National Institute of Nursing Research
Oral History Project
Telephone Interview with Nancy Woods
Conducted on March 24, 2008, by Philip Cantelon

PC: I'm speaking with Nancy Woods.

NW: That's true.

PC: On March the 24th, 2008, and I have your permission to record the call?

NW: Sure.

PC: Thank you. Just a bit of background with your relationship to the National Center for Nursing Research.

NW: Uh-huh.

PC: How did you come upon that?

NW: Well, it was a long – it was a long journey. I started out actually working with the American Nurses Association. It was at that time called the Cabinet on Nursing Research, which was a committee that was asked to look at research activity and research resources for nursing in the U.S. at that time.

PC: And this was what year?

NW: This was probably around 1980.

PC: Uh-huh.

NW: And during the course of my work with that committee, spent a lot of time, I was on a subcommittee that focused on NIH. And so along with Joanne Stevenson, who is the other committee member assigned to look at the relationships with NIH, she and I made a series of regular visits to the institute directors at NIH to talk with them about nursing research activities and their institutes, and to talk about the need for funding to support the kind of research that nurses did, and to try to help them understand what that was actually, because there was not a very clear vision on the part of people outside of nursing, and to some extent, there was a developing vision inside nursing about what the appropriate focus should be for nursing research.

And over the course of several years, we made a series of visits to the NIH director, who, at that time, was Jim Weingarten, and to many of the other institute directors, and to people in their offices about what the research agenda of their institutes looked like. Certainly, we were trying to learn. We did our homework. There wasn't anything – there wasn't the Internet availability at that time. Nobody had web pages in 1980, and so we started out looking in the NIH phone book, and studying things like org. charts to figure out where there might be a match for the kinds of research that nurses did, and whether there would be places where we could look to find the kind of support we

needed for nursing research, and sort of took it from there. We looked at places in the NIH where we thought there would be a good fit with the contributions that nurse scientists could make to the work, and try to do some consciousness raising about that, as we talked with the institute directors.

Then one thing led to another, and as often happens, one looks for moments of opportunity. It was becoming more and more clear that it would be unlikely that there would be a line item in anybody's budget that would focus on some of the work that really needed to be done to inform nursing practice. And we began thinking about well, what would a center on nursing research that would be, you know, located in the office of the director, would that be the right structure? Would an institute be the right structure? We knew the congressional bias was not to create any more institutes than already existed. And we had a political opportunity that the American Nurse's Association helped us work with to introduce the legislation for what was the National Center for Nursing Research. And the legislation passed because we had very good congressional support.

PC: As I recall, the first time it got vetoed in 19 – probably '83, the Health Research Extension Act.

NW: Yes. When it was – are you thinking of the occasion when it was first introduced?

PC: Yes.

NW: I'm trying to remember that particular detail, and I'll have to honestly say, I'd have to probably go back in history and dig around.

PC: Okay. No, my understanding is that it got pocket vetoed, and then it came back in the next session. It was really put in as an institute, then it came back as a center.

NW: That sounds correct.

PC: And it got passed, and vetoed again, and then passed over the veto.

NW: I'll have to admit to not remembering that piece of history as well as you do.

PC: Well, I've been trying to do that. But that was in 1985. But let me ask, when you were – you say you were working with the ANA. You were hired by the ANA to do this advocacy at NIH?

NW: Actually, not hired. This was a volunteer committee through the American Nurses Association. It was a labor of love.

PC: And you were with whom at the time?

NW: I was on the faculty of the University of Washington.

PC: Okay. So you came in from Seattle to –

NW: Yes. This is sort of my community service as it were.

PC: [Laughter]. What did you do wrong, huh?

NW: [Laughter]. Oh, yes.

PC: And the – had you had any input at all with the study going on with the Institute of Medicine between '81 and '83 was looking at the same issue in nursing, and indeed, in '83 when its report came out, recommended an institute?

NW: I was not part of that study. And I suspect possibly Ada Sue Henshaw might have been at that time.

PC: The nursing community itself, when you are pushing for nursing research within institutes at NIH, was it entirely united behind all of this?

