INTERVIEWEE: Brenda Nevidjon
INTERVIEWER: Jessica Roseberry
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PLACE: Ms. Nevidjon's Office; Hanes House

NEVIDJON INTERVIEW NO. 1

JESSICA ROSEBERRY: This is Jessica Roseberry, and I'm here with Ms. Brenda Nevidjon. She is the clinical professor, school of nursing and chief of the Division of Healthcare Leadership, Education, and Management. It's July 13, 2005, and we're here in her office in the Hanes House. Thank you very much Ms. Nevidjon for agreeing to be interviewed today. I appreciate that.

BRENDA NEVIDJON: Thanks.

ROSEBERRY: If you don't mind, if we could start with just a little bit of background of yours, just kind of how you came into the nursing profession. What led you in that direction?

NEVIDJON: To the best of my reflection when I look back, I think probably watching my mother be the caregiver for the extended family probably was one of the influences in my thinking about nursing, so I thought about nursing pretty young. I didn't realize how young until a number of years ago when my mother gave me a bunch of my school stuff, and in there was a fourth-grade essay describing that I wanted to be a nurse and why. I consciously remember in junior high going into high school knowing *nursing*, but it was interesting seeing a fourth-grade essay that really outlined why I wanted to be a nurse. And I really think it was partly the influence of seeing her in that caregiving role for different family members older and ill that probably was part of it.

ROSEBERRY: That's very interesting.

NEVIDJON: Then I had an interesting moment of where you as a little girl get starstruck by something. My grandparents took me to—I have an older cousin who was a graduate from a diploma program in nursing, and they took me to her graduation, and I was little at the time, elementary school. And I vividly remember the ceremony with these women in their white uniforms and their white caps, and they had their candle, and they said the Florence Nightingale pledge. So I have that memory of that moment, too, somewhere, so I think that left some sort of a—one of those little memories of, Oh, wow! (*laughter*) I want to do that someday.

ROSEBERRY: Well, that seems to be—to choose nursing early on. And looking at some of the stories that you've compiled in some of your books about oncology nursing, that seems to be fairly common. To choose early on. Or at least have those early impressions.

NEVIDJON: I think a lot of folks, particularly of my generation, a lot of us—it wasn't because there weren't other choices for women, because, in fact, growing up in the sixties, early seventies, there was that whole movement of more choice for women in terms of their careers. But I think for a lot of us that it was very definitely the choice we wanted. And I can remember in high school having a discussion with my high school math teacher, who had also taught me in junior high, and then he went to high school, and then I followed him to the same high school and had him again for calculus. I can remember him saying that I should be a doctor, and I kept saying I didn't want to be a doctor. And I can remember this discussion at that age even understanding that there was a difference in the roles of a doctor and nurse, and telling him why I wanted to be a nurse.

I was in probably tenth grade or maybe eleventh grade at point, and he said, well, I needed to go to college. He was the one in saying that that had me start looking at college for nursing as opposed to diploma schools based in hospitals for nursing. And had he not had that discussion with me trying to convince me to become a doctor, I'm not sure the guidance counselor would have guided me into a college-based nursing program, even though I certainly academically was in the college-bound track and had the academic grades and the SAT scores and everything like that. I think knowing that I was so set on being a nurse, I wouldn't have been surprised if they had steered me to one of the many, many diploma schools that were right there in my community.

ROSEBERRY: Were those maybe more emphasized at the time?

NEVIDJON: Yes. When I was looking to into school, we still had lots of diploma nursing programs. The associate degree programs in community colleges hadn't caught on yet. Now they're so dominant today, but they weren't then. And many of the college programs actually were five-year programs. I looked at several that were actually five years, so you did two years of liberal arts education, and then you did three years of what would be a diploma curriculum. It was interesting, and then the curriculum evolved into the four-year program that is more common today.

ROSEBERRY: Okay. So why Duke?

NEVIDJON: Well, (*laughs*) that's an interesting story as well.

ROSEBERRY: (*laughs*) Okay.

NEVIDJON: Because I didn't even know Duke existed. I was most interested in Georgetown and secondarily Boston College, and my backup school was going to be the University of Connecticut because I grew up in Connecticut, and that was going to be my

state school backup for nursing. And we were heading down to visit Georgetown because that was my first choice, and just coincidentally our minister's wife said to my folks, "Well, if you're going to Georgetown, you should check out Duke. They've got a great medical school. They probably have a nursing school." So as we planned the trip, we found out well, sure enough, Duke has a nursing school as well, and we thought, Okay, we'll just go a little further down the road. (*laughs*) Partway through Virginia my mother was saying, "This is too far away. (*Roseberry laughs*) You are not going to go to school here." But we had visited Georgetown at that point, and I didn't like Georgetown. The folks were not very friendly where you go to the student services, the admissions office for your tour and stuff like that. They just didn't seem interested. And when I came down here, I really didn't have anything planned—I don't even know if they did anything like they do today where you have these formalized tour groups led by different folks. What I do remember is public parking was over near Cameron Indoor Stadium. There was public parking there, and you know how you came under the archway, coming onto the West Campus quad, and obviously we were looking at the school, because here were two parents and myself and my sister, and students saying, Oh, are you considering us? and walking along and talking with us. One of the students took us down to the admissions office to get information and talk with people, and they showed us where to go and look at the nursing school and the hospital and everything like this, and it was just a very warm, personable environment, and that sold me on the school.

ROSEBERRY: Good.

NEVIDJON: (*laughs*) And the rest was history. I actually applied early decision, and was interviewed by an alum up in Connecticut, and something in the application didn't

get in, and I don't remember what it was. I don't remember whether it was something under my control didn't get in in time for early admission, but I was sort of a late early admission, early regular admission kind of thing because of the snafu that occurred, and so I never applied to any other school. I ended up only applying here. That's how I got to Duke. I credit my minister's wife. (*laughter*) I think at least the first year, I'm not sure my parents would necessarily have thanked her, because they really felt this was so far away for me to be going to school. I mean, today it's standard for kids to do it, but back then a lot of my friends stayed very New England based, you know, New England or Pennsylvania based in their college choices, I was one of several in our high school who went farther afield, and yet today I wouldn't consider 550 miles that big of farther afield as it was back then. That's how I got here.

ROSEBERRY: So what was some of the curriculum like at Duke, or programs, or things that they offered?

