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NEW BRUNSWICK

AN INTERVIEW WITH DONNA NICKITAS

FOR THE

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INTERVIEW CONDUCTED BY

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TRANSCRIPT BY

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Kathryn Tracy Rizzi: This begins an oral history interview with Dr. Donna Nickitas, on July 21, 2021. I am Kate Rizzi, and I am in Branchburg, New Jersey. Dr. Nickitas, thank you so much for doing this second oral history session with me.

Donna Nickitas: My pleasure. Thank you so much. I'm delighted to be with you.

KR: For the record, where are you today?

DN: Today, I'm actually in my home in Old Greenwich, Connecticut.

KR: In our last session, we talked about you getting into New York University and the advice that the dean gave you, I think Dean Earleen McGriff.

DN: Correct.

KR: What was that experience like for you getting your Master's in Nursing at NYU?

DN: Well, first of all, it was monumental. I had been out of nursing school as an undergraduate from 1976. I was in professional practice in the United States Air Force Nurse Corps, home on leave to attend the interview. I have to say this and I mean it, I was blown out of the water when the dean informed me what she thought my pathway or my career in nursing should be. Of course, I was very naive, and I said, "Absolutely, sounds good." [laughter] I was very surprised that I actually got accepted on the spot. Now that I'm a dean, I know you get a formal letter, usually from the Office of Admissions, but I guess she had a lot of political cachet and acumen and she did what she wanted to do. There I was, before I left the interview, she told me that she expected to see me in the fall of 1978. I was able to request a formal early release from my active-duty assignment to return to school. I was released in late August and returned home to Brooklyn, New York to attend school. Indeed, I started school as a full-time graduate nursing student on my GI Bill that fall at NYU.

It was a full-time program, so I went for two years. I loved every minute of it. I think I was just in rapture of the faculty, following the theoretical model of Dr. Martha Rogers. I was deeply involved, both in my academic work and my extracurricular activities for school governance committees, of which I was appointed to at least one-two years. I walked away with that graduate degree knowing that it wouldn't be the last time I'd be back in school. I had my eyes set on doctoral education. My professional peer group was very committed toward advanced nursing education. Many of them were at NYU, if not in the master's program, they were certainly in the Ph.D. program. Don't forget, I was really young when I started, traditionally, at that time, for a master's program. I finished when I was twenty-eight. I mention this as it is not typical for nurses to return to school, as they traditionally practice between four-five years before returning to graduate school.

When I completed my master's, I quickly turned around and started a Ph.D. part time at Adelphi University, knowing that I wanted to continue. That's how profound the experience was, the importance of having an advanced degree, knowing what you can achieve with that advanced

degree. Either you were going to contribute in the clinical line as an advanced practice nurse, as an NP [nurse practitioner], or myself, I went into nursing administration, accepting that leadership role right out of school. I knew I was prepared. I had the leadership experience from the military, but now I had the academic credential with the knowledge that I needed to perform the role, which was very untraditional because, for the most part, nurses who excelled in leadership or management actually came up from the bootstraps or right from the bedside into nursing administration. I felt very competent because I had the experience, but now I had the knowledge, skills, and attributes to lead because I had the graduate degree.

KR: Who were your mentors at NYU, and how did they influence you?

DN: Oh, I had quite a few. Connie Vance was very instrumental, because she herself was an early Ph.D. candidate at Columbia, finishing her doctoral degree, studying mentorship as a topic, as a dissertation, and then she was teaching group theory and the importance and the dynamic of understanding that. Martha Rogers was a very influential nurse theorist and scientist who was studying her theory of human becoming or her understanding of unitary man, as it was called. Dr. Keville Frederickson was on faculty at NYU but later became a mentor for me when I joined the faculty at the CUNY Graduate School in the Nursing Science Ph.D. program. Her academic leadership and advice was instrumental in my development in eventually becoming dean at Rutgers-Camden. There were so many that I can think of that were colleagues and friends who were so vital to my professional development and journey as a nurse.

Nursing finding its place and space at the advanced level was so influential at that time. There were so many more nurses going to obtain a Ph.D. degree in nursing science and research, so they could go back into academia and teach. Now, I wasn't thinking about teaching at that point, but I was influenced enough to think about it later on in my career because of my experience. I thought it was profound because I fully understood and appreciated the art and science of nursing, the importance of having a clinical practice, but also having the underpinning theory and research to support nursing as its own discipline.

KR: After you earned your master's degree, tell me about that early part of your career. What work were you doing in nursing?

DN: Okay. Upon my graduation, I applied for a position as a nurse administrator and I actually was quite surprised--I applied at Bellevue Hospital, a large public hospital in the city, one of the largest and oldest in the country--I got the job! I was the first non-Bellevue graduate to be in a position of leadership. At that point, there were only Bellevue nurses occupying the C-suite, and here I was right out of graduate school, a brand new newly-minted master's, and was appointed as a nurse administrator. This was quite exciting.

I stayed at Bellevue from 1980 to 1984, and I worked in obstetrics and pediatrics. That was my clinical specialty. At that point, I been a public servant all my life. I went into the military, and now I was coming back to clinical practice in a large urban public hospital as a public employee serving the City of New York.

You might have heard a lot of stories about Bellevue, but to experience it on the front line was so very different. It was such a profound experience, one that I will never forget. I was so honored to work with such a talented, creative and caring team of nurses and doctors. Bellevue was affiliated with NYU Medical School, so obviously the medical students got their training at NYU but also rotated through Bellevue Hospital for their clinical experiences. If you could imagine, there was always a crisis or event that was eventful. Bellevue is a tertiary center for trauma, so we received all the trauma in New York in the early and late '70s. Also, we were the primary hospital that was put on alert when the president visited New York City, so there was a red phone right in the CEO's office, should it be needed. Also, if there was any large emergency or disaster, obviously, the hospital was put on alert.

It was a very difficult transition from the military service to the civilian workforce. The mere size of the Health and Hospital Corporation of the City of New York was something I had to make an adjustment to. Bellevue was the premier medical center. I went from a small rural military hospital with less than one hundred beds to a large urban hospital with over nine hundred beds. By size, I was never employed in an institution as large as Bellevue, but the mission of serving the most vulnerable, high-risk, under-insured and uninsured was compelling. It was a safety-net hospital, obviously, for Medicare, Medicaid and uninsured patients. I was employed at Bellevue at the height of the epidemic in heroin and crack cocaine in New York. For me, I was somewhat naive about that whole level of drug abuse in prenatal and in postnatal care. Many of the newborns were affected and addicted, requiring special treatment because of their addiction to crack cocaine, and it was a new intervention that we were really learning about, how to treat these babies and their mothers for recovery, and then, of course, working very closely with the New York City social welfare system, in which many of these babies were initially placed before they were to go home to their families. It was a real wake-up call, in terms of understanding what we now call social determinants of health; food insecurity, housing insecurity, unemployment, lack of education, transportation, housing impact health outcomes. We have a better appreciation how health and social determinants are factors related to health equity and quality of life. Also, we have recognized how lack of access to care and health insurance can exacerbate untreated chronic conditions and complex care needs. Our healthcare delivery system is examining systemic racism and discrimination on patient-centered care, medical errors and care outcome. It's so easy to see now, to note how all of the issues above are essential, because we are so much more aware and informed.

KR: You were working in maternal and child health, and those were also the very, very early days of the HIV/AIDS epidemic. I wonder if you remember anything about that.

DN: Absolutely. At first, in the early stages of the HIV epidemic, we were not sure how best to respond to this infectious disease. It first appeared predominately in men, specifically gay men. We did not have enough research how HIV impacted at that time mothers and infants. It was just the beginning of HIV in New York, and many of the patients we were receiving because they had pneumonia and some other severe respiratory complications or symptoms. We didn't really know what it was per se, but we knew it was an infectious disease. It was highly transmissible. Many of the patients were mixed throughout the hospital, both in the medical and surgical units. There was great fear from both the medical and nursing staff, number one, a large

misunderstanding of how to manage these individual patients. In the very beginning of the onset of HIV, these patients were stigmatized. At that point, at least in New York City, it was very prominent in the gay community. There was a lot of hysteria and stigma around homosexuality and the root cause of the disease. Initially, it was thought mostly to be sexually transmitted, and then we learned, a year or eighteen months later, that obviously other individuals got HIV through transmission of blood products. That was the Ryan White case that became familiar, and then of course it was politicized. It took us a number of years to get the NIH, of which [Anthony] Fauci, by the way, was involved with very early on in his career, and now he's been around the block or two at the National Institutes of Health. Then, it became more obvious that it was transmission through the placenta, from the mother to the infant, and that these infants that needed to be treated as well. Yes, it was quite a time, absolutely. [Editor's Note: Ryan White, a teenager with hemophilia, was diagnosed with AIDS following a blood transfusion in December 1984. White was barred from attending school in 1985 on the grounds that he might transmit HIV to other students. Although he eventually won in court to be able to return to school, he and his family experienced ongoing harassment and scrutiny, exposing the discrimination experienced by people living with HIV and AIDS.]

