Bulger, Roger 2008

Dr. Roger Bulger Oral History 2008

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NINR History Project Telephone Interview with Dr. Roger Bulger

Conducted on March 10, 2008, by Philip Cantelon

PC: I am speaking this morning with Roger Bulger, that's R-O-G-E-R, B-U-L-G-E-R, on March 10th, 2008. Dr. Bulger, I have your permission to record the call?

RB: Absolutely.

PC: Thank you. What I would like very quickly is a quick background of you and why you would have been selected for this Institute of Medicine committee.

RB: Okay. Way back whenever that was, right?

PC: Right. Nineteen eighty-one or –two, I would guess.

RB: Right. Well, I've had a career that never got me away from the academic health center. For better or for worse, I did my practicing that I did as an internist there, I worked in the hospital as a medical director early on in my life, which turned out to become more administratively directed. I was fundamentally somebody who majored in history and English when I was in college, realized I wasn't smart enough to do anything creative with that, and was stuck with seeing if I could go live a life that had something to do with some of those values. In fact, a lot of my concerns have been to attempt as an administrator, you know, I have been a dean of a medical school and then the president of a health science center, actually two of them—one at the University of Massachusetts and one at the University of Texas. Those positions and responsibilities brought me into contact with all of the health professions, first only medicine, then increasingly understanding the value of all of the health professions and especially nursing, especially if we want to think about the values of medicine and health in terms of people first and patients first. That soon leads many people, it certainly did me, to realize that nursing was a terribly important profession, if not in fact more important on a daily basis than the doctors are. Obviously you need both, but all too often we don't realize that. So that was one part, and I think that meant that there must've been nurses somewhere who thought that I might be of some value there. Now the other part of it may have been that I was the second employee, I believe, of the Institute of Medicine, professional employee, when the Institute of Medicine was created. Are you familiar with that?

PC: No, I'm not.

RB: Okay. It's part of the National Academy of Sciences, and instead of there being a national academy of medicine, there is a National Academy of Engineering, and the gurus in science I think found that to be demeaning to them and not operating at the same level. And when the doctors came along with their arrogant plea for an academy of medicine, they said oh no [laughs]. And so what emerged was the Institute of Medicine, which started in 1972. And so in the first four years of its life I was there, and that started the objective—the National Academy of Sciences was chartered as a result of Abraham Lincoln's concern that he couldn't get any good advice. So they chartered the National Academy of Sciences, and the scientists elected themselves, and on the other hand, this organization was to provide the public and its agents with good advice on science and so forth. So that led to the National Research Council, which you I'm sure have heard of, which is a working arm of the National Academy of Sciences. The Institute of Medicine was set up with not just doctors but all the health professions and lawyers and social scientists, etcetera, being chosen for what they've done in the health field, but also because they are committed and willing to work for nothing, to work on committees, and that commitment was part of the deal. It was strange and new to the academy, so I was the second person—the deputy to the president or executive officer, I guess, is the title. Actually for some of those four years, for more of them than either of the first two presidents, I was alone there, they having gone off to different jobs. So I spent more time as the senior person there in those first four years than either of the first two real presidents did. What that meant was that I got to know leaders in these different fields, and I think that's how I ended up, I guess, being suggested and then put on that IOM committee.

PC: Who organized that IOM committee?

RB: The IOM.

PC: Was it the president? There must've been some reason for doing that in the first place.

RB: Yes, and this I think needs to be really checked. I'm sure you're going to do that anyway. So this is my recollection and I'm not sure this is right, but I believe there was at that time a nursing shortage. Periodically, everybody gets somewhat hysterical about whether we have too few doctors or too many, and we're almost always wrong, and whether we have too few nurses and whether we have too few pharmacists and so on.

