RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY

NEW BRUNSWICK

AN INTERVIEW WITH LINDA FLYNN

FOR THE

RUTGERS ORAL HISTORY ARCHIVES

INTERVIEW CONDUCTED BY

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TRANSCRIPT BY

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Johanna Schoen: That kind of explained, for one second, the background, which I had also sent you the material to make sure--are you're okay if we're recording this?

Linda Flynn: Yes.

JS: Okay. What we're trying to do is, Paul has actually written at least one book about the history of Rutgers. I usually work on the history of reproductive stuff, and I'm now starting a book on the history of neonatal intensive care units [NICU].

LF: Oh, my goodness, that's excellent.

JS: I'm so excited about it. At some point, when we can meet in person again, I'll come, and we'll just have coffee and chat about that.

LF: Okay.

JS: Yesterday, I found the motherload of articles about the history of NICUs, and I was very excited about it.

LF: Oh, fantastic.

JS: There's a neonatologist, Silverman is his name, who wrote about the history of his specialty, who is very good and very reflective. So, that was great.

LF: Yes.

JS: At some point last year, Paul approached me and asked whether we could join forces to write a history of COVID at Rutgers, and I had to say yes because that's just really tempting. So, as I was explaining in the consent and description that I sent you, we're basically just starting interviews. We have, between the two of us, picked a bunch of different units that we want to talk to, and clearly the Nursing School is at the very top, right?

LF: Yes, yes. We've been hit pretty hard and are very much involved in the whole pandemic in every aspect.

JS: Yes, I can imagine. Are you training nursing students now to administer the vaccine, because I hear that Rutgers is becoming a vaccine site?

LF: Yes. In fact, our Associate Dean of Advanced Practice is co-chairing that VAX [vaccination] Corps and, yes, we have a large number of students, both graduate students who are already RNs [registered nurse], and undergraduate students, and they will be working in the VAX Corps, yes.

JS: Yes, that's really great. That must be exciting for them, too.

LF: It is. It is, yes. The undergraduates, and we can talk about the challenges of clinical placements during a pandemic, but the undergraduates, this will give them an opportunity for their clinical hours, and it's also an opportunity to be a part of history.

JS: Yes, that's really great. So, let me introduce you to Paul. Paul, can you adjust so that we can see your face a little bit? There you are.

LF: Hi.

JS: So, this is Paul Clemens, Linda Flynn, and, Paul, we just did the background and consent stuff. So, we're actually ready to go. I was being my little efficient self. [laughter]

Paul Clemens: I was a little late, so I'm sorry.

JS: No, you're totally fine.

LF: I hope you don't mind if I occasionally drink my cup of coffee as we talk.

JS: You can do whatever you want, and we're all at home, so we also understand there might be interruptions. I have two dogs who are racing behind me whom I'm trying to keep at bay.

LF: There is someone in the house vacuuming, so you may at times hear a vacuum cleaner in the background, but it's not in this room.

JS: That's totally fine. So, I actually wanted to start a little bit briefly with background information. If you can talk for a moment about where you were born and raised and a little bit about your educational history so we have that, that would be lovely.

LF: Sure. I was actually born and raised in Washington, D.C. I'm a native Washingtonian, and so is my husband.

JS: What did your parents do?

LF: My father was an electronic engineer when that profession was very new. It was an emerging science, and my mother was a housewife. She was originally, I guess, a beautician, a hairstylist, but, in those days, once married, women didn't usually work. [laughter] So, she was a housewife.

JS: When and how did you decided to become a nurse?

LF: I actually decided I wanted to become a nurse when I was five years old.

JS: Wow, that's great, and what led you to this?

LF: Yes, I had one of those Little Golden Books that children used to read, or they were read to me, and one was about Nurse Nancy. It came with a little band-aid, which I thought was really exciting.

JS: That's really funny. [laughter]

LF: There was a line in there that her little friend fell and hurt his knee, and the line in the book read, "But Nancy was a nurse, and she knew what to do." So, I decided then that that's what I wanted. I wanted to know what to do when people got hurt. So, that's what started it, and while I considered other options, that was the one that was always first on my list.

JS: Where did you do your undergraduate years?

LF: University of Maryland.

JS: Okay, and I should know this, but I'm sorry.

PC: Me, too.

LF: Did you?

