The Clinical Center
National Institutes of Health
Oral History Project
Interview with Dr. Gwenyth Wallen
Conducted on August 16, 2022 by Holly Werner-Thomas for
History Associates, Inc., Rockville, MD

HWT: My name is Holly Werner-Thomas, and I'm an oral historian at History Associates Inc in Rockville, Maryland. Today's date is Tuesday, August 16, 2022, and I am speaking with Dr. Gwenyth Wallen for the Clinical Center at the National Institutes of Health, or NIH. This is a virtual interview over Zoom. I am at my home in Los Angeles while Dr. Wallen is in Bethesda, Maryland. Before we get started, can you please state your full name and also spell it?

00:13:30

GW: My name is Gwenyth Reid Wallen. It's G-W-E-N-Y-T-H middle name, which was also my maiden name, R-E-I-D, and then Wallen, W-A-L-L-E-N.

HWT: Thank you. Dr. Gwenyth Wallen is the branch chief for the Translational Biobehavioral and Health Disparities Branch and formerly deputy chief nurse officer for research and practice development and the chief of nursing research and translational science at the National Institutes of Health Clinical Center. Her clinical research specializations include health behavior and health disparities research with special emphasis on methodology and measurement and end of life care, integrative health, and vulnerable populations. Prior to beginning her career as a clinical nurse scientist and nursing administrator, she held advance practice roles as a clinical specialist for neonatology and clinical manager of a Level 3 NICU at the Washington Hospital Center in Washington, DC. Dr. Wallen

also served as a postdoctoral research associate in the Department of Family Studies at the University of Maryland coordinating evaluation research for three state and local responsible fatherhood programs. Dr. Wallen is a member of the Eunice Shriver National Institute of Child Health and Human Development Institutional Review Board. She serves as an adjunct associate professor for behavioral and community health, UMD School of Public Health, and as an adjunct clinical instructor, University of Michigan School of Nursing. Dr. Wallen has a BS in nursing from the University of Maryland, an MA in business management and supervision from Central Michigan University and a PhD in health education from the University of Maryland. In 2008, she completed the two-year University of Arizona fellowship in integrative medicine as part of her developing portfolio of integrative health research. Does that all sound about right?

GW: It does. It just skips one of my titles, which was previous to the past year. For five years I was the Chief Nurse Officer for the National Institutes of Health Clinical Center, so responsible for all the nurses that are passing at the Clinical Center, as well as credentialing and privileging nurses throughout the NIH during that time.

HWT: That sounds like it was about 2015 to 2020. Is that correct?

GW: It started January of 2016 and then continued until 2021, June of 2021.

HWT: Okay. Thank you so much. Again, very important to know. Let's go ahead and dive in. Could you describe your background in relation to your career path, and what initially led you to this career?

GW: Probably if I go way back. I grew up in a family that was traveling globally. My dad was in the Navy and then in the State Department. I was born in Italy and then spent most of my school years in Latin America. About three to three-and-a-half years in each country. Mostly Spanish-speaking countries. So, Costa Rica, Colombia, Chile, and Uruguay. Part of my interest in public health as well as underrepresented communities stemmed from growing up. Although I look a certain way, I am bicultural by nature because I grew up for so many years of my formative years overseas, going to school with other children from each of the countries, so international schools. That kind of set the stage for what I was interested in.

I've always been interested in math and science, but also in service and care of people of all different nationalities and social—just diverse. I'll just say diverse, diverse human beings and considering them as a whole human being.

When I was in high school, I was at a crossroads. Do I want to go into nursing, or do I want to go into medicine? I chose nursing because of the holistic approach to human health, and I became very interested in pediatrics as well as neonatal care. And when I was a student, my parents were stationed near the Bethesda campus. And as it turns out, I came as a student and worked as one of the summer interns with nurses in the National

Cancer Institute. From then on, I was hooked on research, but it was about 20 years before I came back from the clinical to research. And I stayed very interested in pediatrics. Came for about a year-and-a-half as a new nurse to work with Phillip Pizzo's group that at the time had a laminar flow unit at the Clinical Center. I was a brand-new nurse. Lost many of our patients that were on phase one trials and felt like I needed more experience with other patients. One of the nights, one of the moonlight physicians that was on the laminar flow unit with pediatric oncology branch at the Clinical Center was a neonatologist. I had been interested in school in neonatology so I decided that I would start searching for a job in a neonatal ICU. That's what took me to a career that spanned about 18 additional years but focused in the NICU and specifically at the Washington Hospital Center. When my family moved, my husband and I for a couple of years worked at the Medical University of South Carolina in their NICU.

I became even more intrigued by research because we were saving smaller and smaller neonates. So, like 500 grams and less. I thought there's got to be a better way on the promotion side of – and that was at the beginning of when we were studying mothers with HIV and whether we could, if we were saving these 24-week gestation babies, what could we do to help them develop mentally? I decided at first that I was going to go the management route in business management and policy, but I decided that I was missing that science piece that I had so loved my entire life, and so I decided that I wanted to explore getting a PhD. I went back to school, and I again was at a crossroads in my early forties, which is late, but it's not uncommon for nurses, particularly, to decide that they want to go into and get a PhD after they've had a long clinical focus. I was deciding

whether to go strictly into nursing or to go the public health route, and I was very interested in working in the Hispanic/Latino community, Latina community, and so I found a professor at the University of Maryland in College Park who was doing work with the cooperative extension in Maryland. They had a grant which was following women from prior to delivery, so prenatally through postnatally encouraging breastfeeding, as well as nutrition and delaying early solid foods with their infants. So, I started doing community visits and embedded my dissertation into that grant.

I was able to work for four years in, at the time it was a PhD in health education, but it became what's currently the School of Public Health. Because many people didn't understand what health education was, that it was more of a public health view of things, and prevention. They decided that they would rebrand that school and really focus on the whole public health piece.

While I was there, I was trying to decide, do I want to stay in academia, or go back to work clinically? I was there for a year postdoc, but I really missed the clinical aspects of the research. I was recruited to the Washington Hospital Center to work with them for about a year, and the director for women's health at the time became, it was in late 2000, became the chief nurse for the Clinical Center, Dr. Hastings, Clare Hastings. She was the chief nurse officer for the Clinical Center until the end of 2015. She had been my mentor for all these years.

When she came to the Clinical Center, I was still at the Washington Hospital Center. She said, “So how are you doing there?” I said, “I really miss research, and they don’t understand how important it is here.” She said, “How much do you miss it? Why don’t you come visit over here?”

She recruited me in 2001 to the Clinical Center Nursing Department and asked me to develop, which at the time was not what it is now, but a health disparities portfolio. Because she also had worked for a long time at the Clinical Center in charge of the NICU as well as the maternal/child area of the Washington Hospital Center and saw the need for approaching health disparities, particularly maternal/child health. She said, “We don’t have a NICU here, and we don’t have a labor and delivery, but we have plenty of health disparities that need to be studied.” That’s how I started back after almost two decades back at the Clinical Center.

One of the things that I remember well is that one of my NIH new mentors from the National Institute of Arthritis and Musculoskeletal and Skin Diseases said to me a couple of years into my work with her at one of the early intramural clinics, which was in Columbia Heights at the Cardoza Clinic, she said, “You know, Gwen, if you do a really good job you’re going to get more and more responsibilities and more job titles.” I said, “No, no, I came here to do research.” But she’s right. That’s one thing I think at the Clinical Center, especially, because you wear your clinical hat and you wear your research hat. You tend to have to navigate those hats at different times because it’s important to balance the responsibilities we have as clinicians and myself as a nurse, and

when I was the chief nurse, the focus was on patient safety and human subjects' protection but also with advancing the science. Early studies that I did were in palliative care. I wanted to see whether the palliative care team, which was relatively new at the time, headed by Dr. Ann Berger, I wanted to know whether patients should seek palliative care early on in their trajectory or wait until they had pain issues. So, we found that our patients actually did very well if prior to starting their protocols, they were being brought in to have palliative care services with the entire team. That was an interesting study because I had to stop it early because I was supposed to have over 200 patients. But at 158 patients, several of the surgeons that I was working with said, "I'm now a card-carrying member of wanting palliative care. I can't randomize them anymore to having palliative care before surgery as they're going through with these advanced cancers."