NW: Oh, not at all. I remember making a presentation along with Joanne Stevenson at a meeting where we heard a lot of worry being expressed about were we to move out of the – out of HRSA, the Health Resources and Services Administration, where much of the – what money existed to support nursing research existed within the Health Resources and Services Administration, whose mission was quite different. It was only focused on

manpower research at the time. There was a great deal of worry that we would lose control of the little money that we had, that if we moved research into NIH, we would be risking everything, and the possibility existed that we would be putting all of our resources at risk.

PC: And this included the Division of Nursing, which was funding these programs at that point.

NW: Yes.

PC: And these were the manpower programs, basically, studying manpower.

NW: Yes, yes. You know, there was a little bit of what we might call clinical research that was part of the Division of Nursing at that time, but really, not very much of it. There was very little, very, very little money – probably a couple million dollars – at the time.

PC: And their whole budget was, what, around 10 or 11?

NW: I think so.

PC: Okay.

NW: Yeah. My recollection is there might have been around $2 million for what was considered research at that time.

PC: And what about the attitude within the education, nursing education community, School of Nursing? Were they all behind it?

NW: Probably not because nursing education has stakeholders who are employed in all sorts of schools of nursing. Some are in community colleges where the sole mission is teaching. I can't say that the profession was, you know, uniformly supportive because the mission of their institutions was quite different, and I'm sure that there was a bit of worry that we were making such a big issue out of an area within nursing research that was not going to benefit everybody in every school. And that some people saw it as a competition for scarce resources. For example, competition for funding that could otherwise be going to support enhancements in nursing education.

PC: And by that, you mean scholarship money, or recruitment for more nurses at a community college level rather than baccalaureate?

NW: I don't think it would've – I don't think it would've been that kind of funding as much as health resources. You know, what was seen was potential competition for money that would fund other programs within the Health Resources and Services Administration. So largely at that time, the support would have been for bachelor's programs.

PC: These are bachelor of science and nursing?

NW: Yes. Probably DSN and master's programs. But, in fact, that wasn't what happened. What happened was that the funding was from – the funding was – the only funding that moved out of HRSA was about a million and a half to $2 million worth of funding that had supported the manpower research that was being done by – or funded by HRSA at that time.

PC: So it was the manpower money that came out when it got transferred to the center?

NW: Yes. It was the money that funded that kind of research, which was really the only research that was being funded by HRSA.

PC: I'm sorry, I guess – I thought I understood that the 2 million had gone to clinical research.

NW: I'm sorry. I misspoke. There was – it was mostly funding for manpower research that existed within HRSA, but HRSA actually also did fund some clinical research, but not very much of it.

PC: So when we say not much, not less than 20 percent would've been clinical.

NW: You know, I don't know that I could give you a precise estimate at this time.

PC: Okay.

NW: It's just too long ago for me.

PC: Oh, that's all right.

NW: It's a great question, but my sense is that to start with, there wasn't very much money in HRSA, and to go beyond that, the little bit of money that was in HRSA at the time was divided – I guess the most accurate thing you could say is that the money that was in HRSA at that time was divided between research about manpower. So do we have enough nurses, in other words, versus studying clinical problems, like how do you provide optimal care for a patient with diabetes.

PC: What was the situation that promoted, or what's the history that promoted this change in attitude in the nursing profession in the, I suppose, late 70's and early 80's towards a more clinical research?

NW: I think probably what prompted that was the development of the Ph.D. programs in nursing where for the first time, we began to articulate what the knowledge was that we needed as foundational to practice. I think that was probably the most – probably the most significant force. When we found ourselves faced with the need to work with these – work with graduate students and develop the Ph.D. programs in nursing, it was very important that we had the opportunity for schools across the country, faculties across

the country to really be thinking seriously about what it was that should be on the scientific agenda that would support the profession and the practice of nursing, so how would we inform our ability to practice.

PC: Had the medical profession itself gotten more complex and demanded this of the nurses as well?