JS: Oh, you too, Paul? [laughter]

LF: Well, the University of Maryland has consistently been one of the best schools of nursing in the country.

PC: Quickly, is the School of Nursing in Baltimore or in College Park?

LF: You do your first two years in College Park, and then you actually have to then apply to the School of Nursing and that's in Baltimore.

PC: That's what I thought, because I didn't remember it having a major presence. I was there until '69, and I didn't remember. So, I assumed it was probably in Baltimore.

LF: Yes, for sure.

JS: Was the University of Maryland your first choice?

LF: It was. It was. My family was living in the Maryland suburbs, about a mile from the D.C. line, at that point in time. It was the natural choice. It was also, like I said, a very highly-rated school of nursing.

JS: What year did you enter it? I'm asking because I used to teach a class on the "History of Medicine and Film," and I can't remember which film we watched, but there was one about nursing education from the 1950s that my students always had to shake their heads when they saw it. [laughter]

LF: I know. I graduated in '75.

JS: Okay, so the early '70s.

LF: Yes, in the '70s.

JS: How did you like it? What were your thoughts when you started this education, after having wanted to do it since you were five?

LF: Yes, I enjoyed it. I enjoyed it. I had no problems. It was pretty much what I thought it was. I had volunteered as a teenager as a candy striper, so that I could see what nurses did. I'll be honest, I'm dating myself, but I was working during the summer as a candy striper at a large hospital in Washington, D.C. on the day that Medicare became effective. So, I saw firsthand how much it impacted the nurses because all of these patients that had been waiting until Medicare became effective to be admitted into the hospital just converged on the hospital. So, I remember that specifically, but I also saw firsthand what nurses do and how important they are and how well prepared they are, how much they have to know, because they're there twenty-four/seven. The physicians are, obviously, very important and a collaborative member of the team, but they come and go.

JS: Right.

LF: So, it is up to the nurse to notice when a patient's condition changes and to communicate that to the physician and to be the patient advocate. I mean, obviously, it's hard. It was probably harder than I thought in terms of the education rigor, but I was like, what, eighteen years old. [laughter] So, I was in no position to critique.

JS: Well, it is great for those of us who have this goal of what we want to do and then actually get to do it. There's such an excitement that comes with it.

LF: Yes.

JS: I imagine that it was probably much of that as well.

LF: Yes.

JS: Was there any particular specialty that attracted you or that you felt like you eventually wanted to go into, or were they all equally interesting?

LF: During my education, I was particularly drawn to labor and delivery, and that was my first job. It was actually at the University of Maryland Hospital in labor and delivery. Then, I realized that that was very specialized, and maybe I didn't want to be so specialized in my practice. So, then, I went to the hospital, actually, where I had been a candy striper in Washington, D.C. I was on an acute medical floor that had an ICU [intensive care unit] step-down unit embedded into it. I was there for several years and just learned a lot. I was the charge

nurse on three to eleven, the evening shift, and the patients were very sick, very, very sick. I just learned a lot, worked very collaboratively I remember, in those days, and I hope the same is true today. I worked very collaboratively with the physicians and the residents. It was a teaching hospital, so there were a lot of residents around, and we were a good team.

JS: That's, actually, also really heartening to know. So, it wasn't a place that was particularly hierarchical and where as a nurse you felt like you didn't have much standing vis-à-vis the physicians who were on the floor?

LF: No, I didn't feel that at all. The residents, first of all, are younger. They were more our age. In those days, and this may not be true now, but, in those days, it was not unusual for the residents and the nurses to get together on Saturday night and have a dinner party or whatever. No, I remember it being very collaborative at that level. The hospital hierarchy might have had a different view of nursing. They tend to see it, especially in those days, nursing as an expense, as opposed to the contributions that nurses make to the positive patient outcomes. But, with respect to the residents and the physicians, no, it was very collaborative.

I do remember, and I worked three to eleven, one night, evening, that was particularly hard. There were a lot of patients, particularly elderly patients, that came in acute respiratory failure, the complications of congestive heart failure, things that might have been more treatable and would prevent a hospitalization if they had been picked up earlier. I realized at that point that I was on the wrong side of the wall, that I needed to be in the community, visiting those patients who were at high risk on a regular basis and trying to keep them out of the hospital. So, that's when I changed specialties, and I went into community health and Medicare-certified home health.

