Oral History Number: 259-024
Interviewee: Ruth Halland
Interviewer: Gladys Peterson
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Gladys Peterson: This is yet another interview with Ruth Halland. The date is February 20, 1992. The purpose is to add some of Ruth's comments of some ideas and opinions and information that she felt, she wanted to be sure were recorded. Ruth, I know one of the things that you mentioned to me when you called me again was that, about your degree, or not having a degree. We were so busy talking about so many other things that I neglected to get into that and the status of nursing—the requirements of nursing as they were, as they are, and as many people think they ought to be. So let's start with you. You certainly had a very extensive nursing education, but you expressed an idea about a degree. Do you want to expand on that?

Ruth Halland: I have a diploma in nursing, and my family was education-minded and I wanted to get a degree. At the time, I was considering going into nursing school, there was, as far as I know, one school in the United States that had a degree program and that was Missoula. But it was a five-year course and it was the Depression, and there was no way I could go there. I went to County [Cook County School of Nursing?] and got one of the best diplomas in the United States, but I still wanted to get a degree. So later years—in fact, it was about 1960—I started back over at Eastern [Eastern Montana College], we were living in Billings and picking up the subjects and things I needed for a degree in—

[Telephone rings; Break in audio]

GP: You were saying that there was no way you could go to college when you were in nurse's training, but you started back when you were living in Billings.

RH: Yes, about 1959. Taking courses that would apply—required courses at Eastern. I had my transcript credits sent to Bozeman, and I can't remember exactly but it was in the high 90s that I had—

GP: Your average.

RH: Yes. I hope this sounds nice. Some of the girls graduating from Montana schools resented because I had so many credits. Because of the difference in—

GP: Well, you put in an extra year or two in your anesthetists' program, too. You got credit for that, didn't you?

RH: I'm not sure that I did. I don't remember.

GP: But anyhow, are you saying that your evaluation was in the high 90s? That was your average?

RH: Number of credits I got towards a Bachelor's of Science in nursing.

GP: Oh, number of credits, I see.

RH: Then when I moved over here, I started at the university [University of Montana]. I'd take three, five credits—

GP: We're talking about quarter hours.

RH: Quarter hours, yes.

GP: You probably had about half a degree, if you had high 90s.

RH: Yes, I did. Then it came to the place where I needed to go to Bozeman for a quarter, and I had six children, my husband was a travelling man, and my mother was gone, or she would've come and stayed with the children. So I couldn't go. So I'm that close to a degree, and that was one of my goals in life, was to get a degree.

GP: So you probably were in your third year, or fourth year, of college. You were senior standing, but you had to go to Bozeman and couldn't do it.

RH: Yes. To get the public health—

GP: Oh, public health. Degree in public health nursing.

RH: Well, no, it was just a regular degree, but you had to get some experience. Anyway, the program called for going to Bozeman as part of it.

GP: I see. Well, that must've been a disappointment to you—

RH: Yes, it was.

GP: —when you had such an enthusiasm for learning, a real thirst for knowledge, and completing your education.

RH: But it was fun, and I thoroughly enjoyed it.

GP: Well, to think that you're even able to take the courses with six children is quite an accomplishment.

RH: I took them at night, and I was working many times during the day.

GP: Sound just like a school teacher.

RH: Yes. I am all for continuing education for nurses, and for the requirements now this state have—Montana has it and many other states, we weren't the first one by far—to require the nurses to keep their license, to update, to keep it updated—continuing education—and [unintelligible] to get some credits. And I'm all for that.

GP: Where do they usually go for their continuing education? In other words, what is accepted as "continuing education?"

RH: Now, the university out here, they send out fliers. Bozeman sends out fliers. They have these courses and you go to them, seminars, for a few days, a week, whatever it is, and get credits.

GP: I see. Who puts them on? Who puts the seminars on?

RH: Well, the university has something to do with it and their nursing programs.

GP: Oh, the nursing programs, okay. I see. Do you know how often the nurses have to upgrade their licenses, their state licenses? Or renew them?

RH: Oh, yearly. Yearly.

GP: Yearly?

RH: Yes, yes, yearly.

GP: What's that based on, working or these seminars—

RH: This is the state license, the license to practice nursing in Montana.

GP: I see. It has to be renewed every year.

RH: Every year, yes.

GP: Can you do it without having taken some of those courses?