We learned a lot from the patient perspective, which has become and still is a passion of mine is the patient's perspective on what have – a patient who asked me, "You asked me what pain means to me, but I want to know what it means to you. If I tell you as a clinician that I have seven [on a scale of ten] pain, does that mean I get medication? Or does that mean that you think, like, I should tolerate it?" So just having conversations with patients became a big part of my methodology in doing mixed methods. So, qualitative work and qualitative interviews as well as quantitative. And it's evolved from when I first came 21 years ago. I think mixed methods is now regarded as a very important part of understanding individuals but also groups and communities. And not just an extra add-on.

So, in addition to that study, also working with other institutes like NIAMS, as I said. There was this feeling that our patients that were being seen that were immigrant patients down at the clinic that they were doing all kinds of different modalities to keep themselves healthy that might actually counteract some of the medications they were giving. One of the things that I did was go into the community and visit one of the apothecaries for the locals. They let me go in and take pictures. And they wanted, the owner wanted to know whether I was coming in there to try to get everyone to stop doing what they were doing that was considered not integrative but actually an alternative at the time to what they should be doing. What I realized was that there are many things in there that not only – it wasn't about that they were taking so many weird, ("weird" in quotes), types of liniments or oils, but also there was a big spiritual component to it. So, they had a lot of amulets and things that they could pray with or put with to help their pain. That also became part of an interview process including a paper that we wrote called "To Tell or Not to Tell," which was basically asking the patients do you feel comfortable telling your provider everything that you do. Some of them said, "I didn't before, but I stopped taking some of the things that I was doing because now I feel like I have access to care through this clinic" that's also doing the studies that were being done at the time.

And that clinic has evolved and moved in the last years back into the Clinical Center. But we're getting ready to go back into the community again, because there's a need to get representation in our studies by going into the community, not expecting the community always to come into the Clinical Center. So, I'm probably talking too much, but it kind of all goes together.

HWT: It's a wonderful overview. And I mean, there's a lot there. So, I want to ask you, you've anticipated a few questions. But I still, I want to ask you if you want to add anything. Like I said, you've given a good overview and some very great details, but I want to get a little bit further into some of those. But I want to back before we go forward, but I'm wondering why you chose to focus on health behavior and health disparities research. Now you did talk about your background in terms of being international and various things, but was there something else there that you want to add in terms of why those directions? And can you define each of those in terms of your own work?

GW: So, the health disparities piece for me, each of the studies that I've done and each of the clinical places that I've gone, I've seen how where you come from, whether you have access, what you know about health, affects your overall health. It can go anywhere from chronic disease to acute, and so that's where I got interested in the health disparities piece. How could we even the playing field? That was before people were really focused, as they are now in the last few years, on health equity and health literacy. As a clinician, I felt like the playing field was not level. I wanted to figure out how I could make it more level through research and clinical practice.

The health behavior piece for me was about having a toolkit that even if you didn't have access to care, what could you do that would help you in times of, like, to master some of the things that could keep you healthy. And so, over the years I've gotten really interested in this triad of sleep, nutrition, and exercise. And you can't change everything at once.

But if you can figure out where people could make some adjustment and provide them with some tools when they don't have access, then that's where health behavior becomes really important. It becomes more of a partnership, as opposed to, "You have high blood pressure. Go home and lose weight." That doesn't work. (*laughs*)

HWT: Very different, actually. Can you build on that a little bit? Because you also focus on neonatology – which is a word I have trouble pronouncing, for some reason – end of life care, integrative health, and vulnerable populations, all of which you've been talking about. But can you, from an outside point of view, they sound incredibly different. Can you take each of these in turn and describe these roles more specifically? For example, what is an average day like for you? I'm sure that's evolved over time.

GW: So, an average day for me now is really more in the mentorship role, so giving confidence to new investigators that your road isn't going to be as linear as people think it's going to be. That you might be like me, you might start in neonatology but then you get interested in like maternal/child health. Then you say, well it's this whole population, and they exist in a family which exists in a community. And then that kind of in health behavior, it's different than if you're studying one molecule or one disease.

That's what drew me to nursing, too. In a way, although initially they might not look like they're related, much of palliative care and integrative medicine are very similar and areas where people want to understand the patient's perspective, but often leave them out. Like what is a good day for one person is not a good day for another. Like quality of life

for someone with terminal cancer might be being able to get dressed and go outside on their porch and view nature, where for somebody else that would not be quality of life because they would rather be running a marathon.

It's also a challenge, because I often said early in my career that I made people at NIH a little uncomfortable because I was more of a serendipitous researcher. Like one thing would take me into another. Because I worked at the Clinical Center, I knew that one of my charges was to make sure that I was augmenting the research that was being done, as a nurse, being done already at the Clinical Center, not trying to deviate so far that I couldn't—because there were a lot of questions on the populations we already had that couldn't be answered as part of a phase one trial. Nurses initially in the intramural program at NIH were looking at self-reported measures. So, patient-reported outcomes and quality of life. But then we realized there was more to it than that when we started adding the qualitative components to it. And now in this new branch, we're going what seems backwards. But we're in the community, we see something, and then we go back to the bench and look and say gosh, there's something in their diet that's probably causing this, no matter how hard they try with their health behavior, so let's see what that potentially is, back at the bench.

HWT: That reminds me. I wanted to ask you, just as a quick follow up, I think it was when you said you said you were getting your PhD, you were out in the community talking to people. Is that when that sort of evolved for you, that aspect of your methodology in

terms of communicating? Or that happened before then? Can you talk about that a little bit?

GW: It happened during that time. I've kept that in my methodology since that time, of working in the community. One of the early things that I was studying was using cognitive interviewing. If I was asking a question, it was on a survey that was already validated in English, would those questions still be understood the same way by the mothers in the community who spoke Spanish? As it turned out, some of the things that I was asking, they were taking it a completely different direction, so language made a difference. So, it wasn't something that I could just translate and have someone who had nothing to do with the study could just translate into Spanish, and it would work the same way. And so, also getting their stories and trying to understand what was important to them just stuck with me.

I think that's one of the reasons why I was so interested in coming back to the Clinical Center was that Dr. Hastings was very much supportive of me having this community involvement in this community work, which traditionally was not a big part of the Clinical Center. But my thing was people don't live in the hospital or in the clinic. They go home to their communities. So that's a big part of the puzzle.

HWT: Really interesting. I'm glad I asked. You began in nursing but then you received a master's in business management and supervision, and then a PhD in health education. Can you talk about those decisions, and why each discipline is important to what you do?

GW: So, I think initially, as I told you, I was really interested in math and science. So, the business part I thought oh, well, I'm really good at numbers. I'm going to just love doing this business side of things. And I love to mentor people, but I also love managing systems. And I thought, I want to go in that direction sort of in the administrative area. But I realized that I love administration when it's part of the bigger picture. But it's not—there's people that love being administrators, I feel like. That's like what, and organizational change and that piece. And that really wasn't the direction. The further I got away from researcher clinical, the more I realized I want something different. And I didn't – at the time I thought I should have gotten a different master's [degree].

