

# **Carol Porter, DNP, RN, FAAN**

## **Interview Navigation Materials**

Interview #

**Date submitted:** 9 April 2019

### **Interview Information**

Three sessions: 4 January 2018, 25 January 2018, 6 July 2018

Total approximate duration: 2 hrs 6 min.

Interviewer: Tacey A. Rosolowski, Ph.D.

**To request the interview subject's CV and other supporting materials, please contact:**

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### **Interview Subject Snapshot:**

Name: Carol Porter, DNP, RN, FAAN

Interviewed: 2018

Primary appt: Division of Nursing

Research:

Admin: Chief Nursing Officer and VP Nursing Practice (2016 – present)

Other:

Interview link:

### **About the Interview Subject**

Dr. Carol Porter came to MD Anderson in 2016 to serve as Chief Nursing Officer and Vice President of Nursing Practice. In this interview she discusses her approaches to strengthen clinical excellence and research in the Division. She also discusses her background in emergency management, which became relevant as the institution coped with Hurricane Harvey in 2017.

### **Major Topics Covered:**

Personal background and education

Vision for evolution in the Division of Nursing

Leadership issues in nursing

Emergency management: training and experience prior to MD Anderson, 9/11; importance of emergency management training to a nursing career; leadership in emergency management

**About transcription, the transcript, and the views expressed**

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The University of Texas MD Anderson Cancer Center.*

## **Carol Porter, DNP, RN, FAAN**

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# **Carol Porter, DNP, RN, FAAN**

## **Chapter Summaries**

### **Interview Session One: 4 January 2018**

#### **Chapter 00A**

##### ***Interview Identifier***

#### **Chapter 01**

##### ***Emergency Management and Leadership***

##### **A: Overview;**

Codes

C: Leadership; D: On Leadership;

C: Funny Stories;

C: Professional Practice; C: The Professional at Work;

A: Character, Values, Beliefs, Talents;

C: Women and Minorities at Work;

B: MD Anderson Culture;

B: Working Environment;

In this chapter, Dr. Porter provides an overview of what leaders will experience by taking part in Emergency Management. She notes the teamwork that can lead to long-lasting relationships. She also explains that emergency management allows a leader to see the “nooks and crannies” of an institution.

#### **Chapter 02**

##### ***Experience in Emergency Management***

##### **A: Professional Path;**

Codes

A: Overview;

A: Professional Path; C: Evolution of Career;

C: Leadership; D: On Leadership;

C: Professional Practice; C: The Professional at Work;

A: Character, Values, Beliefs, Talents;

C: Women and Minorities at Work;

B: MD Anderson Culture;

B: Working Environment;

Dr. Porter begins this chapter by observing that she was a trauma nurse for ten years before taking on opportunities in emergency management. She notes that trauma parallels emergency situations, and she was intrigued by the need for quick thinking and fast decision-making. She served as Manager of Emergency Services at Englewood Hospital in Englewood, New Jersey (1991 – 1997), an institution situated near a busy highway. She focused on response strategies around hazardous materials. Next she was recruited to set up a Trauma Center at Good Samaritan Hospital in Suffern, NY and served as Director of Critical Care and Emergency Services (1997 – 1999). She explains why this hospital needed a trauma center. She also discusses how the hospital worked with the Hasidic Jewish population, to ensure effective healthcare delivery. She also notes that this hospital was located near Indian Point Nuclear Power Plant, necessitating that the hospital conduct nuclear drills.

In 1999, she explains, she was recruited to Lenox Hill Hospital in New York City to serve as Director of Emergency Services, Emergency Preparedness, and also as the Bioterrorism Coordinator. She explains that the hospital was receiving terrorist threats and also dealing with concerns about the impending millennium.

Dr. Porter then returns to her discussion of her work at “Good Sam” and explains that she had the valuable opportunity to work with a military emergency management specialist at this time. She notes that she provided about 300 instructional sessions for dealing with hazardous materials and threats.

## **Chapter 03**

### ***9/11***

#### **A: Professional Path;**

Codes

A: Personal Background;

C: Leadership; D: On Leadership;

C: Professional Practice; C: The Professional at Work;

In this chapter, Dr. Porter talks about her experience as an emergency management leader at Lenox Hill Hospital when the terrorist attacks occurred in New York City on Tuesday, September 11, 2001. She had been recruited to Lenox Hill Hospital in New York City in 1999 and was serving as Bioterrorism Coordinator. She describes the scenario at the hospital as reports of the attacks on the Twin Towers came through. She describes coping with her own knowledge that her son worked in a building across the street from the Twin Towers and her concerns when she was unable to contact him or her daughters.

She explains how the hospital realized there would be no influx of wounded survivors and how they turned their attention to “what can we do for the community?”

Next, Dr. Porter talks about how 9/11 forced her to realize how important it is for a leaders to control her own demeanor –despite personal feelings-- for the sake of the institution she is

leading. She underscores how important it is for a leader to identify colleagues she can lean on and how important it is to be able to multi-task and attend to the impact the emergency is having on people.

Dr. Porter talks about how her children handled the emergency.

She then reflects briefly on how the city recovered from the terrorist attacks, holding the New York Marathon. She talks about her participation and how this helped her see the city returning to normal.

## **Interview Session Two: 25 January 2018**

### **Chapter 00B**

#### ***Interview Identifier***

### **Chapter 04**

#### ***From Mount Sinai Hospital to CNO and VP of Nursing Practice at MD Anderson***

##### **A: Professional Path;**

Codes

C: Leadership; D: On Leadership;

A: Joining MD Anderson;

A: Overview;

A: Professional Path; C: Evolution of Career;

C: Leadership; D: On Leadership;

C: Professional Practice; C: The Professional at Work;

A: Character, Values, Beliefs, Talents;

C: Women and Minorities at Work;

Dr. Porter begins this chapter by talking about her work as Chief Nursing Officer at Mount Sinai Hospital in New York City. She focuses on her work with the unions, a traditionally adversarial stakeholder, and explains how she was able to build a strong partnership. She notes that after 12 years in that role she was “ready for another adventure.”

### **Chapter 05**

#### ***CNO and VP of Nursing Practice at MD Anderson***

##### **A: Joining MD Anderson/Coming to Texas;**

Codes

A: Personal Background;

B: MD Anderson Culture;

Dr. Porter explains that she received a call from a recruiter for MD Anderson and describes coming to visit the institution for her current role.

Dr. Porter explains that because she had visited MD Anderson in 2010 for a survey, she knew many people and “felt like I worked here.” She explains how she decided to leave Mount Sinai and how she wanted to take on the challenge of seeing how she could contribute to move the MD Anderson bar even higher.

## **Chapter 06**

### ***Areas to Address as Chief Nursing Officer***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;

C: Professional Practice; C: The Professional at Work;

C: Collaborations;

C: Leadership; D: On Leadership;

C: Mentoring; D: On Mentoring;

In this chapter, Dr. Porter discusses areas where she felt she could make an impact at MD Anderson. She begins by summarizing her management style and notes some challenges that arose as nurses became accustomed to her style during rounds.

She tells a story about nursing in orthopedic surgery to illustrate her goal of integrating patient experience and quality scores. She also talks about bringing more use of social media to the institution. She notes that social media was used extensively in NYC, yet MD Anderson was nervous about its use when she arrived. She uses examples to demonstrate the positive impact of social media on perceptions of MD Anderson leadership. She also notes that social media can capture the ‘granularity’ of the institution and its culture. She talks about receiving posts from nurses internationally, noting “you become their hope.” She talks about her philosophy and guidelines for using social media in an institutional context.

## **Interview Session Three: 6 July 2018**

### **Chapter 00B**

#### ***Interview Identifier***

## **Chapter 07**

### ***Developing Nursing with an Endowment from the Argyros Family Foundation***



## **B: Building the Institution;**

### Codes

C: Leadership; D: On Leadership;  
A: The Researcher;  
B: Building/Transforming the Institution;  
B: Fundraising, Philanthropy, Donations, Volunteers;  
D: On the Nature of Institutions;  
B: Working Environment;  
B: MD Anderson Culture;

In this first half of this session, Dr. Porter discusses how she is using an endowment of three million dollars from the Agyros Family Foundation to implement her vision for developing the Division of Nursing [Agyros Family Foundation Nursing Research Endowment]. Dr. Porter explains why it is important to develop the key facets of her vision: the academic and research infrastructure. She first notes that she is using funds to bring in nationally recognized nursing leaders to share information and to consult on how MD Anderson can develop nursing. She has submitted a proposal to hire a full professor of nursing research. She explains her logic: to develop nursing practice at MD Anderson and also to develop a community of nursing leadership within the institution and that has a high profile nationally as well.

Dr. Porter explains that the siloed culture at MD Anderson has held back this growth and she talks about her strategies to work around it. She explains the many successes that the division has had recently –all indications that this long term strategy is paying off. As an example, she discusses how she has begun nominating MD Anderson nurses to be fellows of the American Academy of Nursing, noting that Gary Brydges is the first “home grown” nurse to be honored in this way.

## **Chapter 08**

### ***Observations about Nursing and Hurricane Harvey***

#### **A: Overview;**

### Codes

C: Leadership; D: On Leadership;  
B: Working Environment;  
B: MD Anderson Culture;  
B: Obstacles, Challenges;  
B: Institutional Mission and Values;  
C: Human Stories;  
C: Offering Care, Compassion, Help;  
B: Survivors, Survivorship; C: Patients, Treatment, Survivors;  
C: This is MD Anderson;  
C: Professional Practice; C: The Professional at Work;  
C: Collaborations;  
B: Beyond the Institution;

In this chapter, Dr. Porter gives an overview of the strong performance of MD Anderson and of nursing during Hurricane Harvey in September 2017.

She notes her background in emergency management, but explains that in the northeast, where she had prior experience she had had no experience with MD Anderson policy, particularly regarding the strategy of having a “ride-out team” [see UT System article below]. She talks briefly about adjusting to this new policy.

Next, Dr. Porter talks about the key activities undertaken to ensure effective delivery of patient care during the period when MD Anderson was isolated and supported only by the ride-out team. She talks about ensuring that people in the Incident Command Center and on staff in the hospital units were relieved periodically so they could sleep. Dr. Porter also talks about the process by which nurses from four other institutions came to support patient care efforts. She explains how quality of care was guaranteed and comments on the excellent team-building that was accomplished, such that after a couple of days it was not possible to distinguish MD Anderson staff from the support staff from outside.

Next, she expands on the ride-out team policy and notes that a key challenge was to keep this staff safe and effective by getting them to take breaks.

She also comments on the impact of the fourth meal provided by Food Services to patients and to the team, as well as the fact that the fitness center was opened so the team could wash and decompress.

Dr. Porter then notes that the experience underscored that the staff and patients felt cared for, and the Incident Command Center operated in a respectful and caring way. She explains that the patient care areas never ran out of supplies.

## **Carol Porter, DNP, RN, FAAN**

**Interview Session One: January 4, 2018**

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## **Chapter 00A** ***Interview Identifier***

***T.A. Rosolowski, PhD***

[00:00:01]

It is January 4, 2018, the first time I've said that date aloud, and it's about twelve minutes after ten in the morning. I'm in the office of Dr. Carol Porter, who is Chief Nursing Officer. We're in Pickens Tower, on the eighteenth floor, and we are here today, to talk about Dr. Porter's observations and experiences surrounding [Hurricane] Harvey. This is an interview that's being conducted for our subseries, Making History Now, and I just want a couple of details. I wanted to note that you were recruited to MD Anderson in October of 2016, correct?

[00:00:43]

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***Carol Porter, DNP, RN, FAAN***

[00:00:43]

That's when I started, yes.

[00:00:44]

***T.A. Rosolowski, PhD***

[00:00:44]

That's when you started. This is the first of two planned interview sessions, we might do more if we need that, and I wanted to thank you for devoting your time to the project.

[00:00:55]

***Carol Porter, DNP, RN, FAAN***

[00:00:55]

Well, thank you. Of course, of course.

[00:00:57]

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## **Chapter 01**

### ***Emergency Management and Leadership***

#### **A: Overview;**

Codes

C: Leadership; D: On Leadership;  
C: Funny Stories;  
C: Professional Practice; C: The Professional at Work;  
A: Character, Values, Beliefs, Talents;  
C: Women and Minorities at Work;  
B: MD Anderson Culture;  
B: Working Environment;

***T.A. Rosolowski, PhD***

[00:00:58]

Now, I wanted to kind of start with sort of a general question, because I know, as part of your mandate here at MD Anderson, you're interested in strengthening nursing leadership.

[00:01:09]

***Carol Porter, DNP, RN, FAAN***

[00:01:10]

Yes.

[00:01:10]

***T.A. Rosolowski, PhD***

[00:01:11]

I wanted just to capture, at the outset, your observations on how does preparation in emergency preparedness dovetail or feed nursing leadership?

[00:01:24]

***Carol Porter, DNP, RN, FAAN***

[00:01:25]

That's a great question. First of all, you have to have experience in emergency management. You cannot have experience and take courses while you're on the job, but I believe that if you come with experience in emergency management and take the courses, it's transferrable in the country. I have the fortunate position to have over twenty years' experience in emergency management, while being a nursing leader in New York and New Jersey. So, I believe that in order to be an effective emergency management leader, you have to be extremely confident and you have to know your subject matter. That's why it's hard if somebody just takes a course and then is thrown into an emergency. If that happens, hopefully there are people around that have

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been through emergencies that can guide the person that just took the course. I have been through many, many emergencies in New York City, the major ones: 9/11, the blackout across the city of New York, a major fire in an academic medical center, coordination of dirty bomb drills, I was a bioterrorism coordinator. So I come to MD Anderson with that little niche, which is not—that's unusual for a nursing leader at any level.  
[00:02:51]

***T.A. Rosolowski, PhD***

[00:02:52]

What does going through an emergency of the types that you've just listed, what does that teach you about an institution?

[00:02:58]

***Carol Porter, DNP, RN, FAAN***

[00:03:00]

It teaches whether people work together, is teamwork present. In a severe emergency like I mentioned, it's hard to—it's a little too late to teach people. So, it emphasizes the importance of ongoing drills and education. It's not a once a year thing, it's a frequent thing, because if you're in an institution that doesn't do that, then you have to overcome that hurdle, and if you're an institution that drills and it's just part of the fabric, it's very seamless. The other thing, I think it brings people together. When you go through any kind of emergency, emotional trauma, whatever, at the end of it, you form relationships that you'll have, that you never—it would have taken you five years to form. At the end of it, people have come together because they went through it together. Since it's not common, I think it's good for other disciplines, to see a nursing leader in the role of incident commander. It's unusual.

[00:04:13]

***T.A. Rosolowski, PhD***

[00:04:14]

Why is that?

