Interviewee: Kerry Kosmoski-Goepfert
Date: 03-07-2019
Interviewer: Charitie V. Hyman
Location: Muskego, WI
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Background Noise: We were in a café and for the first part of the interview it was crowded. There is a large amount of background; people talking, plates clattering, waiters moving about.

Summary of Interview: Kerry Kosmoski-Goepfert talks about college; she triple-majored in French, Spanish, and Political Science. She says that her mom knew she loved working with people and encouraged Kerry to move to nursing. She describes initially working in pediatrics and shares memorable stories. She emphasizes taking care of the whole person; she believes that mental health permeates all fields of nursing. She describes learning skills on the job and learning to navigate the "culture of healthcare." She notes achievements in mental health nursing.

Time	**Content Description**
0.00.00	Introductions
0.00.38	Grew up in southeastern Wisconsin, in Milwaukee proper. Spent life in Milwaukee, except for eight years in Madison. Went to school in Madison, for undergrad and master's. Took doctorate at University of Illinois Chicago, and graduate coursework at Kellogg Graduate School of Management at Northwestern University.
0.01.19	Returned to live in greater Milwaukee area, to be close to family, with parents getting older and making sure everything was in place and they were being taken care of.
0.01.36	"I think my memories are really the caring and the lovingness of our family, and the support that we always got. So, it wasn't like a particular place—I could say vacations, yes, and all those things—but it was rather something that throughout all those experiences was the best memory. And people always being there, being supportive to talk things through, but to make decisions, and you were the decision-marker."
0.02.13	No one in family worked in healthcare. Father was tool and die maker, and mother stayed at home at that time.
0.02.47	"I should say I'm probably potentially different from any of your interviewees, because when I went to school, I had a triple major, because I wanted to work in international relations. My majors were French, Spanish, and political science, because I had the dream of working at the United Nations at the time. Through school, my strong suits were really math and sciences. But senior year, I switched and thought I'm done with that, and took more arts and languages … Went to college with the triple major, and what really happened—into the first semester, it was really easy, the languages were easy and poli-sci was easy, and I wasn't challenged enough, and I missed the sciences. And at the end of freshman year, I had a conversation with my mother, a good conversation that really helped me out. And she said, 'You really love people—love helping people. Have you ever thought of nursing? That would be a good match for you.' And she could have

suggested probably almost anything, and I would have taken the turn at that point. So, the influence was really my mother's suggestion. Took more sciences then, got more familiar with what nurses did, and thought, 'Oh, not bad' and decided to do more of that."

0.04.25 Found this more challenging and engaging than previous work—especially because of the sciences (anatomy, physiology, biochemistry, chemistry, etc.).

0.04.40 First degree at Madison was a Bachelor's of Science, with concentration area in nursing. This different from a BSN. "The difference is in Madison you get a bachelor of science global degree, because you're more heavily seeded or educated in the sciences. Where schools give a BSN, their sciences are more intense, and they get a nursing—that's the differentiation." So, the difference is sciences focused on nursing vs sciences that could be put to use in any career. Took classes with pre-med students, pre-microbiologists. "So, you're taking what I call hardcore sciences, much more in depth and breadth. Whereas programs in nursing still have sciences, you may and may not be taking with people in your discipline; however, the discipline in the multidisciplinary grouping would not be pre-med. So, a speech pathologist might take that."

0.06.37 Madison and large universities tend to be a '2 plus 2'—at first two years at university, you take all the prerequisites to get into your program of specialization. So, there's a two-tier system: first admitted to university, and then at the end of sophomore or freshman year, you apply to get accepted into the actual school. "There may be an introductory nursing course during those first years, but normally you're taking your sociology, anthropology, sociology, English, math, and all of your sciences—that's what it was like in the school where I went. And then your last two years are all nursing courses."

0.07.50 On the nursing courses at Madison in last two years of degree: "For me, it was working with patients, working with people, and it was constantly being challenged. I think being an educator right now of nurses, things haven't changed in that, the first clinical are you get where you have patients, all of a sudden you have to synthesize the anatomy, the physiology, the pharmacology, the sociology, the psychology, the growth & development, just to name a few, and you have to come up with plans of care to work with people and their families … So, it's very challenging, very exhausting, because you have to learn how to put all those pieces together, and there isn't a magic wand to let you put those pieces together."