KR: Where were you living at that time?

DN: I was still living in Brooklyn. I was commuting into Manhattan.

KR: What was it like living in Brooklyn during those years?

DN: Don't forget, we were coming out of the crisis, the financial crisis, high inflation and huge budget deficit in New York City in the mid-'70s, early '70s, under the [Mayor Abraham] Beame administration and then Edward Koch. It was a tough time. New York had high crime and a high cost of living. It wasn't safe in any of the five boroughs, safety was top of mind, and everyone was very cautious had to be very careful. The transportation system was highly unreliable. In the beginning, I tried to do the trains and the buses, and it just didn't work. I ended up having to drive myself into New York City, and the traffic wasn't pleasant either. Those were the decades in New York when people wanted to live there, but it was a real challenge.

KR: You went to NYU and got your master's degree on the GI Bill.

DN: [Yes].

KR: What does the GI Bill mean to you, and how did it enable your continuing education?

DN: Well, it actually has been transformed from what it was when I started as a graduate student to what it is now today. It's gone through so many reiterations. For me, it was foundational because it allowed me to pay for most of my tuition, fees and books. Did it cover everything? Obviously not. I had to fill in the blanks, but it was substantive enough to say I could use this money to fund my scholarship enough that I was able to go full time and then I picked up part-time work to keep clinically competent, while I was pursuing the master's. I would say I'm

grateful for it, happy that I had it, it made a difference. I know now because I'm a dean and I have veteran students in my nursing program that it works for some students, not all of the students. I think the benefits are different depending on whether you were active duty or Reserves when you served. Now, it's changed a little bit. Through financial resources, we've been able to support our veterans. I think I mentioned, when we talked last time, that we do have a [Health Resources and Services (HRSA)] grant that allows our nursing veteran students have the financial and supportive resources while completing their undergraduate nursing education. For myself, personally, my GI Bill funding was essential and it made my military experience more valuable and something that I treasure and I'm proud of. I'm happy to say that I benefited from my service, being able to get the funding to support my education.

KR: When you were getting your Ph.D. at Adelphi, were you also going on the GI Bill at that point?

DN: No, no, I had a scholarship that I was able to earn, and I funded most of that myself. I began my doctoral program part time in 1982 and continued to work full time as a nurse administrator at Bellevue Medical Center.

KR: You started off your time in the Air Force Reserves with the 69th Aero-Medical Evacuation Squadron at McGuire Air Force Base.

DN: Yes. When I returned to attend graduate school at NYU, I transferred to Reserve status to become a flight nurse.

KR: We talked last time about your experiences training to be a flight nurse and then as a flight nurse. I was wondering if you could trace your career in the Reserves, the units that you were in, and what you did.

DN: Okay. I finished my active-duty service in the summer of 1978 and returned to New York. I was able to identify a Reserve unit at McGuire Air Force Base in New Jersey. I went to flight school in San Antonio, Texas for six weeks prior to beginning my master's. My tour of duty with the 69th was from '78 to '82. For four years, I served at McGuire. While I was at McGuire, I was promoted to captain and became as a flight nurse. This required one weekend month to fulfill my Reserve status and flight training every six days to maintain my competencies in flight nursing. We would fly training missions through the U.S. and abroad on weekends. It was a wonderful opportunity to increase our flight nursing skills, as well as to travel to Latin America, Puerto Rico, and sometimes even Alaska and Portugal.

When I was not on training missions, I assumed teaching and educational program development for our squadron because I was in a master's program in nursing education. I assumed teaching responsibility for my fellow Reservists. Teaching was one of my strengths, and that's how I contributed and found my niche. So, in addition of being a flight nurse, my secondary responsibility was in professional development and education while I was at the 69th. I remember teaching classes on childbirth and caring for pregnant women in air-evac conditions,

and then I would take on additional assignments as needed in terms of personnel training for both enlisted and officers.

Once I completed my graduate degree in 1980, I began to work full time at Bellevue Hospital. This became a real challenge, as I had to work weekends at the hospital as well as to find additional time for flight training. I ended up leaving flight nursing because I had a full-time job, and it was very hard to get the number of weekends for training. They were twice a month, once for your actual Reserve status, and then to keep your flight hours, you'd have to fly another weekend every other month. I ended up having to work weekends as the assistant director of maternal and child health, and I couldn't manage the two weekends a month. It was a quite a challenge.

I moved to the 34th Medical Service Squadron in 1982 and did whatever necessary training that we needed to do to be combat ready. At that point, we were doing a lot of chemical warfare training, disaster preparedness training, which was critical should we be air evac-ed to the front line. We would be able to provide care for wounded airmen, should it be a disaster, or should it be a chemical environment, and how to provide care in a very secure, chemically-free environment. Then, in that timeframe, from '83 to '88, '89 to '90, I was promoted to major and I ended up doing professional development and education, which was my primary role that I fulfilled, whatever the topics or requirements that needed monthly training. The education would be aligned and integrated in the weekend training requirement, the weekend warrior training, as we called it. Then, from '90 to '99, before I actually retired in 2000, I took on quality control, or continuous quality improvement, as we call it now. I was responsible for ensuring that the squadron met the standards and performance outcomes, committee structures, measures that the Air Force required for annual training and competency. This is an abbreviated overview of my duties, but quality control was my primary responsibility as a Reservist. Then, of course, I traveled during the summers when I was obligated to serve my two-week assignments. We were to travel to active-duty bases and provide additional assistance wherever there was a need.

KR: Where did you travel for those?

DN: I can remember going to Florida, Mississippi, Maine, and sometimes, we stayed local. When I was with the 34th, we ended up going actually to Bellevue Hospital to do some of our training there, which was easy. Mostly, I would say the Northeast Corridor, sometimes in the South.

KR: During those years in the late 1980s and into the early 1990s, there were some major changes going on in geopolitics, including the dissolution of the Soviet Union and then there was Operation Desert Storm. How did that affect you and your unit?

DN: For me, I was on maternity in early 1990. My youngest was born in late August 1990, and my unit was actually one of the first units--the 34th, that is--activated to the front line to go to Iraq. I didn't go. I stayed Stateside because of my pregnancy and then during my postpartum period. All of my unit colleagues there were activated, and several came back ill from the desert. It appears they had picked up infectious diseases. Others had some chemical exposure from the

chemical weapons being used during the war. Several colleagues left the Reserves because of the illnesses that they experienced. It was quite challenging. Of course, being Stateside and not being on the front line was quite different. You're right; the geopolitics, of course, were straining on me and my family, and it got to the point that my husband said, "Okay, I think that's enough. I don't know that we can manage it." We had three young children all under age six. It was a real challenge leaving my husband on the weekends to attend to childcare. I did not want to give up military status, but it was something that I had no choice to do. My family became my priority.

KR: For members of your unit who were activated and served in Operation Desert Storm, the period after that, how were the lessons learned from the Gulf War incorporated into what you did in your unit in the Air Force Reserves?

DN: I would say the underscoring message was preparation, that even though you were trained and you thought you were prepared, you couldn't take it for granted, because once you got to the environment, [it would be different]. Now, remember, our uniforms changed. We went from green to beige, just because of the conditions and the climate, the heat. The temperatures were extremely different. Then, of course, the culture, being in a country that many of us never really knew about or were familiar with what the cultural norms were, the language, the status of women in society and other issues. Not that those didn't happen when our brothers and sisters were overseas in World War II or Vietnam, but this was a part of the world where the religion and customs of Muslim people were vastly different. The military were facing new challenges with where the enemy was not always in a military uniform. It's not like you're starting over, but in many ways, the importance of preparation and preparing prior to assignment was really essential.

Fighting in Iraq and Afghanistan is so different from the war my father fought in World War II in so many ways. They knew their opponent wore a uniform and represented a specific geographic region in the world. Our veterans of World War II, the Korean War and even Vietnam engaged in warfare that was often guided by rules of engagement. In Iraq and Afghanistan, the rules changed, and in many ways, there were blurred lines of engagement, where civilians, not traditional persons in military uniforms, were the combatants. As a health professional assigned to the medical corps, our training on the front lines have changed dramatically. In each new military engagement, medical personnel became battleground ready as they moved closer and closer to the front line. Field hospitals went closer and personnel even closer to the action, and emergency care began sooner, stabilizing and saving lives that may not have been possible in previous wartime scenarios.