[00:04:15]

***Carol Porter, DNP, RN, FAAN***

[00:04:16]

I don't know. I try to promote it almost every conference I speak at. I always do a little talk about the fact that I think it's important to find your niche, like what makes you different than the crowd, and then once you find what you love, then be really excellent at it. I always suggest getting involvement in emergency management, because that's an area that most nursing leaders don't have the experience.

[00:04:41]

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***T.A. Rosolowski, PhD***

[00:04:42]

So it really distinguishes you as a leader.

[00:04:44]

***Carol Porter, DNP, RN, FAAN***

[00:04:45]

Right.

[00:04:45]

***T.A. Rosolowski, PhD***

[00:04:46]

If you warm to that.

[00:04:46]

***Carol Porter, DNP, RN, FAAN***

[00:04:46]

Right. Also, if you happen to work in a hospital, nurses are the biggest staffing pool. So it's good for the nurses, to see the nursing leader in the Command Center and being confident and directing people and checking on people. It's just another leadership trait. I wish more people would be—you have to be interested in it, because it's really something that—I mean, when I was a bioterrorism coordinator, that was a brand new title, I had to learn what does that mean. I was on the Coordinating Council in the city of New York and I learned. But I think it's—you know, there's many niches in nursing but that's just one of them.

[00:05:32]

***T.A. Rosolowski, PhD***

[00:05:32]

Yeah. I was wondering too, I mean I've had many conversations with people in nursing, and they talk about the struggle that—I mean there's a hierarchy in a medical community.

[00:05:43]

***Carol Porter, DNP, RN, FAAN***

[00:05:42]

Right.

[00:05:43]

***T.A. Rosolowski, PhD***

[00:05:44]

And nurses are not necessarily at the top of that hierarchy. Now, does it help if a nursing leader emerges in an emergency situation, does that help establish credibility, I mean what's the impact

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of that?

[00:06:00]

**Carol Porter, DNP, RN, FAAN**

[00:06:00]

The impact to the hospital?

[00:06:01]

**T.A. Rosolowski, PhD**

[00:06:02]

Maybe on how nurses are perceived.

[00:06:04]

**Carol Porter, DNP, RN, FAAN**

[00:06:05]

Okay. Well, I think it definitely, it's definitely they're curious about it, I felt people were curious. When I appeared, when Harvey hit and I came into the Command Center, there were two physicians in there acting as co-incident commanders, and they had been there for a while and I said to them, "Why don't you both go to sleep," and they kind of looked at me and I said, "I have twenty years' experience in this, you're safe. I've been in an incident commander role several times and I could certainly allow you guys to go to sleep." So I think it was a learning for other people and I think that's why the Executive Council of the Faculty Senate, invited me to speak to them. They had a lot of questions about how did you learn this, where did it start and all that. And I think it's a great opportunity, especially for somebody that's relatively new to the organization, to get into every nook and cranny at the hospital that you may not have reached. All of a sudden you're communicating with everybody.

[00:07:10]

**T.A. Rosolowski, PhD**

[00:07:10]

Yeah, yeah. And they get to know you, it's a back and forth.

[00:07:12]

**Carol Porter, DNP, RN, FAAN**

[00:07:12]

Yeah, of course, and your style. We had some fun, we had some humorous moments. When you're under stress, people usually eat more carbohydrates, and that's not just in Texas, that's everywhere. So, when you entered the Command Center, there was bagels and donuts and you name it, and I'm not a big carbohydrate eater and at one point, I was talking a lot and they said, "You have to have a Shipley Donut," and I said, "What's a Shipley Donut?" They said, "You don't know what a Shipley Donut is?" I said, "No, I've never had one." So, I said sure, I took a



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bite, and I came silent, and everybody went nuts, they went crazy, they said, “Oh my God, Carol is not talking.” That was just kind of, it broke the stress, they Tweeted it out to the world, unfortunately, and I had a Shipley Donut and it was delicious.  
[00:08:08]

***T.A. Rosolowski, PhD***

[00:08:08]  
It was a human moment.  
[00:08:09]

***Carol Porter, DNP, RN, FAAN***

[00:08:10]  
Yeah.  
[00:08:10]

***T.A. Rosolowski, PhD***

[00:08:11]  
A human moment with a leader, which is really cool.  
[00:08:12]

***Carol Porter, DNP, RN, FAAN***

[00:08:12]  
So, I think that was—I mean Dr. Karen Lu was the one who Tweeted it out. It was kind of the camaraderie piece of it.  
[00:08:20]

***T.A. Rosolowski, PhD***

[00:08:21]  
Sure. That’s part of building those relationships you were mentioning earlier.  
[00:08:25]

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## **Chapter 02**

### ***Culture, Trauma, Radiation, and More: Gaining Experience in Emergency Management***

#### **A: Professional Path;**

Codes

A: Overview;  
A: Professional Path; C: Evolution of Career;  
C: Leadership; D: On Leadership;  
C: Professional Practice; C: The Professional at Work;  
A: Character, Values, Beliefs, Talents;  
C: Women and Minorities at Work;  
B: MD Anderson Culture;  
B: Working Environment;

***Carol Porter, DNP, RN, FAAN***

[00:08:26]

I was a trauma nurse when I was a clinical nurse, and trauma nursing is very similar to emergency management. When you have a trauma patient come in the door, the first half-hour or so is so vital, and you can't not know what you're doing. So it's the same thing, in an emergency, you have to be with somebody at least that knows what they're doing, or a group that knows what they're doing. It's the same thing in trauma nursing. You're part of a team, but you have to make sure that there's people with experience on that team, as well as people coming into the field, but many people that have experience. It's the same thing here.

[00:09:03]

***T.A. Rosolowski, PhD***

[00:09:04]

Well, let me ask you the question that the Executive Committee asked you, which is kind of where it started. When was the moment when you decided to pursue emergency preparedness, emergency leadership, as part of your career?

[00:09:21]

***Carol Porter, DNP, RN, FAAN***

[00:09:22]

I was a nurse for about ten years and had been fascinated, trying to understand what emergency nurses do, and so I used to, whenever I had a break, I would go down to the Emergency Department and kind of watch them.

[00:09:37]

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***T.A. Rosolowski, PhD***

[00:09:38]

What was it that intrigued you about that scenario?

[00:09:40]

***Carol Porter, DNP, RN, FAAN***

[00:09:42]

I think the thinking on your feet in seconds. I think the challenge to—it challenges everything you've learned and you have to know—you have to be a generalist. At most emergency centers, you have to know a good portion about everything. So, I found that challenging, I found it very rewarding, watching them save people's lives or if they couldn't save their lives, how they handled that piece of it, but I didn't have the nerve to go into emergency nursing for ten years. When I hit about ten years, I transferred to the Emergency Department as a clinical nurse and fell in love with it, I mean totally fell in love with it.

[00:10:24]

***T.A. Rosolowski, PhD***

[00:10:24]

What institution were you with at the time?

[00:10:26]

***Carol Porter, DNP, RN, FAAN***

[00:10:26]

This was a hospital in New Jersey, it was a small community hospital, probably about, I don't know, three hundred beds. It's called Wayne General Hospital, now it's called Wayne General Hospital. At that time, it was called Paterson General, but it was in Wayne, New Jersey, the same hospital. So I went there and it was the physical location, geographically, we were in the suburbs of a city, in a catchment area, where we got a lot of trauma. We were not a trauma center but we got a lot of trauma, and I became expert at that, I just loved it. And that was the teamwork, you know? You knew the physicians who were on, the surgeon on call, it worked seamlessly.

[00:11:18]

***T.A. Rosolowski, PhD***

[00:11:19]

What were the particular gifts that you brought to that team? Everybody brings something different.

[00:11:25]

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***Carol Porter, DNP, RN, FAAN***

[00:11:26]

Well, in the beginning I just, I guess because I was so interested in it, I was so excited by it, because I didn't know it. I knew critical care but I didn't know the quick decision making, the fast action, thinking on your feet like that. I was always with nurses and doctors, the doctors who were emergency certified doctors, and the nurses were experienced ER nurses. I had one particular nurse that was—I thought she just knew everything about it, and she took me under her wings and she just taught me everything.

[00:12:03]

***T.A. Rosolowski, PhD***

[00:12:13]

What was her name?

[00:12:04]

***Carol Porter, DNP, RN, FAAN***

[00:12:05]

Kathy Lindsay, L-I-N-D-S-A-Y. So I never was in a position where, if I didn't know something, I couldn't turn to the person next to me and say listen, what do I do? And then once you go through a couple of scenarios of patients that are really on the edge of death and you get them back, that's like, that's what feeds that, it's amazing. So from there, I went to another Emergency Department, as a supervisor, eventually, and this is how I got into the emergency management piece. This was the emergency nursing piece, but the emergency management piece was that when I went to a different hospital that was close to two major highways, and they were transporting hazardous chemicals on the major highways. So, hazardous materials preparedness started to be what everybody was learning, all the EDs [Emergency Departments]. So we had a drill and we had to get prepared, and we had to know how to protect ourselves and how to decontaminate patients. It was kind of the very beginning of all the hazards, HAZMAT they ended up calling it. That, combined with the trauma, combined with—that started to change, it was ever-changing, so I never got bored with anything. Then, I was recruited—well then I became a Director of Critical Care in another hospital.

[00:13:44]

***T.A. Rosolowski, PhD***

[00:13:44]

And let me just see, because I have that down. Which institution was that, Director of Critical Care? Oh, here it is, Good Samaritan Hospital in Suffern [New York]?

[00:13:54]

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***Carol Porter, DNP, RN, FAAN***

[00:13:54]

Yeah.

[00:13:55]

***T.A. Rosolowski, PhD***

[00:13:55]

Okay. You were there 1997 to 1999.

[00:13:59]

***Carol Porter, DNP, RN, FAAN***

[00:14:00]

Right, right. I was recruited there to build a trauma center, to partner with the physician chair of the ED and to build a trauma center. I had never done that, so I thought that would be really exciting.

[00:14:13]

***T.A. Rosolowski, PhD***

[00:14:15]

You're a new challenges kind of person.

[00:14:16]

***Carol Porter, DNP, RN, FAAN***

[00:14:16]

I love it, I love new challenges, I'm out of the box, totally out of the box, totally data driven. So, it was a community hospital, right over the border, in New York State, but the location, even though it was close proximity to a trauma center, the trauma center was on the other side of a mountain and the weather patterns sometimes wouldn't allow the helicopter to land in the trauma center, so that's why we had to build a trauma center, as a secondary trauma center, because it happened pretty frequently that they couldn't land. So there, I gained a lot about emergency management and I worked with the community, because it was a very community-based hospital, with the physicians. I'm looking at blueprints, and the architects, it was a lot of fun and exciting.

[00:15:08]

***T.A. Rosolowski, PhD***

[00:15:09]

What about working with the community, what did that involve?

[00:15:11]

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***Carol Porter, DNP, RN, FAAN***

[00:15:12]

Well, we were in a community with 40 percent of our patient population was Hasidic, Jewish, and I did not have much experience with that culture, and I found that the hospital didn't train the employees at the level they should be, so they were misinterpreting customs, versus understanding them. So I went to some of the rabbis in the community and told them I understood, and I wanted to understand how I could learn more, and how I could have the nurses and doctors understand their customs, we could give better care to the patients. That was embraced, because that was a different take. They were usually trying to tell you why they do things and I was saying please tell me what you do.

[00:15:57]

***T.A. Rosolowski, PhD***

[00:15:57]

Can you give me an example of how you made that interface happen, around what kinds of customs.

[00:16:04]

***Carol Porter, DNP, RN, FAAN***

[00:16:05]

There's a lot of customs during birth and death, that are very, very unique to their culture, and I didn't understand the importance of the rabbi in a Hasidic community. The rabbi really brokers care, at least in those communities, they were the broker of healthcare, and the patients really listened to the rabbi's direction. So, I didn't understand that in the beginning. I actually interpreted it as, was the rabbi interfering with their care, but it wasn't, they wanted that. That's what they do, that's what they did in that group, that community. And so once I realized that the rabbis really were the brokers of healthcare and were so important to Hasidic families, that's when I really started partnering with the rabbis, and myself, in the medical [team], we were partnering with the rabbis. The Hasidic communities, they all have educators, and so I asked them to bring their educator to the hospital, rather than us using our educator, that would have to learn. Bring the Hasidic educator in to have sessions with the doctors and nurses, which was great.

[00:17:17]

***T.A. Rosolowski, PhD***

[00:17:19]

They could really more fully answer every single question that would be raised too.

[00:17:22]

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***Carol Porter, DNP, RN, FAAN***

[00:17:21]

Right. The other custom that really was a problem until they realized what it was, was the husband would be by the wife's stretcher and would ask the nurse to do something that he could have just reached over and done, but at that time period of the month, he wasn't allowed to do that. So, understanding that, or if he's on an elevator on the Sabbath, he can't push the button, so people would say, when they would say "could you push four," they would think well why can't you push four. Well, he can't, so just push four. So, we kind of took the mystery out of it, and I think because of that, we gained a lot of respect in that community and 40 percent of our patients were from the community. So that was a whole other learning but, we opened up the trauma center, it was a great community event. We were also ten miles away from Indian Point [Nuclear Power Plant], so what I gained besides helping them build a trauma center, I was just part of the team, but I think I was an important part of the team, is that we fell in the required distance from a nuclear plant to have radiation drills. I had never done a radiation drill. That's a national regulatory agency that comes in and so I learned. The team came in and for a couple days they taught us, and then we had to perform a drill and they evaluated us. One of the physicians, I wish I remember his name, because he had me mesmerized. He had actually been at Chernobyl.

[00:19:04]

***T.A. Rosolowski, PhD***

[00:19:05]

Oh, wow.

[00:19:05]

***Carol Porter, DNP, RN, FAAN***

[00:19:06]

I had read about that but he had been there, and I couldn't learn enough from him. Then at the end he wanted to hire me, and I said no. But I was fascinated by it, because it's a skillset that again, you have hazardous materials and now you have radiation. You have to be really secure on how you don and doff protective equipment. Personal protective equipment came and really started to advance, because you had to have impervious, PPE, so that nothing can get through, you had to know how to decontaminate people.

[00:19:44]

***T.A. Rosolowski, PhD***

[00:19:44]

PPE means?

[00:19:45]

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***Carol Porter, DNP, RN, FAAN***

[00:19:45]

Personal protective equipment. Before that, it was kind of loose but, and so we—

[00:19:52]

***T.A. Rosolowski, PhD***

[00:19:53]

Tell me about, because I'm sure that—I mean, I am sitting here not really visualizing exactly what you would have to deal with in a nuclear situation, so a couple of examples would really help.

