CATHERINE GILLISS

November 8, 1996

Dr. Fitzhugh Mullan,
Interviewer

Mullan: Date of birth?

Gilliss: April 18, 1949.

Mullan: The date is the 8th of November, 1996, and we're in Dr. Gilliss' office at the University of California-San Francisco Medical Center campus, on Parnassus Street. We're in front of Pill Hill. It is a sunny late November afternoon and very mild in San Francisco, a beautiful, beautiful time of year, and we're actually in the Department of Family Health Care Nursing, of which Dr. Gilliss is the chair.

But I want to go back to the beginning. You weren't a San Franciscan, I don't think, to begin with. Tell me about where you were born and grew up and what that was like.

Gilliss: I was born in a town in Connecticut very near Hartford called New Britain, Connecticut.

Mullan: Hardware City.

Gilliss: Hardware City, home of Stanley Tool--to a second-generation family from Italy. My maiden name is Lynch, and my

grandparents were Balocki, Gennotti, and Naples. So Lynch was really just a cover.

Mullan: Well, somebody was Irish.

Gilliss: Lynch, and he was.

Mullan: So you're, grossly speaking, a quarter Irish and three-quarters Italian?

Gilliss: Yes. We lived in New Britain, Connecticut, for the first five years of my life. Part of that time, my father, who was a Navy reservist, was called up to go to Korea. We lived in a three-family home with my grandparents. My brother and I were left behind while my father went to war for about a year. At the time, I guess I was about two years old.

Mullan: Yes. Korea was '52.

Gilliss: Following my father's return from the war, we lived there for a few more years and then moved up to a little town right outside of Boston, Melrose, Massachusetts, where I started school, and lived for four years. Next we moved to Stamford, Connecticut, a commuting town outside of New York City, and lived there for about four years. We moved to Bay Village, Ohio, on the west side of Cleveland, in the early 60s and lived there for about four years before moving back to Stamford. My family

lived there until I went to college. We moved each of those times for reasons of my father's career advancements.

Mullan: What was his business?

Gilliss: He worked for Proctor and Gamble and then Lever Brothers, and at the time of his fairly early death, he had held just about every vice presidency in the company and was still on the rise. He was a Park Avenue businessperson.

Mullan: I remember the Lever Building, Lever Brothers Building.

Gilliss: They had a lovely--

Mullan: The first of the sort of glass--

Gilliss: In fact, it was his office that was cleared out and used by Art Garfunkle in--I don't remember the name of the movie, but there was a movie made in his office.

Mullan: What did he die of?

Gilliss: He was fifty-three when he had an MI.

Mullan: That must have been difficult.

Gilliss: Well, it was certainly a surprise. He was a fairly powerful figure, so it was tricky for all of us to imagine that he was not with us any longer and then to decide how to do things when he wasn't around to tell you what to do. Whether he intended to or not, he was always telling you what to do. He gave a lot of advice.

Mullan: How old were you then?

Gilliss: I was thirty when he died, thirty and pregnant, and that was one of the hardest parts about it, the fact that I had a baby that he never lived to see. That's always been very sad for me.

Mullan: Life must have been different in these different communities. Do you have ones that you're particularly fond of and others less so?

Gilliss: Well, we share some level of--I just want to be careful of what I say on tape, [unclear], but we share--

Mullan: You can edit as you go, so speak freely. Start worrying about that and you'll tongue-tie yourself.

Gilliss: We share some level of family humor about being from New Britain, for the reasons that you spoke of initially. It's a pretty blue-collar town, very industrial. Because of the work

opportunities, there were a lot of immigrants there, but it's been pretty much asphalted over. It's a big parking lot now. I don't remember it very well though I still have a lot of family back in that part of the country.

Stamford probably feels more like home than anyplace else, and Ohio is an interesting contrast. What I remember from Ohio is Friday night football, big football players and cheerleaders and a lot of rah-rah. But Stamford was a good place to be, a pretty diverse community, accessible to the beach and New York City and a fairly sophisticated group of people. You could understand that there were possibilities growing up in Stamford.

Mullan: Who were important people in your youth, besides your father, I presume, whose influences have lasted and endured with you in some fashion?

Gilliss: I'm not sure that I would identify anybody as being especially significant--I mean outside of my immediate family--until I got to college. In college there were a couple of people, particularly nurses, who taught me Fundamentals of Nursing, who had characteristics that I wanted to emulate. They didn't necessarily see a lot of potential in me. I remember well the very first clinical evaluation experience I ever had where one of these women gave me a B or B+. It was a fundamentals course, and I remember weeping in her office because I wasn't an "A nurse." But this faculty member was very supportive of me.

Her opinion mattered because she demonstrated good qualities with patients and she was a good thinker.

In graduate school, there was person in particular who supervised me. I went through a psychiatric mental health program in graduate nursing school so that a lot of our--

Mullan: This was at Catholic?

Gilliss: This was at Catholic. There were a lot of opportunities for personal growth as well as professional growth through that process of supervision. Probably the most important set of people following that, and the most important in my career, were the people that I met up with when I got into the Robert Wood Johnson Nurse Faculty Fellows Program.

Mullan: Well, before we get into that, let's pick up a few other things. In terms of youth, I gather you were brought up Catholic?

Gilliss: My family was Catholic.

Mullan: Is there a distinction there that's been growing?

Gilliss: Well, I am not practicing and haven't been for a long time. I married someone who was not Catholic in 1970. There was lots of concern about whether we should even be married within the church in 1970. I found that to be fairly hypocritical. My

husband-to-be participated in all the instruction that the Catholic Church required, and yet the Church's challenge to us was a major hassle for a young person to have to experience.