0.08.50 In the '2 plus 2' program, clinicals begin once accepted to school—junior year—and you have these until you graduate, and then you continue with your theory or didactic courses which address nursing needs.

0.09.18 Clinical experience: "At the time we did two in complex acute med/surg units. They were step-down units from the intensive care units—a lot of post-surgical patients. Also did it on a hematology/oncology floor, and had a community rotation, where we worked with family and the community on the east side of Madison. They started off in Middleton, and then they moved to the east side. And also did a pediatric rotation at that time—schools had peds as rotations specialized, so we did it there. Some of my colleagues might have done a mental health rotation in place of one of their med/surg rotations."

0.10.19 On rotations: “At that time, there were clinicals available in the specialty areas—pediatrics, community health, and psychiatric/mental health.”

0.10.44 “Probably my most memorable was from my peds experience, actually. There was this little baby … and his name was Nicky. And Nicky was a failure to cry baby. And I remember shaking because I got assigned to him and walking into the room. And if you opened up a washcloth, he did not fit corner to corner; he was so tiny. And the nurse said, ‘Can you come all the time? Because when you hold him, he stops crying … And then I was appalled, because I had some communication with parents, and they just didn’t want to come and see him. And normally failure to cry happens if you’re neglected. And I never knew what happened. And then there was a young girl—I did not take care of, and don’t recall her name. But she was kind of a life around the unit at the time, where she had so many chronics and had to have so many surgeries … that she was just never going home in the near future. And so, the nurses actually became almost like surrogate mothers. And so, they would bring her on their hip, with all her tubes … to report. And then they would carry her around the unit, and that’s how she got her love and touch. Those were probably the two most memorable.”

0.12.38 “And probably the other one, when I was a senior, there was a young girl who had lupus. And one of the side effects, or comorbidities, that you can get if you have lupus is kidney failure. And her kidneys indeed failed, and she had a kidney transplant. But she was sick of living her life being connected to a machine. And she couldn’t even come in three times a week—she couldn’t stand it anymore. And one day when we walked into her room in the morning, she had disconnected her shunt in her wrist. If you disconnected your arterial-vena shunt, you bleed out in less than three minutes. And she was gone. And I just remember being so shocked, because she was so young.”

0.13.28 “And I guess I have another one too as I’m thinking back. There was a young man when I worked at the oncology unit. And he was dropdown-dead gorgeous, and he was a farmer, and he was 18. And he was diagnosed with an acute leukemia, and his prognosis was very dim. So, he came in exceedingly healthy, and I got assigned to him, and I kept thinking, ‘What are we gonna do?’ Because in the beginning years you want to do things with tube and things, and you don’t focus on therapeutic things. But we were assigned to talk. And we played euchre—he tried to teach me euchre—I was horrible and all that. But our biggest conversation, the learning, was he was agnostic, and he had no belief system. And me coming from a really traditional Catholic upbringing, it blew me away that somebody could be that sick and have no belief system. And I asked him, ‘What do you think will happen once you pass away?’ And he ceased said, ‘I’ll cease to exist’—I’ll never forget his words. And I wanted to say, ‘Oh, doesn’t that bother you? That there’s no afterlife?’ And he said, ‘It’s just the way it is; that’s what I believe. You have your belief system and I have mine.’ And I said, ‘Okay,’ and he continued to play euchre with me. And over the course of that semester he got increasingly ill. And you’re rotated to other clinical patients. And I came in on the last clinical day with my patient preps all done, and my instructor called me aside and said, ‘You know what, Carrie, one of the patients on the floor requested that you have him today, and so we’ll switch your assignment.’ And I thought,