NW: I think I wouldn't say just medicine, I would say probably all of health care had become much more complex, both in terms of the populations needing care, the kinds of health problems people had, as well as the need for expanding or thinking differently about the systems that would deliver services to people. And that had – you know, that had all sort of gotten, I think, stimulated during the 70's, kind of following the Hill-Burton Act, which builds hospitals across the U.S., and then the need to staff those hospitals in the 1970's, there was a fair amount of attention paid to the education of nurses, and then as we began looking at preparing people better as practitioners, I think we learn that we probably had underused or underestimated the capacity within nursing to provide for the health care needs of the population, and we found ourselves moving into an era in which we needed good science to undergird what we were doing in delivering care to people.

PC: So that, basically, it all came back on the schools of nursing.

NW: A lot of it was coming back on the schools of nursing to look at – to look at ways of providing better prepared clinicians. We had to be more sophisticated in thinking about

the services we were delivering to people, about understanding the outcomes, and really owning the responsibility for the services that we provided.

PC: And let me – when you went around NIH talking to people, what kind of response did you get?

NW: Well, initially, I think we were tolerated and people were polite, but not thrilled to have us appear on their calendars. And because there was a fair amount of legislative support for nursing, I think that – I know the people we met with felt compelled to listen to us, though not necessarily to be thrilled with what we were telling them. I think we did find some kindred spirits in a number of the institutes who said "Hey, you know, if you would like to really see this kind of programming in NIH, here's what needs to happen." Or "If you would like to see this kind of programming, here's what needs to happen in your doctoral programs. These are the kinds of people that NIH needs to have on board to do this kind of work. If you want to be able to compete for extramural funding, here are the changes that you need to make in your Ph.D. programs."

So we were getting a lot of feedback about what the profession needed to do, what the discipline needed to do to position ourselves to engage in the kind of research that other disciplines were doing. But at the same time, Joanne and I, I think, provided a lot of education to some of the institutes about what were the kinds of things that nurses and nursing science could really be contributing. And so some examples of that were we were able to talk about how in our literature, one would find things that were just not on the NIH agenda anywhere else. For example, if we were meeting with the director of

NHLBI, we could talk about how there were people in our discipline at that time who had studied, you know, what is the experience of having a heart attack? What was that like for a person to go through? What were the demands that were placed on that individual by having that diagnosis? What were the – what were the kinds of adaptations that families had to make to have a family member in their household living with heart disease, and then what were the – what were the therapeutics, what were the therapeutic measures or the therapeutic programs that nurses provided to people with heart disease? And we could easily point out where some of those things were not being well addressed as part of the – NIH's current research agendas.

PC: Were some institutes more acceptable, open and acceptable than others?

NW: Oh, definitely. And, in fact, there was – I'm trying to think of the name of the – the names of a few of the people who were really most open. There was a person by the name of Eileen Hassmiller, who was at the National Institute for Child Health and Human Development, who spent a great deal of time with Joanne Stevenson and me talking about the kinds of research that NICHD would fund, and where there was really good fit, for example, with some of the research nurses did on caring for premature infants and their development. And within the National Cancer Institute – oh, this is bad, I can see the woman's face and I'm having trouble remembering her name, but there was a person who looked at the cancer – National Cancer Institutes prevention agenda, who was very, very interested in the work that nurses were doing around cancer screening. For example, working with women on studies of breast exams, and facilitating women's

having mammography, which at that time was still quite new, and was a screening test that was just becoming more and more available to women, but where there wasn't a lot of public information available.

PC: May I ask you to spell Eileen's last name? I heard it, but I'm not sure I can spell it.

NW: I think it – I think it was H-A-S-S-M-I-L-L-E-R.

PC: Okay. Hassmiller.

NW: It's either Hassmiller or Hasselmeyer.

PC: Okay.

NW: And I'd have to go back, and I don't know if I can even find it, but I'll have to go back in my old files, if I still have some of them. And then I'll try to see if I can remember the name of the woman from the National Cancer Institute. But those are two that stand out in my mind where actually what they said was "Oh, we need people to do this kind of work, you know, we don't have people who are sort of taking his holistic view of, you know, people with cancer, or we don't have a science that takes a holistic view of premature infants and their families."