RH: Yes, you can. Then the Montana Nurses' Association was at one time, and I think they still are, they keep track of the credits and the number of what you have accomplished in this continuing education seminars.

GP: Are they the actual association who does the renewing? Who actually re-issues the licenses?

RH: The State Board of Nursing. Now, when you talk to Lillian LaCroix [see interviews 259-025 and -026], if you haven't, she can tell you a lot more about this, because she's been in education.

GP: I see. I see. Well, I'd like to know…I'm sure you know though, how often do you have to get so many credit hours or take a seminar? It's not required yearly, is it? Every few years, or something like that? [pause] If you don't know, that's all right.

RH: No, I don't mind, I'm trying to think.

GP: I can find out from Lillian.

RH: Yes. You can find out from Lillian.

GP: It would be nice to have that on the record, because then maybe five years from now, or ten years, it might be different and somebody would want to look back.

RH: This happens at every profession. I have worked with some girls who never go to workshops, just the workshops they have here. They never do anything to upgrade their knowledge, and nursing changed so fast.

GP: Do the workshops that they attend here qualify them to renew their licenses?

RH: No, they don't. But you still are—

GP: But you're still an RN [registered nurse].

RH: Yes, yes.

GP: So you can still work.

RH: I feel for your own competency.

GP: Yes. Would a hospital hire them?

RH: Yes, they do, and most of the hospitals—the hospitals, all of them I've seen now—have in-service programs that the girls—

GP: That qualify?

RH: They don't qualify, but just so that they know the latest procedures, the latest equipment, things like that, advances.

GP: Well, that's all very interesting. Do you want to talk about requirements for becoming an RN today, Ruth? Is that the proper time to do that? What I'm saying is, I know that there has been a bit of a dichotomy between what it should take to become a registered nurse in 1992. Maybe I can review this a little bit as I understand it. If you go to the vo-tech [vocational-technical] school and take their highly respected LPN [licensed practical nurse] course, pass the test, and work as an LPN, and then decide to go to…that you want to become an RN, there has been some question about whether the credits should be recognized for that first year. Now, do I understand it correctly that they are now being recognized if you want to go on and become say, an associate…get an associate degree or a four-year nursing degree? Is that correct in Montana right now?

RH: You could do it, but I'm—

Christine, don't do that, sweetie. [speaks to another person]

GP: She's about done there.

RH: Go ahead there, I'll get you one, that's fine. It crinkles on the tape. We can hear the crinkle of paper, honey. You go ahead, you're being a good girl.

GP: Yes, she's a very good girl.

RH: It does. Now, I can't tell you exactly, like I said, someone who's a little…see, I haven't been out for…I haven't been active for a long time, although I keep up. Lillian can tell you more about that than I can. But it is true that you get your LPN then you go for some more education, you get your RN and your associate.

GP: Well, I'm pretty sure I know how you feel about the importance of a degree—getting an actual degree in nursing.

RH: Yes, yes.

GP: Do you think it makes them better nurses? Having the degree?

RH: I think along with a degree, you have to have had…get experience. This classmate of mine--

Just lay that down and leave it, sweetie, and then we'll put it away later. [speaks to another person]

—who has been in education and in administration at the University of Oregon medical school hospital, said that one problem is that these girls finish school, they have their Bachelor of Science, they go on without any…with little experience, and get their master's, and they haven't had the experience they need.

GP: I see.

She's fine now. [referring to other person in room]

Is there any attempt to correct that now, by requiring…Maybe this is a question for Lillian, too.

RH: I think that's a…Those education things are a requirement for Lillian. I have contacts with my classmates who are in this education, but I'm not really qualified to say.

GP: But it evidently has been a problem, because some of the nurses who I have interviewed have said that there has been quite a bit of attrition among these four-year degree nurses because when they get into a hospital, they have not been prepared for what goes on in a hospital. Can you relate to that at all?

RH: Yes, I certainly can. I work with them, I work with the LPNs who have not had to do…they haven't done these things, they haven't had the experiences, and procedures. I think it's because we are in a rural community, we do not have the volume.

At County, when we studied something, we took care of it. This is a problem. I guess I'm not loyal to Montana but when people talk to me, I say…women or parents, about young girls and parents about going into nursing, "Go to the largest school you can, where you get broader, practical experience." I believe that girls get…They are hired, they have to train them to do these…the hospitals have to take the time and expense to train them to do things they haven't had the experience to do. They studied about them, but they haven't had the experience.