NEVIDJON: Our first year was straightforward liberal arts courses, and back then there were freshman requirements for students, including—we had PE requirements. I don't even know if they have PE requirements today, and we had religion requirements. We had to take one semester of religion. Classes were either Monday, Wednesday, Friday or Tuesday, Thursday, Saturday, and they were half-day Saturday classes, so your Tuesday/Thursday that first year—now, that changed, obviously—and in my day the Tuesday/Thursday became longer than the Monday-Wednesday-Friday class—so you got the same number of contact hours. But that first year we had Tuesday, Thursday, Saturday morning classes. And my Tuesday, Thursday, Saturday morning class *was* religion. (*laughter*) So I remember that vividly, getting up for an eight o'clock class on

Saturday morning to go to religion, a religion class. But it was probably not unlike even today, you know, people's first-year experience, taking sort of foundational courses, the required ones as well as in your area of interest, and within the school there was some encouragement to look at taking electives that made sense, that might compliment nursing. So that first year, in addition to the required English, the required religion, the required science, and required—we had statistics required—I began to take courses in anthropology and psychology, and I continued that in my second year, but in our second year was when we also began to have some of our nursing content come in. However, our class was called into a meeting and told that, in fact, our second year and third year and fourth year were being changed, and that we were going to be the first class of the new curriculum. And the new curriculum went to a very different perspective of how we as students would learn nursing practice compared to prior. So the curriculum we thought we were coming to was more traditional—sort of traditionally you would have microbiology, and you'd have a pharmacology course, and you'd have an experience in a nursing home really learning how to give the basic activities of daily living kind of care: bathing and helping feed patients and all those kinds of basic things. So what we were told instead was that there was going to be no clinical in the second year as there had been. The clinical was only going to be in our third and fourth year, and that in our second year instead of the discreet components of the different sciences: pharm [pharmacology], and anatomy and physiology and whatever, we were going to have an integrated course, and I can't remember the name of the course now, and it was going to be *x* number of credits in the fall and *x* number of credits in the spring. But: Oh, by the way, the faculty person who is going to teach this can't start until January, so you're

going to do double duty in your spring semester; so our fall we had no nursing courses and no patient contact or anything. So then in our spring semester of our sophomore year was when we really began the program. And then they said, Oh, by the way, we're also changing your junior year and your senior year. And whereas there were traditional rotations where everybody did peds [pediatrics], and everybody did obstetrics, and everybody did med/surg, [medicine and surgery] and everybody did psych [psychiatric nursing], the first year was going to be an integrated approach to learning about delivery of care to patients, and you were going to be assigned for the whole year to the same clinical area. So there's the didactic, which we all took, but then in your clinical you would go into an assigned area, and you wouldn't rotate. And then in your senior year, you were going to do—one semester was going to be acute care, and one semester was basically going to be community-based care, which integrated a number of things. So in the community-based care, that integrated OB [obstetrics], and peds, and typical public health kinds of nursing, so your experiences were very different from the traditional modular approach And the philosophy was that their responsibility as faculty was to teach us how to think and how to analyze and how to find the resources we needed. It was not to teach us every imaginable technique and task, that that was not the level of education to deliver. So we got *really* upset as a class. And I can remember some of the discussion with the faculty when we had this big powwow with them. We felt there had been a bait and switch, you know, that we'd *come* here for this particular curriculum, and *now* they're telling us it's different. And I can remember one of my classmates saying, "Hey, we're the consumer. We're paying for this." And there were some things that changed, that they negotiated with us. I mean, we actually negotiated with the faculty to

change. And one of the bigger changes did have to do with our junior year. And as an example, for my junior year I was assigned to the instructor who had ob-gyn, so she had—in the old Duke Hospital not the new Duke, not Duke North, but in the original, which is Duke South now—she had the labor and delivery area. She had the postpartum recovery area. She had the full-term nursery, and she had the gynecology unit. So as a student group, we had several different units that sort of were in her domain that we could move around in. So you could get surgery through gynecology surgery. You could see peds through newborns and well-baby kind of stuff. And then, of course, you could see babies being born up in the labor delivery area. And we were able to get special permission to go into the intensive care nursery. So we were in pretty good shape. But I had a colleague who was assigned—her group was psych. So she spent a full year on psych where they didn't touch a patient. They didn't manage an IV. So that was what really was upsetting to people that that's how their junior year was going to look. So the faculty said, Okay, after the first semester, in the second, in the spring semester, you can trade up to seven of the fourteen weeks of the semester, but it's got to be a one-for-one trade. You've got to—to get into an OB experience, somebody from OB's got to go to where you are. Well, everybody wanted to come to where we were, so our group, we had the choice of where we were going to trade with people. Then you had psych people, who nobody wanted to go to psych, let's say. But it was very, very interesting. When I think back to the times, the culture of the time which was a time in this country of a lot of advocacy and grassroots and causes from the sixties of the civil rights movement, and the sixties and seventies the women's movement and all, we were a very assertive, consumer-driven class who really advocated well for ourselves. But twenty years later, I

really appreciated what the faculty had done as I began to see some of the things in healthcare beginning to change, because what they really kept coming back to was they weren't preparing us for the job after school when we graduated. They were preparing us for the job that was going to be there at the end of the twentieth century, and that nursing was going to become much more involved with *population* health, not just acute care, hospital based, that we would be community based. We would be looking at wellness promotion and disease prevention. We would be very key in terms of managing chronic illnesses. That you do have, obviously, acute events, but a lot of that chronic disease management and all, and they were preparing us to really think in terms of those advanced roles and to be leaders, to be clinical leaders in the country. And they were real clear about that.

ROSEBERRY: So they saw that?

NEVIDJON: They saw that. They were very visionary in terms of that.

ROSEBERRY: Was that Ruby Wilson, she was dean?

NEVIDJON: Well, Ruby came in as dean in my junior year.

ROSEBERRY: Okay.

NEVIDJON: Dean [Irene] Brown was there when I first came, and then Dean [Ann] Jacobansky as an interim between Dean Brown and Dean Wilson. But the faculty was, I just remember some of them. There were a lot of young, very energetic, visionary faculty. I mean, women—I don't remember any men faculty. I don't think we had any. But women who really were more in their thirties, so a young faculty. We didn't have a lot of grey-haired faculty back then. We had some that were over forty, obviously, but today you look at schools and the average faculty, the average age of the faculty is in the

fifties. I think we would have looked at somebody in their fifties as old. Now today we don't feel old over fifty, but I think as an eighteen-year-old looking at a fifty-year-old faculty I might have said, Wow. What does this person know about the real world?

ROSEBERRY: Who were some of those women? Do you remember?

NEVIDJON: Well, one of the women I remember is Janet Galiene who was on faculty at the time. Janet's specialty was cardiovascular, as I recall. Janet had interest in a lot of areas, but one of the areas that she became such an important figure for me was actually after I got out of school when I was doing my graduate work over at the University of North Carolina. Janet was very interested in terms of end of life and management of people who were dying, which was an area that I was interested in, and for my master's thesis at UNC, my master's project /thesis I developed—and my partner, another student, two students worked with Janet to develop a course and offer a course at Duke, an elective, in caring for people who were dying. And that was very early in terms of the death and dying palliative care movement in this country. We offered that course in 1973 or '74. I can't remember. I think it was '73. So Janet has always had a very special place in my development. There was an instructor, Dr. Whitner, I can't remember her first name, who taught the nursing research course, which was not a required course. It was an elective you could take, and that was the first research course I took, and she was wonderful. She also was a med/surg instructor, and I had some experience with her in my clinical area. And again, she was one of the on the older end of the faculty, not the under thirty, but such a wonderful mentor and coach to the students. Sue McIntyre who, in fact, stayed on faculty and was here until her death a few years ago. Dorothy Brundage who is retired now, just really wonderful, solid, good examples of nurses and

nurse academicians. Dr. Alice Dietz, who did community, a lot of community stuff. She was great. Barbara Germino. She's on faculty at UNC, Barbara Germino was, she was med/surg faculty, and she had students—Osler Ward, which was all women. It was an open ward in the original Duke Hospital. And because the open wards were for uninsured, that was in the days when it really seemed segregated, although *segregated*—I mean, it was probably more segregated prior to my time. When I came, it was anybody who didn't have insurance, so we had Lumbee Indians, African-Americans, and poor whites without—so it was an open ward where you had very few private rooms. You just had curtains. But anyway, Barbara was on Osler, which was the women's unit, and then there was the man's unit on Long [Ward]. But I'll never forget. I traded because I could trade my junior year in that OB. Everybody wanted OB. I spent almost probably five weeks with her and her group and loved working with her. Just loved working with her. She was great. Those are some of the folks that I remember back then.

