. Today is Wednesday, December 13th, and today we will have the fourth in our series of interviews with Sylvia Barker.

[Tape off/on]

SB: Well, it was just so cold I thought I would have to have coffee.

RS: Sure. Sylvia, it's nice to have you back.

SB: Thank you. Good being here.

RS: Well, good, thank you. I'm looking forward to hearing what you have to say. Today we're going to talk a little bit -- or you're going to talk, rather -- about your observations in how nursing has changed during the time that you've been here. I see you've brought a list with you of different things that you want to discuss, so I guess I'll just leave it to you to kind of discuss them in whatever order you'd like about the things that changed in regards to, say, practice, training and conditions, that you found to be most significant. So, whenever you're ready to start, go right ahead.

SB: Well, thank you for having me. This continues to be an interesting experience.

RS: Well, we're glad.

SB: I've been telling folks that this is what I've been doing, and I had a party last Friday night and had forty-one guests.

RS: Wow.

SB: And so I was discussing this with some people, and one of the ladies is a professor at Hunter. She wants to know what is going to happen to all of this, and she wants it published.

RS: Okay.

SB: [laughs]

RS: I'll have to talk to her!

SB: I thought I'd have to tell you about that.

RS: Sure. Good.

SB: But she was terribly excited about this –

RS: Great!

SB: The whole idea, and the opportunity that this supported.

RS: Who is that person?

SB: Her name is Elizabeth Barrett. She used to work here, at Sinai. She is a researcher. She now has her doctorate, and she, as I say, is a professor down at Hunter. At the convention, this last fall, she was awarded the highest honor for research that our association gives, and she will be making a speech at the next convention. That's the way they do it. She's a very interesting woman, and I really treasure her friendship. I was glad she was able to get to the party.

RS: Yes. It seems reciprocal.

SB: Yes. [laughs]

RS: What we'll do is we'll send her a copy of the transcript, and I'll get in touch with her and we'll see what we can do. These observations that you have are wonderful, and you do this so well.

SB: Well, she was really very excited about it.

RS: Sure. Great.

SB: Yes. I've been thinking since we last met about some of the things that I would like to try to recall. I'm afraid that my notes are not very organized, so this may be sort of a bit miss – approach. But, I'll try to make some sort of sense out of it.

I guess the first thing that strikes most of us, and that I've been concerned about is the change in how long patients stay in the hospital. This business about length of stay, which has been such a big issue under the DRGs and under the new reimbursement plans and so forth, and the changes that this has made in how we need to approach our patients and what the nurses need to do for patients.

When I was a student, and we have to realize that I was a student from 1933 to 1936 -- and then I continued to work as staff nurse and head nurse and so forth, on through the years. Take, for instance, a cataract operation. Now, today you hear on television, if you come to the center, you bring somebody with you, and you go home in a few hours. And that's the way it's done today. In the early days of my experience with patients having cataract operations, they were in the hospital about ten days. And for the first twenty-four or forty-eight hours, they were not allowed to move or do anything for themselves. And, in fact, we hired private duty nurses to sit at their bedsides, and we put sand bags beside their heads so that they couldn't move.

The difference in what we're doing today and the knowledge and the technology of some of the things that have struck me about the changes in nursing, because here we were, babying those patients. We wouldn't let them do a thing for themselves.

And now they get up and walk out of the front door, and the only precaution that we ask is that they bring somebody with them so that they will be guided, I guess, and not in harms way. Now, the cataract is obviously – we've learned a lot. The surgeons have learned a lot. We learned a lot about how to take care of the patients. And when they go home, they are pretty self-sufficient.

But now let's take abdominal surgery. Abdominal surgery in the good old days, when I first knew about it [laughs] -- the patient was kept in bed for approximately ten days. I'm talking about [unclear], appendectomies, GYN surgery – surgery female -- things like fibroids and things like that. These patients were kept in bed for about ten days. On the eleventh day, we allowed them to sit up. We called it dangling.

They could put their feet over the edge of the bed and dangle, on the eleventh day. On the twelfth day, we got them out in a chair, and they could sit at the bedside. And on the thirteenth day, we let them walk around a little bit. And by that time -- the fourteenth day -- they probably were ready to go home. A lot of things, I think, happened to those patients, some good and some bad. If they were kept too still and we didn't know about making them breathe and so forth, they tended to get respiratory infections. Sometimes they got vascular [unclear] or something like that. But one of the things that I think was positive about that period of time in the hospital was that they had a chance to get over the affects of the anesthesia.

I seem to have had a crusade -- and I don't think I've done much good with it – it's a crusade within myself and with other people. I think that today, where we let patients go home after surgery with anesthesia, like the laparoscopic surgery for gall bladders, the patients don't have a chance to get over the effects of the anesthesia. And I think that this is doing them a disservice. I think that we, in America, think that if we can get up and run around, we're all okay.

So, allowing people to walk out of the hospital gives them a false sense of recovery. And what they haven't recovered from is the effect of anesthesia. And I think our teaching of patients -- both doctors and nurses -- is lacking in helping them to understand that the anesthesia is the real assault on the body, and you don't get over it as quickly as you may be able to recover your ability to walk around and to wash yourself and to take care of yourself. Well, that's my crusade.

Those are the things that bother me about this change in people being allowed to get up and -- you know, now you have abdominal surgery, and they get you out of bed the very next day. And you're supposed to do for yourself, you're supposed to take care of yourself, wash yourself and so forth.

Which may be a good segue into something about the care that patients used to receive. When they were in these beds, we, as nurses, gave them a back rub twice a day. They got their back washed with soap and water and then rubbed with alcohol and some nice powder, in order to take care of their skin so that they would not have any kind of breakdown or -- and also to give them some comfort.

We had routines that we taught when I was teaching nursing -- we taught the nurses how to do what we called AM care and PM care. Now, AM care consisted of – excuse me -- washing of face and hands, washing of the genitalia, and washing of the back. That was AM care. PM care -- they got a back rub, and maybe they got their back washed if they needed it. But mostly it was a back rub. And, of course, the bed was made very, very snug, so that there weren't any wrinkles. But we did this for the patients.

If, toward the end of their stay -- post-surgery -- we might give them the basin on the table and let them wash their face and hands, but we still washed their back and their legs. And I remember in 1951, when I was hospitalized after an automobile accident in which I suffered a number of fractures of the shoulder and ribs and so forth -- I was very grateful to have the nurse who came and washed me, and the fact of the matter is, I sort of judged them by their ability to give me a bath. When the nurse would really let me put my feet in the water, I felt like I had really had a good bath.

But those were some of the things that we did for patients that nowadays patients complain about, when patients feel that they're not getting it. And they're not. Unfortunately, it's a rare patient that really gets this kind of back rub every day and the bath -- help with the bath. They may be given a basin of water and that's it. Those changes are subsumed under the title of self-care. The idea is that the patient ought to learn to be independent, and that they ought to learn how to take care of themselves. And I sometimes think that it's been over-done, that many patients really need the opportunity to have the care -- the hands-on care -- the real chance to rub a patients back, to wash their feet, to give them the chance to put their feet in a basin of water -- is something that I think we have lost.

However, I'm encouraged because one of my friends has recently been a patient in another hospital, and she was telling me about the kind of bath that she received, which is unique. It consists of seven wash rags impregnated with a substance made from aloe, and heated in a microwave -- in a plastic bag in a microwave -- and the nurse brought this package of wash rags to the bedside, and she used the seven cloths. And if you stopped to think, that's probably one for the face, one for the arms, one for the back, one for the front, one for the feet and one for the genitalia. But my friend said that it was a wonderful bath, that it was very refreshing. And, of course, being a nurse, she also evaluated it from the point of view that the nurse didn't have to carry a pan of water, didn't have to worry about slipping, falling, spilling, or anything like that. And this was a whole new technique for giving a bath. I think other hospitals ought to try this.

It really sounds quite exciting and really is an opportunity for us to look at new technologies.

Certainly, when we were students, we didn't have microwaves. That brings me to talking a little bit about new technologies, and some of the things that have occurred to me that I've been thinking about technologies. Being as I spent a lot of my time taking care of children, having taught for about five years, and having supervised for about fifteen, a lot of my examples of things are going always to relate to the care of children.

We have today, in our nurseries and in our premature nurseries, very sophisticated plastic devices which are called Isolettes. And they are kept warm by electrical connections. They provide an opportunity to give oxygen in a way that the baby needs it. We know now that too much oxygen is not good for premature infants. That's one of the reasons that some of them, in the early days, got blindness, is because we used too much oxygen. During my lifetime in nursing, I saw the development of those devices called isolates or incubators. There was a company called Gordan Armstrong that developed them, and then this Isolette® company from Hasborough, Pennsylvania.

But the first of these, actually, at my design -- the engineers here, at Sinai, made. And it looked a little bit like an orange crate [laughs] but a little more sophisticated. Because our engineers here, at Sinai -- carpenters -- many of them have always been fantastic with their ability to make things. And what we did was to design, based upon some of the published works at the time, a prototype of what ultimately Gordon Armstrong did make into a commercially made incubator.

The whole idea was that it was a box. You can't call it anything else but a box. [laughs] It was a box. But it had a division at the head in which we placed a bulb -- an electric bulb -- which was the source of the heat. And, of course, we put a cushion or a pillow in the bottom -- a mattress for the baby. We wrapped the baby up. I actually made some little garments for the babies, so that they would be properly kept warm. And this was one of the first things that we had, over and above the old-fashioned way of keeping the baby warm with hot water bottles, which was not necessarily done in hospitals. This was done at home. The old midwives used hot water bottles around the babies to provide the heat that they needed. So that was what we had in the beginning. But then, with the introduction of good electrical bulbs, and so forth, we were able to bring heat into these various kinds of cabinets. That's just kind of an example of our technology as it improved over the years.

We see today on patients, all kinds of pumps. There's the pumps that give intravenous fluids, there's the pump that have to drain out wounds. Almost all of them are electrically energized, I guess is the word to use. [laughs]

And they are really very sophisticated. They've even got computers in them now that you can set the buttons to deliver the amount of fluid that you want. We didn't have -- in the beginning -- these are pretty new, and we didn't have those in the beginning.

But one of the pumps that I was thinking about was the one that was called the Wangensteen suction. Now, Wangensteen designed this suction to drain wounds. This was a way. And it actually was a water kind of suction, which was created by having a bottle of water -- one higher than the other -- and the flow of the water from one to the other, was what created the suction. Here, again, our engineers, at the behest of some of us doctors and nurses, created a little wagon -- a little wooden wagon -- that we could put these bottles on with one higher than the other. And then you had to watch them and you reversed them in order to keep the suction going. This was a very primitive kind of thing, but it really did work.