[00:20:04]

***Carol Porter, DNP, RN, FAAN***

[00:20:05]

Well, if there was a leak, if there was a spill at the plant—I have to send you my slides because I don't have it right in front of me, but there's certain circles.

[00:20:15]

***T.A. Rosolowski, PhD***

[00:20:16]

Kind of the hazard rings?

[00:20:17]

***Carol Porter, DNP, RN, FAAN***

[00:20:17]

Right. The first circle, you would have to evacuate. The second circle, which would have touched New York City, it would be contaminated water and food, so it's really a big deal. We played the part and we happened to be within the ten mile circle, so workers would come to us. They would be decontaminated there, but they could also be decontaminated by us.

[00:20:42]

***T.A. Rosolowski, PhD***

[00:20:43]

How do they get decontaminated?

[00:20:44]

***Carol Porter, DNP, RN, FAAN***

[00:20:45]

With water, but in a decontaminated—that's when all the emergency centers started building decontamination areas, and people didn't have that before. I learned about that, how do you build it? You have to pitch the floor, you have to have an outside entrance. You can't come into



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the ED and go that way, you have to come outside. All that just kind of added—I was telling the Faculty Senate, the Executive Council, is that it's like layers. I was an ER nurse, I was a trauma nurse, and that teamwork and camaraderie, and then you throw in hazardous material, okay, and then throw in radiation, that's another level. And then after, when I left that hospital—I mean it wasn't just me learning, it was the nurses and doctors and aides and everybody else, and the community. I learned how to bond with the EMS, the Emergency Medical Services, because they also had to be trained, so they'd decontaminate themselves on the way in. Their vehicle had to be decontaminated. So it was a lot, it was a lot. Then from there, I was recruited—that's when I was recruited into New York City, that was 1999, and within four weeks of me started my job there, I was recruited as a Director of Emergency Services and Medicine.  
[00:22:14]

***T.A. Rosolowski, PhD***

[00:22:15]

And that was at Lenox Hill Hospital.

[00:22:16]

***Carol Porter, DNP, RN, FAAN***

[00:22:16]

Yes. Within four weeks of my arriving on the scene, in what we would call the orientation period, the city started getting threats, terrorist threats, and also, combined with the fact that we were changing from 1999 to 2000, which there was a lot of concern across the world about that. There was also concern that somebody would do some kind of event on that time period. So, because I had some experience, as a matter of fact, when I was at Good Sam, I had the opportunity, during the radiation drills, I had the opportunity—besides the physician, I had an emergency management, ex-military emergency management specialist that worked side by side with me and taught me a lot through that. He was not just radiation, he was all emergency management, so when I went to New York City, of course I kept contact with him. I went to New York City and we started having threats and they knew I had an emergency management background, and they knew I had participated in providing some education and that I had a colleague that was an expert, so we were asked to provide classes for all the providers and the nurses and anybody that would be taking care of patients, on different hazards, different threats that potentially could hit New York City, in bioterrorism, chemical, nuclear, the rest of the gamut. You know blast, think about a blast, like a dirty bomb, et cetera. So we did probably, I don't know, three hundred sessions, while I was on orientation, [laughs] and it was good.

[00:24:13]

***T.A. Rosolowski, PhD***

[00:24:13]

Now why are you laughing? You're remembering something about that time.

[00:24:16]

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***Carol Porter, DNP, RN, FAAN***

[00:24:17]

Well because in orientation—orientation, for a nursing leader, it's really, it's not defined, because if something happens, you have to go into your role. So I think that just like Hurricane Harvey, anybody you hadn't met, you met. You know, doing three hundred sessions on week four of your employment, or week five, I met all the providers, I met all the people that were taking care of patients and it was great. Then, I can't remember whether the city required bioterrorism coordinators before or after 9/11, but sometime in the early 2000s, the city of New York required every hospital to designate a bioterrorism coordinator, so I became the bioterrorism coordinator, besides being the directing of nursing, everything else, for Lenox Hill. I also was a member of the Greater New York Hospital Association Emergency Council, which was, we all got together every month and shared education and everything else, and really formed another link, which I was totally fascinated with because there were really experienced emergency management people there. It was led by a very experienced attorney, I mean it was very high level, and I felt like I was a toddler in that room.

[00:25:37]

***T.A. Rosolowski, PhD***

[00:25:37]

What was it that distinguished their level of expertise?

[00:25:41]

***Carol Porter, DNP, RN, FAAN***

[00:25:42]

Well, some of them, that was their sole job, so some of the emergency management, that's what they did full-time. I also had medicine, I had nursing, I had policies, I had a lot of other things. And then the woman who was running it completely, she worked through Greater New York Hospital Association as an attorney, but I was fascinated that an attorney was so knowledgeable about emergency management. So it was a great group to me. I was there every single meeting, I couldn't wait to get there. So, and then 9/11 happened, and so I don't know whether that bioterrorism coordinator role was before or after 9/11, it was right around it. Then we had been drilling and educating and everything, at Lenox Hill, and when 9/11 occurred, again, everybody went into their mode because they knew what to do. I can stress that enough. You can't just do an infrequent drill, it's got to be part of your fiber. Anyway, so 9/11, of course everybody knows how bad it was, but because I was in charge of emergency management and the bioterrorism coordinator, and I was a director of the ER as well, so that was probably the first real horrific emergency that people were looking to me for leadership, so I learned a lot about that.

[00:27:17]

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## **Chapter 03**

### **9/11**

#### **A: Professional Path;**

Codes

A: Personal Background;

C: Leadership; D: On Leadership;

C: Professional Practice; C: The Professional at Work;

#### ***T.A. Rosolowski, PhD***

[00:27:17]

So what happened during 9/11, that you had to respond to, in situ, at Lenox Hill?

[00:27:24]

#### ***Carol Porter, DNP, RN, FAAN***

[00:27:25]

Well, immediately, I was in the EC rounding on patients and staff, and we had TVs for the patients to watch, and it was captured on the cameras in New York City and there were so many screams and yells for me, telling me to come and look, and that's when I saw that. That was not even imagined by myself, like I didn't even consider something like that. So, immediately you're thinking okay, victims, people are going to come, they could come quickly, it's just like two miles, two, three miles that's it, to the Twin Towers. So, immediately, we went into disaster mode and everybody started to do whatever they had to do in our disaster plan. They got ready, the floors got ready, everybody got ready. At the same time, I had staff come to me saying, "My husband works in that building." So at the same time that I was—and again, I'm not operating alone. There were several of me in that building doing other things, including the president or the CEO. But I realized that okay, we have really, two big issues. Number one, a lot of people have family members in those buildings, so we had to worry about how do you console somebody who just saw the building go down? So I just, I got a hold of our psych, I think I went to the Psychiatry Department, because I don't think we had EAP at that time, we might have but I don't remember. So we reached out to our HR colleagues and everybody else, to please help them. I remember the phones—if I remember correctly, three of the major companies, two companies had towers in the tower and they went down, there was only one cell phone that was working. I had one of them, it was working, and so I told her to call, and of course she didn't get an answer. And it wasn't just her, isolated, but she was the one that was most in front of me. So then I asked somebody to take care of her and try to help her reach her family, whatever. Meanwhile, everything is going and the CEO and I are talking, and they're coming into the ED, and the CNO came over and everything else, and we were getting everything prepared, and in the back of my mind I'm thinking I have this really important job to do, but my son was working in

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a building right across the street.  
[00:29:57]

***T.A. Rosolowski, PhD***

[00:29:57]  
Oh my God.  
[00:29:58]

***Carol Porter, DNP, RN, FAAN***

[00:29:59]  
So I'm thinking oh my God, is he okay, and then trying to be very strong outward, because people are looking at you. If you're going to start to crumble, then we're crumbling with you, so you can't.  
[00:30:11]

***T.A. Rosolowski, PhD***

[00:30:12]  
What's your son's name?  
[00:30:13]

***Carol Porter, DNP, RN, FAAN***

[00:30:13]  
Michael. So, I was about to take a few seconds to try to get a hold of him on the phone and he called me. I was in the EC and he said to me, "Mom, a plane came into the building across the street." He said, "They're telling us to stay on the floor and don't leave the building." He said, "I'm evacuating this entire floor." He was a brand new graduate, college graduate. So he took—and I said—he said, "I love you," and that was it, click, no more cell service for him. So, I actually wanted to vomit, I had a visceral reaction to it, but I was so thankful that he was truly my son, he was evacuating their floor, because he knew that sometimes you have to do things like that, sometimes you have to use your common sense, and thank God he did, because even though he wasn't in the Tower, the heat, the smoke, the ashes, and people jumping out of windows, they were involved in all that. When you see those films with the—he was running just like everybody else was. Anyway, so being the children of an emergency nurse, they were pretty skilled as not a clinical person, but understood emergencies, and I kind of felt that my daughters would be tracking everybody remotely and then would get a hold of me, because I couldn't reach them.  
[00:31:40]

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***T.A. Rosolowski, PhD***

[00:31:41]

And you're daughters' names?

[00:31:42]

***Carol Porter, DNP, RN, FAAN***

[00:31:42]

Amy and Lauren. Anyway, so I continued to do what I was doing. I had a lot of communication with the CEO, who was the incident commander for the institution, and very quickly, we realized that we were not going to get any ambulances, or very few. The city of New York, the community, had a line that wrapped around the whole city block, wanting to donate blood, but we didn't have patients. So we had to pull in our social, our community media people and everything else to say okay, what do we do for the community, because they need to do something, they want to do something. So then I think we started to reach out to blood banks all over, to find out, can you use blood, because we can only use so much because we don't have any patients. That was a pretty common theme around there. Then we assigned people to work the lines, we had volunteers and other people in the hospital, their assignment was to work those lines and give them water, give them snacks, whatever. Anyway, it was probably in the late afternoon when we started getting people that walked up or ran up, some people ran up. If you're a runner you could run, it was only about two miles, two and a half, three miles, so some people showed up early but it was mostly inhalation, smoke inhalation, little bits of fragments in their eyes or whatever, a lot of emotional distress, so we set up a whole counseling center across the street from the hospital.

[00:33:29]

***T.A. Rosolowski, PhD***

[00:33:30]

Let me just pause for a sec, because we're a quarter of eleven.

[00:33:34]

***Carol Porter, DNP, RN, FAAN***

[00:33:33]

Yes, yes.

[00:33:34]

***T.A. Rosolowski, PhD***

[00:33:35]

So, did you want to stop at this point?

[00:33:36]

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***Carol Porter, DNP, RN, FAAN***

[00:33:36]

Yeah, I think so.

[00:33:37]

***T.A. Rosolowski, PhD***

[00:33:38]

Okay, okay.

[00:33:38]

***Carol Porter, DNP, RN, FAAN***

[00:33:39]

The only other thought I would say about that is—because you asked me what I learned about everything else. What I learned about that was how important—you don't realize it, as a leader, how important your demeanor is in an emergency, that you have to—even if you feel like crumbling yourself you can't, and you have to find out who you can lean on. So there was a chair of radiation, of the Radiology Department, who I had worked very closely in the Lenox Hospital, on the emergency management committee we had locally, and he and I were --and the CNO. The three of us were constantly in communication with each other, and then the CEO was not only looking to him, she, whenever we had meetings, she wanted me to sit right next to her. So, it started to make me feel oh, she must think that she can trust me, like it was a whole learning experience, unfortunately, but also then, how to multitask. It's not just the event, it's what did it do to the people around you. Even if you didn't have somebody in that tower or towers, being in the proximity of New York City during that, it had an effect for, I would probably say a couple of years. I mean, and then how do you—the good news up to that—the end of that story, we'll continue another time, is that later on in the afternoon, my youngest daughter, she called me, she got through. Maybe she didn't call me. She might have sent me an email, I think she sent me an email, because I think I had broken away to just see if they—because I couldn't talk to them and I couldn't talk to my son any more. She had gave me the, "I talked to Michael, he's fine, Amy is good, I'm fine, are you okay?" So she had organized everything, again, one of my daughters.

[00:35:46]

***T.A. Rosolowski, PhD***

[00:35:44]

She takes after her mom.

[00:33:45]

***Carol Porter, DNP, RN, FAAN***

[00:33:46]

Right, exactly. Every single time we do anything like that, anything, you learn from it, you

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know you learn from it and you never forget it. We don't have time to talk about it, but the New York City Marathon, Giuliani [Rudolph William Louis Giuliani KBE, former mayor of New York City] was going to cancel it that year. I was supposed to run the marathon that year, and so because I was a bioterrorism coordinator, I couldn't run, because I was, for the next two months, I was working late hours, I was staying over, everything else. And then Giuliani decided to have it, with the fighter jets, you name it, all over, cautioned to don't take food from anybody, because they thought that something would happen. So, I was doing to drop out and somebody said, "Don't drop out, just run until you don't want to run anymore." So I went with that mindset and everywhere you ran past a firehouse, they crossed the ladders across the street. [00:36:51]

[knock on the door] Come in. I know, this is thirty seconds. Okay.

We took food away. You can't go through Brooklyn without taking something from the Italian ladies, you just have to take it. So I took food from them, because I wanted them to feel good, and I ran on adrenaline and I finished the race and I ran on adrenaline. I hadn't run in two months or three months, whatever it was. It was early November, so two months.

[00:37:25]

***T.A. Rosolowski, PhD***

[00:37:25]

That's a great sign of normalcy for the city.

[00:37:27]

***Carol Porter, DNP, RN, FAAN***

[00:37:28]

Yeah. I mean, he made a good decision, you felt safe because the jets were going over the path all the time. Talk about camaraderie? Everybody in that race was doing it because of 9/11, I mean they were in it already but they decided not to cancel. That was another something bright that came—I'm not saying anything bright came out of it, but I think that was part of the healing process.

[00:37:53]

***T.A. Rosolowski, PhD***

[00:37:54]

Well, I think in the aftermath of an event like that, you have to find whatever bright spots you can, to go on.

[00:38:00]

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***Carol Porter, DNP, RN, FAAN***

[00:37:58]

Yeah, oh yeah.

[00:38:01]

***T.A. Rosolowski, PhD***

[00:38:02]

Yeah. Otherwise, it's just constant survivor's guilt, which is not good.

[00:38:04]

***Carol Porter, DNP, RN, FAAN***

[00:38:04]

Yeah, no, no, no. It was a lot of lessons learned, and we don't have time to talk about it, but a lot of lessons learned after that. Anyway, okay.

[00:38:13]

***T.A. Rosolowski, PhD***

[00:38:13]

Well, thank you. We can close off for today and I'll look forward to our next conversation.

[00:38:16]

***Carol Porter, DNP, RN, FAAN***

[00:38:16]

Okay, that's great.

[00:38:17]

***T.A. Rosolowski, PhD***

[00:38:18]

Thank you very much.

[00:38:38]

***Carol Porter, DNP, RN, FAAN***

[00:38:38]

Thank you.

