I graduated from the Springfield Hospital School of Nursing in 1961.

(*Why did you go into nursing?)*

At the time when I went into nursing, women either went to Elms to become teachers or they went to Mercy Hospital or the Springfield Hospital t become nurses. My best friend and big sister who was a year older than I am was going to Baystate so I said, "I think that's where I'll go." I applied and got in and the rest is history (laughs).

(*It wasn't Baystate?)*

It was the Springfield Hospital school of nursing.

(*tell me a little about the program that they had)*

We had a wonderful class maybe makes it so unforgettable. We were very ... what's a good word to describe my class? Most of the time when it was time to study we did but when it was time to play nobody could stop us and we always were one. There may have been 27 students but we were one voice most of the time. And when we decided we wanted a choir, we went out and hired someone and then told the people they would pay for it. And that's the way it went. That's the way it went, you know. We had wonderful Christmas parties our families were always welcome. We started having more and more recreation activities, much to the... and Jeanne M. and the Directors and they had to put up with a lot of nonsense from us. But I still we graduated the best class in 1961. I'm still friendly with some of my colleagues, Some of them are still working. Two are from the emergency room; two material child health nurses, myself, and the lactation specialist. And we still meet about once every three months at Bertucci's to have lunch and for anniversaries. All very talented people, all very different style. And I'm very proud to call them my professional colleagues as well as my friends.

(*when you went into nursing school, did you have any experience in a hospital before then?)*

None whatsoever.

(*What attracted you to nursing?)*

Because my best friend was going into nursing. I mean I can't give you anything deep or profound because that's what it was you know.)

(*You started to... Tell me a little about the school like the first year, how you were introduced, some of the programs...)*

The first year was... actually the whole three years was pretty decent. The first year was difficult because I had always stayed up until midnight for New Year's eve and special events and all of a sudden there we were once we were through being probies, then you got your probie cap ad they put you on nights with more experienced probably with seniors. and I found that difficult because I couldn't sleep in the day time because we had class and I would fall asleep in the middle of class so consequently I almost flunked out of nutrition because I fell asleep and hit my head on the radiator. It was difficult but we all stuck together you know.

The curriculum was... now that's I'm a teacher myself, I look at our curriculum and the only thing is the pharmacology - we had physicians come in and it was done by systems. I don't think I had the best pharmacology course. I had the same thing the interns had but they don't have the best pharmacology course either. When I look now at some of the pharmacology text books and the way it's taught look patho-physiology, I think they tried to do that in my program, but it was you know different physicians would be... have to do an hour a year and they would come in, do their system and get out. I don't think it was that helpful.

(*Let's go back to... had you had clinical before you were put on nights?)*

Yes. You know you have...

I'm trying to get a picture of... what patient care did you have?)

We probably had one or two mornings on the unit. That probably started with bed making you know and the whole quarter - They wouldn't let us... we could talk to patients but we weren't actually treating patients. we were making beds and getting used to the unit and talking to people and then once we had learned to do blood pressures we would go on the unit and do blood pressures on real people. So by the time we... our probie period was over, we had quite a bit of care but nothing

like you would in ICU or something like that. Although when I was a student there was intensive care unit, so a lot of patients were very, very sick.

(*So I'm trying to get a picture of the probationary period. How did they... did you have a test at the end of this or how did you know you'd been graduated...?)*

We were watched so carefully and there were tests as we went along. We lost a great deal of students after the probie period. There was a test plus you were watched very carefully on the unit. We worked with senior students... it's fuzzy because it was so nerve wracking for me and I was just so annoyed that we would spend so much time on making a bed and bouncing a quarter when this poor patient sitting there really needed me to sit down and talk to him. He didn't care about a quarter bouncing on his bed. And that still irritates me.

(*Once you finished your probation, and you went onto nights, how did the curriculum progress then?)*

It progressed when we were on nights and we would get up and we'd get off duty in the morning.

(*That was the first year...)*

That was the first year and the second year.

