ORAL HISTORY INTERVIEW WITH TRACY KAREN GOSSELIN
Duke University Libraries and Archives
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COLLECTION SUMMARY

This collection features an oral history I conducted with Tracy Gosselin on October 13th, 2021. The 101-minute interview was conducted in Durham, NC. Our conversation explored Gosselin's early interest in nursing and later oncology nursing, her career trajectory into leadership roles, and her thoughts on workplace culture and nursing as a profession. The themes of these interviews include nursing education, patient care, and the COVID-19 pandemic's impact on healthcare.

This document contains the following:

- Short biography of interviewee (pg. 2)
- Timecoded topic log of the interview recordings (pg. 3-4)
- Transcript of the interview (pg. 5-28)

The materials I am submitting also includes the following separate files:

- Audio files of the interview
    - Stereo .WAV file of the original interview audio
    - Mono .MP3 mixdown of the original interview audio for access purposes
- Scan of a signed consent form

BIOGRAPHY

From 2016 until 2021, Tracy Gosselin was Chief Nursing & Patient Care Services Officer at Duke University Hospital, a wide-ranging job encompassing nursing practice, education, standards, and accreditation, as well as the implementation of patient care practices. A Massachusetts native and graduate of Northeastern University's College of Nursing, she first came to Duke University in 1993 as a Staff Nurse for Inpatient Oncology. She had developed an interest in oncology nursing while participating in the five year co-operative education program at Northeastern, which included an assignment at Dana-Farber [Cancer Institute], where she became close to patients undergoing treatment. "In the cancer world, there is a series of repetitive visits for many of the courses of treatment," she explains. "You become that familiar face [to patients] and they become that familiar face to you."

After two years at Duke as a Staff Nurse, Gosselin moved into leadership as Assistant Nurse Manager for Inpatient Oncology. After tenures as Nursing Program Manager and later Clinical Operations Director for Radiation Oncology, she became ACNO for Oncology Services. As Assistant Vice President & ACNO for the Duke Cancer Institute, she participated in the development of the Duke Cancer Center, which opened in 2012. In this role, she engaged a variety of stakeholders to develop the integration of services and details that affect patient experience. In addition to creating an Oncology Patient Advisory Council, Gosselin and her staff "work[ed] with patients and families to help us understand wayfinding, to help us understand furniture layout, and selection of [resources]."

Gosselin describes patient experience and care as central to her work as Chief Nursing Officer. "Many of these patients go home with invisible fingerprints of our team members who made a difference," she says. "That sometimes is the difference for our family whose loved one died here, but they didn't suffer. And I think that's a pretty powerful difference that we can make in the lives of others."

INTERVIEW TOPIC LOG (tracy-gosselin-interview-audio.wav)

00:00 Introductions
00:32 Current responsibilities and priorities as Chief Nursing and Patient Care Services Officer at Duke University Hospital
05:54 Role in patient experience and experiences with feedback during rounding
09:45 Full name and upbringing in western Massachusetts; role as junior volunteer at hospital
11:16 Education and choice of Nursing major at Northeastern University; co-op program and placements at Boston Children's Hospital, Dana-Farber Cancer Institute, Boston University Medical Center, and Massachusetts General Hospital; interest in cancer care
15:00 Applications for oncology positions at Duke and UNC; move to Cary for job as Staff Nurse for Inpatient Oncology at Duke Hospital; Hanes House orientation
16:27 Duke Nursing orientations in Jordan Ward and on Hematology Oncology floor
19:09 Early career interests and views of nursing as a profession; influence of family
22:01 Recollections of learning on the job (time management, cancer as a set of diseases, cancer treatment and end of life care)
24:21 Early professional interests in leadership and management; promotion to Assistant Nurse Manager for Inpatient Oncology
28:18 Continuity of care and streamlining of oncology services during early career; implementation of nursing model while Nursing Program Manager for Duke Radiation Oncology
34:27 Experiences as student in University of Utah's College of Nursing virtual PhD program
37:25 Doctoral research in symptoms, quality of life and emotional status in survivors of rectal cancer treatment.
38:51 Experience teaching on Oncology Nursing and Leadership in Duke School of Nursing
40:58 Decision to aim for Chief Nurse position in order to "marry passion and purpose"
42:46 Involvement with Duke Cancer Institute and Duke Cancer Center
45:00 Onboarding and team-building activities as Chief Nurse; importance of senior leadership being present for nighttime and weekend staff; Duke Corporate Education retreat
52:21 Research and education on bullying in the healthcare environment, thoughts on safety reporting, disruptive patient, and professional accountability protocols
56:58 Workplace and patient safety mechanisms in Epic / Maestro Care; impact of COVID
59:59 Work with COO Mary Martin during early months of COVID-19 pandemic; impact on pandemic on nursing and other hospital staff ("fear", "anxiety", "emotional drain"); view of the care that staff provided to patients in early 2020
1:00:00 Development of COVID-19 vaccinations and subsequent wave of infections among "predominantly unvaccianted" people; emotional impact on nursing staff; current "exhausted workforce" and burnout
1:11:10 Work with colleagues Yvonne Spurney, Trisha Choi, Chantal Howard, and Frank DeMarco to create and enact COVID-19 care and safety guidelines
1:17:39 Professional supportive relationship with Chief Medical Officer Dr. Lisa Pickett during COVID-19 pandemic

1:21:37 Early mentorship by then-Nurse Manager Kevin Sowers; pivotal experience facilitating end of life conversation with patient and wife; professional relationship with Brenda Nevidjon
1:31:06 Reflections on personal traits and skills in career
1:33:57 Work with Cancer Center and development of Oncology Patient Advisory Council; work developing dress code
1:37:22 Upcoming move to Memorial Sloan Kettering Cancer Center as Senior Vice President, Chief Nurse Executive, and Chair of Nursing

TRANSCRIPTION (tracy-gosselin-interview-audio.wav)

Josephine McRobbie 0:00
Alright. I'm going to start the recording. And I'll just introduce so we know where we are, and who we're speaking to. So it's Wednesday, October 13th, 2021. I'm Josephine McRobbie. And I'm interviewing Tracy Gosselin. Am I saying your last name right right? Okay. Chief Nursing and Patient Care Services [Officer] at Duke University Hospital. This is part of an ongoing oral history series for the Duke University Medical Center Archives. So, thank you for being part of the project.

Tracy Gosselin 0:30
Thank you for having me. Very exciting.

JM 0:32
So, I thought we could start by talking a little bit about what your current role and responsibilities have been like. And maybe before this week -- your last week on the job -- what a typical week was like for you.

TG 0:44
Oh, great. So current responsibilities in the role were as the Chief Nursing Officer over practice, education, research, and the relationship with magnet designation that we have over ANCC [American Nurses Credentialing Center] and ensuring that, from the standards perspective, we're meeting that. In regards to partnerships in Nursing -- both with Mary Ann Fuchs as our Chief Nurse Executive, my other colleagues as Chief Nurses-- so really working both within the hospital, and within the system. And then also participating a fair amount, and collaborating with, our Associate Chief Nurses, or most senior nurse by service line, either at the entity or system level. So lots of work to define practice, share practice, and most of all, spread best practices.

So there's the nursing component of the role. And then there's some other components, accreditation and regulatory affairs, which most people know as the Joint Commission [laughs]. And the work that goes on with that, and overseeing a leader who has a small team who helps with all of that work. Our chaplaincy program, our dietician program work, along with, we had a new role I was able to create in the last year and a half, an Assistant Vice President for Patient Experience, which was great. And having that person hired in to really take on the patient experience lens versus the Chief Nurse doing it. So it was good, there was transition in a role and being able to create that, to help support the broader organization.

