

Barbara Summers, Ph.D.

Interview #46

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Barbara Summers, Ph.D.

Interview #46

Interview Profile

Interview Information:

Three interview sessions: 23 January 2014, 1 April 2014, 29 April 2014
Approximate total duration of 3 hours and 50 minutes.
Interviewer: Tacey A. Rosolowski, Ph.D.

For a CV, biosketch, and other support materials, contact:

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About the Interview Subject:

Dr. Summers (b. 4 March 1951, Aurora, Illinois) joined MD Anderson 1997 as clinical administrative director for the hematology clinical program. From 1997 to 2000 she served as the Administrative Director of the Department of Nursing. From 2000–2003 she served as Chief Nursing Officer and Associate Vice President of Clinical Programs. Since 2003 she has served as the Chief Nursing Officer and Head of the Division of Nursing. Dr. Summers is Professor and Chair of the Department of Nursing, a department she was instrumental in founding.

These sessions provide a detailed portrait of the activities of oncology nursing at MD Anderson and beyond as the field continues to define and theorize its contributions to patient care and healthcare institutions. Dr. Summers is deeply connected to MD Anderson. She is passionately articulate about the hope that the institution offers to patients and about the role that nurses serve in care.

Major Topics Covered:

A varied work and educational history

History of nursing practice

Development of leadership abilities

Activities and structure of the Division of Nursing at MD Anderson

Oncology nursing at MD Anderson

Development of nursing research

MD Anderson's Magnet designation

The Nursing Congress

Primary Team Nursing

Professional Practice Mode

Creating the Department of Nursing

MD Anderson as a matrixed institution

**University of Texas MD Anderson Cancer Center
Making Cancer History Voices® Oral History Project**

Research Medical Library: Historical Resources Center

Original Interview Profile #46: Barbara Summers, Ph.D.

Submitted by: Tacey A. Rosolowski, Ph.D.

Date: 10 May 2014

This interview with Dr. Barbara Summers (b. 4 March 1951, Aurora, Illinois) takes place over three interview sessions conducted in spring 2014 (for an approximate total duration of 3 hours and 50 minutes). Dr. Summers joined MD Anderson 1997 as clinical administrative director for the hematology clinical program. She is currently Vice President of Nursing Practice and also serves as the Chief Nursing Officer and Head of the Division of Nursing. Dr. Summers is Professor and Chair of the Department of Nursing, a department she was instrumental in founding. This interview takes place in Dr. Summers' office in Pickens Academic Tower on the Main Campus of MD Anderson. Tacey A. Rosolowski, Ph.D. is the interviewer.

Dr. Summers received her BSN in Nursing in 1978 from George Mason University in Fairfax, Virginia. Continuing her education at the same institution, she received her MSN in Advanced Clinical Practice and her PHD in Health Care Administration in 1995. Dr. Summers Just prior to coming to MD Anderson, Dr. Summers worked as a Nurse Specialist in the Department of Nursing at National Institutes of Health, Warren Grant Magnuson Clinical Center in Bethesda, Maryland (1993–1996). From 1996–1997, she served as Manager of the Department of Nursing at that institution, during which time she was recruited to MD Anderson. From 1997 to 2000 she served as the Administrative Director of the Department of Nursing. From 2000–2003 she served as Chief Nursing Officer and Associate Vice President of Clinical Programs. Since 2003 she has served as Vice President and Chief Nursing Officer and Head of the Division of Nursing.

In this interview, Dr. Summers traces the evolution of her thinking about nursing through her varied work and educational history: throughout, she comments on the evolution of nursing practice as a field and her own desire to have an impact at this level of professional practice. Her narrative of experiences at MD Anderson include detailed descriptions of the activities and structure of the Division of Nursing and her mission to develop not only nursing care at MD Anderson, but the stature of oncology nursing as a unique professional practice at MD Anderson. She speaks about MD Anderson's Magnet designation, the Nursing Congress, Primary Team Nursing, and the Professional Practice Model, all which have evolved significantly under her leadership. She also tells how she created the Department of Nursing. Implicit in her discussions is the history of nursing's evolution as a complex and autonomous professional practice (an important theme in the light of still-enduring notions that nurses are "doctors' helpers.")

This interview expands the understanding of the role of nurses and oncology nurses on patient care teams and in complex healthcare institutions. Her narrative provides a portrait of a woman who felt the impulse to lead very quickly and turned her skills to developing the practice of nursing. As her career has unfolded simultaneously with theoretical and practical advances in

the field of nursing, her experiences provide a demonstration of evolution in the field. She also comments on her growth as a leader within different administrative structures: she provides insight into MD Anderson's matrixed structure. These sessions provide a detailed portrait of the activities of oncology nursing, a field that continues to work to define and theorize its contributions to patient care and healthcare institutions. Dr. Summers is deeply connected to MD Anderson. She is passionately articulate about the hope that the institution offers to patients and about the role that nurses serve in care.

Barbara L. Summers, Ph.D.

Interview #46

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Barbara L. Summers, Ph.D.
Interview #46

Segment Summaries

Interview Session One: 23 January 2014

Segment 00A
Interview Identifier

Segment 01

A: Educational Path

Inspired to Enter Nursing: An Altruistic and Intellectual Profession

00:59

- A: Personal Background
- A: Professional Path
- A: Influences from People and Life Experiences
- C: Mentoring
- A: Inspirations to Practice Science/Medicine
- A: Definitions, Explanations, Translations
- D: On Care
- A: The Clinician
- A: Character, Values, Beliefs, Talents

Dr. Summers talks about her family and her mother's influence as a role model. She sketches her educational background and her path to her first job in nursing.

Dr. Summers explains that nursing attracted her because it is an interactive profession where the nurse positively influences the experience of another human being. She also underscores that nursing is intellectually rigorous and demands critical thinking skills and the ability to pull together data.

She next traces her path to college (George Mason University, Fairfax, Virginia, BSN, 1978). She talks about working as a nurse throughout her program and the mentoring she received from the nurses at her job.

Segment 2

A: Overview

The Theory and Advantages of Primary Nursing

14:52

Story Codes

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher
A: The Clinician
D: The History of Health Care, Patient Care

Dr. Summers gives an overview of “primary nursing” and its development as a central concept in nursing. She also discusses its advantages for clinical practice and care of patients.

Segment 3

A: Professional Path

A Focus on Primary Nursing

00:19:12

Story Codes

A: The Clinician

A: Professional Path

C: Mentoring

C: Leadership

Dr. Summers observes that she started in nursing at a key point when primary nursing practice was also beginning, and she selected a hospital that focused in this new area, taking a job taking care of orthopedic surgery patients. She talks her job at a medical surgical ICU and the mentors who encouraged her to think about her career and future, particularly as a leader in nursing.

Segment 4

A: Educational Path

A Master’s Program Leads to Oncology and to an Interest in Pain Management

00:23:04

Story Codes

A: Professional Path

C: Mentoring

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

C: Human Stories

C: Offering Care, Compassion, Help

C: Patients, Treatment, and Survivors

C: Patients

Dr. Summers talks about the impact of her Master’s program on her nursing practice and her vision of her nursing career. She discusses her commitment to oncology nursing and providing “high intensity critical care” to patients and family members.

She sketches her work history and the impact of working in a chronic pain clinic (not related to oncology). She explains social attitudes toward pain and notes her own subspecialty interest in pain and pain management. She tells a story about successfully using multi-modality interventions to treat an oysterman who was very injured and couldn’t work.

Segment 5

A: Professional Path

Thinking about Leadership and Nurses as Self-Care Agents

00:29:31

Story Codes

A: Professional Path

A: The Researcher

A: Definitions, Explanations, Translations

D: The History of Health Care, Patient Care

A: Character, Values, Beliefs, Talents

A: The Administrator

C: Leadership

In this segment, Dr. Summers describes the impact on her career of her Masters program (MSN, 1981, Advanced Clinical Practice) and her specialization in Advanced Clinical Practice. She explains what that practice meant at the time and how her work in this area helped give her grounding for leadership roles.

Dr. Summers explains Dorothea Orem's theory that the role of a nurse is to support a patient in his/her return to optimal health so they can perform self-care. She stresses that nurses work as partners in a patient's healthcare: Dr. Summers gives examples of how this works in practice.

Dr. Summers next talks about how she learned to think differently in her graduate program about self-care and also how she began to realize that she could have more of an impact on care as a leader. Dr. Summers describes her leadership style as "transformational" in that she serves as a role model and inspires people to be at their best.

Segment 6

A: Professional Path

Learning the Complexities of Nursing Care

00:37:26

Story Codes

A: Professional Path

A: Influences from People and Life Experiences

C: Offering Care, Compassion, Help

C: Patients

C: Leadership

C: Mentoring

C: The Professional at Work

Dr. Summers talks about working at the Greater Southeast Community Hospital after receiving her Master's. At this inner city hospital she focused on oncology and pain management and worked with great oncologists and physicians. She talks about the impact of working with patients in extreme poverty. She also recalls being nicknamed "LP" for Leader of the Pack – indication that her leadership impulse showed—and she started to see the impact she might have on nursing from a position of leadership.

Segment 7

A: Professional Path

A 'Hunger' for Leadership; A View on the Independent Practice of Nursing

00:41:42

Story Codes

A: The Leader

A: Professional Path

C: Leadership

C: Mentoring

D: On Leadership

D: On Care

D: The History of Health Care, Patient Care

A: Overview

A: Definitions, Explanations, Translations

Dr. Summers begins this segment by giving credit to JoAnn Duffy, who taught her many leadership lessons. Dr. Summers talks about different kinds of power. She recalls her involvement in an innovative and eye-opening initiative undertaken at Greater Southeast Community Hospital: a collaborative practice established between nurses and physicians, a first step in recognizing that nurses are not mere “doctor helpers.”

Segment 8

A: Professional Path

An Evolution of Leadership Experience

00:58:18

Story Codes

A: Professional Path

A: The Leaders

C: Leadership

D: On Leadership

C: The Professional at Work

Dr. Summers recalls that she had a “hunger for exploring management” and jumped at the opportunity when a position opened in Hematology at Fairfax Hospital. Dr. Summers explains why she was hired and also recalls that she had to teach herself management as there were no books available at the time. She describes the many functions she had to learn and how they became fascinating problems for her.

Dr. Summers observes that she has a pattern of taking on positions that demand confidence and competence and she meets them with confidence and sometimes less competence going in than is comfortable for her. Dr. Summers talks about her pattern of taking on positions that demand confidence and competence.

Dr. Summers gives examples and talks about learning lessons about management people. She then talks about her promotion to the Director of Nursing, which gave her responsibility for many inpatient units as well as for managing leaders. She then talks about her principles for leading managers and leaders to perform at their best.

Dr. Summers says that her habit of moving to leadership positions without having all the skills for the job is an “illness.” (She says she identifies with an article she read on “The Imposter Syndrome.”) She is constantly driven to perform at higher levels and notes that she made her moves when wanted to do something different. She is good at identifying new opportunities, not at maintaining an institution’s status quo.

Segment 9

A: Professional Path

A PhD Program and a Theory of Nursing and Leadership

01:01:59

Story Codes

A: Professional Path

C: Evolution of Career

D: The History of Health Care, Patient Care

A: Overview

A: Definitions, Explanations, Translations

C: Mentoring

C: Leadership

A: Experiences Related to Gender, Race, Ethnicity

In this segment, Dr. Summers notes that she was Director of the Department of Nursing at Inova Fairfax Hospitals for about a year when she felt she was losing her ability for sharp thinking. She decided to go back to school for her Ph.D (though she was still working; Ph.D. Health Care Administration, 1995). She talks about the struggle to get back in the habit of reading and synthesizing information. She also re-evaluated the stresses in her life and moved into a lower intensity job as a nurse educator while she was in her graduate program. Dr. Summers then talks about the ideas she encountered in this program: James Burn’s theory of transformational leadership and Jean Watson’s human caring theory. She saw crossovers between the two and ended up writing her dissertation on this subject.

Segment 10

A: The Researcher

The NIH and an Opportunity to Support Research Nurses

01:20:03

Story Codes

A: The Researcher

A: The Leader

C: The Professional at Work

D: The History of Health Care, Patient Care

C: Patients

C: Patients, Treatment, Survivors

In this segment, Dr. Summers explains that she was recruited for NIH Clinical Services to develop cancer nursing research programs for research nurses. Dr. Summers explains Jean Watson’s care theory in greater detail and talks about its connections with transformational leadership. She then goes on to talk about her role at the NCI (where she arrived “knowing

zip”): she developed a program to support research nurses proposing their own research projects.

Dr. Summers gives an example of a project proposed by a nurse on drawing blood. This demonstrates how a nurse brings a unique perspective to care situations and the issues/questions they raise can be quantified to improve care for all patients.

Dr. Summers next observes that she was a member of the Institutional Review Board at the NIH and learned a great deal about clinical research.

Segment 11

A: Joining MD Anderson/Coming to Texas

An Opportunity to Work at a World-Class Institution

01:29:40

Story Codes

A: Personal Background

A: Professional Path

C: Evolution of Career

A: Joining MD Anderson

In this segment, Dr. Summers explains that after her experience at the NIH, she took a position in the Clinical Center which presented her with a whole new learning curve. At this point, a recruiter called her about a position at MD Anderson. She tells the story of her interaction with the recruiter and explains that she was interested as a new position would allow her to put her dissertation research into practice.

Session 2: 1 April 2014, about 1 hour and 9 minutes

Segment 00B

Interview Identifier

00:00:00

Segment 12

A: Joining MD Anderson/Coming to Texas

Joining an Institution that “Grabbed My Heart”

00:00:31

Codes

A: Joining MD Anderson

A: Professional Path

A: Personal Background

C: Personal Reflections, Memories of MD Anderson

A: Character, Values, Beliefs, Talents

C: This is MD Anderson

C: Offering Care, Compassion, Help

B: Institutional Mission and Values

B: MD Anderson Culture
C: Patients, Treatment, Survivors
C: Funny Stories

Here Dr. Summers explains how she joined MD Anderson. She recalls getting a call from a recruiter, but was not really paying attention until she heard the name, “MD Anderson,” and said, “Wait, can you repeat all of that?” Dr. Summers expresses how important it was to be offered an opportunity to work at this institution. She then describes the early interview and how she came to the decision to try for the position at MD Anderson.

Dr. Summers recalls coming to MD Anderson and standing for the first time in the lobby of the Clark Clinic. She describes how what she saw “grabbed my heart and it hasn’t let go of me.” She recalls sensing hope at the institution. She recalls her meetings with people and her sense that people came to work at MD Anderson specifically because of their commitment to the mission. She notes that even employees not directly related to research or patient care were somehow driven by a sense that they were contributing to the mission, and that “anyone can be instrumental” in forwarding that mission. Dr. Summers notes that even though sad events occur at MD Anderson, but it is a hopeful and joyful place with patients who have a great generosity of spirit.

Dr. Summers continues talking about her interview process and describes the scope of the role she was to take on as Director of Nursing as well as the four week transition period in which she finalized her work at the NIH and came to Houston.

Segment 13

B: Building the Institution

Roles as New Director of Nursing: Working with Growth in a Matrixed Organization

00:16:02

Story Codes

C: Understanding the Institution
B: MD Anderson Snapshot
B: MD Anderson Culture
C: The Institution and Finances
A: The Administrator
B: Growth and/or Change
D: Women and Diverse Populations in Healthcare and Institutions

Dr. Summers begins with an overview of what she learned about leadership in her new role as Director of Nursing as she adjusted to the peculiarities of the institutional structure.

She talks about the institution’s organization in matrices, compares it to other institutions, and notes that at MD Anderson “a lot of what we do seems to happen by magic.” She describes the challenges that arise from this structure at MD Anderson.

Dr. Summers next talks about the projects she worked on as the new Director of Nursing including the Mays Clinic and Alkek Hospital addition. She offers an example of how a MD Anderson decision-making proceeds and shares her leadership lessons.

She talks about the financial clarity that Dr. Leon Leach brought to the institution as the new Chief Financial Officer.

Dr. Summers also sketches how she developed a Professional Nursing Practice initiative. Dr. Summers says that she saw her role as providing the environment where nurses could excel.

Segment 14

A: The Administrator

Associate Vice President for Clinical Programs: Challenges and Views on Communication

00:29:44

Story Codes

D: On Leadership

C: Leadership

C: Understanding the Institution

A: The Leader

C: Mentoring

A: Character, Values, Beliefs, Talents

D: Women and Diverse Populations in Healthcare and Institutions

In this segment, Dr. Summers sketches her three-year role as Associate Vice President for Clinical Programs. She explains that the role intrigued her because it focused on high-level organizational issues. She talks about working with Physician-in-Chief, Dr. David Callendar and comments on the matrix organization of MD Anderson.

Dr. Summers next reflects on leadership and tells stories of leadership lessons she learned. She explains that MD Anderson is different from other organizations because of its clinical leaders. She also revisits the issue of the matrix structure in the organization, stressing that there is no infrastructure to engage physician leaders as well as the rank and file.

Dr. Summers recalls leadership feedback she received from Dr. David Callendar.

Segment 15

B: Building the Institution

Projects as Chief Nursing Officer: MD Anderson's Magnet Designation; the Nursing Practice Congress; Primary Team Nursing

00:39:38

Story Codes

A: The Administrator

A: The Leader

A: Professional Path

A: Contributions to MD Anderson

B: MD Anderson Snapshot

B: MD Anderson Impact

C: Understanding the Institution

C: The Professional at Work

C: Discovery, Creativity and Innovation

C: Professional Practice
D: On Leadership

Dr. Summers talks about accepting the challenging position of Chief Nursing Officer. She notes that MD Anderson was in the process of preparing for its re-designation as a Magnet Institution (by the American Nurses' Credentialing Center).

Dr. Summers explains why the Magnet designation is important to MD Anderson and describes how this designation supports the practice of transformational leadership. She explains that it connects to her role as Chief Nursing Officer and her goal of creating an environment in which nurses are in charge of decisions about practice.

Dr. Summers next talks about the Nursing Practice Congress and the model of Primary Team Nursing model she developed at MD Anderson. She explains how this involves scheduling nursing activities for an entire team and lists the benefits of this model for patients, the institution, and for team members.

Segment 16

A: The Administrator

Challenges in Nursing Today: Building an Expert Workforce

00:55:16

Story Codes

A: The Administrator

A: The Leader

A: Professional Values, Ethics, Purpose

A: Contributions to MD Anderson

B: MD Anderson History

B: Research, Care, and Education in Transition

D: The History of Health Care, Patient Care

D: Women and Diverse Populations in Healthcare and Institutions

In this segment, Dr. Summers lists challenges she must address as Chief Nursing Officer. First she explains how she had addressed the lack of leadership succession planning when she took on the CNO role. Next she talks about establishing the "Launch into Nursing" program to provide orientation for newly graduated .

Next Dr. Summers talks about the current nursing shortage and the challenge this presents to building a qualified and expert workforce for the future. Dr. Summers describes her job as creating an environment for nursing practice that will attract the best and the brightest and also retain senior women. She also explains efforts underway to ensure that nurses perform at the top of their license.

At the end of this session, Dr. Summers speaks about the future of nursing.

Interview Session 3: 29 April 2014 about 1 hour and 20 minutes

Segment 00C
Interview Identifier
00:00:00

Segment 17
B: Diversity Issues
An Absence of Women in Executive Leadership at MD Anderson
00:00:27

Story Codes

A: Experiences re: Gender, Race, Ethnicity
B: Gender, Race, Ethnicity, Religion
A: Obstacles, Challenges
B: Obstacles, Challenges
C: Women and Minorities at Work
D: Women and Diverse Populations

In this chapter, Dr. Summers observes that since her arrival at MD Anderson, there has been little progress in promoting women and minorities above the level of vice president: executive leadership continues to be white and male. She explains that the impediment seems to be a lack of self-awareness, and offers some examples of interactions that show how senior leadership does not see a problem. She observes that there is a similar problem in promoting women faculty and notes Dr. Elizabeth Travis' work (Women Faculty Programs [Oral History Interview]) to advocate for women. Dr. Summers explains why the absence of women in leadership limits MD Anderson's success. She also notes that, in other cancer centers, women serve as senior executives and MD Anderson is an anomaly, even among Houston institutions.

Segment 18
B: An Institutional Unit
The Division of Nursing: An Overview, the Professional Practice Model, and the Development of Nursing as an Autonomous Field
00:09:35

Story Codes

A: The Administrator
A: The Leader
A: Contributions to MD Anderson
C: Professional Practice
C: Understanding the Institution
D: On Leadership
D: The History of Health Care, Patient Care
B: Institutional Mission and Values
B: The MD Anderson Brand, Reputation

Dr. Summers describes the organization of the Division of Nursing and major projects undertaken since she assumed leadership in 2003 to ensure that all members are appropriately licensed and credentialed and that they are always developing nursing practice.

Next she speaks in detail about the Professional Practice Model referring to the “quality care model” depicted in an image produced for the Division. (See transcript for image used during this discussion.) She talks about elements of primary team nursing; self-awareness; professional partnerships; and professional recognition.

Dr. Summers also explains what “achieving autonomy” means for professional nursing and why it is so important to the development of the field. She sketches some of the history of nursing.

Dr. Summers goes on to explain how a team at MD Anderson created the model, revising a practice model in place when she took over the Division. She unique working environment for nurses at MD Anderson and sketches the varied areas in which they function.



Segment 19
 A: Overview
A History of Nursing at MD Anderson
 00:31:02

- Story Codes
 B: MD Anderson History
 C: Portraits
 C: Giving Recognition

In this segment, Dr. Summers sketches the history of nursing at MD Anderson, beginning with the work of Renilda Hilkemeyer (interviewed for OHP). She discusses the contributions of former Nursing directors Joyce Alt and John Crosley, who led MD Anderson to its first Magnet designation.

Segment 20
A: The Administrator
Activities as Chief Nursing Officer; Creating a New Academic Department of Nursing; The Future of Nursing at MD Anderson

00:36:10

Story Codes

- A: The Administrator
- A: The Leader
- B: Building/Transforming the Institution
- A: Contributions to MD Anderson
- B: MD Anderson in the Future

Dr. Summers talks about her activities as Chief Nursing Officer (CNO) and Chair of the Department of Nursing, and offers her views on the futures of the Department and Division of Nursing.

She first talks about her appointment to the position of CNO in 2003 and sketches her main activities to develop patient care, the Professional Practice Model, the Clinical Nurse Advancement Program and the Nursing Practice Congress. She ensured that MD Anderson has Ph.D..

Next Dr. Summers explains a legacy she feels she is building: faculty hires in a new Department of Nursing to create an academic Department of Nursing equivalent in status to other departments. She observes that the creation of the Department of Nursing was not controversial. She offers her views on the future of the Department of Nursing.

Segment 21

A: The Administrator

Promoting “Top of License” Nursing Practice; the Future of Nursing at MD Anderson

00:53:24

Story Codes

- A: The Administrator
- A: The Leader
- B: Building/Transforming the Institution
- A: Contributions to MD Anderson
- B: MD Anderson in the Future
- C: Professional Practice
- C: The Professional at Work
- D: The History of Health Care, Patient Care

In this segment, Dr. Summers talks about the future of the Division of Nursing. She explains the importance of ensuring that nurses are practicing at the “top of license,” noting that in the future nurses will work as coordinators of care. She explains some of the resistance she anticipates from stakeholders and nurses as the role of nurses changes and they are not available to perform roles (that are not “top of license”) currently expected of them. She notes that this change in nurses’ roles will transform MD Anderson culture.

Segment 22

B: Building the Institution

New Healthcare Delivery System; Nurses and Work with Patients and Families; the Future of Nursing

Story Codes

- A: The Administrator
- A: The Leader
- B: Building/Transforming the Institution
- B: MD Anderson Snapshot
- B: Multi-disciplinary Approaches
- B: The Business of MD Anderson
- B: MD Anderson Culture
- B: MD Anderson in the Future
- D: Fiscal Realities in Healthcare
- C: Professional Practice
- D: The History of Health Care, Patient Care
- C: Understanding the Institution
- C: The Institution and Finances
- A: Career and Accomplishments

Dr. Summers offers her views on how changes in the healthcare delivery system are affecting the institution and influencing changes in the practice of nursing.

She first sketches the financial pressures and “mindboggling” challenges of the current healthcare environment.

Dr. Summers goes on to describe the ways that nurses are uniquely positioned to attend to patients and families because of their education and roles in care.

[the recorder is paused briefly]

She then describes the institution-level Patient and Family Experience Executive Committee and notes ways she had already been addressing family issues.

Dr. Summers explains how she is addressing value-based care by focusing on clinical teams.

Dr. Summers next talks about the next steps for the field of nursing.

Dr. Summers concludes with words about how she would like to be remembered.

Barbara Summers, PhD

Interview Session 1 – January 23, 2014

About transcription and the transcript

This interview had been transcribed according to oral history best practices to preserve the conversational quality of spoken language (rather than editing it to written standards).

The interview subject has been given the opportunity to review the transcript and make changes: any substantial departures from the audio file are indicated with brackets [].

In addition, the Archives may have redacted portions of the transcript and audio file in compliance with HIPAA and/or interview subject requests.

