

KENNESAW STATE UNIVERSITY ORAL HISTORY PROJECT

INTERVIEW WITH LOIS R. ROBLEY

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for the

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Thursday, 13 July 2006
Location: CETL House [Center for Excellence in Teaching & Learning]

TS: Lois, why don't we just begin by you telling us where you're from and where you grew up and things like that and schools that you went to?

LR: Well, I was born and raised in Chicago and lived my entire life there until my husband decided to take this new job in Georgia. So I'm a dyed-in-the-wool Illinoisan, a Yankee. I went to school in the suburbs of the city.

TS: Which one?

LR: We lived in St. Charles, in Geneva, which is straight west of the city. I went to school at the University of Illinois at the Medical Center in downtown Chicago. We had an opportunity to do our clinical as nursing students in Cook County Hospital, the University of Illinois hospital, the VA system, and back then we had TB sanitariums where whole hospitals were full of tuberculosis patients that we would go and take care of. So I did my undergrad at the U of I there and became a nurse. I was a nurse for quite awhile and then decided I wanted to go back to school. So I went to the Northern Illinois University, which was in the other direction, in "DeKalb." That's how we pronounce it up north ["L" is pronounced in DeKalb]. I got my master's there in the school of nursing, and my focus then was on education and neurosurgery. I did some of my clinical with a physician who was a neurosurgeon and helped care for his patients' pre-op, and was there, present, during the surgery and post-operatively.

DY: I bet that was fascinating.

LR: Yes, it was very fascinating.

TS: So you're thinking that you wanted to go into teaching at this time?

LR: Yes, it was just about the time that I entered my master's program that I was approached by a faculty member at the community college there in Elgin, who was there with her students at the hospital I was working at. And she said, "You know, you'd be a great teacher of nursing students." "Really?" And she said, "Yes, you ought to come and apply to our program, to teach in our program."

DY: How interesting. What do you think she was picking up on?

LR: Perhaps my interaction with her students and my interaction with patients, because I was doing a lot of patient teaching then. I was teaching diabetics about their disease. Then, we had a lot of liberty to follow the patients that were discharged from the hospital to their home. It wasn't a separate entity, a separate nursing force that took care of them at home. We could follow them as discharge planners, [and] follow the patient at home. I found that so rewarding. You really have continuity with the same patient for a while. So I think she saw all that and invited me to come up. I went up and interviewed just on a lark. You know, "Oh, it's worth a try." [I] had no intention of teaching formally, but I was offered the job on the spot. So I said, "Let me think about this for a bit." I went home and thought about it and I really have always loved education. I loved being a student, so I thought, "Well, let's give it a try for a year and see how it works out." From then on, I've been teaching nursing as a medical surgical nurse and adult health. No children.

TS: No children?

LR: No, no children, I cannot do that. It takes a special person, I think, to deal with sick children.

TS: And their parents?

LR: Oh, yes, more importantly, I guess. So while I went to school there, I continued to work full-time as an educator. Then during the summertime I would work at the hospital, [to] just keep my hand in, and be a bedside nurse again for a while during the summer. That's when I wouldn't teach during the summer; now, of course, it's year round. And then about the time that we were coming down here, just before that, I applied to Rush University for my Ph.D.

TS: I'm not familiar with that.

LR: It's in downtown Chicago, a private institution, connected with Northwestern University. I applied there and I wanted to get the Ph.D. in philosophy because I was really, by that time, interested in teaching ethics. I really wanted to get that foundation, but because I hadn't had the philosophy degrees, undergraduate and graduate degrees, I really didn't qualify as a doctoral student in the philosophy department. It was about that time I got that disappointment that my husband said—he'd been working for the same company for twenty-five years, and they offered him an opportunity to transfer down here to Georgia and do sales/engineering, which would have been a step up for him. He had seen me through my master's and really supported me through all my education that way, and I said, "Well, it's your turn to do something, and I'll go right with you." So that was hard for me. It was not as hard for him. But my whole family is up in Chicago, or Wisconsin, and that was really difficult, having never been away from my family. I mean, family birthdays and all those celebrations, I missed so much, I still do. But we came down here and we had three weeks in which to

make a decision as to where we were going to live and where I was going to work. So, I said, “Well, I want to stay close to a university where I can get my doctorate.” That meant somewhere within the perimeter, within driving distance of Atlanta.

DY: When is this Lois? What’s the year?

LR: 1989. I essentially took those weeks to travel all over the state because it didn’t really matter where we located as far as my husband’s job. I interviewed at all kinds of nursing programs across the whole state of Georgia. I went up to Dahlonega. I went up the east coast—I went to wherever there was a nursing program. Essentially, my husband was already working, so I’m driving all over the state trying to find my way.

TS: It’s a good way to learn the state.

LR: [I] came up here to Kennesaw, which was about the sixth or seventh institution I was interviewing at. [I] was greeted by Vanice [W.] Roberts and just with welcome, open arms. It was the welcome that I received, plus the opportunity to continue to teach what I love to teach, which is medical surgical nursing and to teach my ethics course, too—because, fortuitously, one of the faculty members in the nursing department was leaving for Illinois, and she was vacating the position as the instructor for ethics.

DY: Who was it?

LR: Pam Chally [Pamela S. Chally]. Pam was going to Illinois, [and] I was coming from Illinois. She was teaching the ethics course here, [and] I had taught the ethics course in Elgin, so we essentially switched.

TS: How lucky.

LR: So it just happened perfectly, and I think it was just being welcomed. There were some other places where I felt like I was an intruder, like I had no business applying to their program, probably because I did not yet have my Ph.D., although they did hire people with their master’s. But at any rate, the environment attracted me. It was more on the same aesthetic line as what I was used to, and I just saw an opportunity as just perfect for me. So I went ahead and interviewed, and it was getting late into the summer and I know they were really anxious to hire someone for an open position. So it just really worked out very well. I’ve been here ever since. This is my seventeenth year.

TS: Seventeen years. What’s your husband’s name?

LR: Steve.

TS: By the way, I guess truth in advertising; I was born in Oak Park, Illinois.

LR: Oak Park! I know it well.

TS: Until just a few years ago, I had relatives in Naperville.

LR: I lived in Naperville for a while. In fact, I lived in Naperville when I was taking the train in every day to go to my nursing school.

TS: That's a long way in.

LR: It's a long way in. I did that because my grandmother was living with us, and she had senile dementia, what they termed it then, and my mother and I essentially took care of her at home. So I would come home from school and help take care of her and bathe her and feed her and everything, and then turn around and go back on the train every day to school. That was a bit hard because, you know, if you have to be in clinical by seven in the morning that meant you had to get on a train shortly after five to make it there in time, every time you had clinical. But when you're young you just take those things in stride.

TS: What attracted you to nursing?

LR: I always wanted to do something along the lines of science. I love science, I love such things as high school chemistry and high school physics—I took all the heavy sciences—and I just wanted to be a surgeon. I felt, you know, if you can eradicate the disease that would be the highest calling. But I knew we didn't have the money, for one thing, for me ever to go to medical school and back in those days there weren't the scholarships, and all that stuff. So my mother said, "Why don't you go to nursing school?" I said, "Sure, that would be great, second best." So she's the one that really pointed me to go to a baccalaureate program rather than an A.D. program. She said apply, and we applied for a National League for Nursing scholarship which helped my family put me through school. I was the first in our entire family to go to college and I was the first-born, so of course they expected all their other kids to go to college too.

TS: Right. Any mentors along the way that had a particularly strong influence on you?