ROSEBERRY: Was there an expectation that you would maybe go on to get further education in nursing?

NEVIDJON: Yeah.

ROSEBERRY: Yeah.

NEVIDJON: Yeah, I think that was something that the faculty really encouraged us to think about is, What's your next step after you are out and have had experience for a while? What do you want your next step to be? They didn't see the bachelors as the terminal degree. They really saw us moving into advanced education.

ROSEBERRY: But our graduate school had closed down at that time. Is that right?

NEVIDJON: When I was an undergraduate there were master's students.

ROSEBERRY: Okay.

NEVIDJON: And I don't remember exactly when the master's program was phased out back then. I don't think it was before I graduated. I think it was after I graduated in the seventies. I can't remember exactly, but we had graduate students. We had master's students. There was no doctoral program.

ROSEBERRY: Okay.

NEVIDJON: And *that* was the place that you saw men students. We had no men in my undergraduate course, and the men that I remember from back then were working on their master's degrees.

ROSEBERRY: That's interesting.

NEVIDJON: Yeah.

ROSEBERRY: Were there any men that were in the nursing service itself in the hospital, not necessarily in the school of nursing?

NEVIDJON: Um, yes. In fact, very early on after I graduated, the unit I worked on, Bernie Stewart, who is the clinical operations director in the PDC for urology, was a new—he came a year after I came. So I was there in '72. I think he must have come in '73. So we didn't have many, but we did have men in nursing back then.

ROSEBERRY: Okay.

NEVIDJON: And Bernie's been here ever since.

ROSEBERRY: Well, what was that relationship between the school of nursing and the nursing service? Was it really—?

NEVIDJON: Well, you know, it was interesting. Well, a couple of interesting things because Wilma Minniear was on faculty here, but Wilma got pulled over there in 1970,

and so as a student body, we didn't get to know Wilma so much as a faculty person, Certainly many of us got to know her more in her role as the chief nursing officer. She was a part of that powwow about the curricular change, because she was in a transition mode. I think that was getting rolled out to us—she was still on faculty, and then shortly after that, I think she was pulled over there. You know, we certainly heard. We heard from folks over in the hospital that, Oh, you don't want to hire Duke nurses. They can't do anything. You want to hire a good diploma nurse like the Watts [Hospital] graduates. So in our own organization, you heard that message. Like: Oh, God. Duke nurses. They can't. They just don't get enough clinical. They don't get enough this. They don't get enough that. And in fact, the person who was the supervisor of the unit that I worked on was a Duke grad, and yet even she would say that at times, that Duke nurses just don't come out, they don't hit the ground running. Because there was this expectation then as there is this expectation today—and I don't know why we haven't shed that expectation—is that you graduate from nursing, you take your licensure exam, and you should be fully functional without any kind of transition and understanding you're moving from a student learner role into a full-fledged professional role. That doesn't happen in twenty-four hours (*laughing*) or six weeks. It doesn't happen in six weeks. But the nurses who came out of diploma schools, because really their whole program was about being at the bedside, they didn't so much learn how to learn and analyze and problem solve and negotiate, navigate. They learned how to do. They were very good at doing: very, very good at doing. But they weren't being educated to be the clinical leaders of the future to shape patient care. Different kinds of educational pathways with different kinds of outcomes expected of the students in those programs. So the diploma

nurses would outshine the four-year, not just Duke four-year, any four-year graduate, any baccalaureate graduate, because the baccalaureate program obviously couldn't put as much clinical time in as a three-year diploma time. They just literally couldn't do it. But I was lucky, because one of the things in terms of the relationship between the school and the hospital was that the hospital introduced a program that began after our junior year called PNA, professional nursing assistant. We still have PNAs today, so this goes back then to the summer of '70, I think, and I believe we were the first group. I don't think our current dean, Dean [Catherine] Gilliss's group had that program. I think it was introduced with our group. And so they had so many slots for student nurses if we wanted to stay and work for the summer. Because back then, you didn't go to school in the summer for nursing. Now many, many nursing programs have the option to be able to go year round and get done. And with the intensive programs, like with our accelerated program, you do go year-round. Back then you just did the traditional fall and spring semester, and you had your summer off. But this was offered as: You could stay for the summer and work for us, the hospital. So I stayed, and I got to work as a PNA, and I worked as a PNA on the very unit that the summer before, at the end of my sophomore year, I had been hired as a ward clerk. Again, it was that the hospital was looking for help, and I was married at this point. I had gotten married in sophomore spring semester on spring break, and we were living here, so I looked for summer work. At the end of my freshman year, I'd gone home and worked, but after my sophomore year, I was a ward clerk for the summer, and they had kept me on doing a little bit of weekend work through the year. That unit was one of the units where these PNAs were, so then I got to be a PNA on the unit. And then when I graduated I became a staff nurse

on the unit. So I was very fortunate that the staff knew me. They knew me first as a ward clerk, and then they knew me as a PNA, and many of them took me under their wing. The nursing assistants and the LPNs, they'd say, Oh, come look at this, or Come do this, or whatever. So I was very fortunate that at the same time I was getting my formal education I was getting this informal coaching and mentoring by a wonderful group of folks who were long-term patient care assistants or LPNs who really *were* the caregivers there. You'd have one RN on a shift, and the rest would be LPNs or aides, and so they were the ones doing most of the care of patients.

(*tape 1 side 1 ends; side 2 begins*)

NEVIDJON: What I was saying is today probably somebody couldn't do what I did back then because there's much more regulation and requirements, but in 1970, 1971, I had opportunities as a PNA. It wasn't being regulated at the time, like, "This is only in this job category's scope of practice," so it was very different. It was great. I credit that experience as much as my education for putting me on a very solid foundation for my career.

ROSEBERRY: What was the relationship to the physicians?

NEVIDJON: You know, I loved the physicians I worked with. I certainly was unaware as a student and as a part-time employee in this organization, I was really unaware of the bigger world of the politics around this. I had no idea how nursing and Medicine related back then.

ROSEBERRY: Sure.

NEVIDJON: But the unit I worked in, I was on Long Ward, which was the male medical ward, the public ward, and I loved our patients. We had—that sounds like that's my air

conditioner. (*Sound of high-pitched squeal in the background*.) Is that going to be a problem?

ROSEBERRY: It probably will, let me put it on pause.

(*pause in recording; tape resumes without air conditioner noise)*

ROSEBERRY: Okay.