I neglected to mention somebody else who's been important, and I wouldn't want to have this oversight. My husband has been very important. I've known my husband since we were about eighteen, and we have been married now for over twenty-six years. He had more genuine confidence in me early on than I had in myself. That made a very big difference in the possibilities that I saw for myself for a professional life. It was always assumed that I would have a personal life, and my very Catholic Italian family viewed the role of women in a fairly traditional way. My father admired the nuns who ran hospitals, and he had some sisters who'd gone through teachers' education. I don't know whether they ever worked as teachers or not. They married teachers. So to be a teacher or to be a nun would have been okay. To run a big hospital would have been okay. But here I got paired up with a guy who thought that I could do anything, and he really believed it, and he continued to believe it as my career progressed.

Mullan: That's great. Before we leave the church, realizing you've grown away from the church now, was it an important factor in your youth? Did you go to church schools at all?

Gilliss: I never went to Catholic school. I ran the CYO in high school. But if it had been the Jewish Community Center, I would

have been running it. So the religion itself wasn't a big part of my life. As a social system, it was part of my life, and, frankly, a lot of the beliefs got in my way.

Mullan: How about nursing or medical folks in your youth? Were there people that stood out? Where did the idea of nursing come from?

Gilliss: I think it was embedded, really, in the family set of possibilities for women. In 1967, when I finished high school, I wasn't a star, but I certainly had a respectable record and, I think, an early demonstration of a fair amount of leadership, and it was suggested that if I wanted to be a nurse, that Stamford Hospital was a great place to go.

My father and mother consulted with a physician friend of my father's. My father and both my brothers went to Yale, and this fellow was one of my father's classmates at Yale who practiced in Stamford. My father asked "What should she do? Where should she go? Should she really go to the hospital, and is this the best hospital?" The advice was, "Oh, no. She should go to college."

Mullan: This is go to the hospital for a diploma?

Gilliss: The career advice from the local high school was to go to the local hospital and get a diploma. The contradictory advice from my father's friend, which supported my inclinations was, go to college. So unlike many people my age in nursing who

did go on to get diplomas first, I went directly into college. There was one nurse who did private duty in the family two generations ahead, but, no, I didn't have a very accurate view of what nursing would be like.

Mullan: I'm curious, though. Why nursing rather than just going to college, period? Was there a sense that you needed a vocation quickly? It doesn't sound like this were something you dreamed about as a youth.

Gilliss: No, I didn't. I'll tell you the one thing, it's not very flattering, but the only thing that I've ever been able to recollect in response to this question is that I did have some sense that I could get into a good college in a nursing program and that I could change the focus of my studies if I was unhappy.

My vocational call was to be involved. My interest was more with people than science. And remember, after my basic degree, I went on into psychiatry rather than a more physiologically oriented specialty in nursing. I think I just saw nursing as a way to begin my studies, and the courses that interested me the most were the sociology, psychology, and public health courses.

Mullan: And then Duke [University]?

Gilliss: I went to see it in the spring. Everything was blooming in the gardens. It was beautiful. I fell in love with it. It was also the farthest from home of the schools I applied

to. I got into all of them, and I had a choice, and my parents were willing to support me to go there.

Mullan: And how was it?

Gilliss: Well, it was hard for me. I wasn't as successful as I was used to being. My first semester there, I failed freshman botany.

Mullan: Is the nursing program separate? Would you enter as a nursing matriculate?

Gilliss: I entered as a nursing student. That's right. However, throughout the program of studies, there were general education requirements, and you went to class with students from all over the Duke Colleges. So, for instance, in this first-semester botany course, we were with everybody, the pre-meds, the students who were liberal arts majors, anybody who was going to take biology would have taken this beginning botany course. You know, it was an eight o'clock class. I slept through it most of the time. I can't give a good accounting. I hope my children do better than this! I didn't really know how to study. I didn't know how to be very disciplined. I don't think I was depressed. I don't think it was an issue of being away from my family for the first time. But I certainly didn't have the skills to do what I needed to do in that very competitive environment. It took a couple of years.

I have wondered whether Duke miscalculated my GPA, thereby allowing me to progress, because my GPA was really dismal, really dismal, for several years. By the time I got into doing the things I really wanted to do, I was extremely successful. And, of course, I had been president of my class and president of the school, and I was running things again. And by then, too, I was supported by NIMH [National Institute of Mental Health] traineeships for the last two years of my program. I was supported for the promise that I would go on into psychiatric nursing and earn the master's degree.

Mullan: And that's what you did?

Gilliss: That's what I did.

Mullan: Directly?

Gilliss: No. I worked for a year in Washington, D.C., at the VA [Veterans Administration] Hospital.

Mullan: Did you get married along the way?

Gilliss: I was married before my senior year. My husband graduated on June 5th, and on June 6th we were married in Stamford, Connecticut.

Mullan: You met him at Duke?

Gilliss: No, we went to high school together. He went to Amherst College, and we managed to stay in touch because we both had the same hometown and we visited each other on our campuses. It was a relationship that we managed to sustain through college. We got married, and he returned to the Duke campus with me, at which point we had another very significant event in our life. Within two weeks of the time we got married, he was diagnosed as having Hodgkin's Disease. I was approaching my senior year, and he was approaching radiation and chemotherapy and trying to find a job. Our plan had been to spend that last year in Durham before he went into law school.

Mullan: And he was treated there?

Gilliss: He was. They actually developed the MOPD treatment, coincidentally, and it was successful. He was not symptomatic, but he was a Stage III.

Mullan: And this was 1970-71?

Gilliss: '70.

Mullan: Right on the brink.

Gilliss: That's right. He was truly at the beginning, and we felt very fortunate. He was also uninsured because he had just finished college and he hadn't a job. So we're very grateful to

a lot of the residents and drug representatives who donated care and medications that made his treatment possible.