And now, it's of course, been taken over by different things which are called sump [?] pumps and all different kinds of pumps that we have today. But that Wangensteen device that we created here, at Sinai -- these little -- the men in the engineering department painted the wagons green. I have no idea why they were green. [laughter] I guess maybe it was the paint they had on hand. But they created these wagons for us, and we were able to develop this suction for the patients.

Some other differences in techniques and technology -- I guess we could talk about the use of the stethoscope. Now, the stethoscope was invented – there's been a lot written about that in all the medical literature. Somebody listened through a long tube, and discovered that this could improve their listening skills.

When I was first a student and for many, many years the stethoscope was something that was the private property of the doctor. Doctors used stethoscopes. Nurses didn't use stethoscopes; doctors used stethoscopes. And they used them for whatever it was that they wanted to do. They used them to listen to heart sounds, and they used them to listen to blood pressures because in the early days, the doctors were the people who took the blood pressures, nurses didn't take blood pressures. Nowadays, for whatever reason, and I guess you could conjecture the reasons -- some of them, I think, are because doctors were getting to know more things and had to have greater skills, and they found they were willing to give up some of the tasks that they had been given. The same is true of taking of the temperature, for instance. In the beginning, the first mercury temperature taking was always done by the doctor. Then the nurses began to use temperature thermometers -- the mercury kind of thermometers. Now -- The other day I had to come into the emergency room and they took my temperature with a computerized thing that they stuck in my ear. There were lots of little funny sounds, and all of a sudden, there was my temperature on a display thing -- LCD, are they called?

So, we have these differences in techniques that have come about. But the change in what the nurse does has come about not only with different kinds of technology, but also with the change in what the doctor is doing and with what the doctor was willing to give up.

A case in point is intra-muscular injections of medication. Now, in the beginning of our nursing practice, we were taught how to give hypodermics. Now, a hypodermic was given with a little needle about a half or three- quarters of an inch long, and therefore, you couldn't make a very deep injection because you only had that length of needle.

Ultimately, the intra-muscular injection became the province of the nurse. In the beginning, it was the province of the doctor. Nurses could only give hypodermics, and doctors gave intra-musculars. What brought about that change? Primarily, the sulfa drugs, because the sulfa drugs, and then, ultimately, penicillin, came on the market. They had to be given frequently, usually on a two to four hour schedule, which was twenty-four hours a day. Now, who was around to do this? The nurse. The doctors were most unhappy about having to get up in the middle of the night and give these injections. [laughter]

And so, they finally were willing to give up this task of giving injections by intra-muscular to the nurse. It was interesting, because we had never taught the nurses how to give intra-muscular injections. So, when the Medical Board here at Mount Sinai, finally agreed that nurses were going to give intra-muscular injections, those of us who were teaching at that time not only had to learn how to give the intra-muscular injections, but then we had to teach all of our students who had never been previously taught, and all the nurses who had never been previously taught.

Which may be the beginning of some in-service education. But the taking of blood pressures was another example of something that the doctors really found they didn't have the time for, because they had other more sophisticated things to do, new technologies, new knowledges were being introduced, and the nurse was the person who was at hand. The nurse was always around. She was there twenty-four hours a day. And so, she was empowered to give these things. I think it's interesting.

I made mention of when the Medical Board decided --. The Medical Board here at Sinai, has always had a fairly strong control over what particular procedures the nurse could do. There were -- in the beginning, when we took over the giving of intra-muscular injection, they made out lists of drugs that the nurses could give by intra-muscular injection, and as I have mentioned, they were primarily the sulfa drugs and penicillins. When I was teaching, I was most distressed by the list because we couldn't keep up with the list. With the new technologies that came and the new drugs that came, if you tried to tell the nurse that she could only give what was on the list and then some new drug came along, and the doctor ordered it and wanted her to give it, you put the doctor and nurse in a two-way kind of conflict.

So finally, we recommended to the Medical Board that if the doctor ordered the drug to be given by intra-muscular injection, and if the pharmacy -- the literature that came with that drug -- indicated that it was appropriate to give it by intra-muscular injection, the nurse could give it. The nurse did not have to have a whole big list. So, we finally got rid of that list, which now -- today – it is if the order is properly executed on the patient's chart, then the nurse is empowered to do it. These were cooperative ventures that our Directors of Nursing were able to bring forward to the Medical Board, and to get them to approve of a certain practices.

This was over and above, of course, the practice that the licensure law gives. An interpretation -- I guess I shouldn't say over and above. I guess it's better an interpretation of what the licensure laws provide. We moved down into intravenous work. The Attorney General -- and I'll have to look that date up; I didn't look it up the other day. But the Attorney General of the State of New York -- finally, at the behest of both the Medical Society of the State of New York and the Nursing Association of the State of New York, made a ruling about nurses and intravenous therapy. And they indicated that nurses could give drugs intravenously if they had been properly trained. And the important thing that the nurses -- that the institution -- was supposed to be able to show was that the nurse had been properly prepared to do this. Now we have -- even today, we have some licensed practical nurses being permitted to perform certain intravenous procedures. And all of this has come through -- by interpretation from the Attorney General and from the State Education Department.

So now, here at Sinai, we have a group of nurses who – it's a small group now; it used to be a larger group. But we still do have some nurses who are a part of what's known as the IV Team, as opposed to the doctor always being the one who had to do the IV's. And an interesting distinction is made between IV administration of fluids and drugs by IV versus taking of blood. Now, taking of blood, an intravenous injection, inject -- intravenous puncture to remove blood can be done by a technician. It does not have to be a professional -- either doctor or nurse. But the difference in what you do after that -- whether you give something or not -- and the giving is a professional activity, which continues for the most part, I think, to be allowed. The Pharmacy and Therapeutics Committee here at Sinai does have in the formulary a whole listing of people who are allowed to give certain types of things. Mainly the active drugs and so forth. But this, again, is part of the Medical Board control over practice here, at Mount Sinai, which I'm not in any way disagreeing with. I think that it is a good arrangement for us to continue to work cooperatively between nursing and the Medical Board.

Some other things about technology. I was thinking about the administration of oxygen. We started out, when I first was involved in nursing, we had what was called an oxygen tent. Now, that oxygen tent was a creation of the devil, I think.

It was -- consisted of a plastic kind of hood that went over usually about half of the bed. The patient was ensconced -- his head and shoulders, down onto his chest -- was ensconced in this plastic thing. It was the clear plastic that you could see through it. The oxygen was cooled by being run over ice. And that's the part that was the devilish part about it because we, as nurses, had to keep this ice tank full of ice. The ice was delivered to us on the unit in a refrigerated wagon kind of thing, and it was supposed to be chopped up. But it sometimes wasn't. So, then we had to chop it. And then the tank -- the chest -- attached to the tent became empty. It was our job to see to it that the ice was replaced. Now, of course, ice melts, and so there had to be an outlet for the water, which was supposed to be in a pail. Which, of course, had to be emptied from time to time or it over-flowed. The bane of student nurses' existence was the filling of those ice chests and the draining away of the water and the subsequent having to mop up the floor if, by chance, the thing over-flowed before you got to empty it.

This continued to be a practice for many years, until we are now much more likely to administer oxygen through masks or through tubes and through nasal oxygen. And it seems to work just as well and it sure has gotten rid of the floods that we used to have to deal with for the patients. To say nothing of the fact that I think the patients must have had a terrible sense of claustrophobia, being enclosed in those things.

Of course, if you didn't keep the ice replenished, they got very warm, and this was not good for the patients. So, I think that oxygen therapy and the techniques that are involved are an example of new technologies. It's also interesting that we, as nurses, were the ones who administered this stuff in the early days and now we have a whole group of technicians who are called respiratory therapists, who do all of this plus a good many more things that we didn't even know about or think about at the time.

There's been a fair amount of consternation on the part of some nurses as to whether we were giving up things which we ought not to have given up to other people -- other technicians or other trained people. And when you give up what it is that you are doing with your time, and this, of course, is a whole other subject, in terms of the mix of staff on units today.

But I do think that one of the things that the nurses have hung on to, or should have hung on to, and -- which we are seeing in the literature more and more -- is the teaching of the patients. The preparation for the patient -- we mentioned a few minutes ago that patients go home much sooner. But what has happened to what happened to the patient when they were in the hospital? Of late we've seen newspapers -- a good deal of fuss about how soon a mother goes home after a baby is born. And some of the insurance companies are worried about length of stay, and how much they're going to pay. And even over in New Jersey, I think, they just had some legislator -- legislation to make sure that the mothers are allowed to stay in the hospital at least two days after they've had their baby.

Well, what happened -- I was reading and also talking with some friends. Now the insurance companies have gotten a little bit of sense, and they are providing for nurses to, in some way, visit these mothers who are going home early, to find out how things are going. Which seems to me a very fine and logical use of nurses' skills to be able to visit the mother to make sure that she knows how to handle her baby, particularly first time mothers. And to be able to answer the questions that arise in the young parents household when they get a new baby in their home.

Much of this teaching we used to do in the hospital. If a mother stayed in the hospital four or five days, we had an opportunity to observe her with breast- feeding. We had an opportunity to teach her how to give a bath, and so forth. Now when we send them home so much sooner, we don't have that opportunity. It is pretty unrealistic to expect a woman who has just given birth to a baby to be receptive to teaching of this nature. She's got to try to overcome the experience before she can be ready to learn. So that nurses do have this opportunity to go into the homes, and I think that we almost are seeing a circular -- You know, there's an old saying about what comes around goes around. And I do think that what nurses are doing in the homes today is an example of what Lillian Wald and some of the early pioneers of the Visiting Nurse Service had in mind about being able to care for patients in the home and to give them the training and the education.

It's an interesting thing to observe with this thing called down-sizing or right-sizing or whatever in the world you want to call it. There is some concern in this profession that nurses are losing their jobs in the hospital. The thing that, as a profession, we are beginning to look at, and that we need to look at, is how we can prepare those nurses who have been centered in hospital practice to move into care of their patients in homes. Because that's where the patient is now needing the care.

This brings me to talk a little bit about the term nurse practitioner. The nurse practitioner is an advanced practice nurse who, in New York State, has to qualify for that title by meeting certain standards of education. Those standards of education can be either –- are we running out of time?

RS: We're good.

SB: Those standards of education can either be through special programs in colleges, in universities, or through some other way of demonstrating their ability for this advanced practice. The nurse practitioner is looked upon, and I'm not sure how -- I think it's going to be interesting to see how it all plays out, because in some ways, the nurse practitioner is going to take over what doctors have been doing. And so, some doctors are concerned that they're going to lose out. I think there's a good deal of tension between professional nurses' associations and the medical associations, as to whether we've got too many nurses or too few nurses, too many doctors or too few doctors, and who's going to have what terf.