PC: Uh-huh. And did the basic scientists at NIH give this a lot of credit generally?

NW: I'm not so sure that we talked with many of them because we ended up probably talking with people who were institute directors who tended to have a little bit broader view than only basic science. Now I think what we've seen, you know, several years down the road, 20 years later, we certainly see a great deal of interest in collaboration with basic scientists because they're now able to see the value of nursing in a lot of the translational work that we need to do as teams or parts of scientific teams.

PC: Not an attitude that existed in 1980.

NW: No. [Laughter]. No. The attitude in 1980 was, you know, probably to still be quite convinced that basic science trumped everything else, and that, you know, grudgingly, there had to be a little bit of clinical research that NIH did. So I think, frankly, in some instances, we were very useful to the institutes because there weren't many people who were interested in trying to do clinical research, and that was what we did.

PC: Well, I've always been intrigued with the fact that only two institutes have research in their name, and neither were part of the sort of basic science approach or theory. I don't know whether you'd want to comment on that or not. I just find it interesting that the NIDR and NINR are the only two.

NW: Yes, yes. It's dental and nursing.

PC: Uh-huh.

NW: Well, you know, it's interesting. I suppose we would be inclined to use that in a title whereas other institutes might not because those two institutes have the name 'profession' as part of the institute name. And yet what's important is the work that we do. For example, NINR funds research that is being conducted by physicians and, you know, many other investigators, people who are educated in other disciplines. So it's not just a place to go if you want your research funded and you're a nurse, as much as it is this is a place to go if you want research funding to do work of a certain nature.

PC: You mentioned political issues.

NW: Uh-huh.

PC: Representative Madigan –

NW: Yes.

PC: — was, I suspect, the largest supporter of this?

NW: Well, he was the primary sponsor, which was somewhat unusual because we had had many other friends on the hill who had helped us with trying to move this initiative forward that he found himself in a reelection campaign, and he was facing a gender gap,

and he had very strong alliances with nursing in his home state. I believe it was Indiana. And when he – when, I guess, the American Nurses Association health policy staff on the Hill worked with Madigan's staff, it became clear that he was somebody who would be willing to try to advance the National – it was the National Center at that time. And I think that, although people in nursing might have been surprised at that alliance, I think we were very pleased that there was somebody who was willing to advocate for a center or an institute.

PC: You did not expect that?

NW: I think that there wasn't a longstanding relationship between him and the people who were working on this issue in nursing, so it probably was a bit of a surprise, but I don't think it was – I think everyone might have anticipated that Senator Kennedy would have taken the lead on this, or Senator Inoway, both of whom had been very longstanding supporters of nursing and nursing research.

PC: But they didn't.

NW: For this particular, at this particular moment, it was Madigan who stepped up to do it.

PC: And somewhat to Jim Weingarten's surprise?

NW: Oh, I think probably everybody at NIH was surprised [laughter] by this, but I'm sure Jim Weingarten more than anyone.

PC: Because he didn't expect it, even though people had been talking about it?

NW: Well, I think one could safely say that the – that the NIH administration, at the director level and the institute director, would never have been thrilled by the thought of having anybody on the Hill create or elaborate more of an institute structure. They would have seen that coming out of their own recommendations. So they would have been telling people on the Hill what they wanted, and they would have probably hoped that what would happen is that the funding would be supplied to create the funding for the institute structure that the NIH directors would have wanted to have seen put in place for the institute directors, as opposed to having the, having the community outside NIH – I mean what was probably really unique about this is to have a group of stakeholders across the country be able to stimulate a groundswell of support for this. That caught the attention of people on the Hill.

PC: And that's lobbying through the ANA or –

NW: Well, not just the ANA. What had actually happened was we had created a network across the U.S. with nurses Ada Sue Henshaw and her leadership – Joanne Stevenson and I were working with the Executive Branch. We were working with the NIH institute directors and the director – people in the director's office. And Ada Sue and a group

working with her was actually focusing on seeing if they could create a legislative network around the country that would be able to take the initiative to rally support within the state. So we had a very elaborate telephone tree at that time. And again, remembering there was no Internet, and you couldn't get things done quickly, except by phone. So we had organized a rather elaborate telephone tree of nurses in each of the states who was willing to give some time and support and advocacy for this issue.