(*And the second year you were on nights too?)*

Yes. I spent a lot of time on nights because one of the things now that I realized that if you showed any promise then they would put you were on nights because they knew you were responsible. I shouldn't say that)

(*Did you have any other courses, like anatomy and physiology?)*

Yes. We had a lovely classroom on where we had classes and we had anatomy and physiology and bio-chemistry. Biochemistry was taught by Mr. D. who was from Springfield College. Anatomy and physiology by a professor from Springfield College as well. I can't remember his name right now - great guy but when he got to the reproduction system he was sitting with all these young women and he turned bright red. Thank God we were able to figure out the reproduction system before hand.

(*You probably knew it before hand! I know about that time some of the schools were starting to have their classes done at a collage. Someone has told me that Baystate utilizing AIC, I may be wrong on that.)*

We were utilizing professors from Springfield College who came to us but we did not graduate with an Associate Degree. We got no college credit. They were hired just like I'm faculty for the School of Nursing, they were hired as faculty for the School of Nursing. There is no college credit. I wish there had been because that would have made the transition for people much easier.

(*I understand about that time they started to look to have those courses done at a college. Were you able to have all your clinical rotations done through the Springfield Hospital and Wesson Hospital or that whole group?)*

I went to the Institute of Living for my psyche evaluation in Hartford but most of my pediatrics were done at Baystate. Surgery was done at Baystate. psyche was done at Hartford. That was a very good clinical orientation. It really was. And then we also went to I think Middlefield where they had the school for children that were retarded and mentally ill. That was a day I'll never forget. I think half of us vomited all the way home...

(*why?)*

In those days they really weren't getting any mental health treatment. They were locked up in their rooms and it was... people still remember that. It was one of those things that when together with some of my colleagues we still remember that. I wish they had used another pediatric/psychiatric affiliation rather than...

(*Where there any around?)*

I don't think there were. In 1961 I don't know where you went if you were mentally ill. There was Belchertown. In Belchertown that's what we did - we locked up people.

(*Vermont did the same thing.)*

Yes, exactly. That's the way it was then. And now in retrospect, I think My God, why did we let that happen? As a nation? Let people treat children that way. But

we were treating the elderly that way and we were treating the veterans that way and everything else so I guess we've come a long way

(*I hope so.)*

I hope so too.

(*When you graduated, what was your first job?)*

For some reason we kept hearing that before we got a job anyplace in critical care or whatever, we needed three months of med/surg. So I figured well,... or a year. Well I did med/surg and I won't name the woman but the head nurse I had really was not a people oriented person and I think I had a little hospice in me even then because I would go in and talk to patients and if they weren't on my level, I would sit on their bed. Well, she came in and she laid me out in lavender. I mean this woman told me I would never amount to anything that nurses were supposed to hustle and always be moving and that she didn't have time for me to sit with patients. Well that man is still alive today and he remembers that and he reported her.

(*She did that in front of the patient?)*

Yes, she did. He called the administrator and said I want you to get your ass up here and the man came up and... she was reprimanded, but my days were limited there. So I was so disgusted with nursing that I was going to go to Stop and Shop and become a clerk. And I was walking through the emergency department and I ran into some of the nurses that I had worked with as a student and they said "how ya doing?" and I told them about my experience and Annie S. went around the corner to Ms. B. and said I think we should hire her. So Ms. B. said would you like to come back and work with us? I said Of course I would. And some how... the word had gotten out... I started the following Monday in the emergency department with only my three months in med/surg so I was very happy with that. So now I tell students, If you're a strong clinical student, you don't need that three months of clinical... going to the emergency room with critical care. You learn...