I'm not minimizing that, because often we certainly do. The problem is we don't know what to do about it, and we do something and sometimes that's . . . hopefully not counterproductive but sometimes it is, like stealing nurses from Africa and third world countries to fill up our shortfall. So I think it was in that background. It was a time of significant shortage of nurses, and this committee was formed in principle, and I don't have the record of it myself, so the IOM itself ought to be able to provide you with some of that. Actually Pat Grady would be—she's a member of the IOM, and if that doesn't— I'm sure I can help you find who to go to to get some information on specifically that study and maybe they'd give you the background to it to look at. I feel confident they probably would, but I do think Pat would be the best avenue to do that if that's what you would like to do, and I think it could be very instructive. I cannot even think of the name. There was a very good staff person who I don't know if she's even still alive, you know, but I would think she would be, but I don't know that. But that could be very useful. In any case, that's what the committee was about, and part of the recommendations—and even there I can't tell you what the recommendations were. If you say well, what did they conclude, I can almost always tell you they included more studies, but on the other hand, they also I'm sure made some careful and thoughtful observations about the state of the profession at that time and how to move it forward. I can almost guarantee that, because my whole life since then and before then, I have had some involvement with how do we get more nurses and the role of the university, particularly the advancement of baccalaureate nursing as distinct from just the RN kind of education, which could and frequently does happen at hospitals or just at community colleges, the sort of advancement of nursing into not only the baccalaureate level but beyond for doctors of science and nursing and Ph.D.'s in related fields, like public health or even biochemistry, but a doctor of science and nursing. I can take up all your time on that, but it is a doctorate level degree in a practical part of nursing, for example, mental health nursing. I don't have the right title for it, but you could see where that would go, and the intensive care unit, cardiac care nursing.

PC: So it's all becoming specialized as the medical—

RB: It was certainly moving upward at that point, and with doctors wanting such people and so on and everybody needing them. So that was in there, and the reason I bring that up is because then you get to the issue of who the heck are the faculty at the nursing schools. Well, you know, nurses were particularly, and I think still are, concerned that the faculty be nurses. And I think it's beginning to change a little bit but it's going to have to because they don't have enough faculty and they never have, and never enough well- trained faculty to operate at a collegiate level, the university kind of level, and certainly not at the post-doctoral level. So to do that requires some research. The kind of research that nurses tend to do is not the kind of research that back then the NIH tended to fund.

Nor was it the kind of research that the medical world respected by its molecular nature and outlook. So in any case, that's the tie-in to the research thing. I think I must've mentioned to you I can recall feeling, I mean emotionally as far as I understand myself or understood myself then, I was there because I wanted nursing to get a boost and needed a boost and a lot of work, and it was going to be long term. But I remember when the idea of research and setting up a special thing for nursing research first came up, I was against it, and I don't know when I saw the light.

PC: You were against the idea—

RB: The idea of a separate nursing institute. I believe that this is correct. That doesn't matter from your point of view except that it is my recollection. But as the discussion went on and I came to understand the obstacles for nursing to develop as a profession, it seemed to me timely. I signed on to that, and I don't think any—

PC: When you say develop as a profession, you mean develop as a more scientific biomedical profession?

RB: Well, the tasks that were being confronted by nursing or by the health system required nursing to operate at a higher level. There was greater technology, and there was much more science involved. This was the time when physician assistants were being created to help the doctors with the workload, and the nurses are saying hey, wait a minute, what about us. I can't link the nurse practitioner movement, but I think it preceded some of this. It came after the physician assistant movement, non-nurses coming back from the war, the Korean War and from the military in general, where they had received training and then getting more training and literally doing clinical work under the guidance of a physician, and sometimes at a distance from the physician, physically separated. So as that goes on and as the super-specialization of our hospitals and medical profession and the way things were set up, it became clear that nursing was going to have to have better trained teachers and better trained role models and not to eliminate the basic RN, but the movement was well under way to make it a bachelor's degree entry-level profession.

There was as you might imagine a lot of resistance to that, which I didn't clearly understand. You know, we want the good old country doctor, we want the good old country nurse, and who will be a nurse in Dubuque.

PC: By that you mean hospital trained or community college trained.