'Great'—because I'm not prepped. Well, it was this gentleman—this young man who I'd had way back in January. And I'll never forget that either, because I walked in and he grabbed my hand and said, 'I am dying, and I know that, and I think it's probably today or tomorrow, but I wanted you to take care of me today, and will you just sit with me?' And we had some wonderful conversations. And patients give you gifts. It's not monetary, and it's not something that's tangible. But they give you un-tangible gifts. And the gift from him to me that day—I'll never forget it—he basically said, 'You know what? I've seen the light.' And I said, 'See the light?' And he said, 'I've crossed over. I saw what it's like when one dies, there is a life after, and I do believe, and I wanted to share that with you. And I will be okay, so do not cry for me, but can you just sit?' And I just sat. And he died that morning, and—yeah. I just remember him. But what a gift. I'm starting to cry. And some people might say that he did that just to do it. But I don't believe that. And at that time, that was in the seventies, and at that time, conversation regarding death and dying were just beginning. And Dr Kübler-Ross was interviewing thousands of people, to put together her theory of what you're going through in death and dying … And I really believed that there was a science and that people did go through different stages. And so, for him to do that, that was unbelievable. But you do carry that with you."

0.17.46 "So they gave me gifts. And I figured out that just being there—just being present with people—is so important, versus the physical care, sometimes. So, he gave gifts. That young girl who committed suicide gave a gift of having a peek into someone's world who's 'I can't do this anymore' and making that decision."

0.18.22 On how these experiences influenced interviewee: "I think so [that these experiences caused interviewee to think more about mental health]. When I reflect back, I always was a people person. And I think when you look at my personal belief on mental health even back then was the fact that if a friend called you in grade school and needed you, you were there for them. In high school, somebody had difficult in math or broke up with a boyfriend, you were there for them. And this is looking back—there was something there. But you recognize that we exist on so many planes and it's not all physical. And you have to be okay mentally to go on physically. So, it might not have been classified that way, but it was always important for me to make sure that everybody was okay. And then the experiences you went through in nursing school, you became more and more aware of how important … body, mind, and spirit, the whole person, is. Back then we used to say you have to take care of the entire person, including their spirit. That all influenced the importance of mental health."

0.19.53 "And I think the other thing, going into practice, I knew as an undergrad that I was going back to graduate school. Because I wanted to teach—I didn't necessarily like all the teachers I had, I didn't think they knew what they were talking about. But that's a young person's perspective." At the time, had to practice for seven years before you want into education. "So, I fought the system. And my thinking was, 'Why? Why does this only pertain to nurses? Because MDs take no time. So, when I got out, I truly practiced fulltime for a year, because I knew I was going back to grad school after that. So, I said, 'How can I get the best experience from a physical, physiology, pharmacological, psychosocial

standpoint, that I could best prepare myself to go back that quickly?' And so, I chose to go into a step-down cardiac floor, because at that time you could enter directly into the ICU. Now you can. And I did that for three months and applied for transfer into the intensive care unit. And then to further prepare myself I used to moonlight in the burn unit. And I thought, 'Okay, I'm at an acute care center—I need to have community experience.' And so, I also moonlit at a hospital that was based in the community. I wanted to see the full continuum and see how everyone was affected."

0.21.50 "And mental really permeated all of that. Working with burn patients, there was a lot of death; there was a lot of disfigurement. Just maintaining emotional stability for them. Intensive care unit patients—again working with death, working with their family. I had the fortunate or unfortunate experience of working with the very first toxic shock child in Wisconsin … It was a new disease back then. It wasn't even coined at that point. But at that time, there was a tampon on the market. They were really thick—I can't remember the name … And what the girls were doing, and they weren't changing them each time they were going to the bathroom. But then when they did change them, they caused an abrasion in their vaginal canal. And that opening allowed bacteria to get into their bloodstream, and they became toxic and went into shock. And at the beginning, people were dying—and I want to say dying right and left—but there were a lot of people who died, because nobody knew what this was. And I still remember—she was 16 years old, a basketball player at one of our Catholic schools in town—came in Sunday night not feeling well, high fever, vomiting. And she had been vomiting all day. They thought it was the flu. But because of her temperature and just the way she looked, they brought her to the ICU. We were all dead tired, it was the end of our shifts, and honestly nobody wanted to take on another patient. But some of us stayed and took on, and I left. My colleagues stayed because they were on second shift. And then we were jointly assigned to her, I want to say over the next 30-45 days. And over that time, we worked with the CDC, took blood samples, and nobody knew what it was. And the same thing started popping up in Madison, on the east coast, on the west coast. Women were coming in with signs of shock … And we would hit them with everything … But in those days, kidneys would shut down, the antibiotics weren't effective, and that little girl passed away. But again, spiritually, emotionally, being there. And knowing as a nurse you don't pass it off to the clergy, because they're not always there. But that's part of our role as well."