LR: Well, there was one in grammar school—I call it grammar school because that's what it was called then—Mrs. Byron. She was one of these very professional teachers. She had perfect penmanship and expected the same from us. She had very high expectations for us in class, as far as our behavior and our diligence in our work and expertise in writing—she taught us language arts—and I just revered her. I put her on a pedestal. I thought she was the best of all teachers. I really loved her even though she was a very stern person. I just thrived in that environment, I guess. And then in my master's program, Marian Frehricks was a

- professor of nursing who really was another person I looked up to as a very intelligent woman, a wise woman, the kind of person who just said to you, “I expect you to go on for your doctorate, I do expect you.” And [she] gave me advice about what kind of degree to seek, and just a really genuine person.
- TS: This is at Northern Illinois?
- LR: Northern Illinois. I have lost touch over the years, but as an alumnus you get those alumni letters, and so on, and that’s about as much as I know.
- TS: Did she have a Ph.D.?
- LR: No. Ph.D.’s didn’t exist when she went for her doctorate. She went for an Ed.D.
- TS: I see. I was just wondering, when you got to Kennesaw, I didn’t think a lot of our nursing faculties had doctorates yet in ’89.
- LR: Right. A good number did not. I think Genie [E.] Dorman was getting hers.
- TS: We interviewed Julia L. Perkins, and she went over to Birmingham to get her degree in 1982.
- LR: Maybe Vanice did. I’m not sure about that. [Dr. Roberts received her doctorate in 1990].
- TS: At any rate, not many. So it wasn’t something that would hold you back if you didn’t have one at Kennesaw, at that point.
- LR: Right.
- TS: Although, I gather that we were upgrading the program and people were being expected to go back by the time you got here?
- LR: When I interviewed, they said there is expectation that you go on for your doctorate if you work here. There were no ifs, ands, or buts about it. Of course, I had fully intended to because I had made the first steps and taken my GRE, and all that. Because I didn’t want that to lapse too much, I wanted to get into a program and so I applied, simultaneous to taking the job here, at Georgia State.
- TS: Right.
- LR: I really wanted the Ph.D. So that’s where I pursued my degree.
- TS: Right.
- LR: It took me seven years to finish though.

DY: You were working full-time.

LR: I was working full-time and I had to take a brief leave of absence to care for my sister, who died of multiple myeloma. I had three deaths in a row within the same year. My father died of lung cancer; my sister died of this bone marrow disease—cancer. Then I turned around and came back to Georgia and got the call that my best friend just had lapsed into what we call brain death. She had had an aneurysm that blew in the brain and was brain dead by the time she got to the hospital. So it was three deaths in a row and that took me into a real tailspin, but I got an extension because I really needed to care for my sister. I needed to focus on family and just got an extension to finish my dissertation.

TS: I think I was here ten years before I finished my doctorate.

LR: Oh, really. It takes time.

TS: Of course, we didn't have many doctorates on campus—well, we were hiring them at that time. I finished up in '78. The Ph.D. program—you talked about philosophy, earlier. Is it a nursing program that you were in at Georgia State?

LR: It was a nursing program.

TS: So it must have been a pretty new thing at Georgia State at that time, wasn't it?

LR: It had been in place, I think, for about five years. The classes were very small. There were only five of us admitted at the time to the doctorate program.

DY: So you had a cohort program?

LR: It was a cohort program. It was designed for educators because it was intense during the summer, and then you took one or two courses during the rest of the year. That worked out nice because we became a real tight-knit group.

TS: What was your emphasis in the Ph.D. program?

LR: Well, fortunately, I was in the education track—I believe there was a community track and something else, but because I wanted to stay an educator I took that track. [I] focused on ethics, teaching ethics, learning more about ethics. I took an anthropology course in which I studied ethics there, [and] I took an ethics and religion course as my outside courses.

DY: Interesting.

LR: Yes, it was very interesting. I loved school. I really did enjoy it there. I really fell in love with qualitative research. One of the doctorate students who was just

finishing up gave us a taste of it in a doctoral consortium. She was presenting her research and simulated the voices of the various persons that she had interviewed, and I thought that is just so rich, so evocative, so much more challenging than doing surveys and instruments and that sort of thing. So that's where I focused, and my dissertation was interviewing twenty-two nurses across the southeast who were considered by their colleagues as experts in the care of dying patients. I learned a lot from them. Hospice nurses, ICU nurses, nurses who work on med surgical floors, and I traveled as far up as Charlotte and down to Florida. They had to be recommended by their colleagues as experts. That was extremely interesting. But, as you know, qualitative research takes a while to do, so that slowed me down a bit too.

DY: Were you unusual in, you, the doctoral student, pursuing that? I mean, maybe this is my stereotyping, but I think about a science background, it's quantitative, that you draw on.

LR: We had courses in both quantitative and qualitative, and we had some really strong quantitative faculty, so I think it was pretty well divided. All of us were encouraged to do quantitative because of the time factor, but I simply chose not to, especially with such a topic. It seemed much more appropriate to do interviews and analyze those. I used Ricoeurian hermeneutic phenomenology and [I] fell in love with [Paul] Ricoeur, even though I can't claim to be an expert on that.

TS: And what does that mean?

LR: Ricoeur is a philosopher, and he's still alive as far as I know. A French philosopher, who developed differently than Heidegger a philosophy of phenomenology that really focuses on the spoken word, the written word as text, and so what you gleaned from the interviews really comes from the text. You go through a step-wise process of looking at the whole story first, the entire story, and then you apply questions to the story to pull up more data and more meaning from the research. The analysis took a lot of time.

DY: It sounds like literary analysis.

LR: Yes, he's a symbiotic.

DY: That's what I thought.

LR: Yes. And I appreciated [that] we were steeped in Heidegger, but I had a certain objection to using Heideggerian phenomenology because Heidegger, himself, was a Nazi sympathizer, whereas Ricoeur was imprisoned by the Nazis and he had more of a spiritual bent and a different perspective on right and wrong and in doing ethics research about such things as end of life. You really want to be sensitive to that background of the theorist.

TS: So you got that philosophy degree anyway, it looks like.

LR: In a way, in a way [laughter].

TS: Any mentors at Georgia State that were particularly important?

LR: Alice [S.] Demi was the chairperson of my dissertation committee. She is retiring this year from Georgia State and has served in many different roles there, including director of the doctoral program. She really was positive, and that's what I needed. I needed somebody supportive and positive about the research. She had done some research with dying patients, HIV patients, and she understood the research quite well. But I believe I was the very first person to choose Ricoeur. I think no one had ever heard of Ricoeur before!

TS: Good for you. When you came to Kennesaw in '89—when you came to Georgia in '89, maybe we should just ask you—what did you think of Georgia when you first got here after having spent your whole life in Chicago?

LR: I thought it was a beautiful state and appreciated the cost of living down here, because at the time you could get much more house for the dollar than in Illinois. But the culture just hit me face on, primarily because I was hired and immediately started teaching, and it was just a matter of a couple of weeks. Of course, you have to go through the process of getting your license in Georgia, but it didn't take long. I was assigned to working with students at Grady Hospital, which was probably not in my best interest because I found that I could not understand the nurses when they were giving a report. The culture was just so different. I was in culture shock. I truly was. I just couldn't believe they did things the way they did [laughter].

TS: The standards were not what you expected?

LR: No.

TS: That's not good.

LR: I became angry and, frankly, judgmental because I was used to a certain type of hospital, a certain way of functioning with patients and a real concern for safety. I was just hit with it all at one time. Plus, we tend to eat our young faculty members. Hopefully, we're doing a much better job as a result of our experiences. But they moved me around from hospital to hospital every semester, and you don't get to know one place well enough to feel comfortable there, and you're uplifted and taken to another. It's almost like you had to earn your way into having a set place to take students. That's the reality of it. Now we don't do that. We work things out collegially and people stay pretty much in the same

institution, with some minor changes. But that culture shock was unbelievable to me.

DY: Had you been at a teaching hospital before?

LR: I had been in something very similar to this kind of setting where I was at the community college teaching in an associate degree program. We would go to all the community hospitals just like we do here, so that wasn't different. It was the language, the lingo, [and] the laid-back, laissez-faire kind of attitude. I was used to that regimental stuff.

DY: There are very distinct regional differences, aren't there?

LR: Yes.

DY: You don't know unless you cross cultures.

TS: What about the students? How would you compare the students that you found here in '89 to those that you had up in Illinois?