Mullan: So then you came to Washington.

Gilliss: We came to Washington after I graduated. I went to work at the VA Hospital, and he started law school at Catholic University.

Mullan: And what was the VA like?

Gilliss: Well, the year was now 1971, and people were returning from Vietnam. As a twenty-two-year-old woman, I would have to say it was one of the most frightening experiences of my life. It propelled me into graduate school. I was committed to going into graduate school, but the VA was a scary place because of some of the obvious effects of war represented on the unit. I worked on a unit that was not locked, but there were some very, very disturbed people on that unit.

Mullan: This was psych nursing?

Gilliss: Yes, this was psychiatric nursing. The other thing that was very frightening in Washington at that time was the racial tension. I'd come out of North Carolina, where we worked in very integrated environments, but I guess I didn't understand until I got to Washington what racial anger could be about, what

it could look like. There were times when, working in that job, I felt as though I was the target of racial discrimination as the college-educated little white girl. It was a tough place to be. There were days I woke up and truly wanted to call in sick. I felt paranoid. I really felt terribly discriminated against. I still can't imagine what it must feel like for other people who experience that discrimination over a lifetime, but I can tell you, I wanted out of there. I stayed my year, and I went on into graduate school.

Mullan: And you went on to graduate school partly because you had a commitment to NIMH?

Gilliss: Well, I had, truly, at that point, a moral commitment to go on, but I also had a strong interest.

Mullan: What did you have in mind career-wise? What were you seeing at the time?

Gilliss: I believe even then I knew I wanted to be a college educator. I was not disinterested in the clinical practice of psychiatric nursing, but put in context the fact that it was only one year following the cessation of my husband's treatment, and at that point and for several years after, I really had no idea whether I would <u>need</u> to work for my whole life, whether I would <u>want</u> to work for my whole life, whether I would <u>have</u> to work for my whole life. I still was fairly sure for a while that

I would wind up being a widow. We did have physicians who were attending to my husband who insisted that he probably would die of leukemia, and if we wanted a family, we'd better get started.

Mullan: That was due to the secondary treatment for Hodgkin's Disease?

Gilliss: Right.

Mullan: So you both enrolled at Catholic?

Gilliss: So I went back to Catholic in Fall 1972. He was already at Catholic in his second year of law school. We spent two years on campus at the same time and had a lot of the same friends. It was really a very pleasant experience in our youth, in spite of some of the adversarial circumstances that we were dealing with. We were obviously poor. We both had part-time jobs. At times during the summer we would be on alternating shifts where one would be in school at night and the other would be working at night, but we'd be passing each other or sleeping together from twelve to six, and that was it. But I remember it as a wonderful time.

I left graduate school with the sense there that thinking theoretically was possible for me and that I could organize ideas and make application of frameworks and theories. My understanding of my capacities was really beginning to come alive as I exited the master's program, yet I didn't have a sense at

that point that I necessarily would go back to school. In that time, there were many tenured faculty in schools of nursing who didn't have more than a master's degree. The master's degree was considered the terminal degree in the profession.

Mullan: And were you thinking of academic nursing?

Gilliss: I think so.

Mullan: Why? Where did that come from?

Gilliss: I think part of it was a flight again away from the hospital. I've never really liked hospitals. For nurses, they're very oppressive places, and the experience that I had in the VA was particularly oppressive. And, in part, it was consistent with the family's sense that women could be teachers, and that education was a tool for social nobility in immigrant families.

Mullan: So what happened? In '74 you graduated with your master's degree?

Gilliss: I finished and went to work at the University of Maryland in Baltimore. I taught undergraduate students and did that for two years, at which time I decided that the commute from Washington to Baltimore was more than I wanted to do, and I had been offered a position back at Catholic. I had a very important

meeting at that point with the dean of the school, who didn't need, certainly, to do exit interviews with young master's-prepared faculty departing after two years, but Dr. Marion Murphy was not an ordinary woman. Marion brought me to her office and wanted to know about what my experience had been like, and then she didn't ask me *if*, but *when* I was going to return for doctoral study. It had a very powerful effect, and I began to think, "Wow. This woman thinks I could do it," and it was just a small seed that was planted, but it grew.

So I went back to teach at Catholic, and I had a very similar assignment. Both at Maryland and at Catholic I worked with undergraduate students, and at that time we were very interested in taking the principles of psychiatric care and integrating them into other areas of care. I taught psychiatric principles in the community. I taught psychiatric principles in medical-surgical units. I taught them in OB. It was really a generalist kind of experience, an integrating kind of experience for four years, and I was getting restless.

Mullan: Had your husband gone into law practice in the District?

Gilliss: Yes. He was in a very large firm in the District and having a pretty exciting experience. It was the kind of a place that people think of as a "factory," but when you begin, it's a good place to begin, because there's a lot of opportunity and there's a lot of good supervision.

Mullan: And this was a time when, in psychiatry, de-institutionalization was occurring at great rates. Did that have impact on your teaching and your work?

Gilliss: Well, it was one of the reasons why people wanted me to take the psychiatric principles into the other areas. One of the particularly successful experiences that we organized while I was teaching at Catholic was the development of a nursing clinic in a public housing project in the District, where we offered community-based care and home care, or home care as we knew it then, and some psychiatric care as well. We had a community health specialist and me working with twenty students. They gave us an apartment, and we fixed up the apartment, and we operated out of this little apartment, dealing with all the residents in that center.

Mullan: Where was it?

Gilliss: Langston Dwellings, the first public housing project in the U.S.

Mullan: Sounds like it might be a rough place.

Gilliss: It's rougher now, I know. It was in Southeast [D.C.], and the work that we did there was the subject of my very first publication.