RS: Sure.

SB: But assuming that the nurse practitioner move keeps going, I think we have here a practitioner who can meet the needs of patients who do not need to have the rather

expensive visit of a doctor, but whose questions can be answered by a person who has been properly prepared and educated to answer those questions, and to make some of those decisions. One of the things that was drilled into our heads in the early days of nursing was that a nurse never diagnosed.

That actually held me in good stead. I mentioned having been in the hospital following an automobile accident.

RS: Right.

SB: The accident that I was in occurred in 1951, when the driver of a limousine had a heart attack and died at the wheel. There were three of us from Mount Sinai who were en route to Atlantic City to a convention of the American Nurses Association. And there were three other women, I've always -- they booked them as three assorted women in the limousine. And, of course, it went off the road and turned over. One of the nurses was not injured at all. Another of the nurses had whiplash, and I suffered fractures of the chest and shoulder. The assorted women -- one of the women had no injury. One of them got a spinal -- you know -- fractured spine, and one of them had a broken arm.

Obviously, the ultimate -- well, we all survived and we all got well from our injuries. But we had to go to court in order to collect the insurance from the owner of the limousine. I was put on the stand and what the lawyer for the insurance company was trying to make us believe that as nurses, we should have been able to identify that this driver was having a heart attack. Indeed, he did complain of pain in his arm, but he had also had to lift a heavy package out of the back of the car for a delivery and move, just prior to this episode. Anyhow, when they began questioning me, I said that as a part of the Nurse Practice Act, I was not privileged to make a diagnosis.

The end result of that was that they got me off the stand very fast, and they weren't wishing to deal with somebody who was able to quote the Nurse Practice Act.

That was in 1951. In 1972, the Nurse Practice Act in New York State was changed, and it did, indeed, use the word diagnose in it. The caveat was that the nurse was supposed to be able to diagnose the patient's responses. This is a differentiation between diagnosing that the doctor theoretically does in trying to determine what's a matter with an individual, versus, what the nurse can do to diagnose the patient's responses to a episode whatever it might be. This argument over diagnosis is something which I guess will probably forever persist, but we do as nurses have this prerogative in New York State--

[Tape 4, Side B\

SB: --do have a prerogative and the responsibility to identify what's happening with the patient. And many times, when some of us nurses get together and talking, we jokingly say that we really do know more about what's going on with the patient than anybody else. Which is more than just a joke, one who spends more time with the patients can indeed identify what the patient is thinking, what they are suffering, what they are needing, more than a brief call at the bedside by another professional. The nurse practitioner, I think, is the wave of the future. And indeed, many of our nurses who are

finding themselves without the employment in the hospitals have gone forward to prepare themselves for this role.

There are other advanced practice nurses. I mentioned the midwives. In the beginning, midwives were largely untrained. However, now, and in New York State, we do not recognize anyone but R.N. midwives. Some other states do still have some midwives who have been trained in other ways. But we have the nurse midwife- type here. So that we have advanced practice nurses, nurse midwives, nurse clinicians, and nurse practitioners.

Nurse clinicians are usually more specific to a kind of nursing, for instance, geriatric nursing or cardio-thoracic nursing or something of that kind. They usually, for the most part, up to this point, have been employed in the hospitals. They usually do little teaching other than what they can teach at the beside as they are giving care in a more advanced kind of setting.

Let me see. What else do we have on this list that I haven't talked about? I mentioned the stethoscope, and I wanted to go back to that because in Spectrum, which is a publication that comes out twice a month and is mailed to all the nurses who are licensed in New York State, as well as New Jersey and Connecticut -- there was an ad which attracted my attention because I was thinking about stethoscopes, and the ad was for an in- service program or a continuing education program which was going to be provided by a group called Career Development Systems. And the ad said, stethoscope skills, heart sounds, breath sounds and abdominal sounds. And I was attracted to that because I thought we -- a little bit like Virginia Slims – we've come a long way, baby.

In terms of the use of the stethoscope. In the beginning, nurses didn't use stethoscopes at all. The first use, as far as I'm able to trace, was when they used it in taking blood pressures. Now the nurse practitioner uses the stethoscope, as does the nurse clinician, to indeed assess heart sounds, breath sounds and abdominal sounds. These were uses that were originally the prerogative of the doctor. But now the nurse practitioner, in her advanced training education, is being told the significance of these sounds and how they can be used. And I thought that that was a interesting outcome of what we're seeing more and more nurses taking on.

Another thing that I think we -- I want to spend a little time with is the work of the nurse in terms of the dying patient. When we -- and this ties in a little bit to diagnosis -- when we were students, if a patient died, we were permitted to put on the chart only this phrase: "the patient apparently ceased to breathe". This always kind of irked me, because I knew that in my upbringing in Upstate New York, my mother or the neighbors or anybody else would be able to identify that a patient -– a person had died. I mean, they stopped breathing and they died. We, in nursing, as in the early days, were not permitted to diagnose that that patient had died. We wrote on the chart, "They have apparently ceased to breathe". I'm glad to say that time has changed that a little bit.

And we recognize that actually, by using that phrase "apparently ceased to breathe", we were casting some doubt on our ability to make a decision that somebody had stopped breathing. And this, nowadays, in the legal sense, you don't say that something is 'apparent'. It is either/or. They did stop breathing or they didn't stop breathing.

So much for that aspect of the dying patient.

But I think there's another trend, and I'd like to bring it in. It happens to be something that I'm going to be giving a seminar on at my church within the next month. And that is the era of advanced directives.

The United States government, as well as state governments, have now provided an opportunity for people to identify before they die -- while they are still capable and competent of making a decision, to identify how they want things handled, should they become incompetent. And there are -- in New York State we have the thing called the proxy, whereby a person can identify by name, an individual who will -- should the patient become incompetent -- who will have the authority to make decisions on behalf of the patient. In other states it's called power of attorney, rather than proxy, but it does the same thing.

And then there is another document which patients have the opportunity to fill out, and this is called a living will. Now, a living will gives more detailed than the proxy. It gives the opportunity for the patient -- the person to identify in greater detail what his or her wishes are. The introduction of this by law meant that here in the hospital a few years ago, we had to set-up systems whereby the patients would be given an opportunity to fill out the proxy. And we had to identify who was going to offer this opportunity to the patient. Was it going to be a clerk down in the admitting office? What would be the role of the nurse? Was there a role for the social service department in helping the patient to fill this out?

We, here, at Sinai, identified that indeed the nurse can give guidance to the patient. At Sinai, we are not allowed as nurses to witness the document. The nurse can recommend to the patient other people that should witness it, but we do not permit the nurses to witness these documents.

There's a lot of education that needs to be going on, and my feeling is that under the aegis of the enactment of both the federal and the state laws, the institutions got this thing started. But I'm not at all sure that they are pursuing it as vigorously as was the intent of the law. And I think that it is a responsibility of individuals per se, to decide whether they're going to sign up for this kind of thing.

And that is why I have agreed to give this seminar at church, and to provide anyone who comes to the seminar with the proper forms -- but to also give them the opportunity to think about this and to talk about it, and to plan it in advance. This is obviously quite a departure from the good old days when you weren't even able to identify that the patient had died. Now you're beginning to work with the patient in their preparation for death, and what would happen to the patient after death.

Incidentally, I'm also going to talk in that seminar about all the organ transplants. Here, at Sinai, we have a role. The nurses -- some nurses -- are transplant nurses -- do participate with the families in helping them to make the decisions about organ transplant. Here, again, in New York State, people who have a driver's license have an opportunity to indicate on their driver's license whether they are interested in being a

donor, and there are some other opportunities. But as I say, I think it's a good thing for me to include in this seminar, so I'm going to be doing that.

I talked about preparing nurses a little bit, but I don't think I did go into that as far as I really wanted to, to talk a little bit about the changes in the education of nurses. I was at a Christmas party recently with two other nurses, neither of whom are Sinai graduates. One had graduated from a program in New Jersey, and another had graduated from another program in Pennsylvania. They were women about my same age, and we had gone through some of the same kinds of education, and I was telling them about my speaking with you, and they decided that there were certain things they wanted me to be sure to talk about. [laughs]

I think in one of our previous sessions we talked a little bit about the fact that nursing has a certain amount of militaristic background. And I think it is probably more evident in some of the early practices in the schools of nursing. I have a friend who -- it was actually one of my students -- who tells me that throughout the whole period of her probation -- we had this thing called a probationary period -- that she kept her suitcase down on the floor because she was sure she was going to be sent home.

There was a feeling -- and this was evidenced by these other two nurse friends that I was talking with the other week -- there was a feeling that when you went into a school of nursing, you went in of your own volition. Nobody asked you to come.

And therefore, if they didn't want you, they would get rid of you as easily as they had taken you in. The uncertainty that overwhelmed our student nurses about whether they were going to be able to meet these very rigid standards of those of us who were teachers, and I would have to admit to the fact that I probably fed into some of that uncertainty. I don't believe that I ever was guilty of saying, as some of our teachers were, "We didn't ask you to come, but we can ask you to go." I don't think I was guilty of that, in words. I may have been guilty of that, in terms of what I -- my behavior towards the student nurses.

We demanded adherence to policies and procedures. The procedure book was almost a bible, and the nurse had to learn how to do these procedures according to the book. Or, as they in the early days, they used the phrase per clinic. The clinic, referring to, this procedure, and you had to be able to do it per clinic. Before I came in training or in the School of Nursing, the nurses were expected to write these procedures in little books, and we had some samples, and I think they are in the archives of the laboriously printed handbooks that the nurse had to write down, how to carry out these procedures, and they were small little books, so that she could carry it with her in her pocket.

In 1940, well -- the next stage, I think, beyond the hand-printed little books, came with the introduction of the mimeograph. Then when people began to have this thing called a mimeograph, they were able to make duplicate copies. And so, the clinics were typed on those forms, and then they were run off and we had the beginning of the procedure manual, which again, we have some samples of that in our archives, that became a part of the books in the units. They were on the units. So that instead of the nurse carrying it in her pocket, she had the reference there. In the 1940s, we decided that we would become even more sophisticated, and we developed a printed manual, and that was

done by four of us who were then faculty members, and adopted. Dr. [Frederick] Zeman was our advisor. He is known for a lot of things here, in Mount Sinai, and I think one of the things was that he was one of the editors of the Mount Sinai Journal.

RS: I think that's right.

SB: Yes. And I believe it was because of his [unclear] as an editor that he was assigned to work with us, developing that manual. Following that one, which was really a very sophisticated thing. It had a hard cover, and it was printed by a printing company. Following that, we had a number of these procedure manuals which we –- on which I worked many, many years. I developed; I don't know how many of them -- new editions.