LR: The same, eager to learn. Very scared when they go into the hospital for the first time, shaking in their boots. Very willing to take your advice and your mentorship. I've learned over the years, after they come back and tell me, "Do you know what you did" [laughter]? "No, what did I do?" One person told me, "I gave my first shot and I pulled the plunger out too far and it came out. I was scared to death! You said, 'Just gently put it back in and give the injection.'" And then we walked out of the room, and you said to me, 'You did such a nice job under a stressful situation.'" She said, "I was prepared for you to yell at me." So that's the kind of way I think students typically are, who are so afraid of hurting patients, so afraid of doing something wrong. They're shaking, so that causes them to be a little less dexterous. Over the years you learn, you know, these things will solve themselves. Students will get a lot more adept at doing things. It's pretty much the same. At Elgin, the population there was a very mixed population, too. We had African Americans and Hispanics and Anglos, as I call them, all in the same nursing program, so I was used to that—maybe not the heavy accent, but certainly the diversity. I felt that was not any different. So when I was hired here, I was hired into the A.D. Program, which is the only place I was qualified for because I only had my master's, and I wasn't far enough along in my doctorate to teach in the baccalaureate program. So that's where I started and taught here for one year, temporary, in the associate degree program. Then the next year [I] went over to the baccalaureate program.

TS: We don't even have the associate degree program any more.

LR: We don't. That was a very wise move, in my estimation, because we'd been trying since 1985 to make the minimum entry into nursing a baccalaureate degree,

and I firmly believe that needs to be there. So it's a different way of thinking, despite the fact that I taught in an associate degree program all those years. I think I had the same expectations of those students as I do of the students in the baccalaureate program here.

TS: Right. Now, you said you were on a temporary contract that first year and then you had to apply again for the next year?

LR: Yes.

TS: So you were really lucky that somebody left late in the year, I guess.

LR: That was my entrée.

TS: Right. That got your foot in the door and then you applied for the tenure track position.

LR: Yes. And, of course, I did lock step over the years, the three-year assessment and then for five years, and then I went up for assistant professor and then associate professor and then full professor. Just on the usual year-plot.

TS: When did you get full professor?

LR: Last year, 2005.

DY: You must have seen a number of programmatic changes.

LR: Oh, yes indeed.

DY: It's been tremendous growth.

LR: And I've been involved in them.

DY: I was going to say . . .

TS: That's one of the things we wanted to talk about, was some of the changes that have taken place. Maybe, talk about some of the things you've been involved in, the growth of—one of the things, for instance doing away with the associate degree program.

LR: That decision was not really made with the faculty input. I think it was the leadership of Judy Perkins and Vanice [Roberts] and David [N.] Bennett talking together about the need to move in that direction. I don't recall being involved in that decision, but I wholeheartedly supported them because I think that's where we needed to go.

- DY: So they were just voicing what the faculty wanted anyway.
- LR: Right.
- TS: What were some of the other major changes?
- LR: Going up for accreditation. Of course, that's a lot of work and it caused us to look back at our entire philosophy, conceptual framework, analyze the courses all over again, determine how we had the links between phases of the program and the curriculum and the threads in the curriculum, particularly. I was interested in ethics, where does it show up, and I was actively involved in the writing of that.
- DY: So you did pretty major curricular reform?
- LR: Oh yes. Dramatic.
- TS: What's the accrediting association?
- LR: The CCNE [Commission on Collegiate Nursing Education]. It's part of the AACN—The American Association of Colleges of Nursing. We went through National League for Nursing accreditation twice, and then did the American Association of Colleges of Nursing. We switched over to them this last time, so I've been through three accreditations. Each time you perfect your program.
- DY: It's very healthy to do that, very healthy. It's healthy for us professionally. It's intellectually stimulating. What are some examples of what you re-thought and how you saw your own interests and expertise, particularly in ethics integrated into curricular renovation?
- LR: Well, this last AACN/CCNE accreditation was a time when one of their planks, one of the items that had to be demonstrated through the whole curriculum was ethics and end of life care, because there is a national move to include end-of-life care, in particular, in the curriculums of all schools of nursing across the nation, because we've been so lax in that arena. I was just positioned very well to give advice about how that would fit into the curriculum and where it would fit and what concepts needed to be taught, and so forth.
- DY: This is, I suppose, a philosophical question, but, Lois, why do you think we as a nation and as a people have been so long in coming to an examination and concern with death and dying?
- LR: I think it's because back in the 1900s people died at home and everybody witnessed that whole process and was part of it. Then, of course, death and dying became medicalized, and the whole process of dying was a fight against disease, scientific attitude toward conquering disease with all the research, and so on. So disease and death became the enemy. It was compartmentalized, and so people

died within institutions. That took it out of the family environment, and people just didn't witness it as much, and the whole process was not studied.

DY: And people were alienated from it and afraid of it, and it was removed and objectified.

TS: I remember back in junior college days when we used to have the Cobb County Symposium every year on our campus, that one of our most popular speakers ever was Elisabeth Kubler-Ross.

LR: She was the person who more or less revolutionized it. I still have her book that shows the pictures of those people she interviewed in various stages of their dying process, and I show it to students and they go, "Oh!" They have not witnessed this. They have not seen it. So we're trying to help them understand that by going out to hospice and working with nurses in the hospice [and] working with palliative care nurses in the hospital. But even so, palliation is really the new kid on the block. It's just now that WellStar, for example, is hiring a physician who has a specialty board certification in palliative and end-of-life care. So we're moving in the right direction. It's a slow process, but we're moving. There's more awareness and concern about pain management now and comfort for anybody who's ill and in the hospital. So we're seeing that with the Joint Commission on Accreditation of Healthcare Organizations, they have put as one of their number one priorities, pain management for all patients and comfort. So we see that accreditation process has kind of shoved that into the forefront, so that doctors and nurses have to be concerned about it. Not that we weren't before, but not to the degree that we should be.

TS: Right. Well, I guess one of the big changes for nursing is the creation of the College of Health and Human Services. Were you involved with that change? I guess it was a school before it was a college.

LR: Yes, we were a School of Nursing, School of Health and Human Services, although we weren't called that, were we? I can't even remember what we were called.

DY: I remember School of Nursing, but after School of Nursing. . . .

TS: Did it go straight to College of Health and Human Services? In '96 when we became a university, nursing wasn't. . . .

LR: We were just departments at that time.

TS: Yes, nursing wasn't one of the first colleges. It was a school.

- LR: And then they put us together with Human Services and HPS and called us a college.
- DY: Those were the components that came together—Human Services, HPS and Nursing.
- TS: Was faculty involved in that change, or was that just top down?
- LR: Not really, just top down.
- TS: And then of course, the naming of it, the college is the WellStar College.
- LR: It just happened two years ago.
- TS: Right. And that, I guess, was top down too, with the money that WellStar provided.
- LR: Sure. Actually the master's program was called the WellStar Primary Care Nurse Practitioner Program.
- TS: And I understand nursing is going to have one of the first doctorates on the campus. Is that in the works?
- LR: Well, the way I understand it is that the Ed.D. is the first doctoral program. We're hoping that ours will be the second. It's a conjoint effort on the part of the Bagwell College of Education and our college to put together a doctorate in ethical leadership. Now it's going to be a D.Sc.—Doctorate of Science—with a major in Leadership and Ethics. That's the official title now. Yes, a group of us have been very instrumental in developing the curriculum and looking at the letter of intent that's now down at the Board of Regents. So we're hoping that that'll be the very second one.
- TS: So you'll definitely be teaching in that program, I would think?
- LR: I anticipate that I will be teaching in that program. And it's a doctorate that includes a residency with international focus, so all these folks are going to be traveling abroad to do projects and research.
- DY: Wonderful! That is so exciting.
- LR: Yes. So the groundwork is being laid, as you know, in internationalism. Our new assistant dean for partnerships in international studies is going to be really spearheading that with Darlene [A.] Kluka and our dean.
- DY: Who is your new assistant dean?