PC: And that was through the AMA, or Tri-Council or –

NW: It was the American Nurses Association at that time.

PC: Okay.

NW: This was before the Tri-Council days.

PC: Ah, okay. And once it was established in 1986, did you still stay involved with that and the appointment of Doris Merit?

NW: I was not directly involved in that as much as I was involved fairly early on as a member of the National Advisory Council for Nursing Research, and came on board, I think within a few years. I don't remember if I was on the very first council. I think I might have come on during the second few years of the life of the institute or of the center.

PC: That would have been 1986 – was it after Merit left?

NW: I came on after Ada Sue Henshaw was named the first permanent director.

PC: Okay.

NW: And by that time, there had been some work with the PEP panels, the Priority Expert Panels, to set what the agenda should be for nursing research in the country, and we had identified several areas of study that were seen as very high priority, so one I remember very well was focusing on pre-term infants or pre-term birth. Another focused on HIV/AIDS, and there were a couple of rounds of the priority setting that involved creating very thoughtful position papers on work that needed to be done in fleshing out what a research agenda in those areas would look like.

PC: And then they would then target these for funding through NINR?

NW: Yes, yes. Eventually then what happened was the National Institute for Nursing Research would publish a set of requests for applications for research proposals that would be responsive to these areas of priority.

PC: And in a large – well, I hate to use the word bureaucracy –

NW: [Laughter]. It is.

PC: It's always the people who are more interesting.

NW: Yeah.

PC: Could you give me some character snapshots of the people that you thought were important in driving forces behind all of this?

NW: Oh, goodness. Yes. Well, probably, going back in history, there were – there were a number. And the person who was really the engine behind positioning this cabinet to do some of the really important work was Carolyn Williams. She was the chair of the ANA Cabinet on Nursing Research back in the very early 80's when I became involved with it. And I think it was her very thoughtful leadership and her very strategic thinking about deploying us in small sub-communities to address how we moved policy ahead on the hill, but at the same time making sure that NIH knew that we existed, and that we were going to be trying to articulate the need for nursing research and funding for nursing research. Carolyn got us deployed to the NIH as well as the Hill. Carolyn was also probably one of the people who would've been on the IOM committee to look at the need for nursing research, and I suspect Ada Jay Cox before Carolyn's leadership with the same ANA Cabinet for Nursing Research. I didn't work directly with Ada, but I have heard that she was quite involved in leading the cabinet before I became a member.

PC: When you say the cabinet, explain to me exactly what the cabinet is.

NW: That was the committee out of ANA that I served on. The Cabinet on Nursing Research was basically a committee that took on the responsibility for helping to envision a national center for nursing research and to – or eventually, a national institute on nursing research, which was what we really wanted in the first place. And then it was this committee which ANA called a Cabinet on Nursing Research. It's just ANA's term at that time.

PC: Okay. So cabinet is just a word for the – was it an ad hoc committee or just a regular committee at the –

NW: At that time, it was part of the government structure of the American Nurse's Association.

PC: Okay. Uh-huh.

NW: So we were the group that was charged with looking at nursing research for the country, and sort of envisioning what we needed, and at the same time, proposing the kind of resources that we needed to get there.

PC: And this was – the cabinet was consisted of how many people?

NW: Oh, I'm thinking six to eight. So Carolyn Williams, Ada Sue – Boris Strickland was one of the people who served on it, Joanne Stevenson and I, and I think – though I'm not sure,

Nola Pendra may have been one of the members of that cabinet, but I may be – I may be imagining some of these other folks who worked with me on other committees over the years. I'm sure about Ada Sue, I'm sure about Carolyn Williams, Joanne Stevenson and myself, and I think Boris Strickland was on that cabinet with us as well.

PC: I know Ada Sue is still alive.

NW: Oh, yeah.