GP: Yes. Of course, the time is such an important factor in a hospital, too. Particularly when there are patients who need your services.

RH: Yes. They need supervision until they learn how to do these things.

GP: Now, I'm not going to ask you any more questions, Ruth, until we use the notes that you've made because I don't want to overlook anything that you want to say.

RH: I think it is very important for nurses to be active in their organizations—American Nurses' Association, the Montana Nurse's Association, and in their districts.

GP: It's not a requirement, though, is it?

RH: No, it's not a requirement, no. But if you're going to be professional and take advantages of the advances that come about through these organizations, programs, and political work, you should support them.

GP: Yes, yes. By political work, you mean that you are interested in working for advances that would improve nursing care, nursing benefits—

RH: And hospital nursing improvements. Better care for the patients.

GP: That's what I meant, yes.

RH: Yes. Working conditions.

GP: Yes. Working conditions in caring for the patients.

RH: Yes. I was on one task force here in Montana for safe medication…giving of medications in the state institutions.

GP: Was that a problem?

RH: Yes.

GP: In what way?

RH: They didn't have an RN administering medications. When we were taught…when you prepare a medication, you give the medication. You don't prepare it, and then somebody else pass it. If you pass a medication, you're responsible. And this wasn't happening. And then our nursing homes, the same thing was happening.

GP: Has that been changed?

RH: The last time—and it was a very short time—I worked in a nursing home here in Missoula, it hadn't been changed. When I came on my shift, the medicines had been poured by the RN—the RN does get them ready ahead of me, and I passed them. I had no idea what I was passing, or what the medication was so it tied to the patient.

GP: You say you attend the meetings of the Nurses' Association. Do they still talk about this? Is this still a concern, or you don't know?

RH: No, I don't know.

GP: You don't know.

RH: I don't know if it is or not. Now, Della Swartz [Della Johnson Swartz] was very active. [see interviews 259-020 and -021] So is Pearl [Pearl E. Robbins]. Pearl Robbins. [see interviews 259-017, -018, and -019] They were officers in state, and Pearl, I think was [unintelligible], she was president of the Montana State Nurses' Association.

GP: Yes, she told me that.

RH: Yes.

GP: She said she went to one national meeting in Dallas, I think it was.

RH: I went that year. In '68…maybe it wasn't—

GP: '68 is what—

RH: In '68, I went as a delegate for Montana. Very enlightening and very interesting.

GP: I don't remember what the condition was or procedure was, but she said she was proud to be able to stand up and say Montana does that. One of the few states in the country that was already doing that, whatever it was.

RH: Yes. I don't remember.

GP: Now, have you covered everything on there?

RH: No, I [unintelligible]—

GP: Go ahead, then.

RH: I was going to talk about the fact that nursing started out as a military order way back in the Middle Ages, and it developed through the years and you had someone who was over you always. And a student nurse was low man on the totem pole, and the doctors were over the nurses. What a doctor said, you did, and if the doctor came into the room, or up to the desk, everyone popped up like jack-in-the-boxes. In our nursing school, having raised such standards, we didn't do that, but some of the older nurses resented having the students get on the elevator at the same time they did. Now, the students should wait until your superiors were on the elevator or off the elevator. I didn't…working around the United States, I can't remember in Miami or Denver or Billings—they got it over in Billings, while I was there, jumping up when the doctor came to the desk.

GP: Since you were talking about some of the origins of nursing, it brings to mind a remark that I read in this marvelous book called *Born for Liberty: A History of Women in America* by Sara M. Evans, that one reason that nursing was accepted as profession for women, historically that is—

say Revolutionary, Civil Way days in our country—was because nursing was nurturing. It was the same role as a mother would hold. Then, of course, the reason that this idea was perpetuated of the respect for the men was because he was the father figure. So you had the same relationship in a hospital, or a doctor's office, or a clinic, that you did in a home.

RH: That's right. That is why women have had a…haven't been readily accepted into the medical profession, and many times some of the doctors acted as if you weren't there, you were just a stick, and didn't respect your ability, or your training. Then others were fine, but I found in anesthesia, that it was a different acceptance of the nurse anesthetists. Many doctors don't know how to give an anesthetic and would not give—did not give a safe anesthetic—because they hadn't had the training.

GP: Yes, it's just like any other specialty, isn't it?

RH: Yes. They needed a good nurse anesthetist to give their anesthetic because at that time—

GP: And we're talking 1943, when you were studying that?