And I think it's really the great work of all the people who take care of patients. So you do a little bit of this, a little bit of that. I would say a typical week, there is no week that is typically the same [laughs], yet the days are fairly similar. And most mornings start with checking safety reports, whether it's patient-related [or] staff-related things that happen that people want to make us aware of. Another part of the typical day is meetings. The last year and a half I have spent a lot of time, like everybody else, on Zoom. Or WebEx or Microsoft Teams, but predominantly Zoom. Living in a different type of box, and participating in meetings that way. I think there

[were] some great opportunities [with] using that type of platform that it gave a little bit different flexibility, especially for the workforce. For people who might have had kids, instead of always being on-site early in the morning for a six a.m. or seven a.m. meeting and then having to be on-site for a five, six or seven p.m. meeting, now there's great flexibility on either end of that. So it's one of those things amidst everything with COVID that made 18 months difficult, I think it also helped provide some opportunities for connection. Not necessarily in the best way. So lots of meetings, and meetings could be related to a service line [or] related to hospital operations with my colleagues, either our Chief Operating Officer Mary Martin, or with our Chief Medical Officer Lisa Pickett. Or meetings on [Duke University] Health System work. The Health System right now is working on the strategic plan that will then help define the nursing strategic plan. And so [I'm] working on both of those, with colleagues for both the system plan and the nursing plan, which is really exciting work. I think some of the other key things for University Hospital [are] we've been working on some of the standards around a healthy work environment that come from the ANCC nursing work, which is really some exciting work when you start to think about what comes next after this, right? Recognizing 18 months has been a long time and so thinking about that work, thinking about recruitment, staffing, retention, engagement, for all staff. Because I think it's the recognition that you might only lead a portion of the workforce, yet at the end of the day, what we do is take care of patients. So you really need to be thinking broadly of the over 10,000 employees for this campus. So one of the fun things we did the past week or two was a Burt's Bees give out when people were coming in or going out. So there's the pop-up things that happen a few days in advance, and you're like, "Okay, I'll help set up for that early morning." And so just a variety of different things, meetings where the work gets done, meetings where there is a dialogue about how do we improve something, the topics just really, really vary.

JM 5:54
It sounds like an incredibly diverse set of work experiences. And you mentioned the patient experience portion, and I read that you made a point, maybe up until very recently, to stop into hospital rooms and see what patients were experiencing. Can you talk a little bit about that, and why that's been important for you?

TG 6:15
So, I think it's probably the best part of being a healthcare provider. It's what made me want to be a nurse. And it is what has kept me in the acute care setting. I think the relationships with patients is just this critical point of seeing and hearing through their eyes how they experience us. And I don't think the past year has been easy on them either, especially when every hospital nationally and internationally was dealing with visitation issues, and all the different concerns. Which are very appropriate, when we talk about good infection control practices. What I would say for me, it's just always grounding. It's, "How are you? How is your care? Is there anything I can do for you?" And just hearing a little bit about their story. And the one thing is, people are always grateful. Now, maybe there was something that wasn't right, or some piece that they expected to be different. Yet, even those patients are still grateful. They're like, "I came to Duke, I'm at Duke, I'm at the best." And sometimes they might joke and say, "But I didn't really need the best, but I guess I really did." And I think it's just helping people where they are in their

journey. And it's just a humbling piece to know that when you are sick, and when you are ill, that there's people who will check in.

And I get to watch the teams do it, and sometimes hear things when I'm rounding. And the rounding on our team members, I think it's critically important, to hear their insights. What processes do we need to improve? What processes do we need to put in place? And I think leading from a desk, it's not a good way to do it. Me solving problems for the work I don't do, is not the best. So I think being able to hear the experience from the patients, to advocate for that, being able to advocate for our healthcare team members, and what they might need. So being able to go and see through their eyes. And it's just nice to be with people. I think that's the part of healthcare that's the best. And I think after the last 18 months, it's been so fractured, for different reasons, that just being present is real nice. And at the end of the day, thanking our teams for what they do. Because what they do matters. It's like I tell the team -- whether you're a nurse in our intensive care nursery caring for some of the smallest, vulnerable patients, to caring for a patient in our geriatric clinic, [or] anything in between, right? That many of these patients go home with invisible fingerprints of our team members who made a difference. And that sometimes is the difference for our family whose loved one died here, but they didn't suffer. And I think that's a pretty powerful difference that we can make in the lives of others. Yet for our health care team members, it's hard. So I think that this is an opportunity just to thank people for the work they do. Because it is hard.

JM 9:45
Thanks for sharing that. And I'd love to hear about how your path to this work, too. So in these interviews, we always ask people where they were born, and when they're born -- their birthdate -- and their full name.

TG 9:57
So my full name is Tracy Karen Gosselin. My middle name comes from my mother, my mother's first name is Karen. I was born in western Massachusetts on December 21st, 1970. I even have the supersize Christmas stocking to vouch for that. I grew up about 30 minutes from the hospital where I was born. Small town, there was one elementary school, one middle school, and one high school. And you were, together with your classmates' graduating class, I think, under 100. Small. Grew up there. Played sports growing up. It was pretty clear I was never going to be a dancer. So it was good that sports were a choice at a young age. And then I became a junior volunteer at one of the local hospitals. And I really liked that. So I spent some time in the nursery, had the opportunity to deliver mail, and wore a terrible uniform, terrible uniform. They've gotten better since then. Our volunteers here at least have nice polo shirts with tan pants. What we wore? No, no, no, never again.

JM 11:14
Is this what they would call the candy striper [uniform]?

TG 11:16
Yes, it was an outstanding pinafore that was a salmon-y pink. Yeah, no, absolutely not. But I loved the setting. And I knew when I was going to college, when I was thinking of applying and

looking at schools, I considered nursing, medicine, PT, and special education. And learned pretty quickly, special education, that was too difficult. I have an aunt who was a special ed teacher and was in the classroom, and it was a little too close to my heart. So I went to Northeastern University, did the five year co-operative education program. And the first year was good, because it was a lot of science. So you could figure out which major you wanted. I think my parents were like, "Just pick a major and be done." And I picked nursing. And I look back, and I wouldn't change it since then. And then what got me hooked on oncology nursing, was when I was a student nurse, I had the opportunity to do the co-op program at Northeastern, which is why it took five years in case anybody was wondering [laughs]. And I spent some time at Boston Children's Hospital. And in one of the areas [where] I worked there, we occasionally saw kids with cancer and I was like, "I don't know about this kid thing."

And then I spent some time at Dana-Farber [Cancer Institute] working one of my co-ops and stayed on a little part-time after. And I loved it. I loved the adult cancer population. And I think what it was is there were some outstanding nurses for my co-op experience there, who took me under their wing and just really helped guide me. And also I became close with some patients. Because I think in the cancer world there is a series of repetitive visits for many of the courses of treatment, and you become that familiar face and they become that familiar face to you. And one of the patients who passed away, one of the nurses came to get me and pulled me into the procedure room and said, "I just want you to know Mr. So and So [died]." And I just remember, like, "Oh my gosh." Right? Like, "How?" And the nurse's name was Brian, and the patient's name was Joe. And just trying to wrap my head around that. I had never experienced death. I'd never been to a funeral at that point in my life. But what I remember was the nurses reaching out, like, how was I as the young up-and-coming student nurse who wanted to be a full-fledged nurse and [was] really thinking oncology.

And I think it got solidified. I spent some time at BU [Boston University] Medical Center on a surgical floor where we had a lot of cancer patients, and at Mass [Massachusetts] General [Hospital], and those patients, many of them I still remember by name. And just their stories. And I think it was an interesting way at that point in my life to get to know people, during some of their toughest days. And so about a year before it was going to finish I was all set to take a PRN [“Pro Re Nata” / "as need arises"] job which is, they call and the issue is they need you to work. And my father didn't want any nonsense like that [laughs]. He wanted his daughter to have a full-time job. Because my brother was starting college in Washington, D.C., and there were no jobs in 1992-93. I graduated in June of '93. So I ended up applying at Duke and UNC. Both had oncology jobs. I flew in at night, landed at RDU [Raleigh-Durham International Airport]. And I thought, "Oh my gosh, where am I landing, there are no lights." And there was no Google Maps, there was no nothing. So it was a different time to be a young adult heading out on your own exploring the world thinking, "Oh my gosh." I got job offers from both, chose Duke, finished up school, moved down here. I ended up living in Cary, I think because I was a northern girl who wanted to know how she was going to ride her bike around Durham. People weren't quite sure what to do with me. So I lived in Cary and had my first day here at Duke over in Hanes House, and spent, I think, one or two weeks in nursing orientation. My gosh. That is one thing I think we have improved upon over time. It's gotten a little better, it's not that long. And I met a lot of other new graduates. But I seem to be the only one that lived in Cary, I think it was a joke.

JM 16:27
And what was orientation like at that point?