NEVIDJON: It was such a tightly knit group. So this was a unit that really was—with public patients, your group of physicians were your residents, your junior residents, your senior residents. You had medical students. It was a wonderfully rich learning environment. The patients were so appreciative. They were so interesting from a disease process as well, from a learning—just learning stuff from them. They were wonderful to work with, and there was a closeness. There was a camaraderie. And so if Medicine and nursing weren't getting along in the organization, I certainly was not aware of it in our little unit. And again, I think because people weren't in individual rooms or in individual semiprivate rooms, the patients were friendly with each other. You had a lot of—even though people were sick; I'm not saying they weren't—you had a lot of exchange and communication. People looked out for each other. Patients even looked out for each other in terms of walking down the hall to the men's room together because there were no private bathrooms. There was a little bathroom at the end. You'd see them pushing their IV poles down (*laughter*)—I mean, I don't know how to explain it, because it was a different world than it is today. People stayed in longer. Patients stayed in longer, obviously: that whole length of stay thing that changed back really in the late eighties, early nineties. People stayed in longer, so you got to know them better. You got to do more teaching, or you were able to teach over a longer period and reinforce your teaching

better. In our group on this unit I really didn't see—it was a rare situation where you would have a physician come in, a resident come in and go, I'm doctor. Because if that happened, they got cut down to size pretty quickly by the chief medical resident who said, This isn't how you play the game, kind of thing. So every now and then you'd get somebody who was a little bit off-putting, but it was rare. The physicians on that unit were just—were wonderful, wonderful to work with. But I gather as I've certainly been in this organization longer, I gather there were things going on (*laughing*) in the bigger picture. I mean, some of the problems that were there were the reasons they brought Wilma Minniear over. There were real problems with the person who was in that nursing leadership position before her. There were patient care and patient safety issues that were occurring. I guess Medicine and her and her nursing leadership maybe were at loggerheads a little bit from what I understand now. I mean, I was oblivious to all that.

ROSEBERRY: Is there anything else that needs to be said about your experience as a student at—?

NEVIDJON: Well, it was an interesting time, I mean, beyond nursing. This was when the black student group took over the Allen Building, when we had vigils outside of the chapel in terms of the Vietnam War, where we had the activists on campus counseling and advising young men how to avoid the draft, where we marched on Terry Sanford's house. It was a very interesting time on campus, and we were fairly mild. We were pretty radical for the South, but we were pretty mild compared to what was happening on northern campuses and out west on campuses. But still, there was this very much of an activist community here. At the same time, it was kind of interesting looking back. In my freshman year, I remember everybody got dressed up to go to football games. Now,

in high school I didn't get dressed up to go to football games, but here the girls wore stockings in September when it was eighty-five degrees, and you went with a boy. They bought you a blue and white mum corsage. Looking back, it's so weird to think about that. And then a year later we're out there in jeans, and army fatigue jackets protesting a war. (*laughter*) It was really an interesting time of transition, I think, and some really interesting polar kind of experiences on campus. I enrolled in one of the first, if not the first, black studies courses; and that was incredibly, incredibly eye-opening for me, this seminar. The anger. I had gone to school with black kids up in Connecticut. It's not that I was unaware that there was prejudice and bias and disadvantage in the country and in our own community, but our schools weren't segregated. You just didn't see the segregation. Our neighborhoods weren't segregated to the same degree that you would see down here. I mean, there was obviously some segregation by economic status, mostly, that I was aware of at home when I was growing up. But it was so eye opening to me to hear the hurt and the anger expressed by black students at the time. I'd have to look at my [school] transcript to try to remember the name of the faculty person and how he facilitated that dialogue. It was quite something. I remember that very much. And I remember one of my psychology courses was on the psychology of war because we were still in the throes of Vietnam. Some of the courses that I took at the time that really were very relevant to the times, how they really shaped a lot of my philosophy, not necessarily my nursing or healthcare philosophy, but probably as my folks would say my *liberal* (*laughs*) bent. That really did happen at that time, not that I was necessarily highly conservative as a child. My parents tend to be more conservative than I do. And so even when it comes to healthcare issues, I probably would be seen as a more liberal kind of

healthcare provider in terms of: I believe that it's okay to use embryos for stem cell research. I would advocate for that as opposed to how that debate is going, or the right for a woman to choose. It's a healthcare issue. It's not a society issue. You know, those kind of things. I think very much being in this environment, the Duke environment, and what I experienced, shaped some of that thinking. That if I had been in a different educational setting, I might not have that view, and I think it was very much a part of my education with all those other things that went on.

ROSEBERRY: Thank you. So then UNC.

NEVIDJON: Yes. I stayed here and worked after I graduated in '72, and I went right into the master's program over at UNC, so I was working and going to school.

ROSEBERRY: Okay.

NEVIDJON: Went into psychiatric nursing. I was going to be the next [Elisabeth] Kubler-Ross. I wanted to get a master's in psychiatric nursing to work with people who were dying, not necessarily of cancer, although that was my pull towards people with cancer, but also heart disease, renal failure those kinds of diseases also, but at the end stage not the earlier stage. I was really pulled towards end-stage care. So I wanted to counsel. There was obviously Kubler-Ross, and she actually came here and lectured, and I got to meet her. It was pretty phenomenal. So I started down that path and finished up my master's six years later, because I went into it trying to go full time and work part time. Well, I started with full time and full time, and that was a little hard, and so then I dropped back work a little bit, but I had to drop back on school a little bit just because it was too heavy of a load. And then my husband, my then husband, finished his PhD and was offered a postdoc equivalent in Switzerland, so we moved to Switzerland. So I left

the area and had to take a leave from my master's program. We were in Switzerland for a little over two years while he was doing his research there. So I practiced as a nurse, I worked as a nurse in Switzerland. I had some tutoring by an undergraduate here whose parents were Swiss, and so she was tutoring me a little bit in Schweizerdeutsch versus Hochdeutsch, which is proper German. So she said, "When you get there—let me give you some euphemisms and pronunciations that are unique to that area." I was going to Basel. So I had a little bit of help from her, so I went over with a little bit of language, and then I went into an immersion course as soon as I got over there, and after twelve weeks of immersion, I started woarking as a nurse in the university hospital there, which was a phenomenal, an absolutely phenomenal experience. I had this vision after having worked after my sophomore year—I mean, I've worked—. As a teenager, I worked. I've always worked, and then after graduation having worked and then going right back to school, I thought, Well, this is great. I'll be in Europe for two years, and I'll have fun, never processing the fact that my husband is going to be working, (*laughs*) so he can only have fun so much of the time. So I thought, Well, gee, maybe they could use a nurse, and, Sure. They said, Get a little more German under your belt. I went and saw them when I was probably halfway through my twelve weeks, and then they hired me on, and I went to work. I wanted to work on an oncology unit, and that's where they assigned me. They were one of three European centers that did bone marrow transplants at the time, and it was there and then in the Netherlands and then in England were the three sites that did bone marrow transplants throughout Europe. So then I got bone marrow transplant experience there in the *very* early days of bone marrow transplant, very, very different than it is today, a phenomenal experience. And then we came back here, because he was

put on faculty here. We knew going over that he had a faculty position here he wanted, so we returned here which then allowed me to finish my master's at UNC. (*laughs*) It was a fragmented master's. I think your passion, alliance is always with your undergraduate program. Not that you don't necessarily love your graduate school, but when your graduate experience is sort of spread out like mine was, I didn't have a cohort really that I went through the whole program with and bonded with because I came back to an entirely different student group than the one I had left. It was kind of interesting.

ROSEBERRY: It seems to me that cancer nursing might be unique in the sense that it would be especially hard to be dispassionate.

NEVIDJON: Yeah.

ROSEBERRY: And especially hard to be quick. So it seems to me that that might, if you're talking about academic nursing, that the emphasis might be to be quick, and be dispassionate and clinical and things like that, but it might be a difficult—. It might be difficult to balance the two.