RB: Right. So really there was a struggle, tensions going on within the nursing profession itself, and I think finally as that played out, the baccalaureate program has clearly won and the need for that level has been shown. In fact if you have that level of staffing in your hospital, the results are better. So it happens and it's happened in every other kind of profession as well, including medicine. So in any case, that was going on. And in the mix there in that environment, the question of research and people doing research and able to do credible research and the need to get credible academic faculty recruited and in place would lead one to the need for the NIH or other entities if it was a societal interest to make sure that their kind of research was looked at carefully and considered, and finally people like me and other knuckleheads could actually understand that this is a good idea, there's no other place to begin to understand a little bit about qualitative research, and actually if you talk to the economists, even great economists wouldn't apply at the NIH for a grant because they would never get one. So the social sciences, none of that wasn't there [unclear] as NIH began, and it's still not the culture really. But the institute, the NINR, so the IOM I think in that a reason for getting ahold of that report would be to make sure my recollection is correct that it emphasized this research point and it specifically said there ought to be something, I think it may have even said an institute at the NIH—

PC: Yes, so there was a recommendation on that. What I was curious about was how was the committee itself—was it divided? Did it follow a progression similar to your own?

RB: I bet if you asked other people at the committee, they wouldn't even know that I had that progression. I don't remember arguments or other people who argued against this. And obviously many of the people there on the committee were prominent nurses, I would guess. I don't know how many doctors, other than myself, there were. There might have been ten or twelve people on the committee. I would just say that the idea of having a profession-specific institute at NIH, if you were brought up in the NIH world which was evolving then, but most of us were who were physicians and/or Ph.D. biomedical scientists, they were disease specific. It's cancer, it's heart, you know. And I think that there are really two, to be specific, entities there. One is dentistry and one is nursing for the same reason. The dentists, they're disrespected by the medical elite and the scientific elite, etcetera, even though it's very much a bio—it's a different issue. It's obviously biomolecular-oriented, calcium teeth, fluoride, whatever, surgery, there are plenty, and technical, materials research that go on to support dentistry with lots of new technology coming in, that is research founded really, but it was dentistry, and I believe that got established first. And when that got established, it certainly made nursing from a political standpoint, at least as far as my personal assessment of it, also appropriate even though a lot of what they would be doing would be the behavioral sciences and more qualitative research. So qualitative researchers, which I think you would understand far better than I, began to have something of a home in nursing.

PC: By qualitative researchers, you mean . . . .

RB: Well, caring for the patient. What are the elements that go into care of the patient? What are the environmental factors? Do you want windows that look out? Does that help the recovery of patients? That kind of research. That can be obviously more carefully studied, I guess, but when people—and the patients' reactions to this or to that, the whole cultural and environmental dimensions of patient care would be one of the things that you would look at. AHRQ is another agency that started after that, which was to apply the sciences of evidence collection, often epidemiologic in nature, to medical care and outcomes. That needed a totally separate agency. And if you talk to public health workers and researchers, they're getting a better shake now at NIH as NIH grew. And intellectual horizons broadened some, but they are generally thought to, you know, if they want something they'd better go to the CDC, whose budget is being cut dramatically as we speak. So in other words, the molecularly based thrust of NIH was quite ubiquitous, and what the nurses had to overcome was the sort of intellectual barrier that what they were doing and what they would be researching in is not generally reducible, at the moment, molecular analysis. Plus from the nurses' point of view, it's those doctors keeping us down again. And of course even in the context we're talking about, clinical practicing physicians are glad when they get the results. But if you wanted to do research on clinical medicine, it was often hard to do it. That's why AHRQ got—

PC: When you say AHRQ, that stands for . . . .

RB: The Agency for Health, Research, and Quality. It's AHRQ, and that came even after. So my belief is that dentistry was probably already just in place when our committee was meeting. The research wasn't the primary objective of our committee, it was how to fix the nursing shortage. So we got to the research when we got to the issue of my god, there aren't enough faculty, and there are not enough of them at the right level, and for them to get there, they need to be able to do research, the kind that will move nursing forward.

PC: When this report finally came out in 1983, was it a unanimous report, especially for this recommendation for a nursing—

RB: I think so, yes.

PC: What was the reaction of the Division of Nursing, for example?

RB: I have no idea, except I'm sure they were in favor of it. I mean my guess is they would be in favor of it. The Division of Nursing, where was that? They might not have been in NIH at all.

PC: Public Health Service.

RB: In the Public Health Service. Yes. Well, then I'm not so sure that they would—I don't know. We might have discussed such a thing, so you might see that in the minutes of those meetings, but I just don't recall it.

PC: Okay. Do you recall what the response to the report was?