Mullan: At the same time it was a decade when the expanded-function nurse concept was developing with the nurse practitioner and the advanced practice nurse in more specialized areas. How was that impacting on your career?

Gilliss: It was. As a consequence of this outpatient clinic that we set up, we involved recognized that we were able to do some things and not other things, and if we had a little bit more knowledge, there certainly were areas where we could deliver additional and needed service in that community. I remember well the Surgeon General's monograph "Extending the Scope of Nursing Practice." I believe I still have my original copy in my den at home, but we were reading about and thinking about the development of the role of the nurse practitioner. Having been at Duke in the sixties where the attempt to start nurse practitioner programs was failed and, instead, the PA programs were developed, I had some sense of the potential role for the nurse practitioner.

Mullan: Tell me more about that. I only learned about--Eugene Stead originally had the nurse practitioner in mind--but foundered on resistance?

Gilliss: As I understand it, and in 1965 or so when this was happening, I wasn't yet at Duke, so some of this is second-hand, but as I understand it, Stead, who had worked quite a bit with a woman named Thelma Ingels, had wanted to train her--well, they

had worked so closely together, she was virtually trained, but then he wanted to open up a program to prepare nurse practitioners at Duke, and there was some outcry of professional horror that nurses would take on responsibilities that were those of the physician to actually become physician extenders, and, of course, that was the term that was such a heated term in the sixties and in the middle seventies.

I'm not sure whether Ingels got involved in the PA program development or not, but, of course, that is what Stead went ahead and did, capitalizing on the return of the corpsmen from Vietnam. And that's a very fine PA program. It would have been a great nurse practitioner program. Now, the Duke School of Nursing does offer a number of nurse practitioner programs.

Mullan: So you had been exposed to at least those ideas of [unclear].

Gilliss: Right. And I saw the relevance as I worked in the community and this last educational experience. So Robert Wood Johnson had an initiative to take faculty out of Schools of Nursing and to prepare them to become nurse practitioners. Their notion was that this five-year initiative would sponsor twenty mid-career fellows every year. But hoped to attract nurses who were Ph.D.-prepared, offer them the NP training, and develop a cadre of primary care nurses who had a beginning clinical competence and a research competence as well. What quickly became obvious was that the expectations about those RWJ hoped

they would attract were not matched by the applicant pool. In other words, the applicants were, by and large, master's-prepared people like myself. I was accepted into the second cohort, and that was the beginning of my focused professional development for me.

Mullan: Explain why it was that their expectations weren't met by their recruits.

Gilliss: Well, I think that, for one thing, there were still so few Ph.D.-prepared people in the discipline that it was very difficult to draw them in, and the notion of post-doctoral fellowships in nursing was fairly new.

Mullan: This is called the RWJ Primary Care--

Gilliss: Nurse Faculty Fellows Program.

Mullan: From your vitae here, it says Robert Wood Johnson Primary Care Fellow. Sounds like a blend.

Gilliss: The program did attract a handful of people who were doctorally prepared, but most people with doctorates were in positions were unable to relocate. The Fellowship required fellows to go either to Indiana, Rochester, Colorado, or Maryland to do this training. I think RWJ found that people weren't

mobile and they weren't accustomed to doing this kind of training post-Ph.D. in the 1970s.

It was still a pretty radical idea to become a nurse practitioner at all, and the people who were willing to take the chance were, perhaps, a younger group of people who were professionally younger as well. I was twenty-nine when I applied and pre-doctorate. So I applied and was interviewed by famous people: Rheba deTornay, Con Hopper, Rachel Booth.

It was a powerful experience for me. I remember very well that Sr. Rosemary Donnelly, who had been a RWJ Health Policy Fellow and is now the executive VP at Catholic University. She rehearsed me for my interviews. She was spectacular. She just grilled me. She asked me all sorts of questions, and by the time I got to Chicago for my interviews, I was well rehearsed.

Mullan: Did you choose Rochester, or did they assign you?

Gilliss: They made assignments, and it wasn't where I wanted to go. I was a little ambivalent, but I simply followed the directions. It turned out to be easier, because I was living in Washington, D.C. My daughter was fairly young, six or eight months, when I went up to Rochester, and commuted very easily back and forth between Rochester and Washington. I would come home for five days about every ten days. It all worked, fortunately.

Mullan: Did your husband take care of your daughter?

Gilliss: Well, he was working, but the child-care person that we had hired prior to my departure remained with the family, and she came into the home every day. From the perspective of my daughter, there was not that much change in her daily life. She knew me every time I came home and was happy to see me. But there was a social stigma attached to my choice. When my husband took the baby to the pediatrician he was asked where was the child's mother? When I was without my family in Rochester, people had a lot to say about it. It was the beginning of growing up, realizing you couldn't explain this to everybody, you just had to start doing the things you needed to do in your life.

Mullan: And it worked well?

Gilliss: It was a good experience. Rochester was a very different environment. I felt always as though the faculty and administrators were very respectful and collegial with one another, and it was a good environment in which to be a nurse. I began to understand the notion of "team" in Rochester.

Mullan: And the program in terms of training as a nurse practitioner, you liked it? It was good?

Gilliss: I trained as an adult nurse practitioner, and I thought I had a very solid experience. Plus there were enriching experiences. I worked with George Engel while I was up there. I had to talk pretty fast, but I got into Engel's's regular seminar

with his post-docs, and that was also a wonderful experience. It was about the time that he was writing about the biopsychosocial model. We got to argue with him about his notion of role overlap between nurses and physicians. We challenged his position that there was overlap and that some of it is a function of the people rather than the roles. There was important substantive content in the Fellowship, but there was so much power in the process of coming into contact with people who communicated value, appreciation and interest in ideas. These were famous people, who were accessible and interested in our visions of the future.