0.24.44 On mentoring during clinicals: "Oh yes. Actually, my mentor is one of my best friends now. And it was my very first clinical, fall of junior year. And right now, she's in Utah, finishing her career there. And she pushed me like the dickens—matter of fact, I got migraines that semester. But she just kept pushing me, and we laugh about it to this day. But somewhere along the line … we had conversations and I'd say, 'Why did you do that?' And she said, 'Because I knew you had potential, and wanted you to work to your potential.' … She's a force to contend with … She was very hard on me—expected a lot. The bar was set very high. She did Socratic questioning. And so, once you demonstrated you knew this, there

was always one more question, and one more question, and one more question. And as a student this really raises your anxiety!"

0.26.23 On memories of first days at work after graduation: "I think it's the assimilation into the role of an RN. You know, because you've been educated for so long to become one. And you take your last exam—and I remember one of the professors saying, 'There's no drum roll. No one shouts from the mountains. But suddenly, magically, you are this.' But that happens in every professional's life. I think it's the same thing. And all of a sudden, you're at the job, and you're with all of these people you don't know. And you're expected to be on your own, so that's challenging. They had a three-month orientation period, which was nice. But because nursing has always been a profession that there's not enough of us in, you know, in my orientation program when I went to nights, there was times I was the only person on nights. So, I'm not sure who was orienting me! So, it was trial by fire. So, it was just challenging, anxiety-provoking. Also, during that time you're prepping to take your licensure exam, and at that time everybody was herded into the arena downtown. And when you walk in you have to have picture ID, and they check your picture. And people walk back and forth around tables when you're taking this exam over two days. So, a lot of anxiety. So, it's just learning to become confident and competent. And just learning to navigate—you're hard on yourself, because you expect yourself to be perfect. And I did a lot of research in my later years on the culture of nursing and healthcare. And unfortunately for me and for all of us, we tend to be perfectionists. And so, we tend to be hardest on ourselves. But on the flip side, if you're taking care of people, I would hope you would want to be really, really good."

0.29.07 On learning about culture of hospital: "It would have been nice to have a mentor there, to say 'Look out for this or that'. But that doesn't occur. You learn it as you experienced it. And then you had to sit back and reflect on it. 'Did my day go well? Did it not go so well?' If it did, 'What was under my control?' You learn quickly who you want to go to for help, because they're more relaxed about it versus expecting perfection all the time. So, you learn over time, I would truly say. No one tells you what it is. You get a mission and vision—the organization's mission and vision. And the people who work within the organization do not always emulate it."

0.30.18 On the community of nurses within the hospital: "I think there were unspoken boundaries. The commonality was your orientation class. So, when you were in big group initially, everyone was mixed. Then you get assigned to units. And I worked in a hospital that was circular and had four quads—orange, yellow, blue, and green. And I worked on the orange quad. And over time, the orange people kind of sat with the orange people. And the cultures kind of assimilated that way. And then how you learned about what was going on in the other units was really through conversations with your friends who you had initially come in with, who were on the other units. And then there were times that you'd wish you were on the other units, because the manager was more understanding. We were fortunate that the unit I worked on, our manager was a 'lifer,' and she was just well grounded and just really relaxed and never got flustered, because, you know, she saw it all. So, we were very fortunate and had a good culture."

0.31.57 On working with other staff in the hospital: “This depended on the person. There is a hierarchy that exists in hospitals and always has. And depending on what person occupied what role, the hierarchy could be more pronounced or less pronounced. And you just knew which—it was passed on by word of mouth through the other nurses, ‘Stay away from so-and-so;’ ‘Don’t call so-and-so at this time of night;’ ‘This is what this person likes.’ So, they’re kind of teaching you how to kind of live within the culture. But by doing that sometimes there was poor interactions; for instance, there was one physician who would just scream at the nurses no matter what and was just so obnoxious. But instead of anybody confronting him, they would just let it perpetuate. So that culture was not good when he came on the unit. When other people came on the unit, it was just really relaxed and free-flowing and collaborative, and you were part of a team. So, you kind of learned—you also got verbal cues, or you just look at the faces, the body language.”