- LR: Ben Johnson [Benjamin F. Johnson, Associate Dean for Community Partnerships and Global Initiatives]. I haven't met him yet, but he is in charge of the partnership and internationals. He's in House 58 [Center for Non-Profit & Public Leadership].
- DY: Is there a connection with the Siegel Institute for Leadership, Ethics and Character?
- LR: Oh yes, definitely.
- DY: What's the connection?
- LR: The steering committee for the development of this degree consists of not only us faculty and our dean and the assistant deans, but also folks like Deborah [B.] Roebuck and John C. Knapp, the gentleman who is into business ethics. He came from the Southern Institute for Leadership and Ethics.
- DY: One of the things that I think makes Kennesaw very attractive to people is that, "Well, I came here and I saw the possibilities of doing what I wanted to do." But nothing was set. You could be creative, and it sounds like you have really taken the opportunity.
- LR: A lot of changes. Yes. I've done clinical nursing courses for so long, and then when this opportunity for a Distinguished Scholar came on board, I was just in the right place at the right time.
- TS: I guess that makes the transition to where we're heading with this interview. Let me just ask you about job expectations in '89 when you came. Then when you got into the tenure track position in '90, in terms of teaching scholarship, service—how did that mix play out in nursing, in the beginning of your career here?
- LR: Well, at the beginning I had just started my doctorate program, so I was really steeped in that and teaching full-time, doing clinicals full time. I think my leadership skills that I had practiced in Elgin, up in Illinois, were transferred down here. So, quickly I became a course coordinator over part-time faculty and full-time faculty in some of the larger courses in adult health. That transition into tenure track was just the natural flow of things. I fully expected to get my Ph.D. and was moving rapidly, as fast as I could, to getting it done. So I was just primed, I think, for the teaching in the baccalaureate program. It just fell into place.
- TS: So in 1990, you're in a tenure track position even though you don't have a doctorate, because a master's was considered pretty much the terminal degree at that point.

LR: But also I was making progress in my doctoral program. If I had not been, I doubt whether that would have happened.

TS: So you were an assistant professor in the tenured track and your expectation is to finish the doctorate and teach your classes, and nobody cares about anything else.

LR: Other than the usual. . . .

TS: 500 committees [laughter].

LR: Right! Yes. I started out on the curriculum committee and got very involved in the curriculum committee, and then was at the UPCC [Undergraduate Policies and Curriculum Committee] and was chair of the UPCC. Curriculum was my bailiwick, basically. Having transitioned from the associate degree to the baccalaureate degree, I've always liked designing classes.

DY: Curriculum is one of the most important things, or if not the most important thing, that we do as faculty.

LR: That's right.

DY: The other may well be tenure and promotion. Those two, those are the committees that I have always been on, always wanted to be on, because I see that's the seamlessness of teaching. What you teach—you'd like to have a hand in that.

TS: Right.

LR: And maintaining the quality across the board.

TS: Let's talk a little bit about—in 1989 you finished your doctorate, and is this when you start getting into service to a much larger degree, particularly off-campus service, professional service?

LR: No, I had been doing that.

TS: So you had been doing that even while you were working on you degree?

LR: Yes. And I'll have to look back at this narrative that I wrote. In 2002, I said that over the past ten years I had been doing volunteer work.

TS: That's almost from when you got here.

LR: Yes. I had been so interested in ethics and teaching ethics and felt that it would be important for me to be involved with the ethics committee, and so I was

invited. I invited myself, essentially, and they said, “Yes, it would be great to have an academic on this committee, as a community spokesperson.”

TS: What’s the committee that you’re talking about?

LR: It’s the WellStar Ethics Committee—WellStar Health System Ethics Committee. When I first joined it, it was the Kennestone Hospital Ethics Committee, and, of course, as the changes happened within WellStar, then the committee became a committee of the whole, all five hospitals. So I was asked to segue immediately into that.

DY: What are the five, Lois?

LR: Paulding, Douglas, Cobb, Kennestone, Windy Hill. So there are representatives on the committee for each of those, representatives from the various disciplines: physicians, nurses, social workers, chaplains, [and] administrators. When we were with the Kennestone Hospital Ethics Committee we also had lawyers, and the new committee has no lawyers because we want to focus on ethics, as opposed to being driven by laws.

DY: Do you have any mediators or conflict management people?

LR: Indirectly, but not by training or anything like that, no. It would be good, because that’s what we do.

DY: That’s right.

LR: That’s what we do.

TS: So you’re the one academic person on that committee in ’92?

LR: Right. All the way straight through till today. My role is to sit on the large ethics committee and give advice and consultation about cases, but it was post hoc because the cases had already happened and people have dealt with it, and so on. It was like a review of the case. My role also was as an educator, helping with developing the ethics day, ethics week for the hospital system, which is once a year. It’s an annual event. We have a nationally known keynote speaker come in, and we have a series of workshops where all the staff from all different disciplines can come together and learn more about ethics. I have always been a speaker or I’ve been on the steering committee every year that we’ve had that. We have incorporated even poetry and plays. We had a video of the play “Wit” [Margaret Edson (London: Faber & Faber, Ltd., 1999)], we showed portions of that, but then we had an actual live play that was put on called “B.O.A.T.I.N.G. [Before Offering Another Treatment Identify New Goals].” It’s about the death of a woman. We put that on as part of the ethics day for the system. So I’ve always been deeply involved in that and in preparation for it and the delivery of it. Also,

over the years now, I've taken over the responsibility of doing ethics rounds, the last year I guess.

TS: Are you talking about hospital rounds?

LR: Yes, hospital rounds. What I do is, once a month I go to the critical care units at Kennestone Hospital and I entertain anything about ethics from the nurses, doctors, the social workers, [and] the chaplains. They say, "Oh, Lois, come see this particular patient or family." And usually what happens is there's a family conference that comes out of that, so the family can understand what's going on, and why it is that certain questions are being asked of them, and helping those families and supporting the families as they're making decisions with the medical staff about their loved ones. So usually it involves half of a day doing the rounds and then additional times of coming in the evenings, or whatever, on different days to meet with families. The last one, the physician actually had his nurse practitioner directly saying, "I want you involved in this case because"—well, they didn't say why, but they wanted me to sit in on the family conference

DY: That does sound like mediation.

LR: Oh it is, and it's very emotional and very wrenching to see the reactions of families when they're told some things they need to know, or to listen to their stories about this person or what this person is like, and the disease trajectory. All of that is—it takes a lot of time. But nurses at the bedside, doctors who are busy doing their rounds, they don't have the time usually to conduct these, so we make a point of doing that so that there is time set aside for these conversations.

DY: Do you have pretty fair gender representation? Do you have as many males working in this as females, professionally?

LR: You mean as far as family conferences go?

DY: Well, I think I mean about the professional staff.

LR: I'm the only one doing the rounds—except for Dr. [Richard W.] Cohen, who is the chairperson of the ethics committee; he conducts rounds too. He's the chairperson of the committee, and he has been ever since he's been on the WellStar committee.

DY: What's his specialty?

LR: Orthopedic surgery.

TS: Obvious ethical questions, I guess, in how much you tell a patient, that kind of thing—what kind of care do you give to somebody that's obviously going to die, regardless?

- LR: Those futile cases, what we consider futile.
- TS: Living wills and things like that.
- LR: What do we say to the family? “What do you believe your dad would want done in these circumstances, when he can no longer speak for himself?” We don’t have documents that tell us, [so] we work with the family to help pull that out and do the right thing. Pay attention to the whole person, the spiritual side as well as the physical, as well as the social with the family.
- TS: It’s kind of like what you were saying about people dying at home in the old days. It’s getting harder and harder to die, it seems, when they can keep somebody alive forever, even though they’re just a vegetable, or getting close.
- LR: A long time. Look at Terri Schiavo, fifteen years. With good nursing care a person can live.
- TS: That’s a good example. It can be very controversial when you get into these ethics questions.
- LR: Very controversial. In fact, sometimes, family members will be at total odds with each other. Sometimes a family member who has not been in touch, has been estranged from the family, comes back into the fold when these issues are addressed, and then seems to have as much power as the rest of the family in making decisions. Sometimes it’s very conflicting, sometimes it’s very emotional.
- DY: Or the family members who have been involved in the day to day care as opposed to the ones who are long distance; they may have been talking on the phone, but that’s not being there.
- LR: That’s right.
- TS: So I guess really part of the ethics issue is to encourage people to have power of attorney and living wills and those things, when they’re still in their right minds.
- LR: Only 20 percent of the population has those, so we struggle with that a lot. We try to help family members see each other’s points of view and understand clearly what the status of the person in the bed is. Sometimes that takes having them present when resuscitation is done, or having them present when a wound is dressed, that sort of thing. But making judgments about when that’s appropriate and when it’s not is important. So I do not only the large ethics committee [and] the ethics rounds. I’m then also on call for ethics consults whenever there’s a case or an issue, particularly at Kennestone, so that I can be there pretty quickly, because we try to turn around those within twenty-four hours. When a physician

writes “I want an ethics consult,” or a nurse asks for one, or the chaplain asks for one, we try to be responsive to that.