(*When you think back on the school, what do you think is the strength of the diploma program?)*

In the particular school I went to the strength... I think it had to do with the strength of the student body. We had an unusual class and we stuck together. No one ever got into trouble alone. and we had some great young faculty who by today's standards we would say they were not qualified or prepared. But they understood what we were going through because they had graduated a few years before and there were a couple of gals that really saved our hides coming through and really got us the best experiences possible. The negative parts are sometimes we were forgotten on nights on the units and not enough attention paid to the classroom work because you need that. I mean you can always learn how to learn how to do a catheterization; they shouldn't hold you on the unit for three hours to do that. But youi know, some of the lectures... There wasn't enough attention paid to the theory and to the classroom work, from my personal liking. That's why now I'm pushing people... I tell my friends, please send your child to a baccalaureate program. They're going to be in college for four years and it's a little bit more expensive. But when they get out, they'll really be ready. They won't be afraid to wander off to San Francisco or San Diego or Institutes of Health or whatever. I get letters now from students from all over the country. They're not afraid and I think that's the main difference. We like to work in that environment. We graduated from a three year program and most of the people stayed right there and very few ventured off. Some of them are still there from my class. Good nurses, no doubt in my mind. But not the most confident.,. they're confident but not confident enough to say I'm breaking away and I'm going to NIH for two years. They all got married, had babies and stayed there. And they're still there.

(*Which brings me to another question. What changes do you believe would have improved your education?)*

I think the changes and I think we all agree on that now, we all enjoyed Mr. D. when he came. We used to make fun of him, but when he walked around in the chemistry class and we were taking apart little kitties or something, he brought it down to such as level that we understood. And I think if we had had more classes with college professors, I mean you know, I don't remember anything from that

chemistry class but I'm sure I learned something that I could apply right then and there to my profession. Whether it be... well, laboratory and lab findings or whatever. If you see something, even if you see it in the lab in a cat or dog or whatever, it's very much like the human body, so if you remember what the heart looked like when you were dissecting you can I think you can picture it more easily in a human being. I'm not going to say it was a lot of fun because they'll think I'm a sadist, but you know I enjoyed that part just like anatomy and physiology. I remember shortly after I graduated he came into the emergency room with his son and he said for those of you who don't believe in Darwin, look at this kid. He has a broken arm. So he was just as wonderful professor even though he was a little red faced through the whole reproduction system, my anatomy and physiology was flawless when I left that class with him because when I went to UMass, of course we had to challenge anatomy and physiology in order to go into the program. And I did pretty well.

(*Let's go on past your first entry into practice. You then went on... tell me about your progression.)*

I graduated in '61, spent some time working in Florida. There were four of us that went to work in Miami. We went out there and we graduated in June and went out there in September. And then I had gotten a job in the emergency department and my friend (pause)

Shortly after graduation three of us decided we would go to work in Miami and we worked at St. Frances hospital on the Beach. And in those days if you were from Massachusetts, Sister Francine would hire you on the spot because she thought Massachusetts nurses were better trained than anyone else. And we were well disciplined, so we stayed there for a while... had a good time. Three of us, one of the gals came back to get married, and she took over my position in the emergency department which was good, cause we hung onto that. she had babies and I would go back and work it. Being in Florida was kind of fun cause I did private duty. I worked pediatrics, I was involved with some of the Cuban refugees that came... And then after a while we got sick of that and came back and I went back to work in the

emergency department and was approached by the physician there who asked me if I would be interested in helping him start the neighbor health center He was such a nice guy that I just couldn't say no and at that time there was a person there, her name was Connie P. from the University of Massachusetts who used to come down with students to the Brightwood Health Center It wasn't established as anything then -- She would just come down with students and they would you know have (?) community center. We got that going, you know the Brightwood Health Center which is today very effective and very busy. So I was there for a couple of years and then... I had written a grant and when I signed my name, I signed [my name] and the man came in and said you need to put your credentials down. I said that's it -- RN. He said you can't sign this. Because apparently at that time in order to sign a family planning grant, you had to have at least a Bachelor's degree. So my friend Connie who was a nurse from UMass said can I sign. He said did you have anything to do with it? and I said yea, she wrote most of it. So that's when she said you need to get a bachelor's degree; you don't need that embarrassment again. So I went back to UMass and got a bachelor's degree and then I went to Franklin county. While I was getting my degree, there was a lot of talk about hospice going on. -- it was just little rumblings here and there. I was interested in that because my grandparents had died at home and I thought well why isn't this the way to go for everybody? Well, I realized it wasn't so I got involved in that and when I graduated from that program I was seduced by the Connecticut hospice and I went there to become their first director of the first American hospice. And that was a lot of fun. But the politics involved were unbelievable. Boy did I get smart. That's when I learned that you sit down, you keep your mouth shut and you take mental notes of everything because somebody's going to come back to bite you especially when it's a government thing. And for all the things that Ted Kennedy, if it weren't for him, there probably be no hospice in this country because he came to visit us in Connecticut and he was sold on the idea and he sent Joseph Califono, who was secretary of health, education and welfare to spend a day with us. And Califono then assigned four men to work with us on budget and everything else and the rest