JS: Let me guesstimate. So, that was probably in the early '80s, mid '80s?

LF: Yes.

JS: What was the name of the D.C. hospital where you were a candy striper and then on that shift?

LF: Yes, the original name was the Washington Hospital Center, and it's now known as Medstar.

JS: When you were working there, is it a public hospital or is it private?

LF: I believe it's private.

JS: Okay, so the patient population, I then assume, was mostly white and middle class?

LF: Not necessarily.

JS: Or was it everybody?

LF: Yes, it was everybody, and Washington, D.C. is a very multicultural area.

JS: Right, okay. Just to backtrack once to your experience in nursing school, how diverse was the student population? This is both in terms of race, and also were there any men at that point, or is that too early?

LF: No men. [laughter] There was some diversity but not a lot of racial and ethnic diversity, not a lot; some, but not a lot.

JS: Once you start doing the community health, talk for a moment about that. What time period did you do that and what kind of experiences did you have and how was that kind of work?

LF: I did that for close to thirty years actually. [laughter] I did that for a long time. I started in Washington, D.C., making home visits for a non-profit, visiting nurse associations. I don't know if you're familiar with that term. They're Medicare certified. So, it wasn't private duty. We carried caseloads. We saw about five or six patients a day. Usually, those who were recently discharged from the hospital, sometimes on the day they came home from the hospital. [We] visited them for approximately sixty to ninety days and then hopefully got them to the point where they were stable and families could chime in and help monitor their conditions. So, I did that actually in all areas of D.C., including some areas of D.C. where the post office refused to deliver mail because of the high crime rates.

JS: Yes, I can imagine that doing that kind of work gives you a very different sense of how effective you can be, and also of course brings you into the personal circumstances of patients that you otherwise would never see, right?

LF: Yes.

JS: That's an amazing education.

LF: It is. It is, yes.

JS: At some point, I'll sit down with you, and we'll just talk about that.

LF: That's a whole other story. [laughter]

JS: It's a whole other story, exactly. Tell me what led you to Rutgers and to the position that you have now.

LF: Okay, sure. What originally led me to Rutgers is that my husband took a job with Bell Labs, and so we moved out of the Washington area and moved to New Jersey. So, I wanted to go back to school and get a master's degree. I'd actually started a master's degree at a school in Northern Virginia, which was where we were living at the time. So, I wanted to continue that. I wanted to transfer to a New Jersey school. One of the professors at Rutgers School of Nursing, who's still there, Lucille Joel, was president of the American Nurses Association [ANA] at the time and had written an article in that periodical. I forget whether it was a journal or a

newspaper or something like that, and it was a very good article obviously, very well written. It was about some issue at the time in nursing. I don't remember what it was. Then, under her byline, she had Rutgers University School of Nursing, and I thought, "Wow, if the president of the ANA is at Rutgers and Rutgers is in New Jersey, then that's where I should apply." So, I did.

JS: That was a two-year program?

LF: That was my master's degree. So, that was longer. I guess that was more like four years before I graduated, and then I went right from that program into the Rutgers School of Nursing Ph.D. program.

JS: How much is that classroom based and how much of that is clinically based, and what was your area of emphasis in the masters and the Ph.D. program?

LF: Okay. In the master's, my emphasis was community health.

JS: Okay.

LF: It's a mix. It is certainly classroom based, but you have clinical hours that you have to do as well for that in the community, which I did.

JS: Did you do that in New Brunswick?

LF: My classes were in Newark.

JS: Oh, okay, and where did you do your clinical hours?

LF: I did them at what is now the Visiting Nurse Association of Central Jersey, and that is in Monmouth County. I did them with a program that they had that was grant funded that was focused on healthcare to the homeless.

JS: Ah, okay.

LF: I worked with shelters.

JS: By that time, you were well prepared for this, assuming what you were suggesting about the D.C. experience, right?

LF: Yes. [laughter]

JS: Then, you went directly from there to the Ph.D. program?

LF: I did.

JS: What …

LF: I'm sorry. After that, I did a postdoctoral research fellowship at the University of Pennsylvania.

JS: For how long was that?

LF: Two years.

JS: What was the research fellowship? I mean, what area was that?