DY: So with this new doctorate program, then there may be others who will be able to do what you are doing, because it sounds like a tremendous load, Lois, and an ever-growing need.

LR: Yes.

DY: I think people are just recognizing the need for this.

LR: Yes. And you know, not all cases come before the ethics committee or before the councils, but we’re there at least by phone to help support people who are making decisions, in-between the times that we’re doing the actual cases. This month I’ve had three cases, already, that I’ve been called to the hospital for.

TS: When you’re on call, do you get called in the middle of the night?

LR: Well, usually they wait until the day. But Friday afternoon seems to be a wonderful time to call the ethics call team. It’s like, here we are facing the weekend and what are we going to do about this situation? So that happens. My volunteer work, also for two and a half years, was as a volunteer with hospice. These things are not totally giving to others. It’s really getting back, too. You learn so much by doing. You learn about cases, [and] situations that you can use in your teachings, while keeping everything confidential and trying not to tell so much detail that that case would be recognized. So I was a volunteer. Every Friday after work I would go down to hospice, Tranquility [WellStar Hospital, Austell, GA], which is an in-patient residential hospice, and just be a volunteer. So in that capacity I would help with activities of daily living: feed somebody; let a man, for example, sit out on the patio and smoke even though he has lung cancer, but he had to be observed so that he was safe, could barely hold the cigarette, but still was smoking; or sing with people; or read to people; or play music for them—I’m not a musician, but I could turn the CD on [laughter]; or just listen to them reminisce; or take them on wheelchair rides across to the park, [or] get them whatever food they wanted; talk to families [and] educate families. I was always so drained when I went on Friday afternoons. You know what Friday afternoons are like, but I would get renewed once I got there. I was supposed to stay for four hours—that was my commitment—but sometimes it would be ten o’clock or eleven o’clock at night before I would get out of there, because you get so involved with folks and it’s such a good learning experience, as well as a service.

TS: But you’re doing things beyond your nursing expertise, I guess.

LR: Whatever needs to be done—I always use the experience that I had there with my students, saying, “If you care for families, you’ll be caring for the patient.” This

one gentleman, his wife was newly admitted to hospice, and I said, “You know, you could learn how to just do her mouth care.” She needed it repeated, doing it over and over. He said, “Oh, really?” So I taught him how to do it, and he said, “Why didn’t somebody teach me this a long time ago? I haven’t been able to touch her.” For weeks she was in the hospital. She was in ICU and she had all these lines and tubes and everything, and he thought he couldn’t touch her. She was so ill he couldn’t touch her, and so this was his first opportunity to make the connection with her again, and that’s so sad. It didn’t have to be, but it just happened that way. So the rewards you get from just enlightening someone with such a simple little thing—but he was so appreciative, and families generally are. So you get as much as you give in return.

TS: Right.

LR: And then I’m a volunteer for Critical Conditions^[SM] which is the advanced directives—living will and power of attorney for health care is a special program across the state, now available in all hospitals and all institutions. A booklet, which is an education booklet—and we go out and do workshops at Kiwanis Club, churches and wherever, to inform people about the advanced directives. I’m a part of that.

TS: These are very time consuming, but in a way they really are directly related to your doctoral program.

LR: Definitely.

DY: How do you see your teaching load—and, I suppose, what you’re going to be teaching, also changing, Lois, with this curricular change and the new doctorate and all that?

LR: Well, my teaching load really changed dramatically when I was named the Distinguished Scholar in Ethics two years ago. Now I have half-time teaching, and half-time I do research and work with ethics. So that really opened up the opportunity to do more research. But I was already doing that, anyway, writing grants and stuff, but it gave credence to the whole notion of being an expert in ethics.

TS: Is the Distinguished Scholar in Ethics part of the Institution for Leadership, Ethics, and Character? No?

LR: No, this came out of the \$3.2 million that was awarded to the WellStar . . .

TS: Oh, the WellStar money, okay.

LR: College of Health and Human Services. They named four scholars: a scholar in gerontology—and that’s David [B.] Mitchell—and the scholar in African-

American health, Gloria [A.] Taylor. She's also a recipient of the Preston Award [Philip Preston Community Leadership Award].

TS: We're going to be interviewing her eventually.

DY: I really like her. She's wonderful.

LR: Yes. And the scholar in women's health—we had Lucia Kamm-Steigelman in that position, and then she left us to go to Crawford Long. She was with us for a year. So that is an open position at this point.

TS: What is David Mitchell's?

LR: Gerontology. They're all "the WellStar Distinguished Scholar in . . ." I happen to be [in] "ethics."

TS: Yes. So there's enough money in that to fund the course releases?

LR: Yes, halftime releases.

TS: I see. Is this like a permanent position, or is it like three years and then you rotate? How does that work?

LR: The way it was explained to me, is that after every two years they would reassess each of the scholar positions and then make a decision from there on. We're past the two years now, and I'm still here, so I guess we're doing all right [laughter]. I'm also a consultant to the Nursing Research Committee at WellStar. That committee is pivotal. Any kind of research that comes out of nursing at WellStar goes through that committee for approval. It's like an IRB [Institutional Review Board], but it's not called IRB. So we do joint research between the nurses there and the nurses here, and so I serve as consultant on that committee, as did Vanice Roberts for several years. Now she's turned it over to Tim Akers [Timothy A. Akers]. He is assistant dean for research and scholarship in our WellStar College.

DY: Let's see, you've got a dean, obviously—how many assistant deans?

LR: We have an associate dean, Vanice Roberts. We have Tim Akers as assistant dean, [and] an assistant dean for partnerships and international affairs, which is Ben Johnson. And David Bennett is now assistant dean in special projects. So we've got one, two, three, four. . . .

TS: Who's the chair of your department now?

LR: The baccalaureate department is Christina Horne. And the master's degree program is Genie Dorman right now, and we have a new person coming in.

Genie is going to take on some other responsibilities and Tommie [P.] Nelms is coming in.

TS: Was the Distinguished Scholar in Ethics something that you had to apply for?

LR: They granted it to me. Basically, I think, because of all my work in ethics for WellStar Systems and because of my interests.

TS: Why don't we talk a little bit about some of the grants that you've brought in?

LR: I haven't brought any in.

TS: You haven't? I thought you had been writing grants.

LR: Oh yes. I've written grants and gotten decent scores, but I've never been funded.

TS: So you're still working on that.

LR: Yes.

TS: Well, maybe if you get a doctorate, that'll make it a little more competitive in getting grants.

LR: Maybe. You know, you can get good scores, but NIH doesn't fund but the top 125 sometimes, or so.

TS: Right. And it's very hard for non-Research One institutions to get that.

LR: Right. It seems like the places like University of North Carolina have faculty that are totally devoted to research and that's all they do, and they have won millions of dollars worth of grants from NIH. So yes, that's different.

TS: It seems to me that nursing faculty are doing a ton of scholarship, what you call applied scholarship.

LR: We are and getting published and so on. And that lays the groundwork, too, for possible grant awards in the future. So you have to take baby steps, I guess [laughter].

TS: Well, how have you tied your service to scholarship? Through writing papers?

LR: Yes, some of that. For example, I had an article published in the *Nurse Educator* journal, a peer review journal, about my experience as an academic working on an ethics committee. That whole experience, and what it's been like for me and the kind of support, the kind of learning, that comes out of it, and encouraging other faculty to do that. That came out. Jonathan [B.] VanGeest and I just did an

article, submitted for publication, on using Betty [L.] Siegel's model of ethical leadership and applying it to the whole issue of patient safety, because there is a lot of concern about patient safety in health care institutions, with over approximately 100,000 and maybe even more dying of medical error, in our hospitals across the nation.