Mullan: And did you see, out the other side, going to work as a nurse practitioner or going back to academia? What was your vision?

Gilliss: What I really wanted to do was to continue with what I was doing, but it seemed like I ought to go ahead and complete my Ph.D. then, because I had already interrupted my work life. That's what I did. Ingelborg Mausch was directing that fellowship program. She was extremely attentive and has continued to be supportive throughout my career. Both she and Loretta Ford, Dean at Rochester, said, "You want to go to California. You want to go out to San Francisco and get that degree there, and don't wait." So by the time I was thirty, I was in San Francisco and enrolled in the doctoral program at the School of Nursing.

Mullan: Why San Francisco?

Gilliss: It is rated, along with the University of Washington, as the top nursing program in the country. They believed that I would get good mentoring out here and that there were good things happening in primary care out here, especially with collaborative work in primary care. Bob Crede was working with the adult nurse practitioner program in a collaboration over in the ambulatory care clinic. They had colleagues here that they felt like they could entrust me to. These two visionary women also understood the significance of research, and they believed that it was critical that nurses with primary care training be able to conduct research. So here I came, to a research intensive university.

Mullan: So you came directly from Rochester?

Gilliss: I came directly from Rochester with a short stop that summer at the University of Portland, where I taught in an adult nurse practitioner program, but by the fall we were here, I was engaged in doctoral study.

Mullan: At this point the family moved, too?

Gilliss: Yes, we were all here. My daughter was two, my husband had a new job, and I was seven months pregnant. I waddled into

my first doctoral class, sure that no one was going to take me seriously as a student.

I think the one piece of bad advice I got when I arrived here was not to practice. I was told that it would be a huge distraction. I mean, you've got to remember, the University of California really values research to such an extent that most of the time nothing else matters, and in 1979, the view of my advisors was that practice would be a distraction from research. So I didn't start to practice right away out here, and it got harder and harder, and by the time I did get into practice, it was a different kind of practice, certainly not the management of stable chronic adult problems that I had been trained to manage in Rochester.

Mullan: There was a difference in your practice here?

Gilliss: Yes. The thing I did the most of out here was to do screening work with fairly healthy adolescents.

Mullan: You did this while you were in the doctoral program?

Gilliss: No, I never did any more clinical work while I was in the doctoral program.

Mullan: This was after.

Gilliss: Yes, afterward. Afterward, while I was teaching here, I established a free clinic in a high school in town, for teens who didn't speak English and who needed screening and immunization updates. It was a training site that we could use for our students and a community service.

Mullan: Spanish-speaking?

Gilliss: Twenty-two different languages. Spanish and Cantonese were the most common. We had Tagalog and you name it.

Mullan: In pursuing the doctorate, what did you do your thesis on, and what was your vision as to what you were going to do with a doctorate?

Gilliss: I did want to learn how to do research, and I wanted to stay in academic nursing. In my mind, that wasn't going to exclude practice, but practice continued to trail behind. Rather than being a clinician, I have become "a friend to the clinician." I think that's probably the best characterization.

Remember, I came out of psychiatry and went into primary care. I was very interested in the presentation of symptoms, the presentation of human distress, and how it contrasted between psychiatric and primary care presentations. My work with Engel and some of the people in Rochester suggested to me that in primary care there was a lot of human distress that was presented as physical symptoms. I was very interested in what was then

called "grief-related facsimile illness" in widows. These cases generally involved some form of hysterical translation of a grief reaction into a physical symptom of the deceased.

Just before the doctoral program began, two weeks before, my father died unexpectedly on the East Coast, of an MI. Here I am with this idea for a dissertation, and it turned out that my mother had terrific cardiac pain for the better part of the next five years, and she continued to present her cardiac pain and be told that she was very healthy. You study what you need to know, but I couldn't study that topic any more..

I had been assigned to a couple of advisors at UCSF who were very interested in family health care, and who saw my background as being appropriate to study family health care. I had, in my master's program, some training in family therapy and a fair amount of family theory. In my doctoral program, there was a lot of independent work and mentored research work on families and measuring group level behaviors in families. I had had fairly extensive group therapy training and a lot of interest groups, so translating that to families was not very difficult. It was not what I originally thought I would do, however.

My dissertation was sponsored by Susan Gortner, who was at the Division of Nursing for many years as director. She came here from there in 1978, and I was her first doctoral student in 1979. She had begun some work with families who were making decisions about treatment, and, in particular, had begun a study of families around coronary bypass and their experience in making

the decision about whether to be medically or surgically managed for coronary artery disease.

Mullan: "They" being the family or an individual?

Gilliss: Well, we were interested in both. We were interested in what part the family played and how the individual made the decision. Susan, as a good sponsor, wrapped me into that work as a student and offered me the opportunity to change it a little bit for my own dissertation, so I followed a group of families for six months after surgery and tested a theoretical model about families, looking at how families cope with and adapt to the stress of cardiac surgery. Basically it was like a lot of dissertations: it was a good exercise, and there are a couple of papers from it, but it was mostly training. It was not necessarily valuable for the scientific by products.

Mullan: You've now got nurse practitioner training, master's, dissertation, and doctoral degree. You're now poised to start the rest of your life. We're in the early eighties. The primary care movement, nurse practitioner movement, is growing. What's in your mind? What kind of decisions are you considering? What do you do?

Gilliss: Well, this is not just a story about a nurse, Fitz. This is a story about a woman trying to make a career through this period of time. I have moved my family across the country,

which a lot of people aren't able to do, but I have now a husband, an attorney husband, who has taken the Bar Examination again, passed it in California, and likes it here a lot. So no one was eager to relocate. I had a very good degree and, as you pointed out, a set of credentials in my portfolio that made me fairly employable. I had good research mentoring here, too. But I had to look for a job in the San Francisco community, and I remember very well that there had been a posting for a tenure-track nurse practitioner position in this very department for which I was well qualified, but the faculty had been recruiting and recruiting and recruiting and couldn't find anybody.