LF: Yes, I was at the Center for Health Policy and let's see, it's Center for Healthcare Policy and Patient Outcomes I think is what it's called, with a very famous nurse researcher there by the name of Linda Aiken.

JS: Okay.

LF: She had a lot of NIH [National Institutes of Health] funding and had spearheaded the whole research into the relationship between nurse staffing and patient outcomes, like mortality and the work environment, the organizational culture of hospitals, and nurse and patient outcomes. So, I went there because my goal was to replicate that program of research into other than acute hospital settings, because at that point it had only been done in hospitals. So, that's what I did.

JS: So, did you essentially have to write a dissertation that does that replication, or how does that work in nursing?

LF: Oh, for my Ph.D., I did a dissertation, before I did my post-doc.

JS: Oh, yes, I'm sorry. I was getting the times mixed up.

LF: Yes. My dissertation was on predictors of health practices among homeless women. So, I carried that homeless focus, community-based focus into my dissertation, yes.

JS: So, after the post-doc, is that basically when you went back to Rutgers?

LF: Yes, I did. I was an assistant professor, and I was there for--oh, let me see. I did several things. I was there for a while. Eventually, I left. I had two other positions before I came back to Rutgers about three years ago.

JS: You came back immediately as dean or as interim dean first? I can't remember.

LF: Oh, yes. Well, from Rutgers, I went to the University of Maryland, which is my other alma mater, and then to the University of Colorado, because we relocated to Colorado. I was at the University of Colorado for about five years and went back to Rutgers in 2017.

JS: Okay.

LF: I missed my colleagues. I missed everything about it. So, I came back as a full professor and the director of the Ph.D. program.

JS: You know, this is interesting and it already answers the next question that I was going to ask you, and it's also heartening because it indicates that you really like this program, right, that Rutgers was a place that--so talk to me about what's really appealing about it, both as you were a student in the program and then also as a professor on the assistant professor level and then when you returned from Colorado.

LF: Yes, you're absolutely right. I love Rutgers. That's why I keep going back. Being at two other universities was really helpful because it opened my eyes as to what other schools do, what best practices might be, and so I'm glad I did that. I really like the people. I like the faculty. I like the staff. I like the students. I like the mix of students. Currently, sixty percent of our student body are from underrepresented minority populations. So, that is very appealing to me. I just like the collegiality that I feel there.

JS: That's really great. So, I'm going to turn to last spring.

LF: Yes, okay. [laughter]

JS: I don't know what your answer is going to be, it might be that we're turning to late 2019, but when was the very first time that you remember hearing about COVID and then following up on that that you had that uh-oh thought, "This is going to be something."

LF: Bad.

JS: Yes.

LF: Yes, I remember.

JS: I assume you were more able to understand that this was going to be bad than many of us in other professions.

LF: Yes. Well, the first time I heard about COVID was when most of us did. It was a news story. It was something happening in China. I paid no attention to it at all. [laughter] Then, it was in Europe, and then I still was busy doing other things. I was interim dean at the time. I wasn't appointed yet as the permanent dean, and so I was busy. I was distracted. I wasn't paying too much attention to it. I honestly didn't think it was going to impact us. Then, I went to a deans and directors meeting that was chaired by Brian Strom, the Chancellor of RB [Rutgers Biomedical and Health Sciences] …

JS: I know him.

LF: … Who is not only a physician but a leading epidemiologist as well. He explained what was going to happen in graphic detail.

JS: Do you remember what month that was?

LF: It was basketball season [laughter] because I took a risk and went to a Rutgers game. It was probably, I would say, late February.

JS: Okay. That would have been my guess.

LF: Something like that, and I remember everything he said came to pass, and that was the first time he talked about the death rate in the United States, that, unless we were really effective in mitigation, would reach 500,000. He talked about how it would spread across the country, how we didn't know how to treat it. It was highly communicable. It was going to be a major impact, and that it was being transmitted like now. He predicted that in two to three weeks we would start to see a surge on the hospitals and mortality rates, and he was absolutely right. My husband and I had airline tickets that evening to fly to see our family, and I remember calling my husband from the office and said, "We're not going. We're not going for a couple of reasons. One is that I'm going to be needed right here, and number two it's being transmitted now and we need to isolate." So, yes. So, that's when I first heard, really understood what was happening.