TG 16:29
It was in-person, in a big auditorium. And it was just a lot of didactic presentations. And just sitting there, meeting other people, I think there are about 90 of us who started in that orientation. And just getting to know the other people. Talking about where they were from, where I was from, what our prior experiences were, finding the people that were going to go work on the Oncology unit that were new also. So it was nice, I wasn't the only new grad going to Oncology. And then going up to your units, checking them out, doing your medication tests, doing all these other tests. And it's this funny place where you're like, "But I just finished school, why am I having all these tests?" And back then you didn't have your nursing license yet. So you're a graduate nurse. And I think many of us were like, "Wait a second, what happens if we don't pass our licensure exam? How's that gonna work? And what kind of envelope does the news come in? Is it a big envelope, a little envelope, is it different if you pass or don't pass?" And all those anxieties those first few weeks and months, and then eventually, after the initial orientation, spending time on the unit with your preceptor. [We] oriented in two units, which were Jordan Ward, which was 7800 at the time, and then 9100, which is still 9100 here today, a Hematology Oncology floor. The unit I started on was 5900, the physical plant still exists. There is no 5900 unit anymore. And so that is more the Birthing Center space today. So in some ways, very appropriate when you think of the full circle of life. And so yeah [a] new unit was supposed to open [and] wasn't ready to open. [It] eventually opened. Our nurse manager resigned. So Kevin Sowers became our Nurse Manager. And I loved it. I loved the unit. I loved the population. We were a primary nursing model. So we did everything for our patients, blood draws, you name it. And it was just a great foundation base that really built upon what I knew. And I honestly thought that after two years, I'd head home, and I didn't.

JM 19:09
I am curious to hear about when you were going into college, or when you were a teenager, what kind of kid were you? What was the thing that made you go and volunteer at a hospital?

TG 19:21
So, I was probably a quiet kid until I got to high school. At least that's what my mother reports, when she would have the parent-teacher conferences. I played sports. I played soccer starting in early elementary school, picked up basketball later. So I was always pretty team oriented. Like I said earlier, this girl was not going to be the ballet dancer, that was clear. And then I think the volunteering piece came from, "What do you think you want to do?" And I'd never really been in a hospital. Right? And I don't remember TV shows back then with nurses. And I'm not saying we watched a lot of TV back then, that was not one of the favorite things in the household. But I think what helped was my mom had a cousin who was a nursing professor, who said, "If you're thinking of this, this is definitely what you might want to do, to go in and see." Because for many people walking into a hospital alone is like, "No, thank you." And so I took her advice and applied, and went to one of the local hospitals, which was great, like, "Okay."

And my family was supportive of that. And I think it just, when I reflect back then I think it was just that opportunity to see what you could do, and see what nurses did. Even though I was delivering mail and flowers, and rocking babies at the time. But you got to see a lot of what nurses did. And the work's changed since then, I would definitely say that. But yeah, it was that piece of working with people. I knew I didn't want to sit. I spent some time working for my dad who had his own construction business. And that was terrible. Because it was office work. And it wasn't anything that you really wanted to do, or at least, that I wanted to do. And so I think that was very boring. And so I fast forward from that to now. I don't think I've ever had a day that was very boring at work. Days that have challenged me? Most certainly. But not ever a day where I feel like "Yeah, this is boring."

JM 22:01
And were there skills that you felt like you immediately had that would be useful in your profession? Or were there ones that you felt like you really needed to work on?

TG 22:14
I would say coming out of college [programs] like nursing, it prepares you to be safe. It prepares you to answer questions. I think doing a five year cooperative education program, the amount of patients I took care of as a student, I've never taken care of that number of patients at Duke. And my time management skills were probably pretty well honed, of how I looked at an assignment, how I made my notes about the assignment, how I planned my day. So I think my time management was probably well ahead. It was what I didn't know about oncology. So, I think I maybe had a two hour lecture, and in the day when everybody said "You gotta go do med-surg first." I'm like, "I don't want to do med-surg. I really want to do oncology." And I knew my why. And one of my professors said, "You know what, Tracy, then that's what you need to do." It's where my passion was, it's the population I fell in love with as a student. And so it was learning Duke policies, procedures, learning more about how cancer is not one disease, it's a group of diseases, learning about the treatments. Learning how to be present at end of life, and that sometimes you're never going to have the right words, but just being there is so important for the family, the patient. Learning those skills when bad news is being broken, and you're the middleman brokering between what the patient and their family can understand, and the physician team. Because oftentimes, it's like, "What? What does that mean? What is a code?" And being able to explain so people can actually understand. And I just think those are just some things that school does not prepare you for. You truly learn on the job.

JM 24:21
And you spent about two years as a staff nurse, is that correct? And then quickly moved into a managerial role. So how did that unfold?

TG 24:32
In my undergraduate course we had a leadership and management course. And I loved it. And I'm not sure if it [was] because I was at the point I [where] was just really tired of these supersize textbooks we had on all the clinical stuff. It was just like a refreshing break, like, "This stuff is great." And that, and nursing research were the big changeovers as an undergrad. And stats, that was like, "Wait, you're not going to teach me about some body system, or some disease, or

some[thing] population-focused." Right? "Wait, I don't have to make out nursing care plans, or come up with 10 nursing diagnoses?" Right? And I was like, "I kind of like this stuff." And I think, I don't know, I think partially playing team sports. It never really made me say, "Oh, hey, I think I want to be a leader." But I like the team model. And I think I had some leadership opportunities in college. I was involved in a sorority, and was the secretary and did some different things, sort of like the bringing groups and teams together. And that was always fun to see. "Okay, we're going to go do this at a homeless shelter or do this."

And so when it came open, then I was like, well. I applied for one job, and I didn't get it. And I also applied to go back to school pretty quick at Duke. And then I applied for another job on my home unit, where I started. And that was a little like, hmm, where people said "Well, you just became a nurse, how can you do my evaluation? What do you possibly know?" And I'm like, "Hey, look, I know a lot. And you've all taught me, right?" There's that. And people were supportive, as I learned, and as I grew up. And I got involved really early, when I was a staff nurse, just with committees on our unit, "Why don't we have this? Why don't we do that?" And our manager was like, "Well, why don't you do them?" I said, "Great." Off I go, I'm gonna go do it. So I just think it's those pieces.

And then when one of our clinical nurse specialists, Elizabeth said, "Oh, why don't you do a presentation?" I was like, "What? Me? Stand up? Presentation?" And I think we used overheads at the time. There was no such thing as electronic PowerPoint, that I recall. That was back in the days of slides that went in the little circular holder. But I do think we used overheads. And I think people mentoring, and believing in you, and giving you that little push. And then I enjoyed leading the team. Also got involved in my oncology nursing society, where I got to meet other oncology nurses locally. But then, as my career progressed, I became more involved nationally. And so, mentors external to the organization, which I think was really important in pushing my frame of thought, how I think about things, how I see things, and it was just invaluable. But it all started with those two courses as an undergrad that I was like, "Oh!" And then the opportunity appeared. And I thought it'd be fun. And 28 years later, it's still fun. The headaches look a little bigger, some days, or feel a little bigger. But at the end of the day, I think just being able to reflect back and say, "Okay, did you accomplish good today?"

JM 28:18
Can you remember from your early years of being in a management role and a leadership role, some of the challenges, or successes that you had, that felt like big wins, or things that you weren't sure what to do with?

TG 28:31
I think one of the most challenging situations. So healthcare reform really started moving along. And when I started, it was back in the day of, we admitted cancer patients for their full workup for five days. And that, clearly is not the standard of what we do today. Right? It's done on an outpatient basis, unless somebody is acutely ill. And even then it's sometimes rare. But it was, how do you transition a unit to merge with another unit? And I remember thinking through that, and living through that, when there was no playbook. It had never really happened. We'd moved units at Duke. But we never had to merge two units. And it was hard. So you're trying to merge

culture, people, processes, managers. Yet, I think in the end, when I look back on that very early experience [and] the level of detail and planning. Were there things we probably didn't get right initially? Yep. Did we fix them later? Yes.

I think really trying to keep your focus on the patients, and those who care for them. Because I think what I learned is that you are creating change in other people's lives, and how that might feel to them. And I think that's something I always think about, and try to explain why, right? Even to this day. Are we telling people why? They may not like it. But are we really telling people why we're doing this? Because it was something I don't think I understood until further along in my career. And I would probably say for the other two leaders on the leadership team with me, I think we probably could have explained it better. Yet, I think in the end, it was successful with the work we did.