Chapter 00A

Interview Identifier

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. So we are recording again, and I'll just put the identifier on. So I'm Tacey Ann Rosolowski interviewing Dr. Barbara Summers for the Making Cancer History Voices Oral History Project run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. Dr. Summers joined MD Anderson in 1997 as clinical administrative director for the Hematology Clinical Program. She is currently vice president of Nursing Practice, chief nursing officer, and head of the Division of Nursing. She also serves as a professor and chair of the Department of Nursing.

This interview is taking place in Dr. Summers' office in Pickens Tower on the main campus of MD Anderson. This is the first of two planned interview sessions, and today is January 23, 2014. The time is 1:19.

Thank you, Dr. Summers, for agreeing to participate in the project.

Interview Session: 01
Interview Date: January 23, 2014

Chapter 1

A: Educational Path

Inspired to Enter Nursing: An Altruistic and Intellectual Profession

Story Codes

A: Personal Background

A: Professional Path

A: Influences from People and Life Experiences

C: Mentoring

A: Inspirations to Practice Science/Medicine

A: Definitions, Explanations, Translations

D: On Care

A: The Clinician

A: Character, Values, Beliefs, Talents

Tacey Ann Rosolowski, PhD

[00:00:00]+

I wanted to just start with some background questions, if you could just tell me where you were born and when, and tell me a bit about your family.

[00:01:08]

Barbara Summers, PhD

[00:01:09]

Well, I was born in Aurora, Illinois, which is right outside of Chicago, and I was very young when my father was transferred to New York and we moved to a home in a suburb outside of New York City. My mother was born and raised in Chicago, Illinois, and my father met my mother while he was in Chicago working. So that's how I came to be.

[00:01:41]

Tacey Ann Rosolowski, PhD

[00:01:42]

What's your birth date?

[00:01:45]

Barbara Summers, PhD

[00:01:45]

March 4th, 1951.

[00:01:48]

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Tacey Ann Rosolowski, PhD

[00:01:51]

Thank you.

[00:01:51]

Barbara Summers, PhD

[00:01:52]

I am one of six children, and when my family moved to New York, I believe that my mother was pregnant with my first sister. So we were, interestingly, ordered three girls followed by three boys in our family.

[00:02:14]

Tacey Ann Rosolowski, PhD

[00:02:15]

Now, are you the oldest?

[00:02:15]

Barbara Summers, PhD

[00:02:15]

I'm the oldest of the six children.

So we initially moved into a beautiful home in a suburb of New York City, it was called West Nyack, and the home was built before the Revolutionary War. So we lived there for a couple of years, and my parents then purchased a home in one of the new suburbs. I lived in that home with my, by then, two sisters and then subsequently two other brothers until I was approximately nine years old, at which point in time I moved to Richmond, Virginia, with my family. My father was employed in the pharmaceutical industry, and his work took him to Richmond, Virginia.

[00:03:04]

Tacey Ann Rosolowski, PhD

[00:03:06]

Did your mom have a profession?

[00:03:08]

Barbara Summers, PhD

[00:03:09]

She was a nurse before she got married and started having six children, and then she was a full-time homemaker, and a woman of tremendous intellect, still one of the smartest people that I have ever known, and smarter than I am, actually.

[00:03:29]

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Tacey Ann Rosolowski, PhD

[00:03:29]

And what shape did her intelligence take? There are so many different kinds.

[00:03:32]

Barbara Summers, PhD

[00:03:33]

Mm-hmm. I think she just had tremendous critical-thinking abilities, but she read voraciously. She had a fabulous command of the English language. She had a tremendous vocabulary. She was capable of and truly enjoyed having conversations about politics and economics, and she loved nothing more than having my husband and I come to visit them, and my husband would, in a purposeful way, engage her in a conversation taking a devil's advocate position, because the two of them enjoyed the back-and-forth so much, and she adored it too. So she was just a really, really bright woman, and I believe that she had other wonderful attributes. She was beautiful and she was very loving, but I think her intellectual capabilities were as attractive, in my father's eyes, as every other aspect of her.

[00:04:38]

Tacey Ann Rosolowski, PhD

[00:04:38]

It sounds like she inspired you. I mean, you sound like you really admire your mother.

[00:04:40]

Barbara Summers, PhD

[00:04:41]

I do. She passed away in 1997. I have a great deal of admiration for my mom. And I remember as I was an adult, I one day asked her, I said, "Mom, how in the world did you ever manage six children, bringing up six children?"

And she just paused and looked at me and said, "I had no choice. I had to figure out how I was going to do it. You were here, all six of you were here, so we had to get that figured out."

Yes, I admired her tremendously, and I think she has been a role model for me in terms of mental toughness, I think, you know, understanding that things are not always going to be easy, but if you really apply yourself and your gifts, then you can get through just about anything.

[00:05:33]

Tacey Ann Rosolowski, PhD

[00:05:34]

Now, I read that somewhere you were quoted as saying you come from a family of nurses.

[00:05:39]

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Barbara Summers, PhD

[00:05:40]

Mm-hmm.

[00:05:40]

Tacey Ann Rosolowski, PhD

[00:05:40]

Who else in your family was a nurse, and when did you realize that you wanted to become a nurse yourself?

[00:05:47]

Barbara Summers, PhD

[00:05:48]

Well, Mom was a nurse, and then as I was in high school and thinking about my career options, I became interested in nursing and originally had applied for and been accepted to a three-year diploma-in-nursing program, and I was all set to pursue that and then I started talking to my classmates. And, you know, the allure of going away to college became overwhelming for me, so I decided that I would follow the crowd like a lemming, and took a little detour from my nursing aspirations and applied to a women's college in Virginia and was accepted there and was enrolled in a secondary-education track to become a high school teacher in biologic sciences.

[00:06:38]

Tacey Ann Rosolowski, PhD

[00:06:39]

And this college was?

[00:06:41]

Barbara Summers, PhD

[00:06:41]

Longwood College in, believe it or not, Farmville, Virginia, and it was very much like farmville. There were lots of tractors there. But it was a college town. There was a women's college and there was a men's college in the same town, so, you know, there was the usual college carryings-on.

So I persisted in that education pathway until I got to my junior year and became exposed to the practice teaching and what the reality of teaching a group of high school students would be, and I realized I could not envision myself spending the rest of my life doing that. So I left college at Longwood and I moved back home and I enrolled in a community college in a nursing program to obtain—at that time it was going to be an associate degree in nursing. And I immediately felt that I had made the right decision.

[00:07:42]

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Tacey Ann Rosolowski, PhD

[00:07:43]

What was it that had made you think about nursing in the first place when you were in high school?

[00:07:47]

Barbara Summers, PhD

[00:07:49]

You know, I think it's the opportunity to, number one, be in a very interactive profession where I had the opportunity to positively influence the life experience of another human being, and that has been a theme throughout my career, regardless of the type of position that I've held. So there was that deep calling to be able to assist and support and help others.

The other thing that appealed to me was the fact that nursing is intellectually very rigorous. You know, yes, it includes compassion, although there are certainly nurses somewhere, I'm sure, who are not compassionate. But nursing is about far more than just compassion. I mean, nurses have to have extraordinary critical-thinking skills and to be able to pull together many, many data points of diverse information to create a whole that is reflective of the experience of the client or the patient. So I was just stimulated by that. Nursing also uniquely combines the physical sciences and the social sciences. So it just had a lot of attractiveness to me on an altruistic basis but also on an intellectual basis.

[00:09:16]

Tacey Ann Rosolowski, PhD

[00:09:18]

Were there any discussions that you had with your mother, for example, about nursing? I'm just wondering if her experience influenced you in any way, either the challenges or the things that had inspired her?

[00:09:31]

Barbara Summers, PhD

[00:09:32]

Not really. In fact, now that you mention it, I don't think I ever really spent a lot of time talking to Mom about her nursing practice. I'm sure the fact that I had such admiration for her and the fact that she had practiced in nursing had an influence on my interest, but I didn't really talk with her about that. I wish I had. I wish I'd had the opportunity, now that I reflect on that, to do so.

So anyway, I was in that associate degree program, and I maintained full-time employment and went to school, and because I'd already accumulated so many credit hours in a baccalaureate program, I was able to do some tutoring with nursing students. I tutored them, actually, in writing, writing English composition, which was a lot of fun.

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And then my father was transferred again, this time to the Washington, D.C. area, to northern Virginia. I had not finished my nursing program so—
[00:10:33]

Tacey Ann Rosolowski, PhD

[00:10:34]

What year was this?

[00:10:34]

Barbara Summers, PhD

[00:10:35]

Oh, golly. This was in 1975. I hadn't finished my nursing program, and so I moved with Mom and Dad. On one of his trips up to the northern Virginia area, he had stopped by the local community college to get information about the nursing program, and when he talked to the dean of the community college about me, she said, "Well, she can't come to school here. Because she's so close to getting her baccalaureate degree, she has to enroll in George Mason University and get her BSN," which was wonderful advice then, and I'm very appreciative of that woman having said that to my dad. So we moved up there—

[00:11:17]

Tacey Ann Rosolowski, PhD

[00:11:17]

I'm not sure why you say that. What did George Mason give you that you wouldn't have had at the community college?

[00:11:24]

Barbara Summers, PhD

[00:11:25]

I graduated with a BSN instead of an ADN.

[00:11:27]

Tacey Ann Rosolowski, PhD

[00:11:27]

Okay.

[00:11:28]

Barbara Summers, PhD

[00:11:30]

And you know, the dean talked to my dad about what my experience had been, and I'd finished three years of a baccalaureate program in the biologic sciences, so I'd had my chemistry and my

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physics and my biology and my anatomy and my physiology. So when I transferred to George Mason University, those credits were all accepted, so I had also had my initial fundamental nursing coursework. So I was able to come in and finish my baccalaureate degree in two years, my BSN in nursing .

[00:12:07]

Tacey Ann Rosolowski, PhD

[00:12:08]

Which you received in 1978.

[00:12:09]

Barbara Summers, PhD

[00:12:09]

Mm-hmm.

[00:12:10]

Tacey Ann Rosolowski, PhD

[00:12:10]

Okay.

[00:12:10]

Barbara Summers, PhD

[00:12:11]

And the coursework that I had to focus on, really, was the nursing core coursework, because I had taken all of the other prerequisites, with the exception of a speech communication class, which was required. And that was just an example of synchronicity—it wasn't a coincidence—because that's where I met my husband, because he was a theater major and that was also a requirement for his degree.

[00:12:37]

Tacey Ann Rosolowski, PhD

[00:12:38]

His name is?

[00:12:38]

Barbara Summers, PhD

[00:12:38]

George. His name is George. So George and I met in our required speech communication course.

So I graduated in 1978. And I had worked, while I was in my nursing program at George Mason University, I had worked at a local hospital in the community as a clerk, and I worked evening

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shift and I had the opportunity to work with a wonderful group of nurses who were mentors to me, and I've had very few mentors in my career, but those nurses were mentors to me.

[00:13:12]

Tacey Ann Rosolowski, PhD

[00:13:13]

And what did that look like? What did they give you?

[00:13:17]

Barbara Summers, PhD

[00:13:17]

Well, you know, we would have a conversation and they would say, "What are you learning in nursing this week?" And I'd talk about what was going on in the coursework or I'd talk to them about when I would have my clinical experiences taking care of patients and, you know, issues that I would encounter or situations I didn't understand. And we would just talk about it, and they would say, "Well, that's what I would do," or, "I'd recommend this." Or, as in the course of taking care of patients, they might say, "Why don't you come in with me and help me with this patient, because I'm going to be doing a particular thing, and it will be really important for you to have seen that before, because you probably won't have that experience in school." And when it came to starting IVs, they wanted to be sure that I was good at starting IVs before I graduated, so they made me practice on them, how to start an IV. So the mentoring took all sorts of shapes.

It was also very helpful for me because I interacted not only with the nurses but with physicians, and I developed a level of comfort and confidence in communication with physicians that was very useful to me when I graduated from my nursing program, because when you're a student, you don't have those kinds of opportunities to really appreciate interprofessional practice and to feel comfortable with communicating with other members of the healthcare team.

So, worked there, graduated, took a position in a community hospital specifically because that hospital had primary nursing as its nursing care delivery model.

[00:14:52]

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Chapter 2

A: Overview

The Theory and Advantages of Primary Nursing

Story Codes

A: Overview

A: Definitions, Explanations, Translations

A: The Researcher

A: The Clinician

D: The History of Health Care, Patient Care

Tacey Ann Rosolowski, PhD

[00:14:53]

And what does that mean, “primary nursing”?

[00:14:54]

Barbara Summers, PhD

[00:14:54]

Well, that was in those days. In those days, primary nursing was a model for nursing care delivery that was developed by Marie Manthey. And the fundamental guiding principle of primary nursing is that when a patient is admitted to the hospital, there is one registered professional nurse who is responsible and accountable to that patient for planning, organizing, overseeing the delivery of and evaluating their care outcomes. It was lovely because it allowed nurses to develop strong relationships with individual patients and to be able then to see the impact of their practice on the outcomes of those patients' experience.

[00:15:42]

Tacey Ann Rosolowski, PhD

[00:15:43]

This leads to a question that I wanted to ask you, because I noticed that you've done some publishing and presenting on the theory of nursing. And one of the questions I hope we'll talk about is how nursing has changed over the course of your career. So what were you beginning to understand at the time? What was nursing really about? I mean, you've talking about this very interesting model, one person responsible for a patient. What's the theory of nursing involved in that kind of model?

[00:16:15]

Barbara Summers, PhD

[00:16:16]

Well, you know, there are nursing theories and theoretical frameworks, and then there are

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nursing care delivery models, and then there are nursing Professional Practice Models, and Professional Practice Models are always grounded in a nursing theory. Nursing care delivery models should be in support of a Professional Practice Model. So there has to be consonance and harmony across all of them.

When I was in my nursing program, it was at a pivotal point in the profession when nurses were transitioning their care delivery models from something called team nursing to something called primary nursing, and I graduated right at the cusp when primary nursing was getting started. In the old team nursing model, there would be a team that would include a nurse who would have been a professional registered nurse who would have been a team leader, who would have worked with perhaps another R.N. and an L.V.N. and a nursing assistant. And that team together might be responsible for fifteen patients, and the team leader would assign various aspects of care for these fifteen patients to the team members, but there was no single nurse who had responsibility for a particular patient.

[00:17:33]

Tacey Ann Rosolowski, PhD

[00:17:35]

Now, does that—the advantage—I mean, I’m trying to think of what the advantage is, but I should just ask you what the advantage is of having one person responsible.

[00:17:46]

Barbara Summers, PhD

[00:17:47]

Well, I think the advantage is that you have consistency in approach and you have continuity of care, because one of the challenges with team nursing is that there was discontinuity in care because there could be a different member of the team assigned to address care needs of a particular patient on any given day. The benefit of team nursing is that there was this tremendous sense of camaraderie among the team members because they were all in it together. So with primary nursing, the benefit to the patient was consistency and continuity in care. The benefit to the nurse was seeing the outcomes of his or her nursing practice, that one could observe “Was I effective or not in providing the care planning and the delivery of care to the patient?”

The disadvantage is that nurses were not practicing in a context of the team, so they lost that sense of teamwork and camaraderie that was so strong in team nursing. But that was mitigated somewhat by the fact that then in those olden days nurses worked eight-hour shifts and worked five days a week, and so you were working with the same group of people and seeing them five days a week, you know, spending more time with them than you were your own family. So there was still a very strong sense of community among nurses at that time.

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Chapter 3

A: Professional Path

A Focus on Primary Nursing

Story Codes

A: The Clinician

A: Professional Path

C: Mentoring

C: Leadership

Barbara Summers, PhD

[00:17:47]+

So I selected a hospital specifically because they had implemented primary nursing as their framework. And I spent my first year working in a surgical unit, taking care of primarily orthopedic surgery patients, and then I applied for their critical care residency program, and I moved into the medical surgical ICU, and I worked there for a couple of years, had very good experiences there. In both of those situations I had wonderful managers, and both of them were mentors to me in different ways, but they provided me with guidance in how I should be thinking about my career and the future of my nursing practice.

[00:20:09]

Tacey Ann Rosolowski, PhD

[00:20:09]

I was just going to ask you about that, because it seems like you were making some pretty strategic decisions. So what is it that you were visualizing at the time?

[00:20:17]

Barbara Summers, PhD

[00:20:18]

Oh, my god, what I was visualizing initially is I was going to get paid for taking care of patients. (Rosolowski laughs.) Like, wow, this is great! I have my license. I'm going to get paid for taking care of patients. I'm happy, I love being a nurse, and I wasn't thinking beyond the next day. I loved my patients. I loved my colleagues. It was all great, but I wasn't thinking about school or anything. I felt that a year of experience on the orthopedic unit and then talking with my manager who said, "I support you. You should go to the ICU. It's going to be a good challenge for you. It's going to develop skills that you're going to need to have," I then went to the ICU and, as I said, practiced there a couple of years.

But I had been there maybe six months when my manager called me into her office one day and told me that I needed to apply for and get into graduate school and get my master's degree,

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because I was very smart and I had many opinions, but if I didn't learn how to channel them correctly, I was going to get in trouble a lot. (laughs)

[00:21:28]

Tacey Ann Rosolowski, PhD

[00:21:30]

What were some of the opinions that she was talking about at that time?

[00:21:32]

Barbara Summers, PhD

[00:21:33]

You know, I was very clear in my mind about the standard of nursing practice and how nurses should deliver care to patients and the way that they should interact with patients and other nurses and physician, and the way nurses should document their care and the thoroughness with which they should conduct their assessments. I had an opinion about everything. So, you know, that's all great, but if one doesn't know what to do with that energy, then you can become a real pain in the behind for your co-workers and for your manager.

So, yeah, Ann Lockhart, she was my manager in the ICU, she sat me down and said, "You need to go back to graduate school or else you're going to get in a lot of trouble." (laughs)

[00:22:12]

Tacey Ann Rosolowski, PhD

[00:22:16]

So I'm getting the sense that you had pretty high standards about that.

[00:22:20]

Barbara Summers, PhD

[00:22:20]

I did. I had very high standards, and it's not that I was working with nurses who were not good nurses, but I needed to learn how to more effectively work as a leader and recognize that I had—I tended to be viewed as an informal leader within a work group, and that that is lovely, but it also has a lot of responsibility with it, that you have to accept that informal leader role and understand that that gives you an obligation to use that authority as an informal leader effectively and positively.

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Chapter 4

A: Educational Path

A Master's Program Leads to an Interest on Oncology and Pain Management

Story Codes

A: Professional Path

C: Mentoring

A: Inspirations to Practice Science/Medicine

A: Influences from People and Life Experiences

C: Human Stories

C: Offering Care, Compassion, Help

C: Patients, Treatment, and Survivors

C: Patients

Barbara Summers, PhD

[00:22:20]+

So I did; I enrolled in a master's degree program back at George Mason University, and I decided that I wanted to focus in oncology because I had had the opportunity to care for a number of oncology patients in the hospital.

[00:23:22]

Tacey Ann Rosolowski, PhD

[00:23:22]

I was going to ask you how you decided to focus on oncology. What were some of the key moments that made you think, "Yeah, this is where I'm going to focus my energy"?

[00:23:31]

Barbara Summers, PhD

[00:23:32]

It was the experience as caring for individual patients who had cancer diagnoses, and the realization that I love the relationships that you have with a patient over time when you get to know a patient and their family and you know their story, and you're a part of their life for a period of time. But I also loved the intensity of critical care. And oncology is one of the only specialties where you get to combine both the high-intensity clinical care needs of patients who are very complexly ill, use a lot of your critical-thinking skills, along with building a sustained relationship with a patient and family over a continuum because it is a chronic disease, in most cases, and you're going to see the same people over and over again. So it gave me acuity and chronicity all in the same category of disease. So it challenged me intellectually. It fulfilled me on a psychological and spiritual basis. It was just like the perfect thing. I can't imagine why anyone would do anything else still to this day.

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So I enrolled in an MSN program at George Mason University to become a clinical nurse specialist in oncology. I worked for a bit longer in the ICU, but then my manager, Ann, connected me with a group of physicians who were opening up a pain clinic, and they needed a nurse to run their pain clinic, and I thought that would be a gas, because I was interested in pain management. I learned a tremendous amount. It was a pain clinic that was specifically opened to address chronic pain needs of patients.

So I worked with two brilliant anesthesiologists and two—actually three extraordinary clinical psychologists. So I would work with the anesthesiologists when they were doing interventions for pain, nerve blocks, etc. I would also participate in the group therapy sessions that we would have with the psychologists with the patients, and I came to develop an understanding of the complexity of pain and the different manifestations of pain, and had my eyes opened up to the fact that society has a tendency to like to label people in general, but particularly individuals with chronic pain problems. Society likes to label them as malingerers when, in fact, the pain that they're experiencing is quite real. And while I may not be able to quantify it scientifically, it doesn't in any way diminish the reality of pain for the patient.

So I developed a kind of a subspecialty interest in pain and pain management and began studying the work of Marie Manthey, who was one of the nursing pioneers in pain management and who put forward the statement that pain is whatever the patient says it is, wherever the patient says it is, and whenever the patient says it is, and really adopted that as my operating philosophy for working with patients in pain.

[00:26:54]

Tacey Ann Rosolowski, PhD

[00:26:55]

Now, I assume that at this clinic you saw wide array of patients, not just patients with cancer issues.

[00:27:04]

Barbara Summers, PhD

[00:27:04]

No, and actually, most of the patients did not have cancer. Many of them were individuals with occupational injuries. I remember very vividly, because the Washington, D.C. area is very close to the Chesapeake Bay, and we had a client who was an oysterman, and at that time and even today oystermen will harvest oysters by taking these giant tongs that have handles that are probably fifteen feet long and the tongs are probably, I don't know, five to seven feet long, and they open them up like, you know, tongs you would use on your barbecue grill. But they open the tongs up, plunge them in the water down to the bottom of the bed of the Bay, and then using incredible upper-body strength, close the tongs by pulling them apart, and then lift that up, and

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the oysters are going to be in there.

[00:28:04]

Tacey Ann Rosolowski, PhD

[00:28:04]

And they're heavy.

[00:28:05]

Barbara Summers, PhD

[00:28:05]

Very heavy. And so this man had sustained significant injury from a muscle tear that caused him chronic pain that was very difficult to be relieved. So he'd had a surgical repair of the muscle, but he developed scar tissue afterwards and was just in chronic pain, and so he was an individual who really benefited from multi-modality approach to his pain. The anesthesiologist would do nerve blocks. We would meet with him in the group therapy sessions. One of the anesthesiologists was also a hypnotist and would use hypnosis with him. And so we were able to work with him to get him back to a place where he was able to be employed again. He could no longer use the tongs, but he could drive the boat and be a part of the harvesting of the oysters. So that was just a very—

[00:29:09]

Tacey Ann Rosolowski, PhD

[00:29:10]

Saved his livelihood.

[00:29:11]

Barbara Summers, PhD

[00:29:12]

Yes. It was very impactful for me to see that.

And I held that position, worked for a nurse agency doing critical care work around the hospitals in the Washington metropolitan area.

[00:29:26]

Tacey Ann Rosolowski, PhD

[00:29:27]

And this was about what year?

[00:29:27]

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Barbara Summers, PhD

[00:29:29]

I don't know, '79 to '81.

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Chapter 5

A: Professional Path

Thinking about Leadership and Nurses as Self-Care Agents

Story Codes

A: Professional Path
A: The Researcher
A: Definitions, Explanations, Translations
D: The History of Health Care, Patient Care
A: Character, Values, Beliefs, Talents
A: The Administrator
C: Leadership

Barbara Summers, PhD

[00:29:29]+

And then in 1981, I graduated with my master's of science in nursing in what was called advanced clinical practice, but it was an oncology clinical nurse specialist.

[00:29:42]

Tacey Ann Rosolowski, PhD

[00:29:42]

And I was going to ask you what does advanced clinical practice mean?

[00:29:47]

Barbara Summers, PhD

[00:29:49]

Well, I would say that it could still be applied today to nurses who receive their graduate education with a focus in clinical care and clinical practice, in contrast to nurses who have graduate education in leadership and management or nurses who have graduate education to prepare them to teach. It's really about clinical practice. So it's advanced anatomy and physiology, advanced pharmacology, all of those things, learning about systems and how to use a systems approach when evaluating opportunities for improving care and the environment of care, learning about nursing theory, more in-depth study of nursing theory.

[00:30:44]

Tacey Ann Rosolowski, PhD

[00:30:45]

So how did that experience contribute to your understanding of leadership, help you ground those opinions that Ms. Lockhart had observed? Were you aware of that at the time?

[00:30:59]

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Barbara Summers, PhD

[00:31:00]

Yes, a couple of things. One of the nursing theories that I was exposed to in my undergraduate program and then in my graduate program was developed by a woman named Dorothea Orem, and it's called Orem's Theory of Self-Care, and the fundamental tenet of the theory is that the role of nurses is to support our clients, our patients, to be able to return to an optimal state of health that will allow them to fully engage in their own self-care. But in those times when their illness or their absence of health prevents them from being able to do that, then nurses serve as substitute self-care agents for the patient, doing the things that they would do for themselves if they could.