Not serving on the front line but understanding how wartime medical care has changed is important. The military has become more efficient and effective in managing battle injuries with innovative triage, new emergency and intensive care clinical competencies, the advancement in technology, and the use of electronic health records. The ability to document care in the electronic health record at the time of care and about the injury and then have all of those electronic records travel with the patient as they moved from the battlefield to hospital to outside the theater for air evacuation to Europe was a gamechanger. The technology of being able to

stabilize patients, not at a unit facility, but right on the front lines, and because of that, even though the injuries were as severe as they were, certainly the traumatic brain injuries due to explosives, people survived. Those individuals wouldn't have survived even five, ten, twenty years ago, but because of the advancement in the early '90s and 2000s of our training of our physicians, nurses and medics with the appropriate supplies and equipment that follow them allowed for many more airmen and soldiers to survive because of the level of knowledge and skill in managing injuries sooner at the site, where in several other wars, those individuals would have never made it. They would have died right at the site. Now, is that good or bad? We have many more injured veterans to care for today, certainly those who have come back with traumatic brain injuries and certainly those who have come back with post-traumatic stress syndrome as well. In addition to increase in the severity of battlefield injuries, there has been more reporting in the rise of sexual assault in both Iraq and Afghanistan.

KR: I am curious, when your fellow service members in the 34th were involved in Operation Desert Storm, how did you communicate with them? Did you write them letters?

DN: I did communicate with my fellow service members who returned Stateside. I do recall phone calls and even emails but not frequent letters. I think we wrote some letters but actually do not recall how many in total; I don't remember writing a lot of individual letters to individual people, but do recall writing to the chief nurse and other colleagues who were involved in operations and leadership. This correspondence was a little different, a bit more strategic and then personal.

KR: I was just asking because my neighbor was in the Army during Operation Desert Storm. I was in middle school, and I would write him letters and he would write letters back to me.

DN: I do recall that I was involved with my children's schools who were writing and providing overseas supplies, mostly noting what service members were looking for and what type of correspondence was of interest to them. I also coordinated service-learning projects as a [faculty member]. Remember, I was a faculty member by then. I joined Hunter in '84. In 1990, I helped support my unit with supplies for unit members, and then after 2011, I was more involved because we were supplying supplies and equipment for units that were activated with some of our nursing students who were Reservists. These individuals were activated to active duty to Afghanistan. It was a little different than in Desert Storm.

KR: The 34th was activated for the invasion of Panama. Was your unit involved?

DN: I do not think they were, but I cannot confirm, since I was on maternity leave in 1990. Do you remember what years those were?

KR: It was at the end of 1989 and beginning of 1990.

DN: No, I was not involved.

KR: As you were rising in rank, what was it like for you to be a commanding officer?

DN: The one thing that I noticed, as I rose in rank, my span of control increased, so I was involved with supervising many more individuals to lead, number one, and, number two, [there was] a lot more authority and responsibility directed to me and then up the line to my lieutenant [colonel] of the unit. That was different. When you are a captain, it was like, "Okay, I can do this," pretty easy, small span to control, fewer performance appraisals or evaluations to do, pretty autonomous and independent. As you go up in the structure and become a line officer as a major, my responsibilities expanded. For example, when I became the control executive officer for quality measures and outcomes, [it was] a different program, more responsibility, working collegially with other field officers, who were at the same rank and same level of responsibility and accountability. Yes, it was noticeable. It was dramatic. The position was more serious in what you were doing and how you were doing it, as the impact was greater. I recall when I would be deployed for my two-week summer tour of duty, sometimes the whole unit wouldn't go and you'd get a smaller section of individuals who would go, and because of my rank, even though I wasn't the chief nursing officer of the squadron, I might be the chief nursing officer for the cadres of individuals who were traveling with me for that two-week assignment. Again, with the increased rank, there came more responsibility and accountability.

KR: How did the demographics of the officer corps change over the time that you were in the Reserves?

DN: Wow, this is a really good question. I definitely would say there were many more officers of color that I can recall on Reserve status than I noticed on active-duty status, and I mean that sincerely, in the rank of captain, major, lieutenant colonel and colonel. In fact, our chief nurse was a woman of color, pretty exciting, in the rank of lieutenant colonel. I've noticed it not just in the Air Force, but if I would go to military conferences, it was noticeable that many more nurses, particularly, were women of color and many more men in nursing were persons of color. Then, the whole structure began to change, but I would say it took--I went in '76--it took until the late '80s, early '90s, and certainly late '90s, where you started to see the full integration of the diverse officer corps--not to say that the enlisted weren't, they were very diverse--but in higher rank structure, for sure, definitely more noticeable.

KR: Let us talk about your time getting your Ph.D. What stands out in your mind from your course of study at Adelphi, and then what did you do your dissertation on?

DN: First, I think what stands out most in my mind about the coursework was how the flow and sequence of the course of study was designed. Since I went part time, my schedule was two courses per semester. Each course built on the next, so our foundation and theory courses helped us appreciate the importance of having a nursing theoretical framework in which your research would contribute to nursing science. At first, I had to adjust my work-school-family balance. This was a challenge because by that time I was really in the throes of my work as a nurse executive at Bellevue and I think I had one child by then, so I was juggling my academic studies with working full time. Again, I had a lot of support, because my peers in my professional practice and in my social network of nurse colleagues, a lot of them were pursuing their Ph.Ds., so that was exciting.

Also, I left Bellevue in '84, the latter part of '83. I started at the Hunter-Bellevue School of Nursing in 1984. Coming out of practice and into academia, obviously, was a really big transition for me, but it also gave me the opportunity to pursue the Ph.D. with greater support and ease. I had that academic schedule that allowed me the summers to catch up on my work that I wouldn't normally be able to do during the traditional academic framework. I loved it. I loved the opportunity to be working in academia while going to school and having the access to my colleagues, whose support I often needed to get my schoolwork completed, especially the area in statistics, learning the qualitative and quantitative design methodologies. The theoretical was easy for me because I came out of NYU having used Martha Rogers, but obviously there were a lot of other nursing models that I was becoming familiar with. In fact, my office mate right next door to me was Dr. Rosemarie [Rizzo] Parse, whose theory of human becoming I actually used for my dissertation. I was lucky to have Rosemarie as a neighbor and colleague, so when I started to write chapter two, which was a review of the literature, chapter three, which turned out to be my methodology, I was always able to run next door [makes knocking noise] and say, "Rosemary, am I doing this right?" She was always able and willing to help me. It was more challenging for my chair, I think, because she was not as familiar with Parse's theory.

In the end, my interest was drawn to examining the challenges women were experiencing in managing work-life balance. I wanted to explore how women were able to choose life goals, a phenomenological study of the lived experience of women choosing their life goals. Basically, what I was looking at is what is it like living the experience of being a professional nurse executive and trying to balance work and life. At that point, we were hearing as women, "You can do it all. You can work and you can have a family." Well, we know that that was not true, [laughter] those of us who actually went through it and did it and did it successfully. I had lots of colleagues who I was interviewing--I think I had six or eight subjects--who explained how they did it, but the balance wasn't so much there. Don't ask me to reframe for you; maybe the next time, I can actually give you the themes that emerged. [laughter] I was able to do it because I had the support of colleagues in my university setting. The major finding of my study was choosing life goals is struggling to fulfill competing ambitions while experiencing paradoxical feelings of calmness-turmoil, success-defeat, and security-insecurity, in the process of affirming cherished beliefs. Findings from this study support the value of the phenomenological method for nursing research and enhance the knowledge base of nursing by expanding Parse's theory of human becoming. The findings reveal the importance of understanding more fully the processes of choosing life goals and how choices reflect health.

Being in a Ph.D. [program] and pursuing nursing science and research was valuable. I began to respect and understand the importance of being a discipline and having your own science and knowledge and becoming a steward of the discipline. Now as dean, that's what I treasure because I want to make sure that I have faculty who are capable and competent, not only clinically, but that those who are tenure-track have the scientific knowledge and skills to pursue a research career in an academic environment with success and support through mentorship and obviously the commitment on behalf of the university and, of course, me as their dean. I think I had good foundation. Don't forget, before I came to Hunter, I was at CUNY for more than thirty years. From a large urban public institution transferring to another large urban public institution,

committed to building new knowledge and supporting the research enterprise, I think I was well prepared and I think I've made a seamless transition. Those years, again, were foundational, and I have to say I was able to choose wisely. I think I made a good choice going to Adelphi. In fact, many of my colleagues who I knew from that experience, I know today and count on. One colleague, Mary Ann Donohue, who was a chief nurse around the same time I was in academia, I left practice, she was still in practice, and now we've come back, she's in New Jersey, I'm in New Jersey, and I invited her to be on my editorial board for *Nursing Economics*, because of her expertise that she's had and clinical practice. We go back to 1986, when we both pursuing our doctorates at Adelphi, so, again, foundational.

KR: You talked about being in your master's program and relishing in the experience of higher education, but why did you choose to go into academia? What was it that actually influenced you to take that career path and go into academia?