I think the other success early on I had was when I transitioned to [Duke] Radiation Oncology as their manager, and implementing a nursing model. Because I learned pretty quickly, from spending time in the clinic, patients would come and say, "This nurse," and "That nurse," and I'm like, "Well, they have names. And it's not like there's a dozen of us running around." And they would describe the nurses. And it wasn't always in the best way. So you're like, we need a better system. And [I was] partnering with the physicians, and was told they tried a primary nursing model, where nurses worked with two or three physicians before, but it didn't work. I said, "Well, then I think we need to try it again. Because the nurses want it, the patients want it." It was before we had all these great tools to do continuous improvement. And you just kind of did a little PDSA [Plan-Do-Study-Act model] and said, "Okay, we got input, stakeholders, patients, yes, patients would like to know the name of that person, nurses, okay [writing noise]." Because I think it just goes back to that connection. And usually, the better you know your teammates, the better everybody plays together. And so being able to have that conversation with a couple of the physicians to say, "Well, look, we're on board, here's the plan. And if it doesn't work, we just need to keep working at it." And they were like "[grumpy noise]", and I'm like, "But if you're hesitant or resistant, we need to understand what that's about it. Is it, one, the nurse you're going to be working with, or because it didn't work before? Because it's not working now." And I think being able to just be honest to say, "My plan isn't going to be great. But we've got to start somewhere, because it's not good for patients."

JM 32:23
And what was that like once you implemented that model?

TG 32:26
It was great. It was, I can't exactly say it was my favorite job. But for me, because I was a leader in the department, I also still did some clinical time with one of the more tenured physicians. And it was the piece I needed to stay engaged, to drive different programs and create things that we did for patients. I think it's great. I know they still practice that way, which I think is good. And I think it's good for patients. And I think it's good for nurses to know their patients, see their patients. Especially in a department where patients come every day, Monday through Friday, for oftentimes five to seven weeks. You have that continuity, and the nurse has the continuity with the physician. And you built up trust amongst the team. So I think it was great. I don't know what

they would all say today. But I do know when I was there, and when nurses would look at other opportunities, or pursue something different, a physician was like, "Who's going to be my nurse?" And I was like, "Oh, yeah, remember, you all didn't want to do this?" But then you develop that working relationship.

JM 33:43
Must be a great feeling to hear that.

TG 33:46
I'm like "Yes! Success! At last!" [laughs]. So yeah, that was one of those moments, and it was hard to leave there when I, again, changed roles. But that position was probably one of the ones that taught me a lot about myself. From presenting, and growth, and opportunities outside of Duke with mentorship, and getting engaged with some different work related to the field of radiation therapy. And it really was a tremendous opportunity at that point in my career.

JM 34:27
And somewhere around this time, did you start working on your PhD?

TG 34:31
A little later. I transitioned roles to Director of Oncology Services. So that was inpatient and outpatient oncology. Started working on my PhD. And a lot of people say, "Why did you ever do that, you're an administrative person." But I loved research, right? I like reading my journals still, and seeing what's going on, and learning new things. Because hopefully, the goal is, we're going to make it better for someone someday. So I did my PhD at the University of Utah. And it was a very interesting program because they were funded through the NCI [National Cancer Institute] to do it virtually. And so I feel like I was really hip in the day, before Zoom, with my Polycom software. But they had these very specific requirements of your computer, and you needed two screens. And I was like, "Who uses two screens?" Now it's standard, right? And the Polycom has to work, or you're not going to be let in.

But it was appealing because I was in the third cohort. And there were two oncology nurse researchers out there, one is still there. The other is retired. And I had done a study here for them. I was a site coordinator for a study in radiation oncology, and I was like, "I probably should have applied." And then I told someone that, and they said, "Tracy, they're going to do a third cohort." And I was like, "Oh, maybe I'll apply." So I applied. I got in. And we looked like The Brady Bunch, I called it, because there were nine of us. And the appeal of the program is that we were all oncology focused. And for two nights a week, for three years straight, I had class from about 3:30pm to 7pm. And those were some very long days. And then we had to meet twice a year, for week intensives. But I would say I am still connected with those people. So we moved together. We all finished at very different times. And it was an amazing journey. It taught me a lot about myself. It has helped me when others say, "I'm thinking of it, what should I do?" I'm like, "Let me give you some pearls." Because it is unbelievably time-consuming at different points. Yet, my committee chair, I told Suzy one day, I saw her a few years ago, she and her husband were in town and I said "I'd do it all over again. I might think about a few things differently, nothing to do with you. But I would completely do it all over again."

JM 37:25
What would you do differently?

TG 37:28
It has to do with the data set I used. It was a national data set. And because it was a national data set, so you have your dissertation committee, but then I had a whole other committee that reviewed my papers, wanted all my analyses rerun. And brilliant, brilliant people. Yet not realizing that going in, I have learned a whole lot, right? But it's like you tell people, I still love what I did. I still love it. I looked at survivors of rectal cancer, who all got surgery, chemo, and radiation, and their unresolved symptoms, and how it impacted their quality of life, and mental health, and physical health. And trying to understand how you can potentially provide resource support. To not all, but the ones who are most at risk. And I think it's a great way to think about care, because not everybody needs the same, yet, we know there are certain populations, or demographics, or socio-economic things, that all feed that. So, how do you really think forward about that? So if I never chose this type of role, I'm sure I'd be off in a school somewhere, still thinking about that.

JM 38:51
And when you started working with the School of Nursing, as a Clinical Associate, did that involve teaching?

TG 38:57
Yes. Earlier this year, I did a finance class. I love to teach. I've only done a few semester-long courses and it was on business writing, probably 10 years ago. Courses? I don't know about that. Guest lecture? Most certainly. And that was really a great time. Many of the students were our nurses, and also not our nurses. In Oncology, I think we've been fortunate. Many of our nurses who go back to get a Master's Degree as a nurse practitioner, we often hire. So they know the system, they know how it makes things very easy for them. Hard still, sometimes, to transition the role, but easier than going somewhere brand new. So yes, I have taught in their Leadership program, as well as in their Oncology program, in the past. And a few years ago handed it off to someone. I'm like, "Here are my slides, here are the speaker notes, you can do this, you work in the field." I don't as much, right? And so, just a great opportunity to have someone who is embedded in that clinical, every single day as a nurse, who also got their Master's Degree from Duke. And I'm like, "You can do this, I know you don't like public speaking, just think you're having a conversation for a few hours, and sharing the best." Because I just think that is such an important piece of how you continue to keep people engaged to share their knowledge.

JM 40:39
And so at this point in your career, you had this huge responsibility of doing coursework and doing research to finish your PhD. And once that was done, and let me know if I'm missing anything on the path. So what was your next step there? What were you thinking about at that point?

TG 40:58

Part of it was, do I want to go to a school full time, or do I want to stay in Oncology operations, or do I want to be a Chief Nurse? And, I don't think eloquently back then I could have said it as well. But for me now, I get it. It's -- how do you marry up your purpose and your passion. Right? That sounds good today. I don't think that's what I could have put together about 10 years ago. That sounds like a long time. But it was, "Those are the routes." And I like the operational world. Because it's where change happens faster. And so I think always having that collaborative relationship with the school has been helpful, either with having students spend time with me, me spending time there, our nursing collaborative we have between the health system and the School of Nursing. But I think back then, I was ready to be done [laughs]. But it was a unique transition of, "Go, go go," for so long, that you did have a little more space to think about, what do you want to do next? And so looking at opportunities that were out there to either grow in a leadership role, or in a leadership role specific to cancer, I considered some of those opportunities, and then the opportunity came along here. And I applied, and so that kind of gets us to here.

JM 42:46
And in between that you were with the Duke Cancer Institute. And were you involved with the visioning for the Institute as well?

TG 42:56
A little. At the same time we were doing that, we were building the building. The Cancer Center. So I spent more of my time focused on the building. There were some things that maybe weren't going well. So operationally, I took that, versus the institute. In the Institute, I definitely learned a lot. Dr. [Victor] Dzau was here still, Mike [Michael] Kastan hadn't come yet. I think Carolyn Carpenter was leading that, as our administrator for Cancer Services, then. Stacy Palmer was our strategic planning person. We had some great people who really helped think about what other places had done, and what we could do differently. A certain portion of that was all tied to funds flow, resources, and recruitment. And I think the unique piece with cancer, it's anything from the bench researchers that we have, all the way through to the frontline physician who is right there seeing patients in clinic. And then you have some who do both, right? They're in that translational space, and the clinic space, and the research science space. I think it was an amazing journey, especially for the institution at that time, to change and try something different. And I think it was just, it was a great model. But I think the other side of it is, models also change. Because healthcare continues to change. So how we think about all the different pieces, from your workforce, to your financials, your capital plans, right? All those types of things, why donors give, and most of all the patients. What are those models of the future? So I think it'll be interesting to see how it evolves over time.