[00:38:39]

***T.A. Rosolowski, PhD***

[00:38:39]

I'm turning off the recorder at about ten minutes of eleven.

[00:38:22]



## **Carol Porter, DNP, RN, FAAN**

**Interview Session Number 02:** January 25, 2018

### **Chapter 00B** *Interview Identifier*

***T.A. Rosolowski, PhD***

[00:00:01]

I just want to say for the record that it is four thirty-two on the 25th of January, 2018. I'm on the eighteenth floor, in the office of Dr. Carol Porter, and we're having our second session together, revving up to talk about the experience of the institution during Harvey.

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## **Chapter 04**

### ***Working with the Nursing Union at Mount Sinai Hospital***

#### **A: Professional Path;**

Codes

C: Leadership; D: On Leadership;

A: Joining MD Anderson;

A: Overview;

A: Professional Path; C: Evolution of Career;

C: Leadership; D: On Leadership;

C: Professional Practice; C: The Professional at Work;

A: Character, Values, Beliefs, Talents;

C: Women and Minorities at Work;

#### ***T.A. Rosolowski, PhD***

[00:00:01]+

So, we kind of strategized and said we'd start today with you to tell the story about how you ended up coming to MD Anderson. How did that come about?

[00:00:34]

#### ***Carol Porter, DNP, RN, FAAN***

[00:00:34]

So, I was the Chief Nursing Officer at Mount Sinai Medical Center in Manhattan. I started there in 2004, as a Senior Director of Nursing Operations, and in 2005, became the Chief Nursing Officer and led the—it was a Magnet organization, and led them through two re-designations and had developed a Center for Nursing Research and Education within the medical school. I also developed the Global Nursing Leadership Academy, focused on international nursing leaders, with a group of people, it was very, very successful. I had worked with—it was a unionized environment. I had worked with our union partners and actually turned it around, quality focused, and actually presented podium presentations in Japan and other countries, with the presence of the unions, which was very unusual.

[00:01:36]

#### ***T.A. Rosolowski, PhD***

[00:01:37]

What is that unusual?

[00:01:38]

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***Carol Porter, DNP, RN, FAAN***

[00:01:39]

Because you'd have to have a very good relationship with the union partners in order for that to happen, and many times, union leadership and hospital leadership are adversarial. But I realized that I would not be able to lead union nurses unless I was working closely with union leadership, so I was able to work very—I included them at the table for all quality initiatives right away. So whenever we were doing anything on quality, I had the union leaders at the table helping me and working with me. And then became friendly with them, to a point where I really could be honest with them, very transparent, sharing data on quality and budget and finance and everything.

[00:02:28]

***T.A. Rosolowski, PhD***

[00:02:28]

What would be some sources of conflict between union leadership and the hospital leadership?

[00:02:35]

***Carol Porter, DNP, RN, FAAN***

[00:02:37]

My opinion is that sometimes it seems like a turf battle, but it really shouldn't be, because you actually manage the same people. So as a Chief Nursing Officer, I had the actual title of the leader, but the union leaders, who were not employees of Mount Sinai, actually led the same nurses. So if you look at it that way, you have to really bond and work closely with those union leaders; otherwise, if you're always battling, you're going to confuse the nurses and you're never going to get anything done.

[00:03:14]

***T.A. Rosolowski, PhD***

[00:03:14]

So was the idea—and I just want to make sure I understand the context here. Would the idea be that a nurse would think oh, my hospital leadership has one set of concerns, my union has another set of concerns and commitment to me as an employee.

[00:03:33]

***Carol Porter, DNP, RN, FAAN***

[00:03:33]

Right.

[00:03:34]

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***T.A. Rosolowski, PhD***

[00:03:34]

I see, okay.

[00:03:34]

***Carol Porter, DNP, RN, FAAN***

[00:03:35]

Right. So they could get two sets of directions, versus if we are working together. If I'm working close together with the union leadership and we come together as a team, we even rounded together.

[00:03:49]

***T.A. Rosolowski, PhD***

[00:03:50]

Wow.

[00:03:50]

***Carol Porter, DNP, RN, FAAN***

[00:03:50]

So if we came together as a team and rounded together, it's showing the nurses that we're working together. The other thing is that not only were the nurses unionized but the nurses' aides were unionized, and it was a different union, and I did the same exact thing with them. I worked closely with them, I would pull them in at the table, we would work on quality initiatives. And so when it got to when I was building the Nursing Leadership Academy and the Center for Nursing Research and Education, I included the union leaders in asking them what would they like to see in it, what do they think the nurses would like, even though I was asking them myself. Because it was focused on academics, the president of the union was always looking at when abstracts were due, and the first time she came into my office, when the international abstract was due, she came in about five o'clock in the afternoon. It was due Greenwich Mean Time, which we were trying to figure out what that was at the time and how much time we had to put this together. She had the idea but she didn't know how to put it together, and so we did it together. I was on the computer, she was talking, I was adding and I was writing, and I believe the first one we did, and I can't remember what exactly the time was, but I pushed send probably within thirty seconds of not knowing the deadline because all of a sudden it froze and I said, "Oh, we've missed the deadline." But we didn't miss the deadline. That was for the International Council of Nurses Congress in Japan, and we got accepted for podium presentation and so myself, the president of the union, and then in support, the union leadership of the union that supported the nurses' aides all came. It was me, the only non-union leader, with six union leaders that were not employed at the hospital, they were employed by New York City. So that was a very unusual situation, because that doesn't usually happen, and that was the beginning, and then we started to do other presentations together and we built a

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really strong partnership, I would say mostly focused on quality and a positive relationship. Every once in a while, they had to do something union-ish, but otherwise it was fine. So that was very important.

[00:06:26]

***T.A. Rosolowski, PhD***

[00:06:27]

What do you think enabled you to accomplish that? Everybody's a different instrument.

[00:06:33]

***Carol Porter, DNP, RN, FAAN***

[00:06:33]

Right.

[00:06:34]

***T.A. Rosolowski, PhD***

[00:06:34]

What did you leverage in yourself to be able to do that?

[00:06:38]

***Carol Porter, DNP, RN, FAAN***

[00:06:40]

It started with, as soon as I became the Chief Nursing Officer, within a week, I was in a meeting. The former CNO had left and then after a year they appointed me, and I was in a meeting where the president of the union was there. It was a meeting where the nursing directors and the union leadership got together once a month, and so it was my first meeting as a CNO, with them. I was kind of thinking, as things were happening, and I was explaining to them who I was, what I was—that I was now the Chief Nursing Officer, that I wanted to work closely with them and all that. The meeting was over and we started getting up, and I remember the union—the nursing union leader wasn't nursing union leader, I mean a strong nursing union leader, not employed by the hospital, and I said to her out loud, it just came out of my mouth, it just came out, I said, "I will not be successful in my job unless you and I work together, because we lead the same group of nurses," and you could hear like a pin drop and I thought oh my God, what did I just say? But it was true and I said, "So I need your help, I'm willing to partner with you if you're willing to partner with me." That was, I think the pivotal moment, because it was the first time that was ever said there.

[00:08:03]

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***T.A. Rosolowski, PhD***

[00:08:04]

How did she respond?

[00:08:06]

***Carol Porter, DNP, RN, FAAN***

[00:08:07]

She was kind of shocked and she wasn't quite sure if I really meant it, but she learned that I did mean it. I have developed a lot of good people skills. My background, when I was a clinical nurse and I was a trauma nurse, I think I honed my skills on how do you connect with people very fast, because sometimes patients would come in and wouldn't have more than minutes to live, and so I learned how to make the most of whatever time they had, and how to connect with them, human being to human being, and I think because of that, from that point on, I've been able to do that. So I will usually find a way, even with the most difficult person, to find a way in, and then you have to prove yourself.

[00:09:02]

***T.A. Rosolowski, PhD***

[00:09:02]

Yeah.

[00:09:02]

***Carol Porter, DNP, RN, FAAN***

[00:09:03]

So I think that, anyway, so we accomplished a lot. I was at a citywide level, doing presentations on behalf of collaborating with the unions, and I was—that piece was great. So after being there twelve years, I had done a lot and I started to—there wasn't really a lot—I mean, I already had established the Center for Nursing Research and Education, that was in the School of Medicine. It was unusual, because we did not have a School of Nursing. I did that in collaboration with the dean of the medical school, after he—he wanted me to go through the whole AMC catalog, to see if any medical school had a Center for Nursing Research and Education in the medical school. I didn't find any in the country, unless there was a university attached, and so we both decided it would be very innovative and very collaborative, and it would be a great thing. So I had done that and the research, the global leadership, the collaboration with the unions and changed the environment with teams, improved care. I'm very informal, nurses came up to me all the time to tell me the different things that they needed help with. So I felt that I was at a point where I'm ready for another adventure. This is great, I've had a great time, I've done a lot, but I think I have another adventure in me. And that's when I started to look around and at that time, there were several academic chief nursing officer positions open in the country and I started to interview. [00:11:00]

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## **Chapter 05**

### ***CNO and VP of Nursing Practice at MD Anderson***

#### **A: Joining MD Anderson/Coming to Texas;**

Codes

A: Personal Background;

B: MD Anderson Culture;

***Carol Porter, DNP, RN, FAAN***

[00:11:00]+

Then, MD Anderson called me, because I had surveyed them as a Magnet surveyor in 2010. I always thought a lot of MD Anderson, always talked very positively about what I saw here, but never considered interviewing for this position because it was a cancer hospital and my background is multispecialty. I knew that Barbara Summers [oral history interview] had retired and I was curious about who would be the next CNO, but not thinking I'd have a part in that, only because I fondly thought of MD Anderson. And then they called me up, the executive headhunter called me up and started talking to me about MD Anderson and I said well, "I don't know, I'm sure that they want somebody that's got an extensive oncology background," and they said, "Actually, they're looking for somebody that's got a generalist background and a very strong quality operations background," which I did have. So I just added them in, because I had a couple of them. At one point, I had files on each recruit, search, and I just made sure I didn't get any of them mixed up. So I said, "Sure, I'll come for the interview, it's a great place." And when I came the first time, I think it was for three days, two or three days, and they knew I had been a surveyor. They had done their homework on their side too and checked, and there were a lot of people here that were there when I was here as a surveyor. Tom Buchholz [oral history interview] was the physician chief at the time and when I came to interview, I believe I sent Barbara an email or a message on LinkedIn or something, to let her know I was going to look at it, or something about it. Anyway, I remembered some people that had been here, and I spent five days here doing the survey, so some people looked familiar. Then, I had a lot of physician interviews, but then I also had a nursing leadership interview, and when I walked into the room I thought oh my God, I know these people, and they were all hugging me and saying oh, you know. I said, "You're not supposed to hug me, you're supposed to interview me!" So we had a great time catching up for an hour or so, and then I was walking through the hospital with Tim Jones, who is the executive recruiter for MD Anderson, going from one place to another, and I don't know whether you know the name Beth Garcia. She is the director of Patient Experience. She's been here for about, I don't know, twenty years or so, or I shouldn't say twenty years, probably about fifteen years. She used to work with me, she used to work for me in New York, at Lenox Hill Hospital, she was great. Her and I were strong on quality and we hit it off. Anyway, so I was coming through the hospital by the elevator and Tim and I were kind of

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catching up on the previous interview session. I was interviewing myself, but I was also trying to be a little reserved, and all of a sudden I hear a squeal and it's Beth Garcia saying, "Carol—" and we both were running to each other, hugging, and then I turned to Tim, I said, "Oh, you weren't supposed to see that," I said, "but we worked together." What I had found out is they had grilled her about me before I came here. So that was great, that I found her here, because then I was able to ask her questions I couldn't ask other people. I told Tom, at the end of the second day, Tom Buchholz, I said Tom—he kept checking, end of every day he checked in with me to see how I was doing with the interviews, how everything went, and so at the end of the second day I said to him, I said, "I don't work here but it feels like I work here, because I remember everybody." He goes, "Well that's a good thing, I'm glad you think that." [00:15:12]

Anyway, I left and then I went back home and it was probably at least two months easy, before they wanted to see if I wanted to come back. In the meantime, I was just about to get a job offer and I came back out, and then this time it was some of the same people but more in-depth interviews. I finished with Tom again and he asked me how everything went and I said, "Again, I want to tell you, it feels like I work here." I said, "This feels seamless." I said, "Maybe because I knew all your data and now I'm here in a different light but it's very familiar." Everybody was very positive and everybody wanted somebody that was strong on quality. And then I left again and then probably—it was going faster now, because they knew I was interviewing. Then I told my children, my children were young adults, but I have a very close family. I was preparing them, not thinking I would come here, but preparing them to say, of the—now I have—this is one of the three serious searches I'm in. So I told my kids, I said listen, place A is great and I could work there as well, they were wonderful to me and I believe I'm going to get a job offer, I said, "But if MD Anderson offers me the job I have to take it." I said, "So I want you to know, I have to do it, it's the number one hospital in cancer in the world. I just need to know what that feels like." Mount Sinai was great but it's not number one, and I just wanted a different adventure. Eventually, they were telling me, "Well mom, if MD Anderson offers you a job, you have to take it," so I figured I did my job.  
[00:17:15]

***T.A. Rosolowski, PhD***

[00:17:15]

You did your job, yes. [laughs]

[00:17:17]

***Carol Porter, DNP, RN, FAAN***

[00:17:17]

So, I happened to be in the Caribbean with my daughter and her husband, we rented a little—I rented a place overlooking the ocean, and MD Anderson wanted to have a conference call with me. My daughter and my son in-law were like in the next room and I said, "You have to be quiet, I'm on an interview here," but I'm in my shorts and flip-flops, the ocean is here, we have



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these like Caribbean birds walking around, and they offered me the job. So I said to Tim, I said, “Well how do I accept it? I’m looking at the Caribbean and I’m in flip-flops and shorts.” He said, “I think you just said yes.” I said okay, I was like yes, and then we had more negotiations. So that’s how I accepted MD Anderson, and my daughter and my son in-law were like watching faces pressed against the glass.  
[00:18:15]

***T.A. Rosolowski, PhD***

[00:18:15]

That’s so funny. I have to ask you, what were the questions that you asked Beth Garcia, that you couldn’t ask anybody else, I mean what were the things you needed to know?

[00:18:23]

***Carol Porter, DNP, RN, FAAN***

[00:18:24]

I wanted to know the real deal about the culture, like the culture of the hospital, what it was like to work here. I felt like I would get her honest opinion.

[00:18:34]

***T.A. Rosolowski, PhD***

[00:18:34]

And what did she say?

[00:18:36]

***Carol Porter, DNP, RN, FAAN***

[00:18:37]

Oh, she loves it, I mean she’s still here. She loves it, she was very happy working here, she was praying to God that I would come, because she knew that we worked well together, and she thought it was so ironic that eight to ten years before that she worked for me. I just think it was a familiar person you could trust.