But fast forward a lot to five years ago, I could have never been the chief nurse with multimillion dollar budget, responsible for so much of the Clinical Center budget, if I hadn't had that master's in business. So, I thought I was leaving it behind, but it becomes really important as part of the grant piece, too. And my own budgets and how do you decide when you have a certain pool of money intramurally, how do you use that effectively for your investigators? But I definitely wanted to come back to the public health aspect. That's why I ended up going to get the PhD in health education and community engagement, really.

HWT: Let's talk about what brought you to NIH, and what you were hired to do originally. Again, you have alluded to that early, part of the overview.

GW: So originally, I, well the, for this last sort of part of my career, I was recruited by the chief nurse to come and start a portfolio in health disparities. It was to be a nursing-led portfolio and engage the nurses at the Clinical Center in research.

HWT: So, this might be a good time: you mentioned when we were talking about your bio—and sorry for my dog, she'll calm down (*barking*)—you were hired, you know, chief nurse officer, which you did for quite a long time. Can you talk about that role more extensively?

GW: I can. I had never aspired to be a chief nurse. The reason that I stepped in at the time, it was a very transitional time for the Clinical Center. You had a chief nurse that was leaving to retire after 15 years. But there were also some things happening at the Clinical Center that were in the popular press, too, about whether we were concentrating too much at the NIH on research and not enough on clinical safety and quality. But I had, out of the executive nursing team that Dr. Hastings had, I was the one person that had the background in numbers but also in numbers and data and quality. So, she had asked me whether I would serve as the acting chief nurse before she left. And for a while, even for me, it was I need to be an A-plus chief nurse. I need to concentrate on the basics, make sure our patients are safe and focus on clinical, but I don't want to give up my research. As it turned out, as I was getting my stride, really, [when] COVID came. So COVID changed a lot. I became very protective of our staff. Because nurses were really running the Clinical Center. In order to keep the Clinical Center and the studies going that needed to keep going, we had to have our nurses in the Clinical Center while others were

teleworking. Even the research nurse coordinators were able to telework. But our research nurses who took care of the patients were there. And we were learning, really, as things were coming along.

I began to realize that there were so many aspects that were unknown that I also had to give our staff confidence that they were getting the best protective equipment, personal protective equipment, that I would give them every piece of information that I could as things were moving forward, and that I would be there with them. I would visit the units and come and help them as we were moving forward.

When I look back, and Dr. [James] Gilman, the CEO of the hospital, will say that he contests when I said that I became less of a good mentor to my research staff because I was very focused clinically. And he said, but when you hear all these people talking as I was leaving the chief nurse position, then he says, "I don't think that's true." But my own bar for myself, I felt like I was—I was offered the opportunity to step down from the CNO position and go back to starting this new branch for Dr. [John] Gallin. He and Dr. Gilman supported that and have been supportive of me making a proposal to have this new branch.

Part of this new branch is really what I found most intriguing was one of the goals was to help other department heads at the Clinical Center who really are also focused very clinically but came to the NIH to do research, to collaborate with them and help them get their studies started. And let them know about some of the infrastructure that exists that

they also could have and be part of based on the support from Dr. Gilman and Dr. Gallin and their partnership. So.

HWT: And again, you've anticipated a couple of questions. I wanted to talk about COVID. I think you've said some things, but I want to build on that a little bit. We'll stay there for a moment. Because in particular, I wanted to ask you to talk about nursing during the pandemic. But maybe you could build on that by talking about the response at the Clinical Center to the shutdown. For example, originally – it seems like ancient history, just a couple of years ago – describe perhaps the first month of shutdown and then we can go from there.

GW: There was a lot of unknown. We had to have a lot of trust in each other, both at the Clinical Center level in the C Suite, but also in my nursing executive team, too. Because again, we were looking at the unknown. We didn't know, initially we didn't know what was going to be the best way to do the testing. Would we have reagents to do it? A lot of that discovery was done in the Clinical Center by Dr. Karen Frank, Chief of the Department of Laboratory Medicine and her team as well as Dr. Tara Palmore, at the time the head of the hospital epidemiology department.

And so, one of the good – I had this saying of the goodness of COVID. And one of the things that I think was the goodness of COVID for the Clinical Center was that the department heads, the clinical department heads, really had to band together to really understand each other's roles, because if one department went down because they had

several people infected or something on their staff, another department had to back them up. The nursing department was the biggest department, so we tended to try to fill in. I felt like I had to titrate sometimes, not offering too much, but like offering what the staff could also absorb. Because they already had so much that they were handling by trying to handle home, be at work, not know what they were bringing back and forth yet, and so that was difficult.

It was like you see in the press. Everybody, they, at the beginning all the nursing staff were considered heroes and heroines, and we had places wanting to deliver food and you know, and just things to show their appreciation. But as time went by, our patients and their families were also feeling like, you know, and the investigators, *when are you going to open up to more of the studies*?

One of the roles that I took on was that if an investigator wanted to bring in patients, their team would come directly to me. And I would be able to tell them, did we have enough staff, did we have enough beds, like where could they go. I ended up having a bioethics consult because that started weighing on me because I felt like I don't want to be responsible for slowing down somebody's research. That's too much for one person to decide. That's again where the strength of the team became really important. And also the trust.

Some of the staff trusted that we were doing everything we could, and some of the staff felt like they weren't sure because they were seeing things on the news that some

hospitals were holding back PPE and things like that. Which we did not do. As we learned things, we made sure that we implemented them quickly and across the entire Clinical Center. It was a balance, again, but a different kind of balance to make sure that we still could conduct the research safely. We're still not back to what we originally—we were running almost 200 patients a day on some days, inpatient, and sometimes 600, 400 to 600 in outpatient. We're still not up to that. Again, but, compared to other clinical research facilities, I still think we maintained as well as we could the studies moving through. So we were still doing surgery. We were still doing intervention studies and the Phase I studies. We were still doing transplants, stem cell transplants, all of that.

HWT: Was there such a thing as an average day during that time?

GW: No. (*laughs*) No, every day you thought you had an average day was a day that you were—it might sound trite, but you did see the strength of the human spirit. Because it seemed like there was always someone, whether it was a patient that sent a letter or a nurse, you know, that was just supportive, and felt supported, would say something. That's kind of what you needed each day to make it feel like you could go one more day, go one more day. There's still days ahead of us, too. The unknown, I think, was the biggest piece and trying to balance home and being at the Clinical Center.

HWT: Did you have staff get COVID?

GW: We did, and we had very strict protocols. We had a really good partnership with the Office of Research support and our occupational health colleagues. So, we did not, they did not, I don't know, actually if there was anybody that—there might have been one staff that might have gotten it early on from a patient, we weren't sure. Most of it was actually that they would contract it in the community and then we would make sure that they stayed at home, but they weren't getting it from the patients themselves. I don't have the exact data on that, but most of it was people that were going on the outside and then got it and had to stay home.

HWT: You've mentioned how research was disrupted. Is there anything you want to add to that at all?

GW: Just that it called on, again, that whole idea of partnership. It really, when you have lots of different institutes working and trying to prioritize which—we had not had to do that previously, really. We thought we did until we had COVID. Then we realized okay, there's only so many resources to go around, and we had supply line issues, too. At the time, we had a head of our materials management that had done a lot of logistics in the army, which was really helpful to us. Because he could kind of call out to all these different and try to figure out, but still go through the federal regulations for how things, but he understood like what to do when you don't have necessarily everything you need. Lots of things were still happening that, you know, would happen in any hospital still, but I think what was hardest were people that studied like the types of studies that I do, more of the health behavior studies. Those really did kind of, were just revving up again our

studies. Because, understandably so, the resources really needed to go towards the discovery for infectious disease, but also for cancer discovery that had already, like patients that already had. I think that most of our investigators would say that we're still not back to where we were before, but we're trying to get there.