RH: Yes—

GP: Graduated 1943.

RH: —but even later, unless you have a doctor, M.D., anesthesiologist, head of their anesthesia department, they take the responsibility. Where I worked, they carried the liability insurance. Otherwise, the nurse anesthetist worked under the hospital—as an employee of the hospital—but the surgeon was still responsible for you.

GP: He had the liability.

RH: I don't know if they always had the liability. I don't think they did. But he was your superior, even if he didn't…he wasn't qualified in anesthesia. But they, the men, respected the nurse anesthetists.

GP: You had a year of training in that, didn't you?

RH: About 15 months.

GP: Fifteen months. You took a board exam, afterwards?

RH: [long pause] From the American Association of Nurse Anesthetists certified…the examination…and you were certified. After a certain length of time, you got a certificate as being a certified registered nurse anesthetist. Now, there was a time when you graduated from a certified school—a school that was accepted by the American Association of Nurse

Anesthetists—then you automatically were accepted. It was the last year when I finished that they accepted you like that. After that, the girls all took an examination.

GP: I see. Who was it then, was it that American Association who determined or decreed how much training you needed? And when you were finished with it, did the people you were working with…you said you were at Wesley Hospital, did they have to certify that you had completed the program?

RH: I have a diploma from Wesley—

GP: Oh, you have a diploma.

RH: I have a diploma from Wesley, and these schools were certified or approved—the anesthesia schools were approved—by the national association…the American Association of Nurse Anesthetists. There were some courses in the United States that weren't. When we were in school, we're told, whenever we went into something, make sure that it was a certified course. Now, Cook County, at the hospital, they did train nurse anesthetists, and they got good experience. But I have worked with girls who went through the program at Cook County in anesthesia, and went to a…one girl went up to Barnes [Barnes-Jewish College]—they have a good school down there—

GP: Oh yes, St. Louis.

RH: —because she did not feel competent.

GP: Is that right?

RH: She had experience, but she had no technical book-learning, no…so she didn't feel confident, so she went through the school at Barnes.

GP: She did that on her own, though?

RH: Yes, she did that on her own. Barnes, Charity of New Orleans, Grace in Detroit, Wesley in Chicago, at that time, that had good schools of anesthesia. At Wesley, we…we, I say, because I worked with them—interns in residence in anesthesia.

GP: I think this is probably a good time to discuss this from the book called *Born for Liberty*, in a chapter called "The Cold War and the Feminine Mystique," and we're talking now about the late '50s and the 1960s, dealing with employment for women. First of all, they mentioned married women teacher—prejudices against married women teachers proved impractical. Then it goes on and says, and this is quoting now, "Nurses found new opportunities as well as new problems in an expanding health industry. Hospitals replaced private duty as the locus of most nurses' employment. Placed under the direct supervision of physicians and hospital

administrators, many nurses felt robbed of autonomy and artisanal pride. But hospital employment was more secure, and jobs were plentiful. New divisions of labor resulted in para-professions for nurses' aides and licensed practical nurses (LPNs). Within hospitals, nurses began to develop specialized expertise associated with cardiac, obstetric, and intensive care wards. Female nurses also discovered new bonds of solidarity with other nurses while working together as a team on hospital wards, and they initiated informal methods of resisting doctor's authority."

RH: That's interesting.

GP: Does that recall anything?

RH: No, I never worked anyplace where girls were aggressive enough to do that, to resist authority from the doctors.

GP: But you did experience the authority. That was part of the job, wasn't it?

RH: Yes, yes. I can remember once, as far as the authority goes, when I was working in Miami, they had black surgeries and white surgeries. I was in black surgery, and I liked, I like the Negro race, and—

GP: You were used to working…You had a lot of experience in Chicago.

RH: Yes. They brought a old, old, Negro man down for elective surgery. I [unintelligible] him and I took his temperature, and he had a temperature of 104. I said to the rest, "He's got a temperature of 104, why is he here? Why's he here? He shouldn't have surgery," and it was elective surgery. He said, "He's only a nigger." It made me furious. When the attending man came, who did to the surgery…would've done the surgery, I said, "This man has a temperature of 104."

He said, "What's he doing here? Send him back to his ward."

If that attending man had said, "We'll do the surgery anyway," I was not going to do it. I was going to my boss, Dr. Pierceman (?), who was in charge of the department, and tell him I would not give the anesthetic. I've got a little spunk, and I would've done it.