I think that one of the important things about these manuals was the transition from it being a document for education of the student nurse to being a reference manual for any nurse to use on the units. And I think that's an interesting change. I think we've mentioned before how the School of Nursing really was the forerunner of the Nursing Department. And it established the standards by which the nursing department would function. And I think that the movement of this manual from being a student nurse's handbook to a reference book on the units, is an interesting concept in terms of the change of School of Nursing control to Department of Nursing control of nursing practice. And as it turned out, when the School of Nursing closed in 1971, we were ready, willing and able to proceed with being a Department of Nursing with standards. And until I retired, I was the Chairman of the policy committee, which developed the Policy Manual, which is the current document that is around here.

Referring to these clinics or these procedures, there were several procedures that as instructors of the incoming students, we insisted that the student nurse had an opportunity to practice under the direction of an instructor before she got her cap. A little bit about our educational process. The teacher would demonstrate the procedure to a group of students, and we have pictures in the archives, showing teachers demonstrating those different procedures.

The teacher then expected the student to practice those demonstrations, and the nurses -- the student nurses did spend many an hour in a laboratory on the second floor of the Nurses Residence. They would go down there in the evening, and they would practice these procedures until they became very -- as skilled as they could possibly be. Then they had to demonstrate that, the procedure in the classroom -- take a bath, for instance. When I was teaching, I would select some poor victim to be my person to get the bath in the class.

And I would show them how to give a bath. Then that night, or before their next return demonstration, they would go down to the laboratory, and they would give each other baths, in order to get the skill.

And then, in small groups of -- usually we divided the classes up into twelve because we had six beds. And so, we could use one to give and one to receive a bath, in return demonstration. Then the nurses went to the units to practice, and if it was the day that they were all supposed to be assigned a bath, they would give a bath to the patient. Now, we, as the instructors, went over to the units with them. And, of course, we weren't

able to keep as close an eye as we were in the classroom, but we walked around from one student and patient to another student and patient, to see how this bath was proceeding.

One of the things that my friends the other night at the party were talking about was the fact that we usually -- the student nurses would tell the patients, after they had made –- got them -- given them the bath and made the bed, to lie perfectly still until their teacher came. [laughter] And, of course, the patients always complied. The patients were really very, very kind to student nurses. They liked to have the students work on them, and that they were always -- they wanted to help that student nurse pass that particular hurdle.

The bath was kind of an innocuous sort of thing, I guess, and the patients, because we did teach the nurses a great deal of respect for the patient's privacy. We showed them exactly how to fold the towels and so forth, so that the patient was not exposed. Some of the other procedures that we insisted that the nurse have an opportunity to practice on the patient before she got her cap and became a full-fledged student might not have been so comfortable for the patients because we did require that the nurses give an enema to the patients. We did require that the nurses catheterize the female patient. Nurses in those days did not catheterize male patients. Those would, perhaps, be the more painful experiences.

But again, the patients for the most part were really very, very sensitive to helping this student nurse. Remember that the student nurses ranged -- well, when I went in, in my class -- mostly we were nineteen. But some of the later classes, they were young ladies of eighteen, and I had a Christmas letter from one of my former students who told me that she was only seventeen. Now, I strongly suspicion that she must have falsified her records a little bit.

But being that as it may, she says she was seventeen when she came and trained. And I think that patients frequently saw these young ladies as their children or their grandchildren.

And for that reason, they were very, very sensitive to helping the nurse through this rather traumatic experience that the nurse was having, to say nothing that it might have been traumatic, also, to the patient.

Infection control -- the care of a patient on what we called precautions is another hurdle that the nurse had to pass before she could get her cap. And that was a long procedure. That would take the whole morning, and it was a very tense kind of situation. Because if they "broke procedure," they were scared that they were going to contaminate the whole unit.

Medications. The nurse had to administer medications orally, and by hypodermic, and then, as we finally went into the intra-muscular business, by intra-muscular injection, all before they were capped. Again, the injections -- the nurses actually practiced injections on themselves. But of course, they started out, the tradition was to use an orange.

[laughs] They started out with an orange, but they did use sterile water to practice on each other.

The making of the bed – you've probably heard that the instructors threw a quarter in the middle of the bed, and if it bounced, the bed was tight enough.

I don't remember ever doing it personally, but I do believe that this is part of the traditions. At least my friends were talking about that the other day.

I think there are certain advantages, and I guess that it is the discipline that I'm alluding to, that we really -- maybe these were -- maybe these were harsh times. Maybe we did overdo it sometimes with the students. But there was a certain kind of discipline that carries through. My friends the other night at the party were talking about the fact that they still make their own bed. Now, these are women that -- one of them is older than I am, and one of them is, perhaps, my same age. But we all agreed that we still make the beds at home the way we were taught to make it in the hospital.

That's a kind of discipline when you realize that's something you learned sixty years ago.

But the bed stays together, it doesn't all fall apart with people twisting and turning in it. It is not wrinkly. It is, therefore, comfortable. So, there may have been a lot of emphasis, or what today some people are saying is an over-emphasis.

But on the other hand, I do think that there was a certain amount of discipline that the nurses learned, even through making of beds. Mildred Montag, who was the leader in the field of the two-year program in nursing -- she was the one who designed the associate degree program. She was one of my instructors up at Teachers College when I was there, and she was doing her work.

One of her rather common and famous statements was that you didn't have to make a thousand beds to learn how to make a bed. And this was the idea that that was supposed to be looking at, and that the nursing profession was looking at -- was there too much emphasis on repetitive procedures? Did we need all of that repetition? Did you need to make beds forever and ever and ever, in order to learn? Then we came into the field far along about the same time, the concept of team nursing, where the registered nurse is the leader of the band, but the less well trained -- the less well educated person, like an aide, can be taught to make a bed, which meets the standards of comfort and so forth, and doesn't need to have the background education. As Mildred Montag said, "You don't need to make a thousand beds in order to learn to make a bed."

I think that was demonstrated in the Army -- the [unclear] or the ordinary soldier in the Army learns how to make his bed, and to make it to certain standards, which are similar standards that we did in nursing. And some of the inspection routines are pretty typical.

Another thing that was very important, as far as the nursing education is concerned -- and I may have talked a little about this on a previous occasion, but I do want to tie it in with what we're saying today. I mentioned a few minutes ago that the nurses went down to the laboratory at night and practiced together. In the School of Nursing -- the diploma School of Nursing -- where the students lived together in the Nurses Residence, there was developed a great camaraderie amongst those students, and they became like a family to each other. This is demonstrated by the persistence of our Alumnae Association, the return of our many members for the reunions. I was the guest recently

at the fifty-year reunion of the Class of 1945, and they were, they were really happy to see each other. These were people who hadn't necessarily seen each other for a few years, and they were just so excited about talking and remembering what went on.

I think that with the change from the living in the Nurses Residence and the diploma program, to the emphasis on the college program, we lost something along the way in terms of that esprit de corps, that friendship, that learning together that was really a hallmark of the diploma programs. I'm afraid that we haven't quite substituted for that in our modern day education.

Oh, I was going to talk a little bit about another series of procedures that we worked with. In the period of time that I was a student and that I was teaching nursing, which was up until 1960s, we taught the student nurses how to make mustard plasters, how to make flax seed poultices.

Nowadays, a mustard plaster -- you can go to the drug store and buy it. It's all put together in a little plastic package. But we really taught them how to do it, and they actually mixed them up, and they put them on each other to see whether it would bring forth the redness. And, of course, to show that you didn't leave it too long because you didn't want to burn the patients. We taught them about making flax seed poultices because they were used in the hospital at that time to help in combating infections, direct infections.

We taught them how to do stupes. Stupes were a flannel -- hot flannel -- applied to the abdomen, for patients who had pneumonia. Because in those days, one of the upstanding symptoms of pneumonia was abdominal distention, and by using this hot application, you used turpentine -- hot flannel and turpentine -- did help to relieve that distention. We taught those procedures.

And then in the 1950s, we used the hot applications in the treatment of children with polio. This was a procedure that was designed by Sister Kenny. She was an Australian nurse who became quite famous and really was one of the founders of the Polio Foundation, which ultimately has become the March of Dimes. With the Polio -- the reduction and the elimination of polio through the Salk vaccine, they have turned their interest to other things. But that March of Dimes program was originally a polio program. We taught the nurses how to use these various kinds of what might have been called, more or less, home remedies.

Because I can remember my mother using flax seed poultices. I can remember that my mother used the center of an onion as a poultice for otitis media.

RS: Huh.

SB: This was an old Upstate New York remedy. We taught these things in the program because they were things that were being used.

One of the other things that I taught was the use of leeches. That was kind of an interesting experience. At the time that I was teaching it in the curriculum, I was not aware that we were using leeches in the hospital. It was more or less taught as an

historical kind of thing. We wanted the nurses to know that this was a possibility, and we used to order the leeches from a pharmacy down on Lexington Avenue, which is still there. It's an old-fashioned pharmacy. [unclear] I think is the name. Anyhow, we did show them how to use the leeches.

I was fascinated about ten years ago or less, when the practice of using leeches was reintroduced here, at Sinai. And the fact of the matter was it was because I had some historical stuff, that I was able to find the procedure that was in one of these guidebooks that we had. And I was able to find the procedure to resurrect it for its use in the modern-day era. So here, again, we have seen something that would be the common practice; then it fell into disuse, and now it has come back again. So, the fact that we had the archival procedure for the use with leeches turned out to be kind of handy bit of use.

We were able to do some of that with tuberculosis, also. Some of the archival materials that we had saved were very useful. We, once again, came up to a resurgence of tuberculosis here, in the Hospital.

Tuberculosis had been a disease that had been a real [unclear] in the society, and it was also one of the hazards that you, as a nurse, faced possibly in contracting it. And being some of my classmates did contract it, and of course in those days, the treatment of choice was fresh air, up in the Adirondacks, in Ray Brook and at Saranac. The fact of the matter is there is a cottage up there in Saranac Lake that was donated by the Blumenthals, who are of fame here at Mount Sinai. One of the features of the recent convention held in Lake Placid was a tour of these cottages, and it was something that the nurses that had no knowledge about tuberculosis and about that era, found exceedingly interesting.

This was a very popular tour. We thought that we had gotten tuberculosis kind of under control with the introduction of some of the more modern drugs. However, we now are faced with it once again, all over again. And as I say, some of the materials that we have accumulated over the years, in trying to deal with it, back in the 1930s and 1940s, once again came forward when we started to try to have to think about how we were going to deal with it now. And I do believe, unfortunately, that there's been a recurrence of infection of hospital staff from patients, and the need for us to recognize it as one of the hazards of the -- any health care person, whether it's a doctor or a nurse. Tuberculosis, to a certain degree AIDs, hepatitis, and so forth, these are hazards which seem to be ever present, and continue to be present.