TS: One hundred thousand, did you say?

LR: One hundred thousand a year. So I know that opens up your eyes. And, of course, JCAHO, Joint Commission on Accreditation of Healthcare Organizations, is very concerned about that, and that is a topic for change and improvement across systems, so we wrote an article about that. But most of my research has been done with either dying patients—nurses who work with dying patients. That's going to be published in September in the *Journal of Hospice & Palliative Nursing*. Other research that we've done has been in conjunction with nurses at WellStar. We did a qualitative study interviewing patients who had undergone neuromuscular blocking, where they were in the intensive care unit, on a ventilator, very, very, very ill, very critically ill. They had to be paralyzed—the choice of treatment was to paralyze them using neuromuscular blocking medications. We've known for some years about the phenomenon of people undergoing anesthetic for surgery, of some sort, or a procedure of some sort, and then waking up during the anesthesia being totally paralyzed, unable to speak or blink their eyes and hearing and feeling what was going on. We are aware of that. "Anesthesia awareness" is what it's called. We wanted to look at patients who were paralyzed for the purpose of treatment without anesthetic and determine whether they had any recollections at all about that experience. We interviewed eleven patients, and it took us eighteen months to get eleven patients, because the majority of those patients died. When you're using neuromuscular blocking, they're just very, very, very ill—multi-system failure. So we interviewed all those eleven patients and analyzed that data and that was published in a significant publication, the *American Journal of Critical Care*. So that's peer reviewed, and contributions are made by physicians, as well as nurses, to that journal.

TS: What did you find with the interviews?

LR: Every one of the eleven remembered things about their care, about people who were there, about being told that they were going to have to be tied down if they didn't remain still. That obviously was during the induction period, during that period when they still could move some; being violated—they remembered dreams, being like a dream-like state and being away, far away, trying to find their way toward health care. They remembered suctioning. They remembered the uncomfortable things. They remembered all of it. So our advice to anybody who paralyzes a patient is to give them enough analgesic, enough sedative, so they won't remember these things, because it could be a precursor to PTSD—Post Traumatic Stress Disorder.

DY: Which you've done work on?

LR: Yes, a little bit. So that was—aside from anecdotal—reference to that phenomenon—this was the first research ever done on it. So we got that published very quickly. The minute they saw that document come across their desk, they were really interested in it right away. We've been doing some work on intensive insulin therapy in the critical care unit, so we were looking at how well nurses could learn using a nomogram to plot out the doses of this drug. They had to give insulin to patients who had hyperglycemia in a situation of critical illness. So we studied that, and they implemented that whole process using the nomogram and using intensive insulin therapy at the hospital—at all the five hospitals, actually. So now we're studying the nurses' perception of how well it's working with patients. We're also studying the effect of stress in open-heart patients. We're also studying a new orientation program for critical care nurses. We're looking at was there a difference before the new orientation program that was put in place and then after it was put in place, both for the preceptor and the preceptee, the new nurse who was hired into critical care. So we got the data analyzed and we're waiting for one more piece to be tabulated. Then we'll be ready to write the article.

TS: You said “we” several times. Do you do most of your research as a collaborative effort with others? Is that typical in nursing to do it that way?

LR: Yes it is, and in medicine as well. Sometimes they have the research question, and I have the methodology. I help them with the research process and actually do some of the data gathering myself too, so it is a very collaborative effort. Mostly with masters-prepared nurses and one doctorally prepared, who works in the clinical arena. So it's a tight cadre of people who are really interested, particularly in critical care.

TS: Some of the people we interviewed in biology and chemistry and fields like that have talked about lack of lab space on campus to do meaningful research. Do you find that in nursing also?

LR: See, ours is different. It's more behavioral and human research, so we go to the patients.

TS: That's what I was thinking from what you were saying that it sounds like the hospital and where the patients are, that's your lab.

LR: That's our lab. And it's just natural. The open-heart study that we're doing now with patients who have open-heart surgery, you would think that stress in open-heart surgery has been studied. Well, it has, but open-hearts are done differently now than when that original research was done. They went on by-pass machines and now they're not. They're out of the hospital within five days, as opposed to

- years ago where they were in for twelve, fifteen, twenty days. So it is a new era. But we are going to the homes of patients and we are doing with both the patient and their significant other, who is with them by their side when they go through this horrible experience, and it is horrible. I can say that to a person everyone has cried—the men as well as the women. They came to the brink of their own lives and then back again. It's a real privilege to be welcomed into their homes and to listen to their stories.
- DY: You must see the effects of the stress on the caretakers and the caregivers in the homes?
- LR: Oh, yes.
- DY: Because I know very recently I have a friend whose husband had an aortic aneurysm, and oh boy has that been intense. It's not just a few days or a few weeks; your routine, your household is completely interrupted; change, people come in, in-laws and all that kind of thing.
- LR: You're whole life is turned upside down. And how people cope and the coping mechanisms they use are different from person to person, yet there are some commonalities. They are fascinating.
- DY: It certain is, and very necessary.
- LR: Well, you know, patients do express that it's been cathartic for them. They don't use those words, but they say that it really does help them to tell their stories.
- DY: Of course.
- LR: And, who knows, we might be being therapeutic in some ways.
- DY: Story-telling is a ritual kind of healing used in many, many cultures.
- LR: That's right. And we probably don't do enough of it.
- DY: Yes, that's why I'm so impressed with your dissertation work and how you should keep doing that. Lois, that's wonderful.
- LR: Yes, I'm looking at developing a grant so that we can do some research with decision-making. How families and patients make decisions over some of these very critical issues. Maybe I'll get funded some day!
- TS: I'm sure you will! I've been doing a lot of reading lately about metropolitan universities and what our mission is, not that we're necessarily a metropolitan university, but we're in a metropolitan area here, and what the mission should be

- at institutions like Kennesaw that don't have the wherewithal to be Research One—Carnegie doesn't call it Research One anymore. They changed their term.
- LR: Research Intensive?
- TS: Yes, Intensive and Extensive—I can't keep straight which is which. Anyway, we're not going to be the Research . . .
- LR: The R-1 kind of thing.
- TS: Yes. Let's see, it's extensive, that's the top one (more basic research and lots of doctoral programs and grant money), isn't it?
- DY: We're research intensive [more applied research, some grant money, and limited doctoral programs].
- TS: At least we're trying to get there. But I guess what I wanted to ask is whether you've developed kind of a philosophy of what Kennesaw should be, and how what you're doing fits in with what you would perceive is the mission of a College of Health and Human Services in a state university.
- LR: Yes. Well, I see us seated in our community and just embedded in our community, particularly in our field. We couldn't teach our students if we didn't have the support of the community and the clinical sites that we use. And it's not just the hospitals. It's the clinics, it's the doctor's offices, [and] it's the community agencies. So there's a tight partnership there, and there has to be in order for us to exist. I see the mission, I suppose—even though we're a state university—being so embedded in the community, being of service to the community, as well as tapping into the economic strength of the society around us. I really believe that it's a two-way street. Our students become their employees. Their employees come back and become our students again, in the master's program, for example, and hopefully in the doctorate program, eventually, so we're part and parcel of the community. They can't divorce us.
- DY: How do you see that community geographically? What do you see the boundaries of that community being, in northwest Georgia or . . . ?
- LR: North Georgia. We're spreading.
- DY: That's what I thought.
- LR: We're starting to think beyond northwest Georgia to north Georgia, being the University of North Georgia. I wouldn't have said that three days ago, but because I've learned our new thrust is going to be to have satellite programs, even beyond northwest Georgia, in nursing.