So that was very meaningful for me in thinking about my interactions with individual patients, that my goal was always to work with them as a partner in helping them to return to the optimum state of health that they could achieve and providing support for them to do the things that they would do if they were able. Whether that is teaching them or whether that's helping them with eating and elimination, whatever it may be, doing those things that they would do if they were able but they could not.

I like to tell our young nurses who are thinking about going back to school, "In graduate school, you learn particular stuff that's new, concepts, etc., but more than anything, graduate school teaches you how to think differently than you did before you were in graduate school."

So in graduate school, I was, again, working from Orem's Self-Care Theory, but I started to see that from the perspective of the nurse being my client, not the patient. So, following through with Orem's tenet that the role of the nurse is to help the client to achieve the highest level of health possible, as a clinical nurse specialist, I wanted to be able to support a population of patients realizing the highest level of health possible, and I was going to do that through bedside nurses. So it was enormously appealing to me to come to the understanding that I had the opportunity to have an impact on a much larger number of patients as a leader than I would as an individual practitioner. So, I mean, that clicked for me, and that was wonderful.

[00:33:53]

Tacey Ann Rosolowski, PhD

[00:33:54]

When do you feel your impulse to be a leader began to show itself in your life? Was it something that happened when you were a kid or—

[00:34:06]

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Barbara Summers, PhD

[00:34:07]

No, I think it happened when I was in college and when I was practicing as a nurse.

[00:34:14]

Tacey Ann Rosolowski, PhD

[00:34:15]

And what was it that gave you that impulse to kind of take charge and—

[00:34:22]

Barbara Summers, PhD

[00:34:24]

You know, honestly, I can't tell you, and I didn't really think of myself as a leader, even though my manager identified me as having leadership potential. I didn't really help of myself as a leader until I was in my graduate program and, you know, you would find yourself in—as you do in all graduate programs, you have to do group work. You know, God forbid you would do work on your own. You had to learn how to work in groups. So I would invariably end up being tagged as the leader of the group effort. I didn't seek it, but it was because other people said, “Well, you know, you're good at this,” or, “You're good at that,” and so I would move into that role.

[00:35:08]

Tacey Ann Rosolowski, PhD

[00:35:09]

From what you were saying earlier, you know, it sounded like there was a sense of conviction or confidence that showed itself to people. You felt that you saw something very clearly and you wanted to go for that, like an inner compass, you know. I'm just wondering if that's what people saw that—you know. I don't want to put words in your mouth, but—

[00:35:32]

Barbara Summers, PhD

[00:35:32]

I think, you know, there's lots of definitions of leadership, but I think leading is a state of being. I mean, if you're a leader, you're in a state of being a leader, and everything you do has to be consistent with being a leader. My definition of leadership is engaging the hearts and minds of others in pursuit of a shared vision, but the way you do that is by leading, not telling people what they have to do, but by leading.

[00:36:00]

Tacey Ann Rosolowski, PhD

[00:36:00]

And what is your style of leadership?

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[00:36:02]

Barbara Summers, PhD

[00:36:04]

Golly. I would like to say my style is transformational, that I want to inspire people to be at their very best and to come together around a vision for a preferred future and then move ahead in that direction. So, transformational, inspirational, aspirational, not transactional. I really don't like the, you know, "If you do this for me, I'll give you that. If you get this, then you're going to get your merit increase." I don't think that that pays in the long run as a leader.

I think that I have to constantly be a role model for the nurses in the organization. I have to carry myself as a leader when I'm in settings where I'm the only nurse, because I am. Whether I like it or not, I'm "the nurse." So when people think about nursing, they're not only going to think about nurses that they interact with every day, they're going to look at me and say, "Well, how does she behave? How does she carry herself?" You know, I have to be a good role model for nursing. I have to be a good advocate for nurses and nursing too.

[00:37:26]

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Chapter 6

A: Professional Path

Learning the Complexities of Nursing Care

Story Codes

- A: Professional Path
- A: Influences from People and Life Experiences
- C: Offering Care, Compassion, Help
- C: Patients
- C: Leadership
- C: Mentoring
- C: The Professional at Work

Tacey Ann Rosolowski, PhD

[00:37:29]

So tell me about that moment—you've gotten your master's. Did you feel like that program had changed you in a way and you were kind of reentering the profession, in a sense, with new eyes and a different set of goals, maybe?

[00:37:47]

Barbara Summers, PhD

[00:37:48]

The program changed me in that I came to the realization that I could positively impact the outcomes that care for groups of patients. That definitely happened. I think also I took a position after graduation in an inner-city community hospital in Washington, D.C. that cared for a very poor population and cared for individuals that had limited to no access to preventative healthcare. So all of the people that we took care of were sick with advanced stages of illness that it was very sad because if they had had healthcare available, it may not have occurred. And my focus was in oncology and also on pain management.

So I felt very privileged to be able to be a part of the lives of those patients and to—you know, at that time I really came to recognize that I could not alter what had happened to them in their lives before they came into my life, but working with them, I could help to change everything that happened afterwards. So that was just phenomenal.

And I had the opportunity to work with some fabulous oncologists, physicians, who I respected and they respect me, worked with some absolutely wonderful nurses. I worked with some fabulous colleagues who were also clinical nurse specialists, and we all shared the same boss, the same director, who was a very good mentor, who has come in and out of my life at various periods, and I'll talk about her.

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But the team of clinical nurse specialists was great because we each had our area of focus. One was on Pediatrics and one was on the Emergency Room, and I was on Oncology and Pain and Medical Unit, and one was in Critical Care. So we would have team-based initiatives and projects. I remember one day that I was meeting with my colleagues, and one of them called me "LP," and I said, "Well, what is LP?"

She said, "Leader of the pack." (Rosolowski laughs.)

I said, "I am not the leader of the pack."

And she said, "Oh, yes, you are." She said, "You are so leader of the pack."

So it's like, "Oh, okay. Well, then, if you're the LP, then you have start acting like an LP."

So it was just a wonderful experience, you know, making a difference in lives of very underserved patients and working with colleagues who were committed as I was to improving the health outcomes of these patients. That was great. And, you know, never in my very protected life was I exposed to that kind of poverty or the impact of that kind of poverty ever. I mean, seeing teenagers coming into the emergency room who were actively in labor, who had no idea they were pregnant, or seeing women who were presenting with an open lesion on their breast that was a breast cancer from a cancer that had presented as a lump two years before, and they just hadn't done anything about it, to working with individuals who had sickle cell anemia and who would come into the hospital in sickle cell crisis, in tremendous pain, and then being able to contribute to developing a plan of care for their pain management. So that was terrific and I enjoyed it.

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Chapter 7

A: Professional Path

A ‘Hunger’ for Leadership; A View on the Independent Practice of Nursing

Story Codes

A: The Leader

A: Professional Path

C: Leadership

C: Mentoring

D: On Leadership

D: On Care

D: The History of Health Care, Patient Care

A: Overview

A: Definitions, Explanations, Translations

Barbara Summers, PhD

[00:37:48]+

At the same time, I started to see the potential for having an impact if you were in a management position. And I do want to mention that my boss at the time was JoAnn Duffy, and she was not yet Dr. Duffy. She was the director of Critical Care and whatever in Oncology, so she was my boss, and she taught me a tremendous amount about being a leader and about accountability. She was fun to work with, but she was also dead serious about the work we were doing.

[00:42:25]

Tacey Ann Rosolowski, PhD

[00:42:26]

What did you learn from her?

[00:42:27]

Barbara Summers, PhD

[00:42:36]

You know, I think I learned from her about how to use the various types of power and authority that you have to be able to achieve good, I guess, for lack of a better word, and learned about the fact that there's legitimate authority that comes from your title and your position, but that really is a very limited type of power and authority, that, yes, you can boss people around and make them do things because you're the boss. "You do this because I tell you you have to do it." But that's really a weak type of leadership, and if you have to resort to that, then you probably need to be brushing up your CV and getting ready to go someplace else.

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So we talked about the other kinds of power, the expert power that comes from having expert knowledge in your area, and the referent power that comes from the way that you interact with people and the reputation that you built. So I learned that from her.

I learned from her about the process of developing plans for achieving improvement, if you will, and not only setting the objectives and the timelines, but also being very clear in your mind what is the evidence going to be that will demonstrate that I've achieved the goal, you know, causing you to have to be concrete enough to be able to say, "Okay, here's the evidence that I've gotten to this place," or that this staff has moved to this place. So that, I mean, it was just great. She also had fantastic relationships with physicians, so she was a very good role model for me there.

And in this little—not little—it was a three-hundred-bed community hospital, I was also lucky enough to be working in an organization where the chief nurse and the physician-in-chief were the first in the country to launch an initiative called collaborative practice or joint practice between nurses and physicians. This was back in the early eighties. I mean, this really was pioneering stuff and—

[00:44:59]

Tacey Ann Rosolowski, PhD

[00:44:59]

What did that look like? What does that mean?

[00:45:01]

Barbara Summers, PhD

[00:45:02]

Well, that looked like specific nurses and physicians becoming part of a Collaborative Practice or Joint Practice Committee and together identifying areas of focus for quality improvement—I'll just use that as a general term—within the patient population. So, setting quality-improvement objectives; identifying the strategies that were going to be employed to improve quality outcomes; identifying the metrics and then following them; performing joint record review where the team, the physicians and the nurses, would sit together and would review medical records of patients, they would review the physician documentation and the nursing documentation, to ensure that the documentation was comprehensive and reflected the whole of the patient-care experience.

[00:46:02]

Tacey Ann Rosolowski, PhD

[00:46:03]

Was this part of a process of transforming the role of a nurse or giving formal recognition to things that nurses were already doing?

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[00:46:13]

Barbara Summers, PhD

[00:46:15]

I think it was a first step, back in the early eighties, of acknowledging that nurses and physicians practice as partners, that nurses are not simply doctor helpers. And that was a transformation that occurred in the practice of nursing after World War II. Although the very earliest nurses practiced independently and had no need for physicians at all, there was a period of time where they moved into a more dependent role, where they were fully dependent upon the physicians telling them what to do to take care of patients. But as nursing practice evolved and as this collaborative practice model developed, it became very clear that physicians have a scope of practice and nurses have a scope of practice, and there is a small overlap between the two, and that's the interdependent practice of nurses and physicians.

But physicians have independent practice and nurses have independent practice, and the care that nurses provide patients is primarily in the independent practice. Yes, they carry out physicians' orders, but that's only a small part of what nurses do. And, you know, when I talk to physicians about that, I tell them that, "If nurses only confined their activity to carrying out your orders, we would have patients dying left and right, because your orders are necessary for the medical plan of care, but they are not sufficient to return the patient to a state of health."

So it was just that initial collaborative practice movement was planting the seed that I think has sprouted again in the twenty-first century under the title "interprofessional practice," which is now really coming forward as a paradigm for excellence in healthcare, that you have strong interprofessional practice teams.

[00:48:12]

Tacey Ann Rosolowski, PhD

[00:48:16]

Now, did I hear correctly that in this organization—and the hospital name was?

[00:48:22]

Barbara Summers, PhD

[00:48:22]

Greater Southeast Community Hospital. And it no longer exists.

[00:48:26]

Tacey Ann Rosolowski, PhD

[00:48:30]

That this was one of the first places that had experimented with this collaborative model?

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[00:48:33]

Barbara Summers, PhD

[00:48:34]

The chief nurse and the chief physician were the two leaders who created the whole concept of collaborative practice.

[00:48:39]

Tacey Ann Rosolowski, PhD

[00:48:40]

And what do you think enabled them to do that at this time?

[00:48:43]

Barbara Summers, PhD

[00:48:49]

I think they were both very, very accomplished in their own work, very clear in their professional identity, and not afraid that they would or their profession would lose anything by coming together in collaboration. And they probably looked at and saw the silos that can occur when you have practitioners who are caring for patients in parallel but not in partnerships.

[00:49:23]

Tacey Ann Rosolowski, PhD

[00:49:25]

What a great experience, I mean, to see that.

[00:49:27]

Barbara Summers, PhD

[00:49:27]

Oh, my gosh, it was like—I was so lucky to have that.

[00:49:30]

Tacey Ann Rosolowski, PhD

[00:49:30]

Yeah, talk about transformational.

[00:49:31]

Barbara Summers, PhD

[00:49:32]

Yes, it was huge. It was huge. And it, again, opened my eyes to another way of practicing in partnership.

[00:49:40]

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Tacey Ann Rosolowski, PhD

[00:49:42]

And also, you know, being able to observe two professionals sharing, without ego, the power in that space, because, I mean, I remember that time. There was this thing, oh, you know, the doctors are the gods and the nurses are just the helpers, and not an understanding that there were these different spheres of operation and influence, and, you know, to see that all of that model, old model could be put aside, you could actually achieve something different, that, I'm sure, was really just visionary for you.

[00:50:15]

Barbara Summers, PhD

[00:50:16]

It was very, very impactful for me.

[00:50:19]

Tacey Ann Rosolowski, PhD

[00:50:19]

Yeah, yeah. So tell me what happened next.

[00:50:21]

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Chapter 8

A: Professional Path

An Evolution of Leadership Experience

Story Codes

- A: Professional Path
- A: The Leaders
- C: Leadership
- D: On Leadership
- C: The Professional at Work

Barbara Summers, PhD

[00:50:23]

Well, you know, I started to have a hunger for exploring management, and a position opened up as a manager for a Hematology Oncology Medical Unit at Fairfax Hospital, which is now Inova Fairfax Hospital in northern Virginia. So I figured, nothing ventured, nothing gained, and I interviewed, and I was selected for the job. Well, this was, believe me, one of those “Now that I’ve caught it, what am I going to do with it?” Because I had no formal preparation to be a manager. I knew a lot about working with people, I knew a lot about developing staff, but I knew zippo about budgeting. I had no idea how you do scheduling.

[00:51:11]

Tacey Ann Rosolowski, PhD

[00:51:12]

What do you think they saw in you that made them overlook those lacks of experience?

[00:51:17]

Barbara Summers, PhD

[00:51:19]

I think they saw someone who had clinical expertise in the care of the patient population, who had functioned successfully in an advanced practice leadership role and who had good communication skills and, you know, who could learn the other stuff.

So this was great, I loved it, but, you know, I couldn’t be the clinical specialist anymore. I had to be the manager. So you have to deal with the whole deal of performance management and performance coaching and disciplinary action and developing a schedule. And, you know, there were no books to teach you how to do that, so I spent a lot of time on-the-job training with my own personal self in my office. How do you develop a schedule? I figured out how to do them. I got really good at scheduling. But not an easy thing to do when you’re trying to develop a schedule for a thirty-two-bed unit and you’ve got a mixture of nurses and nursing assistants and

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clerks, and you've got to have the right number all the time, and people want days off here and there. So it was a good challenge, but it was a challenge.

And then I had the challenge of the financial management, too, and, you know, I was not challenged in math. I could do math. But I was challenged in understanding the finances of delivering care within a nursing unit and how to put all these pieces of data together into something meaningful.

[00:52:52]

Tacey Ann Rosolowski, PhD

[00:52:56]

Can you tell me about that challenge? I mean, when you say the finances of delivering care, I'm not sure what's included in that. So what were you learning at the time? What was the scope of what you were learning?

[00:53:09]

Barbara Summers, PhD

[00:53:08]

Well, okay. So I would get my monthly financial report, and on the report I would see here was the total revenue for the care provided on your unit by your nursing team, and here were your total expenses: personnel expenses, supply expenses, drug expenses, blah, blah, blah, blah, blah. And, you know, the goal was always to have the revenue exceed the expenses, and there were these ratios on the flipside of the report that I knew had some meaning, but I wasn't quite sure what to make out of them, so I just had to study it. And one of my first aha moments, because I had always heard people talking about FTEs, FTEs, FTEs, full-time equivalents, and I'm like, "Oh, my god, I don't know what they're talking about." And then one day in my office with my own calculator, I had the aha. One FTE is 2,080 hours of work. That is a full-time person. If a nurse works eight hours per shift and five shifts per week, 2,080 is a full-time employee. I mean, that was just like the most basic building block, but it was a huge aha moment.

Then after that, things just started to fall into place. So I then understood, okay, if I'm looking at what is my expense-per-patient day, how do I break that down into personnel expense-per-patient day and non-personnel expense-per-patient day? If my personnel expense-per-patient day is exceeding budget, then what contributed to that? Did I have too much overtime? Did I have too much paid time off? So, I mean, then it became fascinating and I loved it.

So it was one of those challenges that I had repeatedly in my career where I would go from a position where I felt very competent and very confident, and then I would uproot myself from that position in that organization and go to a new place where I didn't know people, I wasn't confident. I might have had competence but I wasn't confident about that either. And I had to

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rely upon what would become over time a set of knowledge, skill, and ability that could be used to be successful.

So that was a lot of fun. I very much enjoyed that, and I was in that position for a number of years, learning lessons about managing people, you know, learning that as hard as I would try in working with employees or physicians, that there are some people who are just so unhappy in their personal lives, there's nothing you can do to make it better at work. You know, they're just there. You can't fix it.

Learning how to be fair and at the same time hold people accountable to a standard of performance; learning how to develop my ability not to have my face tell everything that I'm thinking. I have a very expressive face, and often I wouldn't have to say a word because people would know exactly what I was thinking, based on my expressions on my face. Learning that there are very few things that come to you as an urgent pressing need that you have to decide on right this moment. Most things can sit for a day or two or three, and give yourself time to think about it, because decisions made in haste are often regretted. So, learning to trust my gut, that going against your gut almost always ends up being not a good thing. So just had a lot of learning about working with people, working with nurses, working with patients, working with families, working with physicians.

And then I had an opportunity for a promotion to a director level, and I applied for that and I received that promotion. So I was then responsible for a large number of inpatient units, and that was all fine and good, but then I was also responsible for Hemodialysis. I knew nothing about that. I was responsible for Psychiatry; knew nothing about that. And I was now in a position where I was responsible for managing leaders, not for managing their staff, so you have to learn how to lead differently. And that was a great experience, a really, really good experience.

[00:58:03]

Tacey Ann Rosolowski, PhD

[00:58:04]

What are some of those differences? How is leading leaders different than leading staff?

[00:58:08]

Barbara Summers, PhD

[00:58:10]

I think the biggest challenge is in recognizing that while oftentimes it might be easier, in your mind, and faster to do it yourself, that if you jump that line and go from yourself directly to the staff and don't hold the manager for that staff accountable for achieving change, then you are really aiding and abetting in their not being successful, and that the more you do that, the less able are you going to be to hold them accountable, because you're at every turn encouraging

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their codependence. Because why should they be accountable? Because they know you're going to fix it.

And then also recognizing that you have to lead people where they are to where you want them to be. You can't lead them where you want them to be. You know, you want them to be high-performing, self-motivated, accountable leaders. Well, that's good, but not everybody comes that way, and so you have to figure out where are they and then help them to develop the skills to get to the place they need to be. So that was interesting.

[00:59:24]

Tacey Ann Rosolowski, PhD

[00:59:28]

I'm curious about this pattern of going from a position where you feel really competent and confident and then throwing yourself into something else. What's the motivation behind doing that?

[00:59:39]

Barbara Summers, PhD

[00:59:39]

I think it's an illness. (laughter) I don't know. I've done it repeatedly, though, in my career, and it is not intentional, believe me. I mean, I don't sit and think, "Oh, good, I'm going to move myself to incompetence," because it's a horrible feeling when you get there.

And I actually remember the promotion I got to be the director, there was serendipitously an article in a journal about the imposter syndrome, and I read that and I thought, "That's me." And, you know, the imposter syndrome basically says that you find yourself in a situation or a position where you're like a duck and your webbed feet are paddling as fast as you can under the water, but on the top you're trying to appear as cool, calm, and collected as you can be, but you're living in complete fear that one day people are going to figure out you don't know what you're doing.

Now, so that completely described me, but it goes on to say that really it's a normal and a natural feeling and that it actually drives to better performance. But I sent that article to the woman who had been my boss, whose position I took, and I remember she sent me back a note, handwritten note, because in those days we had no email, and she said, "You're no imposter. You're the real thing." And I saved that note for years and years and years.

I don't know why I did it. I have no idea why I did it. I think it was because I would get antsy. I'd be in a job for three years, and then I'd start getting antsy, and I'd want to do something else. So I was always very good at starting things up, identifying new opportunities, launching them. Not so good at maintenance. And interestingly, though, when I was promoted to be the director, I

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had come to a place where I had decided, “Well, I like this job now, being a manager. I think I’m just going to do this for the rest of my career.” And I was good with that. And then this opportunity presented itself, and off I went.

[01:01:52]

Tacey Ann Rosolowski, PhD

[01:01:52]

Mm-hmm. A new challenge, new mountain to climb.

[01:01:55]

Barbara Summers, PhD

[01:01:55]

Yes, a new mountain to climb.

[01:01:55]

Tacey Ann Rosolowski, PhD

[01:01:57]

Yeah, a higher peak.

[01:01:59]

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Chapter 9

A: Professional Path

A PhD Program and a New Theory of Nursing and Leadership

Story Codes

A: Professional Path

C: Evolution of Career

D: The History of Health Care, Patient Care

A: Overview

A: Definitions, Explanations, Translations

C: Mentoring

C: Leadership

A: Experiences Related to Gender, Race, Ethnicity

Barbara Summers, PhD

[01:01:59]

Yeah. So I was in that director-level position for, I think, about a year, maybe eighteen months, and I started to feel that I was intellectually getting not sharp—I don't want to say rusty, but not sharp—that I was spending my days reading memos and responding to memos. It was like all day long reading memos, responding to memos, getting a problem, figuring out how to fix the problem. And I just thought that my ability to really have deep thinking, it was shot. So it was extremely superficial, but if it came to anything where I actually had to give serious thought, I just felt that I had lost that. So I thought, “Well, I think I'm going to go back to school.”

So I talked to my husband. He said, “Sure, if you want to do that, it's great with me.”

So I was in my regular position as the director. I enrolled in a Ph.D. program. I was accepted into the program. Of course, they said, “Well, what are you going to focus on for your dissertation?”

I'm like, “Who knows? I don't know. I'm here for the experience. I have no idea what I'm going to study.” And I started in the program as a part-time doctoral student.

[01:03:27]

Tacey Ann Rosolowski, PhD

[01:03:27]

And this was at George Mason again?

[01:03:27]

Barbara Summers, PhD

[01:03:29]

Yes. But the interesting thing is that each time I went back, they had all new faculty, so there

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were only two faculty that I had experiences with two times during my three tours at George Mason.

[01:03:43]

Tacey Ann Rosolowski, PhD

[01:03:43]

That's great. So basically a new experience each time.

[01:03:45]

Barbara Summers, PhD

[01:03:46]

A new experience every time, mm-hmm.

So I went back to school, and I would carry two courses a semester while I was working full-time, and my first semester back was extraordinarily difficult because I had forgotten how to read scholarly papers. So my first semester included a course in theory, and we were reading these very deep papers. And I remember with horror, I had them all copied and at home, and I sat down and read. And I was highlighting as I was reading, and after I finished reading, I had highlighted like 95 percent of the piece of paper, and I had no recollection of what I had read. I had just completely lost the ability to read for meaning and content. I had become so accustomed to scanning for just a few key points so that I could make a decision and move on.

So I had to relearn how to be a student and relearn how to read and to think and to synthesize again, read multiple papers, and synthesize the information from those papers and then be able to write about them and speak about them.

So the first semester was tough, but then I got the hang of it, and I moved on to my second semester. And by the time I finished my second semester, I realized that between the demands of school, which were substantial, two evenings a week in class and then all of the out-of-class work, and the demands of work, you know, working fifty or more hours a week—and, oh, by the way, I was married. My husband and I never had children, but I was married, loved my husband very much. I felt that I was failing in all three areas, and I wasn't happy, because I didn't think I was giving my best anywhere.

And I sat down and thought about it, and I said, "Well, Barbara, you're the one who made the decision to go to school, no one made you do that, and so if you're going to be happy, something's going to have to give. So you could drop out of school. No harm, no foul. Or you could leave the position that you're in and go into a position that won't be as demanding and stressful as this administrative position. Because I'm definitely keeping the husband."
(Rosolowski laughs.)

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So I decided to do that, and I moved into a position as a nurse educator/clinical specialist in the same organization, focused in oncology, and I was able to be a sane person again. It was wonderful. So I was then able to actually enjoy school.

[01:06:37]

Tacey Ann Rosolowski, PhD

[01:06:38]

And did the teaching—because I'm just thinking you gave up the job that had made you feel you were losing your intellectual sharpness anyways, so did teaching help with the learning side as well?

[01:06:50]

Barbara Summers, PhD

[01:06:50]

Well, the development of the staff was very rewarding, so I enjoyed that, but I also would teach a course every semester for the university as well, a graduate-level course. So I enjoyed that. So I felt very challenged and very fulfilled the whole time. And I would have three or four graduate students with me at all times, but I came to have an appreciation for the fact that while I was nearly omnipresent, that no matter what the need was, people could call on me, and I was like the Fix-o-matic, that in the end, that being the Fix-o-matic was disempowering the staff, not empowering them, because they learned how to be helpless. Because why would they figure stuff out for themselves? I could fix it for them. So I had to stop that.