I think that I have covered my list, with the exception of a couple of things, which I guess we will hold over for next time.

RS: We can do that.

SB: All right. I've been talking quite a while.

RS: You talked long today. [laughs]

SB: Yes, I did.

RS: We'll see you next time.

SB: Okay.

[Tape 5, Side A]

RS: [overlap of voices, unclear] [December 19,1995] This is a continuation from the last visit, where we discussed various recollections of the way nursing had changed over the years that you have been here. Sylvia, it's good to have you back again.

SB: Well, thank you. It's good to be here.

RS: Great. I see you have some notes as to what you want to talk about.

SB: Yes.

RS: I'll turn the floor over to you.

SB: Okay. Yes, I do have a few notes. I try to think before I come, so I won't be wandering too far. I was looking over some of my materials -- what I have at home -- and I came upon a copy of the remarks that I made during Nurses Week in 1982. At that time, I believe, the people who arranged for the nurses celebration, invited me to be one of their speakers. And so, this article that I came upon is what I put on the record that day. But the thing that hit me that I hadn't talked about very much, and it relates to a question that I think you asked me in the very first session, was my recollection of some of my contacts with the doctors.

I guess -- I don't know why I had so much trouble bringing them to mind. But in looking at this particular article, I thought that I had made a point there in 1982 that was worth repeating today. [laughs] I referred the people to the 1981 annual report of the Hospital, which had just been published and its topics were the origins and coming of age, and on that coming of age page is a composite picture of four great pioneers from Sinai. One was Dr. Abraham Jacobi, another doctor, Richard Lewisohn, the third, Dr. A. A. Berg, and the fourth, Dr. Bela Schick. I was somewhat taken aback to realize that in my life at Sinai, I had worked closely with three of the four.

Dr. Berg, Dr. Schick, and Dr. Lewisohn. I did not ever know Dr. Jacobi. [laughter]

In describing it for the nurses there at that Nurses Day celebration, I recalled Dr. Berg. He had a red carnation in his buttonhole because that was what he always wore, and the other thing that I called to mind, which I didn't mention when I talked about Dr. Berg the other day, was that he always operated on a patient on January 1st.

RS: Why?

SB: It was one of his trademarks.

RS: Why was that?

SB: Well, I think it was part of a superstition, as far as he was concerned. I think that in some cultures, what you do on the 1st of the year is supposed to be a good sign for the year to come.

And I suspect that that's probably what it was. He was a very interesting man, and somewhat odd. I think that he would be quite capable of having a feeling for this kind of thing. All I know is that those of us who had to take care of the patients on New Years Day could guarantee that he was going to be in the operating room that day.

Dr. Schick is a person with whom I had really quite a close relationship because he was still Chief of Staff when I first -- or perhaps he was emeritus. But he was still around when I first was in Pediatrics. And some of the things that I haven't mentioned before that recalled to mind when I was reading this article about him were some of his notions.

The diet for the children was created based upon the NEM system, which is short for the Nutritional Equivalent of Milk. He had designed this menu that never changed. The children always had the same things for breakfast and dinner and supper. He was adamant about our making sure that the children ate it, because if they didn't, they weren't going to get the nutritional value that they were supposed to get. And, of course, the kids didn't eat it. [laughter]

And I have often wondered if our ploy of wrapping up what they didn't eat and putting it into the rubbish in the utility room rather than in the garbage pail in the kitchen, if he ever caught on to the fact of what we were doing.

Because we knew that he came to the kitchen to look and see if we had thrown anything away. So, we got around that by wrapping it up and throwing it in with the rubbish. Dr. Schick would not allow us to let the children have playing cards. You know, cards that you play bridge with, or something like that. They weren't allowed to have those. It was one of his feelings that they shouldn't have it.

RS: He never articulated why?

SB: No, not that I ever heard him. Again, I think it was just his own belief that that was a way of leading children astray and we shouldn't do that.

Another thing that was outstanding about his tenure while he was in charge of pediatrics was that the children were not out of bed. He kept them in the bed all the time, where, in some later writings and remembrances of my time in pediatrics, we very often got the children out of bed and had them sit at the table to eat and things like that. But he maintained that they were supposed to stay in the bed when they were in the hospital at all times.

Dr. Lewisohn was a surgeon, and the fact of the matter is that he was one of the chiefs of surgery. I think he may have followed Dr. Berg as chief of G.I. surgery. At any rate, the other thing that was more significant, I think, is his work with preparation of citrated blood for transfusion, because he did do some of the pioneering research in the use of citrated blood. All three of these gentleman -- Dr. Berg and Dr. Schick and Dr. Lewisohn

were, to my way of thinking as a youngster, coming into training -- age nineteen and so forth -- they seemed to me like ancient gentlemen at those times.

I expect, perhaps, they weren't as ancient as they seemed. [laughs] But they certainly did seem like ancient gentlemen. So much for some of the pioneers in the medical profession and some of my remembrances of them and some of my contacts with them. Maybe I'll think of some others. I'm sure I will. But these came to my mind as I was re-reading this particular talk that I gave on that Nurse Day in 1982.

One of the things that has been kind of interesting has been my opportunity to see the growth and development of what they now call the campus. The building changes that took place over the years, from the time I came until the present time. When I was supervisor and when I was teaching in Pediatrics, we had a separate building for the children. And that was located on 100th street, occupying some of the space that is now occupied by the Annenberg Medical School building. Along with that children's building was a smaller building attached to it, which was the children's clinic. And on the other side of it, there on 100th Street -- this would be on the south side of 100th Street -- was the residence of the head of the Hospital, which is a little interesting change, and I'm going to talk a little bit about housing in a minute. But a little interesting change as we now see it -- I think the head of the Hospital now lives in the suburbs. [laughter] I guess he's responsible for his own house.

I expect he's probably paid enough so he can be responsible for good living. But in the early days, the provision for the head of the Hospital -- he was called variously, but usually superintendent -- was that there was a building in which he could live, a house in which he could live. And that house was right next to the children's building, there on 100th Street. When they got around to build Annenberg, those houses all came down.

Across the street on 99th Street were a couple of other interesting buildings. One was the dormitory for the employees, and that is an interesting concept because as the demographics of the area have changed, the employees live in their own houses wherever they choose to live. But there was this dormitory -- if I remember it correctly, it was about eleven stories tall. It was divided for both male and female residents, and it was there on 99th Street.

Next to it was the old laboratory. I think it was called the Lewisohn Laboratory. In the bottom of that was the morgue. We could see -- from some parts of the Nurses Residence -- we could see out over the tennis courts, and observe what went on in those buildings. [laughter] And so we sometimes did have ringside seats as to the comings and goings of the morgue.

The auditorium, called the Blumenthal Auditorium, was also there, and it, too, was all torn down. All of this whole area was razed for the Annenberg Building. The auditorium was a very interesting, nice, elegant building, and it was the scene of a great many different kinds of activities, convocations of one kind or another, as far as the medical staff were concerned, and conferences. And as long as the building existed, it was the site of the graduation of the School of Nursing. It was where my graduation was held. That building, of course, is now gone.

Some of the other buildings just before I came to Sinai, they had opened the building which was called at the time it was opened, a semi-private building. And that building was on 5th Avenue, running to 100th and 101st. It was an interesting building, and it was looked upon as being a very modern building, in terms of delivery of patient care when it was built. In the first place, there were only twenty-six patients on those floors, and I will talk a little bit about more buildings, in comparison, in a minute. But the twenty-six patients -- twenty-four of them were in six four-bedded rooms. And then there were two single rooms. Now, this four-bedded room and one single room all faced on to 5th Avenue, and only one -- the other single room -- was on the opposite side of the corridor, and faced out into the other buildings. This was done by intent, and the person who designed it believed that it was important to use the 5th Avenue view and Central Park as an outlook for the patients.

Another feature about that building was it was called a semi- private building, and it had four beds in a room, and at that time, a four-bedded room was looked upon as being semi-private. Now, later on, particularly as Blue Cross and other insurance companies got involved in paying for care, the concept of semi-private was changed to a two-bedded room. But for many years here at Sinai, four-bedded rooms were [unclear] as far as semi-private accommodations were concerned.

Another feature of giving care in that building was that they introduced at that time a concept that they called group nursing. Now, the idea was that four patients in one of the four-bedded rooms would be cared for during the daytime eight hours by two private duty nurses. And during the evening and night hours, they would be cared for by one private duty nurse. This, of course, was a way of saving money. I mean, you would have very, very close, well documented and well delivered care, but you wouldn't have to pay as much because you were only paying -- well, I don't do the math in my head very well, but you were paying half as much during the day time, and a quarter as much during the evenings and nights as you would if you had a private duty nurse. And yet, you had this opportunity to hire your own nurse for this kind of care.

This building was open in 1932 and we have to recall that this was during the end of the Depression, or really, kind of at the heart of the Depression. And so, this also served as a way of providing employment for private duty nurses. Many of those nurses who were what we called group nurses, did that almost exclusively, and they worked for certain doctors. Certain doctors would try to have their patient admitted to the rooms that were designated as pre-approved. Usually on each floor, about two of the rooms would be designated for this type of group nursing. The rest of them -- the patients would receive floor care at the hands of the floor staff. And the floor staff, of course, consisted of some graduate nurses, increasing in number as time went on, and student nurses. I thought that in recalling that it was important to remember that building. It, too, has gone down [laughs] in order to make -- well, I guess the plaza is pretty much where it was before. But when they built the new Guggenheim building and the new plaza, that was one of the buildings that went down. Later on, just to keep the figures straight, before they tore down this so- called semi-private building, it was designated as the Housman Building. And I'm not just sure of the date of when that change took place. It took place while I was here, but I don't know the exact date.

The Guggenheim -- the Private Pavilion, which was built [starting] in 1913, was first called the Private Building, and then at some point in time, also during my time in being here, it became the Guggenheim. And, then, of course, it has now become 1245, no, it's got a number 1249, I guess it is, 5th Avenue, where the children are. That's been an interesting building to watch change.

When I was a student and first went to work in the Private Building, it was really a very elegant building, and the people who used it -- they were all in private rooms. It was nothing but private rooms in that building to begin with. The conditions in which they would stay were special, and they were different. The [plates] were pretty flowered designs, and the trays were bigger. They had huge trays, and they were so heavy to carry.

Those were the days when the affluent patients did come to that building for their care, and, of course, the "private" referred to the fact -- not only that they were in a private room, but they had a private physician or surgeon taking care of them.