0.33.38 On the hierarchy: “The hierarchy has changed over time. However, it still exists. And the strength of it, again, depends on who’s in what role. The differences that’s caused the change in what’s occurred, the shift, was the healthcare environment and also all of the quality improvement, and patients getting more involved in their care. Partly there’s more collaborative interaction with physicians. But we also academically teach people how to collaborate. So, there’s more being done at the front end to mold what I call being a good citizen. And sometimes it doesn’t work.”

0.34.40 “Well, it’s interesting, because healthcare—if you look back at the culture of healthcare, the first hospitals were established by nurses around the turn of the century. And the physicians got more involved in a business sense when they realized it could be more profitable.” “Healthcare organizations mirror to a great extent the service—the military—where military is hierarchical, very patriarchal—and that’s what hospitals were in the ‘20s, ‘30s.” Some studies suggest that there are important cultural similarities between hospitals and military environments; including some crossover of personnel between medical and military professions. Also feels that to some degree changes mirror the progress of the women’s movement. For example: *Maude* traces a life from late nineteenth through twentieth century and reflects the generally drastic changes of the times.

0.38.06 Interviewee worked for one year fulltime before going back to school. And then went back to school and made sure that continued to be part-time for 8-10 years at two different jobs, “because I still wanted to increase my skills and maintain my confidence in practice”. Taught in spring and fall, but in summers worked fulltime in hospital, moonlighting on weekends at community health hospital.

0.38.54 On ‘fighting the system’ to go back to school: “Academically, I was strong. Academically, I had gone to Madison as an undergrad. And I think people just listened. There was that criterion that was in the books, and it was addressed, and I explained, ‘This is what I’m doing, why I’m doing it, and this is my goal.’ And it just went away. And if I’d just sat back and waited, they’d have been fine with that too [laughs].”

0.39.49 Bachelor's and Master's received from UW-Madison, and PhD from University of Illinois, Chicago, with coursework at Kellogg Graduate School of Management, "because I wanted the lead person there on my dissertation because of his background, and he actually is one of the lead guys at Kaiser Permanente now, in California."

0.40.28 In Master's, took a Master's in Science with a focus in nursing. "I was an overachiever, so I did a triple Master's. What it was a Master's of Science, but with three concentration areas. And so, for practice, it was a cardiovascular clinical nurse specialist. I knew I wanted to educate, so adult education was the second one. And the third one, because I wanted to research in healthcare, was healthcare systems leadership. And in that prong, I was able to take a number of courses … through the College of Business, which I absolutely loved."

0.41.22 On the idea of teaching nursing: "As a student, I really developed it as a student. And then the other thing then that I began to develop, and probably developed more fully when I was in my Master's program, is that I always wanted to join education and practice or service and education, whichever way. Because at that time, there was a split, meaning they worked parallel to each other. It was almost in my mind like toddlers in parallel play. And yes one fed the other. But in order for education to feed service or practice, you have to understand what practice means—in my mind, more in depth than what we are. And even at that time, I was shocked to find that there wasn't joint meetings … But in hindsight now, I understand it more. Because at that time, nursing was still trying to find its ground. So, in the '70s and '80s—it wasn't until the '90s that this changed—they would have the administrative staff of the hospital, they could be in one tower of the hospital and then nursing would be in a separate ... and they didn't have the same support. So, it's kind of like everything was evolving."