HWT: In terms of unexpected outcomes, you mentioned this kind of teamwork. Is there anything else that comes to mind? Sort of unexpected outcomes. Things that have surprised you because the pandemic has happened.

GW: I think the, just the interdisciplinary nature of, although you know it, or I knew it in my mind, we are so dependent on our facilities. Like the Office of Research Facilities. Like it's really important if you're going to change a unit that's going to become available for only COVID patients, you've got to know who you're going to work with from the Office of Research Facilities. Because I'm not an architect, I don't know how the air gets handled. It wasn't just clinical people working with clinical people or our facilities people working in isolation. We had put in systems, including something called a morning huddle where it had been put in before COVID, but it became really important to maintain it, even if we couldn't be in the same room together, to have this morning huddle where people would have access to this room so that we could talk about all the things that had happened in the past 24 hours. And so, I think that to me that was a big, that was a big "ah-ha" moment, is how closely we were going to be—

Which originally came, interestingly, in Ebola. Because when we had Ebola, (*laughs*) I don't know how my luck works this way, but I was covering, when we got the first Ebola patients, Dr. [Clare] Hastings was the chief nurse, but she was away at the time. And so that's when we also realized how important these interdisciplinary relationships between facilities, you know, waste management, all these things, they go together. It's not this group tells this group what to do. And the level of trust, I think, is just, whenever there was a break in trust, it took a while to get it back. We had to be really careful. Communications became really important. Like you couldn't delay communications because you didn't want, and I would say often in our team up on the sixth floor, if we don't communicate this, our teams are notorious for making up the information if they don't have the right information, so we need to make sure they get the information. I think that became very obvious during the time, too.

HWT: Just one more question about that. Is your impression that that kind of learning from the pandemic is institution-wide? Or individual? In other words, talking with colleagues about these kinds of unexpected outcomes? Anything like that?

GW: I talk about it a lot with the people that I'm with. But I don't think that, and I think Clinical Center people talk a lot amongst themselves. But I don't know that people that weren't in, they didn't always have the full picture if they were outside of the building. So if it was a clinical director that maybe hadn't been in the building for a while, it was like, well, why can't I have more patients there? That kind of thing. But at the same token, I think we have had to realize that when people were coming back into the Clinical

Center in these last few months when things got opened up a little bit more, even though we still have PPE and screening, that we couldn't expect our physician colleagues or our colleagues from other departments, whether social work, nutrition, if they may not have been in the building for them suddenly to know exactly what was in our heads that we had been living for the two and a half years. It worked both ways, too. Because sometimes we had expectations when it was like well, how could they know how that worked.

HWT: Then you said you were sort of hitting your stride as chief nurse officer when COVID did hit. Can you talk about what your initial goals were for that position? And then how they evolved, obviously, before COVID? And then we've talked about COVID, if there's anything you want to add.

GW: One of the things that I was interested in, one of the things that I'm most proud of as chief nurse was the opening of the two palliative care suites on the third floor. For a long, long time, Dr. Ann Berger, Chief of the Pain and Palliative Care Service and I, ever since my first study had felt like yes, you're on a study, but sometimes you've been with these physicians and these teams, if it's a phase one trial it's not curative, but you've been with that team, you trust that team. You'd love to go home. If you can't go home, wouldn't it be nice to have an environment where we trained our nurses to truly take care of palliative care and have a high-touch, low-technology kind of environment in these two suites. That was one of my probably proudest things that we did towards the beginning of my time as chief nurse is opening that up with Dr. Gilman and others on the unit.

I think the other piece was, one of the things that worried me on the pediatric side was we were getting sicker patients and we did not have, I didn't feel like we had the right kind of monitoring that we needed. When they hired Dr. Zenaide Quezado, Chief of Pediatric Anesthesia to head up the pediatric anesthesiology group, she was also interested in having four beds that would be monitored beds where kids wouldn't necessarily be in an ICU setting, but they should be closely monitored by specialists. My vision was to focus on clinical. I felt like we had some areas where staff had been there a long time and maybe thought well, this is a research center, we don't have to keep advancing our clinical skills in all these different areas, but it was important that we do that.

We have a really strong adult ICU under Dr. Henry Masur, Chief of Critical Care Medicine. But we also needed to have a way to take care of pediatric patients. And that's continuing to grow. That's a big strategic initiative for the next years that will be there.

Then the last thing that I really wanted for us was to start a Magnet journey. So, we started the journey to Magnet, which is the designation for hospitals, it's really for the hospital. But it's through nursing as sort of the lead. It has shown that if you go through the tenets of Magnet and have better outcomes with your patients and more satisfaction with your nurses, and better relationship with your interdisciplinary colleagues, these hospitals tend to have better patient experience, also. They are on the Magnet journey. And I did not get to be the person to get them there. But I felt strongly that if we had a framework and got started, and so I put in place the funding for that to have a consultant.

And they continue to work on that. Then I'm going to continue to work with them on the research side of it, because Magnet hospitals have to have a research component that's headed by nursing. I'm assisting them with that.

HWT: Can you describe the Clinical Center when you first arrived, and then the evolution that you've witnessed since that time?

GW: When I first arrived, we were in the older building, in the Magnuson side of Building 10. We've moved over to the CRC side. I think the quality of our care is continuing to improve, our clinical care now. I think we are functioning at a higher level in terms of the data that we're collecting for outcomes. And even though we don't have to have some of the same – like, we are a joint commission accredited, and so we have all that piece. Some of the CMS things that other hospitals have to have, we don't have, but we want to hold ourself to a higher bar. Because if you don't give really care, then how do you know how the research is working? Baseline has to be superb care. I think we're getting better at realizing that reporting things is not bad. It's a way to get—reporting clinical issues through teams is a very good way to improve clinical care and improve clinical practice. Probably the biggest thing, I think, is doing more of the biobehavioral work. When I first came it was like, why are you here? Shouldn't you be at like AHRQ or HRSA or one of the, CDC? This is for mostly like bench science. I think it's evolved and continues to evolve and will continue to evolve to be more about that research of the whole person, that health isn't just at the cellular level, but you have to understand it all. It's going to be that going back and forth through the translation continuum.

I think our staff is more diverse than it was when I first came. We continue to have a lot of diversity within the nursing, within the nursing staff.

HWT: Just on that last point, I have a separate question about that a little bit later. But what do you attribute that to? Is that your own efforts? Are those ongoing efforts on the part of the center to recruit? Or what is the reason behind that change?

GW: I think that it's working together towards, like, saying that we could do better. Saying that our patients are diverse, and they want a diverse group of clinicians and researchers. So, I think it's not one person necessarily, but it's also collaborating with our human resource colleagues. While I was chief nurse, I developed a really good collegial relationship with human resources and just giving us ideas of how we could do, different ways that we could try to aspire to have more diversity. There were still issues about making sure that people are at all levels, that there are people in leadership, not just your staff level, but also midlevel and higher executive level. I think it's more of a partnership than any one person. I do think that in order to say that we want to be partners with our patients in research, we have to have partnership with clinicians that come from diverse backgrounds and diverse ways of looking at answering questions. I try to do that, and I try to have different ways of bringing staff into the Clinical Center. Like trying different—and I learned that from Dr. Hastings, too, that there's different ways of bringing people in that maybe is not the traditional way that every 20-year-old, or 22-year-old isn't ready to be a postbac, or to, if they have to support their family. So maybe

it's that they're working, but then they still want to have some training in research, but not necessarily as a fellow. There's different models, and that's one of the things that [we're] really trying now in our new branch to develop some of these models of bringing folks in at different points along their careers.

HWT: Then of course early on you mentioned that, and it's a new role, you're the branch chief for the Translational Biobehavioral and Health Disparities Branch. Can you talk about that?