is history. This guy spent so much time with us in Connecticut. If it weren't for him. And he was always attentive and when we became Medicate approved, we had this big reception in March, Ted Kennedy came out and the rest of us were dancing on the tables in Washington and he couldn't climb on the table but he was very... it was great to have him on our side. Cause that probably wouldn't have happened. So when I left there, I went for work for the National Institute of Health in Bethesda, MD. And that too was a wonderful experience because that's where I found nursing at its best. I met with Marie Manthey who wrote the book on primary nursing, and she had helped me with primary nursing at the Connecticut hospice, so when I got to NIH, I said this is what they're doing here is primary nursing, it just haven't called it that. And I said they're fiddling with it and farting around with... can you come down and spend the weekend with me? So she did and we met with the staff and we did adapt her model at NIH which was kind of fun. They were doing it anyway, they just didn't know what to call it. And it's still I think one of the greatest places for nursing. The nurse is so involved with critical thinking and critical aspects of nursing and it was a wonderful place to be. Then my father got ill so I came back to the Berkshires and I was the Director of Ambulatory Care which was the emergency room, the outpatient, the health service and occupational health. So I did that for a couple of years and that was kind of fun, but I didn't much care for the hospital environment. I much rather be out in the home care setting because. when Iwas between jobs and degrees and everything, I always went back to home care while I was getting my first Masters at the University of Hartford, I was covering nights for the Springfield VNA. They didn't have any evening hours or night hours so I said to the director, give me a beeper and we'll start this thing on evenings and nights. You got to do it and I can handle it. So that's the type of stuff I always got involved in. A risk taker, always out there on the edge of something. I've spent a lot of time at home care regular home care and with hospice and loved it. I still to this day involved with the hospice care in the Berkshires and I still love to go out and see patients. I have students who are with the VNA in the Berkshires and I still ove it when they go out and come back and tell

me their stories. It's the best experience, especially now when they come home, they're so much sicker, it gives the students the opportunity to use their critical thinking skills to deal with families and that's where it's at.

(*What course do you teach?)*

I teach the community focus course. Community focus would be seniors have to do with the home care setting. Community focus on line with the RN students coming back for their bachelor's degree has to do with the community and it's more the community assessment an looking at population. They would look at seniors in Pittsfield who are at risk for cardio-vascular disease, and they would focus in on that population. Or they would focus on children with obesity in schools. It's totally population based and they do very well with that. I find that nurses who have been involved in hospital nursing for a while, I say to them all those problems you see in the ICU, we can prevent them. All you have to do is put your thinking cap on and get creative and some students take it seriously and they go out. A group a couple of semesters ago went to Big Y and they helped the elderly read labels. And the Big Y gave all the seniors a big magnifying glass if they couldn't read, and I thought that was swell. It was partnerships with the community and the school of nursing and everything else. Community to me is such a big... encompasses... and you know, I used to take students to Jamaica in January right about this time of year when all of you were freezing to death here, I would take students to Jamaica and we'd go to Princes Margaret hospital and work there. Most of the time the students were delivering babies with the midwives, but they would also go out in the bush and deliver babies and visit diabetics in the home and just use their skills. But they had to use their minds...