0.43.14 "Because how do you communicate? How do you run down the hall to say, 'I just had this brainstorm idea' or 'Help me with this.' And it's just the hierarchy again. And it's really reflective of a lot of things going on in society. We were very different. I'm pleased to say though I've realized what I wanted to do. I mean, I was able to do lots of things, and you know, after my PhD, I opened up my own consulting firm, and became an external consultant to healthcare systems. And we were a thinktank to envision what healthcare of the future—which is now today—should look like. And I'm pleased to say that things are in place. Still need to be tweaked a lot, but they're there. And I knew that I wanted to be in academia. So, after making my inroads on the service side, knew I wanted to be back there … But the fun part is in the last 20 years, I've been able to be on the academic side, but be involved in an administrative position for 10 of those 20 years, where we could shape curriculum and policy. And we were part of a strategic planning group that actually formulated a committee across the state of Wisconsin, where the nursing administrators and the academicians meet 2-4 times a year in the different regions, to work on initiatives that are collaborative. We're at the same table, talking. It's really fun. So, I was president of that for a while. And I also had the opportunity to be chair of the American Association of Colleges and Nursing, and education group, and through that worked with educators across the country to shape the curriculum moving forward.

0.46.04 As a holistic practitioner, felt that needed to know the family and patients; felt that can use those things to help them get better. Holistic practice is getting to know people from a 360 view. And interviewee imparts that on to students. "Therapeutic communication: the mental health of a patient is equally as important as their physical health, because the two are intertwined. And so, always practice that. Always do projects where they had to address those aspects."

0.47.42 In 2007-08, interviewee ran for Associate Dean position at Marquette, transitioning out after 10 years. "This was at the time when care was too expensive and wasn't necessarily the highest quality. So, the question was how we get our students to be better clinical decisionmakers and see people and reach out to people holistically, so that we're getting them ready to take care of patients for the next generation. So, we had thinktanks at the college with people from every specialty present. Lots of headaches, because we had to work progressively. And we develop a curriculum that we thought was strong in critical decision making. And part of it was we wanted to de-stigmatize certain areas in health. And so, we looked at, as a thread, freshman to senior year, we threaded mental health concepts. The other thread we put in there—we believed people needed to understand that only a percentage of the time does a person interact with the acute care sector; they need to know what comes before or after … So, we had a project that required thinking about community health and think about that holistically. And we looked at leadership, because they needed to be leaders. And we looked at ethics, because we wanted to develop them further on their ethics. And we did spiritual development … We also deliberately infused quality and safety education as a thread."

0.50.59 "So let's talk about mental health. Out of all of them, mental health is probably the most disenfranchised. Traditionally in curricula, we would offer mental health as a course. And you may or may not have gotten a clinical rotation. That's how curricula were structured, and it was almost a silo-ing of that. 'Okay, I'm learning about mental health this semester, and I'm done with that and I passed.' … But how do we get them to realize it's important in the total picture. And that's why we threaded it. So, freshman through senior year, we made sure we had simulated experiences and we also had patient care on assignments that really helped students understand and work better with patients with mental-health conditions. And you know when you're thinking about mental health—not everyone has schizophrenia or psychosis … Anxiety is one of the biggest. And we still have to learn to deal with it. And the goal was—we also instituted where they had a standard assessment of the status of someone's mental health. And we wanted by the end of the four years for that to be just second nature—when they did a physical assessment, those questions would just be added in."

0.52.38 "And part of mental health is safety too." Instituted idea of keeping "going upstream" with other questions to probe safety (seatbelts or funs). "And in essence, after all this, seeing how stable is the individual."

0.53.32 On stigmatization of mental health: "For me, it means you label someone and it's a bad label. If they have a mental health issue, you avoid it. If they're mentally ill, they're different from you and therefore they're not part of the community in which you live. So, trying to get them to recognize that we all have something as

part of us, our past, or our relationship. And it doesn't mean that it's bad. Like, someone had an appendectomy or appendicitis or a heart attack; this person had a nervous breakdown. Somebody has psoriasis; this person is a manic depressive. So, normalizing it more, if that makes sense, so that they're not giving any negative vibes to it but instead trying to treat it and trying to help the people deal with it so that they can function."

0.54.50 On where the stigmatization occurs: "I think it's everybody [both general population and medical professionals]. I think yes. I'm gonna say yes. And I had a think in my head about factual data that made me arrive at that decision. Because you know, when you did your mental health training, you always heard about the worst-case scenarios. And then, you know, nobody wanted to go to, like, Mendota, the state hospital, or who wants to go on a locked ward. I mean, there's something wrong with them, so why would we deal with them? So, treated very differently. And because our instructors might have been anxious around them, that is passed off to you. And it's the same thing. So, we have to have the teachers be sensitized to it and to recognize it."