DN: Great question, and I know the answer. There was a colleague at Hunter who was teaching a course in nursing administration, and she needed preceptors for her students. Remember, I was the assistant director of maternal and child health and she was preparing mid-level nurse managers, and as an assistant director, she asked me if I would be a preceptor. I remember doing it for several academic semesters over a period of at least two years, precepting. By the end of 1983, she received a grant from HRSA [Health Resources and Services Administration] to open up a program in nursing administration, a master's in nursing administration, preparing mid-level nurse managers. Between the head nurse and the chief nursing officer, there were these mid-level managers, and that was the focus of the course. That is where I had experience. That's what I was doing daily, managing the operations of maternity and pediatric nursing at Bellevue. After doing four years of sixty hours or more a week, I said, "Maybe this could be interesting." Twenty-four/seven, we had unions, we had strikes, it was New York City, we had blackouts. You name it, I experienced it. I said, "I might want to do this," especially as I was getting closer to my Ph.D. and moving away from coursework, now having to come up for my candidacy exam and then the Ph.D. defense. So, I talked it over with my husband, and I said, "Okay, I think I'm going to try this." I wasn't yet pregnant with my first child, but I said, "I'm willing to take a chance and I'll try it."

I left in '84 and was assigned a position on the grant. I was a grant assistant, because I didn't have a Ph.D. I had a master's; you had to have a Ph.D. to be appointed to a full-time faculty position. It was great. I went to teach with Jo Kirsch; she was the project officer for the grant. I ended up teaching leadership courses and others courses as needed in the nursing administration master's of nursing program as a grant assistant. By the time I got close to the Ph.D., the dean of the school said to me, "If you finish, we would be very interested in hiring you full time." When I actually completed my Ph.D. in '89, I started as assistant professor on a tenure-track line. It was because of that preceptor experience and exposure to working with Jo that secured my interest in academic nursing as the next career choice.

KR: Describe your career in academia and the trajectory of your career.

DN: Okay. I was very fortunate because when I was onboarded as a newly-appointed assistant professor, the dean was straightforward and very clear of what the expectations were of an early-career assistant professor, "The way you get tenure and promotion is you do X, Y and Z. Obviously, you have to be an engaged citizen, to serve the school and the college, but we expect you to be a scholar, so you have to have a program of research." Teaching at that point at the university, at least at Hunter College, was critical. I mean, if you had to focus on teaching, service or scholarship, it was teaching probably first before the research and the grantsmanship.

For the early years, I figured it out, polished and tied my shoes, received solid faculty evaluations, embarked on research, built a program of research, and certainly understood the curriculum process. I taught primarily in the graduate program because this was a three-year-funded program. When the grant was over and one of the faculty members who was teaching with me as well in that program ended up leaving around '93, '94, '95, I started to teach actually across the curriculum, not only in the graduate program, but I started to do more undergraduate teaching, both theory courses and clinical courses. Those first [years], it was not like it is now, when you get six years. Your tenure run was four years; in your third year, you'd come up for reappointment, and then the tenure review in year four. I was tenured and promoted to an associate professor. I did about eight years as an associate professor.

During that time, I was restructuring the nursing administration program. We designed a dual degree with Baruch College, which was our business school in CUNY, with a master's in nursing administration and a master's in public affairs in the early [2000s]. I think it was 2002 or 2003, I went on sabbatical, wrote the curriculum and program proposal, got it approved at the college level and at the state board of education. We opened the program in 2004, I was appointed coordinator for the dual degree for several years, probably up into 2011. We opened up a Ph.D. program at the Graduate Center, CUNY in 2006. The Graduate Center confers doctorates and special master's degrees, and we opened up a Ph.D. program in nursing science and I began teaching in the program. I received a joint appointment from Hunter to the Graduate Center teaching health policy. I was promoted to a full professor in 2009 or so. I ended up really loving teaching Ph.D. students. I taught one course and then another; I taught a writing course, a policy course. I was starting to chair committees. Then, I think in--I'm getting my dates correct--but probably in 2013, the executive officer for the Ph.D. program left and I became the executive officer of the Ph.D. program from 2013 to 2018, when I left to go to Rutgers-Camden as dean. I enjoyed teaching all levels of nursing, undergraduates, graduates, and eventually doctoral students. However, now as dean, I have a greater appreciation of the entire nursing curriculum, undergraduate program and a master's program and a doctoral in nursing practice.

KR: During your career at Hunter and at the CUNY Graduate Center, what were you focusing on in your research and scholarship?

DN: In the beginning, as I said, my focus was in qualitative research. I was interested in work-life balance in women nurse executives and their choices and goals. Then, I kind of switched a bit and I began to focus more on nursing education and preparation for nurse administrators and executives. At the same time, my scholarship in leadership and management began to expand as I was drawn to leadership competency and capacity. I was teaching in the master of science in

nursing management program and wanted to better understand the theories and concepts, as well as the differences in leadership versus management.

Once I began to appreciate organizational systems and the role of leadership in governance, I soon realized how power, policy, and politics were critical to human relations and systems. I also realized at one point that if you really were going to impact changes in clinical practice and healthcare on the front line or on the governmental level, you needed to understand how regulation, legislation and standards impact health care and health care delivery. It was great working at the system level within the organization, but to really have the influence over practice in the profession, you needed to go up the hierarchy. I started to get involved in government affairs. I sat on several nursing committees or programs or professional practice committees within the school of nursing, college and professional associations. Then, I began to build upon that board experience and work with other colleagues who were also interested in the policy and the politics of health care and nursing and then, of course, public health in particular.

I expanded my interests in public health and community health issues and aligned them with clinical practice. Since I was interested in maternal-child health, I became acutely aware of the high rates of asthma when I was working in the hospital, especially in young children with asthma. The rates of childhood asthma was especially high in the Bronx. I received grant funding and began working with New York school nurses, both in Manhattan and the Bronx, to explore educational programs for school nurses, as well as asthma intervention and prevention services.

In my early years as an academic, I aligned my clinical nursing specialty with my scholarship, but as my career advanced, I assumed administrative responsibilities and curriculum re-design at the graduate level. My scholarship transitioned and teaching was at the graduate level. I picked up the curriculum on leadership and management in nursing administration and then moved into health and public policy at the doctoral level teaching in the nursing science program. I think you can see that reflected in my CV in my writings, both in books and in peer-reviewed publications.

KR: I have a specific question relating to maternal health care. There has been a lot written recently, in the past couple years, in *The New York Times* and other publications, about maternal mortality rates during childbirth, which is especially disparate with women of color.

DN: Yes, data confirms significantly higher pregnancy-related mortality ratios among Black and American Indian/Alaskan Native women. These gaps have not changed over time.

KR: I am wondering if that is something that you have written about and then also with your practical experience if that is something that you have observed over the past several decades.

DN: Well, obviously, everything that you said is true. We always knew that women of color were at high risk, mostly for premature births, but we didn't really appreciate the level of health disparities and impact of racial disparity on maternal mortality until we began to drill down on the higher incidents of death, mortality, in women of color. I think that's what we're beginning to

understand. When you put those together, what we're learning is there is systemic racism within the healthcare system and, more importantly, racism in how we care for individuals of color, particularly around maternity and mortality. The major causes of maternal mortality are hemorrhage, hypertensive disorders, sepsis, and obstructed labor. Sometimes women do not have access to prenatal care but also do not receive safe care during birth due to underlying racial or ethnic bias or discrimination. Healthcare providers are not always attentive or listen to the complaints or notice the symptoms while attending to women of color. Their concerns are not heard, as in the case of [Serena] Williams, the tennis player. She was aware that she had complications post-delivery, but it took a long time for her to convince people that she needed care. She's not the only one. There were also stories from women of color, including physicians themselves, who knew what was going on and yet their needs were ignored.

We've gotten a lot better about listening to women in childbirth and better in understanding and caring for the child-bearing family. In New Jersey, in particular, the first lady Mrs. [Tammy] Murphy has focused on maternal mortality for women of color in the State of New Jersey. There is the New Jersey Maternal Care Quality Collaborative, a multidisciplinary team of stakeholders who oversee the establishment of a shared vision and statewide goals for decreasing maternal deaths, injuries and racial and ethnic disparities under the umbrella of Nurture NJ. This is a statewide awareness campaign to reduce infant and maternal mortality and morbidity and ensure equitable maternal and infant care among women and children of all races and ethnicities.

We have faculty at the School of Nursing who are understanding about putting postpartum bundles together on what are considered factors that lead women of color to experience trauma or difficulty, and a lot of it is better understanding of what these women need, particularly on care of early discharge. Now, we're sending women home with a set of discharge instructions, not only themselves but their caretakers, to look for early and postpartum symptoms, whether they're physical symptoms or psychological symptoms, to assess; don't underestimate that when you experience them, you ask for help early and as often as you need.