GP: Well, you've got a little spunk. You also have a lot of principle, too. Strong principles, I'm sure of that. Well, I just wondered if you wanted to respond to that at all. But generally, it was the policy that you followed the instructions.

RH: Yes, you followed the instructions of a doctor, what the doctor said. I remember I was working up here at a small hospital, and they would send…The economy was poor and the doctors were thinking of the finances of the patients, and they sent their OBs home so fast.

They do now, anyway, but they sent their caesarian sections home. I said to this one doctor, "Why do they go home so soon? These women have worked and worked hard all their life. They're going to have prolapsed uteruses from the work they do." He mentioned the economy, and I did say to him, "But Dr. so-and-so, the OB men do not do this."

Now, when I was a younger nurse, I probably wouldn't have told him what the OB men said to do for their caesarian sections. So younger girls, I hope, can stand up for the right things.

GP: Well, times have changed, no question about that.

RH: Yes, they have. That was a simple thing, but still, didn't do things like that, didn't tell a doctor.

GP: No. Before we get back to whatever else you have there, this just occurred to me, what did you think about the situation in Helena of the nurses who had saved the pain pills because they were not available when patients needed them?

RH: That was a difficult situation, but I think I would have raised a stink.

GP: You mean as a nurse?

RH: As a nurse. So that we had the medication to give to the druggists, the pharmacists. They could adjust [unintelligible], legally, so that we could be covered.

GP: Rather than put your own personal self at risk.

RH: Yes.

GP: I see what you're saying.

RH: They were thinking of their patients, yet it wasn't legal. It's a hard decision.

GP: Yes, it would be. Well, I guess they didn't really realize the trouble they were going to get themselves into, either, did they?

RH: No, no, they didn't.

GP: Do you have some more items on your paper?

RH: Yes, I do. I was going to say [pauses] across the street from our children's hospital, from the children's building, was a laboratory. And in that…two of the doctors that worked there, were the Dicks, Dr. and Mrs. Dick [George and Gladys Dick], they were both—

GP: You're talking about Cook County Hospital?

RH: In Chicago, yes, Cook County. They developed the Schick test for diphtheria and…immunizations, I should say, test immunizations for diphtheria and also for scarlet fever.

GP: Is that right?

RH: Yes. The Dick test was for scarlet fever and immunization and the Schick were for diphtheria.

GP: I kind of remember that term, Schick test.

RH: Yes. That was already being used, but when we went there to Cook County as students, I had had scarlet fever. But they came, Dr. Dicks came to the hospital every week and gave the girls shots—the girls that hadn't had scarlet. A number of them, we could watch the clock, and after a certain time after they'd had their shots—we were always in class—[laughs] they left with their hands over their mouths and ran for the bathroom. [laughs] Then, when my children were born, I asked for scarlet shots for them—the Dick shots.

GP: I didn't even know they gave them. Are they still doing that?

RH: No. They have the new antibiotics take care of it.

GP: Once they get it.

RH: No, even…Well, yes. The pediatrician told me on my last baby that what they were doing, so we didn't give her the shot for scarlet.

GP: Either that, or it can be used as a preventive in cases where they don't want the disease to develop, right?

RH: Yes, and there isn't much incidence of rheumatic…I mean, of scarlet fever. I say of scarlet fever and rheumatic fever because it many times caused, associated with rheumatic fever.

GP: Well, that's interesting, I've never heard of…I've heard the term, the Dick test, but I really didn't know what it was for and never knew anybody who had it.

RH: Then at the contagious hospital there, which was a three-story building at Cook County Hospital, we had all kinds of contagious diseases, of course, and lots of polio at that time.

GP: I'm glad you brought that up.

RH: Many, many iron lungs. Over in the children's hospital, we gave, did a lot of Sister Kenny's treatments and in contage [contagion?] of the hot dressings. Real hot, moist dressings. Another experience I had was the Orthopedic Doctors Association of Chicago brought…Sister Kenny, at that time was in Minneapolis, and she came, they brought her to Chicago and we had the opportunity of listening to her. Now, she had been treated so badly in Australia by the doctors—

GP: She was a native Australian.

RH: Yes, she was. In England and Australia, they called nurses "sisters." She worked out in the outback and developed this treatment, and the doctors wouldn't accept it there. When she came to the United States and worked over in Minneapolis, many of the doctors accepted her treatment here and many didn't, because she was a nurse.