GW: I realize that for my team, right now we're working to develop our strategic plan and kind of more of a solid mission because we have our funding now. I told our group, there's about fourteen of us, and there's five of us that are PIs, "think of it as a startup company." Because on days, it feels really risky, but on other days it feels so rewarding and innovative and fun that it does feel like a startup company. Because some of my investigators are very new in their careers, and they're in their twenties and thirties, it was just by chance I used that term, but that resonated with them. They've repeated it back to me sometimes when I'm sorry things are like, it seems chaotic but it's an organized chaos, but that's how science is sometimes. They said, "But if you think about it as a startup company, that's kind of what it's like." I think learning how to communicate with some of the new fellows that are coming out and making them also feel like it's a secure place to look at a tenured investigator and say, "I think there's another way to do that, or I'd like to know why your expectations are like this."

We're doing research that I think it's at a tipping point right now. I have one investigator who I brought on as a staff scientist, and she's studying cooking behavior but in the context of biological mechanisms and cognitive response to cooking and how the act of cooking and being like a part of all of your senses, how this can affect whether you take on a Mediterranean diet if you're an at-risk heart patient. It's taking all the best of everything that NIH has to offer.

I have another, a brand-new assistant clinical investigator. She's in her late twenties, early thirties. We have combined some data that we have from the microbiome with some colleagues that I've introduced her to at NIAAA that specialize in MRI of the brain of alcohol use disorder patients, and trying to figure out the gut/brain connection from what was see on MRI structure and what we see in the microbiome that we had tested in the lab. So it really is, it's just come, the where I started and where I am now is just, I could never have thought that that much could happen in such a short, it seems long to them, but to me it's like that's, if you think about it, it's just amazing that it can happen. So now it's also mentoring them in kind of the whole idea of getting papers out the door and all the NIH things that you have to do to make sure that you have a sustainable career.

But also, I think this group of investigators, I find them so exciting because they have this almost philanthropic mindset about the science. The science is amazing, but they want the science to matter. They want to see how it translates, and it's helping them balance that though so that they're not spending too much time in the community and not enough with the science, but so that they're both like moving forward together so that they can

advance the science and provide policy information and things like that. I think it's a really exciting time at NIH. I really do. I have two nurses and then a physician is our staff scientist and then I have a biostatistician who has specialized in genetics and genomics, and she's doing the microbiome work with us. She's another person who's been at NIH like 20 years. She's told me, I never knew that I could really advance like this way, in my science, in this methodology. So it's exciting. It's exciting work.

HWT: I'm definitely hearing why you feel that it's rewarding. Why is it risky?

GW: Because sometimes you, there's at NIH if, when you're a new scientist, I'll put it this way, new scientists, I feel like part of their journey is to realize that high risk brings high reward. You have to take a chance. You can't know the answer. We have had some investigators that have come and gone. They want to almost know what the answer is going to be before they start their research. Well, it doesn't work that way. We've got to put our funding forward to say we might not find anything, but if we do, it's going to be an amazing discovery. I think that that's—and also moving things around. Your lab can't stay static. Maybe 10 years ago I didn't need someone who specialized in bench science, but now I do because I have investigators that are going back to the bench. Or perhaps that money that could be spent on X shouldn't be spent on Y. But if we hypothesize this, we need to do it. It's those kinds of things that I think—

That's what intramural was built on was—at least, that's how I was taught—high risk, high reward. So, it's convincing them that it's not risk the way we think of risk like

disease risk, or risk of danger or anything like that. It's more like, where do you put your efforts into? I think what I'm seeing with, especially with this group that I have now, is that for clinical researchers there really is an art and a science to it. It's not all science. When you're a clinical researcher, there's an art to seeing, like bringing the patients in to help, have them help you design the studies and having the community help guide you on what's important to them. I think that's the thing that thing that has stuck with me over time is it's not always, the science is the priority for the intramural program, but because we're clinical, there's also an art to it, too and experience that you gain through not just all the successes but also some of the misses that you do along the way.

HWT: Which I actually want to ask you about, but I'm going to hold off on that question for a moment. How would you say what you do fits into the Clinical Center more generally?

GW: I think we fit better now than we ever have before because of the translational piece. I think we really are able to, because we're with the patients either in the community and/or outpatient or inpatient, we're able to translate fairly quickly back and forth. What I'm really hoping for is also that when we get to a specific point, that some of the work that we'll be able to do can be handed over to, like, the nurses at the Clinical Center to, once there's more evidence. Say it's for, like, cognitive behavioral therapy for insomnia to help patients with sleep. There's mounting evidence that certain programs work. We shouldn't have to keep studying it and studying it. We should be able to give it to them to be able to look at outcomes and do more of a quality sort of a quality improvement and practice kind of study. I think that's where we fit in is to try to generate pilots for people but also, to give them some direction intramurally on additional questions that can't be

answered necessarily by the primary questions on some of the disease-specific populations.

HWT: In this conversation of course, we've been talking about several successes, and I want to know if there's anything else you want to talk about in terms of what you feel are successful efforts. I also want to ask you about setbacks, which you just mentioned, or misses and describe what happened and what you learned from those experiences.

GW: I think some misses are really not always communicating my expectations or my own disappointments for something that I was doing, whether it was as an administrator or as a scientist and being able to share those experiences with staff without making them feel like it's all about me. Like there's this very delicate balance about saying, "I've experienced what you're experiencing now" without making it seem like it's all about me. Like, let me tell you about how it was for me. I think over time, what I've realized, too, is that I think early on in my career at NIH I took a lot of things personally. I felt like if someone said, "Why are you doing qualitative research, we don't do that here," I took it very personally and focused on that, and it's not personal. But it takes sometimes years of being in what you're doing and becoming more, having more expertise in like a certain methodology to realize that sometimes it's about teaching people why you're doing things the way you're doing it, why aren't you going straight into quantitative. Why is qualitative as important as quantitative in some certain studies. I think that was a big part of it.

I also think that leadership is difficult sometimes in any institution. At NIH, people come, and they're experts. Many of them are experts in their field. So you have to – early on someone said you've got to park your ego at the door, because you're going to be sitting next to somebody who discovered the gene for X disease or you're going to be sitting to the person who that disease is named after. If you spend your whole career taking everything personally, it's going to slow you down. I think it took me a while not to have that kind of feeling.

Also, as a woman scientist, I think, and as a nurse, because I was asked early on, "Why do you want to be a researcher?" Nurses are very supportive of the research that we have. Still there are not that many tenured nurses at the NIH or the Clinical Center. I think that over time that's been something that I wasn't willing to say. I haven't had a nursing degree since my bachelor's degree, but it's a part of my identity. It's part of how I view our patients and our community, so it's important to me. It fits well with the interdisciplinary team. But I think that, I still have misses with that sometimes. I go to meetings, and I have to kind of hold my own anger or my own sense that it's not about me, it's about really understanding that we each have a piece of this puzzle.

HWT: Interesting. I'm wondering in total, this is maybe a little broad considering your career, but I'm wondering what you think your work is built upon. What came before. Does that make sense?

GW: I'm not sure.

HWT: Well, in terms of, you know, in terms of, for example, you were talking about the role of nursing with research. So, you're building on that. Who came before you? Were there people or places that sort of laid the groundwork for what you've been able to do?

GW: They're definitely along, probably one of the people that I've admired the most at the Clinical Center is Dr. Christine Grady, the head of bioethics. She and I have worked collaboratively over the years. I've just admired the way that she has approached the research that's important for human subjects protection and the bioethics side of things. I think early on she's been one of the people that has, it's very difficult to say nurses can't be researchers when you have a world-renowned bioethicist that is a nurse and a researcher. I think she really put that foundation down.