As times changed throughout the years that I was here, we began to see some changes take place in that building, and one of the changes was that some of the larger private rooms were converted into two-bedded rooms. This was probably an answer to the comment that I made about the insurance people insisting that semi-private accommodations were two-bedded, and so we needed to provide -- to get some two-bedded rooms, and that was how they did it. They did convert some of the larger private rooms into two-bedded rooms.

Then, of course, the most recent change that's taken place here, with a huge renovation to make it accommodate the children. I mentioned the children having their own building on 100th Street. The next place where the children were cared for was in the main hospital building -- the surgical wing, which was part of the 1904 buildings. The floors -- the second, third and fourth floors were converted to the care of children. They had been surgical floors prior to that. And I might say -- I guess you cannot that I know anything about it, but according to the history, the first children's pavilion -- first children were cared for in the building that we called the North Building, which was on the corner of 101st Street and 5th Avenue. That, when I came, was actually the building where the [unclear] wards were. Then, ultimately, it housed ENT and orthopedics on the first and second floors, and on the third and fourth floors, the neurosurgery [beds]. And when I was a student that was what was in those buildings -- in that particular building.

I mentioned the surgical building, which was one of the original 1904 buildings, and which now, of course, is all gone because it made way for the new Guggenheim building. I wanted to talk a little bit about -- there were two companion buildings, called the surgical and the medical buildings.

They had five floors in them for patient care, and then the sixth floor was a roof. And on the roof of the surgical building, we had male patients, and on the roof of the medical building, we had female patients. And those roof areas were convalescent areas, where patients were transferred from the units up there to convalesce. Those wards had a capacity of somewhere between thirty-six and forty-one patients. Twenty-seven of those patients were in one large room.

That was the beginning -- where I began to give nursing care, we were in these huge, huge rooms with twenty-seven patients. Now, down the corridor and quite –- (I'm sure that it would be frowned upon as being not politically correct) -- but down the corridor, we called the rooms the "back" rooms. Perhaps it would have been better if we had called them side rooms, but we always called them the "back" rooms. They were the rooms that were either four-bedded or they were two-bedded rooms in that section of each of the units. But they were rooms where we took care of the really critically ill patients, where we frequently had the oxygen tank that I mentioned last time, and so forth. Some of those four-bedded rooms down the corridor were used as a type of recovery room because the concept of the post-anesthesia recovery room had not yet been designed. And so, the patients came directly from the operating room back to the unit, and on some of the floors, we designated one of those four-bedded rooms as a place where we would put the patients when they came back, post-anesthesia. And we would be able to assign one or two nurses to watch over them more closely than they might be in that huge, twenty-seven bed unit.

There were advantages to the twenty-seven beds all in one place, and that was that the head nurse's desk was just inside the door, right in the center. The door was in the center of the area, and to the left and to the right there were beds. And then all around the unit, across from you, were the whole beds. The bed number fifteen was exactly across from the door -- the entrance door.

But the head nurse or the charge nurse could pretty much see what was going on with all the patients, and also, what was going on with the kind of care that was being given. And some of the nurses who were my students when I was a head nurse on Ward U -- even today, remember some of my watching over them and calling them. One of my Christmas cards, in fact, this year reminded me of the fact that I kept such close tabs on them, when they were giving care.

The privacy, of course, was provided with curtains that you were supposed to draw around the patients when you were giving care that required privacy. But I think that those were very interesting, and the change in the architectural design from those early wards with twenty-seven patients in one room, to our new Guggenheim building, where there's nothing bigger than two beds, and a lot of single bed rooms, as well, is quite different.

It took a lot of doing for nurses who had been brought up with this concept of watching the patients from the central area, and being able to keep your eye on all of them, to having them in rooms up and down a corridor.

It took a lot of doing in order for nurses to get into the sense that they could really control what was going on, and see what was happening.

But I did think that I wanted to mention a little bit about some of the buildings that we had -- that I had seen change. I was here, and I worked on committees for planning the buildings for the building that houses maternity now. That was the Magdelaine & Charles Klingenstein Building. I worked on the committee for the other Klingenstein Building -- the one on Madison Avenue, which housed, houses, has housed a variety of things, most notably psychiatry on the top floors, with a variety of other constellations of care on

the other floors. And right now, they're still doing some more re-building and reconstructing there. I think that's a building in which you might say we may keep on trying until we get it fixed. [laughter] The way it ought to be.

RS: Get it right.

SB: It never was a very good building in which to give care. It was designed like the old Semi-Private Building, with four-bedded rooms. And that is one of the things that they are getting rid of, as they do the renovation these days. They're breaking them down. I think the largest rooms now are three-bedded, and most of them are getting to be two-bedded rooms. Because the concept of four-bedded rooms is just not working anymore. I guess it did at one time. I was in on some of the planning committees for the new Guggenheim, as well, although not as much intimate involvement in that.

Mentioning the children's building reminded me to mention briefly the respirator center that we had for polio. Dr. Hodes, as you know, was a very famous virologist, and he did a great deal of research on polio. So, he was interested in a polio unit. He convinced the powers that be at Mount Sinai that we needed one, and I think that one of the ways that he was able to convince them was that he was willing to give up one of his children's floors to the development of this respirator center. During that time, we didn't lose any beds with children. Because what we did was to take, create some small -- what we called annex units.

I mentioned a while back that we had the clinic building, which was right next to the children's building. Well, on the second and third floor of that clinic building, we created two more units to make up the number of beds that we gave up for the respirator center. But this respirator center was known as the Jack Martin Respirator Center, and we did have it open for a number of years, and even though polio was not one of my specialties, I learned a lot about it, and got to know a lot about it before we got finished with having that unit there.

I don't know how many years it existed. I guess probably six or seven years that we had that unit. Primarily the patients were in respirators. They might be in old, traditional iron lung respirator. Or we began to see the beginning of what was called the chest respirator -- Cuirass type of vacuum, created by a motor and attached to the patient in order to assist them in breathing. Actually, when you see the devices like you see on Superman, Chris Reeves -- when you see what he's wearing, as opposed to what the creations that we were using at that time, it's amazing to see the change in the technology.

But we did some good work with that Respirator Center. Some of our patients were always respirator-dependent, and when they had to be moved from our unit, some of them went down to Goldwater [Hospital]. Goldwater was one of the -- and I still think they have some respirator patients down there post-polio at Goldwater. But I thought that I wanted to mention the use of one of those units in pediatrics for the Respirator Center. It was an exciting time. And, of course, the Jack Martin money has now been diverted into other uses. I think they're involved in AIDS now, aren't they?

RS: I believe so.

SB: Yes. That whole group of people who rallied around -- Jack Martin was a young man who lost his life to polio, and this effort to provide for care for patients was the outcome of the garment district people who were involved originally in the Jack Martin effort.

And they have continued to be big donors to Mount Sinai, and changed their allegiance once the polio [unclear] was passed to the more current scourge, which is AIDS. I guess that's about all I can think of about buildings, as far as I can remember.

But one of the other things that I wanted to talk about, which kind of fits into this business of big wards and the twenty-seven beds, were some of the changes in food service.

When I was a student, the food was sent up to the units. And this was when I was a head nurse, also, and for many years thereafter -- until sometime in the 1960s, when we changed the system. The food was sent up to the units in electrically heated carts, which consisted of wells in which you could put the containers of the vegetables and the meats and so forth and so on, and then down on the bottom of the cart, is where the desserts would be. The cold things would be down there. Now, this cart was brought to the floor by a porter-type person from the kitchen. It was hitched up with the long electric cord to an outlet in the middle of this twenty-seven bed room. [laughs] And then the trays were wheeled in on to -- this way - - this cart. The trays had been set-up in the pantries -- unit pantry -- by a person who was called a ward helper. This was her responsibility to set-up the trays with paper tray covers, silverware, a cup and saucer, and a glass of water -- a beverage.

RS: Who was this person? Was it a staff person?

SB: This person was part of my staff -- part of the nursing staff. She was one -- this person, this ward helper, was one of the very, very first auxiliary type people that we saw on the unit. I think that actually in the beginning, the nurses did all of that setting up of the trays. But at the time that I got there, we had this person on a unit who -- her main duties were to set-up those trays and she also passed out the drinking water -- pitchers of drinking water -- to the patients at their bedside. The milk was in a refrigerated container that was kept cold by ice that had to be added to it. It was a stainless steel thing. We called it -- fondly called it "The Cow".

It had a spigot on it, and if the patient was to have a glass of milk, it was brought out of the spigot and put on the trays. The head nurse was responsible for serving these trays, and at the time that the food got up there -- of course, one of your objectives was to get the food to the patient while it was still hot.

So, everything else on the unit stopped when it came time to feed the patients. And the head nurse was surrounded by her whole staff and she dished out the food based upon a list that identified whether the patient had soft diet or regular diet, or what the patient was allowed to eat. And as fast as the head nurse could serve the food, then one of the nurses carried the tray to the patients.

I think it's significant that this was a function of nursing. This great change that has taken place now in food service as we see it today, and that change began to take place, I

think, in the 1960s. They built in the kitchen downstairs, what was the old cafeteria, and that was where the main kitchen was. They built a service belt, whereby the trays were set-up in that main kitchen, and they were transferred to the unit floors on big wagons. But they were already set-up. This was opposed to the food coming in the bulk wagons to each tray being prepared in the main kitchen, and transported to the patients. They had little heating units like Sandstone, that where – that places -- that plates sat on, and they were covered with a cover to keep them hot.

Now, at that time, the people who served those trays were what we called tray servers. And they were employed by the dietary department and the kitchen. They had nothing to do with the nursing service per se. And unfortunately, this system, while it may have had some merits, and it certainly did relieve the nurses of a lot of responsibility, the attention to the patient got lost as far as I'm concerned. Because in order for these tray passers to move from one floor to another, and get the trays passed, they were instructed to set the tray down in front of the patient. Now, if the table had not been cleared or if the patient was unable to clear the table, they would set the tray anywhere. The whole objective that they had to do was to get that tray in there and get out so they could go to the next floor.

We had a lot of trouble trying to get the system to really work to the advantage of the patients. Theoretically, at the time that the trays were supposed to come, the nurses were supposed to go over -- nurse or nursing staff, it could be a nurse -- was supposed to go around to each of the patients, make sure that they were what we called set-up. In other words, that the tray table was in place in front of them, that it was cleared of books and stuff, and that they were sitting up in their bed, so that they could reach. And then, theoretically, someone from the nursing staff was to go around and see to it that the patients were indeed able to eat, and were getting their food, and if they needed help in cutting the meat, to give them that help.

This was one of the most difficult transitions that I can remember of, in terms of helping patients. I think the latest thing is that they have modified the system, and these tray passers have now -- I believe -- been given more responsibility, as far as the patient is concerned. You see, in the beginning when the thing was designed, the tray passer was really focusing on the trays, and not on the patient.