And then the other lesson that I learned is that no matter how hard you're working and how many hours you're putting in, people don't appreciate you more because of that. All they do is notice the few times when you're not there and ask you, "Where were you?" Very hard lesson to learn, very hard lesson to learn, because you can end up feeling very underappreciated when, in fact, if you can step back and look at it through a little bit of an objective lens, you can't blame people for that. Because how could they possibly know that you're working twelve hours a day every day? I mean, they only see you for a snippet. The problem is, every snippet that they have, you're there. Well, that just seems to be coincidence to them. So I learned a lot about—not about working shorter hours, because I still worked terrible hours, but I learned a lot about if you're going to work long hours, you need to be able to put some boundaries around that. So that was a difficult lesson to learn.

[01:09:02]

Tacey Ann Rosolowski, PhD

[01:09:03]

Tell me about the lessons you were learning in your graduate program. How did your interests evolve?

[01:09:07]

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Barbara Summers, PhD

[01:09:12]

Interestingly, in that very first course in theory, I became very interested in leadership theory, and in particular in Burns' Theory of Transformational Leadership. And then I became exposed to a nursing theory developed by Jean Watson called Human Caring Theory. And as I read about transformational leadership theory and I read about Human Caring Theory, it was just so clear to me that there were tremendous crosswalk between the key concepts of the two.

[01:09:51]

Tacey Ann Rosolowski, PhD

[01:09:52]

And who was the originator of the Human Caring Theory? I missed the name.

[01:09:56]

Barbara Summers, PhD

[01:09:56]

Dr. Jean Watson, W-a-t-s-o-n. And then transformational leadership is James Macgregor Burns.

So it was like I was—

[01:10:07]

Tacey Ann Rosolowski, PhD

[01:10:07]

I'm sorry. What were the crossovers that you saw between these two areas?

[01:10:11]

Barbara Summers, PhD

[01:10:11]

Well, that became my dissertation.

[01:10:12]

Tacey Ann Rosolowski, PhD

[01:10:12]

Oh, okay. Neat.

[01:10:13]

Barbara Summers, PhD

[01:10:14]

I mean, I had just never heard about Watson's Caring Theory before, so it was like a kid in a candy store, because what she described just resonated deeply in my soul. So, you know, I really

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got into that, I really enjoyed that and enjoyed exploring more about leadership theory because my doctorate is in healthcare administration.

And then in my coursework, in my finance course or courses, taught by CFOs from local hospitals, it was really interesting for me to see at a very macro level the economic approach to healthcare.

And then in some of our healthcare administration courses, I had one fabulous faculty member, Dr. Hazel Johnson Brown, and she passed away in the last eighteen months, but she was so tremendously influential for me as a leader. She had been a three-star general in the army and had been responsible for leading all of the nurses in the Army Nurse Corps. She had this beautiful deep voice. She was a very tall African American woman, very distinguished, and no nonsense, no nonsense. Hazel was like the best.

And she would teach us these little pearls, and some of her pearls—I pass them along now—are things such as, you know, because they were all women in the class, we didn't have any men in our class, she'd say, "Ladies, now as you're executives, you have to remember that you can't do the job for the people who are working for you. You have to cause them to do their own work." And she said, "And as I have had conversations with many people over the course of my career, you need to remember if you're doing someone else's work for them, you have to have this conversation, and you have to say, 'Right now it's taking two of us to do your work. That's one more than we need, and I'm not talking about myself.'" (Rosolowski laughs.)

She was so funny, but very strong, very clear, and incredibly compassionate and very encouraging, you know. We would write our papers for the course, and then she would immediately sit down with us and talk to us and say, "Okay, now you need to submit this for publication, and let's talk about how you're going to edit so you can submit it for publication."
[01:12:58]

Tacey Ann Rosolowski, PhD

[01:12:58]

Wow.

[01:12:59]

Barbara Summers, PhD

[01:13:00]

So I just became very, very energized.

[01:13:03]

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Tacey Ann Rosolowski, PhD

[01:13:04]

Mm-hmm. And as you're talking, I'm just thinking, "Wow. This woman's experience is so different from mine," because most of the people you're mentioning are women. So you were in a field where you had female role models and mentors.

[01:13:15]

Barbara Summers, PhD

[01:13:15]

Mm-hmm, I did.

[01:13:15]

Tacey Ann Rosolowski, PhD

[01:13:16]

And so many of us in other fields had zippos, I mean really none. So that must have been really something. I mean, this is an era where women were really moving through ranks.

[01:13:28]

Barbara Summers, PhD

[01:13:29]

It was. It was. And it was interesting, because these were not like mothering mentors. These were tough-as-nails mentors.

So, you know, I moved forward in my doctoral studies and continued working as a clinical nurse specialist, and got to the place where I had passed my comprehensive exams and I was admitted to candidacy, and now all I had left was my dissertation. And I had vowed I would never, ever be an ABD person who had done everything but get their dissertation completed, because I had had too much blood, sweat, and tears.

So right about this point in time, I was recruited for a position at the National Institutes of Health within their Clinical Center, working with the Nursing Service in the National Cancer Institute intramural program, which means the clinical services on the NIH campus. So I was brought in to be a research nurse specialist for the ambulatory care nurses in the NCI and the inpatient nurses in the NCI. So there were two inpatient units, two clinics from Radiation Oncology involved, and I was brought in very specifically to develop a cancer nursing research program, and it was perfect for me because I was nearly complete with my doctorate. Being a government employee and being in this position offered me scheduling flexibility, so I was able to work four ten-hour days, and that gave me a three-day weekend every week so that I could travel for my data collection for my dissertation, because I traveled up and down the East Coast interviewing nurse executives and getting some quantitative data from surveys administered to staff.

[01:15:32]

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Tacey Ann Rosolowski, PhD

[01:15:33]

You had mentioned that your dissertation focused on that overlap between transformational leadership and Human Caring Theory. Could you just give me a snapshot of what that was?

[01:15:43]

Barbara Summers, PhD

[01:15:44]

I came to have the belief that as nurses change roles, they continue to practice nursing and they continue to use nurse caring interventions, but they shift their focus from the patient client to the organization as the client or the team as a client. And I just saw really good consonance in what Burns said about the way leaders interact with others, with the way Watson described the way nurses interact with others.

[01:16:26]

Tacey Ann Rosolowski, PhD

[01:16:27]

Could you just tell me what does Jean Watson say about how nurses interact with others?

[01:16:31]

Barbara Summers, PhD

[01:16:34]

Well, I think—I mean, she's got a whole book on it.

[01:16:37]

Tacey Ann Rosolowski, PhD

[01:16:37]

Right. (laughs) I know I'm challenging you here.

[01:16:40]

Barbara Summers, PhD

[01:16:40]

Yeah. She would basically say that when nurses are in caring relationship—not *a* caring relationship, but *in* caring relationship—with others, that there is a resonance between what she called the *geist* or the spirit of the nurse and the spirit of the patient, where they join together in this brief moment where the nurse is able to reflect back to the client, the patient, everything that the patient is manifesting, so that the patient can more clearly see for themselves what's going on, and they can begin the process of self-healing. And that presupposes that nurses come with a very set of clinical skills, that they know how to do a physical assessment, they know how to appropriately administer medications, they can take care of a wound, but it's this additional

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joining of the spirit of the patient and the nurse that produces the healing moment.

[01:17:48]

Tacey Ann Rosolowski, PhD

[01:17:51]

It sounds like a very powerful theory.

[01:17:53]

Barbara Summers, PhD

[01:17:53]

But that so resonates with Burns that, you know, leaders, transformational leaders, join with their followers, they join their hearts and minds together. It's like, wow, it's the same thing.

So that's what I did. I interviewed nurse executives and I asked them to talk about their nursing practice as nurse leaders and to give me exemplars of the ways that they used caring as a nursing leader. For example, one of the stories was around a nurse executive who had one of her direct reports, a director, who developed cancer, and she talked about the way that as the nurse executive she worked with her team to care for this colleague who had developed cancer, and that included not only caring for her personally, but caring for her team.

So it was just so fascinating to hear people talk about the way that they used caring, but they used it as a leader and as an executive. So I then would take the interviews, have them transcribed, and then I would use content analysis in reading through them, and I initially performed just a latent content analysis to see what emerged from it. Because I had identified my biases and I knew what I was going to be looking for, so I kind of wrote those down, put them aside, and then I just looked to see what would emerge. Then I did an intentional or manifest content analysis first using Watson's Caring Theory and then second using Burns' Transformational Leadership Theory to see if there was actually evidence of that in there, and I did find that that was the case.

[01:19:45]

Tacey Ann Rosolowski, PhD

[01:19:45]

Interesting, yeah.

[01:19:46]

Barbara Summers, PhD

[01:19:47]

So I was now at NIH, so maybe that's where we need to stop, because I think—is time up now?

[01:19:54]

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Tacey Ann Rosolowski, PhD

[01:19:55]

We were going to go till three.

[01:19:56]

Barbara Summers, PhD

[01:19:56]

Oh, were we?

[01:19:57]

Tacey Ann Rosolowski, PhD

[01:19:57]

But if you need to do things, that's—

[01:19:58]

Barbara Summers, PhD

[01:19:58]

No, I'm okay. So I can take us up to the point in time when I came here. How about that?

[01:20:03]

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Chapter 10

A: The Researcher

The NIH and an Opportunity to Support Research Nurses

Story Codes

A: The Researcher

A: The Leader

C: The Professional at Work

D: The History of Health Care, Patient Care

C: Patients

C: Patients, Treatment, Survivors

Tacey Ann Rosolowski, PhD

[01:20:03]

Sure. Why don't we do that. Yeah, because I did want to ask you next about your activities at NIH. What was the—

[01:20:09]

Barbara Summers, PhD

[01:20:10]

Oh, that was a great experience. You know, it's interesting, because when people say, "Who were your mentors?" I say I didn't really have any, but as I'm talking to you, I had lots of them.

[01:20:20]

Tacey Ann Rosolowski, PhD

[01:20:21]

You've mentioned a few, yeah.

[01:20:22]

Barbara Summers, PhD

[01:20:23]

You know, as I finished my dissertation—well, let's talk before the dissertation. So I was again uprooted from an organization where I worked for ten years. I knew everybody. I knew my networks. I knew how to get stuff done. And I came to NIH and I didn't know where the bathrooms were, I didn't know zip. And I'm like, "Oh, my god, they hired me to develop a research program, and I know nothing about science. What am I going to do?" (Rosolowski laughs.)

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But luckily, there was a very seasoned scientist who was employed at the Clinical Center and who had developed a wonderful model that supported staff nurses in conducting research, and so my job was to apply that model within my division with the nurses. So I was greatly relieved, and she was able to be a resource to me.

[01:21:21]

Tacey Ann Rosolowski, PhD

[01:21:23]

So what was the project and what were its goals?

[01:21:26]

Barbara Summers, PhD

[01:21:27]

The project? Well, the intention of my role was to have bedside nurse-driven clinical research, to have nurses identify research questions and then to work with them so that they actually went through the entire process of flushing out their research question, going to the library, doing a literature review, summarizing the gaps in the literature, identifying hypotheses if they were appropriate, then talking about, okay, what were the methods going to be, who were the subjects going to be, what kind of data did we need, how are we going to analyze the data.

So through weekly meetings with staff who were interested, we would identify a topic, start to have some initial questions. The staff would go through the literature review. I had a librarian who would work with me. We'd pull papers. I'd divvy them out to the staff. They would review them. We'd come back, we'd talk about it. We'd develop our final hypotheses. Then we would, as a group, talk about the rest of it, and as a group we would write the protocol.

[01:22:35]

Tacey Ann Rosolowski, PhD

[01:22:37]

How long had this been going on at NIH?

[01:22:40]

Barbara Summers, PhD

[01:22:41]

A year before I got there.

[01:22:42]

Tacey Ann Rosolowski, PhD

[01:22:42]

Okay. So it was relatively new. Because I'm thinking it seems like this is part and parcel of the

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rising prominence of nurses having their own sphere of influence.

[01:22:53]

Barbara Summers, PhD

[01:22:54]

Yes, yes.

[01:22:54]

Tacey Ann Rosolowski, PhD

[01:22:54]

So the NIH is supporting that.

[01:22:56]

Barbara Summers, PhD

[01:22:56]

Very much so.

[01:22:57]

Tacey Ann Rosolowski, PhD

[01:22:57]

Great.

[01:22:57]

Barbara Summers, PhD

[01:23:01]

It was great, because you had the opportunity to allow nurses to really exercise their intellectual curiosity. So I worked with a number of teams of nurses, you know, looking—I worked with a group of pediatric nurses, and they were fascinating. They were interested in—the typical pattern for administering a particular drug was to take the patient’s vital signs every fifteen minutes in case the patient had an adverse reaction to the drug. But when the nurses reviewed the literature, there was nothing to substantiate the need for every-fifteen-minute vital signs. It had become like the pattern and the habit everybody did, every hospital. It was just like that’s the way it was.

And then when the nurses began looking at the incidence of what we call hypersensitivity reactions, the incidents were low in the literature and in their clinical experience they were low. And then the nurses began looking at hypersensitivity reactions and the literature about hypersensitivity reactions, identification of hypersensitivity reactions never happens because of vital signs ever, ever, ever, ever. It always happens because of patient expression of symptoms. So here we have nurses dutifully performing every-fifteen-minute vital signs in futility, because if the patient is going to have a reaction, it’s not going to show up in their vital signs. By the time it shows up in their vital signs, the patient will be purple.

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So the nurses designed a lovely study where they randomized patients to every-fifteen-minute vital signs, which was the standard, and then the intervention group, they did vital signs every thirty minutes. And they found absolutely no difference in their ability to check hypersensitivity reactions. So that was great because that was taking control over their practice.

Then we had another group that was very interested in the detrimental impact for cancer patients of having to have a lot of blood tests done. And most of these patients have something called a central venous catheter in place that remains in place, and you can draw blood samples from that. But when you draw the blood samples, you have to take about 5 milliliters first and discard that because it has Heparin flush solution in it. So every time a patient had their blood drawn, we were throwing away 5 milliliters, and then we were taking 5 or 10 milliliters for the blood tests. And so you start adding that up, no wonder we had to transfuse patients, because we were, you know, phlebotomizing them.

So the nurses asked the question, “Well, could we withdraw the discard but then reinfuse it instead of throwing it away?” So we thought we could do that because we could put a stopcock on and we could just draw it out and then do the thing and push it back.

And I said, “Not so fast. We need to study this, because what if we have contamination of the blood? Or what if during the time that the blood is sitting in the syringe, you get clots?”

So we talked to the Infectious Disease folks, and they didn’t think as long as it was a closed system there was a high risk of contamination, but there was a great potential for developing blood clots. So we devised an experiment where we studied discard blood for the presence of clots, and we worked with a physician, hematologist, in the lab. And it was great because the nurses actually learned that routinely reinfusing discard blood is not a good practice, because there was a substantial percentage of patients whose blood would develop some amount of clotting, so you would be pushing that clot back into the patient.

But that was great fun, too, because, I mean, that had a little bit of a laboratory component because we would have to take the blood and immediately put it through a filter to see if there were any clots in there. So that was great. They got that published too. So we just had great fun. And the nurses felt very strongly that they were influencing practice using science.

[01:27:30]

Tacey Ann Rosolowski, PhD

[01:27:30]

Yeah. I mean, they’re taking all of the things observed at the bedside but then turning it into evidence with proof. Very, very neat.

[01:27:38]

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Barbara Summers, PhD

[01:27:38]

And then I was also very fortunate because I was a member of the Institutional Review Board, the IRB, at the National Cancer Institute, and, you know, that was like the *Who's Who* in cancer research, who would come and submit their protocols for review by the IRB. And so I learned more about research, about clinical research, serving as a member of the IRB than I learned about research in my doctoral program, because your doctoral program teaches you the tenets of conducting research, but not clinical research, not clinical trials. So I just viewed that as a really great opportunity to learn more about clinical research, but I also learned about the way that scientists should comport themselves. When you have to appear before an IRB, you don't go in there with guns blazing; you go in there with a sense of humility and appreciation for the feedback you're going to get from the IRB, not defensiveness, etc.

[01:28:38]

Tacey Ann Rosolowski, PhD

[01:28:40]

It sounds like you learned a lot through negative example there. (laughs)

[01:28:43]

Barbara Summers, PhD

[01:28:43]

You know, I did, but I also learned by looking at some people who were very famous in cancer research and who could be quite flamboyant when they were not in front of the IRB, but they would come into the IRB, they were like little puppies, they were so well behaved. I was shocked it was the same person.

[01:28:59]

Tacey Ann Rosolowski, PhD

[01:29:00]

And do you think it was genuine?

[01:29:01]

Barbara Summers, PhD

[01:29:03]

I think it was learned behavior, that they knew that if they went in and they behaved badly, that they would be punished and their protocol wouldn't be approved, so, you know. (laughs)

[01:29:12]

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Tacey Ann Rosolowski, PhD

[01:29:13]

Right. Just learning to play the game.

[01:29:15]

Barbara Summers, PhD

[01:29:15]

It was a conditioned response.

[01:29:16]

Tacey Ann Rosolowski, PhD

[01:29:16]

Right, right. Interesting.

[01:29:17]

Barbara Summers, PhD

[01:29:18]

But I learned it's possible not to get defensive when people are asking you questions or giving you feedback. It's just that they don't understand your perspective. And so, number one, you should accept the feedback for what it is, which is feedback, and, number two, respond thoughtfully and with appreciation. And they may not be correct, but they're not trying to play gotcha. So that was great.

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Chapter 11

A: Joining MD Anderson/Coming to Texas

An Opportunity to Work at a World-Class Institution

Story Codes

A: Personal Background

A: Professional Path

C: Evolution of Career

A: Joining MD Anderson

Barbara Summers, PhD

[01:29:18]+

So I finished my doctorate, and at the same time, serendipity, an administrative position opened in the Clinical Center, and it was a position that administrative responsibility for Critical Care Services and the Vascular Access Services. So my boss called me to her office and asked me if I'd be interested in that job because I'd had a background in management and administration. And I thought about it for a minute, and I said, "Sure. Great opportunity." And I had been doing the other thing for about three years, so I said, "Sure, I'll do it."

And then I accepted it, and then I got in that job and I'm like, "Oh, my god, what did I do?" Again. Because now I had to be a director of a Critical Care and Vascular Access Services, which I've taken care of patients with VADs and I've taken care of VADs, but I haven't been on the end of the inserting of them. So I had to develop relationships with a whole new group of nurses, a whole new group of physicians, learn all new processes, get involved and enmeshed in all of the challenges that come from a management position that you don't have to experience when you're the nice friendly research nurse specialist who they're everybody's buddy.

But I was, you know, moving along with it and making headway and making good progress, and one Friday afternoon I was in my office and my phone rang and I answered it, and it was a search firm, a headhunter. And, you know, when you get on the list, you get called by people all the time. So it was a typical Friday, and I was literally going through all the paper on my desk and putting them into balls and practicing getting them in the basket across the room, and really not listening to the woman, just being polite. So she was going blah, blah, blah, blah, blah, and I'm like, "Got it, got it, got it."

And then she said, "And the position's at MD Anderson Cancer Center."

I said, "Wait a minute now. Can you start over again?" Because my husband and I had talked about the reality that once I completed my doctorate, it was entirely possible that we would need

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to move somewhere else for me to have the opportunity to actually apply the doctorate to a position, and MD Anderson was such a place where one might be able to do that.

So the woman described to me the position as the administrative director of the Hematology Center in the Hematology Inpatient Services. So at the time it was six outpatient clinics and six inpatient units. So I was quite intrigued, intrigued enough to tell her that I needed to think about it over the weekend and I would call her back the next week if I was interested.

So I went home and talked to my husband about it, and he said, “Where is it?”

I said, “I think it’s in Texas. I think Dallas or Houston, I don’t remember which.” And then I remembered, you know, “I’ve got a couple friends who live there and who work there. Let me just look it up real quick in my own directory.” Because there were no, like, websites. We’re talking 1997. Maybe there was a website, but it wasn’t like the kind of thing you’d go out today and do. I’m like, “Yep, it’s in Houston.” And I think I had been here actually one time before for a meeting, like in the eighties, but it was a typical professional meeting. You don’t get outside the hotel.

So we talked about it, and my husband said, “Well, if it’s really a world-class organization and you’re interested, I think you should talk to them about it.”

So I called the woman back on Monday, and I said, “I’d like to learn more.” So we then set up time for her to do an in-depth telephone interview with me that was a couple of hours long.

So maybe we’ll stop there, because that’s how I came to be here.
[01:34:02]

Tacey Ann Rosolowski, PhD

[01:34:03]

Sounds good. Sounds good.

[01:34:04]

Barbara Summers, PhD

[01:34:04]

I had zero intention of leaving, none at all, but then this wonderful window of opportunity opened, and that really is a theme for me. A window of opportunity opens and I jump through. Because my father told me years and years ago that when a window of opportunity opens, think carefully about not jumping through, because it may never open again.

[01:34:26]

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Tacey Ann Rosolowski, PhD

[01:34:30]

All right. Well, we'll stop here for today. Thank you very much. And I am turning off the recorder at 2:52.

[01:34:38] (end of session one)

Barbara Summers, PhD

Interview Session 2 – April 1, 2014

Chapter 00B **Interview Identifier**

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. So now we are recording officially, and the time is 10:54. I'm Tacey Ann Rosolowski, and today is April 1st, 2014. I am on the eighteenth floor of Pickens Tower in the Office of the Vice President, interviewing Dr. Barbara Summers for our second session together.

So thank you very much for making this time for me.

[00:00:29]

Barbara Summers, PhD

[00:00:30]

My pleasure.

[00:00:31]

Chapter 12

A: Joining MD Anderson/Coming to Texas

Joining an Institution that “Grabbed My Heart”

Story Codes

A: Joining MD Anderson

A: Professional Path

A: Personal Background

C: Personal Reflections, Memories of MD Anderson

A: Character, Values, Beliefs, Talents

C: This is MD Anderson

C: Offering Care, Compassion, Help

B: Institutional Mission and Values

B: MD Anderson Culture

C: Patients, Treatment, Survivors

C: Funny Stories

Tacey Ann Rosolowski, PhD

[00:00:31]

And when we ended up last time, you were right at the point of telling me about you were at the point where you were coming to MD Anderson in 1997. So I know we strategized a little before the recorder was on, how you wanted to deal with the time you spent here. If you could tell me a little bit about who recruited you, why, and then those first steps, basically those first six years, what you wanted to summarize about that.

[00:00:55]

Barbara Summers, PhD

[00:00:55]

Yeah, surely. And the reason that I had expressed an interest in focusing most of our time on my position as chief nursing officer is that as I reflected on our first interview session, it seemed as though I was just really talking about myself all the time, and that is highly unusual for me to talk about me. And I know that's okay, but I want to make sure that I have the opportunity to be able to speak to the practice of professional nursing at MD Anderson because it has such a wonderful legacy and I feel so proud to be able to be a part of that legacy.

[00:01:30]

Tacey Ann Rosolowski, PhD

[00:01:30]

Absolutely. Though I did want to say, from my perspective, I thought that the information that we covered about particularly the development of your research interests and the development of you as a leader was really essential for understanding what you bring to MD Anderson. So I did not—

[00:01:49]

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Barbara Summers, PhD

[00:01:50]

Oh, thank you.

[00:01:50]

Tacey Ann Rosolowski, PhD

[00:01:50]

—by any means feel as though that was time ill spent. (laughs)

[00:01:53]

Barbara Summers, PhD

[00:01:53]

Thank you. Oh, well, I can't wait to see what I said. (laughter)

[00:01:55]

Tacey Ann Rosolowski, PhD

[00:01:56]

No, I thought it was extremely valuable and very interesting.

[00:01:58]

Barbara Summers, PhD

[00:01:59]

Well, thank you. Thank you.

[00:02:00]

Tacey Ann Rosolowski, PhD

[00:02:00]

I look forward to seeing how that all plays out here at MD Anderson.

[00:02:04]

Barbara Summers, PhD

[00:02:04]

Okay. Well, in 1997, I was in my position at the National Institutes of Health, and I believe it was late in the afternoon on a Friday, I think, and I was in my office. At that point I was in an administrative role, responsible for Critical Care Services and some Vascular Access Services. And I was doing my usual Friday desk cleanup, and the phone rang and it was from a recruiter, a headhunter. And I frequently got those phone calls. And she started doing her spiel about, "You know, I have this opportunity, and I was wondering if you'd be interested, and let me tell you a little bit about it."

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And I was doing my usual being polite and listening to her as I was balling up pieces of paper I didn't need anymore from the week before and tossing them into the trash basket like I was shooting goals from the basketball court. And she finally got to the end and said, "This opportunity is at MD Anderson Cancer Center."

And like mentally, I went [demonstrates], "Okay, back up. Could you start over again from the beginning?" Because the mere mention of the premier Cancer Center in the world just was astounding to me, that anyone would come to me about such an opportunity.