JS: So, then because you guys are smarter than we are, I assume that the next day you essentially jumped into action, trying to figure out what to do in terms of the Nursing School, right?

LF: Yes.

JS: What were your thoughts? What were the things that you felt like you needed to address first?

LF: Basic crisis management principles. I alerted our leadership team, the vice deans, the associate deans, the assistant deans of the undergraduate and graduate programs. I alerted them that at some point we would probably be switching to remote classes versus in-class courses, although we weren't asking faculty at that point to make that transition. It was still very early but started to really deal, at least begin the conversation, and this has been the theme throughout, how do we keep our students, our faculty, our staff and our patients safe and still educate the next generation of nurses and nurse leaders? I refer to it as threading the needle. It's a very fine line to walk, and we were going to have to make some really tough decisions about--how much do we keep students in clinicals? How do we educate them? How do we get those clinical hours in a way that meets their learning objectives and doesn't halt their graduation progression, but, at the same time, keeps them out of hospitals that are overrun with very infectious and contagious COVID patients?

JS: It's interesting to me because I remember, and this was, I think, when you and I emailed about the early graduation of that nursing class, right, in the hopes that they would be able to enter the labor force, and I was actually thinking about that. In fact, I had a discussion with my students. I was teaching that class on the "History of Medical Ethics."

LF: Yes.

JS: There were a bunch of nursing students in that class, and we had a discussion about the ethical issues involved. Basically, after the University shut down and we went remote, I just turned the class to the history of pandemics.

LF: Yes.

JS: I felt like it was on everybody's mind. Let's just go there and let's do nothing else. So, that's what we did. What were the discussions that kind of surrounded this issue of placement and the early graduation of those students and what to do with them and how to place them?

LF: Right. In terms of clinical placements, the faculty's opinion really ranged the gamut. There were faculty who thought, "No, no, we have to protect the students. That's the first priority, even if it means halting clinical education." Then, there were faculty that were like, "No, send them into the hospitals. Assign them COVID patients. They have to learn. This is a great learning opportunity." So, I would get emails from parents of the undergraduate students, you can imagine, right, and the students themselves, undergraduates, saying everything, the same dichotomy, "We want to get the education we paid for, and we want to be in the thick of things," versus, "Oh, my God. You're not going to send me into a hospital, where there may be one COVID patient." So, the reaction of students and their parents, particularly undergraduate, was very mixed. I didn't think that we necessarily needed to appeal to the extremes, but we needed to rationally and logically decide what was best. I collaborated very closely with the chief nursing officers at our hospital partners, particularly the RWJBarnabas system.

JS: Okay.

LF: We became very close colleagues. I would call them early in the morning. They would call me early in the morning. Eventually, the decision at that point early in the pandemic was made for us. The hospitals were just overwhelmed, just overwhelmed. The good news, I'll start with the good news, is that I've heard, and I'm sure it's true, that in New Jersey every patient that needed a hospital bed got a hospital bed and every patient that needed a ventilator got a ventilator, but I can tell you they had beds everywhere. They had beds in the lobby. They had beds in the cafeteria. You know this. They had beds everywhere. There was also the issue of nurses. While most of the nursing workforce were really valiant, and we know that, they had their moments. They would break into tears. I understand that there could be medical students that ended up fighting over PPE [personal protective equipment] or nurses fighting over PPE at that time. They just didn't think that they could handle students. To be perfectly honest with you, and I think this was true of all the hospitals in New Jersey, they didn't want the students to see that.

JS: That's really interesting, and it's not surprising, but when you started the story, I wasn't sure what the outcome would be, whether we end there or whether end on the other side.

LF: So, they kicked us out of clinical, and this was like last March. So far they're thinking about kicking us out now, but they haven't yet, at least not all of them. So, it's a different situation, but last March nobody knew what to do. We didn't know how to treat it. We didn't know. So, we

converted, I think like, I don't know if I mentioned this before or not, but at the same time the University made the decision that classes would be remote. So, our faculty, who were used to teaching face to face, we were not an online school by any sense of the imagination.

JS: Right.

LF: Most of them had never even taught online before. They converted 162 courses to remote in one week.

JS: Yes, over spring break, right?

LF: Yes.