- TS: You say three days ago . . . ?
- LR: When I had a conversation with my dean [laughter]. But I've always thought that we are a strength in north Georgia. We are one of the leading nursing programs in the state.
- TS: Does north Georgia encompasses all of the Atlanta metropolitan area, or do you think more north?
- LR: No, I think more Marietta north. I mean we attract students from north Georgia. We have people who come from Ball Ground and Jasper, who come to our nursing programs already. I mean, not a whole lot, but we see that there is growth in health care up there in the north Georgia mountains because of the influx of retirees. So now they have a new hospital, the Piedmont Mountainside Hospital is up there in Jasper. It's out in the country.
- DY: Where everyone's living up there building their mountain homes.
- LR: That's right. So they have a need for health care, even if they have to be helicoptered from that place to St. Joe's [Saint Joseph's Hospital of Atlanta], or something. But there is a need, and they are functioning with lower level practitioners at this point, LPNs. A lot of the small community hospitals have relied on very few RNs and mostly LPNs, to bring the care into these places. And they are trying to upgrade themselves, so the need for educated people up in that area is going to be increasing. So we see ourselves as providing that, even though there's North Georgia College & State University in Dahlonega.
- TS: I was going to ask you who our competition was.
- LR: So forming those partnerships with technical schools and associated degree programs—we're already in Rome, as you know. We're teaching a satellite group up in Rome.
- TS: No, I didn't know that.
- DY: I didn't either.
- LR: Yes. We have a whole group of thirty, forty up in Rome that are taught at Highlands [Georgia Highlands College]. They've given us lab space, expanded the laboratory for the students and classroom, and we're teaching up there. We're doing some clinicals up in that region, but most of them are in the metro Atlanta area.
- TS: We've heard from some people that they think service is not really counting for as much on our campus, and scholarship is becoming the "all," the only thing that matters. You're shaking your head, so I guess you're thinking the same thing?

LR: Well, I've been told that loud and clear, that scholarship is our focus and particularly for me, as a scholar, that needs to be my focus. However, I see some of my service as very scholarly in that I wouldn't know the research questions to ask, if I weren't embedded in and part and parcel of that process of giving care to patients and families. So I see it as parts of a whole, but I'm being directed.

TS: But you're not being rewarded for the service parts.

LR: "You need to let go of the service, Lois. You can't do all that service. You've got to really refocus more of your attention on research."

TS: Now is your position unique because you're a Distinguished Scholar?

LR: We have now tenure tracks, if you will [in the WellStar College]. Solid teaching is your focus, or teaching and scholarship together, or primarily scholarship for those people who are teaching in the master's programs exclusively. And we're moving toward having a cadre of master's faculty and baccalaureate faculty. We haven't done that. We've done so much back and forth, and we haven't been designated. But that's going to be happening—that if you're designated a person who teaches in the master's program, that you would be focusing on scholarship—so because, I am a scholar and because I'll be doing that in the master's program and even the doctorate that I need to let go of some things.

TS: I guess the follow-up is, how do you feel about these changes that you see?

LR: Well, it's exciting, in a way, because I've already focused a lot of attention in that area, but I'm burning my candle at both ends. Yes, many, many hours, too many hours devoted to work, and not enough to home and myself. So I know that that's the direction I need to go. It's how do you say "no?" How do you say, "I can't help you with this research project at the hospital," for example? I'm a consultant on the Nursing Research Committee, so they know that I provide. But WellStar is also starting to see the light, too. They've hired a person to be their nursing researcher for the first time ever. So now they're seeing that they need to invest time and money and effort into having their own people to lead their research endeavors. So that gives me great joy, because that releases me from being the only person who's guiding and directing their research. All these nurses have been through a master's program and did a mini-research project. They're learning.

DY: There's nothing like experience either.

LR: That's right. We all learn from every project we do. So, how do I feel about it? I'm excited, but I'm also grieving it a little bit because that service portion has been rewarding and is important to them and to me. So I have to figure it out yet.

DY: It sounds like you will almost be in another remove from it and that might be what you're feeling—that you are now at the place that you can direct others to do what you have been doing solely, all along. But that's a good thing. That's teaching too.

LR: That's right. We'll see how it goes!

DY: I think you do wonderful work.

LR: Thank you! Now I wish I could interview you guys [laughter]! I want to find out about what you do!

DY: This is the first time in a long time we've interviewed someone who's done oral histories and interviews. She shows no surprise when Tom's carefully watching the tape.

LR: Oh no. I know what it's like.

TS: I know the day's going to come that it's not going to tell us that it's stopped.

LR: I had that happen once and I lost half of an interview.

TS: Well, I've run through my list of questions, I think. Dede, do you have anything that we haven't talked about? You sometimes ask people what they're the proudest of, of what they've done at Kennesaw.

DY: That's a good question for Lois because she has so much to choose from.

LR: I don't know. I'm the kind of person who doesn't like to pick pieces, who sees myself as a person with some integrity and wholeness, and it all meshes together. So pulling one thing out as being the most important, or the most significant—I guess being given the position of being the Distinguished Scholar. I think that was really significant, if I had to pick something.

DY: Because it's honoring what you have done, acknowledging that, and encouraging and empowering you to continue to do it.

LR: Right. And so all that behind the scenes work is understood, what it's worth and that it's being acknowledged.

DY: Well, I think when you're a pioneer in an area, as you have been, then people don't always recognize it until—what—it makes prime time television programs? And that is a question I wanted to ask you about. Those of you who are working, especially as you are, so intimately and intensely, not just in health care, but in a particular area, the television programs that are on now that are focusing on

those—does that make your job easier or hard? Do people come in with these pre-conceived ideas—this is how my surgeon will act?

LR: They do have preconceived notions, and what I try to do is to focus on the facts. For example, the program *ER* [NBC] that lots of people watch, and a lot of our students love and they come in with these stories from *ER* all the time—and they think that everybody who gets resuscitated survives. Somebody did a study once and counted the number of times that resuscitation happened on the program *ER*, and actually identified what percentage were successfully resuscitated. In that case, 83 percent of the patients were successfully resuscitated. So then you use that as a teaching tool, and say, “Well, now, what is it really? What percentage of patients survived a resuscitation?” It’s about 16 percent, because most resuscitations are done when people are close to death, or about to die.

DY: Do you talk about *House* [FOX]? Do your students talk about *House*? Do you watch it?

LR: I don’t watch much television.

DY: Yes, I know.

TS: I don’t think you have time to.

LR: I have watched that. I’ve never watched a whole episode all the way through, but snippets of it. It’s a little far-fetched, but students will come in with the stories, and then we’ll talk about it, and we’ll use it as a teaching tool. We also like things in the news like the sixteen year-old who has leukemia, who has refused to have more chemotherapy, whose parents are behind him 100 percent and then somebody reported them to DFACS as being neglectful of his care because. . . .

TS: That’s an ethical issue.

DY: It sure is.

LR: That’s an ethical issue. So you take scenarios like that, that you hear from the news or see on the television, and we process them.

DY: Yes, it’s almost like you have another text out there.

LR: Oh yes, always! There’s always something. When the Terri Schiavo case was on the news so much, we talked about that. We looked at the real history. So, yes, it’s great teaching because it’s public information. Then you use it to your advantage in making a point, or at least ferreting out all the different viewpoints and perspectives, and having the students deliberate themselves and come up with an answer as to how they would behave if they were in a situation like that, because nurses are all the time, all the time.