And she repeated all of the information, describing a job as an administrative director for the largest clinical service in the institution, for the Hematology Services then, which included Leukemia and Lymphoma, and at that time called Bone Marrow Transplantation. So we had six outpatient clinics in that, and we had then six inpatient nursing units that went with it.

So at the conclusion of the sales pitch, the headhunter and I agreed that she would call me the following day on a Saturday and we would do a telephone interview. And I was intrigued, very. I had colleagues who worked here at MD Anderson, Debbie Houston [Oral History Interview], being one, Mary Cunningham [phonetic] being another, Paula Reeger [phonetic] being another, very, very well-respected nurses in the oncology nursing circles.

So I drove home and thought about how am I going to tell my husband that I'm talking to someone about a job in Texas, and I just, you know, sat down and spoke to him about. And, you know, being the wonderful man that he is, he said, "You know, when you got your doctorate, we knew that someday there might be an opportunity like this for you to be able to use that education and your experience." And he said, "If this turns out to be the right job, then that's a really good thing and we'll go for it."

So I had my very in-depth interview with the recruiter the very next day, and it progressed rapidly to having me flown down here for my first set of interviews with a lot of different people. I spoke with—actually, before that, then I had to go meet the recruiter in person. I guess she had to make sure that I, you know, looked as legitimate as I appeared to sound on the telephone. But that was then followed by the flight down here to Houston.

And one of the things that I will long remember is as I was on the plane flying to Houston, I was asking myself, "Now, where is Houston in Texas? I don't really know. Maybe they have cowboys and tumbleweeds and that kind of thing there." So I was greatly surprised when I arrived and found it was just like Florida, because I came here during the summer.

And I checked into my hotel room, and I was anxious, of course, the night before. And the next morning I took the shuttle from the Houston Marriott Medical Center, which is still here today, and it dropped me off in front of the Clark Clinic lobby. And I walked into that lobby, which is where I was to meet the person who was going to greet me and take me to my interviews, and I

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had the opportunity to stand there for a few minutes and just take in what was MD Anderson, and it grabbed my heart and it hasn't let go of me since then. Because as I got here, I saw patients and their family members who were sitting in the lobby—and at that time all of our medical records were paper—and these individuals, many of whom were new patients, were sitting patiently waiting to be called to be registered, and they had on their laps stacks of paper that were copies of their medical records and folders that had copies of their diagnostic imaging studies, and you could sense palpably hope in the atmosphere. There was just a tremendous sense of hope. And I felt at home, and I have not felt otherwise since then.

So I had the opportunity to meet with a great many individuals, as is often the case, and particularly in the MD Anderson style you are subjected to nonstop interviews after interview after interview after interview, and it gave me a good sense of the institution and of the people who worked here and the profound commitment that folks have to the mission of the organization, more so than in any other organization where I had worked.

[00:07:56]

Tacey Ann Rosolowski, PhD

[00:07:56]

What were you picking up on specifically at the time through these nonstop interviews?

[00:08:01]

Barbara Summers, PhD

[00:08:02]

You know, what I was sensing so clearly is that people who come to practice here at MD Anderson, who come to work here at MD Anderson, regardless of their role, whether they are, you know, a world-renowned surgeon or hematologist-oncologist or a clinical nurse or a housekeeper, people come here to work because they are attracted to the mission of the institution, which is to eliminate cancer. And for those individuals who know that they can't personally eliminate the cancer, what they understand is that they can still be instrumental in addressing that mission to eliminate cancer by making a difference in the lives of the people who entrust their care to us.

So there was just this very, very strong commitment to our mission and also to the goal of making a difference in the lives of people with cancer. You know, I joke and say that one of the things about coming to work at MD Anderson is that no one wakes up one day as an employee and looks around and says, "Oh, my gosh, everybody here has cancer." They know that coming in the front door, and that takes a special commitment when you come in here, and it takes an individual who has the capacity and the capability to understand that this is *not* a depressing place to be. It's a very hopeful and filled-with-joy place to be that occasionally has sadness because people do die, but there is so much joy and so much hope here. And the gifts that we are given in form of generosity of spirit from the patients and their families, they're just invaluable, absolutely invaluable. So I was able to see that with the patients and families as I interviewed,

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but I was also able to hear about that from the nurses and the physicians and the case managers and the administrators that I spoke with.

So I had two days of interviews and then I was sent back and waited. And, of course, by now I was very intrigued and deeply wanted the job. (laughs) So I had to endure the interview process as other candidates were brought in here and interviewed. And I got a call probably three weeks later that I was one of two finalist candidates, and they wanted me to come back for a second round of interviews and bring my husband.

[00:10:49]

Tacey Ann Rosolowski, PhD

[00:10:52]

Can I ask you, you've talked about what attracted you to the heart of the institution. What about the position you were being offered? What were the challenges that were intriguing you about the job? And what was the job at the time?

[00:11:06]

Barbara Summers, PhD

[00:11:07]

The job at the time was being the administrative leader for three distinct but related clinical care services: the Leukemia Service, the Lymphoma Service, and Bone Marrow Transplant Services. And administratively I had operational responsibility for the clinics, so there were six outpatient centers, the Physicians Office Practices plus the Apheresis Center, plus the Bone Marrow Aspiration Center, plus our Fast Track Laboratory.

So I had that operational responsibility, and that was intriguing because there were a multitude of challenges in being able to effectively and efficiently see the numbers of patients that were coming through those centers. The volumes of patients were larger than anything I had ever experienced, and they were growing astronomically. Over the course of a three-year period, the volume of patients doubled in size. So we were constantly dealing with the challenges of not enough exam rooms and how do we schedule the physicians' template so that we can accommodate the patient demand and also respect the physician need to have some academic time for their research and, you know, how do we expedite the processes of bringing patients into the institution. So a lot of those things were administrative challenges.

And then on the inpatient side of my responsibility, I had operational responsibility for running six inpatient nursing units that were affiliated with those clinical services, so there were all of the inpatient operational responsibilities that one has of ensuring the quality outcomes for the patients who receive care, ensuring, both inpatient and outpatient, that the nursing team was appropriately credentialed and had competence to provide the care that the patients needed.

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Then also another really intriguing piece of it was that I would have responsibility for the activation of the new Alkek Hospital, because as I interviewed here, that was under construction. And when the Alkek Hospital opened, it was going to be used exclusively—well, not exclusively, almost entirely for the hematology patients.

And so there were just lots of challenges, and it was a different environment at that time. And there were challenges, too, in terms of working with individual physicians and other members of the clinical team who could be sometimes badly behaved and unprofessional, and mostly reflected in outbursts of temper and, you know, just not able to find a way to channel that frustration or that anger or the energy in a way that could be productive. So all of that was presented to me as challenge, and I was told, actually, that although I had been informed about the challenges, that I couldn't appreciate the magnitude of the challenges until I got here, and wasn't that ever the case.

But I got here and it was good. I brought my husband down for that second interview, and we went out and looked at housing, and, you know, we had the obligatory dinner with the spouse to make sure that he was not an axe murderer or anything crazy. (Rosolowski laughs.) And, you know, we looked around Houston and we felt very comfortable here because it's a very southern town in the way that people interact with one another, and since we're both Virginians, that kind of resonated with us.

So two weeks later, I was offered the position and I accepted it, and I gave my notice at NIH, and I had a four-week period of time where I was doing transition between leaving NIH and starting at MD Anderson. And in that time, we had to put our house on the market in Virginia, had to find temporary housing for me down here, and then had to make our plans for getting me down here with a car. So we found a furnished apartment that was very close by, and the plan was my husband would stay up in the D.C. area with the dog and one of the cats. I would be down here with one of the cats. And that worked out well for the first couple of months because, of course, the hours that I was working were horrendous. I missed my husband, but it was just as well he wasn't here because I didn't have to feel guilty because I was neglecting him.

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Chapter 13

B: Building the Institution

Roles as New Director of Nursing: Working with Growth in a Matrixed Organization

Story Codes

C: Understanding the Institution

B: MD Anderson Snapshot

B: MD Anderson Culture

C: The Institution and Finances

A: The Administrator

B: Growth and/or Change

D: Women and Diverse Populations

Barbara Summers, PhD

[00:11:07]+

So I started on that adventure, and I learned so much about aspects of leadership that while I had been exposed to them conceptually in my formal education and I had had experience with things like communication on a practical basis, never to the extent that they were absolutely mandatory here.

[00:16:29]

Tacey Ann Rosolowski, PhD

[00:16:29]

Tell me about that.

[00:16:30]

Barbara Summers, PhD

[00:16:31]

Well, I came here and I learned quickly that at this organization, which is a magical organization, a lot of what we do seems to happen by magic, in that we don't have here the very typical structures and processes associated with running an enterprise the size of MD Anderson that you see in other organizations. And specifically in every other organization where I have practiced, there is a hierarchical—not bureaucratic, but a hierarchical structure where the senior-most executives would meet, and in that meeting they would discuss business operation strategy at their level and they would determine what pieces of communication then needed to be cascaded down to the next level, and what pieces of information did they need to have brought back up to them for decision-making, and so that most senior executive group would then break out and they would have meetings with their direct reports, and they would cascade the information down and also ask for specific information. And that group would then cascade to the next group

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and to the next group. And that's also the process by which decisions were determined and communicated. And that did not happen there, and it does not happen now. There are no such channels.

[00:17:59]

Tacey Ann Rosolowski, PhD

[00:18:00]

How does it work here?

[00:18:01]

Barbara Summers, PhD

[00:18:02]

It's all by matrix and relationships, so that's what I learned. I spent my first six months believing that whatever competence I thought I had, I had deluded myself. I was reminded of a paper that I had read a number of years before about the imposter syndrome. I was certain that one day that MD Anderson was going to wake up and realize that I was an imposter and not capable of doing my job, because I would attend meetings and there would be no background information for me, and I would listen intently and not have any idea what was being discussed. But I'm a smart woman, so it wasn't a lack of intellect. It was just that I had no frame of reference for how work was accomplished here. But I learned quickly it's accomplished through developing relationships and networks, and that if you have something that you need to accomplish and you don't know how to do it, the best thing that you can do is call someone, and then from that individual, although they may not have the answer for you, they will be able to tell you some other people that you may call and talk to about it.

So after six months, I had developed enough of a network and I had developed a pretty broad array of relationships, and I began to have big chunks of information fall in place, and I began to understand how to get progress and make things happen here.

[00:19:27]

Tacey Ann Rosolowski, PhD

[00:19:27]

What were some of the first projects you were trying to work on when you were developing this knowledge about the matrix-versus-hierarchical systems that you'd been accustomed to?

[00:19:37]

Barbara Summers, PhD

[00:19:41]

Well, in the ambulatory care areas, my first week of employment I was thrown into a facilities planning meeting for the expansion of the clinic space, and it was at that meeting that I met an individual who's still a very close colleague, John Wright [phonetic], in the Facilities Division. John is a planner. And he and I both came into a meeting with one of the hematology department

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chairmen with a set of blueprints that had been signed off by this chairman and all the other chairmen, and we were under the impression, because we came from organizations where there was a very logical flow of information in decision-making, we believed that this was what was going to be happening, and we were just kind of reviewing it, only to have the department chairman very vocally express his displeasure with the plan and express his desire to have accommodations made that were totally asynchronous with the plan that was in front of us.

And I remember John and I looked at each across the table, and our eyes both got big, and I know at the same time we were thinking, “What have we gotten ourselves into in this place?” (laughs)

So we were able to very quickly kind of pull ourselves together and engage more senior leaders in the Division of Cancer Medicine and get some background and poll all the players at the table and start moving forward and gaining consensus, and really gained an appreciation for the fact that you have to over-communicate here to ensure that people are adequately informed and feel that they have an investment in an initiative and that their investment is honored and appreciated. Because the pace of activity is so high, and people become so busy, that one day blends into another, and it's not at all difficult for individuals to completely forget about plans that have been made, and then when they're presented with information, it's as if they had never been involved in the first place. So that just speaks to the need for just very clear communication. [00:22:09]

Tacey Ann Rosolowski, PhD

[00:22:10]

I just want to say I'm really glad you're talking about this, because you're being really clear about the operation of the institution, and that's actually a very special piece that this interview is bringing to the collection.

[00:22:10]

Barbara Summers, PhD

[00:22:24]

Okay. Well, good, good.

[00:22:25]

Tacey Ann Rosolowski, PhD

[00:22:26]

So I'm delighted that we're doing this, the “how it works” part.

[00:22:28]

Barbara Summers, PhD

[00:22:29]

Yeah. I mean, there was just a lot of imprecision in how things worked. I was in my position in

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the first month, and I was communicating with the business manager for the Center, and I said, “I’d like to sit down with you and take a look at our financials and see how things are going.” So we sat down and we looked at the clinical activity and the clinical revenue and the expenses, and I remember asking, “Well, what are the payer sources for the revenue?” And we didn’t have that information. I said, “Well, let’s talk a little bit more about the revenue side.”

And at that point in time, there was no detail behind the revenue. It was just amount of dollars that were posted to your company centers. And I remember just frowning my brow, and as this business manager would say, and raising one of my eyebrows, and just saying, “Well, do you ever get worried that because you don’t know where the revenue’s coming from, it could go away and you wouldn’t know it or you wouldn’t know why?” And, yes, of course, it had occurred to her, but there were no systems to address that. So that was very, very interesting.

And right around the time that I started working at Anderson, that was also the time that Leon Leach [Oral History Interview] was recruited and started working here. And Leon, I think probably maybe a year into it, a year and a half maybe into it, brought in Ben Melson [phonetic], who was the CFO. And Leon and Ben brought some rationality to the budgeting and finance piece of it so that things were transparent and there was much better understanding of what was going on.

Other challenges that I encountered were like the big challenge of how were we going to activate and operationalize this hospital. We were going to open up twelve floors of a new hospital building, and the facility itself had been designed down to the selection of paint colors by the former president, Mickey LeMaistre [Oral History Interview], who was a lovely man, but he had made all these little minute decisions about design with a few other people, and so the folks who were actually going to have to practice in the built environment had had no input into it at all. So we had to get our clinical teams in that facility as quickly as possible so we could start thinking about how care was going to be provided, because it was a different footprint than the existing hospital building. So that was a huge challenge.

And then, of course, there were, understandably, upsets because people were finding that there were built-environment decisions that were made that would have a profound impact on the way that care was delivered, but the people who delivered the care hadn’t been consulted.

[00:25:28]

Tacey Ann Rosolowski, PhD

[00:25:29]

You’re talking still in the Alkek Hospital?

[00:25:31]

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Barbara Summers, PhD

[00:25:31]

In the Alkek Hospital, yeah.

[00:25:32]

Tacey Ann Rosolowski, PhD

[00:25:32]

Okay. I was just curious if there were issues in other places in the institution.

[00:25:35]

Barbara Summers, PhD

[00:25:35]

No, no, but that experience, plus the construction experience in the clinic, really just hammered home for me the importance of casting a wide net and identifying stakeholders and always erring on the side of bringing more people to the table than fewer people to the table, because you have nothing to lose by getting more input.

So we kind of slogged through all of that, and then I discovered other challenges, such as we were actually going to be adding an additional large number of beds, and there had been no plan or provision put in place to hire additional staff to take care of the patients in the beds. So that was a big scramble. So I actually reached out to a leader back in Virginia who I had worked with many, many years previously, before I went to NIH, and I knew that she had progressed. She had completed her master's degree, and she was now in a much more senior leadership position. So I recruited her down to become the director of the Bone Marrow Transplant, Stem Cell Transplant Unit.

[00:26:53]

Tacey Ann Rosolowski, PhD

[00:26:53]

And her name?

[00:26:54]

Barbara Summers, PhD

[00:26:54]

Her name is Patty Johnston [phonetic], Dr. Patty Johnston. And that is one of the smartest things that I've done in the time that I've been here, because she's an outstanding leader and, golly knows, she was brave and took on the challenge and did a great job.

So, you know, just dealing with, again, the consequences of no infrastructure to guide you, I'm new to the organization, I'm trying to take the assignment I was given by one of my bosses—because I had multiple bosses—one of my bosses, to take care of the Alkek activation, and it was

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just a lot of learning in a short time.

[00:27:33]

Tacey Ann Rosolowski, PhD

[00:27:34]

Who were your bosses?

[00:27:35]

Barbara Summers, PhD

[00:27:36]

Oh, my gosh, I had many. I had John Crosley [phonetic]. Dr. Crosley was the former chief nursing officer. Wendy Austin [phonetic], who was the division administrator. Then, of course, the physicians all thought they were my bosses, so I had multiple people who were providing me with direction. But that's okay. I mean, you have to be able to work in a matrix organization successfully if you're going to be successful in this place.

So, you know, the other thing that I worked on at that time was professional nursing practice development, and I was fortunate to come into an organization where nurses and nursing practice were highly valued and very well respected, and that goes back to the legacy of Renilda Hilkemeyer [Oral History Interview], who was the very first chief nursing officer in the organization and a force to be reckoned with. Renilda really was one of the founders of oncology nursing as a specialty practice, and she set the tone way back when MD Anderson first started, of excellence in practice.

So I was really fortunate to be able to come into a place where nurses held themselves to extremely high standards of practice, and I viewed my role as not just an administrative director for the Hematology Center, but also director of clinical nursing. My role really was one of providing the environment so that nurses could excel in their practice, and that includes attending to their professional development needs, ensuring that the staffing plans were adequate to meet the needs of patients for nursing care, and also developing the nursing leaders who were managing these teams of nurses, both in the ambulatory areas and in the inpatient setting.

Chapter 14

A: The Administrator

Associate Vice President for Clinical Programs: Challenges and Views on Communication

Story Codes

D: On Leadership

C: Leadership

C: Understanding the Institution

A: The Leader

C: Mentoring

A: Character, Values, Beliefs, Talents

D: Women and Diverse Populations

Barbara Summers, PhD

[00:27:36]+

So I was very busy my first three years doing all of those things, and I started here in the administrative director position in September of 1997, and then around July of 2000, I was promoted to a position of associate vice president for clinical programs, working with Dr. David Callendar, who at that time was the executive vice president and physician-in-chief. And that was another one of these opportunities that presented itself. I was not looking for it, but I was in a meeting with David Callendar about some other issue—I don't even remember what—and in the meeting, he encouraged me to apply for the position. He made it clear that there were a number of other individuals also applying for the position. So he encouraged me to apply for it, and I investigated more what the position was about, because it would be entirely different from the work that I had been doing. It was really essentially serving as the chief of staff for the physician-in-chief, and I would have some direct reports, but I would not be administratively responsible for clinical operations.

As I learned more about it, I became very intrigued because it would have been extremely challenging, because the focus of this position would be in an area that I had no prior experience. I really would be very much focused on initiatives at the level of the organization, initiatives focused on faculty recruitment, retention, etc., working at a high level with senior faculty leaders in addressing challenges that they had. And I was also very intrigued at the opportunity to work with David. He's a phenomenal leader, and I liked him and I respected him.

So there was a very long process of interviewing, and it was a highly competitive group who came through the interview process, but in the end, I got the job offer, and I was just delighted when I got the call from David. So it was about July or August of 2000, I started in that position. And it was interesting, because my first week I was once again brought back down to the novice position where I had been three years previously. I had come into an organization, I was reduced

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to novice; I didn't even know where the restrooms were; there was no structures and systems; I had no network; I had no relationships. Now I came into a new position. I had never functioned in a role like that before. I at least did know where the restrooms were and I did have some relationships with people, but those relationships were not going to be the relationships that I would eventually call upon to be effective in my role.

So my very first week, I remember David came to my office and sat down and gave me an assignment to work with the laboratory medicine division on helping them to resolve some challenges that they were having regarding—I don't even remember what the specifics were. So I listened very intently and I wrote some things down, and he said, "So, are you okay with that?"

And I said, "Sure." I said, "I'll come to you if I have some questions."

And he said, "Okay," and he got up and left.

And I just sat there, and I thought, "What have I gotten myself into?" Because I really didn't know where to begin with it, other than pick up the phone and call some people that you know. So I did that, and I eventually ended up talking to people who had information that was beneficial and could allow me to be effective in assisting this division with the resolution of the challenges that they were having, that they were not able to do it on their own, because there was some external forces that were involved. So it was, you know, kind of crawling and then toddling along, and then I got up and I was running pretty quickly.

[00:34:16]

Tacey Ann Rosolowski, PhD

[00:34:16]

What did you learn? Because you said this was operating in a leadership role at a whole other level of the institution. What was the learning curve in terms of leadership there and what you were learning about yourself?

[00:34:32]

Barbara Summers, PhD

[00:34:34]

Well, there were a couple of things. One is that I was reminded again of the potential for a title to carry weight with every comment that a person makes. So with a title like associate vice president and the knowledge that I was working as the associate vice president for the physician-in-chief, anything that I would say could be taken and interpreted as speaking on behalf of the physician-in-chief or sharing private information or confidential information or giving insight or leads or even being perceived as using my title to accomplish work, rather than accomplishing work through collaboration and partnership with people. I had learned that previously in some of my first managerial roles, and it had really kind of faded to the back of my mind, but it came forward very loud and clear as I moved into this position, that just because of the title, people

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would pay unique attention to the things that I said as if they were, you know, profound edicts, and I was just really very impressed and reminded of the power of words and the context of the words.

The other thing, though, that I really learned about was forging effective partnerships with physician leaders and the fact that that was critically important in this organization, because this is an organization that is—I mean, we say “faculty-led.” I would say it is, yes, the people who are in official leadership positions, many of them are physicians, but it is certainly physician-focused. And that’s just the way that it is, and so if you’re going to be able to be effective and accomplish your work, you have to be effective at forging partnerships with physicians, and it’s in a very different way than you see in other healthcare institutions.

[00:37:04]

Tacey Ann Rosolowski, PhD

[00:37:05]

How so?

[00:37:05]

Barbara Summers, PhD

[00:37:06]

In other healthcare institutions, the administrative hierarchy really—they may bring physicians to the table and have them join in conversations, but the decision-making isn’t contingent upon whether the physicians are happy with or buy into a decision. So it’s just a different way of getting work done.

[00:37:27]

Tacey Ann Rosolowski, PhD

[00:37:28]

What difference does that make here, having it more directly physician- or clinician-led?

[00:37:33]

Barbara Summers, PhD

[00:37:35]

I think it makes it more challenging to get the work done, because we don’t have the structures and systems to meaningfully engage the faculty physician leaders and the rank and file in a way that results in durable decisions. So we have a great deal of difficulty still in disciplined decision-making and then evaluating the impact of the decisions and then going back and revisiting any aspect of the decisions based upon the evaluation.

I also at this time—you know, I was not focused on nursing at all. This was not a nursing-related position. And what I did learn was to become—I’m pretty sure I learned to become a more effective listener, because I remember getting feedback from my boss, David Callendar, that he

had observed in meetings when he and I would be meeting with individuals who could be particularly challenging, that my tendency was, instead of listening intently to what they were saying and trying to understand the underlying message, I was immediately formulating my response to what they were saying, and so it interfered with my ability to truly understand what was at the root of it. And once he pointed that out to me, that opportunity for me to become more self-aware, his holding that mirror up to me was invaluable, because then I really began to practice actively listening and taking that part of my mind that wants to have an immediate response and letting that rest. So I benefited from that.

Chapter 15

B: Building the Institution

As Chief Nursing Officer: MD Anderson's Magnet Designation; the Nursing Practice Congress; Primary Team Nursing

Story Codes

A: The Administrator

A: The Leader

A: Professional Path

A: Contributions to MD Anderson

B: MD Anderson Snapshot

B: MD Anderson Impact

C: Understanding the Institution

C: The Professional at Work

C: Discovery, Creativity and Innovation

C: Professional Practice

D: On Leadership

Barbara Summers, PhD

[00:37:35]+

Then there was the day, three years after I had been in this associate vice president position, the day when David came to me and offered me the position of the Chief Nursing Officer. And I was surprised, to say the least. The previous chief nursing officer, Dr. Crosley, had left fairly quickly, and David had offered me this opportunity. Initially I thought, "I don't know if I could do this, because I didn't have this on my radar and I don't know if I could be a Chief Nursing Officer." Then I stepped back and I thought, "But wait a minute. Who would he possibly bring in here who could do it better than me?" So I again took the position of, "I believe I have some fundamental skills that can be useful. I believe I have a passion for nurses and nursing practice that can promote advancements in the practice of nursing and that can benefit the nurses and patients in the institution. And, you know, nothing ventured, nothing gained."

So I said yes, and moved into the position, and it was definitely drinking from a fire hydrant, not even a hose. It was directly from the fire hydrant. There were multiple opportunities for us to look at nursing practice and how we could improve it and how we could strengthen it. We were in the cycle of preparing for our second Magnet nursing designation, and there were some areas that we really needed to work on and focus on to be able to authentically meet the standards for Magnet designation.

[00:41:50]

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Tacey Ann Rosolowski, PhD

[00:41:53]

Can you tell me about that? Since you brought up the Magnet, that was one of the things I wanted more information about that. What is that Magnet designation, and why is it so important to the institution to have that?