[Begin Tape 1, Side 2]

Mullan: This is tape one, side two, of Cathy Gilliss.

So there was a job posted.

Gilliss: I came upstairs to say I was interested in this job. I presented myself to Brenda Roberts, who now works with me as vice chair of the Department. She was vice chair then; she's vice chair now, and she had to give me the sad news that the faculty had just decided to close that position because they hadn't been able to find anybody qualified.

I needed then to figure out where I was going to go, what I was going to do. I went to Sonoma State, which is not where I wanted to go. I wanted to be someplace where there was a research intensity, and at Sonoma State there was a teaching

mission, but there was a job for a doctor-prepared nurse practitioner. So I did go up there for a period of about nine months as a lecturer--and it was a grant-supported position for their training grant to prepare FNPs.

I did some clinical evaluation. I taught a little bit of clinical content, but I taught the nursing theory course and some research. At the end of that period of time, they asked me to stay, but the UCSF here offered me a post-doc. I came back and completed a funded post-doc here under the direction of Ida Martinson, to study more about families.

At the conclusion of that year, having, I think, demonstrated to a lot of people that I ought to be kept, the position was re-opened, and I did compete favorably and was appointed as an assistant professor on this faculty. That was Fall, 1984.

Mullan: What were you doing? From '84 to '93, you were other than department chair. In '93, you became department chair. So I want to divide it into two periods, the before-'93 period first.

Gilliss: Even in that period, my responsibilities changed a lot. Before I was tenured, I was protected. I needed to get my research career started, and I had very little to do with the NP programs. They didn't want me to practice. They didn't want me to be teaching in the NP programs. Those were assignments for master's-prepared clinical people, and I was asked to teach

family theory, family intervention. I began to get a little bit more involved with some of the doctoral mentoring that was going on, some doctoral dissertation qualifying exam committees, but my research career was really launched, and again, Susan Gortner continued to take a very strong interest in me.

In 1984, she and I were funded by the then Division of Nursing to continue our work with bypass patients and their families. And in 1986, we went in to the National Center for Nursing Research with another RO1, to continue our work on bypass families. There was a time in there as an assistant professor, where I was running two pretty large clinical trials, and I had forty people employed under me in these two research projects. It was something of an administrative nightmare.

Once I was tenured--and I would have to go back and look, but I think it was '89--once I was tenured, I was allowed to be more involved in the NP program, and it was the family program because that was the one that was administered out of this department. I continued to teach courses in the family area and managed the program overseeing the administrative aspects of one of the largest and most successful programs in the school, master's programs in the school, and I then had the responsibility, too, for the state contracts for that program and the federal Division of Nursing grants, too.

I thought I knew what academics was about, but I really learned a lot from '84-'93 here at UC. This is a big and complicated place, and it was necessary to take at least that much time to find out how things worked around here and how to

juggle the responsibilities that are somewhat extraordinary. But I managed to be research productive and learned how to and write and do the scheduling required to be successful here.

Mullan: Was the department chairmanship something you had in mind? How did that develop?

Gilliss: No. Again, it was not on the screen. There's a book that I'm reminded of now; Mary Catherine Bateson wrote a book about women's lives called Composing a Life. I do think, as Bateson describes, that it's much more characteristic of women's careers that we capitalize on the opportunities that are presented to us, rather then plan all our moves. At the time that we were searching for a chair in this department, we initially--in fact, for some period of time--conducted a fairly extensive national campaign for chair, and it came down to the dean deciding that we were not going to find somebody from outside, and she invited inside candidates. Two of us expressed interest. Although I was the candidate of choice, the other candidate did find an opportunity outside the university, and within about six to eight months left for a very important deanship at another school.

So here I was. I came forward at that point in my career in this particular department because I liked my colleagues, because in relation to my colleagues I had the seniority that would afford me the opportunity to try academic administration. It's like it's a dirty job, but somebody's got to do it. But truly,

in large measure, I did it out of sense of love and order. I mean, I wanted to create a climate for the people I cared about here to be able to do good work. And I think we've done a really good job of that. I tried to flatten the organizational chart from very vertical to more horizontal, I opened up the budget, started teaching people how things got done. It changed the place in some small but important ways.

Mullan: Tell me about the department as a whole, not so much for its history but to understand what you have helped develop and now run. What is the role of the Family Health Nursing Department within the school and within the larger medical center? I recall from my visit before that you've got every brand of advanced practice nursing related to family that there could be, but that's, in fact, the nurse practitioner part of the department which has other elements to it. But what is your role in the school, and what is your role in the medical center?

Gilliss: The school was departmentalized in the first half of the seventies. In this department we've always been responsible for training experiences in the care of women, families, and children. At present we're one of three clinical departments. The fourth department is the Sociology Department. In our department we have large specialty offerings in pediatrics, pediatric nurse practitioner, women's health, family health care, midwifery, perinatal care.

Mullan: These are all practice programs as opposed to academic programs?

Gilliss: At the master's level, yes. Well, they're academic degrees, but the outcome and the focus of training is really clinical training. It's a master of science degree, too, so we really are focused on trying to educate people to think scientifically and to be beginning scientists and practitioners in their field. There is a large doctoral program in the school. People interested in pediatrics, family care, women's care, tend to be assigned to sponsors in this department. Most of our work is community-oriented, outpatient oriented. Our work in the hospital, per se, is not very obvious. We do have one very obvious exception to that. We have a faculty member who is a member of the PCRC group here, the Pediatric Research Center, the nationally funded pediatric center for research run by Diane Mara here, and she is very interested in infant pain. We have one other person who trains people in neonatal nurse practitioner roles, and she also has a very obvious presence in the medical center.