[00:19:03]

***T.A. Rosolowski, PhD***

[00:19:04]

Sure.

[00:19:04]

***Carol Porter, DNP, RN, FAAN***

[00:19:05]

Even if I’ve met you before, I’m asking you a question, you may be giving me an answer that you think I want to hear, but she’s going to give me the real answer, so that’s why I wanted to

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talk to her.  
[00:19:16]

***T.A. Rosolowski, PhD***

[00:19:16]  
Oh absolutely, I mean you need to find somebody who is going to kind of give you the unvarnished version.  
[00:19:22]

***Carol Porter, DNP, RN, FAAN***

[00:19:22]  
Right.  
[00:19:22]

***T.A. Rosolowski, PhD***

[00:19:23]  
Yeah, it's very important.  
[00:19:24]

***Carol Porter, DNP, RN, FAAN***

[00:19:25]  
I have to tell you though, the last thing about that. Once I accepted, I got off the phone and I said, "Oh my God, I accepted, oh my God I accepted, I'm going to Texas?" I said you've got to be kidding me, and then I had to brace myself for that, like what's that whole experience going to be.  
[00:19:42]

***T.A. Rosolowski, PhD***

[00:19:52]  
Yeah, the northerner coming to Texas.  
[00:19:43]

***Carol Porter, DNP, RN, FAAN***

[00:19:44]  
I just felt it was not just an adventure in healthcare, it was an adventure in a different culture, an adventure in okay number one, what can I do to make them better than they even are now, like how can I contribute to nursing, to even up the bar a little bit more. I'm bringing to MD Anderson, a very strong knowledge of quality and how to lead it, and magnet, so I felt like I could contribute.  
[00:20:16]

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## **Chapter 06**

### ***Areas to Address as Chief Nursing Officer***

#### **B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;  
C: Professional Practice; C: The Professional at Work;  
C: Collaborations;  
C: Leadership; D: On Leadership;  
C: Mentoring; D: On Mentoring;

***T.A. Rosolowski, PhD***

[00:20:17]

What were some of the—I mean when you were here and looking around, getting a feel for the lay of the land, what were some of the things that you were already thinking oh, here I can address this, I can address that. What was your intuition?

[00:20:31]

***Carol Porter, DNP, RN, FAAN***

[00:20:31]

You mean like when I was interviewing?

[00:20:32]

***T.A. Rosolowski, PhD***

[00:20:33]

Yeah, and just getting a sense of the culture.

[00:20:35]

***Carol Porter, DNP, RN, FAAN***

[00:20:35]

Well, with the physicians, and many of them interviewed me, the theme with them is they wanted a hands on CNO. They wanted someone that really knew clinical and quality, and I do. They wanted someone that didn't have any airs, that was approachable, out there working with the physicians and the nurses and really keeping in touch. That's what I do. So I felt good with that, because what they were looking for, that's what I do. I thought that was great and the fact that they were so interested in that, I felt good that I could work with them. The nurses, I think the strength was the quality connection. A lot of times CNOs are removed, like they're a little bit aloof and they don't really have a direct line to the frontline staff, and part of my management style is rounding, and I found on the frontline staff. So, I connect with those frontline nurses

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purposely, because then I want them to feel comfortable to tell me what's working well and what's not working well, so I can help them fix it. The clinical nurses that interviewed me were great and again, they just wanted somebody they could talk to and somebody that could help them.

[00:22:04]

***T.A. Rosolowski, PhD***

[00:22:05]

What were you hearing from them about what needed to be addressed?

[00:22:09]

***Carol Porter, DNP, RN, FAAN***

[00:22:10]

They really wanted mentorship, I mean they wanted to be mentored, they wanted to learn. I think the fact that I had been a magnet surveyor and the fact that I was a CNO in New York City, they felt they could learn from me and they knew I was approachable already, so it's not like, you know. And once I came here, and I still tell people and I mean it, that I don't just have an open door policy. If you need to see me, I want you to stalk me, you come here and you just sit in that waiting room until I come out to get you and that's unusual. I've had a lot of CNOs in my career that they would just about say hello to you. So here, many, many times Kim will say she doesn't have any time, she's busy and it's true, my whole calendar is busy all day, but if you really need to see me, I can find ten minutes, I can move things around. Her job is to protect my time and so that's why I tell them, either come—like the directors, I said come to my office and just stick your head in. I said to the clinical nurses, I tell them come upstairs, come into the waiting room and tell them you're waiting for me, and then eventually, I'm going to see you, I'm going to come out and grab you and bring you in. I've done that several times. [laughs] A group of nurses were up here a couple months ago and they sat down in the waiting room and they asked them if they had an appointment and they said, "No, we're here stalking Carol Porter," and they were like "Stalking?" And then they said, "Carol, somebody's here stalking." I said, "Well that's okay, that's what I told them to do, I'll be out in a few minutes." So I think that gets around real fast, that gets around real fast. So when I came here, groups of nurses started wanting to meet with me, like the wound care, again because they're strong on quality. The clinical nurse leaders wanted to meet with me, some of the ADs. I think they got used to my management style about rounding, because in the beginning they thought I was criticizing some of their work, because they weren't used to it, when what I really was doing was I was trying to mentor them. So, I found graphs that were not presented correctly or the data should have been done differently, and so I then had to tell them, I was associate dean of nursing research, so I do this normally, I just can't help myself. I have to look at your data and I want to see if I can help you, and then we'd go over all their data, I'd ask them questions, and then that got out throughout the hospital that oh, she's not criticizing us, she's teaching us. Then eventually what I did was when I do that, every once in a while, I give them a little hug, just because I'm in

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Texas, and they like that, they like that connection. Now it's no big deal, now when I round, they're saying, "Dr. Porter, come here, I want to show you this," and they show me the graphs. Even with Dr. Pisters, I rounded with him on some of the units twice or three times so far, and as soon as we walked on the unit, they're running up to him, "Oh, come on Dr. Pisters, we want to show you our quality data." They bring him to the board, they explain all their data, and he said to me, "This is great, that they want to take me to their data to show me what they're doing." So, I feel like I've had something to do with that. I made them feel it's really important.

[00:26:01]

***T.A. Rosolowski, PhD***

[00:26:02]

That's exciting, I mean that's a culture change and that didn't take all that long really.

[00:26:07]

***Carol Porter, DNP, RN, FAAN***

[00:26:07]

No. I had myself an Excel spreadsheet the first year, to make sure I got everywhere. Now, I think now, I also, now I'm going to the areas that are doing fabulous and explaining to them why it all fits together; the patient experience, the clinical quality, the staff engagement, all that, and that you can't just give an award for patient experience, because part of the patient experience is the clinical care. So I just went to P-9 today, they just got a quarterly award for their patient experience, but while—and actually, I did it with Beth Garcia. Beth Garcia was talking to them about their patient experience scores and I was checking out their quality scores at the same time, and so when I got a chance to talk to them I told them, I said, "You're the whole package." Not only did you do great in your quarterly patient experience scores, but all of your nurse sensitive indicators are great, and you have a mobility program so you're preventing things, and you're doing just culture. I said, "You are the entire package."

[00:27:19]

***T.A. Rosolowski, PhD***

[00:27:20]

What's P-9?

[00:27:20]

***Carol Porter, DNP, RN, FAAN***

[00:27:21]

P-9 is orthopedics and surgery. Then that spurred, I would say, a half-hour conversation with all of them, about why they think it's important, do they realize how important it is. I asked them to share it with other units as a best practice. I told them maybe we should do a video clip of you guys because what you're doing here, we should just do it on other units, just replicate it. So I try to take the time to have that conversation with them, because they want to explain why they

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do what they're doing, and I think they value the fact that I know, I understand it. I'm not going to say you did a good job unless you did a good job, so if I say you did a good job, I think they know that I mean it.

[00:28:13]

***T.A. Rosolowski, PhD***

[00:28:13]

Well, it devalues it if you varnish it. Also, it doesn't do honor to all the energy they're putting in it, if you don't notice it at all. I mean, allowing them the time to express it and find their language is going to help strengthen the culture that is making this possible and enable them to share it with other units.

[00:28:35]

***Carol Porter, DNP, RN, FAAN***

[00:28:35]

The other thing, well of course you take photos, because they know that by tonight, they're going to be on Twitter. So when I first came here, it was really a very minimal social media culture. I don't think it was looked at so fondly here. I came from a very big social media presence in New York City, I had LinkedIn and Twitter, and so when I first came here, I met with the Social Media Department to tell them this is what I'm going to do, so please follow me and tell me if I do something that you don't like, but I'm going to do it, because it's 2017, or 2016 when I came here. So every meeting I went to in the beginning, I would say hands up if you're on social media, and it would be like one or two people, but now, like they're all going up. Then I encouraged Steve Hahn to be on it, now he's Tweeting out, and Peter Pisters has become very social media savvy, so now there's no problem because if the CEO/president is on it. So now, it's turned full circle because now, if I don't post these pictures on tonight, I'm going to hear about it tomorrow. They're going to say where's our pictures, how come you didn't post them, because they want to re-Tweet it.

[00:29:52]

***T.A. Rosolowski, PhD***

[00:29:53]

What's the impact of that, what is the benefit that's coming from that increased presence?

[00:29:58]

***Carol Porter, DNP, RN, FAAN***

[00:29:59]

On social media? Well, I think it's reward and recognition for our own staff, because they like to be seen, because then even if they don't—some of them don't quite get how to do it, but you can just re-Tweet it. All you do is hit it and you're done and they can then take whatever you put down about them and put it on their page, which is nice. The other thing which I think is as

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important if not more, it gives the world a glimpse into MD Anderson that's not harsh and cold and sterile. Like today, the pictures I'm going to post was, after we went up there to give them— have given them the ward, then they had a little celebration in their conference room, balloons were hanging from the ceiling and a big poster on the wall. That's going to show, Oh, that's a cancer hospital, how can they be doing that? Because people think it's all about poor outcomes and it's not. We were laughing and we were all like huddling, and so it shows reward and recognition but it also shows leadership being humans, which I think is very, very important. I have had so many CNOs that are so not like that, that I vowed that if I ever became a CNO, I would not be like the ones I had. It shows the diversity of our staff, multi-diverse staff, which is great, and we're all laughing. So it's a quality thing, they just got an award, there's a celebration and oh my God, in the middle of that, I see a CNO's head. And then I—I don't post a lot of words on Twitter because you can't, I do some, but then I take some of that content and I'll put it on LinkedIn, because the LinkedIn, you get more of the CEOs and other people looking at it. I really do more narrative on that to give them like a real insight into what it's like here.

[00:32:12]

***T.A. Rosolowski, PhD***

[00:32:12]

Do you find that using social media helps you kind of come to a new understanding? I mean, if you're paying attention to what to post on social media, do you have a different understanding of the institution? I don't know if that makes sense.

[00:32:29]

***Carol Porter, DNP, RN, FAAN***

[00:32:31]

Well I think you may be more granular. I would be granular anyway, but I capture the granularity, because I want that captured for other people. So, I'll get comments on LinkedIn, Twitter, about, "It must be nice to work there," or "Boy it looks great," from all over the world, from all over the world. Or, if we do something here, I have a couple colleagues in Saudi Arabia, "That sounds great, Carol, good work," things like that, and then anybody that follows me can read that. So it's also teaching the nurses here that it's not just about MD Anderson, it's not just about Texas or the country, it's about the world, and so I try to teach them that. The same thing at Sinai. At Sinai I said, "It's not just New York, it's not just the United States. People around the world are watching us, people around the world are watching the nurses here." You know that because every once in a while you get a nurse from a remote part of Africa that comments on your post and you then become like their hope. I've seen it, because I go to international conferences and I'm at a conference and all of a sudden a nurse walks up to me, "Oh my God, you're Carol Porter, you and I are connected on LinkedIn," and then I check, we both check and say oh my God, we are on LinkedIn and I follow you, blah-blah-blah. So it's kind of—I can only imagine what it is if you're in a remote part of the world without many resources, and you're trying to understand what healthcare is like in the United States in a

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number one hospital. So I feel that we have an obligation to educate nurses everywhere, and other people. One person said, “Isn’t it depressing, working there?” I said, “No, there’s more living than anything.” So then I said okay, so now I have to post what we do that’s so unusual, like around the holidays, on our stem cell units, one of the associate directors always have a party for the patients and family, and has rock and roll music and line dancing. So all the patients have their masks on, their IVs dripping, and the associate director is up there with her cowboy boots leading in line dancing. I post that every year, because now you’re—what do you mean, it’s not sterile? The patients are out in the hallway and they’re having fun. So it gives people a glimpse of cancer care with a very human approach, and I have fun. The first time there was that little snowstorm and a couple of flakes were on a palm tree, I took a couple pictures and I posted it and I said something about how I brought the weather from New Jersey down to Texas, that kind of stuff.

[00:35:41]

***T.A. Rosolowski, PhD***

[00:35:42]

Yeah, yeah.

[00:35:43]

***Carol Porter, DNP, RN, FAAN***

[00:35:44]

So I feel very good about my contribution to getting them involved with that, and they all—everybody was worried that they would be inappropriate. They’re not inappropriate. I told them, I said social media is—whatever you put on social media should be okay on the front page of a newspaper, and it’s all for reward and recognition. Because they wanted guidelines, I said, “If you always use it for reward and recognition or education, you’ll always be fine.” So that’s my whole social media thing. I think nurses in general aren’t as savvy in social media as they should be. Doctors are.

[00:36:30]

***T.A. Rosolowski, PhD***

[00:36:31]

We’re at ten minutes after five.

[00:36:33]

***Carol Porter, DNP, RN, FAAN***

[00:36:34]

Okay, I know. Well that was good.

[00:36:37]



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***T.A. Rosolowski, PhD***

[00:36:37]

That's good, and we will definitely have another session.

[00:36:38]

***Carol Porter, DNP, RN, FAAN***

[00:36:39]

At least we got into MD Anderson now.

[00:36:39]

***T.A. Rosolowski, PhD***

[00:36:40]

We've gotten to MD Anderson. No, this was really, this was really great. I mean, I think it's—I'm enjoying the way you're talking about this, because the stories layer together, a lot of practical activity, leadership philosophy, and understanding of culture.

[00:36:58]

***Carol Porter, DNP, RN, FAAN***

[00:36:59]

Right.

[00:36:59]

***T.A. Rosolowski, PhD***

[00:37:00]

It's very complicated storytelling and I think it's very rich, so I'm really happy that we're having these conversations.

[00:37:05]

***Carol Porter, DNP, RN, FAAN***

[00:37:05]

Good, sure. I think it's great.