[00:42:04]

Barbara Summers, PhD

[00:42:06]

The Magnet designation is important from an external perspective as well as an internal perspective. External to the institution, it is a designation of excellence in nursing practice. It's a designation of the value with which nursing is held by the organization. It's an indication to nurses that this is a true magnet, in that you will be attracted to practice here because the practice environment is very supportive of nurses. It's an indication to patients and their families that the level of nursing care here is of the highest quality. So that's externally why it's beneficial.

Internally it's beneficial because to meet the standards for Magnet designation requires that the organization have in place all of these supports and structures to ensure that nursing is practiced at the highest level. So it requires that there be evidence of transformational leadership on the part of the chief nurse, but also the other nursing leaders in the organization.

[00:43:23]

Tacey Ann Rosolowski, PhD

[00:43:23]

What does that mean exactly?

[00:43:24]

Barbara Summers, PhD

[00:43:26]

It means that the—and I'll focus on the role of the Chief Nursing Officer. It means that as CNO, being a transformational leader, that I am involved in decision-making at the highest levels of the organization as they relate to clinical operations and patient-care delivery and will have an impact on nursing care and nursing practice. It means that as a transformational leader, I initiate change in the organization, both within and outside of nursing. It means that as a transformational leader that I engage the hearts and minds of the entire nursing community in pursuit of a goal or a vision. So that's what that's about.

And then another aspect of Magnet designation is around the concept of structural empowerment, and that really talks about how do we create the environments whereby nurses, clinical nurses are actually in charge of practice decision-making. And the way that we have done that here is through the development of our Shared Governance Model, which is our practice congress, our Nursing Practice Congress, which has actually evolved into an

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interprofessional practice congress.

[00:45:00]

Tacey Ann Rosolowski, PhD

[00:45:01]

I've not heard anything about this Nursing Practice Congress. Can you tell me more about that?

[00:45:05]

Barbara Summers, PhD

[00:45:06]

Yes. The Nursing Practice Congress is comprised of nurses as well as other healthcare professionals now—respiratory therapists, pharmacists, social workers, case managers, patient transportation, etc.—who are elected by their peer group to serve as Nursing Practice Congress representatives or delegates, and their responsibility is to come to Nursing Practice Congress and to make decisions about clinical practice on behalf of their constituent group. So, you know, I like to say it's what the United States Congress would look like if it were functional. And the beauty of the Nursing Practice Congress, or the Practice Congress, is that any clinician can bring an issue forward to the Practice Congress. An issue, idea, or a concern can be brought to the Congress. The Congress then listens to the individual presenting the issue and makes the decision whether or not it's an issue appropriate for the Practice Congress. And if it is, then the Practice Congress authorizes the creation of a team that will be focused on this particular issue.

[00:46:25]

Tacey Ann Rosolowski, PhD

[00:46:26]

Can you give me an example of something that would come up in the Congress?

[00:46:29]

Barbara Summers, PhD

[00:46:30]

Sure. One example was an issue that was brought forward that resulted in developing an algorithm to manage patients who were complaining of chest pain in the hospital that would allow nurses to initiate specific interventions while they were waiting for a physician to come and evaluate the patient. So, I mean, that was lovely because the end product was a nurse-initiated chest-pain protocol that would allow nurses to order an EKG and order specific laboratory tests to be done and to make sure there was an IV started if the patient didn't have an IV, while they were simultaneously calling for a physician to come and evaluate the patient. So that involved nurses working with cardiologists and the EKG technicians and Laboratory Medicine.

Another example, which I think was just lovely, is an issue that was brought forward to support patients who became physically ill while they were here as an outpatient and soiled their clothing

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because they had an accident of elimination, couldn't make it to the bathroom in time, or they had vomiting or whatever. This group came together—it was a very lovely interprofessional group—and created a process so that if that happened to a patient, that we would then have a team, small team, that would include a nurse that would come down and be with the patient, evaluate them, make sure they were stable, and then give them a pair of scrubs so that they could change their clothing, and also some toiletries so that they could get cleaned up so that they would be able to be comfortable and not have to be embarrassed and be in soiled clothing for the rest of the day.

[00:48:25]

Tacey Ann Rosolowski, PhD

[00:48:26]

Now, you talked about both of these examples as being lovely, and that's an interesting word that you've used to identify. What do you mean by that? What does that word mean when you say that's a lovely example of something happening?

[00:48:40]

Barbara Summers, PhD

[00:48:41]

It's lovely because the clinicians identified the issue, owned the issue, and resolved the issue, and that's what you want to see happen. You know, they don't want and they don't need and it's not good for me sitting in my chief nurse office to come down with decisions, because I am *not* at the front lines practicing. I am not the expert. So the thing that's most lovely is that these professionals are owning their practice and they're making their own decisions about their practice.

So the Nursing Practice Congress has been just tremendously successful and effective and has a very high rate of issue resolution. They have a database where they track all the issues that have been brought forward and what the resolution and outcomes have been. It's been really very good to see that, and it just continues to build that sense of professionalism among the nurses.

[00:49:36]

Tacey Ann Rosolowski, PhD

[00:49:36]

Now, just to clarify, is this congress unique to MD Anderson, or is it something that's happening in other institutions?

[00:49:43]

Barbara Summers, PhD

[00:49:44]

There may be some other institutions that have a congressional model. The first congressional model that I'm aware of was at the Inova Fairfax Hospital, and that's decades ago. And actually,

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when we developed our congress model, it was somewhat modeled after the Inova Fairfax Hospital model. Subsequently, other institutions have taken up this congress model that we developed, and they have implemented a variation of it in the organizations. It's not the norm. And most other hospitals have a councilor model where they have a council that looks at clinical practice, a council that looks at education, etc.

The thing that's unique about this model is that the delegates are elected by their constituent group to represent their constituent group, so the responsibility of the delegates is actually to communicate with their constituents to say, "This is the issue that's come up. This is the team that's been formed. Please get involved if you have an interest in this. These are upcoming decisions. If you have thoughts or input, please let me know."

[00:50:51]

Tacey Ann Rosolowski, PhD

[00:50:51]

And I see how what's unique about this model is precisely what you've described in those examples, that it comes from the front lines, it comes from the people who are hands-on. They're solving it. They're taking ownership and resolving the problems.

[00:51:06]

Barbara Summers, PhD

[00:51:06]

Exactly.

[00:51:07]

Tacey Ann Rosolowski, PhD

[00:51:08]

Very interesting.

[00:51:08]

Barbara Summers, PhD

[00:51:09]

So, structural empowerment, transformational leadership. Probably the most important standard for hospitals that are being redesignated, who've met the Magnet standards and are now in redesignation is the demonstration of our creation of new knowledge, improvements in practice and innovation. And over the years, the Magnet designation process has shifted from organizations reporting processes, like, "Oh, we have the Nursing Practice Congress and it meets once a month and we make sure we have 75 percent attendance to reporting outcomes." And so because you can't have outcomes if you don't have the processes in place, so now the focus is really on what are your outcomes, and the outcomes are of utmost importance when we're looking at new knowledge, improvements, and innovations.

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So as an example, in innovations, we have through our nursing Professional Practice Model, which is grounded in relationship-based caring and is based upon the Theory of Quality Caring developed by Dr. JoAnn Duffy, we have now built a new nursing care delivery framework in the hospital called Primary Team Nursing that involves creating a dedicated team of nurses and nursing assistant staff who provide care consistently to the same group of twelve or sixteen patients. And they are all scheduled together as a team, and they work under the guidance of a bedside clinical nurse leader, who is a master's-prepared nurse, but who is practicing at the bedside. This is not a manager. And they focus on continually improving the outcomes of their care.

So because they are practicing in a team with a clinical nurse leader, they are able to evaluate the outcomes for this small group of patients, and they're able to visualize in real time the impact of their practice and make adjustments to their practice so that they can improve the outcomes. It also significantly improves the continuity of care for patients and families, which results in greater satisfaction for the patients and families. They have a higher degree of confidence that their information is being communicated effectively and handed off from one nurse to the next nurse because they actually are seeing fewer nurses. They have the same care providers over and over.

It's greater satisfaction for the multidisciplinary team because they are interacting with fewer numbers of nurses, and so they are getting more consistent information about the patients. We are much improved in our continuity of planning and delivery of care because there are fewer people involved, and so we can maintain that consistency. And then there's tremendous benefit in satisfaction for the team, the nursing team, because they, number one, are a much tighter group, and so they come to know one another at a deeper personal level and they can celebrate their successes as a team. They also can see the fruits of their labor. They can actually observe from beginning to end what happens with a specific patient family who comes in to receive care in the hospital. So that's an example of an innovation.

[00:54:49]

Tacey Ann Rosolowski, PhD

[00:54:49]

Can you tell me more? The primary care teams was on my list to explore further. There was a lot of reporting on this in the MD Anderson internal media. Is now the time to delve into that a little more, or would you like to kind of talk about other issues that you were confronting in this first—

[00:55:11]

Barbara Summers, PhD

[00:55:12]

Well, I want to make sure that just we get a number of the issues out, and then we can come

Making Cancer History®

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back.

[00:55:15]

Tacey Ann Rosolowski, PhD

[00:55:16]

Sure, okay, we'll come back to it.

[00:55:16]

Chapter 16

A: The Administrator

Challenges in Nursing Today: Building an Expert Workforce

Story Codes

A: The Administrator

A: The Leader

A: Professional Values, Ethics, Purpose

A: Contributions to MD Anderson

B: MD Anderson History

B: Research, Care, and Education in Transition

D: The History of Health Care, Patient Care

D: Women and Diverse Populations

Barbara Summers, PhD

[00:55:16]

I mean, Primary Team Nursing is something we've been working very diligently on for the past two and a half years, but we have been planning for it for four years.

But other issues that we had included we had no succession planning, leadership succession planning, at all, and we had zero bench strength for leadership positions. So if a nursing leader left because their husband got transferred across the country, we had no choice but to externally recruit, because there were no people inside who were prepared to move into the position. So that was a key area of focus, and I wanted to ensure that we put together a pipeline for future leader in nursing, and we did that in a very intentional and deliberate way by creating what we called academic cohorts for individual nurses with the talent and the passion to move into leadership positions. We supported them in obtaining their master's degree in a leadership role. It could be an MBA or an MHA or a master's degree in nursing with a focus on leadership. And through that program, we were able to just significantly strengthen our bench strength so that we have been able to, by and large, recruit internally for promotion, although not exclusively, because you don't want an organization to become entirely inbred. There's always benefit in bringing in external individuals as well, but at least we have internal candidates that we can interview and consider for these opportunities.

The other major area that I addressed very early on in my tenure as the CNO is that when we brought new graduate nurses into the organization, we had no formal orientation program for them. They were treated just like any other experienced nurse coming into the institution. And I mean, that was just not a good practice, because it's well identified that when nurses graduate from their basic education, they need to have a clinical training period just like physicians do. When physicians graduate medical school, they go to a residency. We don't turn them loose and let them start practicing medicine, because they can't safely do that. Nurses can't safely do that

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either. So we created a graduate nurse residency program that we call Launch Into Nursing. It's a one-year program.

And at that same time, we made the decision to only hire baccalaureate-prepared nurses, no longer to hire associate-degree nurses. And as the nursing shortage has become more real with each passing year, as we have more nurses reaching retirement age than we do have nurses coming out of nursing programs, we have to rely heavily on recruiting new graduate nurses. So we recruit them by the busload. And this year in the spring graduates, I think we're hiring eighty new graduate nurses, and we pretty much hire no fewer than fifty with each graduating class. So we have graduates who come out in the spring and then come out in December. So we hire fifty and sometimes we'll hire two groups of fifty and stagger them, and that's how we're building the workforce of the future.

Now, that presents challenges because we have to have senior nurses to mentor these new nurses, and we can't underestimate the importance of that mentoring and taking the wisdom of our senior nurses and leveraging that to develop our junior nurses. But it has transformed the picture of the kind of face of nursing, particularly in the hospital setting.

[00:59:15]

Tacey Ann Rosolowski, PhD

[00:59:19]

The nursing shortage, a topic that comes up over and over again, what are the factors that are combining to create that?

[00:59:27]

Barbara Summers, PhD

[00:59:28]

There are a number of factors. First of all, the demand for nurses is going to continue to grow up because of the aging demographic of the United States of America. All of the baby boomers are getting older and they are consuming more nursing care. And as the baby boomers get increasingly older, they are going to require more healthcare, and healthcare involves nurses. So there's a greater demand by virtue of the aging population.

At the same time, the individuals who are in nursing, if you were to look at the demographic profile of registered nurses in the United States, the average age of a registered nurse is still probably forty-five years of age or north of that, and that's come down a bit in the last few years because of new graduates, but we are going to have an increasing demand for nurses at the same time that we have a lot of nurses who are baby boomers retiring, and we do not have graduates from nursing programs coming out at the same pace as we have retiring nurses.

[01:00:37]

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Tacey Ann Rosolowski, PhD

[01:00:37]

Why is that?

[01:00:38]

Barbara Summers, PhD

[01:00:39]

There are a couple of factors. One is that after the baby-boom generation made their career decisions, the next generation of individuals, particularly women, had multitudes of career options open to them, not just nursing. You know, when I was in high school, of course, you know, my parents would have been very supportive of me pursuing whatever I wanted to, but it was somehow understood that smart young women would go to college and they would become nurses or they would become teachers. That's changed. I mean, smart young women become engineers, they become attorneys, they do all kinds of things, so nursing was no longer one of the few professional opportunities available.

And then the profession of nursing went through cycles of having an excess of nurses, and when you have an excess of nurses and nurses start getting laid off, it becomes a less attractive career option. And in my time in nursing leadership positions beginning back in the 1980s, nursing has gone through cycles of shortages and then abundance and then shortages and then abundance. But we are now definitely in a shortage phase that's going to get worse over time. So we have more people retiring at the same time we have greater demand for nursing and nursing care and nurses, and we have Schools of Nursing that can't keep up the pace of graduating nurses to replace those leaving the workforce, never mind add additional nurses to the workforce.

So my job at MD Anderson is to make sure that we have a practice environment that is highly attractive to the best and the brightest young nurses, one that encourages our senior nurses to remain engaged in practice so that we can leverage that wisdom, and providing an environment where we can nurture and develop our young nurses to become experts in their practice. And then also designing models of nursing-care delivery that leverage the unique knowledge, skill, and ability of a professional registered nurse and that we eliminate non-nursing responsibilities from our professional nursing. Because nurses are very capable and very flexible, they often end up taking on responsibilities that they don't need—

[01:03:31]

Tacey Ann Rosolowski, PhD

[01:03:32]

How interesting.

[01:03:32]

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Barbara Summers, PhD

[01:03:32]

—and that are not part of their practice, but they do it because they're kind of all-purpose. They can do that, so why not have them do that? Well, the reason not to have them do that is because every task a nurse takes on that does not require the expertise of a professional nurse, that reduces the time the professional nurse can give to the patient. So you have to do that kind of risk-reward evaluation. Is it so important that the nurse take on this responsibility which is not in the realm of professional nursing practice, is it so important that we are willing to give the patient less nursing care?

[01:04:10]

Tacey Ann Rosolowski, PhD

[01:04:11]

Is that discussion about refining the role of the professional nurse, did that fall on receptive ears when you first presented it here at MD Anderson? Because it meant, obviously, that other individuals were going to have to pick up those roles.

[01:04:28]

Barbara Summers, PhD

[01:04:29]

You know, it's not an edict, and it's not a conversation that has a "by this date, we are going to." It's really an evolutionary process, and we have been working on the evolution most intently on the inpatient side, but I'm embarking upon the conversation with the ambulatory nursing leaders as well. But we have had the luxury of having an almost unlimited pool of registered nurses in the ambulatory clinics, which are doctors' office practices, and the consequence of that has been that because we had so many professional nurses, they'd do all kinds of things that did not necessarily require a professional nurse.

So now that we are having to address the very unpleasant reality that there are not as many of these professional nurses available now and certainly not in the future, we have to say, What are the most important contributions of a professional nurse in ambulatory care? And for those things that do not require a professional nurse, let's identify is that a medical assistant? If so, then let's shift our focus and let's bring in medical assistance to perform those roles, and let's reconfigure the role of the professional nurse to focus on nursing so that the doctors don't feel that they're getting less support, the patients don't feel that they're getting shortchanged in terms of their care experience. but we're very clear about how we are spending the dollars we're investing in nursing.

[01:06:00]

Tacey Ann Rosolowski, PhD

[01:06:02]

It's just about noon, and would you like to close off for today?

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[01:06:07]

Barbara Summers, PhD

[01:06:07]

Yeah.

[01:06:08]

Tacey Ann Rosolowski, PhD

[01:06:08]

And I'm hoping you can open up your schedule, because we certainly have a lot more things to talk about.

[01:06:12]

Barbara Summers, PhD

[01:06:12]

Absolutely.

[01:06:12]

Tacey Ann Rosolowski, PhD

[01:06:13]

Okay, great. Thank you.

[01:06:14]

Barbara Summers, PhD

[01:06:14]

Yeah. So, you know, the whole issue of the future of nursing, it's a challenging time that is filled with tremendous opportunity but tremendous risk as well, and I believe that in my thirty-some years in nursing practice, we are at a unique inflection point where nursing will either blossom into its true potential to influence the health of the community-at-large or there is the risk of it becoming irrelevant if it doesn't transform.

[01:07:02]

Tacey Ann Rosolowski, PhD

[01:07:03]

Interesting.

[01:07:03]

Barbara Summers, PhD

[01:07:08]

So we can kind of pick up after that and spend some time—I want to focus a bit on new knowledge, innovation, research. I want to talk about the development of the Department of Nursing with the faculty appointments. I want to talk about nurse scientists and the research that

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nurses are conducting. So, lots of things still to talk about.

[01:07:30]

Tacey Ann Rosolowski, PhD

[01:07:31]

Yeah. I look forward to it. Thank you.

[01:07:33]

Barbara Summers, PhD

[01:07:34]

Thank you very much.

[01:07:34]

Tacey Ann Rosolowski, PhD

[01:07:35]

And I'm turning off the recorder at about one minute after noon.

[01:07:37] (end of session two)

Barbara Summers, PhD

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Chapter 00C

Interview Identifier

[00:00:00]

Tacey Ann Rosolowski, PhD

[00:00:00]

We are now recording, and this is Tacey Ann Rosolowski. Today is April 29th, 2014, the time is 10:34, and I'm on the eighteenth floor of Pickens Tower in the Office of the Executive Vice President interviewing Dr. Barbara Summers.

This is our third session together, so thanks for making time for me in your very, very busy schedule.

Chapter 17

B: Diversity Issues

An Absence of Women in Executive Leadership at MD Anderson

Story Codes

A: Experiences re: Gender, Race, Ethnicity

B: Gender, Race, Ethnicity, Religion

A: Obstacles, Challenges

B: Obstacles, Challenges

C: Women and Minorities at Work

D: Women and Diverse Populations

B: Critical Perspectives on MD Anderson

Tacey Ann Rosolowski, PhD

[00:00:00]+

Before we turned on the recorder, you had started talking about issues of diversity and women and we kind of wanted to continue with that subject, so, please, the promotion of women, tell me what your thoughts are about this.

[00:00:45]

Barbara Summers, PhD

[00:00:46]

You know, I've been in the organization for nearly seventeen years, and in the course of that period of time, I have observed little progress in the arena of meaningful promotions of women and/or minorities, meaning persons of color, into positions of executive leadership in the organization above vice president. There have been a number of presentations, reports that have been written, you know, I would say gestures of appreciation for women, yet the executive vice president level and the president continue to be white males. And I'm not taking potshots at any of the individuals in the roles, because they are wonderful people and they are very talented. At the same time, I firmly believe that there are equally talented women who could serve in those leadership roles, equally talented men and women of color who could serve effectively in those roles.

[00:02:07]

Tacey Ann Rosolowski, PhD

[00:02:08]

What do you think the impediment is?

[00:02:09]

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Barbara Summers, PhD

[00:02:10]

I think the greatest impediment is self-awareness and the fact that the Executive Committee members, including Dr. DePinho, who lauds his wife appropriately but really doesn't see the importance of having that same approach as we're selecting other senior leaders, and then the four executive vice presidents, Dr. Burke, Dr. Leach, Dr. Dmitrovsky, Dr. Buchholz, and Fontaine, the executive chief of staff, our CFO is a white male. I mean, we could just go down the line.

So it's a pattern that repeats itself, and having had conversations with senior executives in the past about this challenge and this concern, I have been told—and this is in the past—"Well, look, Adrienne Lang is a member of the Executive Committee." And technically that was correct, but Adrienne Lang served as a vice president who was the chief of staff for the president. Adrienne Lang was not a key decision-maker in the organization. She did not hold the same power and authority that the executive vice presidents did. So that was actually, to me, quite dismissive.

And another time there was a response to me, "Well, look at all the women who are in clinical administrative director positions in the organization," which is effectively they're managers or administrators of clinics. I mean, just no insight into the fact that that is *not* the type of position that we're talking about. So we have that issue when it comes to administrative leadership, same issue when it comes to promotion of women into leadership roles in the faculty arena and to department chair roles and division head roles.

Shortly after I had been appointed as the vice president and chief nursing officer, probably within three months of that time to six months of that time, I was informed by my boss at that time that my peer, who was then the vice president of Ambulatory Operations, was being promoted to be a senior vice president, and this is a gentleman who was twenty years my junior, who had far less experience than I did in healthcare administration; not just nursing, but healthcare administration.

[00:04:44]

Tacey Ann Rosolowski, PhD

[00:04:45]

And this peer's name?

[00:04:45]

Barbara Summers, PhD

[00:04:46]

Gerard Colman. I mean, Gerard was very charming, but completely unskilled. And when I asked my boss why did that happen, why was I not even given the opportunity to compete for the position, the response I was given, "Well, that was just the decision that he and the president had made."

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So I went to the president at that time, Dr. Mendelsohn [Oral History Interview], and I said, “John, I would like to understand why I was not given the opportunity to be considered for the senior vice president position.

And astoundingly, his response to me was, “Well, no one would listen to a wom[an]—nurse.” And either way, that was so telling.

[00:05:29]

Tacey Ann Rosolowski, PhD

[00:05:29]

Yeah.

[00:05:29]

Barbara Summers, PhD

[00:05:30]

Because what he was saying to me is no one would listen to a woman nurse. I mean, I was just absolutely appalled, absolutely appalled.

So the problem hasn't gone away. Liz Travis [Oral History Interview] has devoted years to trying to influence to a greater degree in what's happening in the organization. She has been terrific as a mentor and sponsor for women and as an advocate for women, but her ability to be effective is limited by the people above her. So, you know, unless and until MD Anderson can get to the place where it recognizes that we need to have women who are bona fide members of the Executive Committee, not the chiefs of staff for the executive vice presidents, but bona fide members of the Executive Committee, we are going to be limited as an organization in our success.

[00:06:28]

Tacey Ann Rosolowski, PhD

[00:06:28]

How so?

[00:06:29]

Barbara Summers, PhD

[00:06:29]

Because there is a difference in a way that men and women lead. There is ample evidence that describes it. Not saying that men's leadership style and women's leadership style are superior one to the other, but recognizing that women bring a different approach to leading and managing, and women are particularly adept at working within teams and building teams and approaching the team as a community, engaged in a shared effort to achieve a vision.

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We don't have that here, which is why there continues to be starts and stops in engaging particularly the faculty in a trusting relationship, because we have an effort to do it, and it's being led by men who don't intrinsically understand or value the importance of teamwork. And they try hard to do it, but it's not a part of their DNA and they haven't honed that skill set, and so then they kind of drop it off and then we have to start again. So it's just an observation. I would like nothing more than to see that change.

[00:07:46]

Tacey Ann Rosolowski, PhD

[00:07:48]

Just quickly, how does MD Anderson stand in advancing in this area vis-à-vis other peer institutions?

[00:07:58]

Barbara Summers, PhD

[00:08:03]

I think when you look at other organizations, other big systems, you're going to find women in senior executive leadership positions, almost uniformly. You know, I'll just leave it at that. You can go out and look at the organizational charts of these organizations.

[00:08:21]

Tacey Ann Rosolowski, PhD

[00:08:23]

Okay.

[00:08:23]

Barbara Summers, PhD

[00:08:23]

And interestingly, very frequently you find women in senior leadership positions as CEOs or system-level COOs who have a background in nursing, because nurses who have advanced through the ranks of nursing leadership have become quite skilled in not only leadership, but operations, management, and administration. So MD Anderson is a bit of an anomaly.

I would say that Memorial Hermann System is similarly afflicted with a propensity to have white men in their leadership positions, but Methodist has women in senior leadership positions. Texas Children's has women in senior leadership positions. Catholic Health Initiatives, who's coming into the backyard, has women in senior leadership positions. UTMB has women in senior leadership positions. We're just kind of hanging out there and not in a good way.

[00:09:23]

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Tacey Ann Rosolowski, PhD

[00:09:25]

Well, thanks for addressing that. Shall we shift gears now—

[00:09:29]

Barbara Summers, PhD

[00:09:29]

Yes.