(*How did that fit in with the curriculum?)*

Some of the students used it for their family. Some used it for their clinical experience. You had to count the hours and had to put it towards something. Most of the students chose not to do it for any credit; just to do it for their enrichment because they learned so much there. I made them use their hands and their senses. They would say to me how can I listen to a fetal heart -- I don't have a fetal scope?

In Jamaica the nurse midwives had this thing they used it looked like a funnel and that's what they used. And when they came back, they all said the same thing: I learned how to listen and all these wonderful things that I can do with my hands and If I just listened or smelled or just... for them it was a great experience. For me too.

(*When you're talking about this I'm thinking about the diploma program, the ADN and the baccalaureate. It would be my feeling and I'd like to get your take. We're off of diploma, when you're thinking of it you had three years. You had time for experiences. You're telling me about the baccalaureate program and there are opportunities there (?) winter semester that mid semester... little thing that you do... what to put in it? Opportunities... What are your thoughts on the nurses who are coming out of the ADN program: as an educator?)*

The faculty from the ADN programs would ask me if I could take some of their students with me in January. And my answer to that was always no, not because I wanted to be uncooperative, but they didn't have the knowledge base that I needed; that whole community piece. I'm sure their nurses were probably better changing dressings than my university students. But what they had learned in semesters before not just the nursing courses, but the nursing anthropology and some of the psych courses and electives that they have in most colleges on diversity. 'Cause I'm very much a diversity buff. If we don't learn how to work together in this world, the end of the world is going to come faster than we think it is. So they had to take courses in diversity and... know pretty much how to interact with people that are different than them. Like the Jamaicans or we had to take students to Ghana so they had to be familiar with their habits and those things before they leave so they don't gawk and stare.

(*This was not part of the planned questions but as you brought it up, I wanted to get your opinion because from what I'm gathering, there is so much more opportunity in that.... good for your program.)*

There's always something going on in a four year program. Recently we've gotten involved at UMASS with the H1N1[flu] and that's a whole thing - it's not just

learning how to take shots; you have to go to all the leadership programs on pandemics and...

(*all put out to the mass*

Absolutely. But the students have to do that as part of their curriculum. Like it or not you're going And they have to assume responsibility for certain clinics you know, so that they know Yea, it's not just a great vaccine, let's go learn how to do shots. But they have to look at the history of pandemics, the history of this pandemic, look at the cultures and whatever and why are we doing this and why pregnant women and everything else. So when they're out in general pulbic they're very knowledgeable. Plus they know how to give shots!

(Well. They do! Having participated in ... I understand. At this point, just another extra. I'm also looking at clinical competence is and as an educator, what are your thoughts on clinical competence. We talk an awful lot about it in nursing and I've heard many different... what are your thoughts?)

Clinical competence... we spend a lot of time on this at UMass although I teach in the Berkshires and I teach online but I still go in for the meetings and we look at clinical competence and we look at how to measure and I still think it's outcome based. That doesn't mean you have to have a good outcome. You have to look at outcomes and good outcomes are always favorable. There are some people who are still bullshitting their way through competencies...

(Meaning?)

That they... for some reason have gotten away with...

(*You talking faculty or students?)*

Students. And they give lip service... we have these wonderful case studies that people have to do and they have to... that's where you look and you read it and critical thinking, yes critical thinking. Now and there are some people who give lip service to that. And it's obvious to me because when I read one and then I read their friends, they're very similar.

(*It's not just lip service, it's plagiarism!)*

Right. And I call them on it you know, and that's difficult when you have a big classroom because you can't be with every student 24/7 -- you just can't. I have students who manage to get all the way to the senior year and people have doubts about them and when they go out in the hospital the nurse at the hospital will say there's something about the student I just don't get. He's never there when the critical ...or she's never there... and it started that I asked them to check blood pressures and when I go in it's different. Very different. So not everybody is clinically competent. Sometimes people are... if you don't know what you're listening to when you're listening to a chest and somebody dies, well, maybe nobody will ever know but that could be me or it could be my mother or it could be you. So we try to nip that in the bud early and I'm sorry to say it's not always caught on paper in the case studies. It has to do with being with the student whenever they're doing things. I think the clinical model -- clinical educator model that UMAs uses with Baystate works because they're always with the nurse. And we say why are you coddling them so much? Well why we're coddling them is just that somebody is listening to a pair of lungs or a heart and they hear something, they should be able to turn around and grab someone and say what am I listening to here? or they should say I think this is what it is. And I found that the nurses at Bay State have become very receptive to having a student working with them. And I have a feeling that our students are stronger and more clinically competent now graduating because if you're alone and you hear something and you don't know what it is...