PC: And the others?

NW: I'm sure, I'm sure all the others are.

PC: Okay.

NW: But that's a good question, given our – well, I guess we're not so old [laughter].

PC: No, no, you're not. You're not. No, you're not [laughter].

NW: Well, we're all sort of 60's. I mean I was probably one of the younger people on that group at the time.

PC: I've talked to Jessie Scott.

NW: Oh. Wow. [Laughter].

PC: That's when we're getting up there.

NW: Yeah. Oh, my gosh, yes. Jessie and – I'm trying to remember the person who was the director of HRSA at the Division of Nursing at that time. I think it was Jo-Eleanor Elliott. I remember these people because there were a lot of people in the country who were not all that happy with us. [Laughter]. I do remember having a few tense meetings.

PC: With Elliott or Scott?

NW: Well, I think Jo-Eleanor was worried that we would undermine HRSA in the Division of Nursing. And, of course, none of us really wanted to do that. But what we did want is there to be research support available to the National Institutes of Health for Nursing Research, much as it was for any other kind of health sciences research at the time.

PC: Now did – it's Jo-Eleanor Elliott? Is that the way –

NW: Uh-huh. Yes.

PC: Okay. And did she take – well, Scott headed the division of nursing, but Scott told me she had left by – she retired by 1979.

NW: Yes. And so Jo-Eleanor Elliott was the Director of the Division of Nursing at the time that we were working on this.

PC: So she replaced Scott.

NW: She did.

PC: Okay. And so your meetings were with her and trying to explain what you were doing, and not trying to vulcanize the nursing profession.

NW: Yes, that's correct. And she actually was, you know, she actually was friendly to the idea. I think she was doing her job and expressing some concern that, you know, that there might be an anticipated consequence for the division. And, you know, that was something that we worried about also.

PC: Uh-huh. But it didn't happen.

NW: It didn't happen. In fact, the division grew [laughter] and got – they ended up getting more support, probably because we were then able to make very clear what the contributions are that, you know – were that we were making, and so the division got funding to help support doctoral programs and nursing education. And that was a good thing.

PC: You mean the division did.

NW: Yes.

PC: So they got the funding for doctoral programs in nursing education.

NW: Yes. They funded what are called training grants, which were grants that were given out to universities to help their faculty develop Ph.D. programs.

PC: Okay. Did you know Doris Merit?

NW: I knew her a bit. In fact, I was invited to give a lecture that's named for her at Indiana University last year.

PC: Did she come?

NW: Oh, yes. Yes, she did. Yes, she was there.

PC: And had you known her before when she first took over the national center?

NW: I got to know her briefly in that role, and probably I would have known her a little bit better, but living on the West Coast always makes it a bit harder for us since we have to

go all the way across the country to see people. And so I got to know her just a bit, but not deeply.

PC: And was – is she a surprise in that appointment? What was the reaction?

NW: Oh, I think the initial reaction was "What?" You know, "The first institute director is a physician." And my response was "This is a wonderful gift to us because we have an experienced and seasoned administrator for the institute who's an insider." And had the first institute director been an outsider to NIH, we would probably still be writing the job descriptions 20 years later. You know, how important, what a gift it was to have a seasoned scientific administrator from NIH assigned to be the first, the first director. That was a wonderful thing for us.

PC: And that selection came about how? Do you know?

NW: Well, I'm sure that that was the NIH director's prerogative.

PC: But here's a guy who didn't really want the center there in the first place.

NW: Uh-huh.

PC: But was it an attitude of "Well, I've got it. I've got to deal with it. I might as well do the best I can with it rather than let it die"?

NW: I think that probably was the case. And I think, by appointing somebody like Doris, you know, in the very best intentions, and I'm pretty certain it would have been Jim Weingarten who would have appointed her, he made an appointment of somebody who was going to safeguard the quality of the science. So, you know, if this was going to be a weak institute with work that really didn't pass muster, he wouldn't have had to see that happen on his watch as NIH director. And Doris had been tapped to do other work as a senior administrator within NIH before she had – she worked closely with Ruth Kursteen, who is, I think, maybe still at NIH.