GP: I see, that was the reason for that.

RH: Dr. Leventhal (?) was in Chicago and was president of the orthopedics group at that time. Came to the nursing school with her, and there were a lot of people there for the lecture—her lecture. She was still on the defensive. We had a girl in our class who was always asking lots of questions, and the questions were good. So she would ask her why this worked, and Sister Kenny didn't like that. She was upset, she got ruffled. Dr. Leventhal would stand up immediately and explain.

GP: Why it worked?

RH: Why it worked, yes.

GP: Well, that's interesting.

RH: Yes. Polio was a bad—

GP: Yes, I remember. See, we lived in Minneapolis. My husband was in graduate school there. We moved there in 1948, and we were there until January of '51. The Sister Kenny Foundation was very well-known at that time.

RH: Yes, and I think all over the United States.

GP: I remember that. Maybe it was particularly known in Minnesota, I don't know, but I remember hearing about it. I know they solicited funds the way the heart fund does today, cancer society does today, too. She seemed to have a lot of respect where we were.

RH: Yes.

GP: I might've asked you this the other day, Ruth. Were you working with these polio patients? I guess what I'm saying is, were you exposed to these contagious diseases? Did you feel that there was any risk being with these people?

RH: No. No place did we ever, did I ever feel at risk, and I don't think the other girls did. The only thing…that place was in the tuberculosis hospital. You did kind of have a thought in your mind about getting tuberculosis. Our patients there at Cook County were so sick, so many of them, with advanced tuberculosis of the bone, of the throat, so we saw the worst, worst part of it.

GP: Did you wear masks at all?

RH: No, we didn't wear masks. But we washed our hands frequently, and in a tuberculosis hospital, the patients are taught to protect everyone—the environment. They sneeze, they cough into a Kleenex and it's put into a sack that is disposed of and burned. I went through my time there in the tuberculosis hospital and in the general hospital with…many times, and especially where our patients were, didn't have the advantages, lower economic people were more apt to have tuberculosis. You run more of a chance of being exposed to it in a general hospital, than in a tuberculosis hospital, because the tuberculosis people know how to protect themselves and others. I went through there, and I worked until 1959 or '60 without a positive Mantoux test for tuberculosis.

GP: Now, what do you mean? You hadn't taken the test, or you just were negative? [talking at the same time]

RH: [talking at the same time] I'd taken it, but it'd always been negative.

GP: It was always negative.

RH: I was taking care of a lady in Billings who was admitted—she had multiple sclerosis amyotrophic lateral sclerosis, that's the Lou Gehrig, what they called Lou Gehrig's [disease]. She couldn't talk, she had a tracheotomy, she could just move her fingers, that's all she could do up to her tracheotomy. And we had to suction her continually. Her admissions sheet X-ray showed that she had calcified nodes in her lungs. When she expired, at the post [post-mortem (autoposy?)], they found she had active TB. The calcification had broken down. We washed our hands, I did, continually. So when we found out the pathology report, I went to the doctor on the case, a young man, and told him. He said, "Oh, that's so far down in her bronchial tree, you couldn't have got it." Imagine an M.D. saying that. But, young men didn't know about TB. It was pretty well under control throughout the country.

GP: It was, but it was still around, I remember that.

RH: It was still around. And my arm, I had been…He gave me a test, a Mantoux, and, oh, how my arm swelled up and swelled up. Then the lady who was in charge of the TB association in Chicago…I mean, Billings—it was my next door neighbor—and she called me right away. I said, "Do you want to see my Mantoux?" So through the tuberculosis association, I had weekly, or monthly…or twice-a-yearly X-rays. But what had happened before I became positive, was that working with the school system, we had tested the high school students, give them them Mantouxs, and in two different schools, three weeks apart, I had had a Mantoux. We give them to each other, practice on each other. So that we knew…we could pinpoint when I was exposed, which doesn't happen very often.

GP: So what was your exposure?

RH: I was put on a…went to my internist—

[speaks to someone else] Put that down, honey. Don't do that.

My internist called the doctor in charge of the tuberculosis program in the public health department.

GP: This was in Billings?

RH: This was in Billings. Yes. Now, my internist was a good man, but he didn't know about it either—the treatment. So I was on one of the specifics for tuberculosis. Isoniazid—I was on that for a year. There were other…There were a couple other drugs that were specifics, but this was done so that if I ever became active, I would have these other two drugs to fall back on. And nowadays, many tuberculosis patients aren't hospitalized at all.