[00:09:29]

Tacey Ann Rosolowski, PhD

[00:09:30]

—and talk about some of the issues lingering from our last session [unclear]?

[00:09:34]

Barbara Summers, PhD

[00:09:35]

Absolutely.

[00:09:35]

Chapter 18

B: An Institutional Unit

The Division of Nursing: An Overview, the Professional Practice Model, and the Development of Nursing as an Autonomous Field

Story Codes

A: The Administrator

A: The Leader

A: Contributions to MD Anderson

C: Professional Practice

C: Understanding the Institution

D: On Leadership

D: The History of Health Care, Patient Care

B: Institutional Mission and Values

B: The MD Anderson Brand, Reputation

Tacey Ann Rosolowski, PhD

[00:09:36]

And where would you like to start? You had wanted to address the Nursing Practice Model and then wanted to talk about the Division of Nursing, and, I don't know how do those things come together. Where is a good place to start to tell that story and the relationship between those things?

[00:09:51]

Barbara Summers, PhD

[00:09:51]

Well, I think one place to start is to expand upon the definition, if you will, of Division of Nursing, because the Division of Nursing is not confined to the inpatient hospital administration. Actually, the Division of Nursing is not at all synonymous with inpatient operations. The Division of Nursing is the entire community of professional nurses at MD Anderson Cancer Center, so that includes all nurses practicing in clinical positions, in advanced practice nursing positions, in positions where they're supporting clinical research, so it really is the organizing structure for professional nursing practice.

One of the key responsibilities of the Chief Nursing Officer is to ensure that the members of the Division of Nursing are appropriately licensed and credentialed, that we are continually developing the knowledge, skills, and abilities of our professional nursing members, and that we are advancing the capacity of the professional nurses to govern their own professional practice. So that is very different from my role running the inpatient side of the organization and the hospital.

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And as we think about the Division of Nursing and the practitioners of nursing in the organization, an element that is critically important for nurses practicing in any setting is that we are able to reference a foundation that is our Professional Practice Model that describes the ways in which nurses think about their practice and engage in their practice. So we have probably in the last eight years really focused on our Professional Practice Model, and in the last three years we have completed an intensive review and revision of our Professional Practice Model, and that was accomplished through our nursing governance structure that included a team that was a cross-sectional representation of nurses practicing in every role at MD Anderson.

So the Professional Practice Model incorporates our core values of the institution of caring, integrity, and discovery, but it starts at the center with relationship-based caring. And the focus of relationship-based caring is that one feels cared for and feels cared about, and that is our Quality Caring Model. And interestingly, the relationship-based caring occurs with the nurse and the patient and family, the relationship with the nurse and the interprofessional teams members, the nurse and the community, but equally important, the nurse in relationship with self, having self-awareness and engaging in self-care. And this is a fundamental tenet from the Quality Caring Model from Dr. Joanne Duffy, who developed the Midrange Theory on Quality Caring, and her proposition is that unless one cares for oneself, we are hampered in our ability to engage in caring relationships with other individuals or teams.

Then the structures or components that support our Quality Caring Model include our patient care delivery system which we call primary team nursing, the notion of professional partnerships, which are the collaborations that we have internally as well as externally, internally with our interprofessional colleagues, externally with professional nursing colleagues, professional organizations, etc. Professional recognition is a key component of our Professional Practice Model where nursing expertise is visible, highly visible, and we make sure it's visible, that it's valued, and that nursing expertise is understood. Professional recognition also includes maintaining professional autonomy, where nurses continue to own the independent portion of their nursing practice.

[00:14:52]

Tacey Ann Rosolowski, PhD

[00:14:52]

Now, you've mentioned the issue of autonomy several times. Why is that such a key element?

[00:14:59]

Barbara Summers, PhD

[00:15:02]

Autonomy is a key element in professional nursing practice because when nurses receive their license to practice, they are, in fact, licensed to deliver nursing care to patients independent of any other interprofessional provider, so they do not have to rely upon physicians to write medical orders for nurses to engage in nursing practice to care for patients.

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There is an independent portion of practice in nursing. There is an *interdependent* portion of practice in nursing. It's in the *interdependent* component of our practice where we collaborate with physicians and other team members in the interdependent realm when a physician will generate medical orders and nurses will partner with the physician in carrying out those orders if it is, for example, performing a treatment with the patient or delivery a medication to the patient. But nursing practice is *not* defined by those things that physicians order for patients to be done. So it's very important that nurses continue to remind themselves and focus on the independent autonomous portion of their practice, which is what differentiates and defines the role of the professional nurse.

[00:16:27]

Tacey Ann Rosolowski, PhD

[00:16:30]

I picked that up and was thinking about kind of the traditional view of nurses that I remember from when I was a child, as doctor's helper.

[00:16:41]

Barbara Summers, PhD

[00:16:41]

Doctors' helpers. Exactly.

[00:16:42]

Tacey Ann Rosolowski, PhD

[00:16:42]

So it's interesting that this is now being theoretically built into the way that nursing is conceptualized and kind of addressing that old assumption. To what degree do people still hold that assumption about nursing?

[00:16:59]

Barbara Summers, PhD

[00:17:00]

I think that there is still a significant number of people who believe that nursing practice is, in sum, the carrying out of the physician's orders and being a doctor's helper. Nursing as an autonomous professional practice, though, has roots back into the 1960s. I remember as I was getting my baccalaureate degree in the seventies and we were studying nurse theoreticians and identifying the professional practice role of nurses at that time focusing on a theory of nursing called the Theory of Self-Care developed by Dorothy Orem, where the primary function of nurses was to serve as substitute self-care agents on behalf of the patient, performing for the agent those things that they would do for themselves if they could, if they were able.

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So that's why we emphasize in this Professional Practice Model our professional nursing values of autonomy, accountability, and excellence in practice. That's why we emphasize our nursing shared governance, which is a multidisciplinary shared decision-making body, but always keeping at the top of mind that our duty is to the patient as a nurse. That is our solemn duty to the patient and family, not to MD Anderson, not to the chief nursing officer, not to the president of MD Anderson, but my license says that my duty is to my patient.

And then—go ahead.

[00:18:35]

Tacey Ann Rosolowski, PhD

[00:18:36]

Well, I just wanted to ask you where this practice model came from. Is that something that you developed? Where did it evolve?

[00:18:44]

Barbara Summers, PhD

[00:18:44]

The practice model was developed by this team of nurses that I referenced earlier, who were formed out of our nursing governance structure called Nursing Practice Congress, which included a cross-section of nurses in all roles in the organization and involved an extensive review of the literature, going through a values-clarification exercise so that we would understand our professional values, selecting a theoretical framework for nursing practice.

And the Duffy Quality Caring Model was selected as the theoretical framework, identifying the structural components of our Professional Practice Model that include the professional recognition, the patient care delivery system, our shared governance structure, our professional partnerships and then taking Duffy's Quality Caring Model and focusing on what are called caring factors, eight caring factors in Duffy's model, which are the unique contribution of nurses to the caring relationship that occurs with patients.

You know, we don't believe, and Dr. Duffy doesn't state, that nurses are the only professionals who care for patients. *All* professionals who are healthcare providers go into the profession because they want to engage in compassionate, caring relationships with others, but nurses are the profession that uniquely use caring interventions to promote health and healing. So nurses use caring as a method of promoting health and healing in patients, so that includes such activities or factors as what we call mutual problem-solving, where nurses help patients and their family members to address, confront, and learn about their illness and their current health state and then enhance the ability of the patient and family to participate in decisions about their care. So that's mutual problem-solving. That's an intentional intervention on the part of nurses.

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Another intentional intervention that nurses use is something called attentive reassurance, where nurses make a conscious effort to be fully and authentically available to the patient and fully attentive to the patient, where we can reflect back to the patient what we are seeing them express to us, so that the patient can then have that clarity to begin the process of healing.

Nurses also, of course, provide care to meet the basic human needs of our patients, that we understand every human being has basic physiological needs, basic needs for love and belonging, basic needs for self-actualization, and we support patients in meeting those needs when they often can't do that for themselves.

So there are eight caring factors in our model that describe the ways that nurses practice which uniquely provide healing for the patient, in addition to the nurse's clinical skill set of being able to perform a physical assessment and identify abnormalities, and in addition to the nurse's ability to sit and teach a patient about a new medication, in addition to the nurse's ability to deliver medication that has been ordered by a physician, in addition to the connecting work that nurses do where they are communicating key points of information from the patient to other care team members or among the care team members.

So we've really intentionally focused a great deal of time, effort, and energy on our Professional Practice Model because we want nurses to continually be reminded of the unique professional contribution that they bring to the healthcare delivery setting so that they don't fall into the trap of valuing their worth in terms of how well they are helping physicians.

[00:23:19]

Tacey Ann Rosolowski, PhD

[00:23:21]

What is the impact—well, first let me ask when did you launch the Professional Practice Model and how have you seen its impact evolve?

[00:23:29]

Barbara Summers, PhD

[00:23:31]

Well, we had one when I became Chief Nursing Officer, although it was not well developed and well articulated, nor was it well understood by most of our nurses.

[00:23:40]

Tacey Ann Rosolowski, PhD

[00:23:41]

And you became—2003 is when you [unclear].

[00:23:44]

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Barbara Summers, PhD

[00:23:44]

2003. And probably in maybe 2006 we began a process of refining that Professional Practice Model, and we used the same approach of bringing together cross-section of nurses. We developed a Professional Practice Model that it was overly complicated to the point that it was even difficult for me to explain it, and it had no resonance with the clinical nurses because they couldn't understand it either, even though a group that included clinical nurses had developed it. It was just far too complicated and not practical.

So, consequently, we, in 2011, I think, began the process of again going back to basics and saying, "Let's start over again and develop a Professional Practice Model that includes our values, that speaks to the innate contributions of nurses, but let's create a model that has resonance with nurses at every level and that is something that has enough resonance that anyone can explain it." So that's kind of been the evolution over time.

[00:25:01]

Tacey Ann Rosolowski, PhD

[00:25:01]

And what's the impact now, now that nurses at MD Anderson are actively working with or kind of absorbing and working with this model?

[00:25:10]

Barbara Summers, PhD

[00:25:11]

You know, I think the impact is probably one of those intangibles, although in speaking with nurses—and actually I write monthly about the caring factors and the way I use these caring factors in my leadership practice, and I invite nurses to submit stories to me about the ways they apply their caring factors.

[00:25:37]

Tacey Ann Rosolowski, PhD

[00:25:37]

And you write about this in what venue?

[00:25:38]

Barbara Summers, PhD

[00:25:39]

In an email that's distributed to all nurses. So I think it just starts to get them to think about, "Okay, how do I use mutual problem solving with my patients?" and heightens their awareness. And then when I have the opportunity to speak with nurses and ask them about offering an encouraging manner with patients, like, "How are you conveying messages of support to your patients and their families? And how are you demonstrating your openness to individuals

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expressing their feelings? If they're particularly angry, how are you demonstrating your openness to hearing them talk about them?" It just allows them verbally to reflect on the ways that they are practicing nursing, which then just strengthens their identity as a professional nurse with an independent duty to their patient. So there's not like a meter that we use to measure nursing adoption or internalization of Professional Practice Model. It's really a culture—I don't want to say a change, but a culture enhancement.

[00:26:51]

Tacey Ann Rosolowski, PhD

[00:26:51]

And are other cancer institutions creating practice models of this kind? I mean, because one of the questions I wanted to ask you is, you know, what about oncology nursing here at MD Anderson vis-à-vis other cancer centers? How does this practice model enhance the strength of oncology nursing here?

[00:27:17]

Barbara Summers, PhD

[00:27:18]

Well, you know, I would say any top organization, top-performing organization, is going to have their own nursing Professional Practice Model, and the neat thing about it is that it has to be a model that is resonant with the nurses who practice in the organization and is reflective of the ethos of the nursing practice in the organization. So there can't be just a standard model that you plug and play in any organization. It really has to be an effort that is organic and grows out of the practice of the nurse. So there indeed other comprehensive cancer centers that have nursing Professional Practice Models that are different than our Professional Practice Model but that, nonetheless, have the same goal of providing the framework and structure for nurses to ground their professional practice.

[00:28:11]

Tacey Ann Rosolowski, PhD

[00:28:11]

Very interesting. Now, do you travel to talk about this practice model? Have you given papers on this practice model, I mean, sort of what the MD Anderson take is on Professional Practice—I mean, it's very interesting. Essentially it's a reflection of the culture and strengthening the culture.

[00:28:29]

Barbara Summers, PhD

[00:28:30]

It is. And the short answer to that is no, not yet. We've done quite a bit in terms of presenting and writing about our patient care delivery system primary team nursing, which is one component of the Professional Practice Model. I want to see papers written and presentations

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given about our Professional Practice Model and how it lives and breathes in our organization. But we've been, I think, more focused on deploying the model and having conversations with nurses regarding the model so that we really feel that it is deeply internalized and hardwired into their practice.

[00:29:15]

Tacey Ann Rosolowski, PhD

[00:29:16]

And how have you deployed the model?

[00:29:20]

Barbara Summers, PhD

[00:29:20]

Oh, there's an entire plan for the implementation, dissemination and implementation of the Professional Practice Model that involves the communication from the nursing leaders at every level as well as champions of the Professional Practice Model at every level and multiple types of communication that go out for the staff to consume on the PPM, and we have a brochure on it. We have areas of focus for what we call team huddles, which are very short staff meetings, where we focus on a component of the model, one of the structural components or one of the caring factors.

We highlight the use of the Professional Practice Model in our town hall meetings. We at Nurses Week this year are going to be focusing on the human caring factors as we celebrate Nurses Week during our big town hall—what we call the Dr. Summers Show. It's like a talk show. But I'm going to be giving away Nurses Week gifts that focus on, for example, basic human needs. So I'm giving away gift cards to local restaurants in recognition of basic human needs. So anyway, we just use lots of different strategies to get that out there.

[00:30:50]

Tacey Ann Rosolowski, PhD

[00:30:51]

And what's been the response?

[00:30:52]

Barbara Summers, PhD

[00:30:52]

Oh, I think nurses like it. I mean, it's great because it reminds us of what we do and what's unique about nursing and why we went into nursing to begin with.

[00:31:02]

Chapter 19

A: Overview

The History of Nursing at MD Anderson and Today's Activities

Story Codes

B: MD Anderson History

C: Portraits

C: Giving Recognition

Tacey Ann Rosolowski, PhD

[00:31:06]

Would you like to speak more generally about the Division of Nursing now, kind of an overview of the history of the division since you took over?

[00:31:15]

Barbara Summers, PhD

[00:31:16]

Well, I think I can just talk about my understanding of the history of nursing at MD Anderson, which is the Division of Nursing, and that is that when MD Anderson became an official cancer hospital, the first chief of nursing was Renilda Hilkemeyer [Oral History Interview], and Mrs. Hilkemeyer, who passed away a couple of years ago, was one of the founders of oncology nursing as a specialty practice. And MD Anderson was just so fortunate to have her as the first chief nurse in the organization. Of course, the organization was quite a bit smaller at the time, so she was a very hands-on leader in terms of she did the hiring of the nurses and she hired the nurse managers, etc. But, you know, that was a time when we had maybe a couple hundred nurses at most.

But what she did was to establish for the organization the value of nursing care to our patients and to be able to have a relationship with the president of the organization and the physicians within the organization that continually emphasize the important contributions of nurses and nursing. Mrs. Hilkemeyer also had a reputation for defending nursing and defending nurses and being a very strong advocate for nurses and for nursing practice. So she was the founder of modern oncology nursing in general, and then she was really the founder of nursing practice here at MD Anderson.

And then when Mrs. Hilkemeyer stepped down from her position, Joyce Alt became the chief nursing officer. This is all before my time here. Mrs. Alt, I think, was very helpful to the nursing profession in promulgating the role of the advanced practice nurse at the time, which was the clinical nurse specialist, and really focusing on elevating the practice of professional nursing within the organization, hiring very talented and highly educated nurses into leadership and management positions. So she took the work that Mrs. Hilkemeyer had done and then brought it up to the next level.

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And then following Mrs. Alt, Dr. John Crossley was the chief nursing officer, and he became chief nursing officer just prior to my arrival at MD Anderson in 1997. I think he arrived in '95 or '96. And Dr. Crossley brought, number one, an additional focus for nursing leaders on the stewardship of our financial resources, so ensuring that our frontline nursing leaders had the skills and understood their responsibility for managing human resources, fiscal resources.

He was also responsible for the development of our first Professional Development Model, called the PDM, which was a model that recognized that nurses develop as practitioners from novice to expert over a period of time. So he led a team that developed this structure called the PDM, where nurses would be hired in as novice and would advance along that continuum to advance, beginner, competent maturation and would meet specific performance criteria at each one of the levels. And that was really the first time we had a robust Professional Development Model. Prior to that, there had been something called a clinical ladder, which was more commonly found in other hospitals where you could be a Clinical Nurse I or a Clinical Nurse II or a Clinical Nurse III, but those were not really designed in the same way to highlight the development of professional capacities. So Dr. Crossley did a very nice job with that.

And he also led the organization to the first Magnet designation, which was a major step, and MD Anderson was, and is, a member of the Magnet Charter Hospitals, so we were one of the first fifty hospitals in the country to become Magnet designated. So he made those very important contributions to nursing practice at MD Anderson.

Chapter 20

A: The Administrator

Activities as Chief Nursing Officer; Creating a New Academic Department of Nursing

Story Codes

A: The Administrator

A: The Leader

B: Building/Transforming the Institution

A: Contributions to MD Anderson

B: MD Anderson in the Future

Barbara Summers, PhD

[00:31:16]+

And since my appointment as the chief nursing officer, I really view my role as carrying on the legacy of excellent chief nursing officers and I'm here to ensure that we are providing our nurses with the support and resources necessary to give excellent care to our patients. So the things that I have endeavored to focus on include taking the Professional Development Model developed under Dr. Crossley's leadership and convening a group to revisit that Professional Development Model, because it had been in place for probably twelve years, maybe more, and refining it based on our experience.

So that now has evolved into the Clinical Nurse Advancement Program, still taking the novice-to-expert concept but applying it very differently and now saying that there are basic role expectations for any professional registered nurse, and along the continuum, there are additional aspects of your professional practice that we expect to see evolving. The Clinical Nurse Advancement Program also put a stake in the ground and stated that every nurse will be required to have professional board certification by the time they have five years of clinical practice experience, which has not been noncontroversial. It has caused quite a little kerfuffle, because we were saying our nurses all have to be board-certified. And we've now moved past the kerfuffle and it is now accepted as that is the way it is, nurses have to be board-certified, because we need to be able to demonstrate to our patients and families that we have nursing professionals who are practicing at the highest level, and that is demonstrated by getting your board certification.

We also really worked on the Nursing Professional Practice Model, which I just finished explaining to you. We took the nursing governance structure, which when I became chief nurse was something called a council structure, where there were a number of different councils—a Research Council, Education Council, Practice Council—which had been somewhat effective but was limited in its ability to engage the frontline nurses in decision-making in a meaningful

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way. So there were individuals who volunteered for the councils and they made the decisions, but it wasn't truly representative of the large body of nurses.

So, again, I convened a team and charged them with coming up with a new model for our Nursing Professional Practice, and that team created our Shared Governance Model called Nursing Practice Congress, which it's been in place six years, I think, now, and is a fairly novel structure in that the Nursing Practice Congress is made up of nurses and interprofessional team members who are elected by their peers to serve. We talked about that.

[00:39:40]

Tacey Ann Rosolowski, PhD

[00:39:40]

You talked about that last time, yeah.

[00:39:42]

Barbara Summers, PhD

[00:39:42]

So that was a significant point of evolution for practice. I've also worked to really formalize our nursing workforce and development programs so that we could ensure that we have a pipeline of clinical nurses, advanced practice nurses, and nursing leaders for the future, and that's been an effort that I have had under way for probably the last eight years, and we continue to refine that. But it's been very, very successful. We probably have somewhere in the neighborhood of fifty to sixty doctorally prepared nurses in the institution right now, and we continue to have literally hundreds of nurses enrolled in academic graduate programs annually, as well as we've done a really nice job of developing and refining our new graduate residency program so that we now hire a hundred to two hundred new graduate nurses every year, put them through a residency program, and that's been quite beneficial to the nurses and to the organization.

[00:40:52]

Tacey Ann Rosolowski, PhD

[00:40:56]

You had wanted to address the issue of hires, too, faculty hires.

[00:40:59]

Barbara Summers, PhD

[00:41:00]

Mm-hmm. That was really—you know, people tell me, "Well, that will be one of your legacies," is that we were able to—I don't want to say "advocate." How about I was able to build on the professional history of nursing here at MD Anderson and the accomplishments of all the people who preceded me, and leverage a window of opportunity that presented itself to formally create a department, academic Department of Nursing within the organization that is equivalent to the other academic departments, whether it's an academic Department of Neurosurgery or an

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academic Department of Psychiatry or an academic Department of Thoracic Cardiovascular Surgery. We have a Department of Nursing.

[00:41:58]

Tacey Ann Rosolowski, PhD

[00:41:59]

Just so I understand the administrative structure, where does the department sit vis-à-vis the division?

[00:42:06]

Barbara Summers, PhD

[00:42:07]

The department resides within the division. Just as the Department of Neurosurgery and the Department of Thoracic Surgery reside within the Division of Surgery, the Department of Nursing resides within Division of Nursing. The key for the establishment of the department academic structure is that that's the framework necessary to appoint nurses to be members of the faculty at MD Anderson, and our physicians here are all faculty members, and they may have a component of education in their roles because we have fellows or residents here, but were not faculty like you would see in a School of Medicine or a School of Nursing. Yet the nursing faculty here within our Department of Nursing must demonstrate that they are making contributions in the areas of innovation and research, in service to the institution, in education of doctoral students or graduate students, and then in their area practice, whether it's clinical practice or administrative practice.

[00:43:18]

Tacey Ann Rosolowski, PhD

[00:43:22]

What was your strategy or rationale for fleshing out the hires within the department, this new department?

[00:43:29]

Barbara Summers, PhD

[00:43:31]

Well, really the purpose behind pursuing the establishment of the Department of Nursing is that we were having an increasing number of nurses pursuing doctoral studies here who had a passion for and an interest in becoming nurse scientists and conducting investigation using the same robust scientific method that physicians use, and to be having the same recognition as faculty members that the physicians have. So the establishment of the Department of Nursing allowed us to formally recognize we have doctorally prepared nurses who have the capacity to engage in original science, who can design and conduct their own studies, who do publish professionally, present professionally, who do participate in education and mentoring of doctoral students and graduate-level students, and who demonstrate expertise in their area of practice, whether they're

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an advanced practice nurse or a nurse leader in an administrative position. So that's been really great.

[00:44:44]

Tacey Ann Rosolowski, PhD

[00:44:45]

Was establishing a Department of Nursing controversial?

[00:44:48]

Barbara Summers, PhD

[00:44:49]

You know, interestingly, at the time it was not controversial, and the feedback that I got most often was, "I don't know why we didn't do this before." So as I presented the rationale to the various groups that had to approve the establishment of a new department, I never had anyone say, "Oh, well, this doesn't make any sense." I had people say, "Well, why didn't we do this earlier?" So that tells me that it was time, that people understood that there is legitimacy to the role of a nurse as an investigator in science and that that nurses can, in fact, sit at the table as a faculty member along with other faculty. So we did that, and I think I had my faculty appointment four years ago and started building the department, so I'm the chair of the department and I have the rank of professor, and we have four faculty in our department with some additional positions to fill over the coming years.

[00:45:52]

Tacey Ann Rosolowski, PhD

[00:45:53]

And what was the decision-making process for making those hires? Who are those four faculty members?

[00:45:59]

Barbara Summers, PhD

[00:46:00]

Well, the four faculty members are Dr. Joyce Dains and Dr. Anecita Fadol, F-a-d-o-l, and Dr. Robert Massey. And then I have a position under recruitment right now, so I can't give you a name for that. But each of them has a different area of focus. Dr. Massey is also a director of clinical nursing, with responsibility for our inpatient surgical units, and his program of research is in the area of postoperative recovery from abdominal surgery and pain management. Dr. Fadol is a nurse practitioner with specialty in cardiology and her area of research focuses on individuals who develop cancer treatment-related heart failure. And Dr. Dains is an advanced practice nurse who practices in cancer prevention, and she's also the director of our Advanced Practice Nursing Program. Her area of focus and research has been in the development of the advanced practice nurse workforce as well as development of tools to support advanced practice nurses in the community to effectively conduct cancer screening.

So the process of getting these individuals appointed to faculty positions is the same as any other faculty position here, which is the application had to be submitted to the Clinical Faculty Review Committee and was reviewed by that committee and had to be approved by that committee. So there were not less stringent requirements for nurses to be appointed faculty members. The requirements are identical for nurses or other physicians or other doctoral clinicians like clinical psychologists. Everybody has to meet the faculty criteria.

And I'm actually very pleased. The faculty have done very well. We are at a point where in their appointment they've been in their positions for three years, and we are now getting ready to complete their progress review, which occurs midway between the appointment and the six-year appointment they get reappointed. So the purpose of the three-year progress review is to get unbiased feedback from other faculty members that will help us in the continuing development and strengthening of our individual faculty members. And as we're going through their accomplishments, I'm just very delighted for them, because they've done very, very well.