I don't know whether it's just women in general, but it took us a long time to put the spotlight on [this]. We always knew about early death in prematurity in infants, but we've kind of ignored the early care and interventions in the postpartum period for mothers. Now, we've said, "Wait a minute. We're more responsive, screen earlier and be more aware." Are we there yet? We're seeing improvements in terms of outcomes, but we certainly can't take our foot off the pedal in terms of meeting the needs of especially women who don't have the social network and support that they need for good outcomes throughout pregnancy, during pregnancy, and after. There have been some really exciting nursing care models that have done early intervention for teenage moms or mothers who were discharged early and follow through. I think we're using nursing science and evidence-based practice to improve maternal outcomes. I'm happy to say that I think we're on the right path.

KR: Over the course of your career, how do you think nursing education has evolved?

DN: I'm happy to say that we finally are coming along. In December 2017, New York State now requires all nurses to obtain a baccalaureate degree in nursing within ten years of receiving

their initial RN license. After nearly fourteen years of lobbying, New York State finally passed their "BSN in 10" law, requiring the entry into practice to be a baccalaureate degree. There are still a lot of associate-degree programs in New York State, but these nurses will have ten years to complete their BSN. But I think it's really practice that's changed and influenced nursing education, that said, "Wait a minute, we know that those nurses who are prepared at the baccalaureate level have better outcomes than those who do not." So, it was practice that pushed nursing education to say, "We want more baccalaureate programs, and that's the preparation that we're going to use when we hire nurses at the bedside." It was the Magnet model, the Magnet designation at hospitals, that really drove that change, I don't want to say for us, but pushed nursing to a higher level of practice at the baccalaureate level than associate degree. Now, most acute-care hospitals prefer not to hire associate-degree nurses, but when they do hire them, they hire them with the expectation that they will pursue their nursing education and get a baccalaureate upon contract and then they make them promise that they'll fulfill that. What we saw, when that change began to happen, when hospitals started to hire predominantly baccalaureate nurses, the nurses who were associate-degree prepared ended up going into long-term care, rehabilitation, home care, and not coming to the hospital setting. In New Jersey, the state nurses association is supporting its BSN in 10 (A1762-S1082) Assembly bill in Regulated Professions Committee and the Senate Health Committee. There is support to move this legislation forward in the next legislative session.

In Rutgers-Camden, our School of Nursing is fostering premier relationships with local community colleges, where we allow for articulation for those students who have completed an associate's degree to transition into our RN-BS program. I think we've come a long way, certainly not only with the baccalaureate, but the importance of advanced-degree nursing, nurse practitioners, nurse midwives, clinical nurse specialist, DNP [Doctor of Nursing Practice] nurses, who are at the front line doing primary care, recognizing the importance and the contributions that they make in health care. There are certainly not enough primary-care physicians to go around to meet the needs of communities, particularly vulnerable communities or communities in rural settings, where we know nurse practitioners practice at a higher level.

KR: When you were at Hunter and the CUNY Graduate Center, were you unique in that you were a Reservist?

DN: I wouldn't say that I was unique as a Reservist. There were several nurses and non-nurses in the academy and many who I knew as faculty colleagues and students alike who were Reservists. It was just the nature of the beast. I would say that more of us, because of our age, were in a voluntary Army or Air Force Medical Corps. I would say I knew a lot more individuals who were nurses and physicians who were in the Reserves because that was the nature of my contacts, but I was also aware that there were other individuals outside of Hunter College who were veterans as well. I know that we had, just like we have at Rutgers, we had an Office of Veterans Affairs for students, which supported Reservists and active-duty folks who were coming back or coming off service to go to school, so that I was aware of how the college was providing support services for students.

KR: You retired from the Air Force in 2000 after many years of service. What was that like for you retiring? How did you feel?

DN: I certainly had more time on my hands, [laughter] but it was different. There was a cadre of different friends who gave up their own time on weekends and two weeks during the summer to be away from their families to meet the requirements of their service. What was really nice is when I was still in the Reserve, I was friends and colleagues with--I think I mentioned this to you--a nurse who I was with in the 69th who became the Secretary of Veterans Affairs in the State of Connecticut, Linda Schwartz. I've had connection to friends from the military, and then of course you meet people in the community or at work who are veterans. There is a natural bond that forms between these individuals. We have a shared lived experience, regardless of the branch of the military served or position (officer/enlisted). It is something about wearing that uniform and oath of office that connects us. There's a sense of camaraderie that never goes away from you. It always stays with you.

The exciting thing now is that at Rutgers-Camden, I get to work with the Director of Veterans Affairs [Fred Davis] very closely. In fact, we had a call today. I'm waiting to sign some paperwork for a student who needs a scholarship and I need to get on the VA [Veterans Administration] site to sign it for her. It's a part of my life that has stayed with me. Even though I'm not a Reservist at this moment in time, I'm a veteran. I still get the privilege of interacting [with veterans], especially being at Rutgers and being at a Purple Heart University that has such distinction and honor.

KR: We are coming up to the 20th anniversary of the terrorist attacks on September 11, 2001. As a New Yorker and as somebody who worked in New York City institutions, what do you remember about September 11, 2001?

DN: Actually, it was devastating on many levels. I had a firefighter who was in my class who lost his life in 9/11. I wasn't in the city that day because I wasn't teaching on that Tuesday. I came into Manhattan by train, got off at 42nd street, and of course Hunter-Bellevue was on the Lower East Side. It's about twenty blocks [away], so I walked down 42nd to First and across on First down to 23rd. There was a police officer at every corner. The city was quiet. I went down to First. There were actually orange garbage trucks, sanitation trucks, in front of the UN [United Nations] blocking off First Avenue, so that you couldn't go uptown on First. Lining the streets on both sides of First Avenue were police cars from different cities and states. As you went down First Avenue, there were crowds and crowds of people in front of Bellevue, putting posters up of their family on the fence in case anyone recognized them. Then, more importantly, you could smell and see the smoke rising up into the sky from downtown at the site. The acidity of the smoke just stayed in the air for weeks on end. The sorrow and pain lasted for many months, as the pile of damaged buildings and fires lingered.

Because I commuted by train into Manhattan, there were many cars that remained in the parking lot when I'd come home at night, which normally would have been empty at the end of the work day. Obviously, there were a number of families from Greenwich, Stamford, Westport and further up the New Haven line who [their loved ones] never came home, right in your in your

backyard. I can remember being in Manhattan at Hunter in '93 when the first bombing happened, and that was pure disbelief. But the level of damage and trauma from [2001], you'll never forget. Just like those who were in Pennsylvania and Washington, D.C., we will never forget where we were and what we were doing at the moment the planes hit their targets.

It was an event that rocked all of us. I mean, we had students who had family members, we had faculty and staff who had family members who were impacted. The Borough of Manhattan Community College, one of our sister schools in the City University System, was just one or two blocks [away from the World Trade Center], and those buildings were impacted as well, so that we felt it personally as a loss in the CUNY system. On multiple levels, I was involved, certainly from a faculty perspective, but also those were my neighbors in the community where I lived. At that time, I was the president of the YWCA of Greenwich, and there were many family members in our YWCA community that were impacted from that loss as well. Even though I lived in Connecticut, New York is only forty miles away. It was so devastating. Then, of course, we had family and friends who were firefighters who were on that pile and several years later had lung impact disease because of not being fitted with the appropriate equipment. Many assisted without knowing or having the necessary equipment that they should have had that they didn't have and we didn't know better.

KR: I would like to shift and talk about your coming to Rutgers University. How did the opportunity come about for you to become dean of the Rutgers School of Nursing-Camden?

DN: That's a great question. Actually, I was in a previous search for dean at another university. I was a finalist, not selected. God works in strange ways. It was not my time. But because of the experience that I had with Korn Ferry, I developed a very collegial relationship with the recruiter. She said, "How'd it go?" I said, "Boy, this was really a tough search. It was grueling in terms of the timing and the effort and energy." Be that as it may, we left on very positive terms. I think that was the end of June 2017.

I'd say probably in late September, early October, she reached out to me and said, "Oh, I'm involved in another search. I think that you would be a great candidate." I finally turned her and I said, "Abigail, I don't think so," Abby rather. I said, "That was great, but it was grueling. I'm not ready to do this. I'm certainly not going to go back and ask my colleagues for references." She said, "Relax, that was not your fault. I agree, it was grueling, but I think that you should really take me seriously. Be patient and do this." I said, "All right, let me think about it." She said, "Wait, wait, wait, I'm not going to let you get away so easy. Just go on the website, take a look at the scope of what we're looking for, and get back to me." I promised her that I would do that.

I did my due diligence. I looked at the scope of the work, the call for the position. What really tipped me was I went to the website and I looked at the campus--the Camden website--and I looked at the School of Nursing. Now, remember that I said to you in the first interview last week that I knew exactly where it was because it was right down the road on 95 [from McGuire Air Force Base], Exit 4 is Camden, Exit 7 is McGuire, which is now called the Joint Base [McGuire-Dix-Lakehurst]. The geography was easily found, so it wasn't a big problem. I talked

it over with my husband. He said, "Well, okay, you've got nothing to lose. Why don't you just do it?" I ended up saying, "Okay, I'll throw my hat in the ring." I filled out the material that the search firm required, and before I knew it, I was set up for an interview to go down to Camden to meet this search committee.