JS: Let me jump back to that for one second. So, given that this meeting with Brian Strom, where you first became aware of what this meant, was in February, even if it's late February, there's a lag of two to three weeks, where you totally understand what's happening, and the rest of the University, at least the part that's not associated with RBHS, they must, from your perspective, be seeming to [be] bumbling about and not really knowing what to do and why aren't they closing? Am I right?

LF: The thought crossed my mind, not that they were bumbling, but I was looking for a decision, and RBHS was the most flexible. As deans, and I could talk about that in a minute, we decided that not everything could be remote.

JS: Right.

LF: Right, because we have to, at some point, students have to at least have some contact in the skill labs or something. So, we can't keep them totally off campus. But we definitely felt that our courses, our lecture courses, needed to be remote. We sometimes have a hundred students in a lecture hall. We couldn't have a hundred students in a lecture hall, not something that's sustainable in a pandemic. So, they converted their lecture courses to remote. Then, we also started buying software and looking and assessing software that was virtual clinical, where there would be a virtual patient in the module, in the online module, and the students would be able to do things or recommend things or assess, particularly assessment. That way we used what we called evolving case studies for teaching purposes, so a virtual simulation, where we might have one faculty member all alone in the simulation lab with a high-fidelity mannequin, and these mannequins talk, they do whatever you want them to do, who might go through a simulation, "This is how you handle this situation. This is how you suction a trach [tracheotomy]. This is what you do on a cardiac arrest," that kind of thing. So, we reverted to virtual clinical. In those intervening weeks, before we knew what was coming and before they kicked us out, we concentrated on clinical hours. By the time we actually were asked to leave the facilities, most of our students had already gotten most of their clinical hours that they needed for patient contact.

JS: Basically, you used those interim weeks to kind of push them through those hours?

LF: [Yes].

JS: That's smart and really interesting.

LF: We got as many hours in as we possibly could. We got as much skill labs time in as we possibly could doing this.

JS: Yes, because the other thing that really strikes me about what you're saying is when I look at the way in which remote instruction worked in the History Department, there's so much adjustment you can do. You can't really lecture to a class eighty minutes in a session and do that twice a week, and certainly the kind of skills that you have to teach that we don't even have to teach, you of course can't do remotely. Did you feel that you were, in the end of the spring semester, able to teach students what they needed to know, or did you feel like there was a gap between what you really wanted them to know at the end of the semester and what you were able to achieve? How did that adjustment work?

LF: Yes, I think we actually, in the end, did very well, despite everything. It would not be a paragon of remote teaching by any means, but we are now starting to get--in fact, I got a couple last week--emails from those graduates saying, "I now realize how much the School of Nursing was successful in giving me the knowledge that I needed during a pandemic." So, that's very heartening. I don't know if that's representative of the whole graduating body, but we still have very high board pass rates. So, that did not drop. We're up in the ninety-six, ninety-seven percent ...

JS: That's incredibly impressive.

LF: … For first time pass rates. So, we did good enough, let me say.

JS: Yes, that is more than good enough.

LF: We do have, and we had at the time, onboard an instructional designer who helps faculty. Now, that instructional designer in the past was focused on helping faculty in in-class learning, flipped classrooms and stuff like that, but was also able to help them to make that transition. That instructional designer still holds like monthly sessions, seminars and whatnot, on remote learning and, of course, meets with faculty one on one as well. We recently had a guest instructional designer come and do a workshop with our faculty. He has his Ed.D. with a specialty in remote learning. So, that was nice. As we can, we bring in additional resources for the faculty.

JS: I think one of the things that's fascinating, if you're in a health-related field, is that COVID of course doesn't just foreclose opportunities, but it also opens new ones, right? In the way that I for instance found that I was engaging my students in discussions and exposing them to materials about issues that we usually don't talk about, and many of them having to do both with rationalizing medical care but also with questions about death and dying. Do you really want to be hooked up to a ventilator and what does that mean at the end? Resuscitation, questions surrounding resuscitation, all of those kinds of things. So, I guess I wonder how you saw those

opportunities, whether you saw those happening in the Nursing School and whether they were instructors and topics that got attention that usually don't get the kind of attention that you were giving to it in the spring?