[00:37:07]

***T.A. Rosolowski, PhD***

[00:37:07]

Well let me just say for the record, thank you.

[00:37:09]

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***Carol Porter, DNP, RN, FAAN***

[00:37:10]

Yes, thank you.

[00:37:11]

***T.A. Rosolowski, PhD***

[00:37:11]

And then I'm turning off the recorder at ten minutes after five.

[00:37:15]

***Carol Porter, DNP, RN, FAAN***

[00:37:15]

Okay, perfect, thank you.

[00:37:16]

**Carol Porter, DNP, RN, FAAN**

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**Chapter 00B**  
***Interview Identifier***

***T.A. Rosolowski, PhD***

[00:00:01]

Okay, so our counter is moving and I'm laughing because we've already started talking, as we always do. It is July 6, 2018, and I'm in the office of Dr. Carol Porter, Chief Nursing Officer, for our third session together.

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**Chapter 07**  
***Developing Nursing with an Endowment from the Argyros Family Foundation***  
**B: Building the Institution;**

Codes

C: Leadership; D: On Leadership;  
A: The Researcher;  
B: Building/Transforming the Institution;  
B: Fundraising, Philanthropy, Donations, Volunteers;  
D: On the Nature of Institutions;  
B: Working Environment;  
B: MD Anderson Culture;

***T.A. Rosolowski, PhD***

[00:00:01]+

We've started talking about an important endowment that nursing received, the Argyros—is that how you pronounce it?

[00:00:23]

***Carol Porter, DNP, RN, FAAN***

[00:00:24]

Argyros, I think.

[00:00:24]

***T.A. Rosolowski, PhD***

[00:00:25]

Argyros Family Foundation Nursing Research Endowment. Okay. And what was the year that was received?

[00:00:30]

***Carol Porter, DNP, RN, FAAN***

[00:00:31]

I don't have it right in front of me, but I believe it was 2013.

[00:00:33]

***T.A. Rosolowski, PhD***

[00:00:34]

Okay, 2013. And you were talking about the disposition. Can you share how much it was?

[00:00:40]

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***Carol Porter, DNP, RN, FAAN***

[00:00:41]

Five million.

[00:00:41]

***T.A. Rosolowski, PhD***

[00:00:42]

Wow, okay.

[00:00:42]

***Carol Porter, DNP, RN, FAAN***

[00:00:43]

The initial discussions were in 2013. I believe initial document was in 2013, but it was not finalized until 2016. I came here in October and it could have been end of 2016 or early 2017, when Tom Buchholz [oral history interview] pulled me into this discussion and then we had a couple of calls with the representative of the family, about the endowment. It changed a little bit from the initial document. An initial document was to endow a chair of nursing, but after my assessment coming in and looking at the department, which is the Academic Department of Nursing, we were not ready to endow, to bring a chair, into that department, because we needed to focus on building a stronger infrastructure for research. So upon discussion with the family representative, it was supposed to be two million to a post-doc fellowship, a million, administrative costs, and two million for an endowed chair. So we asked that we use that two million that was earmarked for endowed chair, to become the research endowment, so that we could build the research and then eventually go for a chair. So I would say some time before Tom went to California, probably early last year, the document was signed and changed to that, that was an addendum. So we still have the post-doc fellowship money, the administrative cost money, and now the two million for the endowment for the research. [00:02:29]

We have started to bring in high level visiting scholars, like Dr. Joyce Fitzpatrick. We had, under this program, we brought in—and we have an ongoing two-year relationship with Joyce Fitzpatrick now, to help us build research. We recently brought in Dr. Joyce Black. She's a nurse researcher, nationally known in skincare, because of the vulnerable population that we serve and some of the drugs, the skin toxicities and radiation therapies are a unique population, so she's going to help us. She spent two days, I want to say two weeks ago, and I'm going to give her a call and see if she'll come maybe every quarter for the next year to help us. She's very interested, and I think as much as we were interested in her, she's interested in us now so it's great, it's a perfect match.

[00:03:25]

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***T.A. Rosolowski, PhD***

[00:03:25]

That's great, that is great, yes. Hopefully, we'll be able to capture her in an interview as well.

[00:03:30]

***Carol Porter, DNP, RN, FAAN***

[00:03:31]

Yes. Well, I will give you the dates that she's coming back.

[00:03:33]

***T.A. Rosolowski, PhD***

[00:03:33]

Absolutely.

[00:03:33]

***Carol Porter, DNP, RN, FAAN***

[00:03:34]

This is all under the umbrella of Argyros. Anyway and then we—it hadn't been approved yet, but I've discussed it at a faculty meeting, about putting forth a proposal for a full professor of nursing research. That would be the first time that we would ever have one at MD Anderson, if they approve it.

[00:04:00]

***T.A. Rosolowski, PhD***

[00:04:00]

Why is that important, to build the research dimension of nursing here?

[00:04:06]

***Carol Porter, DNP, RN, FAAN***

[00:04:07]

Well, I mean MD Anderson is the number one cancer research facility in the world, and the majority of that is based on physician research, and we are really in the beginning stages of nursing research. It's not connected, so we have pockets of great nursing research, but it just hasn't been connected together. If I'm able to bring a nurse, a full professor, which means somebody that is well known across the country, if I'm able to recruit someone like that, then everywhere that nurse researchers live at MD Anderson can be a dotted line to this head of nursing research. That person, if he or she is a very high level researcher, can teach, coordinate, has a vision, guide, that's what we need right now. We need that for the post-doc fellowship of the Argyros Foundation, we need somebody like that, to lead that post-doc fellowship. So, it would be a great opportunity for somebody to establish a true coordinated research program in nursing research, of course MD Anderson, to start the post-doc fellowship on oncology. It would

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be a wonderful career opportunity for somebody, so I'm really, really, really hoping.  
[00:05:34]

***T.A. Rosolowski, PhD***

[00:05:35]

Well it sounds like things are, as always, the pieces have to be set in place, a slow process.  
[00:05:40]

***Carol Porter, DNP, RN, FAAN***

[00:05:40]

Yeah, I mean, so I'm very pleased that we got this far and now we have to just wait for final approval. Everybody has been shaking their heads yes, not saying the word but shaking their heads, and they understand why it's necessary. It would also give us a place on the national nursing research presence across the United States, because right now, we just have a spotty kind of presence. We have some great researchers. Lori Williams is an example. She is an RN, she's a researcher, and her area of expertise is symptom management, but she wasn't connected. And I'm not saying reporting structure, I'm saying practice. So it doesn't matter who your boss is, but you come together around nursing research. She's very—you know, I just spoke to her yesterday, she's tremendous, and so my bringing a professor of research in, all these people would want to come together, so it would be a whole new phase for us, it would be wonderful.  
[00:06:51]

***T.A. Rosolowski, PhD***

[00:06:51]

What kind of impact would that have, that kind of more integrated, connected community that you're envisioning? How would that affect how nurses have an interface with all the other research that's going on at MD Anderson? Is that part of the equation as well?

[00:07:15]

***Carol Porter, DNP, RN, FAAN***

[00:07:16]

Yes. I'm glad you said community, because we have a community of nursing leadership meeting, but I would like to have a community of nursing research, so that all the researchers, wherever they are, could be on inpatient ambulatory, in faculty departments, et cetera, would come together and share best practices and kind of mentor each other. Yes, I mean nurse researchers are very respected by MD researchers and PhD researchers. It's just that I really believe, again, it's my opinion, that it's more because—it's not because they didn't want to work together; it's because they don't even know each other exists. Every time I talk about nursing research with physicians, they are all interested. So I believe once we organize it a little bit better, maybe by—if we get the position approved, if we can attract somebody within the next I don't know, eight months or so, maybe by this time next year we'll be on our way to really

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connect that, so that a skilled expert nurse researcher professor would be able to come up with a plan, look at all the cancer institutes, find out where the areas are that nurses could best serve to improve research. Symptom management is a very big research area, survivorship is another one, nurses played great roles in those, and then also, we would have a bigger connection with the NINR, the National Institute of Nursing Research from the NIH, which is another, that's another thing we're trying to do. [00:09:17]

Under the Argyros Foundation, every year the NINR in Washington, has a one-day gala, where all of the major nursing researchers from all over the country but also some from other countries, come together in Washington, and it's a big gala and then there's a whole dinner meeting with awards and information, a very big deal. We really haven't had a major presence there, so this year, thanks so the Argyros Foundation, we're going to sponsor a table at that gala, so it's going to be known to NINR, that MD Anderson is there. We're going to sponsor people going to that gala, so that they can be there and experience that meet, mingle with top researchers across the country, so that will be a learning experience, and get interested in the NINR. It's like it's unfolding, it's kind of exciting. There's so many layers to it, but it's starting to have some groundswell to it. Then, so the connection would be—break down the silos, communicate out to the organization, have an experienced, well-known nurse researcher as our lead. That person would be at research meetings that we currently are not at, and be able to see where nurses can assist other cancer researchers, at a researcher level, and then also bring in the up and coming, the clinical nurses or the APRNs, who are in the beginning of their careers, who may be thinking professionally, that this is an area they want to go into, and kind of mentor and guide nurses. I think it would be great for attracting nurses to MD Anderson as well, because now you have not only the mission of MD Anderson, “end cancer,” but you also have professional growth by a named researcher. So I think it's going to be wonderful, it would be wonderful.  
[00:11:44]

***T.A. Rosolowski, PhD***

[00:11:44]

Yeah.

[00:11:45]

***Carol Porter, DNP, RN, FAAN***

[00:11:45]

Now, any time we have like a visiting scholar or any grand rounds, we're trying to name it under Argyros, so that we have an umbrella, we have an endowment, because a lot of this would not be possible without that endowment.

[00:12:04]



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***T.A. Rosolowski, PhD***

[00:12:04]

It also helps, I mean even if—I mean the name is sort of intriguing, people would look twice at it. I think also, announcing that it has this substantial funding, I think attracts people's attention, like wow, this is something new, let me even read this email or whatever.

[00:12:21]

***Carol Porter, DNP, RN, FAAN***

[00:12:21]

Right. I don't know, again I wasn't here, but there's never been a formal announcement of the Argyros Foundation endowment. So we've been—we use it, but we need to—we're trying to work with Development, to say let's pick a date and let's just make a formal announcement. Maybe they were waiting until we had a little bit more, this is when we'll be done with it, and I think that by the end of this year, we can show that because of this, we're starting to move up the ladder on research. We've submitted a report, year-to-date, what we've done, and that could be the reason that we haven't, but even if we don't announce it this year, we should announce it next year's nursing week, or something like that.

[00:13:20]

***T.A. Rosolowski, PhD***

[00:13:20]

Yeah, yeah, for sure. Let me ask you this question, which comes a little bit from my own experience, because I too have experienced this issue of doing something that's cool and intriguing to people and then when I talk to them people say yeah, wow, that's here, we could do that? And really, the geological pace at which information about that spreads out, do you find—because you've had experience at a number of institutions. Is this an institutional situation in general or is it particularly pronounced here at MD Anderson, in having these silos and these little corners of activities?

[00:14:03]

***Carol Porter, DNP, RN, FAAN***

[00:14:02]

Oh, I think any large organization, healthcare or not, you're going to find silos. It's not done for a negative reason, I think it's done to get work done. But then I think, as the workplace has changed, silos were probably more embraced years ago, but now everything is interprofessional. It used to be, earlier in my career, it was nursing did their own meeting and physicians did their own meeting, and respiratory therapists did their own meeting. Now, when we look at any kind of improvement, there's one of everybody, which is so much healthier. So I think it might just be a sign of the workforce changing, and so now, people seek out multidisciplinary members of teams, which always works better, because everybody has a different perspective. I even like to

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put somebody on—  
[00:15:17]

***T.A. Rosolowski, PhD***

[00:15:17]  
I'm going to close the door real quick.  
[00:15:19]

***Carol Porter, DNP, RN, FAAN***

[00:15:20]  
Yeah, sure, sure.  
[00:15:20]

***T.A. Rosolowski, PhD***

[00:15:20]  
I'm sorry. You like to put?  
[00:15:22]

***Carol Porter, DNP, RN, FAAN***

[00:15:22]  
I like to include members of—we put a team together for improvement. Sometimes I like to put a member of the—pick a member that is not a content expert at all, because they'll ask questions that we wouldn't ask. It's like students. Students are great because they ask you a question that you probably haven't thought about for twenty years, and it's always a great question, like why do we do that? So I usually tell people that work for me that if you find yourself on a committee and you can't figure out why, it's because you don't have content expertise, but it's good that you don't, so ask the questions.  
[00:16:01]

***T.A. Rosolowski, PhD***

[00:16:02]  
Oh yeah, yeah, that's interesting.  
[00:16:03]

***Carol Porter, DNP, RN, FAAN***

[00:16:04]  
Yeah, yeah, I like that.  
[00:16:05]

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***T.A. Rosolowski, PhD***

[00:16:06]

Exactly, exactly, the fresh perspective, outside the box. It's really important.

[00:16:10]

***Carol Porter, DNP, RN, FAAN***

[00:16:11]

Yeah. And then even working with process engineers, that was not totally embraced by nurses, but process engineers are great because they have no clinical experience and they ask all the right questions.

[00:16:28]

***T.A. Rosolowski, PhD***

[00:16:30]

Well, I'm glad we chatted about that.

[00:16:32]

***Carol Porter, DNP, RN, FAAN***

[00:16:31]

Yeah. So it's exciting.

[00:16:33]

***T.A. Rosolowski, PhD***

[00:16:34]

It is very exciting.

[00:16:34]

***Carol Porter, DNP, RN, FAAN***

[00:16:35]

It's exciting.

[00:16:35]

***T.A. Rosolowski, PhD***

[00:16:36]

Would you like to transition now?

[00:16:38]

***Carol Porter, DNP, RN, FAAN***

[00:16:39]

You know what, let me add one more thing, because is along that same line. American Academy of Nursing, I think we've talked about it before, is the highest level of an organization for

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nursing in the country. To be a fellow of the American Academy of Nursing, I want to say out of about three million nurses, about seventeen hundred are fellows. So it's very prestigious, you have to meet a lot of criteria, you have to have done things out of your scope of service, so it's not just what you do in your job, it's how you impact nurses in the community, in the country, in the world, how you make a difference in different ways. Anyway, Barbara Summers was a fellow. I don't know whether she came here as a fellow or became a fellow while she was here. I came here as a fellow but there's no fellows of the academy at MD Anderson. So, my goal is to—I can sponsor two a year, but my goal is to sponsor as many MD Anderson nurses that qualify, to get them in. Garry Brydges, that's B-R-Y-D-G-E-S, Garry Brydges, he's the head of our CRNA group, nurse anesthetists, and very accomplished in his profession, from creating a website that I think over seventeen hundred CRNAs use around the world. He goes to Washington, he testified on opioid use, et cetera. He's the president of the CRNA organization for the country, I mean he's really accomplished, so I sponsored him, along with a professor from outside, and he just got notified that he got in.