I went down in early December and thought it went fairly well. I either wore a red suit or red glasses, and I said, "It looks like the color matches here. I didn't know that I was scarlet red before even coming to the table." Of course, that was a big hit. It was great. They had the chairs of the committee, students and faculty and then representatives from across the campus and the search committee people attended as well. I thought it went well. I answered all their questions. I remember Bob Atkins walking across the street with me to wait until my husband was able to pick me up, and he said, "I think you'll be a good fit," because I had a lot of understanding of the community and the partnerships that were critical. That was, I think, the first week in December. By December 16 or 17th, I was called back for another interview to meet the faculty, to meet the staff, to do a presentation, and meet the other deans and other vice chancellors at the school. By Christmas, I think it was a day or two before Christmas, the chancellor informed me, "We selected you. You're our candidate of choice." I said, "All right, I think I'm ready," and I ended up saying yes. [Editor's Note: Robert Atkins, RN, Ph.D., serves as an associate professor in the Department of Childhood Studies at the Rutgers Camden College of Arts and Sciences and as the Director of New Jersey Health Initiatives of the Robert Wood Johnson Foundation.]

I came down several times in the early spring. The budget manager called me and said, "Listen, Dean, this could be your budget. Do you want to be in on it or not?" I said, "Oh, absolutely." So, I ended up going down one or two times to do the budget with them and then went down in April. I just needed to get my understanding of the structure, a brand-new school, which was another feature that brought me here. Here was an opportunity to go into a new building [Nursing and Science Building] that just opened up that fall of 2017. I came in July, so it was really just six months old by the time I got there, fully opened and new.

Here I am, three years later. It was a good fit in so many ways. First of all, having worked in CUNY for so long in a large urban public institution--it's funded by the State of New York--to understand the budgeting system and governance as it relates to public education and understanding and working in a unionized system, so that was an adjustment. It was just new faces, a new place, and right now, it feels like home.

KR: What was your transition to Rutgers like? What were those early days like for you in your deanship?

DN: I did a lot of listening. I remember that much. It was very easy because I was the first dean going into this new office, so it was easy just to get all my boxes from CUNY transferred over and put things away. I was very fortunate to have a wonderful team who helped me unpack, as you can imagine. I took my time getting to know the system and getting to know the faculty and staff. I made an effort to meet every individual faculty before the start of the fall semester. I was able to hire my own executive administrator when I arrived. We have been a perfect match.

Sharlene Joseph-Brown is an experienced administrator. She has prior experience working in a dean's office. Her guiding hand and assistance made my transition seamless. Then, the rest was learning to work with the staff that I had not known from a variety of divisions within the school and around the campus. There are always policies and procedures that were new but always someone to assist when needed.

[It was] very different. I came from a large public university system that had one chancellor and each college with its own president. There are twenty-two or twenty-three colleges and universities in CUNY. Now, I have a chancellor and we report to a president, so that flipped that model a little bit. Camden is certainly a smaller campus. Hunter had twenty thousand students, the Graduate Center a little bit less than that, but still a large campus. The structure, the governance, the curriculum, I understood. Camden because of its size, I think we have 7,500 students now, there were probably a little less than seven thousand when I first started, so now we're up a little bit more in terms of the population. I was able to adjust, learn to work with the campus leadership cabinet, different units and deans. I was able to restructure and create an organization that I think is a good fit for the Camden School of Nursing, and now we're working on a new strategic plan.

Now, we're getting to write our own new strategic plan, so the timing couldn't be better. I'm working with the Rutgers Center of Organizational Leadership. I'm working with Dr. Ralph Gigliotti and his team to help me forge that new strategic plan under the auspices of President [Jonathan] Holloway and now with new Chancellor [Antonio] Tillis. It's a pretty exciting time to be at Rutgers, I would say.

KR: In 2013, there was the merger between Rutgers and the University of Medicine and Dentistry of New Jersey, UMDNJ, and that formed Rutgers Biomedical and Health Sciences.

DN: Right. I am very familiar with that merger. Many of my colleagues who experienced the merger have filled me in.

KR: Given that the merger took place really just a few years before you came on as dean, how did that impact your acclimation to the School of Nursing in Camden?

DN: I understand, although I wasn't there when the acquisition happened, we picked up Stratford, which was part of the University of Medicine and Dentistry of New Jersey. That acquisition was, I understand, a challenge. The integration and alignment with both schools coming together, as I understand, was not easy. I think it would be a challenge for anyone to change and adapt. It wasn't completely finished by the time I got to Rutgers, but I think we've kind of hammered it out a little better and we're more aligned. People have stopped saying, "Well, that's what we did then, and this is what we do now." We still have some faculty who were part of the merger, but I think we have alignment now within a Rutgers structure. We're not two universities; I think that we're one. [Editor's Note: The New Jersey Medical and Health Sciences Restructuring Act went into effect on July 1, 2013 and shifted six schools of the University of Medicine and Dentistry of New Jersey to Rutgers and two to Rowan University in Camden, including the School of Osteopathic Medicine in Stratford and the Graduate School of

Biomedical Sciences. The restructuring act also created the Rowan University/Rutgers-Camden Board of Governors. Rowan opened the Camden-based Cooper Medical School of Rowan University. There are joint degree programs offered by Rowan and Rutgers-Camden, as well as the Joint Health Sciences Center, shared by Rutgers-Camden, Rowan, and Camden County College, which is located at the intersection of Broadway and Dr. Martin Luther King Boulevard.]

The thing that's different with us is we don't have a medical school. The Rutgers School of Nursing has RBHS and they work with the deans of the medical schools, the pharmacy school, the school of health sciences and so on and so forth. We are really the only health professions school on the Camden Campus. We have lots of autonomy, which allowed us to build and develop new community relationships with diverse partner institution and community and government agencies.

In Camden, we have what is called the "eds to meds" corridor. The School of Nursing is located a few blocks away from the main campus. We sit on the corner of Federal and Fifth Streets. As soon as you turn the corner onto Martin Luther King Boulevard, you enter the medical corridor of Cooper University Hospital, the Joint Health Sciences between Rowan and Rutgers University, Rowan Medical School and M.D. Anderson Cancer Center. All of those health systems in the educational corridor are a good fit for us. We've gone out of our way to establish an interprofessional education model with the Rowan Medical School and the School of Nursing, along with the Rowan pharmacy schools and other schools of health sciences in the region. It's been very beneficial to have such committed interprofessional colleagues who want to work across disciplines. We have an IPE [Interprofessional Education] Committee that meets several times a year and creates opportunities for clinical simulation.

Because of that, we're at the table. During Covid, I've had the opportunity to work with colleagues at Newark, New Brunswick and RBHS on the Covid Clinical work group, and now another group called the Vaccine work group. I would have never had the opportunity to meet my colleagues because of just geographic boundaries, unless I met them at the Administrative Council meeting. Now, Zoom has made it possible that we're now serving on multiple committees, and we have more interaction, both at Camden with other personnel, not just me as a dean, but other representatives on the Camden Campus, and working with our colleagues in New Brunswick, Newark and at RBHS. That's been exciting.

Even though we are located on different campuses, we're all one university. Sometimes, it feels like we're three different or four different institutions, when we're really one. I think that's the strategic clarity our president is seeking to define the scope of work when we talk about our educational endeavors. Where is the clarity? What do we do? How can we work mutually in ways that are beneficial across the campuses, even though we're in different locations?

KR: Yes, that is one of my questions. How closely do you work with folks at the School of Nursing in New Brunswick or in Newark?

DN: Okay. I would say, first, I know a lot of them professionally because of our professional membership associations, but I do have to say that Dean [Linda] Flynn and I have made a real strategic promise and effort to work better with one another. Even before the pandemic, we were speaking by phone at least twice a month and more if needed. However, since Covid and working remotely in 2020, Zoom has become our preference at least twice a month during the academic year to check in, because there are issues that even though we're on different campuses, just professionally, we seek each other's advice and assistance. I was able to count on Linda when I needed a tenure review of a full professor. I was short on a faculty line. She came in and assisted me. I think we called on her again just recently asking if one of her faculty members can help us in another promotion or tenure review. She said yes. We share our associate deans because she has a DNP program, I have a DNP program. We've put our associate deans together and certainly our undergraduate associate deans together as well. There is ample opportunity for us to work with one another. Also, Linda and I have been on several committees together. We sit on the Covid work group together, we've had some meetings, and now Rutgers Health, which is a council that looks at health system issues, we've shared together as well.

Besides working with nursing colleagues, I get to work with other colleagues throughout the university, not just at Camden. Obviously, I have to work with the General Counsel's office as dean, when we have contracts review or we need their legal assistance. Mike Palis, who is our current provost, has allowed the deans to work with other deans in the north to think about joint research ventures together.