But by and large, our contribution is in outpatient programs of care. We run a Young Women's Clinic across the street in ambulatory care, which cares for pregnant teens and their infants for a period of time and then makes referral back to adolescent medicine and pediatrics. We have clinical contracts throughout the city to offer services at the Hastings School of Law for

women's health care, for family planning services at City College. We have a variety of contracts like that.

But our biggest commitment and I think one of the areas in which we've offered a lot of leadership in the school is Valencia Pediatrics. We own and operate a pediatric practice in the city of San Francisco which was once owned by a physician, a pediatrician who worked closely with one of our faculty who's a pediatric nurse practitioner. We train our students in that center, and we conduct research. It's really a model of nursing practice and collaborative practice; we hire a board certified pediatrician who works with us in that site as well.

Mullan: As you look at your role as departmental leader at this point, how do you parse and value your several roles? I don't mean value, but in terms of time and commitment as well as in terms of "druthers," what are your roles?

Gilliss: Well, there's not enough time to do the things I like. I'm expected to have about half of my time be taken with administration, and I'm sure it is. I'm expected to continue to be a working scholar and teacher, and at this point I do continue to teach. I have one course that I co-teach at the doctoral level in family theory and research. I have a course that I co-teach now at the master's level to the family nurse practitioners that integrates what they've learned about care with ideas about family. And I'm very excited--I'm just getting back and I'm very excited about spending more time with those FNP

students. I watched graduation last year and as the students crossed the stage, I didn't know their names. Tears came in my eyes to think that I was so far removed from that part of my teaching responsibility at this point.

Teaching is the hardest thing to get back to because the teaching work that I do now is really through the faculty. I do a lot of doctoral dissertation direction and also qualifying exam direction, and I am participating in about four different research projects, and there's just sixty hours every week. The thing I really need to beat back into shape but have trouble with is national leadership responsibilities. I've just completed a year as president of the National Organization of Nurse Practitioner Faculties. I will stay on their board for a third and final year as immediate past president. I've just taken on the presidency of the Primary Care Fellowship Society, and that will be a six-year board commitment. I've done two years as president-elect, and now I'll do two years as president, and then the two years post. The century will have come and gone.

I have the good fortune, I guess, to be invited to do a variety of different things, and it's sometimes hard to figure out which of those things I really want to do and which ones I should do. I do try to toss a lot of opportunities to our faculty to give them a chance to move into some of those activities.

Mullan: Give me some stats on the department. How many students, how many faculty? How many do you graduate a year in the nurse practitioner programs, for instance?

Gilliss: I'll also give you my annual report which I've just finished.

Mullan: Just generally.

Gilliss: We've got about thirty-five faculty in the department, fifteen staff. Generally we have about 150 to 200 master's students in the department. It varies a little bit from year to year. Sometimes we take more. We have a very robust and well-qualified applicant pool for our programs, and when we need to, on behalf of the School, we will over-enroll, but I think at this point we're trying to stay a little bit lower, but maybe 200 master's students and then probably about thirty doctoral students.

Mullan: Two hundred master's students, does that mean you'd be graduating a hundred a year?

Gilliss: Yes, out of this department. Of course, all these programs are thought of as school programs, but we'll be graduating twenty to thirty nurse practitioners out of the pediatric nurse practitioner program, probably thirty out of the family and women's health group, we'll have about ten midwives,

and the rest in a variety of other different foci in the department. We probably have about five people finishing the Ph.D. every year.

Mullan: Let's spend a few minutes on sort of the big picture and controversial questions, and let me ask some sort of probing questions to kind of get you to put forth your ideas on where things sit. The nurse practitioner movement has grown apace. How do you feel about the nurse practitioner movement in terms of numbers, level of preparation, and level of organization in terms of certification versus state versus whatever? Give me your thoughts about the state of the union of the nurse practitioner movement.

Gilliss: I've just been involved with the National Organization of Nurse Practitioner Faculties analysis and publication of a book on the pipeline. They, as have a number of other groups, looked at what programs are like, how many credits people are offering, what the trends are in nurse practitioner education, what the output looks like, and one of things that impressed us as we looked at the changes in programs in relation to output is that there are increasing numbers of people who are actually focused on specialization and not on primary care as they go through these NP programs. Our sense as we completed the policy analysis of this work is that although we're putting larger and larger numbers and the numbers have grown--I don't know them off the top--

Mullan: I've seen the study. They're growing by 1,000 grads a year, 1,000-plus to 2,000-plus.

Gilliss: It has. It's grown about 300 percent--

Mullan: That's the Johnson-Harper Workforce Analysis

Gilliss: Yes. And although that number has increased, it's not at all clear that they're all going to go into primary care. We believe that because of the scope of practice that's available in the NP programs, that many people are coming back and learning those skills and then taking them out to new settings that are specialty-focused. So I think it's a little bit premature--

Mullan: Did the scope of practice determine that because--

Gilliss: Well, I say scope of practice because the clinical specialty programs don't teach comprehensive diagnosis. Many don't teach about health assessment of the whole body. Many of them are very, very focused and not built on a base in primary care. Some of the people who return to study in nurse practitioner programs have--

Mullan: The post-master's.

Gilliss: Well, the post-master's group is a good example. They have a basis in practice.

Mullan: So you have advanced practice nurses who are insufficiently broad in their skills. They come back and take a nurse practitioner degree in order to broaden their skills?

Gilliss: Yes.

Mullan: And yet some numbers of new nurse practitioners are, in fact, reducing their focus to a subset.

Gilliss: Right.

Mullan: So what is determining that? I mean scope of practice, to me, sounds like state laws.