GP: Yes, they're just given the drugs.

RH: They're given the drugs, and they still should not expose children under 16, should not be exposed to them—tuberculosis patients—because children and young people are especially susceptible.

GP: I see. I'm interested in those iron lungs. You said they had a lot of iron lungs at the contagious disease hospital there at Cook. Was this the young age group—children and young adults?

RH: No. We had some old ones.

GP: You did?

RH: Yes, we did.

GP: I thought that that was supposed to be a disease of mainly younger people.

RH: It strikes everybody.

GP: Strikes everyone. Lots of fatalities by the time they were in the iron lungs?

RH: I think they were quite successful in treatment.

GP: They were?

RH: Yes, but they had to [unintelligible] afterwards.

GP: It depends on the individual, of course.

RH: Yes. And just what is affected and how badly.

GP: Yeah. I was just wondering if any of them ever really regained their health, though, after being in an iron lung.

RH: I would say they had a lot of residual, and you still see people my age who had polio at that time that are still affected, yes. [unintelligible; talking at the same time]—

GP: They're still affected by it in one way or the other.

RH: One way or the other, yes.

GP: I see. Well, I certainly remember that it was a very dread disease.

RH: Yes, it was.

GP: I could tell you some stories, but this is your tape and not mine, so. What else do you have there, Ruth, that you wanted to comment on now, so we don't forget it?

RH: I think that's about all I have noted here.

GP: I see. Well, I can't think of anything else, except to say that you certainly have had a rewarding life, haven't you?

RH: Yes. With all the advancements in medicine and it's getting more technical all the time, I feel that a nurse cannot have too much education.

GP: That's a good way that we can conclude this, and we're looking at your five-year-old granddaughter down here?

RH: Yes.

GP: It would be nice if some of this was going in, being absorbed in her little head, wouldn't it?

RH: Yes.

GP: At least it's on tape now, and maybe someday she'll get to listen to how wise her grandmother is.

RH: My children, my daughters, I know some of my sons, and my daughter-in-laws will be interested.

GP: Well, good. So I've taken a lot…I've taken another afternoon here, but I know that the archives [Mansfield Library's Archives and Special Collections] are going to appreciate all this and students are and even people interested in history. So thank you very much.

RH: I hope I haven't put in too many "ums" and "ahs" in. [laughs]

GP: Not at all, you've been very, very good.

[Break in recording]

GP: We've just thought of another subject that Ruth has an opinion on. So, Ruth, tell us about men in nursing.

RH: The first men nurses [unintelligible] that I can think of were in the Brothers Hospital [Alexian Brothers Hospital?]. They took care of men. [laughs] If they got a woman in, I don't know what they did with her, but they wouldn't take care of the women. I've worked with some male nurses in Chicago who told of the problems with women coming into the hospital, and how the Brothers didn't want to take care of them, because they were women. They didn't think it was nice, I believe. But I worked with the young men here in Missoula and also had them take care of me. They have been very good, and sometimes they would ask me about different nursing procedures that they hadn't had experience .

GP: Oh, is that right?

RH: Yes.

GP: Where were they coming from, generally?

RH: Well, I think… [pauses] One of the young men out at Deacon, [unintelligible] Deacon [Deaconess Billings Hospital?} when I was there, I thought he was from Miles City, but they

have accepted men here. I know a couple of men who have gone into nursing. One man had almost-teenage children before he went into nursing, but it something he'd always wanted to do. He's working down at St. Pat's now.

GP: I see. They're still in the minority, by far.

RH: Very much so. Very much so, yes.

GP: But being more accepted, it's getting more common to see them in the hospital.

RH: Yes. More and more men are going into…as nurse anesthetists, in anesthesia.

GP: Oh, is that right?

RH: Yes. That's a good field for a man because he can also take some hospital administration and then go into these smaller hospitals, and he can be director of the, nurses, nursing service, he can be administrator, he can give the anesthetics. He's well-prepared to manage a small hospital.

GP: A job like that would certainly command a higher pay, too.

RH: Higher pay, and nurse anesthetists have always, have always been at the top of the pay scale and above, way above, most nurses. Unless, the girls with the degrees get better.

GP: Okay. Well, thanks again.

RH: I have enjoyed this, Gladys.

GP: Well, I have, too, and I've learned a lot.

[End of Interview]