JM 45:00
And so when you moved into the role of Chief Nursing Officer, what were your initial goals for that position? What hadn't been done the way that you would do it?

TG 45:12
So, you're always thinking, "What is that going to be like?" And I'm having those same reflections again, and people say, "Oh, read the 90 Day Manager book." And I say, "Ok, let me

read the 90 Day Manager book, lots of helpful advice." And funnily enough, I pulled out the book again for my next journey, I think I just might want to pull some tidbits out of this. I think I was acutely aware that I had led our Cancer Institute clinical component of nurses and other team members across the system, and our hospital-based ambulatory clinics. Yet, there were a lot of nurse leaders who didn't know me. Now they knew me, but they didn't know me. And I spent time those first several months, doing one-on-ones with all of them. To sit down and understand who they are, what their goals are, what brings them joy in their work, what are some things they would like to see that were different, and stuff like that. So that really helped set the stage for some of the work we did around team-building. And it's a big team. Because you have your Nurse Managers, your Directors, and your Associate Chief Nurses. And then at the very front line, we have our Clinical Leads, which are staff who are 50% clinical and 50% administrative. How do you bring this huge group together, where we have service lines, yet, we all need to share, collaborate, and partner. And a lot of time, early on, we looked at meeting re-design. How do we collapse some of these meetings? How do we get more inclusive? We did some really fun retreats. And that was where there is the fun part, but there's also the learning part.

JM 47:07
And can you tell me a little bit about those?

TG 47:09
Yeah. So, it was not so much about nursing, or Magnet [model], it was about leadership and being present. And, so when you asked about the presence piece and rounding, one of the things I've done since I took this role was --and I rounded before even this role -- I would round at night on the weekend up and down the stairwells. And when people see you at 2am they're like, "Okay, what happened? Nobody comes at 2am." And I'm like, "Well, guess what, here I am. So let's say hi." And get to meet people and thank people, because I think our staff who work predominantly nights and weekends, don't see leadership as much, especially senior leadership. So that was really important to me, connecting, and hearing, and understanding. I think setting that level of presence made it easy to say to the frontline leaders, and everyone else, "You need to see your people, your people do not work for me. They work for you. They work for you." And as much as they say they don't want to see you. I know they want to see you. And I'm not saying you need to do it every week or every month. But you do need to think about what that means. Because their connection is to you. Right? You're the one who answers their questions. You're the one who supports them. And then you do all the management functions, too. But the leadership piece.

So our first retreat was with Duke CE [Corporate Education]. And I was like, "These are the thoughts I have, but we're not all working off the same mental model of what I think and what they think." And nor should we be, because we're all new working together. So one of the things we did was, so we had our retreat, our first retreat, and we did this work on something called VIBE. It was vision, what is your vision as a leader? How are we communicating that, how are we sharing that with those we lead? What does invitation mean? Which is, I think, even more important now. It's one thing to invite someone, but do they actually feel a part. Are they going to want, or do they feel, included? And are we inviting them to speak and supporting? And so when I think about the work we did, for me it was fun, and it was fun to watch them have fun

and learn. And then we had another one where we did like an egg drop. We didn't break the egg, right? That was one of the key things, they had to build parachutes. We did another where we did some work to support the community, with bike building. So the kits came. It was a lot of fun, but really framing that around why teamwork works, and you didn't necessarily get to work with your colleagues, that you knew already, you had to work with different colleagues to build the bike. And so helping people get out of the norm, and really taking away the key lessons that I think are just really so important. So we've done that, we've done some other activities with a resilience speaker.

And then, we didn't have our retreat in 2020. And we didn't have it this year. Because if I said to people, let's do a retreat via Zoom, there's too many pages of people, I can't see them. And I just don't know where that's all going to evolve to in a future state. So that part's strange. But I think we did a lot of good work, we implemented a dress code policy, where we surveyed the nurses, got a lot of feedback, I had a workgroup of about 80 staff to start. All my newest best friends. Something I tell people, if you're ever a brand new Chief Nurse, do not ever worry about dress code your first year. Wait. But it was important. And we were the last hospital in the system to go live. So that work was important. So we did that together. I've been able to implement the Caring For Each Other program, our CEO program, which helps with debriefing to really help support all types of frontline and non-frontline people when events arise in our care setting, or even not in our care setting. So I think it's just a lot of those opportunities, that as you get to know the people, you start to see where you fill in. And I think that's why I stayed on the operational side, because there's always plenty of work to do [laughs]. And didn't go to a school, because you could make a difference.

JM 52:21
I saw in some of the papers you've written and presentations you've given in the last several years that one area of focus has been on bullying and the work environment. How did that become an interest for you?

TG 52:37
Well, most nurses have been bullied. I was one. I clearly remember that my first year of practice, and the emotions I went through. The mentor who helped me confront the person, who had no clue. And it popped back up when one of my colleagues reached out. And said, "Do you want to present this at the Oncology Nursing Society meeting with me?" I was like, "[uncertain noise] Okay, let's do it." So I look back on that, and it was impressive. And I've given talks to some big groups before. What was different is we probably had 400 to 500 people in the room. And it was a two hour lecture. But we made it interactive. And it's always good when you're presenting with someone really well, even though she's external to the organization. When people get up to tell their story, it's just this powerful piece of, we really need to move this forward here. And so trying to understand, with the work that Dr. [William] Richardson and Cindy Gordon have done around the PACT [Professional Accountability] program and professionalism for physicians that to just say, "Oh, do that," in nursing but not understand if you have that issue, well, I read our professionalism events in the SRS [Safety Reporting System] system. So I know it happens. Nursing to nursing, other disciplines with nursing, non-nursing.

And I think that, one, you have to raise awareness about it. So we did our survey. I'm sad to be leaving and knowing we're going to create a program very similar to the physician one. But I do plan to stay in touch to hear how it all goes because I think that peer coaching is so important. And I think the other times sometimes there are the bullies who just had that one day, their kid got sick first thing in the morning, they got rear ended, who knows, and they'll never do it again. And they're like, "Oh my gosh." And then it's worrisome, though, if they're the people who we let stay in the culture who do that, when people are like "Oh, they're a good nurse, or they're a good this." Well, who cares, because everybody else is leaving because of this, right?

And so helping leaders engage around that is also going to be important, that here are the behaviors. And this is what we expect. And I think it's hard because everybody sees it, hears it, and knows it, and then it's the very hardest stuff to track down. Like the eye rolls, and how people think about assignments, or everybody else is invited to go out to breakfast after night shift, but not Sally, right? And now, look. As nurses, we're all going to need a nurse someday. I'm not getting any younger, and I sure as heck ain't taking care of myself, right? So you can either continue to prune your garden, or you've got to grow it. And you've got to grow it. And it starts with each of us saying how do we engage in those conversations? How do we manage that? And I just think it's important. And I think the other piece I was shocked a little bit about, when I transitioned into this role, was the number of disruptive patients that we care for. And in oncology, we had them but predominantly in an outpatient setting, they go home. Inpatient setting, someone would have the conversation and we'd be done. And I think over the years, for a variety of reasons, just how people are, that is absolutely unacceptable [laughs].

JM 56:58
And there's a sign at the entrance [at Duke University Hospital] that says that.

TG 57:02
We spent some time working on that. I partnered with our Chief Medical Officer, we did an Institute for Healthcare [Improvement], IHI, program and it was the Joy in Work piece. And it really starts with, do staff feel safe? And it was hard, because I emailed the staff and followed up, when I would see the safety events. I'd try and track them down on their schedules, just to check in. Because I've been the nurse who's been bullied, I've been the nurse who's taking care of not nice patients, I've met family members in this role who I've [thought] you need to figure this out. But you cannot do this. This is unacceptable. As much as you want to support people, we're a hospital. And I think we did a lot of good work. We're able to create a health system disruptive policy, a disruptive patient policy, we did the signage work. It was fascinating understanding from other institutions, they'd share their signs. And so I was like, "All right, who has the best language?" And how do you morph this into one, and then said, to communications and marketing, "I think you can all do a better job with this." You don't need me doing this.