There were clinical nurse specialists at the Clinical Center, many of them that aren't there anymore, that laid the foundation of saying, like, nurses can really begin to look at genetics. There was a nurse, a PhD nurse, named Jan Yates, and she had been there since before I was there. She had worked with NHGRI, and she had said everything goes back to genetics. She was one of those people that I can just vividly remember that she was always pushing the envelope for like testing technology before people were using that much technology. Testing new ways of making science exciting to nurses online and through websites. She laid that foundation, I think, for saying there are nurses at the Clinical Center that can do this.

I think, also, Dr. [Suzanne] Wingate, that was the Clinical Director for NINR, she had at one point been a colleague of Dr. Yates' also but then left NIH, came back to be clinical director. She was another person that I think before she retired, she was really laying the foundation that nurses can do research, they can be PIs, they have to be held to the same standards, the bar has to be high as it is for everyone else, but we can do it. I think she was a very good influence on the NINR while she was there as the clinical director. Because she brought our groups together and she sat as one of the last things that she was doing was sitting as the chair of the medical executive committee. She brought a lot of really good ideas to the medical executive committee at the Clinical Center. I think that also laid the foundation that nurses are very good researchers but also very good clinicians that can collaborate well. And she showed that through her chairmanship on the MEC.

HWT: And of course, you've received a long list of awards, including the NIH Clinical Center Director of Science Award and the National Institute of Heart, Lung & Blood Director's Award for diversity and recognition of exceptional work to expand the diversity of populations recruited. What are the major awards and honors that have been the most meaningful to you personally?

GW: I think the most meaningful one was the mentorship award that I received. It was unexpected and I had the person who had nominated me gave a presentation at the award that meant a lot to me. And she talked, she was early in her career. She received her PhD when she was with us, Dr. Alyssa Brooks. And she talked about how, which I never had

really thought about, but she said, “You have this way of pushing a person into doing things that are more than they thought that they could do. Then when that person that you’re mentoring accomplishes it, it just makes them realize that they have it in them.” Pushing wasn’t the word that she used, but just encouraging people to go outside of their comfort zone.

That really stuck with me, and that’s why mentorship became even more important to me. Because I think that there is a point where you are encouraging someone. And even most recently I had a postbac IRTA who is now just this week got their white coat ceremony at the University of Alabama, Birmingham. But we had difficult conversations because she said, “You make me work much more than any of the other postbac IRTAs that I know that are here. And I’m doing this independent work with you.” Then when she left, she called me back, and she said, because since then she’s been, two of the papers that she was instrumental in and a co-author on have been published and she got a postbac award at the postbac poster presentation. She said, “I really didn’t know.” She said, “I learned so much about myself and that there were things that I could do that I just didn’t realize I could do, and that it was hard work, but I had a lot to show for it.” And she was only with us for like nine months, but they were difficult conversations because the easy way would have just been to say, “Okay, we won’t do that.” But she’s extremely talented and extremely smart, and I think she needed to see that that work could translate into her being recognized for that. And including the poster, I said, “You have to own what you’re going to talk about.” And she must have done multiple, I don't know how many iterations, but the work that she did is beautiful. We just this week got a paper published

where she did the whole design of the graphic of how to explain this very complex system of cytokines and how they affect sleep in alcohol use disorder patients. I think that's the long story, but that's why mentorship's important to me. It's seeing what other people can't find inside themselves sometimes.

HWT: Wonderful. I wanted to ask you just a couple of questions, and I know we're at the one-and-a-half-hour mark. Just a handful of questions. I promise it won't take forever. Do you have some more time?

GW: Yeah, sure, sure. Yeah, I didn't make any other –.

HWT: I read in *Nursing Outlook* that you co-published an article last July defining the role of individuals prepared as a doctor of nurse practice in symptoms science research. Can you describe or perhaps give an example of a training model that supports collaboration? Which you've talked about a lot, collaboration. And perhaps some outcomes of these interprofessional collaborations?

GW: That particular collaboration, the one that was in the *Nursing Outlook* with Dr. Letitia Graves. She had come to me early on because she was the Robert Wood Johnson Fellow at NINR. She had come to study there, but she also wanted to be attached as closely as I was to clinical. One of the things that we did after we wrote that paper was, I connected her with one of my team members, who was also an early investigator who had expertise in looking at symptom clusters. Dr. Graves is now an assistant professor at the University

of Texas. She has been able to continue working on her topic of interest by having two PhDs and then being able to work with also the clinical DMPs, which are the clinical practice part of the doctorates in nursing but also focusing on spinal cord injuries. Also rehab medicine allows the cross-fertilization of these PhDs and looking at symptoms which could be pain issues but they could also be, we often put sleep in there. Pain, nausea, all kinds of symptoms that you can imagine. I don't know if that answered your question, but that's sort of how we start.

Other ways that we've started interdisciplinary teams are to start a, by starting a journal club. And sometimes we have a particular area of interest, and we'll start a journal club that has, like right now I have one between Dr. Frank, who heads up DLM and myself, and we bring in nutritionists, statisticians, microbiome people. There's only a small group of us, but we bring forward papers that maybe we don't know everything about but somebody else there does. Then through that we develop the collaboration and started supporting each other and getting ready to do a study led by Dr. Frank with us as collaborators that just got approved like earlier today with amendment. There's different methodologies for how to bring people together, other than kind of I need this or I need that. It's more like, it becomes more collegial and long-term.

HWT: Fantastic. In a completely different article a few years ago, February 2019, you co-published again, this one was called "Integrating Genomics into Oncology Practice." This was in *Seminar and Oncology Nursing,* in which you described the CC's experience in

integrating genomics into nursing practice. Can you discuss that experience a little bit here and why integrating genomics into nursing practice is beneficial?

GW: My interest in it started back when I told you, Janice Gates, Jan Gates was the person years ago, 20 years ago, she said, "Nurses need to know about genomics." And so, over the years, we got to a point where when I was the deputy chief of research and practice development, I felt like there were a few core competencies that all nurses at the Clinical Center had to have. One of them was to do evidence-based practice. Another was the role of a clinical research nurse, but the third was basic genetics and genomics. Because if you went on rounds with a team who was conducting research or you had a patient who was filling out the consent forms, oftentimes if they had more interest in kind of what was going on with the genomics or genetics side of their disease process, it would be the nurse that they would ask like in the middle of the night or something, right? They would say, "I was thinking about this, and do you know?" We felt like our staff really needed to know more about that.

We started, again, with that group we tried to do it more casually to start. So we looked to see where the gaps were. But we started with an interesting group, and we started reading Dr. Collin's book and several other of the like *The Double Helix.* We had this book club. We started it that way, and then we got people interested in wanting to teach it. And I gave the nursing department, we can't do everyone all at once, but over the next two years, everyone who's already here will get it. Then when they come new, they'll each have to come. We had a basic course and then an intermediate course. The basic course is

mandatory, and most want to go on to the intermediate. Some of the feedback from the staff was, "I finally understand when I'm going on rounds now like what they're talking about."

But to make it sustainable, it had to become a competency. Because otherwise, it's like, if you're interested, read about this, or if you're interested, read about that. And so, it needed to be a competency that they could sustain.

And the other thing that's a big part of nursing at the Clinical Center is what's called shared governance where the staff themselves are involved in their practice. And so through getting them involved in helping make decisions about what should be the competencies and kind of how practice should be rolled out in the Clinical Center, it's like community research in that you involve the people that it involves the most in what they're doing. But we had many of the really good investigators, like world-renowned investigators, come and speak as some of the faculty for the course. And so that really brought it alive. And then having the bioethics side of it. So that's how that evolved.

HWT: So let's talk about the clinical learning environment a little bit more. What do you feel is best practice in the clinical learning environment?