NEVIDJON: I think one of the that things I saw early on as a student and then as a nurse is the opportunity to develop a level of intimacy and relationship and offer support with people with cancer very differently than any other disease, and I worked a lot with people who had diabetes, and I certainly worked with people with heart disease because I'm a medical nurse not a surgical nurse, although I worked with surgical patients; but my love is with medical conditions not surgical conditions. Part of that is because you—oftentimes with people with medical conditions, you do see them more than once. With surgery you tend to see them once. And you're right. It can be a little bit more, you know, you have a short-term interaction with them. That's it. They're gone. They're

healed. By and large surgery is—surgical nursing is a pretty optimistic nursing. I mean, you've got sick people post operatively, but by and large they're going to get better. So something very early on in terms of working with people with cancer showed me that this was probably a special field I wanted to spend my time in, and even before going to Switzerland, I had spent a lot of time with cancer patients. And oncology nursing has been just a wonderful specialty to me, and when you look at and talk with folks about oncology nursing, you have so many directions in oncology nursing you can go, because you can work inpatient: it can be in bone marrow transplant, it can be in surgical oncology, it can be in chemotherapy. It can be outpatient: you can be a hospice nurse. I mean, there's so many choices within oncology. And the interesting thing a few years ago when there was a lot of surveying around nurse satisfaction, oncology nurses are less dissatisfied than other nurses. Not that our satisfaction necessarily jumps off the scale, but we're not as dissatisfied as nurses in other specialties. And I really think that's because the relationship you develop with patients and their family in oncology, even if your employer isn't saying thank you, there is that appreciation back from patients and families that you give but you get in return. What you learn, the courage you see in people facing cancer also feeds and rewards and energizes oncology nurses. I don't know if that's making sense, but I think that's why oncology nurses maybe less dissatisfied.

ROSEBERRY: Okay. Well, as you yourself became more of an administrator, does that also provide, does that take away more from the clinical, from that sense of—?

NEVIDJON: Yeah. It was a very—well, I sort of ended up in the administrative track. That was not my career plan. I mean, my career plan really was to do my master's, work

for a while as a clinical specialist, go back and get a PhD in clinical psychology, and be a psychologist working with cancer patients. But while I was in Switzerland—well, before I left for Switzerland, Duke had been designated one of the original twenty comprehensive cancer centers under the Cancer Act under President Nixon. And while I was gone the Morris Building, the cancer center was being built, and a good colleague back here, Evelyn Morgan, kept in contact with me, letting me know what was going on, and she was really hopeful that I'd come back and maybe be the manager of the inpatient unit. And so when I came back, and the construction was still going on, and I was working part time while I was finishing up my master's, she kept me very much in the loop; and when the position opened up, I interviewed and was offered the position. So I ended up in a management role, whereas I thought I was going to go in a clinical nurse specialist role a couple of years before. But the interesting thing was, was that in that management role, I still had a lot of clinical. So unlike today where the managers may not have as much clinical involvement, back then the nurse manager really was very involved in terms of patients and families. I led cancer support group with an oncology social worker. It was just different back then, so I was still very close in terms of providing hands-on care. I was also managing: you know, performance evaluations, hiring, firing, writing schedules. You didn't have the budget kind of stuff that you have today. It was much, much simpler back then. I think the hardest thing in terms of management was not that position, and it wasn't anything that I did in the eighties. I think the hardest decision was making the move back to Duke in '91 into a divisional director, because I was going to be the divisional director for the medical and oncology units, about ten units in Duke North and Duke South that I was going to be responsible

for. And that really took me away from patients. Up until then I had been able to, even in my management roles out on the West Coast, I had been able to stay pretty close to patients and patient care opportunities and stuff. Even in the job I had, I was the first product line, service-line manager in an organization out there where I was managing the cancer services. Even in that role, I still every now and then would be called upon to put an IV in somebody with difficult veins because I—at one time, I was very good at inserting IVs. (*laughing*) It was a technical skill I just had a really good skill in. Other skills I might not have been as good at, but I was in terms of IV's. So even then I still had those moments, touching patients, not in like, Let's counsel, or, Let's do support groups or whatever, but in that hands on and pushing chemo when I was the clinical director at the University of Washington out there. Again, I was still able to step into the chemo room even though I was managing. I was managing a construction project as well as managing staff and stuff like that. I still had the ability to slip in and maybe sit with somebody, teach them about their chemo and administer their chemo at the same time just to keep myself close. I didn't have to. A lot of it was because I wanted to. But when I came back here, it really was going into a nursing administration role. And I had to debate: Was that really the path that I was going? And, sure enough, that was the path I was going, and I could still go out on the units, and I would vicariously live (*laughing*) from the experience talking with the nurse managers and the staff, but that was really the step away from roles that kept me still close enough to patients and their families. And I debated about that, making that move. And since then, my roles in administration became broader. But when I took the manager job, when I go back to taking a manager job instead of saying, No, I'm looking for a clinical nurse specialist job, one of the things

that I had really learned in working both at Duke and in Switzerland is that as a nurse, I could take great pleasure and pride in the influence and the effect I could have one on one with patients and families. As a manager you could affect an environment that many nurses work in. And I was really committed to creating a work environment where nurses—and that's why I took the oncology nurse, the manager job here. It was—Jordan Ward is what the unit was called—because I wanted to create an environment where nurses would practice at the *absolute* highest standard with the absolute best care for patients and at the same time be supported in their own professional development and excellence. And we had that. I was there for three and a half years, and it's really kind of interesting to see many of the nurses who worked with me in those three years what they went on to do as nurses in oncology. Many of them are still in oncology in advanced roles and in leadership roles in other parts of the country. So we had a pretty unique experience. We were given that opportunity by the organization. And so when it came time for me to decide did I want to leave oncology, because I saw coming back here, even though I had oncology units, I saw that it was going to take me a little bit out of oncology purely. I found myself going back to that same thought that I had back in the late seventies, that this allows me to influence yet a broader organization. That's what led me there.

ROSEBERRY: And then as you—became even broader. (*laughter*)

NEVIDJON: Yeah, well. Yeah.

ROSEBERRY: And more eventually in charge of the—.

NEVIDJON: Yeah, the chief operating role.

ROSEBERRY: Well, I don't want to skim over those years when you were not at Duke.

I don't know if there's anything that you'd like to say about them, but I guess I'm primarily interested in Duke, unless you have anything you'd like to say.

NEVIDJON: Well, I think we're certainly a product of all our experiences. I think what I experienced on the West Coast—first of all I was in Canada for four years and then the other six I was in Seattle, but what I experienced out there was the change in our healthcare system. So what was fascinating in coming back in '91 to Duke was that Duke hadn't changed. (*Roseberry laughs*) In the ten years I was gone, there was no indication that any of the stuff we had had to do out in Seattle, with the payer market and all that, had not hit here. What I didn't realize at the time is that, Well, of course not. This is not a major metropolitan market. This is a secondary market for the insurers, and we don't see those changes first. Where you see those changes first are your big metropolitan areas, your West Coast. And so in some ways I felt like, Oh, my God. I'm going back in time, when I came back to Duke. I was really shocked at how progressive things had felt in Seattle, and how they didn't feel that way here. It seemed like Duke was stuck. (*Roseberry chuckles*) Also nursing was in a very—I was very surprised, because when I left, I felt nursing was very strong. We had a very strong leader in Wilma Minniear. She was an *incredible* mentor to me. And I thought, Gee, nursing is going to really be great. Well, when I came back, I was surprised at how dysfunctional nursing was and just the organization operationally. People talked about, Oh, you stay in your foxhole. You don't put your head up. That way you don't get shot. And it's like, This is not the message of a healthy culture. I was used to cultures out on the West Coast that were energetic, team oriented, customer oriented. People took risks. People spoke their mind, and here it was just 180 degrees. Coming back, I thought, Wow, what's happened?