RB: Well, not really. I don't think I'm a good person to—I think the proof is in the pudding. With regard to this point, it probably was a very useful or an operative report. By that I mean it had an impact on what got done and was used by those who wanted to get it done, and it was a report that the Congress could use, which ultimately has to approve any new NIH entities.

PC: Did you follow that with any of the congressmen?

RB: No, I didn't, and that isn't what the IOM—that isn't the way they are supposed to work anyway.

PC: I mean you personally as the dean of the school in Houston.

RB: No, I didn't do any—it's not impossible that if it came up for discussion that I would have been in favor of it and encouraged it and so on. But even in that function and that context in those times that we were in, let's see, that was in '83, it was one of those things that even the University of Texas health system would have been for because it would have meant an advance in potentially an income for its several nursing schools. You know, and an advancement of research. There may have been biases within the people in the system against nursing, you know, the usual thing was they should just be their RNs and the handmaidens of the lord. That was just the way it would play out, and people hadn't thought about it. Certainly there was never any negative approaches to that, and if anyone asked, they would have said fine. And even now, it's a drop in NIH's bucket.

It's not a huge investment.

PC: When the Center for Nursing Research was established, it's interesting that the only two institutes with research in the name are, I believe, dentistry and nursing. Is that correct?

RB: It sounds right. The National Institute for Childhood Diseases, let's see, NICD, it certainly is—

PC: None of the others feel that they have to contain research in it.

RB: Well, yes. Now I'm not sure the Fogarty Center for International—it may say international health, but it may also say international research. But it's the same kind of issue I would say.

PC: Reassurance that real research goes on here, huh? [Laughs]

RB: I guess so. For the doubters, it's not enough reassurance. It doesn't work.

PC: When the center was established by pressure from Congress, I guess—

RB: Right. It would put money in it, that would be suddenly . . . .

PC: And yet the individual in charge of NIH then, Dr. Wyngaarden, was not in favor of it.

RB: Is that correct?

PC: That's correct, yes.

RB: I would think so, yes.

PC: Did you know Doris Merritt?

RB: No, I didn't. I don't think I did. I may have, but at least now I do not believe I knew her.

And I don't think she was on our committee, for example, although that may have happened. I just don't know.

PC: I don't believe so. So when the center was set up, you were—

RB: I was in Texas, and I had my passport that would get me out of Texas sometimes and get me back in it and was always careful to appreciate that it's the only state in the union that has permission and a mechanism established by which it can secede from the union. Or what is it? They can get six senators? It's an elaborate thing, but it's never going to happen because not only other states don't want it, but Texas doesn't want it either. But in any case, my thing there, I was pretty much totally involved with what I was doing at the academic health center and with six schools and all the rest of that stuff.

PC: Okay. One of the persons who was on the committee was Otis Bowen.

RB: Right. Can you tell me what he was? Was he the president of Amherst or something?

PC: No, at that point he was professor of medicine at IU, at Indiana.

RB: Oh, okay.

PC: And then of course he became secretary of HHS.

RB: Yes.

PC: And he was the individual who started or who at least initiated the center.

RB: Great. And he was positive about it? I would think so.

PC: Well, he must have been. He was on your committee.

RB: Well, he didn't object to it and he was—that's great. Unless I'm wrong, he was also a practicing doctor—

PC: That's correct.

RB: —in a community, and he may have had a clinical professorship at the University of Indiana, but I bet he wasn't paid by the university.

PC: He was a professor and director of undergraduate family practice education.

RB: Okay. So probably he had a real thing and he might've had some of his income when he did that. That's interesting. That was when family practice was kind of just beginning and he was a family physician. That's what I remember. He really was out there doing it in a community. Now maybe he moved to Indianapolis and—

PC: No, he'd been the governor of Indiana as well. So he was well connected politically.

RB: So by then he was on his way up.

PC: And Reagan then appointed him the secretary of HHS, so I wonder if he had played a special role in the discussions of the committee. Did the committee divide itself up or let the staff do most of the work?