0.56.08 On changes in healthcare in Wisconsin: "It's too early yet to say. But what I can say that there have been huge movements." Interviewee used to be on statewide board looking at how to care on people with mental-health issues in the community and noticed the big change from an in-patient to out-patient focus, except for the criminally insane. "Because, again, it exists on a continuum."

0.57.09 "A lot more people wanted to go into psych. Another change is that people freely talk about conditions in class, and it's not necessarily hidden. Or students will say, 'So-and-so is on this antidepressant medication.' It's conversational, versus something that's taboo."

0.57.43 "It's just conversational and it's also done from the perspective of 'Okay, they have it. So, what can we do to help? Is there something that can be changed in the environment?' Reminds interviewee of the changes in attitude towards service animals over time.

0.58.14 "They're normalizing it, and you can see it. They're not nervous around it. The behavioral patterns, you know, they don't ostracize. They include."

0.59.03 On challenges for healthcare and nursing in Wisconsin: "We're so short of nurses. The shortage is huge. And the problem with the shortage, while you're trying to decrease the shortage, the shortage stays the same and gets worse because people are tired out there and so they leave. So, I would say the shortage is huge. The other thing is how do you get the supply up. Faculty are aging, and it's not a high-paying profession [faculty]. There's not enough space on academic universities to have larger classes necessarily. And then if we don't stop teaching traditionally—you have to have so many hours working with clients in a healthcare facility. It's not mandated, but people come up with a magical number and say, 'So much.' And I question if it has to be that, or if we can be creative and, say, use simulated experience. Some of these conditions are rare and might only be encountered once or twice—and simulation might be a good way to go."

1.01.11 On simulated clinical experience: Worked with engineers to design a mini-hospital in our college, "and they're very fine-tuned. We hired someone who's the president of the National Association of Simulation to look at how do you

develop these scenarios. It's taking them through a patient-care situation when it's not real life, and so therefore the danger—the risk if they do something wrong—is minimal. But even going through the simulation, it helps them function when they come to it."

1.02.53 On something that the interviewee would change about nursing in Wisconsin: "You know, I think at the advanced practice level, the education really could function in a general practitioner sense—like, a family physician—they could function independently, versus having a co-signer or a person who oversees them." This is a state-by-state variable requirement. "Probably the other thing is, it would be really cool if all of the boards of nursing across the states could get on the same page and function under their own charter, so to speak. The problem is that every state has a state board of nursing—and that's not itself a problem—the problem is who sits on that state board, and the requirements vary from state to state. There's some states where the board is entirely comprised of MDs, and other states where the board is almost entirely consumers, and maybe one medical professional. And because of that, we're not necessarily in control of our own practice. Now, I think you need to have oversight without a doubt … But it's very hard to get everyone on a consistent playing field." For example, every time the nurse practice act opens, they're afraid they're going to lose privileges. "Doing this would open more opportunities and would help provide more healthcare for individuals" if everyone could function doing what their license allows and what they're competent to do, this could help to decrease the backlog in healthcare systems and the shortage in nurses.

1.06.01 Feels that Wisconsin is one of the most progressive states in nursing, insofar as nurse practice acts are not restrictive, and there's a lot more in terms of what nurses can do, in terms of oversight or an order from a doctor. "To bring it down, I can remember when I was in Texas—I was speaking at something or other—and I was talking about what people can do. Here, if you look pale and woozy, we'd put you on a chair and check your vital signs. That's an independent action that I would do, based on what I saw. And a friend who moved down there, and was practicing, she can't independently make that decision to do that. That's just crazy." Generally, differences between what nursing and advanced practice practitioners can do, even though RN certification is national; different states have different pass rates. So, students encouraged to take exam where expectations highest, so that it would be easier to move from state to state. License bears seal of state where you're licensed, so would still be subject to their rules. Some states are 'compact states,' meaning that no re-licensing required if you move to them, although you may have to do a continuing ed class. In other, 'non-compact' states, requirements are more onerous.

1.09.53 Feels that this arrangement is very limiting for nurses and healthcare provision, but that things are better than they used to be, with more 'compact' states.