GW: I think the best practice is to listen first. See what, and not just listen to the nurses, but also listen to our interdisciplinary colleagues, to our clinicians. What are our physicians seeing? Where are some, where do they see maybe a lack of clinical expertise or where

we could improve some of our practice. Right now, one of the things that started, and I continue to mentor the clinical specialist involved in this, is, who has a DMP, is having the nurses all go through a neuro assessment so that it's part of what they do. So that they could be the first ones to be able to, a very comprehensive neuro assessment. So they will see quickly, more quickly, like that there's a changing neuro or cognitive change in a patient before they have to go directly to the ICU or something like that. So those, doing, part of that is also being open to using simulation and having an environment where people feel like they don't have to be perfect at it from the very beginning, and making them not feel like you're like, well, why did you do that? More like, "Just walk me through like your thought process when you did X in the assessment that you did." As opposed to, "Why did you do it?" And I think being non-punitive is also very important in a clinical learning environment. Allowing people to feel safe and comfortable to ask questions when they have them, or to raise them as, "There's an issue here. I feel like," you know, "My group doesn't understand this." And preparing them for the changes that are coming ahead, too.

That was a big part of the palliative care suites was really preparing the nurses that they were going to be going to the Casey House in Montgomery County and really seeing what it was about, and that it would change the way that they were going to be caring for some of these patients. So, yeah.

HWT: What do you feel can be done in the short and long term to increase the effectiveness of the clinical learning environment as the critical site for physician education?

GW: I think simulation is going to be a big; it has to continue to grow. I know that that's a big part of [what] Dr. Gilman is interested in as well as Dr. Masur because sometimes we don't have the same volume of patients that people are getting in clinical learning environments, like in a hospital that's getting hundreds and hundreds of admissions. You have to be able to have simulation to prepare people, but also to keep them sharp in between because we're also seeing new things. There's no book to read about some of the things that we're first seeing because they're phase one trials. But to have the clinical learning environment be what it should be, we have to continue to grow and bring in patients. I mean, that really is the goal, too, of bringing in, getting back to where we were, to having more patients and more experience. I do think that the simulation and interdisciplinary teams is really important. Because I think you have to know what the communication looks like. So perhaps there is a nurse practitioner that is more facile at something in an emergency situation than maybe a brand-new fellow. And how do you do that in an emergency so that you're not making someone feel like you're pushing them out of the way, but that you're actually bringing each person and their expertise in for the benefit of the patient at that moment in time. I think learning how to communicate in those situations is just as important as understanding what the physiological change or the acute change is at that time.

HWT: You mentioned communication. Just building on that a little bit, how would you say that you identify approaches or strategies that allow the medical education community and the profession to improve the environment that provides the context for physician education? Also how do you foster improved communication and emotional health?

GW: I think emotional health is a big piece of it. I think there is the "heal the healer" [idea], and I think there is, again, another tipping point right now at the Clinical Center to really focus on [the] wellness of each of the physicians and also of nurses but especially physicians. I think nurses for a long time maybe outside we're not taking care of ourselves as well as we should sometimes, but in clinical settings, nurses tend to, at least before COVID, band together and kind of support each other. I think that sometimes the expectation for, and this is coming from a nurse, that the physicians are supposed to have it all together, all the time. It's just impossible. We have to be able to support each other and kind of be watching, too, and be mindful of kind of, you can't be a healer if you're not healed yourself. I think that's a big part of it.

Also, I asked the nurses in the ICU during COVID, I said, "You all are the ones that are seeing, you just got trained to take care of the COVID patients. What does it feel like? What keeps you going?" This was early on in the pandemic. They said, "Because we feel like a community. We feel like a community in the ICU. We know that Dr. Masur is going to support us. The other physician colleagues, the attendings are going to support us, but our nurse manager is also there. She's right beside us. She's going to give us the information she has. And we function as a community." I think that's an important part of a clinical learning environment, too, is to feel like you're a community. I think the more we learn about diversity of community, diversity of community can be diversity of your community of your healers in specific areas. I think that was a good learning experience for me because I thought why are they able to still make these videos of how they're

banded together and they feel like a community and why are they willing to do–? It came from trust. Trust of each other in that community. I think that continues to be important because it's not easy to reach out and tell someone I'm having a hard time. And the NIH, I mean, we're taking care of the sickest of the sick, and so often it will take its toll sometimes.

HWT: I wanted to ask you what increases or decreases the rate of burnout in that environment, but I think you've answered that question unless there's anything you want to add.

GW: No, I think I've pretty much described it. But it's taking care of each other. Ourselves, but also each other. Yeah.

HWT: I noticed that you co-published another article, "Developing the Research Pipeline: Increasing Minority Nursing Research Opportunities." This was in *Nursing Education Perspectives.* In it you stated or you and your co-author stated, that it had been acknowledged that limited academic and research training opportunities specifically designed to develop a group of minority nurse scientists was available. That was in 2005. It's been a while. And I'm just wondering if you could talk about either your own initiatives or those of the Clinical Center with regard to minority nurse scientists and how the field has evolved over the last 17 years in terms of recruitment, which we did allude to before.

GW: I think there's still work to be done. I think one of the reasons for our branch, too, is to provide a place where people are interested to come to study what they're interested in, too. We're not all interested in studying the same thing. But taking people where they are, too, in their career. I have a postdoc right now who continues to work in his role on one of the clinical units because he is at a point in his career and has a family where he can't just stop working and take a fellowship. What we've done, this is just an example, is work together with the Clinical Center to say that 20 percent of his time will be spent with me getting some postdoc experience. So, he is able to; it's in addition to his fulltime job. This is someone who in order to make ends meet was really trying to work time and a half by going to other units and learning other things. By doing this, I'm able to provide him with the experience, and he doesn't have to make the choice between doing what he loves clinically and then also getting a postdoc experience because he got his doctorate in public health. He just finished within the last year. So that's one example.

We've tried different types of programs. Funding sometimes becomes the issue. I had a postdoc who worked, who is from a Native American or Northern Plains community. Ended up going from us to Johns Hopkins. She had them contact me with the new branch. They just got awarded through their office of the provost to have a pathway to PhD for underrepresented nurse scientists. We'll be hosting them starting next year and then trying to connect investigators in our group with investigators that are going for their PhDs to bring in some of the more underrepresented minorities that are striving to get their PhDs there because they need environments where they can excel and see what nurse scientists can do. So that's another example.

HWT: I just have one follow-up question about diversity, equity and inclusion more generally. Which is, you know, in your opinion, how they should be defined or operationalized within the clinical learning environment and within medical education. Any other sort of general ideas about that?

GW: One of the slides that always comes to mind, I had it while I was chief nurse and after Mr. Floyd's murder, we had this time that I called Time to Talk and Time to Listen. One of the things that the nurses wanted to do was to have, and this was before the Clinical Center had their overarching DEIA initiatives, they started an Equity, Diversity and Inclusion Council with the staff. One of the slides that they showed was about what's different about equity. It comes to mind because they had a slide that showed a young child looking over into a stadium, and in the one picture, the child can't see anything inside the stadium. Then the next picture they have a box that makes them tall enough to look into the stadium. To me, every time I think of equity, I think of that. It's not trying to – it's giving an even playing field. It's giving people the opportunity that maybe did not have the opportunity. Just like the example of someone who cannot quit their job right now to take a fellowship stipend but is going to be an amazing researcher. Should we not have that? Equity sometimes looks different than what people expect that it looks like. It's giving someone, for me it's giving that person the level playing field so that they can be an active participant in the clinical learning environment in the science development.

HWT: Finally in terms of the clinical learning environment, what do you think, or what commitments should healthcare professionals have towards patients?