Well, Wilma retired, and then there was a period when they didn't have—they had an interim, and then they hired somebody they also hired to be the dean of the nursing school, which, how can one person split themselves in two like that? If she was at the school of nursing, she was needed at the hospital. If she was needed in the hospital, she was in the school of nursing, whatever. So then she was gone after a couple of years, and then there was again a period of interim management. Then the person who actually recruited me here was brought in. So there had been in the eighties all this sort of fragmentation of leadership here, so it began to make some sense, why nursing didn't seem as strong to me as I thought it would have been given what I had left. If that makes some sense.

ROSEBERRY: Sure.

NEVIDJON: But some very, very dedicated, very wonderful folks are still in leadership positions over in the hospital and then survived the nineties. (*laughs*) The nineties here, finally the trends of the country caught up with the area, and changes needed to occur, and the organization, obviously, is very, very different than it was even five years ago in terms of what's happening in terms of the organization. And what I think sometimes people don't understand is it's not because somebody in some office at Duke is sitting there saying, Oh, let's see. What kind of masochistic thing can we do to the people today? A lot of this is the external regulatory environment, the external policy environment, what happens in your community, population trends, all sorts of things that impact care delivery. Not somebody just out to be sadistic. Not masochistic, sadistic. (*laughs*)

ROSEBERRY: Let me put in another tape.

NEVIDJON: Yeah.

(*tape 1 ends; tape 2 begins*)

ROSEBERRY: I wanted to ask you about the chief operating officer position.

NEVIDJON: Yes.

ROSEBERRY: First maybe if you could just articulate some of the responsibilities of what you were doing.

NEVIDJON: As a chief operating officer really it was the management of the day-to-day things at Duke Hospital. And I had the chief nursing officer reporting to me, which is a little different than the structure today where the chief nursing officer reports to the CEO.

ROSEBERRY: Okay.

NEVIDJON: So back then when Mike Israel as chief operating officer the structure changed, and so the chief nurse reported to the COO, and when he became CEO, he kept that same structure in place. And so nursing reported to me as well as the responsibilities for the rest of the operations hospital. That includes things like fiscal operation, care delivery, patient satisfaction, employee satisfaction, all of the things you would think of in terms of running an organization. It had to do with regulatory compliance and all those kinds of things. Now, as you recall, too, during this time we decided to become a health system. And so I had been in the job barely at all when we were talking with Durham Regional, and then the next thing you know we got Raleigh Community. So by 1998 when we formalized the system, we had begun working with a consultant group and doing integration work, trying to integrate the organizations, and Mike had had me be one of the co-leaders of that integration, the clinical integration effort. The operational integration I should say. The other was Larry Suitt who was the COO at the time over at

Durham Regional, and we were really, this was really prior to Raleigh Community getting folded into the health system. We spent a lot of strategic time looking at how might we integrate certain kinds of functions across the organization, so I was also very involved at a strategic level related to health system development, which was a little bit unique, I think. It was great experience. Unfortunately a lot of what we saw as being beneficial—and *we* wasn't Larry and I. It was a big group of people from both organizations. We just happened to be the team leaders. A lot of it didn't come to pass, and a lot of it didn't come to pass because I don't think the organization was prepared to deal with some of the political flack, you know, the reactions. If we were going to consolidate this or integrate this, and we were doing some other things across the health system, and then, of course, we brought Raleigh Community in, a lot of HR standardizations, so payroll, to standardize payroll and job descriptions and classifications and time and attendance and all those kinds of things, so that some of the other things we just, just now I'm hearing them start to talk about. So you know, here we are five or six years later from when we had designed and outlined some of that stuff. So yeah, I mean, it was sort of like, Mike [Michael Israel] as a CEO was, he was CEO of the hospital, but he also had responsibility for all the clinical facilities, clinical programs in the health system, so that was the hospitals, it was the community care programs, it was the Duke University Affiliated Physicians [DUAP] and all. So he had a big external role, not that he certainly wasn't focused on Duke Hospital, because he kept that CEO title plus his VP title. So it was an interesting time. I mean, I think as a COO, I had some of what's very traditionally a chief operating officer role, but I was probably functioning more like the CEOs at Durham Regional and Raleigh Community Hospitals, although I

wasn't called that. I didn't have full CEO responsibility, but I had a tad of those as well. We went through an awful lot of major culture transformation at the time because when you try and bring in other entities, we brought in Triangle Hospice, for instance. It's small, but we'd never had a hospice organization before. And you want to keep some of the uniqueness of what makes an organization good, but you also want to brand yourself as a healthcare system. So we were working very hard and very long, and at the same time dealing with huge volumes of patients. Our census was high and all those kind of things.

ROSEBERRY: You were talking about some of the political flack that came.

NEVIDJON: Um-hum.

ROSEBERRY: Where does that come?

NEVIDJON: Well, you know, a lot of the community physicians didn't want Durham Regional to become part of the Duke Health System. When Dr. [Mark] Rogers was here as CEO he had, and I think even when Vic [Vickery] Stoughton was here before him going way back to the early nineties, I think those two CEOs also saw that the future meant Duke and Durham Regional need to align, that where the market was going, the market wasn't going to be able to sustain all these individual hospitals. They were going to have to align, and Vic saw it, and Vic was only here for less than a year. When Dr. Rogers was here, he actually began to raise that issue and sensitize them. The community was like, the community docs were: No way, no how, kind of thing. And so we actually I think at least at three different points had talked with Durham Regional. That third point when talking with them was when it actually came to pass. But you had community physicians who were saying, I don't want this. You're going to put us out of

business because of all your doctors over here, not ours. So it was those kind of reactions. You had employees over there who found they were going to be swallowed up by big Duke. So you had all those kinds of reactions. There were concerns. For instance, we looked at integrating the laundries. We had two laundries. We were running a laundry, they were—. Something as simple as what I was saying about this integration of operations. Let's go to one laundry, right? Well, we were a unionized laundry. They were non-unionized. We began to look at things, and it's like you're dealing with—and they didn't want, their employees didn't want to be unionized. Prior to being the chief operating officer when Dr. Rogers was here as CEO, and we looked at right sizing the organization, long before this community really thought there was going to be a need for any of these hospitals here to decrease their number of employees. And we had done some financial modeling that said our employee-to-patient ratio was pretty high, and at a certain point it looked like our expenses were going to be outpacing our revenue, and that would put us in the red. And so ahead of that happening, we began that whole process, and the headlines that occurred in terms of: Fifteen hundred people are going to be laid off! and trying to manage the panic on that. I was the chief nurse at the time, and trying to *not* have registered nurses fleeing out the door was very, very difficult. People were really concerned that when Durham Regional and Raleigh Community came in, we were going to lay off Duke employees. That brought all that up again. The time you spend communicating with your own employees about what's going on, lots and lots of time going into those kinds of things. Those are some of the things that you get involved with that you have to manage. And then there's that whole community fear or push back or politicking or turf protection kind of thing. I mean, a lot of our physicians

didn't understand: What the heck are we spending money on Durham Regional? Why were we buying Raleigh Community? That was money that we could be using to do *x, y, z* for them, so not all our physicians were on board with the direction we were taking. Many of them were not. They didn't see us going in that direction.