RB: Oh, no no. The committee [unclear] IOM works is—and I was involved with the creation of how they work so that's why I can speak a little more authoritatively. I can remember only a couple of the meetings of this particular committee, but the balance between what the staff does and what the committee itself does is pretty carefully worked out. So from meeting to meeting, the agenda for what they are to do will be—first of all, the committee decides how we're going to go about getting the results or getting to answer the questions that are posed to it. And so then the staff starts working on those things, and when it comes back, the committee looks at what the staff's done and says, you know, can we do more of this and more of that and so on. So it's an interaction. The staff is not charged with suggesting the recommendations. It may write draft recommendations, and it's up to the committee head sometimes whether two or three people on the committee work with the staff about something, or staff use those people for helping them with the first draft, etcetera. But it's pretty much balanced. Since everybody is volunteering their time—that we even said, you know, a day a month. So if you signed up, if you accepted members up in the IOM, you were in effect giving two weeks of your life like going into the army. But we seldom—we couldn't use the people all that much. We didn't have enough going on, and even now as the numbers proliferate I'm sure, they have trouble making use of all the members to the extent the members would like. But in order to make it work, you have to have a first-rate staff, too, and they have to have some role.

PC: Did you head one of the sections or not?

RB: No, not on the nursing, as far as I know. I'm not sure we divided up into sections, but maybe I'm wrong about that. I just don't remember

PC: Catherine Bauer was the—

RB: Yes. That's great.

PC: And Michael Millman.

RB: Yes. And Michael Millman I know is still alive. I think he's at HHS somewhere. He would be a very good source if you can find him. I think he is still there at HHS.

PC: When we talked the other day, you said you later became president of the Friends of the National Institute for Nursing Research.

RB: Right.

PC: When was that?

RB: In 1988 I came to Washington and was the president of the Association of Academic Health Centers. That was all the people who had jobs like I had at Texas and Massachusetts, and in our area here, GW and Howard and Georgetown all have a vice president for medical affairs or health affairs, University of Maryland and Johns Hopkins and so on. So these are the people who in principle needed to be interested in all the other professions, and part of my personal mission was to make that, you know, we recognized that the doctors and the medical schools make up seventy-five percent of the budget of an academic health center and the rest is divided up with pharmacy and public health and nursing and dentistry to varying degrees. So somebody asked me to be on the Friends of the National Institute for Nursing Research, and a number of the deans of the nursing schools inside our academic centers were involved with the sort of elite group of nurses who were perceived of and did run the Friends of the National Institute for Nursing Research, and who were involved in pushing for the center and then the institute, politically as well, including the second—the first institute director, Doris Merritt, was—I don't know whether she was the first. She wasn't the head of the institute when it became an institute.

PC: No.

RB: The lady from Michigan was. Now the dean at Michigan, Ada Sue, and she was very active. Anyway, Joe Califano was on this board. I noticed that when I of course said yes, I'd be happy to work on it.

PC: When you say board, on the—

RB: Friends.

PC: From the Friends board, okay.

RB: And I think my recollection of that is simple enough in that I know that I felt that they needed to have more non-nurses on this board, and part of my function with their concurrence, I tried to pick out people who I felt really cared about nursing but who were physicians, in most instances, from my membership. Not my membership but the membership of AHC. In other words, people with responsibilities to nursing and nursing education because of their job, even though they were doctors. If you asked a nurse from a nursing school on an academic health center campus what they want most that they don't have, they would say then and frequently will still say it now, they want a seat at the table where these white guys hang around and make all the decisions and divide up the money and decide what they're going to do. So the idea that we might bring a few people into that environment was welcome to those people who were on the Friends there, and that was my only function. I mean we had meetings in person, a significant number of meetings teleconferencing, talking with people who at least I seldom saw otherwise. I guess in a couple of years, they asked me to be the chair, and I don't know whether we did that. Joe Califano never participated. He was a member but he never really participated. I don't know whether his name is still on the darn thing or not. So my only achievement, and I didn't achieve it, but at least I didn't—obviously the experience wasn't so bad, and I think in general people thought it was useful, the nurses thought it was useful to have a non-nurse chair of the Friends. I think I did it for two years, and maybe at their request a third year. I'm not sure.

PC: This would have been in the eighties?

RB: Well, I think it was. I've got a little thing I meant to look up. But when I retired from that, I think it would have been '93, but I'm not sure of that. I have a little plaque.

That's the only reason I know. Now maybe if I looked on my own CV, it will be there.