[00:48:47]

Tacey Ann Rosolowski, PhD

[00:48:48]

It sounds like really a key landmark in the Division of Nursing to have that department.

[00:48:54]

Barbara Summers, PhD

[00:48:55]

Absolutely, have that department. It legitimizes the presence of nurses as clinical caregivers, as educators, and as scientists.

[00:49:07]

Tacey Ann Rosolowski, PhD

[00:49:10]

Now, you've mentioned the nurse scientist a number of times. Is there more that you'd like to talk about with that particular role? When you said "nurse scientist," I thought, of course, of physician scientist. Those are two parallel tracks.

[00:49:25]

Barbara Summers, PhD

[00:49:26]

Well, you know, we use the term "physician scientist" here in kind of an unusual thing. We call people a physician scientist if they spend 80 percent of their time in a laboratory doing research and then 20 percent of their time in clinical practice. The term "nurse scientist" is generally used in the profession of nursing to describe doctorally prepared nurses who are engaged in the design and conduct of original research. So it's not a designation of a percent effort in research. It's a

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designation of education, a degree, as well as the capacity to engage in original research.

[00:50:08]

Tacey Ann Rosolowski, PhD

[00:50:12]

Now, what's your future vision for the department? You're at the three-year mark now. What do you foresee in terms of an efflorescence?

[00:50:23]

Barbara Summers, PhD

[00:50:24]

Well, I have supported our faculty in submitting numerous grant applications. As the monies from the NIH are shrinking, of course, the application process is far more competitive. So we have successfully competed for some foundation funding, but we have yet to get a big NIH grant. We need to get that done.

One of my challenges is that I have multiple roles, and when an individual has multiple roles, it's entirely possible to be highly competent in many roles, but in my case, my competence as a department chair is limited when it comes to the procurement of grant funding. And that's not to say that the other department chairs in the organization are superstars in getting NIH funding, because they're not, but we are such a small department and my area of focus has been in research and administration and as an administrative leader, so I'm not an academician who has great expertise in developing the research portfolio of our faculty.

So I have been able to identify mentors for our faculty to help them, but I really want to see us hire a department chair who is not me, and I want us to bring in a department chair who has an established track record of grant funding, who is recognized as an effective nurse scientist and who can come in and take the department, and I will happily hand it to them and say, "Please take this and develop it to the next level."

[00:52:16]

Tacey Ann Rosolowski, PhD

[00:52:17]

What's the timeline for getting a new department chair?

[00:52:19]

Barbara Summers, PhD

[00:52:19]

Oh, I don't know what the timeline is for that, you know. As we had our change in leadership structure, I had had a commitment to move forward to hire a chair, and then financial exigencies presented themselves and there were holds put on recruiting, even for people who had just been

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recruited into leadership positions and given commitments for packages to hire faculty. They were not allowed to hire faculty.

So my desire to bring a chair into my department is not a high priority, although I'm going to surface that again with my executive vice president bosses, the provost and the physician-in-chief. Because I'm very good at what I do, but even I have limitations. (laughs) Even I have limitations, and I feel that if I want to act in the best interest of the department and in the best interest of building the academic capacity of our faculty in our department, I need someone who has more expertise than I have.

[00:53:24]

Chapter 21

A: The Administrator

Promoting “Top of License” Nursing Practice; the Future of Nursing at MD Anderson

Story Codes

A: The Administrator

A: The Leader

B: Building/Transforming the Institution

A: Contributions to MD Anderson

B: MD Anderson in the Future

C: Professional Practice

C: The Professional at Work

D: The History of Health Care, Patient Care

Tacey Ann Rosolowski, PhD

[00:53:27]

What about other roles in the division or, say, your future view for the division as a whole?

[00:53:37]

Barbara Summers, PhD

[00:53:39]

You know, I think that we as a division and as a community of professional nurses have a huge challenge ahead of us in redefining the practice of professional nursing and ensuring that we are able to evaluate our most significant contributions and then design the role around those contributions. It's commonly referred to as ensuring nurses are practicing at top of license.

Nurses and any professional actually can, but nurses are particularly vulnerable to falling in the trap of taking on responsibilities that don't require the preparation of a baccalaureate-prepared professional nurse but—

[00:54:29]

Tacey Ann Rosolowski, PhD

[00:54:29]

Yeah, I think last time we talked about how you—

[00:54:30]

Barbara Summers, PhD

[00:54:30]

Yeah, because nurses are very flexible and very smart, they do take on roles that are not necessary for them to take on. So we—I mean, this is going to be a huge, huge undertaking. We've already launched some of that in the inpatient area, and we're starting to have

conversations in Ambulatory Care, but it's going to require us to rethink the way that nurses come to work every day.

In Ambulatory Care, for example, as nurses come into their practice environment every day, in the future, in this future world, they're going to be practicing collaboratively as a member of a team that will include a physician and will include probably mid-level practitioners and will include a medical assistant or two or three, but the nurse will not be functioning primarily as a doctor helper. The nurse will be there functioning as a coordinator of care for the patients and as a navigator for the patients, helping the patients to transition the continuum of care to ensure that the patients are doing the follow-up that's necessary, communicating with the patients regarding their responses to treatment, a totally different focus than what they spend their time doing today. [00:55:47]

Tacey Ann Rosolowski, PhD

[00:55:49]

Do you anticipate that there's going to be some pushback on redefining nurses' roles in that way? I mean, I can just imagine at a personal level, you know, you've got a group of people, "Well, wait a minute, so-and-so's always done that. Why do we suddenly have to change and someone else has to take on that role?" What are your strategies, your visualizing for addressing those kinds of on-the-ground issues?

[00:55:49]

Barbara Summers, PhD

[00:56:13]

Well, I absolutely do think that there's going to be resistance, particularly in those circumstances where we have physicians and nurses who've been working together for ten, fifteen, twenty years. So we have to be realistic as we're planning for the transition. We need to ensure that we have stakeholders involved and not driving the definition of nursing practice, but involved so that they understand the thinking behind the way that we are defining nursing practice, having the stakeholders involved in articulating what is the assistance that they need, particularly in the outpatient area.

When they look to the nurses to be their helpers, what is it that they're needing help with? And changing the paradigm from the perception that we're taking something away from the physicians to one where we actually are going to be keeping the nurses and allowing them to serve the patients more comprehensively. At the same time, we're going to be giving you more medical assistant help. So you're going to continue to have all the help that you need, and we're going to have the nurses engaged more effectively with the patients.

And then recognizing that not every nurse is going to want to make this transition, nor is every nurse currently employed here going to be able to make the transition, and so having a period of phasing where we don't say, "Off with your heads if you can't function in this new role. Then

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you can't work here," but having a period of time where hopefully those nurses who can't make that transition are towards the end of their career, and as they retire, we fill the position but not with someone functioning in exactly the same way. It's a huge culture change. It's going to take us a number of years to make this happen.

[00:58:06]

Tacey Ann Rosolowski, PhD

[00:58:06]

Yeah. I'm just kind of getting my head around that, it seems, and, you know, working with shifts in self-awareness and how identity—

[00:58:14]

Barbara Summers, PhD

[00:58:14]

All of that. How do nurses think about their practice.

[00:58:16]

Tacey Ann Rosolowski, PhD

[00:58:16]

Right.

[00:58:16]

Barbara Summers, PhD

[00:58:17]

We do have nurses and nursing leaders in Ambulatory Care who understand the opportunity here, but that doesn't mean that there is not going to be tremendous resistance, because there will be.

[00:58:31]

Tacey Ann Rosolowski, PhD

[00:58:31]

Interesting.

[00:58:34]

Barbara Summers, PhD

[00:58:34]

So it's not at all uncommon in the clinic to have a physician say, "Well, Barbara is *my* nurse," or for the nurse to say, "Oh, I'm Dr. Smith's nurse." And, in fact, the last time I heard a nurse say that, and I said, "Goodness," I said, "you know, what would you think about instead of saying, 'I'm Dr. Smith's nurse,' if you just introduced yourself and said, 'Hi, I'm Cynthia Strong, and I'm the registered nurse who practice with Dr. Smith'?" She looked at me like I had five heads. (laughs)

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So I think that that would be a good, like, thermometer to tell me about the potential obstacles that we have, that she thought it was perfectly fine to describe herself as being Dr. Smith's nurse, as if she had no identity herself. You know, her identity was only in the context of Dr. Smith.
[00:59:34]

Tacey Ann Rosolowski, PhD

[00:59:35]

Now, is this a generational thing? Are nurses who are graduating now less likely to have that kind of paradigm?

[00:59:41]

Barbara Summers, PhD

[00:59:42]

Well, I think to the extent that we can leverage new graduate nurses and help them not fall into that trap, that would be tremendously helpful.

[00:59:49]

Tacey Ann Rosolowski, PhD

[00:59:49]

Well, I'm also thinking, too, you know, with the movement that you are fostering to establish credibility, establish autonomy, I mean, it's giving women their own identity as practitioners, so that I'm getting a sense now of how this is part of not only culture, but redefining how nurses understand themselves and what they do.

[01:00:13]

Barbara Summers, PhD

[01:00:13]

Right, right. You know, you're not Dr. Smith's nurse; you're Patient Jones' nurse.

[01:00:18]

Tacey Ann Rosolowski, PhD

[01:00:18]

Right.

[01:00:19]

Barbara Summers, PhD

[01:00:21]

So we need to think about who is our duty to. Our duty is to the patient, not the physician. Our duty is to the patient, not the institution; that we don't come to work to help Dr. Smith, we come to work to provide care to the patients and to collaborate with Dr. Smith.

[01:00:35]

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Tacey Ann Rosolowski, PhD

[01:00:35]

Or even we come to work to develop our own capacity to provide care—

[01:00:39]

Barbara Summers, PhD

[01:00:39]

Absolutely.

[01:00:39]

Tacey Ann Rosolowski, PhD

[01:00:39]

—and the first person who receives that is the patient.

[01:00:41]

Barbara Summers, PhD

[01:00:42]

Right.

[01:00:42]

Chapter 22

B: Building the Institution

The New Healthcare Delivery System; Nurses and Work with Patients and Families; the Future of Nursing

Story Codes

A: The Administrator

A: The Leader

B: Building/Transforming the Institution

B: MD Anderson Snapshot

B: Multi-disciplinary Approaches

B: The Business of MD Anderson

B: MD Anderson Culture

B: MD Anderson in the Future

D: Fiscal Realities in Healthcare

C: Professional Practice

D: The History of Health Care, Patient Care

C: Understanding the Institution

C: The Institution and Finances

A: Career and Accomplishments

Tacey Ann Rosolowski, PhD

[01:00:42]

Interesting. Very interesting. Yeah.

I'm wondering how some of these issues dovetail with some of the challenges that are arising from changes in the healthcare delivery system. When I was doing background research, that came up over and over again as something that you have to address. Could you talk about what some of those changes are and then how these movements in nursing practice are addressing them?

[01:01:15]

Barbara Summers, PhD

[01:01:17]

Well, there are almost, you know, a mindboggling number of challenges in healthcare today. Some of the challenges that come to top of mind for people most frequently include the financial pressures, and in combination with the financial pressures we have the expected shortage of workforce members to deliver care. Physicians, nurses, every type of healthcare worker are going to be in short supply. Then we have the need to significantly improve the attitude towards and structures and systems that allow us to meaningfully engage patients and families as partners in their care. Those are just three things that are happening right now, and you can just add on to

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that the requirement that every organization demonstrate the value that they're contributing to the health of the individuals that they care for.

So when I think about those challenges, the good news is that they're related and that you can tie one to the other. The better news is that we have very good initiatives already under way that are designed to address these challenges, that we have a very strong Workforce Development Program for nurses, that we are refining our patient care delivery system for nursing practice that will allow us to elevate the practice of nurses so that nurses will be practicing at top of license, which will mean that as we have a shortage of professional nurses, we will be prepared to address that through our pipeline, but also by having refined the practice of the nurse so that we will not need as many professional nurses as we have right now, because we will have nurses practicing at the highest level and not serving in the role of the medical assistant.

And then the hiring of educationally baccalaureate-prepared nurses and providing them with professional development so that they become skillful in the art of engaging patients and families as members of the team that makes decisions about their treatment. And to be able to do that, nurses have to, number one, themselves become activated and engaged and believe in the importance of patients and families as partners, not just passive recipients, but active partners. And then the nurses have to become skillful in activating the patients and the families and using our nurse-caring factors to bring the patients and families to the point where they believe they have the capacity to be members of the team.

And then promoting health literacy with our patients, so that the patients make informed decisions and have the capacity to ask the right question so that as decisions are made in partnership with the patient and family, it's truly informed, and they understand the entire array of options and the consequences of each of the options.

[01:04:48]

Tacey Ann Rosolowski, PhD

[01:04:48]

Now, working with families is, of course, something that I've heard a number of clinical MDs, clinical faculty, talk about, but it also seems that the nurse is uniquely placed to work with that because the relationship is so—perhaps there's more contact with a nurse, and the relationship is established there. Can you tell me more about that, sort of the nurse in the family dynamic, the nurse in the dynamic of the patient psychology?

[01:05:25]

Barbara Summers, PhD

[01:05:26]

Well, you know, one of the areas of focus in nursing education is, number one, the paramount belief that the patient is the family; the patient is not the person. The patient is the family. And nurses are exposed to Family Systems Theory in their education because we understand that no

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individual comes to us as an independent human being without contacts with other human beings in their lives. They come to us with a constellation of relationships. They have relationships within their nuclear family. They have relationships within their work family. They have relationships within their community family, their church family.

So understanding that the individual who presents with the identification of patient has multiple attachments, and in the context of cancer care, these attachments physically come with them everywhere they go. So you almost never see a patient by themselves in the organization. They always have family with them—one, two, three, four, five family with them.

And I would say that the culture of the organization is one that is accepting of the fact that the patients and the families are always together. I think that our physician colleagues have an understanding of that dynamic of patient comes with family. I don't believe that they have the same formal educational exposure to the importance of family and the family unit, and the fact that then contributes to the very pressing need for us to be thinking about treatment in the context of family, not only how is the family going to help the patient, which I think is kind of where most of the physicians focus, but what is this experience of cancer going to mean in terms of the roles of the individuals in the family.

If the individual with the cancer diagnosis is the husband, and he has been the primary wage earner and he has a wife who has been working a part-time job, and some adolescent children, and the husband becomes profoundly debilitated because of the cancer treatment, well, then the roles change at home. The wife's role changes, the adolescent children's roles change, and that change can have a dynamic that can be very detrimental to the family unit, can be an impediment to healing for the patient, so you have to be—
[01:08:12]

Tacey Ann Rosolowski, PhD

[01:08:12]

Now, just thinking about the level of depression and—

[01:08:12]

Barbara Summers, PhD

[01:08:13]

Oh, my gosh, you have to be attentive to all of that.

[01:08:14]

Tacey Ann Rosolowski, PhD

[01:08:14]

—masculine identity, all of these issues.

[01:08:16]

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Barbara Summers, PhD

[01:08:17]

All of that. So I think nurses are, just by virtue of our education, more attuned to the fact that the patient and the family really are the unit together, and understanding that there is family that extends beyond the biologic relatives, that people can, and do, benefit from having the support of their co-workers and the support of people, if they are part of a faith community, the support of people in their church community.

So, again, MD Anderson, I think, accepts patients and families coming together. We understand that they travel as a pack. But we haven't really gotten our arms around true patient and family engagement as partners in decision-making. How do we meaningfully engage them in decision-making? And we're more in the stages of informing the patients who have the family sitting next to them of the, you know, let's say, two or three treatment option and then kind of recommending one. So that's kind of using a consulting model. That's not really engaging the patients and families fully. It's not bad, but we could do better, because if they are truly engaged, then they take ownership for the way that they can contribute to the outcomes instead of just being recipients of care.

[01:09:49]

Tacey Ann Rosolowski, PhD

[01:09:49]

Now, is this developing beyond this consulting model? Do you have initiatives in progress?

[01:09:57]

Barbara Summers, PhD

[01:09:57]

Oh, yes, we do, and lots of other healthcare institutions do too. I mean, there was a report in 2012 by the Institute of Medicine on the need to radically change healthcare that highlights the importance of patient and family engagement. And then in 2013, the Institute of Medicine put out another publication focused specifically on cancer care, and that singled out the necessity for patient and family engagement as partners in care delivery and care decisions.

[01:10:29]

Tacey Ann Rosolowski, PhD

[01:10:29]

What are some of the initiatives that the Division of Nursing is taking to develop this?

Let me just pause this for a second.

[01:10:38] (end of first audio file)

[The recorder is paused.]

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Tacey Ann Rosolowski, PhD

[00:00:00]

Okay.

[00:00:00]

Barbara Summers, PhD

[00:00:04]

So this is not an initiative that can be run by nursing. Nursing has to be an integral part of it. So we have an institution-level Patient and Family Experience Steering Committee Executive Committee, and we are working with physicians and social workers and all the members of the team in designing our strategic plan, forming our Patient and Family Advisory Council, etc. I am one of the executive cosponsors for this effort. I have a physician who is also my partner and executive cosponsor.

[00:00:49]

Tacey Ann Rosolowski, PhD

[00:00:49]

And that is?

[00:00:50]

Barbara Summers, PhD

[00:00:50]

Dr. Marshall Hicks in Radiology. He's the division head in Radiology.

What I would say is that we are just launching this as an organization. The Inpatient Nursing Operations has been focusing very extensively on our patient experience and patient engagement strategies for probably five years, and two years ago, I created a position for director of Patient and Family Engagement, and that person now actually leads the Patient Experience Steering Committee. She has a physician partner, but she really is the driving force behind that. So I think that we have brought this to an acute level of awareness. We've been able to demonstrate the enormous progress that has been made in our patient experience. Scores for the inpatient areas, we now have to find equivalent success in Ambulatory Care, which we don't have yet.

[00:01:56]

Tacey Ann Rosolowski, PhD

[00:01:57]

Mm-hmm. Interesting. Wow. This has been such an interesting conversation, because, I mean, as I said in the very first session, I really realize that I didn't know what nurses do. (laughs) And so here's a whole other area that's just opened up, quite amazing, and also obviously opening up the future of the field as well.

[00:02:21]

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Barbara Summers, PhD

[00:02:21]

Yes.

[00:02:21]

Tacey Ann Rosolowski, PhD

[00:02:22]

It's an enormous transformation, adding a whole new facet. Are there other ways that you're addressing changes in the healthcare delivery system? We've listed these various areas and we kind of exhausted those at that point: the financial pressures, the shortage of workers, the need to improve the attitudes, which we just talked about, and the demonstration of value of [unclear].

[00:02:52]

Barbara Summers, PhD

[00:02:53]

Yeah, I think the demonstration of value and financial pressures go hand-in-hand. We have to be able to demonstrate, to prove that we are continually improving the quality of outcomes while we are simultaneously reducing costs, not to a point of zero, but to a point where we are getting the best value, which is the highest possible outcome at the lowest possible cost.

Tacey Ann Rosolowski, PhD

[00:03:24]

And how are you going about assessing that?

[00:03:26]

Barbara Summers, PhD

[00:03:27]

Well, we're actually, as an organization, engaged in a very formal activity called time-driven activity-based costing, and we're doing that in partnership with some folks up at Harvard Business School, Dr. Michael Porter [phonetic] and Dr. Bob Kaplan [phonetic].

[00:03:42]

Tacey Ann Rosolowski, PhD

[00:03:42]

I'm sorry, the name of that was time-driven—

[00:03:44]

Barbara Summers, PhD

[00:03:44]

Activity-based costing, TDABC, where we work with clinical teams to understand the contributions of each member of the clinical team to the delivery of care to patients, and then using a costing model, we assign the dollars that are required to perform that activity, and then

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we determine how many times that activity is performed by which level of provider, and from that we can demonstrate the cost.

[00:04:16]

Tacey Ann Rosolowski, PhD

[00:04:16]

Wow.

[00:04:17]

Barbara Summers, PhD

[00:04:17]

And then we are measuring the outcomes of care, both the patient-reported outcomes as well as the clinical outcomes. And our goal then is to use the TDABC information to review each of the individual clinical team member contributions and identify do we have the right people performing the right work. And that's where we start to look at redefining roles and responsibilities and optimizing the skills and the training of every member of the team and focusing them on those things that they uniquely can contribute.

[00:04:57]

Tacey Ann Rosolowski, PhD

[00:05:01]

Do you anticipate that this result in a lot of changes?

[00:05:04]

Barbara Summers, PhD

[00:05:07]

I think that the need to improve value is going to result in tremendous change across healthcare. I think that we're challenged, number one, to figure out how do you measure it.

[00:05:18]

Tacey Ann Rosolowski, PhD

[00:05:19]

Right.

[00:05:19]

Barbara Summers, PhD

[00:05:19]

I mean, that's just a huge challenge in healthcare in general. We tend to measure value in terms of what bad things didn't happen. We have much more difficulty in quantifying what are the good things that are supposed to happen. So that in itself is a change. When we look at nursing quality data, really it's defined in terms of bad things that don't happen. We look at our rate of fall. We look at the rate of pressure ulcers. We look at the rate of infections of central venous

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catheters. Those are all bad things, and so we want to reduce the numbers of those bad things, but we have a difficult time—same thing in medicine—very difficult time defining what are the good things that we're supposed to see. So when you look at medicine, you tend to measure, for example, in cancer, are we delivering cancer care treatment which is in alignment with the accepted treatment algorithm for this particular diagnosis.

So in healthcare, we're just generally challenged to define a positive outcome. With cardiac care, we look at, okay, how many readmissions have you had to the hospital for heart failure? Well, that's measuring a negative event, because we have a hard time defining what are the positive things.

So, yeah, we have a lot of change ahead of us, a lot of change ahead of us, *and* we have to incorporate patient-reported measures. We can't just be looking at our processes. We need to include the perspective of the patient and what are the patient-reported measures, and beyond that, what are the patient-reported measures that are of importance to the patients, because there's an entire universe of patient-reported outcome measures, called PROMs, but there has been very little work done in identifying which of these PROMs are actually important to patients. We've had patients help us design the instruments to measure these things. What we haven't spent a lot of time figuring out, okay, we've got all of these measures, but which ones do you really care about? So they've been designed based on what clinicians think patients care about. So it's an exciting time.

[00:07:31]

Tacey Ann Rosolowski, PhD

[00:07:32]

Very exciting time.

Tacey Ann Rosolowski, PhD

[00:07:32]

Well, we have a little less than ten minutes left, and I wanted to ask you, first of all, if there's anything else you want to add on subjects that we've already touched on.

[00:07:43]

Barbara Summers, PhD

[00:07:44]

I can't think of anything right now.

[00:07:46]

Tacey Ann Rosolowski, PhD

[00:07:46]

Okay. Well, then my next question would be what are the next projects that you want to see

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implemented in your role as VP of Nursing and for the division. I mean, is there anything not yet on the table but something that you really want to see put in place?

[00:08:06]

Barbara Summers, PhD

[00:08:08]

You know, I think just building on the things that we have initiated. I want to see us build on our nursing care delivery model, primary team nursing. I want to see us really redesign the role of the professional nurse in oncology care. I want to see us build our body of nursing science. I want to see us continue to advance the level of educational preparation of our nurses. I want to see us as an organization become highly skilled in the area of patient and family engagement.

So I want to see us take these things that we've been talking about and optimize them and get us to the point where we are the best of the best in each of those arenas, with the goal that we are focusing on the patients and families that we serve and that we are also focusing on getting the best possible experience for the people who take care of the patients and families.

[00:09:15]

Tacey Ann Rosolowski, PhD

[00:09:17]

And how would you like to be remembered? I know retirement's not on the deck yet, but looking now at kind of what you've done here at MD Anderson, how would you like to be remembered?

[00:09:29]

Barbara Summers, PhD

[00:09:31]

I think I'd like to be remembered as, first, a nurse who was an effective leader in advocating for the advancement of professional nursing and the improvement of outcomes of care for our patients. I think on a personal level, I'd like to be remembered as being inspirational and aspirational and someone who challenged and encouraged others to be their very best.

[00:10:10]

Tacey Ann Rosolowski, PhD

[00:10:12]

Is there anything else that you'd like to add?

[00:10:14]

Barbara Summers, PhD

[00:10:14]

I can't think of anything. It's been a delight, though.

[00:10:18]

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Tacey Ann Rosolowski, PhD

[00:10:19]

Yeah, I've really enjoyed talking to you. It's opened a whole new window on the institution for me, certainly.

[00:10:24]

Barbara Summers, PhD

[00:10:24]

Well, I appreciate the opportunity.

[00:10:26]

Tacey Ann Rosolowski, PhD

[00:10:27]

Well, thank you very much for your time, Dr. Summers.

[00:10:29]

Barbara Summers, PhD

[00:10:29]

My pleasure. Thank you.

[00:10:30]

Tacey Ann Rosolowski, PhD

[00:10:31]

And I'm turning off the recorder at 11:55.

[00:10:35] (end of session three)