[00:18:31]

***T.A. Rosolowski, PhD***

[00:18:31]

Oh, wow.

[00:18:31]

***Carol Porter, DNP, RN, FAAN***

[00:18:32]

So this is, I'm very excited, because he is our first homegrown, MD Anderson nurse, that will be a fellow of the academy. So in November, I think it's like the third or fourth of November of 2018, he'll be inducted. So that's a very big deal, because that's going to show the nursing group here that okay, it's not just talk, we're starting, because I'm going to look for my next two for next year, and I'm looking at people in nursing and outside nursing, that are nurses. So that's a very big deal, because what it does for the country is it puts us on that map.

[00:19:16]

***T.A. Rosolowski, PhD***

[00:19:16]

That is very exciting.

[00:19:18]

***Carol Porter, DNP, RN, FAAN***

[00:19:19]

So it's very—it's all these little pieces that have to come together, but it's exciting. Now we can change the topic. [laughter]

[00:19:27]

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***T.A. Rosolowski, PhD***

[00:19:27]

No, that's terrific, and I think it really does kind of bring it full circle, because we started this conversation with all the little bitty pieces that the Foundation enabled.

[00:19:38]

***Carol Porter, DNP, RN, FAAN***

[00:19:38]

Yes.

[00:19:39]

***T.A. Rosolowski, PhD***

[00:19:39]

And then here are the little spots where okay, success here, success here, and slowly but surely, they're all going to make this great mosaic that makes the vision come into being.

[00:39:48]

***Carol Porter, DNP, RN, FAAN***

[00:39:48]

Right. You have to just make sure you realize the little achievements.

[00:39:52]

***T.A. Rosolowski, PhD***

[00:39:52]

Along the way, yeah.

[00:39:54]

***Carol Porter, DNP, RN, FAAN***

[00:39:55]

All along the way. Then, Garry takes that back to his community. I was in the OR this morning, the OR meeting, and told Anesthesia and the surgeons about it, so they're going to celebrate. So it's like all this—it's great.

[00:20:08]

***T.A. Rosolowski, PhD***

[00:20:08]

Absolutely and it motivates people, because people in the frontlines really need to see that the vision is working, that it's taking shape.

[00:20:16]

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***Carol Porter, DNP, RN, FAAN***

[00:20:16]

And that there's a pathway, and that somebody they know is in. It's great.

[00:20:21]

***T.A. Rosolowski, PhD***

[00:20:20]

Yes. I think that's a mistake, I mean I'm kind of watching a couple of things happening in the institution right now where there are really high level planning meetings and they're all great, but okay, I'm concerned that this information—a lot of people know these meetings are taking shape and there's a lot of cynicism, like oh yeah, they're talking about this, it's never going to happen, it's never going to affect us.

[00:20:46]

***Carol Porter, DNP, RN, FAAN***

[00:20:46]

Right.

[00:20:47]

***T.A. Rosolowski, PhD***

[00:20:47]

And so people need those little bits of information along the line, to say yes there is movement, yes we're doing stuff at a pretty high level, but look at these concrete things that really are having an impact for you.

[00:21:00]

***Carol Porter, DNP, RN, FAAN***

[00:21:00]

We're doing an Employee Notes article on Garry.

[00:21:02]

***T.A. Rosolowski, PhD***

[00:21:02]

Cool.

[00:21:03]

***Carol Porter, DNP, RN, FAAN***

[00:21:03]

Also, we have a couple other recent accomplishments by nursing. We have a new communications person and she's helping us to get the word out so that we need to celebrate people who are accomplishing things.

[00:21:19]

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***T.A. Rosolowski, PhD***

[00:21:20]

Yeah, absolutely.

[00:21:20]

***Carol Porter, DNP, RN, FAAN***

[00:21:21]

Because it's not just good for their career but it's good for MD Anderson, it's good for the patients.

[00:21:24]

***T.A. Rosolowski, PhD***

[00:21:24]

Absolutely, absolutely. Now we'll change the subject.

[00:21:28]

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## **Chapter 08**

### ***Observations about Nursing and Hurricane Harvey***

#### **A: Overview;**

Codes

C: Leadership; D: On Leadership;  
B: Working Environment;  
B: MD Anderson Culture;  
B: Obstacles, Challenges;  
B: Institutional Mission and Values;  
C: Human Stories;  
C: Offering Care, Compassion, Help;  
B: Survivors, Survivorship; C: Patients, Treatment, Survivors;  
C: This is MD Anderson;  
C: Professional Practice; C: The Professional at Work;  
C: Collaborations;  
B: Beyond the Institution;

***Carol Porter, DNP, RN, FAAN***

[00:21:28]

Okay, fine. [Dr. Rosolowski] Okay. Are we going back to the hurricane?

[00:21:33]

***T.A. Rosolowski, PhD***

[00:21:34]

Yeah. Well actually, we haven't even started talking about the hurricane yet. We were kind of at the point. [laughs] I know you've still been dealing with the hurricane, the aftermath of it.

[00:21:45]

***Carol Porter, DNP, RN, FAAN***

[00:21:45]

So you know that it's been in a couple of the internal magazines, there's a lot of information.

[00:21:52]

***T.A. Rosolowski, PhD***

[00:21:52]

Yes, there is a lot of information. So why—the reason that I wanted to chat with you about it was to kind of first of all, get—because you were a relatively new leader when this came about, and so this was quite an amazing lens through which to see this institution you had just joined, or



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had relatively recently joined.  
[00:22:13]

***Carol Porter, DNP, RN, FAAN***

[00:22:13]

Right. It was in August, August, 2017, the end of it, the hurricane, and I joined October of 2016. So it was just under a year.

[00:22:23]

***T.A. Rosolowski, PhD***

[00:22:23]

Yeah, so just under a year. Part of what I wanted to chat with you about was—and of course you brought very substantial experience in emergency management. So here you are, watching an institution go through this huge emergency and respond to an emergency, having just gone through some leadership changes.

[00:22:45]

***Carol Porter, DNP, RN, FAAN***

[00:22:46]

Sure, sure.

[00:22:46]

***T.A. Rosolowski, PhD***

[00:22:47]

That's really the perspective I wanted you to bring, kind of what was it, what did you learn about the institution by observing that process, and then kind of how did you obviously participate very centrally, in stewarding the institution through it. So where would you like to start? I mean, I could ask you specific questions if that would help.

[00:23:08]

***Carol Porter, DNP, RN, FAAN***

[00:23:07]

Well, I would start when, I think when the hurricane was approaching. I've had many—I've been through blackouts, 9/11, a direct hit on New York City hurricane, you name it. We had evacuation of a hospital to our hospital, I mean I've been through a lot. A nuclear plant, you can go on and on, I've got a lot of emergency management background, but I never lived in Texas and I didn't understand rainfalls here. Now I have a better understanding, almost two years later, that rain is not just rain in Texas, but rain in Houston can be torrential and can flood even though you wouldn't think it would flood. I believe that my reaction to that hurricane, I guess it was that weekend, when it looked the day before, in the afternoon, it looked like maybe the weather report wasn't right, because the sun came out. I think that's what caught a lot of people and was

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confusing, and then all of a sudden that night, torrential rains in the morning, the streets were flooded. My response was based on my previous emergency management experience, not based on MD Anderson's policies, to twenty-five years plus emergency management experience in several hospitals, incident command is incident command.

[00:24:39]

***T.A. Rosolowski, PhD***

[00:24:39]

What were the differences, because I really don't know what the differences would be.

[00:24:44]

***Carol Porter, DNP, RN, FAAN***

[00:24:45]

Well, I mean I only experienced one hurricane, but I think it's not knowing all the rules and regulations around—particular to MD Anderson, I was functioning on kind of a national rules and regulations level. So, when I had them—I called the UTPD [University of Texas Police Department] that morning and said I can't get in, do you have a high water vehicle, I'm three miles away, and they came out and got me. I went right to the Incident Command Center and again, not everybody knew that about my background, but there were two people in the Incident Command Center and I said, "Okay, you guys can take a break, I'm here," and they kind of looked at me like yeah? I said, "I have twenty-five years emergency management experience, and I've been incident commander in several emergencies in New York City, or always in the Incident Command Center, so I'm good, you guys need some sleep." So immediately, we started to have about five or six people that were familiar with incident command, that kind of rotated through so that people could get sleep and keep tabs. So I think that it was a fast way to learn all the major players across the hospital, and I think you know, I did question some things that I didn't understand why we did it. I just really reacted based on my experience, which was fine. I think that there was tremendous teamwork, there was a tremendous focus on, once we got through the emergency two or three days, on how do we allow our people to get home to their families, to take care of their own homes, their own families, and that's when we started accepting offers for help from outside organizations. So I think that whole piece was different, being able to, you know? A lot of people worked on that, being able to coordinate with four other hospitals and have all their staff credentialed by HR and everything checked and vetted by all of their incident command centers and/or their executive leadership, vetted their staff before they even got to us. And then to bring in four hospital clinical teams, mostly nurses, some doctors, some lab, some pharmacists, was a very concerted effort between nursing, HR, and any mothers, to get them in, make them feel welcome, work with our staff to welcome them, make our staff understand that these people are coming in so you can go home. One thing that I thought was interesting was that our staff are very protective of their patients, our patients, so when they—even though they kind of orientated quickly, this new staff coming in, in the beginning they didn't want to go home, because they were protecting their own patients. So, we

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had to work with them to say, as long as you've orientated this person, of course we're going to intermingle MD Anderson with outside staff, but your patients will be safe and we're going to make sure and we're going to round, and we're going to make sure everything is good and everything else. I think it took a couple days before they started to say okay, I'll go home. So that shows the commitment to MD Anderson, right?  
[00:28:35]

***T.A. Rosolowski, PhD***

[00:28:35]  
Yeah, yeah.  
[00:28:36]

***Carol Porter, DNP, RN, FAAN***

[00:28:36]  
Then, it was such—I think the biggest thing I was blown away by was that the hospitals that sent staff, within a couple of days, you would not be able to tell who was our staff and who was their staff, because everybody was working together so well. Each hospital sent one or two leadership people with them, most of the time it was nursing leaders who came, one or two nursing leaders, and they stayed while their staff was here and they kind of cared for their staff. And then we bonded with their nursing leaders and then we all looked after everybody. It was an amazing experience that it went so smoothly, that people worked so well together.  
[00:29:26]

***T.A. Rosolowski, PhD***

[00:29:26]  
What were the other hospitals that participated in this?  
[00:29:29]

***Carol Porter, DNP, RN, FAAN***

[00:29:30]  
It was Northshore, Banner, UT Southwest, and then I believe it was Ohio State. I'd have to check for sure, but it was Ohio State that sent, I believe pharmacists and a couple other disciplines, you know that was the least amount, but the biggest groups came from Banner and Northshore, and they were doing an amazing job at their end, vetting all their staff, getting everything together, we had conference calls with them. It was so—it worked so well. That was a really, really nice thing.  
[00:30:08]

***T.A. Rosolowski, PhD***

[00:30:09]  
How amazing. I had a couple of thoughts as you were kind of giving this overview, and the first

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was that it really surprised me that no one knew about your emergency management experience. How did that happen, that that kind of didn't come up?  
[00:30:27]

***Carol Porter, DNP, RN, FAAN***

[00:30:27]

Of course a small group knew because they hired me.

[00:30:30]

***T.A. Rosolowski, PhD***

[00:30:31]

Right.

[00:30:31]

***Carol Porter, DNP, RN, FAAN***

[00:30:31]

So it would be on my CV. But I'm not in the emergency management role here. Matt Berkheiser knows because of course he would know that I was coming in with emergency management background, he knew.

[00:30:47]

***T.A. Rosolowski, PhD***

[00:30:48]

He was the one who is tasked with mobilizing the Command Center.

[00:30:55]

***Carol Porter, DNP, RN, FAAN***

[00:30:54]

He's in charge of emergency management. Matt and I connected as soon as I came here, because of that common bond. So I started going to the emergency management meetings and everything else, so he knew. Anybody on the emergency management group knew, but when you get outside of that. I think it's unusual that a CNO has an emergency management background, that's what's unusual. I don't know why but to me, nursing and emergency management are a good fit, but it doesn't happen often.

[00:31:27]

***T.A. Rosolowski, PhD***

[00:31:28]

Okay, well that clarifies that, that makes sense. Now, what were some of those—I mean, I don't want you to speak about anything that might be sensitive obviously, but during that period, in

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those first days, because the storm made landfall, I think it was the Friday morning?  
[00:31:48]

***Carol Porter, DNP, RN, FAAN***

[00:31:49]  
Right, right.  
[00:31:49]

***T.A. Rosolowski, PhD***

[00:31:50]  
Or Friday night, and then by Saturday, the rains came to Houston, bang, Sunday things were a mess. So was it Sunday, that you came into the institution?  
[00:32:00]

***Carol Porter, DNP, RN, FAAN***

[00:32:00]  
Whatever the day, the morning after the night when it started.  
[00:32:07]

***T.A. Rosolowski, PhD***

[00:32:07]  
Yes, that was Sunday morning, you came in. I woke up and looked out my window and somebody was canoeing down my street.  
[00:32:13]

***Carol Porter, DNP, RN, FAAN***

[00:32:13]  
Because Saturday afternoon is when the sun came out a little bit, and then probably about eight o'clock Saturday night was when it just came down.  
[00:32:21]

***T.A. Rosolowski, PhD***

[00:32:21]  
It just came down completely, right. So in that period, when the Incident Command Center was getting up and running, everybody's kind of finding out, what were some situations that might have been, you were looking at this and saying huh, what's this response, and then kind of adjusting how MD Anderson was. You know, like what were these situations that might have made you think two or three times, about what was happening, in response? And here I'm really learning, you know asking you to reflect on what were—what's the decision making process that MD Anderson was going through and what the rationale was behind that, which may have been

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different from your experience.  
[00:33:06]

***Carol Porter, DNP, RN, FAAN***

[00:33:07]

Right. Well, I was not familiar with the right out, that kind of methodology, because it's not used all over. I think it's used in states that get hurricanes, but many emergencies, you don't have time to plan. So I guess hurricanes you can plan, but most emergencies you can't plan. There were a couple of things around that, that I questioned.

[00:33:43]

***T.A. Rosolowski, PhD***

[00:33:44]

Such as?