PC: Well, I can find out.

RB: I haven't looked at it for years. Anyway, the reason I was extended, which was not something I was particularly interested in doing—I don't understand all the reasons because we were deciding—I think my function was to help put a process in place which would determine succession to the president's role and would determine how you got onto the board in the first place. What we did do, now I don't, is that we agreed that there would—so we had to rewrite the charter and make really a few changes, but they were process things. But what in effect happened, and that may have been why I agreed to stick around at it for a little bit longer than ordinarily, we wanted to alternate a nurse with a non-nurse. So we wanted to make sure we had enough non-nurses on the board to have some choices for the nominating committee to make. I think there was a nominating committee which is what we were putting in place, and we wanted to have a—I think we did a two-year period so that when an appointment was made to the chair, the chair-elect would also be chosen, so that the follow-on person would know that it was coming to her or to him and would be watching a little more carefully of what went on. So that's what happened, and I think whatever—there had been no terms. In fact, I think somebody's been the head of it for five years or something.

PC: Did the organizations, either the AHCs or the Friends, lobby in Congress to get the institute established by '95?

RB: No. The institute was probably established in '85.

PC: The center was.

RB: I thought this was the 25th anniversary coming up.

PC: Yes, but it starts with the center.

RB: I see.

PC: It's really at NIH. So the center starts at—

RB: Well, Pat Grady was already well in place as the head of the institute when I was on the Friends. So whenever the institute became an institute—when was that?

PC: I think '95.

RB: No kidding. Okay. Well maybe I'd better look at my—I can tell you I spent a fair amount of time personally—I went to see Pat Grady to find out what she wanted from us. Basically it turned out that what we did was mostly to set up—we had an annual dinner, that's what they did, and the income from that dinner was what they used to function the rest of the year. I never lobbied, and I think you would be very careful not to lobby if you're involved with a not-for-profit organization like this one is. But what you can do, and what we did do, was we, I don't know while I was active whether we had two or three of these over a course of some, one a year maybe, but we may have actually, anyway, but what we would do is have, you can educate and you can try to educate the staff and/or members of Congress or the Senate up on the Hill. So you get a room from one of them to use, and you can actually provide lunch for those who come, and then have a series of presentations for them to listen to and to take examples away with them if they wish to, and they can come and go as they would. I remember we were in another nursing crisis at that time. I think there's a constant nursing crisis actually. So what we really did was we had some of the researchers who looked at this question of baccalaureate nursing and what's its impact on the hospital, and there was data coming out then that was presented and is quite compelling and it's continued to be that way, that it makes a difference to have baccalaureate nurses. So then was presented some of the research that goes on at the institute for nursing research. In fact all of that was interwoven here so that we were showing the impact of the research funded by the nursing institute on everyday practice of health care. And we paid for the people coming in, no one got an honorarium and so on. I would say it's important not to call that lobbying. In a generic sense it may be, but in the legal definition it isn't. It's education and it's an education function and we're not getting there and saying we think you should double the budget of the National Institute of Nursing Research. That isn't the purpose of the meeting. It was just to educate them about nursing, where it stands, and why research might be important. Pat Grady came to that, and I'm not even sure whether she said anything, but she was there and she was pleased to be there. The other thing that we did is that it was clear that what she really wanted, would be very happy with and what we provided—I forget what our profits were from these dinners exactly, but it was timed so that it's when all the nursing deans and some of their faculty came to an annual meeting in Washington, I'm sure that still goes on, so they buy seats or tables. And we were able to give her twenty-five thousand dollars, I think was the goal, and I think we made the goal. We were able to give her twenty-five thousand, and we paid the company on a regular basis who managed the affairs and would set up the meeting. They would do the dinner and they would set up a thing like the meeting up on the Hill. By the time we paid them over the year and gave her twenty-five thousand dollars and had one of these sessions or maybe two, there was no money left. Now the people who were providing the money obviously came from the schools, and they came and had the dinner and other people bought tables, so it actually—I'm sure it's sustaining itself just as the same thing is happening with the Friends of the Dental School. When you get with a cancer institute or the heart institute, you can go to people or chapters or whatever to ask for some money for the support of the friends issue, and for bringing—and I would think they can—they may bring in more money. But what Pat used it for and wanted it for was that that would allow her to pay the way of either speakers or people she was thinking about recruiting to come to NIH and to talk and to see whether the chemistry was right, etcetera. As she was moving along, that was a real plus for her. So I can't speak for her now on that issue, but I think it did broaden her horizons and her impact, even maybe on the campus a little bit of NIH.