The good thing about a system is you can go in your address book, look up a name, and make an introduction, because you have a Rutgers address. I have found scientists who I ended up interviewing for *Nursing Economics*. I have found bio-statisticians that my nurse faculty needed assistance for to review a grant. It's a great opportunity to be a dean, not just because of your position, but you have full access and assistance for you to do your daily operations, not only for yourself, but for your faculty and for students, so it's pretty good.

Of course, there are special opportunities to travel together. In my first eighteen months or so, I traveled to Hungary, Puerto Rico, Cuba, and Paraguay. I went on a trip to Cuba about two years ago with faculty from up north who joined us, which I would not have had the opportunity to meet them because it was still early in my deanship. Just being on the trip created a good network across the university.

KR: In our first session, you talked about the HRSA grant to recruit veterans into the School of Nursing. What are some other initiatives or programs that you have laid the groundwork for at the School of Nursing?

DN: There's certainly lots of room for partnerships. Prior to coming to Camden, our faculty and our Senior Associate Dean for Academic and Faculty Affairs Marie O'Toole was involved with a relationship with the City of Camden Housing Authority. One of our faculty members, Kathy Jackson, asked if she could invite some of their representatives to come to campus to meet me, because they were interested in expanding health services for their residents. When they arrived,

they came with a team of about eleven or twelve individuals. That first contact began to lay out an infrastructure that has grown significantly in the last three years. They've been able to open up a new housing complex in South Camden called Branch Village, which is about 280 residents, and in that new facility, the Michaels Corporation built a clinic that they had every intention of having Rutgers nursing students provide services. I think in early 2019, when it was completely finished, they invited us to do a tour, and both Kathy Jackson and Marie O'Toole said, "We can do this." By that spring or early summer, we started to provide services and educational courses for the residents in their newly-minted community center. That summer of 2019, we started to do sports physicals, absolutely free, for children who were going to college or needed camp physicals or sports physicals for the fall, so that they can play football. Word got out on the street that the nursing faculty were doing free health physicals for students, and by December of that year, we did near a hundred physicals alone. If it wasn't for Covid in 2020, we would have continued. However, I am pleased to say we have a fully operational health center at Branches, where our New Jersey Covid-19 AmeriCorps nursing students and faculty provide testing, education, information, vaccination, and boosters for our Camden City residents.

As a member of the Rutgers Covid work group, I found out that the system--RBHS was doing telehealth--I was able to get the electronic program that they were using. We ended up using that telehealth module for the patients that we were seeing at Branch Village and also at Ablett Village, another housing facility that houses young families and single adults. In the beginning, we were able to provide PCR Covid testing in the community because of Rutgers University. Again, because I was on the committee, I was able to make contact with the docs who actually developed it, and then we were able to use it eventually for our own students and for the residents that we were caring for. Those relationships, now from the HRSA grant, looking at grants in the community, we wrote a small RFP [request for proposal] for the Housing Authority, where they'll be able to use nursing faculty and embed clinical experiences in the Housing Authority for older adults who are using the assisted living community model of care, as well as opening a free health center now at St. Paul's Episcopal Church, right around the corner from the School of Nursing. We've opened four health centers under my leadership, with the support of my faculty practice. [Editor's Note: In the spring of 2020, RUCDR Infinite Biologics developed the first saliva-based test to detect SARS-CoV-2 coronavirus. RUCDR, headed by Andrew Brooks, worked in collaboration with Spectrum Solutions, PerkinElmer, Thermo Fisher Scientific and Accurate Diagnostic Labs to develop the test.]

Again, we were creating new the models of nursing care, but we're also building a research enterprise and nursing science. We have recruited a new senior associate dean for nursing research, Mei Fu, from Boston College. She started in June 2021 and has hit the ground running, mentoring and guiding faculty scholarship and research. We've been lucky with securing the HRSA grants and other private foundation grants. We've received RWJ [Robert Wood Johnson Foundation] grants for Covid as well as the Department of Health of New Jersey through our work with Covid in South Jersey. I think we're making headway. We are good partners. We're reliable partners. We're certainly in the neighborhood, and we stand up as good neighbors. As you know, we, like other Rutgers campuses, consider ourselves an anchor institution in the communities that we live in.

KR: You talked about this Covid work group. Is this a Camden-specific task force?

DN: No, this was established from Tony Calcado, who is our EOC [Emergency Operations Center Coordinator], and he established several committees. This was a committee of faculty in the health sciences or health professions across Rutgers, and we met probably from last [year], 2020, February, March, and we're still meeting to this day. Now, we're focused on making sure that all of our students are vaccinated, all of their paperwork is updated in the portal, and that we're ready to go September 1.

KR: Let us discuss the early days of the pandemic and the Covid-19 Task Force. By the way, Tony Calcado and Brian Strom have been interviewed by the director of the Rutgers Oral History Archives, and I interviewed Barbara Lee, the former Senior Vice President of Academic Affairs, all of whom were a part of the Covid-19 Task Force. What was it like, in February and March 2020, being on the task force, and what was being talked about?

DN: I have to say that very early in the pandemic, we were very fortunate at Rutgers, because I think Tony was very aggressive understanding what the implications of the pandemic were for the university, certainly having Chancellor Brian Strom, an epidemiologist, who got his arms around this early, saying, "This is serious, and here's what we need to do." We started to gather the information and use the science very early in our plans, knowing all along how serious it was not just for Rutgers but for the entire State of New Jersey. What we didn't understand at that point, in February, was that by early March, we would be making plans that before we send students out the door for spring break, we needed to make sure that we were prepared during spring break; should we not come back to campus that we had a plan to make sure that we would be able to transition to remote learning when the light switch went on. I remember that Tuesday, which was March 10, because we left campus on March 11, and us saying to the faculty--we were in a conference, we were all streaming live for the faculty who couldn't be [there]--"Listen, we're not going abroad in 2020. We will go on spring break and we may or may not come back immediately. We may take another week before we come back." Then, while we were on spring break, all of us were notified that we would not be returning to campus in the spring. Rather, all of our courses would be remote.

We went into what I would say was a full acceleration, because it was what was required. We did not fully appreciate what was going to be needed, not only for the students who had to have theoretical classes online, but what we were going to require of health professions students in nursing, social work, medicine or pharmacy, who all had practice, clinical placements to complete their clinical course requirements. The hospitals and community-based agencies closed their doors to non-employees and visitors. They also would not allow any students into their organizations. We had to create virtual clinical experiences for our students, so what we would have done in person, we now had to create through a virtual clinical scenario. This completely disrupted our clinical courses for our juniors, who would not have an in-person clinical for an entire year. We had to be concerned for our graduating seniors, who would have no clinical experience during their last semester. What were we going to offer for them?

We got very creative! We had a unique opportunity to work with our close health systems, one or two institutions; Cooper and Virtua [Health] said, "We'll take your students as externs, and we'll hire them as an extern. We'll pay them, and then hopefully by the time they graduate, they would be interested in a position with us." We modeled it first with Virtua. I think we placed up to thirty-five interns with them, externs, and then we did the same thing with Cooper University Hospital, which proved, by the way, to be very successful.

Then, we had to figure out what we were going to do in the fall of 2020. We extended those externships, as well as creating what we called critical-care technicians with Cooper for our junior students, to provide interested students clinical experience. Then, by November 2020, we got a call from Cooper University [Hospital] that said to us, "Listen, if we get the vaccine, which we think we'll get, would you help us?" We said to them, and this was with assistance from Dr. Gracias, Rutgers Health, he said, "Yes, but tell them only under the condition that they will vaccinate you and your faculty and students to participate." That's what we did, not only Camden, but Newark and New Brunswick created a vaccine course, a Covid-19 vaccine course. What we did was hired additional part-time lecturers or part-time faculty to take our students into the Covid sites as clinical groups, like we normally would have done if we were in a hospital. We staffed up the largest Covid vaccine center in Blackwood, New Jersey, in southern New Jersey. They were open six days a week. Four of those days, we staffed with part-time faculty and students, thirteen-fifteen students in a group, and then on the weekends, on Friday and Saturday, covered with faculty volunteers who, as registered nurses, supervised students, and we sometimes used our alums. We did that all the way through June 2021 when the center closed.

Then, in March 2021, we opened a vaccine clinic in Camden City at the Kroc Center, and we used our New Jersey Covid AmeriCorps students, our senior students--we had eight of them--with a nurse faculty member to staff that clinic two or three days a week. Now, we are out in the community. We are doing pop-ups and working with a core group, Cooper University Hospital, the Camden Department of Health, along with several other small pharmacies and community-based agencies, like the Camden coalition CAMcare and others, to support the vaccine effort. Our community clinical partners have continued to meet weekly on Zoom in what we call a "micro summit" to review and update vaccination clinics in and around Camden County. This has been extremely helpful as well to remain agile and address the many variants of Covid, including the rapid rise of Omicron cases and increased hospitalizations. [Editor's Note: The last sentence referring to Omicron was added to the transcript by Dr. Nickitas in January 2022.]