ROSEBERRY: Sounds like a turbulent time.

NEVIDJON: Very, very turbulent. Very turbulent. Actually in hindsight, I should have realized how turbulent those years were going to be, because I was officially in the position in August, I think it was. I had really started sort of in June-ish taking on some of the work, but officially I think it was August. We had that very bad accident of the Butner patients, the psych patients in late August, I think it was. There was a highway accident on [Interstate] 85, and then we had Hurricane Fran in September, and I can remember saying to a nurse colleague, a national colleague, that, Boy, one of the ways as a nurse moving into a COO position—and as a nurse you think you know a lot about the operations of the hospital—but I said, "Prepare for a hurricane," because all of a sudden you've got people coming telling you, We've checked the roofs. Anything that can blow is off the roof. We've done this. We've ordered tankers of water to come in, et cetera, et cetera. It was an incredible orientation to being a chief operating officer. (*laughter*) I thought at the time I should write a little pamphlet for nurses who want to be COOs. So you want to be a COO? Here's some things to think about. Here's a little primer.

ROSEBERRY: Well, tell me about being female in kind of the upper echelons of—

NEVIDJON: You know, that was interesting, that I was in the position over a year I think before I recognized the symbolism of my being in that position had for many people, positive and probably (*laughs*) negative, too. When I was first announced, I

actually received communication from people in the community who I didn't know, nurses, who said, Congratulations. This is wonderful what you're doing for nurses, what you're doing for women, this kind of thing. And I didn't realize that I was carrying sort of a symbolic message in terms of women and nurses at Duke because Duke has such a tradition of a male-dominated, doctor-dominated—the organization. The university is male dominated and the health system, and in the hospital it's doctor dominated, and that sort of struck me about a year into the role when Mike had a conversation with me about a conversation that he and Dr. [Ralph] Snyderman had had, that one of the chairmen had complained to Dr. Snyderman about some interaction with me, and Mike's comment to Dr. Snyderman was, "Now, if that had been me, you would be saying, Atta boy, and giving me a pat on the back. Is it because she's a woman that—?" The woman is the bitch. The man is the hero with that same kind of tough line. I mean, I'm not an aggressive—I'm an *assertive* individual, but I'm not a mean aggressive, *rrr, rrr, rrr*, you know, like men sometimes explode. I don't explode. I may explode privately, but I don't explode and cuss. I've seen the men at the table cuss. I don't swear at the table. I may swear in private—and seeing them get red and blow up kind of thing. But in this particular situation we were dealing with, it had to do with who was going to pay for what and funding, et cetera. Well, there are some regulations around what a hospital can do and what they can't do, and sometimes you can get into a Stark violation or whatever. And so I was basically firmly holding the line. This proposal can't—we can't do it, kind of thing. Well, you know, I guess the chairman didn't like it and went and complained to him, so I became the bitch in that situation. And it was at that point, sort of a year in, that I realized it *is* different for women, and Mike and I had this conversation. He said, "I just

want you to be aware." And I said, "So how do you want me to play this then? I mean, if *we* made a decision administratively that this is not what we can do and this is why, and I've got to be the message carrier." And yet on the flip side on more than one occasion when I was definitely dealing with gender bias issues, Mike would say to me, "Don't make it about gender, Brenda." And I'd say, "Okay, help me here, then, because it is very much, very much is gender right now, and you're a man and you can say, Don't make it gender, but I'm the woman sitting in this chair, and this is playing out like gender." And so it wasn't easy, and I was the only woman at several tables for a long time, and then that began to change. Dr. Snyderman hired Jean Spaulding. That brought her to a table that I had been the only woman at. And then obviously other women have actually started getting into more senior positions in the organization. But there *is* a gender bias, and there is a different style. There's no doubt in my mind. And what I see today is there is a nurse in the COO position in Kevin [Sowers], and while I realize it's a slightly different scope than I had, but what I see is he doesn't—that in fact because he's a guy, that's what they see. They don't see *nurse,* whereas they saw *woman,* and then *nurse* got right attached to it. I mean, I got a message towards the end, you know, before I left the position that the physicians felt nursing had gotten too strong in the organization. And I'm sure that was attached to me, that you had a COO who was a nurse. You had several others in leadership positions on that operations team in the hospital who are nurses who were here or who are still here who came out of—they're nurses, and that was perceived as nursing had gotten too strong. So twenty-some odd years ago, thirty years ago, I may not have been aware of a context in this organization in Medicine and nursing, but in hindsight looking back I think there's a real love/hate thing

at Duke about, How strong do you want nursing to be? And I think the current chief nursing officer certainly *is* experiencing that and had experienced that. And yet I don't see why it has to be one versus the other. I mean, in a hospital, you're foolish if you don't have strong nursing, because that's why there are hospitals, because patients need nursing care. They're not in hospitals because they need the doctors. They're in hospitals because they need the nurses. So why wouldn't you want strong nursing? Why wouldn't you want strong nursing leadership? Look at all the patient safety issues. I don't mean just at Duke. I mean nationally, as we've paid attention to patient safety in hospitals, who's there twenty-four hours a day, seven days a week? Who is the surveillances system of a hospital? It's *not* the doctors. So why there isn't a better collegial—I think one on one there is, and I think I certainly had good one-on-one relations, but then when you get into position and title, some of what begins to happen with the politics of that—and gender came into play, and profession came into play at different times. But just an interesting little anecdote in terms of style. I was working with Paul Newman, who is the executive director of the PDC [Private Diagnostic Clinic]. We were jointly working on some things trying to bridge and have some consistency between the PDC and the hospital, and we were doing a presentation to this senior group, which, again, was all men. And I had been on vacation, and Paul and I had been working on this through e-mail, but it had been his secretary putting the PowerPoint and everything together. So on a Monday morning where I had just gotten back the night before from vacation and I was going into like an 8:30 meeting, he says to me, "How do you want to do this?" And I said, "Well, you've really worked with the final version of the slides, why don't you take the lead and I'll chime in?" Which is what we did, and it

was a good presentation. The message that came back to me later in the day from, again, Dr. Snyderman via Mike, is, "What was wrong with Brenda? Why was she not presenting? I know this was mostly her work, and Paul went along. Why was she letting Paul do the presenting?" For me it wasn't about the person. It was about the work, and it was interesting that the view of that was, Who was standing there? And I'm thinking it's the content that's important. It's that we get this across. I also thought that for a roomful of men, the presentation was on customer service, that, Oh, well, of course you'd expect a woman to do that, that more powerful would be to have the male do that, and because he had also worked with his secretary putting the final slides together. It was just a pragmatic reason. But I found it fascinating that the feedback to me was, Why wasn't *I* up there? I had probably been really the lead on it, which was true. He was right there, but to me it was about the work, not the spotlight. But a lot of people see it as the spotlight, and I think men—and maybe that's a biased statement—but I think the men at the table that I worked with always were jockeying for the spotlight. It was fascinating to see. I also learned, you know, you look at a table and you always learn sort of the language of the table, and the language of the table I walked into (*laughs*) with those men was, I agree with you a hundred percent, and then they would just slam the person. It was sort of one of compliments followed by a *pow*. (*laughs*) It was fascinating to watch that communication. I agree with you a hundred percent. They would never say, I disagree, or, You're a fool. It was, I agree with you a hundred percent, but as soon as they would say, I agree with you a hundred percent, you knew there was a contrary statement coming behind that. It was really bizarre, really bizarre.