PC: I misspoke. I said it was '95. It was '93 for the institute to be done. So from the time of the report to the time of the founding of the center, it was about two-and-a-half years, from '83 to '85 or early '86, and then from the center to the institute was to '93.

RB: Good. Well let me see if I can—I just had moved out of my office. I'm looking for my—I at least could get you the date when I was—if I'm lucky here I'll find it.

PC: Find the right wall?

RB: Well, it's not hanging. It's in a bag because I moved out of my office, and I can't bear to throw some things away I guess.

PC: Doris Merritt left, was just simply the acting person at the center, and then Ada Sue Hinshaw took over.

RB: Okay. And my plaque says September 2000 to June 2002, I was president of the Friends of the National Institute of Nursing Research. So it wasn't ' 95. I don't know how I got that.

PC: Okay.

RB: And I have a gavel to prove it.

PC: [Laughs] Is there anything else you'd like to add about the early founding—things out of this?

RB: Well, now the other part of it is that I think that strategy worked of getting other non- nurse educators or leaders into the involvement with some connection with the nursing institute, so that they would know something about what goes on and what their research is so they could talk about it back at the ranch and with their colleagues at the association.

We brought the nurses, the dentists, a couple of [unclear] in there and pharmacy and allied health and their associations into membership at AHC. So they came to our meetings, they participated in it, and of course the only one who wouldn't join was AAMC because that would make the vice president seem more important than the dean. [Laughs] And sometimes the problem is that a third of the vice presidents are also the deans of the medical school. But finally the new president of AAMC has joined so that we have these—we've brought the nurses and they've been very active in the affairs of the academic health centers. What's happened is that I think that has led through really the Friends and the wisdom of the nurses who looked around and said, you know, we need more than nurses here. And Joe Califano's not it, because he doesn't come and he's not relevant to their world as much. So I think that in this last couple of decades, some real progress has been made in dealing with getting them to the table better than they

were and are bringing it up because you might find out whether others think that, are they at the table more in their world back at the academic center or are they at the table more nationally and are they at the table in a more significant way at NIH itself. And I think Pat Grady has actually had a very positive impact, has worked collegially and is obviously very intelligent and has been given some of the trans-NIH functions to do that actually—and then how do you deal with death and dying, etcetera and so on, there are [unclear] courses. So I think the improvement of the interprofessional interconnections are in the end very relevant and will turn out to be and are relevant to patients when you finally get down to that, where the rubber hits the road.

PC: One last question. Did you work with the ANA? Were they part of the report or follow- up to that report?

RB: The best people to really ask about that would be some of the nursing leaders themselves.

Polly Bednash—there's always a tension between the ANA, the AACN, the colleges of nursing, and then the other one that also does some accrediting. But I would say that the ANA wouldn't—it was the deans who were pushing toward the baccalaureate for example. The ANA tended to be, I would think, somewhere in between them and this national league. It's the NLM isn't it? National League of Nursing? God, how could I forget that? But anyway, it's the big one that does a lot of the accrediting for the community colleges and for the RN programs, non-baccalaureate programs, and represents a lot of people. And they of course would not be much disposed [unclear] themselves out and having a baccalaureate work for us. So I think that they will try and have tried to come together around these issues, and I do not know any more details than that and I haven't been involved in doing that. That's probably where they need just nurses to work on it.

PC: Okay. Well, thank you very much for taking the time out today.

RB: Well, I'm sorry to take so much time for you.

PC: No no, not at all.

RB: I'm glad we worked out, and I'll see if I can find this CV.

PC: Okay. Appreciate that, and if there's anything else sometime that you recall, give me a buzz.

RB: Okay. And please do the same if there's something I can help with.

PC: Okay. I will certainly do that. Thank you very much.

RB: All right. Have a good day.

PC: You, too. Bye.

RB: Bye.

[End of interview]