We've learned a lot. We learned that you can't do this alone, that the way you lift the community up is that you do it together as a whole. Believe it or not, we've become very collegial and respectful toward each other as institutions and as colleagues. As I said earlier, we meet once a week on Zoom to plan events and increase our outreach. Of course, obviously, you know that we, along with Newark, had a real struggle in the beginning to reach our most at-risk, vulnerable populations. We have to build trust in communities of color by working with our community health workers to inform, educate and vaccinate. We're doing better now in Camden, about seven-six percent vaccinated, so we're still trying to drive our numbers, especially in children between the ages of five and eleven. [Editor's Note: The last sentence referring to the vaccination rate was added to the transcript by Dr. Nickitas in January 2022.]

KR: Rutgers has instituted a policy to require students to be vaccinated. What were the discussions that went into the establishment of that policy?

DN: I think that policy started at the top with our president working in consultation with Tony Calcado and his team about what would be our position. Believe it or not, Jonathan Holloway made a very provocative choice very early on. Rutgers was the first university to say, "If we're going to come back, we're going to come back and make sure our environment is safe and secure and free of the virus." He made it a commitment. He said, "We might get sued one way or the other, but I want to be on the right side of history." If we want our students to return, which they want very much, as much as we want, and meeting the faculty and staff, we've had to institute a policy that would ensure that we would be protected.

Having said that, there is a Covid Clinical work group that has been meeting almost weekly since the beginning of the pandemic. We have had challenging conversations about how to advise the university on policy and procedures, including maintaining a safe workplace, but also how make vaccinations available throughout the university. By early spring 2021, our clinical leaders and staff were working with the State Department of Health to make sure that Rutgers had sufficient vaccines, so when we were able to vaccinate--remember, we did a tier system in the beginning when vaccinations became available. We wanted to have a plan in place when vaccines would be available. Come mid-May, we had enough vaccines for all four campuses. In Camden, we opened up a vaccination clinic, with the support of campus administration, our Wellness Center, and our School of Nursing, and we were able to provide vaccines to staff, students, faculty and even local Camden residents.

Once the university mandated vaccines, the campus made sure that we had vaccines available unless, of course, there was medical or religious exemption, which is screened by a special committee. Once vaccinated, you are obligated to upload the documents into the portal that you've been vaccinated, before you will be allowed to attend classes on campus. For all of us who are in the health professions, all of us on the front line of care, if you're involved with patients, you have to be vaccinated. We're talking about compliance. We've been communicating with our faculty and staff to ensure they're compliant by August 1, just like our students will have to be compliant. Otherwise, they won't be able to return. They'll be getting a pop-up message. I think it's going out this week, if not yesterday, that every time you go into your NET ID, it asks you the questions, "Are you vaccinated? Are you interested in getting vaccinated? Here's where you can get vaccinated, and if you are vaccinated, here's where you go and upload." It's like the pop-up message you get when you go on to a website and you just want to click it off, and this is not going to let you click it off. It will come up every time until such time that you submit your required papers that demonstrate that you've gotten vaccinated.

As I said, I'm really excited. Certainly as a health care provider, but now as dean, I want my students to be safe. I want our faculty and our students to be protected. I want to provide an environment that is safe, including our offices, classrooms, clinical labs and simulation labs. I think we have a good understanding and appreciation of the science that we will do the right thing. Don't forget many of our own Rutgers faculty and staff are actively engaged in Covid

research. More importantly, we all want to return to campus, to our offices and our classrooms, but it won't go back until all of us are vaccinated and understand the importance of it.

KR: What have been your personal experiences since February and March of 2020?

DN: I can tell you, there have been several. As dean, I am very fortunate to have faculty who have been essential in providing support to our campus community and our Camden City community. I too have been on the front line vaccinating residents with our nursing students, both our New Jersey AmeriCorps students and other students at Blackwood. I've also helped out on campus. It's been great to be on the front line and work with students to help them understand the importance of infectious disease, understand the importance of surveillance, reinforce to them and to the residents that they speak to on why this vaccine is critical. We've gotten faculty to volunteer their time and support the students as well. Also to work with our government, our local legislators, our commissioners on the local level, to support other organizations that are equally committed to fulfilling vaccinations, and then to change the curriculum a little bit. We need to put in a lot more resources into the infrastructure of public health. We need to build capacity with our community health workers, stress the importance of surveillance, provide additional staffing and supplies for testing, vaccination, and boosters, as well as how to adjust our lives to living with this pandemic, including continuing to wear our masks, wash our hands, and avoid large crowds. Judy Persichilli, who herself is a nurse, is the Commissioner of our [New Jersey] Department of Health. It's one thing to be involved in a pandemic; she says, "This is a historic pandemic and we're making history." She's worked very hard under the Murphy Administration. She said, "We're going to get to seventy/seventy-one percent and we're not done yet." We're very close.

We're lucky to be in the Northeast Corridor working with surrounding states like Pennsylvania, New York and Connecticut, whose local governors are working equally as hard to ensure vaccinations and mandate masks. But we have to keep our boots on the ground, work with our local communities to promote accurate information and education, use the science to guide our decisions, and also work to protect our children by keeping them safe and in school if at all possible. Communication is key. How do we overcome misinformation? What kind of communication do we offer? How do we use our local ambassadors of all sorts, whether they're community health workers, whether they're professional nursing students or medical students or other health allied professionals, who are of the community and can provide trusted and accurate information? How do we provide incentives so that people don't think twice, but that they really understand what the pandemic means? Those who are unvaccinated now are at greatest risk because of the Delta and now Omicron. [Editor's Note: The last sentence was edited by Dr. Nickitas in January 2022 to include the Omicron variant.] We're not over it yet, by any means. We still have work ahead of us. I am fully committed, as well as our chancellor and other deans, to bringing our students back to campus and in-person learning. Safety and well-being of our students and faculty is key.

KR: Last spring, a number of students in the Reserves and National Guard were activated, both at the School of Nursing in Camden and at Rutgers-Camden in general.

DN: That's correct.

KR: What sort of support did the faculty and administration at Camden provide for those students who were activated?

DN: I think the support was seamless. We knew that this was going to happen; we had heard that there may come a time where the governor would activate Reservists and Guardsmen in New Jersey to help out, and it came true. I remember getting a call from Fred Davis, saying that we need to be prepared, "Would you help me?" I said, "Absolutely." We had a list of standing students who we knew might be activated. We informed their divisional chairs that they might be activated, and then we worked with the faculty to identify what courses those students--and there was more than one [student]--what courses students were enrolled in and how we would be able to give them a little bit more time to get their academic work done, knowing that they were working twenty-four/seven, those students who needed the extra time to complete their work.

Don't forget, I not only had students activated, I had faculty activated. Kevin Emmons, who is my associate dean for the Center for Interprofessional Practice and Education, was activated by the state. Judy Persichilli actually appointed Dr. Emmons as chief nurse to open up a clinical site at the Convention Center in Atlantic City. The site was a small field hospital of less than fifty beds that opened up in the southern New Jersey region. He left campus in early April and didn't return back until June. Dr. Emmons seamlessly completed all of his courses that he was teaching, going to faculty meetings and attending to his work as chief nurse down in Atlantic City. Talk about agility and flexibility! Dr. Emmons was so responsive and responsible in all of his duties. When the government calls, they expect you to show up. It's up to the rest of us who are left behind in the civilian world to say, "Yes, we get it. We will work with you." We made the promise, and I think we fulfilled it and we did the work that we were asked to do.

KR: We are nearing the end of our time for today. At this point, what else would you like to add?

DN: That's a great question. I think the piece that I didn't answer and that we could probably come back to is the notion of service. Military service is one aspect of my career, but it's the service to self, to others, which is my faith-based service, but also my connection to service vis-à-vis my profession in nursing. As nurses, we have an obligation to do good, and by that, I mean serve society through our social policy statement of providing care that is recognized as appreciating the human dignity of all individuals, ensuring that we provide that care to all, healthcare that is equitable and just.

I have a long history of public service, not only to the organization that I belong to now, which is Rutgers, and formerly the City University of New York, the Health and Hospital Corporation of the City of New York and my military service. I've served my profession [through] professional membership organizations, as well as to volunteer on boards and commissions. I believe in community and civic engagement, as well as social responsibility. When you want to leave a legacy, you want to make sure that you do it in a way that fulfills you and you find your passion. I think I've been fortunate and have been able to create a career and a pathway for me that's been

purposeful, filled with a lot of passion, where I can be influential to improve the populations or communities I serve.

KR: I think that is a good point to stop. Thank you so much for doing this oral history interview.

DN: You're welcome.

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Reviewed by Kathryn Tracy Rizzi 7/27/2021

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