- TS: It sounds like there's a good balance in your classes between the liberal arts and the clinical, or practical part, of education. Is that true throughout our nursing program, do you think?
- LR: Well, you see some classes lend themselves very well to that, and I have to teach some of the classes that lend themselves to that kind of teaching. In fact, I'm teaching a course that called Perspectives in Nursing: the legal, the ethical, the issues in our profession, the professionalism, how you are to behave, what our image is, the communication, that sort of thing. That Perspectives class—we invited a nurse who is a writer, a poet, to come in and share some of her poetry. So we can do that in that class. But when I'm teaching shock, I'm teaching care for patients with diabetes, when we're focusing on endocrine disorders, that lends itself much more to Power Point and pictorials, and that sort of thing. We always use AV, though, to some extent, some visuals, to help the students understand. But, yes, I guess the Medical Humanities has been around for a long time. The Nursing Humanities is growing right now. There is more literature out on the creative side of nursing and the stories of nurses, more about the humor that's in our profession. So, yes, there is the opportunity. We just pick wisely. We slip it in. And, of course, I love literature.
- TS: I keep hearing that there is a critical shortage of nurses.
- LR: Very critical, and it's going to get worse.
- TS: Because they don't pay them enough, or they have other alternatives?
- LR: Multi-factorial, and those are two of them. One of the reasons, also, is the lack of faculty in nursing.
- DY: Yes, you're a rarity with a Ph.D.
- LR: Yes, some programs have had to close because they didn't have faculty to teach the course. Some programs have had to scale back the number of students, because they haven't—some 53,000 potential nursing students have been turned away because of the lack of faculty. We have faculty that come into nursing and teach with us for a year and then go back out to the hospitals because they can make double what we make here. You can't blame them, you really can't. Faculty also have multiple responsibilities. Nurses at the bedside do their work and go home. No papers to grade and all that. There are other things, you know that. Plus people don't go into nursing, oftentimes, because they do have other options. There are many more careers available to women and we're predominantly still a women's profession. There are only 7 percent of nurses are men.
- TS: What about our students?

- LR: About the same. A little higher, about 8, because we do tend to attract males into Kennesaw State, I think, because of our role models: David Bennett and Dr. Sowell [Richard L. Sowell]. Another issue is that we have a whole host of nurses—nurses are getting older—the average age of nurses is forty-three, so as all those folks retire we don't have the numbers to come and supplant those. Young women are being more choosy about their professions.
- DY: Yes, they have more opportunity. They have the resources to go to medical school, if they want to, for an M.D.
- LR: And it is true now that 50 percent of the applicants for medical school are women.
- TS: Is that right?
- LR: Yes, it's finally turned the corner.
- TS: What about the ones that get accepted?
- LR: That's what I meant. They're accepted into medical school. That's going to change the horizon of everything.
- DY: But anyone who has been critically ill and, certainly hospitalized, your experience is with the nurses.
- LR: Twenty-four/seven, the nurses are there. Doctors come and deliver and then go. They spend three to five to maybe ten minutes.
- DY: And there's a host of them!
- LR: Yes! Sometimes twelve or thirteen different doctors come in. So, yes, if nurses left the hospital, you wouldn't run a hospital, you couldn't do it. You can't run health care without nurses. So we're trying to attract people into the profession. We're doing all we can to recruit, even at the elementary school level. Is that what it's called now?
- TS: I guess.
- DY: We all went to grammar school.
- TS: That's the name that survived from the days when schools were Latin grammar. Are our nursing students typically straight out of high school or typically non-traditional?
- LR: Non-traditional. In fact, we have what we call the accelerated group, we have that program; we received funds so that we could take in another thirty or forty

students who already have degrees in other areas. They had their baccalaureate. We put them on the fast track to get through the program within eighteen months, sixteen months I believe it is. They are bright. Because they've already gone to college, they know what this is all about; and they're all adults who have families, non-traditional, and they take this very seriously. They are taking a full load, unlike many of our students who do it part-time. They are bright and they are fun to teach and they bring such richness from their backgrounds into the discussion, so it really is fun.

TS: Right. You teach a course Perspectives in Nursing. Is that an introductory course?

LR: No, actually it's at the senior level. After they've been through Mother, Baby, Adult Health, Psych-Mental Health, they come to me and then we discuss. They get some of that professionalism early on in Marie [N.] Bremner's course in sophomore year, but this is where they get it. And they've had some experience in the profession, so they can really discuss these issues—the political issues, for example, the macro issues in health care. We discuss such things as managed care and the pros and cons of managed care, so it's more of a capstone than it is an introductory one.

TS: We've often asked people why they've stayed at Kennesaw. It may be pretty obvious in your case, but maybe not. Why have you stayed?

LR: Well, it's just a good fit, I think. The opportunity to switch perspectives and the ability to grow, develop myself as a researcher and as a writer, being given the freedom to do that. And, you know, when my sister was dying and I needed to take a leave of absence, there was absolutely no question about it. Having that support from colleagues and they just picked up the ball and took over my classes. I didn't have to worry one iota about it. I had enough to worry about, of course, but just having colleagues—that when you come up to them in the hall, and they say, “Oh, how are you doing?” You have this camaraderie. In every area and in every type of work, you have disagreements and all that sort of stuff and battles, but I think we are a fairly cohesive faculty. A lot of us have been here for a long time. The same group, I mean, Chris [D.] Horne and I went to school together at Georgia State. She was teaching at Clayton [State University], at the time, and I got her to come up here, and, you know, it's like we're friends. In fact, Beverly [J.] Farnsworth, I'm sure you know her. She's retired. She gets a small group of us together every semester for a fun day out. She can make all the arrangements—she's got the time to do that for us, and we stay in touch that way. We complement each other.

TS: There are a bunch of you, Judy Perkins and Vanice Roberts have been here for a long, long time, and, of course, [L.] Annette Bairan has been here for ages.

LR: There must be something about it that keeps us all here, and I think it is that, and I think it's the fact that we're comfortable with each other to a certain extent. This is a growing place. There's always a need for us.

TS: Did we talk about all the service that was behind the Preston Award in 2002?

LR: Let's see, ethics committee, volunteer, the critical conditions—we talked about. No, the whole thing: *On Our Own Terms: Bill Moyers on Dying* [PBS], when he had that series on television—I was the point person, the chairperson for the Georgia Coalition for Quality End-of-Life Choices. [I] worked with a whole host of hospices and health care institutions in our area to spread the word, get the satellite down links, make sure that we got people involved, and congregated an audience for that.

TS: It's hard to imagine what Bill Moyers hasn't done.

LR: Right. And then I think that was all for the Preston Award. I've done other things too, but that was all the Preston Award.

TS: Anything else you want to talk about?

LR: The Health Care Ethics Consortium of Georgia, I've been involved in that and that is a consortium of hospitals across the state that address health care ethics issues. I would say that is a great place for those of us who are oddballs to get together and talk about the meaningful things in our profession, to rehearse cases, to learn about negotiation, to network. That's been a real support, I think, for all of us on ethics committees, because I'm the only person in our college that deals with ethics to this degree, so having that outside connection has been helpful. Because then you have people from Georgia State, from Emory, you know, and we're together on the same page. That's about all.

TS: You know, it's been great for us to do these interviews because we're learning so much about what's going on, on our campus. It's just astounding.

LR: We all have our own little silos, don't we?

DY: We do!

LR: We don't have the time to get to know what's going on in other buildings. It's sad.

TS: Well, it is, but I guess it's a reflection of the fact that we're doing so much, too. I've thoroughly enjoyed the interview today.

LR: Thank you, I have too. It's kind of neat to wrap your mind around all the stuff that you're doing and take stock.

TS: I was telling somebody the other day that I was proud just to be at the same institution with somebody who was doing as much as he was doing, and the same applies to you too.

LR: Thank you.

DY: We have many, many talented people who are so busy that they can't see what they do!

LR: I know. And like the book clubs, I would love to go to those.

DY: Oh, I hope you'll be able to.

LR: I've only been to two of them, and then we had the Scholarship KSU—a long time ago. It was Bob Hill [Robert W. Hill] in English.

DY: That was awhile back.

LR: That was a long time ago, but that was so neat; that was great. We need to make time to do those things. So I'm always reading anyway; I'm sure you are.

DY: I have one story [and] I'm going to send you a copy of it, if you don't already know it. Do you know Raymond Carver short stories, *What We Talk About When We Talk About Love* [: *Stories* (New York: Knopf, 1981)]? What would interest you about it is the story—the characters are all gathered around the table, just sitting there drinking and talking and there's a surgeon there. He's the only medical professional there, but they begin to talk about their own experiences with love, and he says—oh, he's a heart specialist—and he says the time that he saw the greatest love was this elderly couple who had been in a car accident and they wanted to be in the same room with each other. And he said, "I don't understand it, I mean, he couldn't even turn to see his wife, he couldn't see her." I think you would love this story!

LR: Sounds like I would.

TS: Thank you for coming at the end of the day to talk with us.

LR: You're welcome.

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