And then the work we did with Epic, or Maestro Care, to really help people understand if we have patients that could potentially put them at harm. So a lot of that work about the environment and caring for our staff, who we asked to take care of patients every day. And there's always concerns. Whether we have victims of violence that come in through our ED [Emergency Department], through our OR [Operating Room] platforms, our intensive care units, they're real

issues. And I think instead of shying away from it -- has our policy been perfect, has it fixed everything? No. But I think as a leader, if your staff don't feel safe, you're going to have to figure out what that means. I think one of the most recent good things we've done, pre-COVID we were looking at visitor management systems. And we had signed off on [inaudible], and we implemented it during COVID. So every day if you're an inpatient visitor, you're getting a badge. This is the way this works, right? It's the year 2021, people. We're not the first hospital to implement this. And I think those are important things in our work environment. And other things we're doing around the staff duress button, so they can call for help, and really just trying to sync all that up to best support them.

JM 59:59
Would you be comfortable both telling me a little bit about what COVID was like in the early early months, and it's still going on, obviously, but a little differently.

TG 1:00:08
So, I think many of us were like, "Okay, how many weeks is this going to be?" Clearly, many weeks turned into many months. And I think it was this rapid -- I had the opportunity for University Hospital [with] Mary Martin, our Chief Operating Officer. She and I shared the incident commander role for the institution. We spent a lot of time together in the DMP [Duke Medicine Pavilion] conference room. You're trying to learn clinically what's going on, and things were changing so quickly. We could review a policy on Tuesday, the next day we'd see it and I'm like, "Why are we reviewing this?" "Because we changed it." "Okay, let me review it again." And I knew how I felt fatigued by that. I can't imagine what it was like on the frontline, right? Because you're learning and trying to get everything in place. And so there was that piece of it. Mary and I, we would work 12 days, two off, we each took a weekend. Those were very long weeks [laughs]. Those work weeks were long, and we joke about them still. Because the presence was important, to come in, to make sure staff had their PPE [Personal Protective Equipment] in the units we designated as COVID. And then, as our processes got more hardwired, we didn't need to have quite as long a work week.

And then I think one of the hardest parts to see was always watching the staff. Whether it's nurses, physicians, respiratory PT, any of our clinical teams, or our environmental service. Anybody you see [sigh] on the designated units, the fear of the unknown. Because it was what we didn't know. But we had really, really sick patients who were dying and getting transferred into Duke because of what we do, right? And you couldn't fix that. And so if you're me, I like to fix things. Again, it doesn't have to be perfect, throw the spaghetti on the wall, somebody else might make it look better, but let's just get the ideas out there. That you couldn't fix. You couldn't take it away for them. You couldn't take away the anxiety of going home with not knowing. So, you know, we got scrubs for them. I went out to the warehouse several times to check on our PPE supplies because I never wanted to say to someone, "We have plenty," and we don't. And we always had plenty. It made me feel better [laughs] to see it myself, if I was gonna say that.

I think as it went on, just the emotional drain. And I think especially for any of our frontline leaders who manage staff, the impact it had on their frontline staff. Of children not being in school, now you're their teacher, now you're their camp counselor, now you're this. "How am I

going to work this schedule?" "What do I do?" "How do I do this?" "Why can some people work from home, and others can't?" It was just a lot, and at the same time you're trying to get your frontline leaders, "Here's this, here's that, here's the new policies." And they're caught in a Catch-22 right? Because you have us saying okay, and then you get their staff saying, "But I need to change my schedule." Hard. Hard for them.

And I think there were times when rounding you would watch the staff taking care of these patients and [pause] just what they did for them. And I think, hours. Hours in those rooms, hours with the PPE, and the masks, and sweating your tail feathers off. And a local artist did the 40 portraits for us of some of our staff who submitted photos during that time. And it was pretty powerful. It was in the gallery and they each then got their own portrait, and it's very touching. They brought me a book and said, "Tracy these are the portraits."

Then we came forward with the vaccine, right? So you're going through the summer, the fall. And, the good thing was, "Well, flu season didn't happen last year, because everybody knew what to do, they finally learned how to wash their doggone hands, and not show up if they're sick." But I think the winter was hard because at the same time the vaccine came out, our numbers went up, and our acuity went back up again. And it was just like, "Okay, alright, let's go." But our processes were pretty solid. Our PPE was very solid. Those things were very good. Coming into spring, as the volumes came down, I think frustration about vaccination. The monoclonal antibody was out there. I had some opportunities, I spent time staffing in the monoclonal clinic at different points. And even in August, I went out there for another day, because it's an additional thing for our workforce to do.

And I think people have their perspective about vaccination, everybody has a perspective on something. I think what was genuinely sad is what we had so hoped for, is not what prevailed. And the anger, well, probably a lot of anger about a lot of things during that time. But when our most recent round of COVID volume [started] going up, at the same time, May, June. I remember thinking in the end of June, beginning of July, "Wow, we might have a normal fall." Ha-ha-ha. And then you start to see, vaccinations really plateau, really [lowering sound]. And our numbers went up. I remember rounding in our Medical Intensive Care Unit, and one of the nurses said, "Tracy, if you were here yesterday, we were all just crying." And when they hear from families, "Oh my gosh, we're sorry. We know it's not a hoax now." [pause] That's just really hard. You can't fix that for them. And I think it also taught me about the lack of trust with medicine, in general, in society. That we have the stage studios -- like when you hear this stuff, I'm like, "I can't make this up if I tried." Look, people, I don't have nurses who have time to be actresses. We don't have that luxury.

And so knowing this round was very different for us. Predominantly unvaccinated people, some breakthroughs, but predominantly unvaccinated people. Younger. Young. And when families apologize, and the staff are just like [trail off]. Lots of time spent doing different debriefings, the ethics piece comes up, because, yeah, we agreed to care for [patients], we have a code of ethics in nursing. Almost every healthcare profession does, that I know. And just this [pause] piece that I feel is going to be broken in healthcare for a long time. That there were also all the patients that came in who were sicker than usual, without COVID. So you have the perfect storm and when

you're a fixer, and you can't fix that for people, I can't fix the emotional toll. And when I see nurses say, "Tracy, we're used to death, we're just not used to this much of it." I can listen, I can bring other resources to listen, I can offer you our PAS [Personal Assistance Services] services, our CEO Program to debrief, I can offer you ethics. But I can't ever make it go away.

And I think for some people, definitely the transitions out of the acute care platform. And not just nursing. Outstanding people, outstanding talent. But that amount of death is not normal. And I think it's going to take some time to heal. I think the profession as a whole, and healthcare in general -- we're all pretty burnt out. You want us to step up, but there's only so much stepping up you can keep asking a pretty exhausted workforce, regardless of role, to keep doing. So I think it's hard. And then at the same time, we're onboarding new respiratory therapists, new in health care who were like, "Okay," but also had limited time in hospitals. So they're trying, they're even more behind than what they would be, right?

JM 1:10:32
Because their training was during the first year of COVID?

TG 1:10:34
Yeah. So really trying to work through a lot of that. So I do think it's going to take a long time for it to heal. And I think the team -- they're outstanding people -- and I can appreciate their frustration and their anger. And, you just hope that when people's grandchildren or children or they themselves need health care, there's going to be the health care resources in place to do that.

JM 1:11:10
So, I wanted to ask you a little bit about mentorship, and starting maybe with the COVID time. Do you remember people that you were really leaning on, either colleagues or mentors?

TG 1:11:21
[Laughs] Yes. A lot with our Associate Chief Nurses. So we kept the majority of our COVID patients -- children went to the Children's Unit, mother, baby -- pregnant moms -- went to Mother/Baby, the rest all sat in our Medical Surgical Critical Care Service Line. And our nurse leader, Yvonne Spurney used to be a manager of our Medical Intensive Care Unit, a while ago, before she became the Associate Chief Nurse, which she's been for probably a decade now. [Pause] I can't really think of anyone who has been here probably more than her over the last 18 months. To support her team, to help people with behaviors with family members that maybe weren't always ideal. And I think Yvonne leaned in, and was present for her staff, advocated for her staff, to this day advocates for her staff. And with that, always the patients.

A lot of work around visitation. So North Carolina legislation has passed about visitation, about clergy. So we were pretty good because we have Trisha [Choi], who's our Assistant Vice President for Patient Experience for Duke. I said, "You've got to make a grid, we need criteria, because if we ever get asked by a regulatory body, how are we letting people in or out." So she made a nice grid, and we've been working on it across the system. So it helps us understand what are things looking like in the community, in the hospital, staff vaccination, and then different areas of how they might look different.