ROSEBERRY: (*chuckles*) Very interesting.

NEVIDJON: Yeah.

ROSEBERRY: Well, I guess was there any way in that context maybe to strengthen nursing or the school of nursing?

NEVIDJON: I think I broke barriers in the organization, and I think that strengthened things for women, for nurses. I mean, I didn't go into the position thinking that, and I didn't necessarily exit the position fully aware of that, but being away from it now what I've recognized is the table, the table changed at Duke, and I was part of making that happen. I wasn't alone. I mean, Mike was the one who obviously promoted me and supported putting a woman and a nurse in the COO position, and you never get to where you end up completely alone. There's a lot of people who usually help successful people along the way. You learn from others, and they support you. And you know, I think that I left a legacy of opening of opportunity for others, men as well as women, nurses as well as non-nurses, whites as well as people of color. Because (*laughs*) there was a point in time when somebody pointed out to me that my next hire needed to be a straight white male, that I had created enough diversity (*Roseberry laughs*) of gender, of race, of sexual orientation in terms of the people that I had promoted, that I needed to find a straight while male to promote. (*laughter*) I said, "Okay." I mean, there were plenty.

ROSEBERRY: (*laughs*) Gotta meet your quota there, too.

NEVIDJON: Well, I mean there were plenty of straight white males who existed. I didn't think I needed to hire one. I needed to hire the others, and I was equally committed to promoting people from other kinds of backgrounds, too, that leadership didn't only come from an MBA, so when you look at people, even people who are there now, you've got nurse in Kevin, Kerry Watson came out of a radiology tech background

before he went and did his MBA. I mean, had somebody from a social work background who was in a high level. So there were people who came to the table who—it wasn't just because I wanted a token this or a token that. It was because of the talent they brought, but I wanted a diverse table. I wanted an inclusive table, so that when employees looked a social worker could say, Yeah, I could be an administrator one day, or an African-American could say, Yes, African-Americans can get into top leadership positions here. It's not all white males. And there's nothing wrong with white males. I'm married to one, and I love him very much. (*laughs*) But that's how the organization was run at one point, and it's not unique to Duke. It's many organizations were that way. But yeah, I think by being given the opportunity to be the chief operating officer, whether it was a conscious agenda or not, I was able to promote talent that created a whole different table and perspective at the top of running Duke Hospital, and that was a great legacy to leave.

ROSEBERRY: Yeah. Am I right in thinking that the nurses at that point were talking about unionizing?

NEVIDJON: Yeah, at a couple of different points in my career over there, the nurses talked about unionizing. It started in the mid-nineties, and then, yeah, right after I came over to the school, it got pretty hot and heavy over there. And frankly, I think if the nurses knew the true story, they could have unionized; but I took a high road, and I always take high roads in my decisions. I think if they knew that the doctors wanted the nurse at the top out, that would have added fuel onto the whole—because my departure from the COO position was because—it *was* because the physicians had convinced Ralph that nursing was too strong. They wanted physicians to have more authority, and so they wanted to make a change. And so I don't know how much say Mike had in that, whether

he was even allowed to say anything. Basically he left shortly, you know, within a year and a half or so after. But I think if the nurses at the time who were increasingly discontent knew, because so many of them when they realized, they were all happy for me. They knew I had a young son. They knew the kind of hours I was putting in, and so many were just thinking, Oh, good. You're going to take care of you. You've worked so hard. So many were very, very pleased for me that I was moving in a direction to take care of myself. And many suspected there was something that went on at the time, but if they knew, if they had been a fly on the wall and heard the conversation about: The doctors feel nursing has gotten too strong. Wasn't that fascinating then shortly thereafter my announcement that there was much more activity around the union? They weren't related, but it could have been. It could have gotten tied together.

ROSEBERRY: Interesting.

NEVIDJON: Yeah. Yeah. It was very interesting. But you know, you could see it coming. I had hired a consultant, recommended us hiring a consultant group the prior year to do an assessment of the organization, and they thought we had a mild-to-moderate risk, and that—in terms of unionization—but that escalated pretty quickly. What they—why they based the risk, when I saw the data that they came back with, I was very discouraged because we had worked so hard on so many things within Duke Hospital, and one of the key pieces of information of why the nurses were dissatisfied really was out of the control of hospital leadership. It was health system, and the decisions that were being made at the health system level. The attention that the health—I mean, they really felt like nobody cared about the nurses at Duke Hospital. It was all about Durham Regional. It was all about Raleigh Community. It was all about the big salaries of the

health system executives, and so there was a lot of interesting information in their assessment, and some of it was just stuff that was beyond our management.

ROSEBERRY: So now?

NEVIDJON: Yeah, now is an exciting time over at the school. (*laughs*) Lots of good stuff happening. You know, with new leadership in the organization in so many places lots of potential. I mean, I love the fact that in nursing—I'm a very good example of (*laughs*) why nursing is a good career in terms of being a clinician or an administrator and now to being an educator. I mean, I've always loved teaching and working with students, so this was a good fit for me in looking at leaving the COO position. What else might I want to do? I was given the option, What do you want to do, Brenda? Do you want to stay in the health system, or do you want to leave the health system? I had already had conversations with Mary Champagne about coming on faculty at one point.

ROSEBERRY: Well, if there's anything I've missed, I was going to wrap it up now, but if there's anything that I've missed.

NEVIDJON: Well, just it's what I was saying. I just think that nursing really offers people so much choice, and the education, I mean, going back full circle, the education that I got here, I really think that faculty looking at that curriculum of what they wanted to prepare for the future, it was the *right* preparation for me. I certainly went on and got the advanced education, and that master's certainly helped, and I certainly had hoped to go on for the doctorate a *lot* sooner than now and never was able to (*laughs*) for a variety of reasons. But I always look back on my experience as an undergraduate here and my early days as a nurse here as so influential in terms of where I've been and just the risks I've been willing to take, the choices I've made at this organization. I'll never forget:

Wilma Minniear, when I was leaving for the West Coast gave me this (*indicates paperweight on desk*), and I still keep this, she slipped that in the pocket of my lab coat, and she said, "Now, I want you to go out there, and I want you to prove yourself to you, because you don't have to prove yourself to us. We know what you're capable of. So you go out there and prove yourself to yourself, and then come back to us." And I thought, How prophetic that in 1991, I still have my little paperweight, and I'm coming back to Duke, because I never thought, when I left Duke in '81, I never thought I'd be back at Duke, never intended that I was going to come back to this organization. I'd already done that once. I'd gone off to Switzerland, and I'd come back to the organization. I never thought I'd be back for a third time. But I'm glad I did, very, very much.

ROSEBERRY: Well, thank you so much. It's been a pleasure talking with you.

(*end of interview*)