Now, with the new system that they have just inaugurated with the new building, I believe that those people have the title Patient Care Assistants, or some such thing as that, and the idea is that they are supposed to help the patient -- not only see to it that the tray gets in front of them, but to help the patient to eat. Which I hope will help. It's been my general feeling that we do not do -- at Mount Sinai -- a very good job in terms of food service for our patients. My own feeling is that a patient could easily starve to death if their family didn't watch over them. [laughter]

It seems to me as though people really do not take seriously the need for good nutrition in the patients and in the hospital. Having said that, we'll stop on that.

Children -- in the children's pavilion, we did not change the system at the same time as we did in the rest of the hospital. And this is primarily because of my own feeling that we needed to have closer supervision of what the children were getting, and I didn't feel that having trays set-up down in the main kitchen and brought up to the patients without

nurse intervention was going to see to it that the children got the proper food. Now, after I stopped being supervisor, things changed and ultimately, they did introduce the same system for feeding the children as they did for the adults. But for some time, there was an interim there where we did not join the new system.

One of the other things that occurred to me that I hadn't talked too much about was something about the work schedule. The workday -- when I was a student and as a young graduate, and for some time thereafter -- was actually a seven-to-seven workday. But you didn't work that whole time. You came on duty and you might have come on and worked from seven-to-nine and then had off from nine to twelve-thirty. And then you would return and work from twelve-thirty to seven with a half-an-hour off for supper, between five and seven. That was the day shift. Now, at two-thirty, we started the evening shift, and the nurses worked from two-thirty to eleven, and they were given time off for supper at that time.

When we became graduate nurses, we worked an extra hour. If you went on at seven, you worked from seven-to-ten, and you only had from ten-to-twelve off. Or, if you had the afternoon hours off, you might have one-to-three as a graduate or one-to-four as a student nurse. In the early days, before the 1950s, the class time for the student nurse was extra to her ward assignment. In other words, if you had a [unclear], if you were working two-thirty-to-eleven and you had a class from say three-to-four, you had to go report on duty at one-thirty to make up for that hour that you were going to be away at class. It was not until, according to my review of the history books, it was not until --

[Tape 5, Side B]

SB: As I say, it was about sometime in the early 50s that the class time for the student nurses became a part of their regular workday schedule. Now, was this every day of the week? How much time off besides the hours during a work day did you have off? We had one day off in the beginning, and that was a half a day during the week, and a half a day on Sunday. So that you might work from seven-to-twelve on a Wednesday, and then you would have what we called a P.M. Or you might have what we called an A.M.

You might have to be off for the morning and come on to work for the afternoon. And then on Sunday, it either was a morning or an afternoon. The staff was pretty much divided in half, so that there would be coverage in most of the morning and the afternoon.

RS: Who worked out that schedule?

SB: This schedule was created by the head nurse. That was one of -- the head nurse was always responsible for that scheduling. As far as I know, all the time that I have ever been in nursing, has been one of the head nurse's jobs [laughs] to see to it that the staffing was properly arranged.

Now, of course, when you began having student classes -- for instance, after the probationary period, the next period of study for the student nurse was called what we called block, and it was when they began to learn more about medical and surgical nursing. In that block period, they might work mornings on the units and have classes in

the afternoons. And this, of course, became much more sophisticated as we changed it, so that the nurse was getting her classes as a part of her work day. During that block period, the instructor was the one who gave a list to the head nurse and said that such-and-such student would be on at such-and-such a time because she was the one that was arranging for their educational experiences.

When I was a head nurse, the supervisors -- the, my supervisor - - and, I think, of course, it was a part of the plans initiated by the director and assistant directors of the nursing department -- we were able to have one whole Sunday off a month. There happened to be four supervisors, four units -- no, there were five units - - and so the supervisors generally gave each head nurse a different Sunday so that she didn't have to short-change herself too much.

That was really quite a boon because if you got your other half day on a Saturday afternoon, you could actually have Saturday afternoon and all day Sunday off, together, all in one piece, which was quite new. Because most of the time, our time was pretty fractured. It was pretty much broken up, as I have indicated, into the three hours off or something like that. But you sure did learn to use those times. We would manage to run down to Bloomingdales and do a little bit of shopping -- especially at Christmas time.

You would just make the best use of that two or three hours -- whichever it was that you had -- by, as I say -- I think Bloomingdales must have had a corner on the shopping of the nurses from Mount Sinai, because it was about the easiest place to get to. [laughs] But we would, we would really accomplish quite a lot on those times. Or, if you had to go to the post office or something like that, you made very good use of your time.

But that work schedule was quite something. I think that -- we also worked -- some of us worked a seven-to-seven night schedule. This was -- as a student nurse I did it, and I also did it as a graduate nurse. Generally speaking, it was a float assignment. In other words, you would come on and you would be assigned to work wherever they needed you that night. As far as having any time off during the night, I have in my scrapbook, a note from the night supervisor saying, "Miss Barker, tonight you may go to your room from one-to-three in the morning. Please do not discuss this with anyone else." [laughter]

I think the point was that she was trying to introduce this -- perhaps not with all the blessings of the powers that be in the nursing department. But that she thought that those of us who were working that shift could do well to have some sleep time.

I had my obstetric experience up at Columbia Presbyterian as a student, because, of course, we did not have obstetrics here at Mount Sinai until 1953. All of us who graduated prior to that had to go somewhere else for our obstetrics. And they had somewhat of an even more sophisticated system of allowing this rest period to take place. They had set aside rooms whereby they had cots, and you could have two hours nap in the middle of the night. I always hated to go to that room because it was dark, and I was always afraid that I was going to trip over somebody.

But at any rate, they did provide for that, and I have a feeling that was what they were trying to do down here, although they had to do it a little differently.

The thing that has intrigued me in watching some of the machinations of nurses these days in terms of time schedules, we worked very, very hard to get the student schedule so that it was an eight-hour day, and so that it included the class time, so that they were not working these terrible, heavy hours. The change -- the eight-hour day [twelve-hour day] to an eight-hour day was a big deal here in New York City. It was championed by the District 13 and the Alumnae Associations in order to get the hospitals to change, particularly the private duty. Because private duty had been working twelve-hour shifts, and to get it into eight-hour shifts and -- some of our archival materials that we sent over here has shown the efforts that were made.

A few years ago, however, there began this movement that the nurses wanted something which they called flex time, which had ended up by meaning that if you have more days off or if you worked fewer days, you worked longer days.

And so, it seems to me we have solid gone full circle and we're really back in those places, where flex time is still a factor that nurses are working three or some multiple thereof -- three days of twelve or thirteen hours in order to get in a thirty-seven-and-a-half hour week. I understand that right here currently, this is a big issue because it is written into the contract that we will have flex time, and I believe that there is a good deal of controversy at the present time, how it's going to work out with this new contract.

There are pros and cons to it. Certainly nurses who are married and have children and who need to have more time at home -- can have longer periods of time -- that is, if you work four days or three days a week, and you're home the opposite, it certainly does give you more time to do things. However, I do think that there is a certain strain and stress to people working these excessive hours. Proponents of flex time and proponents of the idea that staff can work extended periods of time say, "Well, look at those people who work over-time in order to earn extra money." This has been one of the big arguments for a flex time schedule, that folks can work over-time and work double shifts and do all sorts of things like that in order to earn extra money, why not formalize it in some kind of a scheduling system? I'm not sure that any research has been done that really shows that definitively whether nurses are less able to give the kind of care that we want them to give when they're working these long hours or not. It seems to me that it's just logical that if you work too many hours, you're going to be tired.

And you're not going to work that well. But it's been an interesting thing to watch in the last -- well, flex time has been a factor here, at Sinai, since some time in the 1980s. So that now we're in 1995, I guess fifteen years or more flex time has been one of the big things. And there have been all these changes in the scheduling, the Baylor System and all those different kinds of changes. So that the efforts that our fore-mothers put through in the 1930s to get to an eight-hour day, have in many ways been changed by this newer breed of people who are trying to figure out different lifestyles and different ways of doing it.

I guess that takes care of what I was going to talk about, as far as work schedules are concerned. I wanted to mention, just for a few minutes, about men in nursing.

The 1971 class of the School of Nursing graduated one man. He has the distinction of being the only male graduate from the Mount Sinai Hospital School of Nursing. But that

is by no means the only male nurse that ever has set foot into Mount Sinai. The fact of the matter is, and I think that at some point in time I'll get the figures so we can have it accurately, but at one point in time, I know that Mary Lou Creedon, who is the recruiter here at Sinai, had determined that our percentage of male nurses on our staff, exceeded the average in the country.

RS: Really?

SB: We apparently have always had an ability to accept the concept of having male nurses work side by side with the females. However, it was not always done with the greatest of ease.

We had some male nurses doing private duty -- a few doing private duty. But I think that the first real effort that we had to integrate the male nurse into our lifestyle here at Sinai, came in the 1950s, the late 1950s, and we affiliated -- we accepted -- affiliate students from the mental hygiene hospitals in the State of New York. [There are] four mental hygiene hospitals in this vicinity. Creedmoor, being one of them, and the others -- Pilgrim State. There were two others out there, on Long Island. They had schools of nursing, and they had always accepted men. They had always had men in their student body. The State did not believe that those schools were offering appropriate and adequate medical, surgical experience for the graduates of their school, to take state boards and to become full-fledged nurses. And they -- the State insisted, the State Education Department insisted that they, these nurses, enrolled in those programs had to have some better medical, surgical experience - not only medical, surgical, but pediatrics and obstetrics. We -- Mount Sinai -- entered into an affiliation agreement to take those students and one of the big changes in our lifestyle was that it brought male students into our institution.

It was not always easy to figure out how you were going to integrate these male students into the lifestyle of our institution. They lived at home. They lived in Long Island, so that we did not have the problem of the Residence; we didn't have to house them. At least I don't think we did. But maybe we did house them. At any rate, if we did, we separated the boys from the girls. I'm sure of that.

But, as I say, I think that that was one of the impetuses for giving us some experience. It was kind of forced on us, if the institution was going to take these students and those of us who were working here as supervisors and head nurses -- these students were coming to our floors -- we had to deal with them. That was all there was to it. So, whether we approved or disapproved, liked or didn't like -- I think that we learned to accept the concept that these young men were quite capable of giving care.

New York State had always required that the male nurse who is going to a School of Nursing, have lecture courses in obstetrics, but they did not require hands-on experience in obstetrics in the beginning. They finally did begin to accept the male nurse as a part of the obstetrics experience.

Another impetus to our bringing males into Mount Sinai to work was during the period of the 1960s, when we were recruiting nurses from England. Now, England has always had a lot of men in nursing.