Yvonne has done an amazing job. Last I checked, we had a patient from last fall, who is still with us who is COVID positive, who has a young daughter, very young daughter under the age of five. And I hope he goes home. And so when Yvonne says, "What do you think about his young daughter?" I'm like, "Okay, make sure she's masked, make sure we do this. And let's not do it for more than an hour or two." But I think it's that type of advocacy where we know more today than what we knew a year ago around visitation. And visitation is good for our patients. It's good for our staff. Because we're not standing in the room every hour, every second. When I think about her work, and advocating for all the goals of care conversations and end of life, people actually need to come in and see their family member before we withdraw. Just really outstanding.

I think Chantal Howard, who's the Interim Chief Nurse for University Hospital with my transition, really led our ambulatory endeavors with getting testing up. "The big party tent" as we called it that was down in GC Lot, I think, one of the lots. And then it's like, "Oh, there's gonna be thunder and lightning today, and rain, and how are we going to deal with that when we've got all these plugs running on the pavement? And the work she did with that, getting the protocols in place, helping to transition that to other parts of the health system. And then the work she did with our monoclonal infusion center. When we were asked to stand it up, it's not like you can just go find people right away. And it was great because I'm like, "Well, I'll come help you. They've just got to make sure I'm competent on the pumps again." And she said, "Well, Tracy, you're gonna have to pass your medication exam." I said, "I did one of those. I did that like 27 years ago, how am I going to pass a med exam?" [laughs] But I did, I passed it, thank goodness. And so it was before people were vaccinated. It was a little different being out there in August when I went to staff for a day, because clearly there's a vaccine, but people don't want it. And so she's done great work bringing up that and supporting that. So we're still able to do that, which I think has been wonderful.

And then Frank DeMarco, who's our Associate Chief Nurse for Emergency Services. We had a little team that got really busy going out to the nursing homes and leaned on Frank a lot because a lot of our cases came in through our ED. So our ED nurses were good with PPE, doing the nasal swabs. And he would take a group of usually about five to six, go hit a local nursing home or assisted living facility that needed our service to understand what was going on, with some of our ID docs. Pretty amazing. And then also did a lot with the vaccination efforts, both for staff on campus, as well as in patients. And then he and Chantal worked a lot together on off-site vaccinations when we had Blue Devil Tower open for vaccination, the Graduate Student Center, or something, I can't remember the exact name of it. But really, knowing that Yvonne was so busy, her job was to take care of her staff who would care for these patients. And so where do you flex, and move people, use their emergency background skills, their ambulatory skills? And then many of our other Associate Chief Nurses were looking at their volumes of surgical volume staffing, if we could redeploy, all the different things to best think about how do we take care of these patients?

JM 1:17:39

Is there someone in particular that you would reach out to if you yourself were having a stressful day, and needed to vent? You don't have to share if you don't want to, but I'm curious about those close relationships.

TG 1:17:49
Oh, that would be Dr. Lisa Pickett, our Chief Medical Officer. We spent a lot of time rounding together. She and I are both stairwell walkers. And the thing I said to her is "Lisa, let me just tell you about this [Memorial] Sloan Kettering [Cancer Center]. In New York, the buildings go up. We are horizontal. So, 11 flights in DCT. I've got 24 flights in some of these buildings." So we spent a lot of time walking the stairs, walking the units together. And I think there were points where I said to her [about] some of the visitation requests. Unbelievably sad things that, you know, you hope -- I don't know, at least for me, I hope [paise] that I did as right as I could considering the circumstance. With families with infants and newborns, and all sorts of stuff. And I'd say to her, "This is just [pause] terrible. I hope, in the end, they were all the right decisions." So she would be the one I would talk to, and we would joke and I'd say to her some days, "No time for crying. Because if I start crying, I don't know if I'm gonna stop." Right? I think it's not just about being a nurse, it's about being a human being. And showing up, and watching, and listening, and seeing, and doing. And it is probably one of the strangest times I will have ever had to lead in healthcare. And then if there is another pandemic I'm out [laughs] I'm retired.

But all joking aside, yes, she would be the person. Because I certainly didn't want to talk to my husband about it. He just knew his wife was exhausted. And we'd do whatever she needed to do. But I think Lisa was the person who understood the most because, one, she's clinical. And two, we just, we would round together before COVID. So it was just natural after. And I knew she got it. And same for her with me. It's like, "Oh my gosh," She works [Monday] nights in the SICU. And I'd text her just about every Monday night and say, save some lives. And when I'd see her the next day, she'd be like, "Oh, that was a rough night." And I think if you can't have any empathy, compassion, I think it makes it really hard to take care of those you're leading. And for them, then to take care of the people who entrust us with their lives or their family's lives. And yeah, there were definitely some days where, "The counter is going in the wrong direction. Bring it down." [Laughs] So yeah, I don't want to be like I was in July, end of June and July, when vaccination rates were good before they plummeted. Because I think we all thought it would be a few weeks, that went to a few months, to a year and a half.

JM 1:21:37
Well, thanks for sharing that, I appreciate it. It's good to know about some of the relationships within these buildings, too. And you mentioned an early mentor, who kind of walked you through this interpersonal situation. I'm wondering if you could talk about them, or other people who have been there for the long term?

TG 1:21:53
Oh, yeah. So, that was Kevin Sowers. He was the Nurse Manager, and I was probably still feisty from Boston. Probably at least once a month, I was like, "I gotta get back to the city. I don't know where I've moved. What was I thinking?" And of course, you just knew the name, I knew

the name. So I [thought], "That's a good place, and all that good stuff. I'll learn a lot." And of course, I never went back. And when I said to Kevin, he goes, "Well, what do you want to do Tracy, now that she's said this to you?" I said, "Well, first of all, I'm angry. How do you talk to people like that?" I had never really experienced that. And I said, "Well, I want to just tell her to, you know, stick it." I said, "But I can't. I said, "And I have to wait until I'm not angry." So he gave me some good coaching tips of practic[ing] it, know what you're going to say. And I said to him, "But you know this person, they always have something to say before you're done." He goes, "Then you just need to tell this person 'Please do not talk until I am done.'" And I did. When I finally the following week said to the person, "Can I talk to you?" They said, "Well, just talk to me here in the hallway." I was like, "Nope, we've got to go into a room." And I started and they jumped right in and I said, "Again, like I said, please wait." Because I knew I was a jumbling mess on the inside, like [unhappy sound] trying to get through that. And [he] just was really supportive.

When I had a patient -- two profound patient experiences I had, probably, my first year. One was a patient I took care of the whole year, Freddy, who had Whipple surgery for pancreatic cancer five years prior. Here I am as a new grad. Fast forward for him five years, he has recurrence and metastatic disease. And every time he was in the hospital, I took care of him. I was his primary nurse, I got to know him, his wife, his family, his grandson. And eventually there was no more treatment. And you're watching this person just deteriorate. And I want to say Freddy was probably late 40s, early 50s. Had his own company, from Virginia, great family. And the bizarre thing was, he knew he was dying. And his wife knew he was dying. But it was also very clear, they never had this conversation to each other, and what that would mean if he did die with us, what a code would be. And I thought, "Well, now I know the physicians have these chats, right?" Again, it comes back to "You've got to broker this because you got to help them accept it." So I went to Kevin and I said, "I gotta ask you a question." And he goes, "Tracy, what is that?" I said, "Well, you know Freddy and his wife." And he said, "Yep." I said, "How do I do this? They're both suffering, because they both know they need the conversation. So the sooner we get beyond that, there will be no suffering, we're gonna be great." And so, he gave me some advice, and he goes, "Okay, what are you gonna do?" I said, "Well, I think I'm going to set up a plan, I'm going to talk to them both, let them know we'll come together at this day and time." And I was like, "Okay."