PC: Yes.

NW: A very, very senior, very seasoned person. And she and Ruth actually worked together on writing the first task force report on women's health for the entire public health service years before there was an Office of Women's Health Research. So here was somebody who was not only sensitive to the needs and issues of research and research training, and who could certainly be entrusted with developing this new institute. But here was somebody who had an unassailable reputation as far as her work with – on behalf of women and women's health. And I think that there was some wisdom in that assignment with respect to working with this group of largely women researchers.

PC: And how did you break that down? I mean I suspect you don't want to be caught in that all the time just as a single-gender nursing issue, do you?

NW: No, no. Not at all.

PC: And how did that get broken down, or did the funding priorities tend to break it down?

NW: I'm not sure I understand your question. Can you try me one more time?

PC: Well, I just wondered if you were trying to get away from seeing nursing as a gender-oriented, you know, for women –

NW: Uh-huh.

PC: And as a more, you know, the broader professional issues, did the priorities set by the advisory council try to do that, or was it – and also, with the education programs? Did they attract more men into nursing at a higher level?

NW: I don't know that gender was much of an issue around the time of the establishment of the institute. But if you're asking was it sort of a closed shop for men, oh, no. It has never been.

PC: No, I knew that. I just –

NW: But I guess I don't know how to answer your question really, as much as to say given that the dominant membership in the discipline with women, and nursing has for all of our history a dominant – predominantly a woman's discipline, that selection of Doris, who had the sensitivity to some of the challenges that women faced in science and in the health sciences in particular, and also in the health professions, that that choice was probably a really smart one.

PC: Let me go back. You mentioned some of these people – for example, could you describe Nola Pendra for me? Just character and description.

NW: Nola's work had been focused on health promotion and prevention, and she had worked very hard to create a research agenda around – instead of managing disease and illness, had worked very hard on trying to help develop a research agenda and her own research around promoting health.

PC: You mean wellness?

NW: I'm sorry?

PC: Wellness? When you say –

NW: Yes, yes.

PC: — promoting health?

NW: Health and wellness.

PC: Uh-huh. And how would you describe yourself in that regard?

NW: My – most of what I have done has focused on women's health. I actually started out my career focusing on more traditional in-patient care issues. My master's thesis was focused on sleep problems that patients had in critical care units after they had had open heart surgery. And I was headed to continue that work, but as it happened, I ended up taking care of somebody with a really serious head injury who had been almost beaten to death by her husband, and discovered domestic violence as a problem. And then sort of from there got involved in a couple of other projects with women, and sort of stood back and realized that we didn't really have much in the way of formal understanding of a unique need of women in the health care system. Now we probably didn't have a good understanding for men either, but you know, it was a period in history where there wasn't much understanding of women aside from obstetrics and issues around birthing.

So I really got caught up in thinking about why is heart disease different for women than men? You know, why does our health care system not have better ways of interfacing with social services around domestic violence? Why do we have treatments for breast cancer that are quite ineffective? This was back in the 70's. And really found myself getting more engaged there.

PC: And has this carried through in what NINR has been doing more and more in these areas as well?

NW: To some extent, yes. I think you know we had the first NINR funded – one of the first NINR-funded centers for research in the country, and we had the first NIH-funded center for women's health research in the country, which NINR actually supported back in 1989, which was before there was even an Office of Women's Health Research at NIH.

PC: But that wasn't a formal – I wouldn't say women's health was ever a formal priority for NINR.

PC: But it did fill a gap that nobody else was doing.

NW: Yes.

PC: Are there other issues that you think are important that I have omitted?

NW: You know, at the moment, this has been like a trip down memory lane for me, and I would have to think about that some more.

PC: Okay.

NW: You really started me on a trip thinking about things that I worked on a very long time ago. I guess it isn't that long ago, but it sure feels like it.

PC: A lot of changes since then.

NW: Yes. Yeah.

PC: In the profession, and because of what happened then. I think a final question would be how would you evaluate those probably five, or maybe a decade of ferment in the profession? Let's say 1978 to '88.