Men in nursing has been a fairly common phenomenon in England. So, when we were recruiting from England, it was only natural that if a man wanted to come, that we would recruit the men as well as the women. Here again, we had to provide them with certain education. I think I mentioned previously that one of the courses that I was influential in when I was in charge of in-service was preparing the nurses from England to take state boards. They were called PCCL courses, and we had to [unclear] to men who came over from England, had no obstetrics, because over there in England, they did not get obstetrics. So, we had to provide for them to have this experience. So, I think that that was another impetus to our having bringing some men, into nursing at Sinai.

Another impetus was when we opened psychiatry. Now, psychiatry was opened as a full-fledged department when we went into Klingenstein. KCC was opened in 1963. So that was about the time that psychiatry came. Psychiatry has always been a field where male nurses were working. So that when we began recruiting for our psychiatry department, it was quite usual that we would expect to recruit some male nurses.

In fact, some of the male nurses that we recruited into the psychiatry division in that time, became very important leaders. One was Leslie Hooper, who was the supervisor in psychiatry at the same time that I was supervisor with pediatrics. And his friend, who was Ernest High, who was a head nurse and an assistant supervisor in psychiatry. Both of them moved into leadership positions. Leslie became an Associate Director of Nursing, and Ernest became Assistant Director of Nursing. And when they left here, they went up to Bronx Children's State Hospital, which they opened, when it was built, in leadership positions.

Other men who came to us at that time, into obstetrics, did move into leadership positions, either in the obstetrical department, or -- I mean physiatry -- or into other parts of the hospital. Jim Thurman, for instance, came as one of the staff nurses in psychiatry, and when he retired from here, he was an Assistant Night Administrator – Assistant Night Administrator. It's interesting that the outstanding person, and just recently awarded that significant post in Mount Sinai -- I guess he's the Employee of the Year or something -- whatever that title is -- is a nurse, a part of the nursing department, and a man.

So, I think that we have really given opportunities here at Sinai, for men in nursing. I was talking with a friend of mine at church Sunday, whose brother has just graduated from a program in nursing, and he is thirty-eight years old, and he's just graduated from a collegiate program. I said to her, "Is this his second career?" Because this has been one of the characteristics of men in nursing, that it has been a second career for them. We took advantage of that here, at Sinai, during some of the period of time when we dealt with shortages. Men who retire from the fire department and the police department at an early age -- because that's the way those two departments work are ripe for a second career.

And many of them have gone into nursing, and have done very, very well in the field. My friend at church said no, her brother wasn't a second career because had been bopping around all his life, and he hadn't had any career. I said, "Now, now, now, now, now. Don't call it that. He has, too, had a career. And this is his second career." [laughs]

But whatever it is, but I do think that men in nursing are on the increase. I think the most recent statistics that I saw show an increase in New York State, and that they do have an important role. And I do think that in spite -- if you ever pay attention to the nursing journals, and you read the letters, there's usually controversy of some kind, that somebody has written something that is snide, with reference to a man, and the men rise to the occasion and write back.

There's always been some controversy about it. But I think here, at Sinai, we have really done a pretty good job of being able to handle the men. And I think that leads me into a little bit of a discussion -- demographics. Because both of those gentlemen that I mentioned -- Mr. High and Mr. Hooper -- were black. When Leslie Hooper was Associate Director, we had a lawsuit brought against the Nursing Department by some of the private duty nurses. And he was the person that had to appear in court or wherever it was he had to appear. And many of those private duty nurses -- it was ostensibly supposed to be accusations of discrimination. However, in that hearing with his being black, it served us well. [laughs] The case was thrown out.

It's been interesting over the years, as I've been working here, at Sinai, and thinking about it -- even these past few months or weeks, when you and I have been talking. It's been interesting to think back about the introduction of people of color into our working milieu here, at Mount Sinai.

When I first came to Sinai, there were relatively few people, other than white, Caucasians. In my class, we did have one Chinese girl from Hawaii. I'm not at all sure if that was a token [laughs], but at any rate, we came into the school in 1933, and that was certainly a bit unusual to have someone -- even of that ethnic group.

RS: Ethnic [unclear] what was the typical composition of the class? Do you remember?

SB: Of my class?

RS: Yes [unclear].

SB: Well, in my class, there were a lot of Catholic girls and the Catholic girls were primarily Irish or Slavic -- Polish -- that group. There were a goodly number of Jewish girls, which is kind of an unusual thing, as I think back about it. Because in those days, in 1933, Jewish girls were not encouraged to go into nursing by their families. The fact of the matter is it was not really looked upon as being a good thing for them to do at all. Mainly, the Jewish girl at that time was expected to get married and have children. If she did decide to do something else, I believe that her family generally thought that being a teacher was a much more respectable thing than being a nurse. However, we did have -- I don't know how many -- but I would say that we had upwards of ten or fifteen out of the eighty-eight of us, who were Jewish. And then there were those of us who were just plain Upstate New Yorkers, and people from Georgia and Mississippi and Louisiana and everywhere else, who were just plain ordinary, white, American people. [laughs]

RS: [laughs] There were quite a percentage of people from the south, then?

SB: Yes, yes.

RS: I see.

SB: One of the things in my class and in that era, during that time, prior to my coming and afterward, Sinai had a very, very high rating, as far as an educational experience. Sinai nurses have always made a name for themselves, no matter where they went or what they did. If you said you were a graduate of Mount Sinai, that became almost an open door to almost anything that you wanted to do.

RS: I see.

SB: So that the young ladies who were looking for a career and looking for a good school, came to Mount Sinai. I've always figured that the Catholic girls came -- because many of them had been brought up under rather strict Catholic background, and I've always figured that they thought that they might be able to shed that a little if they came into a culture that was completely different.

RS: I see.

SB: I don't know. But it seems to me that that probably had a good deal to do with it.

The introduction -- well, I think I mentioned once before, and I should mention it in this context -- during the Second World War, we had working here a large number of the Japanese people who had been interned, men once they got released to the work field -- this was -- a large group came here. We had a lot of them. So that was a beginning, again, of an introduction of a different ethnic group.

The introduction of the black nurse here, at Sinai, seems to -- in my mind -- to have followed about three different trends. Number one, there were two excellent schools -- black schools of nursing here, in New York City: Harlem and Lincoln. Lincoln always had been a bit more hoity-toity.

RS: Sure.

SB: Harlem being a City hospital, the Lincoln School of Nursing being an independent school. People who graduated from Lincoln thought they were a little bit better than the ones that graduated from Harlem. But both schools were very, very good schools. And a lot of those nurses went into private duty. When we began hiring private duty nurses -- began accepting them here -- and it was not a hard transition. A good many of our patients were perfectly happy to have a private duty nurse who was black. Not all of them. Now, there were some that were pretty adamant that they wouldn't have any kind of black nurse. But a good many of them did hire black nurses.

This is kind of a two-edged sword, as far as I'm concerned, because we like to think of ourselves in nursing as professionals. And I'm not at all sure that some of those people who were hiring nurses were looking up on the nurse or not as a professional, but rather as a manual laborer. But that is just -- I guess it's a fact of life here, in the United States.

There came a time when it was decided that we needed to begin to think about hiring some black nurses on the staff. We didn't have any. I was approached as the supervisor

in the Pediatrics, with the concept that there was an excellent applicant who was black, and did I think that we could integrate her into our life in pediatrics. And I said, “Yes”. I mean, Miss Warman and Miss Wolfson both thought I could do it, and I saw no reason why I couldn’t. [laughs] So I said, ‘Yes, fine. We would take her.’ So, she was the first black staff nurse hired at Sinai. And she worked at Sinai for a few years, and then she went on. She was an excellent person and she went on -- ultimately got a doctorate in nursing, and was a professor up at Columbia [University]. That was sort of like opening the doors. And from there on in, we began taking more and more qualified black nurses.

It’s been my experience in the beginning -- and that’s not only here at Sinai, but also for the two years that I was at Michael Reese, that one of the things that I saw happening was that the people who were hiring always hired the best.

They always were careful to see to it that this person that they were hiring had the qualifications par excellence. And I do think that that’s one of the things that made it easier for us to integrate more and more people of color into our life.

One of the things that I have noticed, although we’ve tried our best during the time that I had anything to do with it, we tried our best to be considerate about making sure that some of the leadership positions were filled by some of our black staff. I think that’s been one of the difficult things. We haven’t always done it as well, perhaps, as we ought to. I don’t think that I can fault Sinai for it. I don’t think that any institution, whether it’s health care or business or anywhere else, have integrated into their higher level positions -- the blacks -- any more than they have women, for that matter.

But I think that we have done a really good job. Some of the changes that I think have not only been – it’s been part of society. But it’s also been the changes in the community around the Hospital. The Hospital community, the area -- this area. Well, if you read back in some of the history, when they moved up here to 100th Street, they thought they were moving to the country. [laughs]

When I got here in 1933, the surrounding, all the shops, all the stores, all the businesses -- everything around us -- were largely Jewish-owned, Jewish-maintained. And the people who lived in the community were largely Jewish. And when I say the community, I mean as far away as 1st and 2nd Avenue and 106th Street and that whole area. One of my classmate’s father was a cobbler, over on 106th Street and 2nd Avenue. That was the demography of the area when I first came here.

But as New York City has changed, it has changed remarkably here, in this area. And I think that the introduction of better housing for people of color – for the immigrants from Puerto Rico, for the immigrants from Jamaica, and so forth -- has meant that the community supports this group of people. And this is their hospital, and therefore, they seek employment here. I think that this is one of the things that has -- not only do we have in nursing, more nurses who are black or nurses from other countries, but we also -- throughout the whole Hospital -- that the whole work force is made up of people from different cultures and different backgrounds. We have tried, in nursing, to recognize the need for us to be sensitive to these different backgrounds.

During the time that we were hiring so many nurses from England -- when I say we hired from England -- yes, that's where we hired them from. But a lot of those nurses were Caribbean, and they had gone to England for their education, and then they came here, to Sinai, to work. We learned a great deal about some of the feelings that run very high amongst folks from the Caribbean, and we learned very early on, when we were housing, that you don't house people from Bermuda with people from Jamaica. You don't do that. [laughter]

We learned a lot of other things about their culture. So, in learning those things, sometimes rather painfully because we didn't know. In recent years, part of our educational programs have been devoted to trying to help people from the different cultures, share their own beliefs -- their own backgrounds -- and so forth, in an effort to give better care. And this has been picked up not only by our educational division here at Sinai, but this has been one of the efforts on the part of the State Nurses Association, to help people to learn to work together to come from different cultures. And likewise, not only the people themselves who are doing the work, but hopefully, they'll have a better understanding of the patient.

Because our patient population is the same as our work population. So those have been some of the thoughts that I've had about the demographics. How much time do we have?

[End of interview]