And it was hard. I talked with the wife, talked with Freddy. Next day we had the conversation. I had somebody cover my call bells. And it was just one of these, "Here's what I'm seeing, and what I'm hearing." Not disclosing anything that wouldn't be appropriate to their relationship. And I said, "I just think we just need to have a discussion about what each of your wishes are. Because it could look very different if we don't all have understanding." And I remember him telling her, her telling him, all three of us crying. But it was this really, to see the stress relief of, "I don't want to give up on you." [Pause]. And him knowing that it wasn't her giving up on him, it was that it would be peaceful. And that we would manage his symptoms, and the family could all be there. And they could say goodbye. And knowing somewhat, as best you can think about, what the days ahead would look like. And when I went to leave the room he said, "Tracy, I just have to thank you." And I was like [sad noise], and cried. And I said, "No, you're welcome." And he's like, "No, I really need to thank you." Yeah. And then, about a week later, the charge nurse

called me and said, "If you want to come in, I know you're off. He's probably not gonna make it through the night. He's not alert. And I'm sure he and his family would love to know you were there. And you can say goodbye." And I was like, "Oh." So I came in. I mean, I knew he would die with us, and saw them and talked to him, even though he was unresponsive at that point. But to see the family. And then the next day, they called -- I was off the next day -- to let me know he had passed away. And I just remember thinking it was so worth having the conversation. But it was that new skill of, how do you, how do you really lean in? And that was hard.

And then Kevin was there another time when I had a patient who had a psychotic break, and I was like, "Holy moly." So I'm like, "Okay, nothing here, nothing there." Everybody was standing outside the door. He was like, "You've got this." I'm like [patting noise] and everything, right? I don't remember psych that well. But always listening, providing good advice. And then I think many other people who serve as mentors in your career, and fast forward and one of the funniest things was when I took the role of the Chief Nurse for University Hospital, I was again, reporting to Kevin. "Wait a second, you're doing my eval again? This is weird. You did my evaluation when I was a brand new nurse." That full circle, come back around. And I've stayed in touch with him since he's left, and used him as a reference for my new role. And when he heard I was offered it, I mean, he knew, but once all the emails went flying out of every institution, he immediately called. And he's like, "I'm so proud." I said "I know, and just remember, it wasn't me who made you lose your hair. Just remember that Kevin, please."

But I think it's people like that, Brenda Nevidjon, who's external to the organization now. And then even non-nursing mentors, that value of building out your skill set in different ways, with coaching opportunities. And really just trying to push you in a gentle way, but knowing they see something. And I think for me, it's sort of how when I think about it now with the people I mentor -- internal, external -- you learn that they see something in you. And even though you don't see that in yourself. Yeah, it's a very humbling moment when you reflect on that. Little did 22-year-old Tracy Gosselin know, when she came to Duke in 1993, that we'd be sitting here today having this conversation. And no, I didn't think that. Yet, I think I'm here because of so many people who came before me. And so many people who stand with me, and just believe in the work we do. And I think that at the end of the day, I couldn't ask for anything else in my career.

JM 1:31:06
And what do you think are those things that they saw in you, that you couldn't see in yourself yet? Maybe different things at different times?

TG 1:31:13
Oh, I definitely think feisty, and a lot of energy. The energy still remains. The past 18 months, it dimmed a little bit, but it's kind of coming back up again. Curious, the problem solver, fixer, always saying "But what if?" Or challenging, [for example] "Well, why can't we do that?" Or, "But maybe if we tried this." And always in a respectful way. And I think that it was many of those skills that were so small, compared to my clinical skill, right? They're more the interpersonal people skills, problem solving skills, some of the operational analytics. That then [they thought], "Oh, these are skills you're going to need to develop in her." And I think that was

a lot of it. I also think playing team sports really helps [laughs]. Because I appreciate the title. Yet, at the end of the day, it takes every single person to do what we do here. And I think, "Yeah, if you need me to staff, I'll come help." My scrubs were always in the office. And you might need to show me, but I'll keep it safe. And I think you can never really forget where you've come from. And I think that my family and friends would probably say, "Yep, you go girl." And I think that's what my mentors and colleagues would say, as long as you have the energy, and the belief, you can change the world, you might as well just keep believing that and go. But it was probably the turn of, "Okay, I believed I could do." Versus when you're earlier in your career, and you're like, "I don't know about that. I don't think I want to talk to 100 people, never mind 500 people." Right? Or you could learn how to use Zoom, or Microsoft Teams [laughs], or all those new skills that you learn. But I really do think at the end of the day, it's those people who help you move forward.

JM 1:33:57
And I know we kind of popped around a bit with the chronology of your career, and I hope that's okay, and we sort of got to everything. But is there anything that we missed that you'd like to talk about, or anything you're especially proud of from your time here?

TG 1:34:09
Oh, my gosh, so many things to be proud of. Personally, I think it was finishing my PhD. Check. Professionally, there were the things we did as a team in the Chief Nurse role that I talked about before. I think one of the best things that engaged a variety of stakeholders was when we did the Cancer Center, and working with patients and families to help us understand wayfinding, to help us understand furniture layout, selection of stuff. And from there, we created our Oncology Patient Advisory Council. And I think that is something, still to this day, is that our patient and family advisory councils have grown to more of a system level with recent work we did last summer, going and presenting to them to say, "Does this make sense?" I think those are the things. Being able to shape and influence, with their input, to make good decisions. I think when I think about the Cancer Center, yes. As people always tell me, "Tracy, it could have been bigger." And I'm like, "Okay, but there's certain rules on the campus with the Chapel and height of buildings and how we do things, and how much do you want to finance, et cetera." But when I think about it, and I think about the volume and how busy it is, I think the work the team did, and the patient and family piece, and engagement we had around what we could do was so important. It is something that, when I walk through it, I'm proud. And when I think about the things in this role, there's so many things. Really helping the team understand that dress code is a big issue, because you're talking about people and their personality. And when you're trying to move forward in a way that represents the discipline at the bedside, you want it to be professional. And I remember saying to all the leaders, "The first one that falls, it's gonna be for all of us. It's all of us. It's not just me, but it's you and your peers." And I would say really trying to create that nursing piece, with a lot of nurse leaders, to understand their accountability and their responsibility. So I'm proud of that work. And I tell people I look forward to cheering from New York. And when I'm in North Carolina, I will continue to cheer. Because I am immensely proud of the care I've received here, my husband's received here, and the many friends and friends of friends that I've referred here. So I think it's been amazing work. Amazing work. So, I am very proud.

JM 1:37:22
And can you tell me a little bit about your next role?

TG 1:37:26
My next role. So I will start in November at Memorial Sloan Kettering Cancer Center in New York City. It is a Chief Nursing Executive role. And a Department Chair. Their structure is very different from ours, because they are a freestanding Cancer Center. So they don't necessarily have a school attached with it. So there are some different pieces there. And Sloan Kettering is right around 500 inpatient beds, so about half the size of University Hospital, and it is all cancer. Then they have a little over 20 ambulatory sites of care, in both New York and New Jersey. They care for pediatrics, and adult patients. So they do have a pediatric cancer program, but predominantly adult, because that is the bulk of cancer diagnoses, in adults. So a very expanding ambulatory platform. Really getting into the communities that they serve. Decades back when I first remember Sloan, I often thought of them as being that everybody had to go to Manhattan, the main hospital, the main campus. And with their growth strategy, [they're] really getting into communities, so that you can get some of the best cancer care in the world, and you do not have to leave your community, depending upon what your diagnosis is. So, I am looking forward to that. Leading their talented group of nurses, working with many partners across different teams, and new physician partners. And everybody has told me already I need to get waterproof boots. So, I guess I'll be ready for that. Winter is going to be different. I tell people to let me know, send me a text at the beginning of February. I'll let you know how I'm doing, if my teeth have stopped chattering.

So yeah, so it's really a great opportunity at this point in my career to grow further, work with a board -- I've never worked with a board -- work with philanthropy in a very different way. Help create the architecture around the work we do, versus not. And so I think that having that more senior role now, really being able to do some of that work, I'm very excited to be working with their Nurse Scientist around, setting our research strategy that will tie with philanthropy, as well as tie in with some of the clinical trials and other work across the care continuum. So there's some really great things that tie into my clinical background, but also into the leadership and operational world. It's gonna be an adventure, but it'll be exciting.

JM 1:40:40
And you have at least the background of the cold weather, but it goes away quickly, I've found. It's harder to go back to Indiana for me at this point, because it's just much more chilly.

TG 1:40:51
Yes. It's gonna be a quick four blocks to work. That's all I have to say. The summers will be fine. Spring, fall. But I'm like "After 28 years. What? Wait, I said yes? Okay!"

JM 1:41:06
Well, congratulations on this new position. And thank you for all the work you've done here, and thanks for speaking with me today.

TG 1:41:13
Thank you. I appreciate it. Thank you for having me, and for hearing a little bit of my story.

JM 1:41:21
I'll end the recording here.