(*You may try to describe it but...)*

Right. Or you may not. You might think Oh God I wonder what that was. So I think the clinical nurse educator model put in place put in place at UMASS by Sister Jeanette C. years ago really works. That was her big thing. Oh my God, I can't be with them all at the same time! And there are some nurses who love to work with students. There were some of course who have bad habits and not nothing to do with students. Well, all we have to do is put some time and effort into selecting people who want to work with them. I find now that students who had a good experience with their clinical nurse come back later to visit her. It works. And that's

myi take on clinical competence. There are some nurses... they slip by us and I don't know what to do about that. You notice that when you have a family member that's sick and you know the roommate is going into congestive heart failure and finally have to say "I think she's in heart failure. And I say really? How could you tell? and you can tell if you hear enough people in heart failure and you can tell by listening to them. And then they run and they get the doctor and he says she's in heart failure. So that's silly nonsense but I think we have a long way to go in the profession with clinical competence because not everybody's got it. And I think there are too many entry levels and too many...nursing assistants are given too much responsibility and they don't know what they're listening to and they take a blood pressure and it can be as screwy as can be on the machine; everybody can see, including the patient, but they chart it and that's it. It doesn't get reported to anybody. So I worry about that as much as I do about the clinical competence of the nurse because if she doesn't know what that nursing assistant just found she can't do anything about it and maybe that patient will die.

(*Unless you have somebody with you that can...)*

That's right. See, at home it's a little bit different because if you have a little symptom. Everybody's got those little blood pressure cuffs and it tells you everything you need to know (laughs). My mother is 93 and she's got one. She'll call me and she'll say the heart was bleeping on the pulse side. I'll say what was your pulse. It's 82 . You're supposed to take Cardia if it goes over 70. Oh, okay. Health Care. 93. If the nurse were taking her blood pressure everything would have looked fine: 136 over (*and an 82 would be fine).* That's right. So what is clinical competence?

(*I asked you)*

I know. I don't think... I think the reason we're having so much trouble in it nursing these days because it's very difficult to define. And I've asked physicians the same question: do you guys ever sit down and talk about clinical competence?

(*talking about physicians (?)*

No physician to physician. And they tell me the same things: sometimes we really don't know. My mother's physician says there are certain guys who will never cover my practice. They won't gossip about it but you know why because they don't respond appropriately to... a lot of them just... they think the elderly are pretty stupid when it comes to reporting symptoms and yet they're probably the most knowledgeable because they've been living with this heart or this whatever.

(*And they know what's different...)*

Right. My diabetes is different today than it was yesterday. I have this very foggy feeling and my blood sugar is thus and such. And if you call one guy he'll say well, take a pill or something. While others will say get yourself down to... get a blood test done and then they come to find out they're sky high well sugar isn't going to help them. That happened to a neighbor of mine at Keystone Woods. Thank God her physician said listen, you're only around the corner. Just go over there and have them call me immediately with the blood sugar. It was 588. So brought her into the emergency room, they fixed her up, she went home and everything was fine. That's clinical competence.

(*And then they teach her to take her own blood... and check it and know when to report; what to report...)*

She had done that but she thought it was wrong. But know when to act...

(*Do you have anything else to add?)*

No. I hope I was helpful.

end

Note: Ms. Asselin is one of the co-authors of: Dreher, Melanie, Dolores Shapiro and Micheline Asselin; (2006) *Healthy Places Healthy People; A Handbook for Culturally Competent Community Health Nursing Practice*__Sigma Theta Tau International