LF: Our graduate students are RNs. So, they're already practicing. So, while at the height of the pandemic and even now, because right now the number of new cases is actually higher than it was last March, so they're dealing with school and they're also working in the hospitals and they're also caring for COVID patients. Our undergraduate students, many of them, last spring and now, are working as nursing assistants in hospitals. So, they could see what was happening, or their family members were being affected as well. Issues of death and dying were front and center with them, both undergraduate and graduate. Our concern was not so much teaching them about those issues or even the ethics, because I think ethics is sort of integrated throughout the curriculum in a sense, but it was the emotional toll that this was taking. It was intense. I mean, you know how intense it was.

Worse then, I think hospitals and the healthcare professionals are managing it a little better right now. That could change tomorrow as surges continue, and I'll give you two examples. We had a Doctor of Nursing Practice student, which is an RN, in class remotely with the professor, and she suddenly started crying. Within a few minutes, the whole class was crying. It was just a cumulative event. The same thing happened with our undergraduate students. It was an undergraduate student who started crying in class, and then she started to describe to the professor why. The night or the day before she had worked a shift as a nursing assistant at the hospital, and her entire shift was putting bodies in body bags. So, clearly, we were already planning this. We were already doing some of these things, but we started offering--it was their mental and emotional health that concerned us.

JS: So, what did you do to address that?

LF: We hired a nurse who was a trauma resilient specialist to come in and do a series of seven workshops with faculty, staff, students, but particularly the faculty and students, the nurses.

JS: These workshops, were they open to everybody?

LF: Yes, they were open to all students.

JS: I'm sorry that I'm interrupting, but everybody took part at the same time, right? So, nursing students and faculty and staff were there at the same time? There weren't different workshops?

LF: No, they were not in different workshops.

JS: Okay.

LF: It was mostly nursing students and faculty, I think, at that point, because they talked about building resilience when you're in those situations. When you're watching people die one right after the other, and there's nothing you can do. So, it was mostly geared for them.

Then, of course, I've been on multiple task forces, and I still am. One is led by Frank Ghinassi from the University Behavioral Health Center, a psychiatrist. They put together a whole list of resources within the University, workshops and private sessions as well, where students and faculty could go for counseling and for mental wellness activities and things like that. The person that did the resilience, the trauma resilience training, also was open to working individually with faculty and students if they needed a session or two. I think she offered like one complimentary session, and then they could work out whatever, however the reimbursement went on a private basis for that. Currently, we have scheduled Phil McCabe, who is in the School of Public Health, and he's going to be doing some training, mental wellness, more resilience training for this year. That was our concern, still is. I mean, we're prepared to see PTSD [post-traumatic stress disorder] for a long time.

JS: Yes, that doesn't surprise me. Did you guys tape those seven sessions?

LF: I think we did. I'll have to check on that.

JS: Can you check, and if it's possible, would it be possible for us to watch them? Or, if you have a curriculum? I'll also, in an email, ask you for the name of the person who did them because that would be interesting too.

LF: Yes.

JS: I find this fascinating. This is just kind of a side story as we're winding down and then clearly, if it's okay with you, we'll do a follow-up interview. The question of resilience has always been one that I have found really fascinating, like how do clinicians do their work when they have one patient after another dying? I come from this partly from personal experience because I have a partner who died of very--well I have no longer have her because she died, but a very aggressive endometrial cancer. She was treated at Sloan-Kettering, and I started volunteering there afterwards because they did such a great job. I remember going back after she had died and having a long conversation with the oncologist and the oncology nurse, because I was literally concerned about how do they do their job, right, when they work in that kind of field, where you are in an area where you just know one patient after another is eventually going to die, and you've gotten close to them. So, that is such important work. Do you suspect that this will lead to longer term curricular changes where you integrate those kind of resilience trainings in the long run? I mean, how did you address those questions of resilience prior to COVID?

LF: I don't know that we did, quite honestly. There's always maybe an element of that. We mostly addressed that by the students, the undergraduate students, have to take courses in psych mental health, and so they learn therapeutic communication and they learn principles of resilience and things like that. But I don't know that we particularly focused on it with respect to themselves. We have a very large and active student services office, and they serve as counselors and advisors and things like that, and they offer maybe an occasional workshop or a seminar or something on those things, but I don't know that we did.

JS: Do you think that doing so will be contained to the COVID time? Or do you think that from here on out, it will be more integrated into the nursing curriculum as well?