GW: That patients are truly partners. Not that we say they're partners, but that we teach them how to help guide their care. When they come in and have, whether it be with the nurse, the research nurse, the physician, that they have a part to play in that. But that we open up the environment so that they can trust us and feel like they have that opportunity because they know themselves the best. But over time, people begin to doubt that they know their own bodies as well as they know them. Because many of them have gone through many, many encounters of people kind of saying, "Well, I don't know what you have," or, "I don't know exactly how to help you." I think that partnership is really, really important and that they exist in a community, in a family and in a community. You're not just, you see an individual in front of you in a particular encounter, but they also have everything that's part of their life that they're going to go back to too. They have their family, whatever that structure is, and they have their community. Then they have what brought them here from the years. Just like I'm giving my story right now. They have a story to tell. So, they need to be able to—and it's very difficult when the average patient, I think, is supposed to have seven minutes with their physician. It really does take everyone putting those pieces together. Because if a patient tells the nurse a 20-minute kind of self-story about how they got here, that has to be able to be communicated in an interdisciplinary team or if the social worker then spends another amount of time. I think that's the piece that we're all, in healthcare, we're still always striving for is to figure out

how to get those interdisciplinary pieces together in such a way that the patient doesn't have to keep retelling the same thing over and over again.

HWT: Excellent. We've talked about mentorship throughout, and you've mentioned Dr. Clare Hastings. You've talked about some of the professionals who have come before and what your work is built on. You've also talked about the fact that the award that you received, the mentorship award, was very meaningful to you. We've talked about mentorship, but I wanted to know if there's anything more generally that you would like to talk about with regard to mentorship. I'm curious about the role of mentors in your field to begin with. Anything there?

GW: One of the things that I think I've realized more lately because I've been a very invested mentor is we talk about how the new investigators or mentees are vulnerable, but I think as a mentor you become vulnerable too, because you often invest years and years into mentoring someone, and so, you have to be true to yourself, too, and say, you told that person that it was their journey to take. And so, they're taking the journey that they want to take and not get disappointed. What I mean by that is sometimes you have someone that you've invested a lot of time in to be a researcher, and they get to a point and they're like, Oh, this is not really for me. You have to realize as a mentor that you have some vulnerability, too. That you have to check yourself, too. Like you have to be honest with yourself and not use, like learn from relationships with other, but each person you mentor, it's a collaborative mentorship if it's a true mentorship. And you learn from that. and then the next person is new. Their slate is clean. I have to sometimes work at that so

that I'm not holding back, but I'm the same mentor that I always was. Not like well, I better be careful because who knows that this person is, this investment is worth it, because it's always worth it. The investment in it is always worth it, and I always learn more. I always do feel that I learn more than I give. I also have realized that we have some of our postbacs and postdocs that come back, and they say, "I really didn't understand what you were talking about. And then like two years into med school, or three years into being a new doctor, I suddenly realized, that's what she meant when we were talking." I think those are rewarding moments, but it's hard. It's an investment of the person you're mentoring, but it's also an investment of yourself into really understanding that person. It's not just about their science. It's a delicate balance of being caring but not getting too much into somebody's personal business but letting them know that you're there to support them. Because early career scientists, it's very, very stressful. I think, letting them know that you're there; you're not trying to pry but you notice that something's not right and then letting them come to you when they're ready, that you'll be there. I think that's a really important part of it, too. That's why I think some people do think that true mentorship is really hard. Because it does take, whether it's as a clinical mentor or as a scientific or both, the trust factor becomes that really important piece.

HWT: I'm just building on that a little bit. What advice would you give to encourage young clinicians and scientists to continuing to pursue their goals or to seek out necessary resources, even despite setbacks?

GW: I often tell my own early career investigators, nobody knows your research better than you do. You're the person who, even though it feels like you're early in your career and everybody can contribute to it, you know what you set out to do. You have to stick with like yes, use the resources available to you and have conversations, but don't think that if you didn't get the right answer the first time that it won't be at the second or it won't be at the third time. I often tell the story of Watson and Crick sitting in taverns in Europe drawing double helixes on napkins like they describe in their book because everybody thought, "what are they talking about?". I love to tell stories like that because sometimes, and it's hard, too, to explain to your family members who aren't scientists. Like what are you studying and how is that relevant? I think they have to trust themselves, but they also have to seek out good collaborators and good mentors. Because they can't do it in isolation, it really takes— I think one of the biggest tolls of COVID was not that ability to sit in a room together. Even with all the computer things that are available, there's nothing like standing in front of a white board or with a bunch of papers and pens and colors and being together. I think our staff looks forward to that time when we can do that together more together, too, because you never know when you're walking through the hall, even, something serendipitously happens and that's the beginning of a science question. So, I think that's a big piece of it.

HWT: Exactly. Then hopefully we'll have some of those moments again. Starting to happen.

GW: Yeah, it's starting to. Yeah.

HWT: I have one more question before we sign off. Before I ask it, I'd like to know if there's anything that we haven't spoken about in terms of your career, your roles. It could be COVID in particular, talking about nursing during the pandemic or anything at all. Mentorship, anything that we haven't talked about that you would like to add.

GW: I think we've talked about most of it. I love the environment. It's difficult at times because there is a bureaucracy that's there, too, because of being in a federal facility, but for instance, I just came back from vacation. I was so excited because I knew that there was all this stuff that we're doing, and it's just so much fun. It's a very inspiring kind of environment, and I hope that it will continue to evolve these next few years and continue to be that place for people. Because it's like the best of clinical and academia and all of it together. It's just an amazing place. But I think it makes sense that after as many years as the Clinical Center's been open and the intramural program, that we're going to have some changes in how we approach the science. But I'm excited about it. I'm excited about what lies ahead. Because it's happening so, for so much happening so quickly. The students that are coming out of the university, our postbacs, they're amazing. They're just like with artificial intelligence, and just all the things that they, but they're also like wanting our clinical expertise. Being able to have clinicians with like some of these just brilliant PhD and scientists and statisticians is just, to me the sky's the limit. We just have to like, I was telling my one investigator today, I said, "Things can be hard." But I said, "We have to just keep finding the joy in discovery." And I really think that's part of it. It's just finding the joy in the intellectual piece of it. And just the joy of the discovery process itself.

HWT: Wonderful. Well, my final question is again a focus back on you, which is to describe the total impact of your work to date or to describe your legacy, again, up until now.

GW: I don't think that I'm done yet. I think that's the best part of the answer. I really want to go further in the whole idea of how as a whole human being how our mind, our emotions and our physiology as well as our environment and some of the social determinants of health, how they all play together. I think designing some of those models are a piece of that, and I'm not there yet. But I think being able to involve the patients. I've never had a study yet if I listen to the patients early on on how it should be designed that failed me. Many of the times I had experts telling me what to do, and I almost did it, and then a patient said, "If you do that, I don't think—"I hope that that continues to be the legacy of my work is how patients and communities contribute to what we're trying to discover. Because some of it they won't be able to, but they'll be able to tell us what they want to find out. Then it's up to us to put the pieces together, all the way from the bench to bedside community and back. So, yeah.

HWT: I think that's a really good place to sign off unless there's anything else you would like to add.

GW: No. Not at all. I've been very nervous about this. (*laughs*) I don't know. I can talk, but for an introvert, sometimes it's hard to know kind of how to approach things. I truly was

surprised and honored that I was asked to do it, but hopefully, I don't know what it will sound like, but—(*laughs*)

HWT: I think it will sound really thorough, and it's important. So, really, it's been a pleasure. And everybody feels, you'd be surprised. Most people say the same thing. Whether or not they're introverted is another question. But just it can feel awkward to have that level of focus on you and your career, but I think it's obviously super important. So, thank you so much.

GW: Thank you, too. And if there's anything that you need from me, just let me know and I'll be happy to provide it.

End Interview.