[00:33:44]

***Carol Porter, DNP, RN, FAAN***

[00:33:45]

A lot of HR things, but I mean kind of rules. Again, remember, I was not familiar with all this, right? So I just used basic nursing leadership skills and incident command skills, and reached out to make sure that the people that were in the hospital had come in with clothes and things to stay, because you couldn't leave. So I guess I was rounding up on the units saying you can't—there's no way you can get out of here, because we have a moat around us and we're in the middle of a lake right now, it's not safe. So, and then as people were calling in from the outside, I would say, "You can't get here, you can't get here," because it was truly like a lake. So I think making sure—my biggest thing was, and I was part of it, rounding on the staff, looking at—because my experience is during an emergency, especially nurses and doctors, they will not go to sleep. They'll think that they can work forever, but all the research shows, your decision making is going down and you don't even know it, you need to get away. And so we were rounding on people and looking at them and saying, "How long have you been working? Did you take your four hours on, four hours off?" Or asking, saying, "Listen, you need to have a break now," and actually saying Nancy, relieve Carol, Carol is going for break, so that we cannot ask them, just tell them you're off now for four hours, go take a nap, whatever, and just to make everybody feel safe. [00:35:35]

The other thing that we did very well, I think, was—and this was our food services. They were feeding everybody, because we had about five hundred plus patients in the hospital, plus visitors, plus staff, all those stats we have, we have tabulated. Everybody was being fed because the visitors couldn't leave either, right? So they fed everybody on site and all the visitors, and they had three meals a day and everybody got fed. I want to say about the second day into it, Food Service added a fourth meal, so the fourth meal was around eleven o'clock at night, and it wasn't

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as big as the three regular meals but it was a meal, and that was a crowd pleaser. I talked to somebody that was in the military about that, and he said that there's evidence about feeding like that, when people go into battle, that they get extra rations. I don't know if that's true or not but that's what they said. But it just helped people tolerate it and it was such a positive, in a crazy situation, so that was wonderful.

[00:36:58]

***T.A. Rosolowski, PhD***

[00:36:58]

So did people—were these meals delivered to the individual units or did people take a break and go get them?

[00:37:04]

***Carol Porter, DNP, RN, FAAN***

[00:37:04]

Both, both. Some were delivered to the units, or some sent people and they brought meals back, or some went to certain pickup points, like the park or different places, to pick up food. There was a big attention focused on providing food and water, and not skimpy, I mean actually very decent, very decent.

[00:37:33]

***T.A. Rosolowski, PhD***

[00:37:33]

Who made the decision about that fourth meal?

[00:37:35]

***Carol Porter, DNP, RN, FAAN***

[00:37:35]

It must have been Frank Tortorella, he's in charge of it. I'm not sure.

[00:37:39]

***T.A. Rosolowski, PhD***

[00:37:40]

Yeah, interesting.

[00:37:42]

***Carol Porter, DNP, RN, FAAN***

[00:37:43]

It was wonderful. It doesn't sound like much but that's a creature comfort.

[00:37:47]

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***T.A. Rosolowski, PhD***

[00:37:48]

Oh yeah, oh no, to me it makes perfect sense. I mean there's nothing—you feel cared for, you feel someone is thinking about you, and especially the extra. Somebody thought about me, to give me something more.

[00:38:02]

***Carol Porter, DNP, RN, FAAN***

[00:38:02]

So if you were at home, you might have made your way to your refrigerator about ten-thirty, you said what's in there.

[00:38:07]

***T.A. Rosolowski, PhD***

[00:38:08]

Yeah, exactly.

[00:38:09]

***Carol Porter, DNP, RN, FAAN***

[00:38:09]

You said what's in there, but there was no—they couldn't do that. I thought that was brilliant and it helped make people feel cared for, they did.

[00:38:15]

***T.A. Rosolowski, PhD***

[00:38:15]

Well and especially if they know they're going to be up during the night, to say wow, somebody wants me to feel nourished as I'm looking at this.

[00:38:22]

***Carol Porter, DNP, RN, FAAN***

[00:38:22]

That, and the other thing that was also addressing comfort needs for the staff, is opening up the gym and completely supplying it with towels, washcloths, shampoo, soap and everything else. People would take turns going to the gym, there's plenty of showers, it was very well equipped, and just using those facilities to take a shower and go back to work, that was another big, big deal. And then of course, when we were able to start sending our own staff home. When, I would say six days, seven days out, we were—people were going home, maybe five days out, I'm not quite sure, but we were at the entrance of the hospital and a nurse came down. Well, I didn't know whether she was a nurse, but a woman employee came down and she had like a cart with all kinds of personal items on, that she must have brought in when she came in, and she was



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with a man that was a family member. It was her father and she was a nurse, and she was a relatively new nurse to MD Anderson, and as they were leaving we had—when people were going to try to go home, we had to make sure that their route was accessible. So we were trying to put up maps and making sure that they were able to get back to their home and all that. As they were leaving, I talked to her and I thanked her, and she told me she was a new nurse. I said, “Well thank you so much for helping,” and her father said, “Thank you for letting us.” I mean, that was amazing.

[00:40:11]

***T.A. Rosolowski, PhD***

[00:40:12]

Yeah.

[00:40:12]

***Carol Porter, DNP, RN, FAAN***

[00:40:12]

Yeah. Thank you for letting us and thank you for taking care of my daughter.

[00:40:15]

***T.A. Rosolowski, PhD***

[00:40:15]

Oh, wow.

[00:40:16]

***Carol Porter, DNP, RN, FAAN***

[00:40:16]

Yeah. So it was a terrible situation that MD Anderson really excelled in.

[00:40:25]

***T.A. Rosolowski, PhD***

[00:40:26]

What did you learn about the institution as you were going through that process?

[00:40:30]

***Carol Porter, DNP, RN, FAAN***

[00:40:31]

I knew that MD Anderson has a culture of caring, you can feel it, it's palpable, but I think that sometimes in emergency situations, the caring part of you doesn't come out because you're nervous, and so people could shout orders and things like that, versus working together and coming to agreement and understanding, with the best choices, and then having kind of a structure where a defined incident command group then kind of lets everybody know what the

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plan is, so that there's no chaos. So I think what came out over and over again, I've heard it from the patients, I heard it from the visitors, was that visitors felt care for, that patients felt cared for, they weren't afraid. So the fear factor, they weren't afraid, they knew that we were safe and that the Incident Command Center and everybody that interacted with it, were all respectful and caring, making sure that we were all okay. Everybody was like, "Are you okay, are you okay?" That kind of stuff. But, about two, three o'clock in the morning, it was probably Sunday, going into Monday, where we were it, no one was coming in or out. I was walking down the Skywalk and it was weird, but it felt like a fortress, like you felt safe. It was a safe place, everything was going as best we could, we had no patient events, the staff was being cared for, we had a plan to have these hospitals come and help us and get our staff out. It was just kind of a feeling that we were doing everything possible. I don't know how to explain that, but it just felt like there was no one out there but me, and it just felt like a very thoughtful moment.  
[00:42:35]

***T.A. Rosolowski, PhD***

[00:42:35]

I had a little bit of a moment like that before the storm hit, because I was here on the Friday and the institution, I mean the library, closed early. I had to be here for lunch and so I was having lunch over near the Apicius Restaurant and somebody was playing the piano and there was all the food smells coming from that restaurant, and everything was so calm and fine, I mean the storm hadn't even hit yet, but I thought wow, I wish I could just stay here.

[00:43:13]

***Carol Porter, DNP, RN, FAAN***

[00:43:13]

Right, right.

[00:43:14]

***T.A. Rosolowski, PhD***

[00:43:14]

It just felt like this was a calm haven, and so it was a little bit of that feeling and it's hard to put your finger on, how that happens, but I mean that that feeling was even starting. Really interesting.

[00:43:32]

***Carol Porter, DNP, RN, FAAN***

[00:43:32]

I think anybody that had to ride the storm out felt safe here.

[00:43:36]

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***T.A. Rosolowski, PhD***

[00:43:36]

Yeah, very interesting.

[00:43:37]

***Carol Porter, DNP, RN, FAAN***

[00:43:37]

Including the patients and visitors. They were being fed along with us, so they felt like part of the ride-out team, they just did. And then even when things were getting a little better and we were rounding in all the different areas of the hospital, maybe four or five days into it, and I can't remember who I was rounding with at the time, but when we saw people we'd say what's going on, are you okay, and everywhere we went, they were smiling. The feeling was that everybody knew that everybody was doing everything for everybody, so I thought it was good. I think it was a good response.

[00:44:24]

***T.A. Rosolowski, PhD***

[00:44:25]

Was there anything that came up during that period, that made you think okay, we need to rethink how we do that? I mean this is a problem, some evidence of a problem has emerged, that we need to address even in our normal operating situations.

[00:44:46]

***Carol Porter, DNP, RN, FAAN***

[00:44:46]

Right. You always have an after actions meeting, which Matt Berkheiser had several after actions meetings, with several different groups, and then collated all the comments from all the meetings he had, for all the areas that we should tweak or improve or look at. So that all was done immediately, and I'm sure that the list isn't completely done yet.

[00:45:14]

***T.A. Rosolowski, PhD***

[00:45:15]

Was there anything that struck you, when you were going through it, like oh yeah, the to do list for after?

[00:45:21]

***Carol Porter, DNP, RN, FAAN***

[00:45:22]

I think that defining ride on recovery a little better, but they're working on that, so.

[00:45:30]

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***T.A. Rosolowski, PhD***

[00:40:32]

What was it that kind of came to your attention as needing more clarification or needing better process?

[00:40:39]

***Carol Porter, DNP, RN, FAAN***

[00:40:40]

I think the understanding of what that means by everybody. Not everybody had a good understanding of what that meant. So I just think a clearer defining of it and more education on it.

[00:45:54]

***T.A. Rosolowski, PhD***

[00:45:55]

How would you define it?

[00:45:56]

***Carol Porter, DNP, RN, FAAN***

[00:45:57]

I don't want to answer that.

[00:45:58]

***T.A. Rosolowski, PhD***

[00:45:58]

Okay. [laughs] Okay.

[00:46:01]

***Carol Porter, DNP, RN, FAAN***

[00:46:01]

You know, I have years of not having that, so I'm not the expert in that definition. What I'm an expert at is making sure we have enough caregivers to take care of the patients, whatever you call it. I know we're working on, we're still working on that piece of it.

[00:46:24]

***T.A. Rosolowski, PhD***

[00:46:25]

Are there things in the patient care area, that you felt like okay, yeah, here's an area? And let me actually—because this will read on the recorder for sure.

[00:46:34]

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***Carol Porter, DNP, RN, FAAN***

[00:46:35]

Sorry, sorry.

[00:46:35]

***T.A. Rosolowski, PhD***

[00:46:36]

That's all right, people play with their toys. Is there something in the patient care area that you're kind of looking at now, or looked at in the aftermath?

[00:46:46]

***Carol Porter, DNP, RN, FAAN***

[00:46:47]

Well, we had enough supplies, enough food. All that, when a storm is coming, everybody tops their oil and there's a lot of things that everybody should do, so we didn't have to worry about that, we had all the supplies we needed, probably for a week or more. Frank and others, once the roads were passable, got supplies in, kept getting more supplies in. So we were okay with that, we didn't run out of supplies. I can't say, I mean the—I can't say anything negative about the care, because we had staffed for what we needed and they were there when the storm hit, so it wasn't like people couldn't get in, they were there. They just couldn't leave.

[00:47:44]

***T.A. Rosolowski, PhD***

[00:47:44]

Right.

[00:47:45]

***Carol Porter, DNP, RN, FAAN***

[00:47:45]

So we had our staffing on the inpatient side was fine, and then the ambulatory was just sporadically open, once the roads opened, but they had closed early, which was a good thing. I can't say that—we didn't have any patient adverse events, none. I think there was a lot of -- communication did a really good job, communicating to the staff, and also constantly having flyers, so that on the trays that they got, they'd have an update, they'd have an update on their TV, of what's going on, because they could watch the weather, also, this is what MD Anderson is doing. Some of them were hand delivered as the—whoever the nurse leader was on that unit, as they rounded, they gave out the flyer and talked to the patients. Some came on their trays, some can around, handed to them, so there was multiple ways to communicate to the families. Remember, the families were there, they were living there, so they got the information, the patient got the information.

[00:48:49]

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***T.A. Rosolowski, PhD***

[00:48:50]

What was the number of—do you recall numbers of patients and family members that were in?

[00:48:55]

***Carol Porter, DNP, RN, FAAN***

[00:48:55]

All that is here, yeah. There's an institutional data, it's actually probably online.

[00:49:03]

***T.A. Rosolowski, PhD***

[00:49:03]

Yeah, just curious if you—

[00:49:07]

***Carol Porter, DNP, RN, FAAN***

[00:49:08]

The number of patients was over five hundred, I just don't know how many, and I'm sure they're online. There were many, many presentations done across the organization, that had those stats.

[00:49:21]

***T.A. Rosolowski, PhD***

[00:49:21]

Yeah, yeah. I was just curious if you happened to—

[00:49:23]

***Carol Porter, DNP, RN, FAAN***

[00:49:23]

And they're in the—inside magazines, dedicated to the hurricane, they're all in there.

[00:49:31]

***T.A. Rosolowski, PhD***

[00:49:32]

Well we're at ten o'clock now.

[00:49:33]

***Carol Porter, DNP, RN, FAAN***

[00:49:33]

Yes

[00:49:33]

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***T.A. Rosolowski, PhD***

[00:49:34]

Do you want to close off for today?

[00:49:36]

***Carol Porter, DNP, RN, FAAN***

[00:49:37]

Sure, yeah that's great.

[00:49:38]

***T.A. Rosolowski, PhD***

[00:49:39]

I'm sure you've got more meetings to go to.

[00:49:39]

***Carol Porter, DNP, RN, FAAN***

[00:49:40]

Yes, yes.

[00:49:40]

***T.A. Rosolowski, PhD***

[00:49:40]

So, just wanted to thank you.

[00:49:42]

***Carol Porter, DNP, RN, FAAN***

[00:49:42]

Thank you.

[00:49:42]

***T.A. Rosolowski, PhD***

[00:49:43]

And we're closing off our conversation at about two minutes after ten.

[00:49:48]

***Carol Porter, DNP, RN, FAAN***

[00:49:48]

Great, thank you very much.

[00:49:49]

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***T.A. Rosolowski, PhD***

[00:49:50]

You're welcome. I wanted to say for the record, that we actually started at about nine eleven this morning.

[00:49:54]

***Carol Porter, DNP, RN, FAAN***

[00:49:55]

Yes.

[00:49:55]

***T.A. Rosolowski, PhD***

[00:49:55]

Terrible number. You went through that too.

[00:49:58]

***Carol Porter, DNP, RN, FAAN***

[00:49:58]

Oh, yes, yes, I did.

[00:49:59]

***T.A. Rosolowski, PhD***

[00:49:59]

[laughs] All right, on that note—

[00:50:01]