NW: Yeah. Oh, yes. Well, I would say it was a transformative kind of change in that had we never created the policy change that created the institute, there would be a lot missing from the fabric of health research in this country, and it would be largely the integrative approach to health. So looking beyond just a biomedical approach to caring for people and understanding their health problems, it would have been – there would be some areas of research that probably would not have had the liftoff it has had. So some of the work on end-of-life care that's even being done now in other disciplines probably would not have gotten such a strong start: the work with low birth weight infants, some of the work on HIV/AIDS where there was fast uptake, probably faster than we saw in the biomedical world, the work on symptom management, pain management, management of other symptoms, much of that came out of nursing.

PC: Okay.

NW: So if you follow the intellectual roots back in time –

PC: Yeah. I knew someone at NIH who was in pain management, but I never knew what institute she was with. I just never asked her. I will the next time I see her.

NW: Yeah.

PC: And was this – well, you called it a transformation or evolution or revolution, whatever, led by mostly younger people?

NW: I'm trying to remember if I was ever really a younger person.

PC: [Laughter]. Twenty years ago, you were much younger, 20 years younger.

NW: Yeah. That's true.

PC: Or 30 –

NW: In my early 40's, yeah.

PC: Or 30 years ago, yeah.

NW: Well, actually, looking back on it, I think there was – probably the generation was different than the age. We were all of – the first generation of nurses who got doctoral preparation did it in education because that was open to people in nursing, it was accessible to women, and I'm of the second generation. We got – we studied for a doctorate in a related skill, so I'm of a generation that got doctoral education in physiology, sociology, psychology. My degree is in epidemiology. So we were an inherently interdisciplinary group. We went off and studied in all these other fields, and then came back and worked in nursing. And I thin it was that – we got really solid research training. And I think we were in a better position to lead this because of that.

PC: Interesting. And that –

NW: And then, of course, there's this next generation which is educated within our discipline, so their view of the world is a little different than ours, as it should be.

PC: And this group that you had talked about on the advisory council, Stevenson and Henshaw and you and Pendra – go back and lose a name, I know it began with S, but Strickland, all came out of that, and Carolyn Williams all came out of that Ph.D. group.

NW: Yes.

PC: And they were all in – they got it in – well, what did we say? Interdisciplinary fields, but not nursing itself.

NW: Uh-huh.

PC: And I suppose Jan Heinrich would be in the same crew.

NW: Yes. Jan had a doctorate in public health.

PC: Yeah. So that's – but that's not an educational thing, but it would be interdisciplinary?

NW: Well, I think the critical feature was not only the interdisciplinary, though that was certainly part of it, but it was a strong education of scientists.

PC: Okay. Uh-huh.

NW: And so because we had that, we could see the need, and we could articulate what that need was.

PC: Does that also mean the leadership in the ANA was changing as well?

NW: Probably, though I think that may have been – you know, there at least was tolerance for what we were doing.

PC: Uh-huh.

NW: You know, I don't know that I remember clearly enough who was behind what we were trying to achieve with NINR at that time from ANA, but at the very least, people were not obstructing it.

PC: Sometimes that's the most positive response you can get.

NW: Yeah, yeah. And we probably could not have hoped that things would have been better, you know, than just not getting in the way.

PC: Well, I want to thank you very, very much.

NW: Oh, you're welcome.

PC: I've enjoyed the conversation, and want to take advantage of following-up with you, if I may, when I have additional questions.

NW: Sure. Sure. I would be very happy to talk with you more. And you really, as I said, you sort of have led me on a trip down memory lane, so I'm going to have to think a little bit more about some of the questions you asked me and se what I can reconstruct.

PC: Well, I'll give you a buzz sometime in a month or so.

NW: I'd like that.

PC: Okay, great. Thank you very much.

NW: Oh, you're welcome. I'm looking forward to reading what you – what you write.

PC: So am I [laughter].

NW: [Laughter]. I understand that.

PC: Thanks again.

NW: You're welcome.

PC: Bye-bye.

NW: Bye.

[End of Interview]