LF: I think it probably will be and I hope more content on pandemics and the epidemiology, what does transmission rate mean? What do positivity rates mean? What is containment versus mitigation? All those kinds of things will be integrated into the curriculum. Yes, it raises an interesting question, and you're right. It brings things to the forefront that maybe we hadn't really focused on enough.

JS: Yes, I think I really noticed that partly because of that class I was teaching where really my goal then at the end was to equip students with the tools to understand what was happening to them. So, one of the things that I did for them is that they had to write these plague journals. They had to write five hundred words each week about their experiences for the rest of the semester, and then, at the very end of the semester, they had to take what they had written and write a paper about what they had learned in terms of the history of medical ethics with all the materials that we had discussed that then surrounded COVID and pandemics in general. I did get the impression that it helped them to figure out what was going on and to kind of deal with it in some way, shape or form, despite the personal challenges that everybody faced at home. So, that was really interesting and kind of rewarding, and it did make me think about what we can do as instructors that can be helpful for generations out, even when we are not facing a pandemic?

LF: Yes.

JS: Yes, that's interesting. When were you able to place undergraduate students in clinical settings again?

LF: Summer, last summer.

JS: Okay, and from what you said earlier, they're still there, and it's unclear whether they're going to get withdrawn?

LF: Yes. They were there during the summer. They were there during the fall. It hasn't started yet. The spring semester starts, I guess, in two weeks or something. So, their clinical rotations haven't started yet. We are getting some messages from some of our placement facilities that they may need to cancel our placements because of COVID. So, we're just starting to hear that. That is a distinct possibility. It's a little different this time in that, number one, we know how to treat COVID a lot more, a lot better than we did. Up until this point, it's been more like a slow wave. Patients would come in, they'd stay for a few days, they'd go home kind of thing, and the hospitals weren't feeling overwhelmed. They're starting to feel overwhelmed.

JS: Yes, and the vaccine, it's just like kind of going past each other for a little while until it gets together, right?

LF: Right.

JS: Well, Paul, do you have anything that I forgot right now?

PC: Well, to the extent that the universe is large enough so that this is not a question that makes it too specific, I was wondering to what extent would the students in your program who actually had to do clinical work get or, the flipside of that is, avoid getting COVID-19 themselves.

LF: Yes, it's a real problem. We've had maybe, since October, about forty or fifty students test positive. So, they don't necessarily avoid it. But what we've done is for undergrads--now, our graduate students are an entirely different population of student--but for our undergraduate students we don't deliberately assign them to a COVID patient. When they're in the clinical area, they need to wear face shields and procedure masks. We did some testing as soon as the saliva test was perfected, but now we're doing weekly testing of our students. Our graduate students are, and I just have to hand it to our faculty, particularly our nurse anesthetist students and faculty, because that's all they do is take care of COVID patients. These graduate students are registered nurses who are getting a doctoral degree in a specialty in nursing. Not our Ph.D. students, they're not doing clinical, but our Doctor of Nursing Practice students are very much in the clinical area. We have an acute care nurse practitioner program that's in the ICU. So, they're with COVID patients, as are their faculty. These faculty practice not only with their students, but they practice outside because they have to to maintain their skill level to be certified and to be faculty in our emergency department nurse practitioner program, that faculty and those students. They wear N95s and face shields and a higher level of PPE than do our other students. So, we haven't prevented them from getting it. Our positivity rates are still very small compared to the general public. It's like two percent as opposed to fifteen, twenty percent.

JS: Well, I so appreciate you taking this time, and if it's okay, we will be back with more questions, and I'll send you an email about the resilience training issue.

LF: Yes, and I'll look into this and see if we still have them. I know they were recorded so that people could attend who couldn't attend on the other times.

JS: Could look at them, yes.

LF: I would be happy to talk to you. Again, there are some positives that have come out of this that I'd like to share, but I really thank you for focusing on this. Our nursing associations nationwide are encouraging us to take notes on all those kinds of things, but we're busy.

JS: I was going to say you have so much on your plate.

LF: Taking notes and doing diaries or anything like that for the most part. I really appreciate your interest in this.

JS: You're so welcome. This is when historians come in conveniently.

LF: So, again, I hope this was helpful.

JS: It was great.

LF: I hope I answered your questions.

JS: Thank you, and have a lovely rest of the day.

LF: Thank you, you too, bye, bye.

JS: Bye.

----------END OF TRANSCRIPT----------

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