Gilliss: Because of the scope of the educational program, which is much broader in the NP programs, those are attracting people back, both to get the master's and to do the post-master's work. If you want to learn how to do these things, you may not learn them in a CNS program, but you would in the nurse practitioner program. So the fact that we've seen the volume increase in the NP programs doesn't necessarily mean that we're going to glut the primary care market, because our notion is they're going through NP programs, but they're going to come out and go in a variety of different directions--primary care and specialty care.

So I think what's very important as we watch for a while. I wouldn't necessarily "shut off the faucet." I think we have to watch for a while and see where these people are going, and we

need to be especially concerned that the education programs that are high-quality programs. In that regard, the National Organization of Nurse Practitioner Faculties has been working in the last couple of years on a few projects that I think are really important.

We brought together and originally facilitated a meeting of the certifying groups, the four certifying organizations for nurse practitioners, to encourage them to work together. They were really at odds with one another. We encouraged them to work together.

Mullan: What are the four certifying agencies?

Gilliss: The American Nurses Credentialing Center, The American Academy of Nursing, the National Certification Board of Pediatric Nurse Practitioners and Nurses, and the National Certification Corporation. Those groups were asked by the National Council on State Boards of Nursing to work together to standardize information about their examinations and to standardize what the certification meant, because in some cases it was entering into practice, in other cases it was an exam that you could only enter after you had practiced for a while, and the states were in chaos about whether these exams could actually be used as a document that could validly document a level of practice or beginner practice.

So we brought those groups together. We got them started. We stayed on them until they started moving together to do the

work that the National Council wanted them to do, and they are doing that.

Simultaneously, we brought together a group of interested parties around program approval of the accreditation process so that the accreditation process would more carefully look at the factors that we thought were quality markers of NP programs, and that work has continued to move forward.

At this point, in nursing there's some question about the future of the National League for Nursing as our primary accrediting group, but the work continues to move forward.

Mullan: Is it the NLN that does the basic nurse practitioner accrediting separate from or subspecialty [unclear]?

Gilliss: Right now they accredit bachelor's and master's programs, and not specifically nurse practitioner programs.

Mullan: It's accrediting.

Gilliss: It's accrediting.

Mullan: So the national certification of nurse practitioners comes from one of those four groups?

Gilliss: Yes. I'm sorry if I mis-spoke, too, but the certification is an individual testing for an individual person. Accreditation is a program level--

Mullan: The four you were speaking of do accreditation? They do certification?

Gilliss: The four I was speaking of do certification. And then the second initiative is about accreditation, getting good markers of quality for NP programs.

The third activity that we've been involved with is another collaborative with the National Council of State Boards of Nursing where we are working with them to try to develop guidelines for family nurse practitioners for their curriculum preparation and certification in the area of pharmacotherapeutics, and this is, in part, funded by the Bureau of Health Professions and AHCPR. NONPF has convened an Expert Panel to develop the curriculum guidelines, and the NCSGN has an Advisory Council that's really more focused on how we'll sell this to the member boards in the states. But again the notion is, there ought to be some quality guidelines, which can be used across the country so that movement from state to state does not create barriers to practice.

I think that those three projects that NONPF is involved in are especially important.

Mullan: The nurse practitioner movement strikes me as contradictory. In the one sense, it is terribly flexible because it's terribly disorganized by at least the standards of some professional groups, in that there is different amounts of

training, levels of training, certifying and accrediting bodies, and it's arguably a complicated at least, if not a mishmash of-

Gilliss: Yes.

Mullan: On the other hand, the tendency of nursing leadership has been to embed it in academic hierarchies that are fairly rigid themselves, or fairly defined, and invite a highly academized approach to this emerging or relatively new profession. So on the one hand, you've got a sort of crazy quilt of levels of training, levels of certification, and so forth. On the other hand, you have a tendency to weld nurse practice training into fairly muscle-bound institutions, academic health centers and the like, and follow some fairly tight and fairly inflexible model of training. Is that commentary accurate, and where is it all headed?

Gilliss: I don't think that is totally accurate, although it's undeniable that nursing is a very disorderly matrix of programs. A nurse is not a nurse is not a nurse, and you know that because of your long history in the field of health care. And it's a very democratic world. Rather than, for instance, doing away with all those routes into nursing, what many of us would like to do is to create better connections between the entry levels. As a largely "pink" profession and one that wishes to enfranchise and diversify its body of participants--

Mullan: That's a gender rather than political commentary.

Gilliss: Correct. That's gender. This is a woman's profession, by and large, and there are a number of people who are in it because they need a job, and it's kind of a blue-collar industry at certain levels, and we would like to be able to do a better job of connecting and creating opportunity for those people who enter it as a job and move along in the profession if they wish. That's very different from medicine, where there is one way in.

So historically it is the way you describe it, but the current trend for nurse practitioner education--and the workforce book that we've referred to already demonstrates this, too--the trend is toward the closure of the certificate programs and the movement into the master's education for the NP. And I think that's important.

Mullan: That certainly has been historically the trend. Is that good?

Gilliss: I think it's good because I expect somebody who finishes a graduate program to be a good thinker. Now, medicine and health care is a lot more complex today, and everything's changing so fast, there's no way I can prepare somebody with all the information that they need. I have to prepare them with enough information to get started and then help them learn how to think and find the rest of the information that they're going to

need in the next five to ten years. That's really the best I can do in two years.

Mullan: What do you say to someone who says that the nurse practice movement, particularly in its cutting-edge or leading-edge programs, is simply replicating medicine on a kind of short-track level? By the time you get to the program at Columbia, for instance, where you have nurses not only having independent practice but hospitalizing their own patients, have we not, for better or worse, simply replicated a doctor with a shorter track and arguably some pinking of it because it comes from nursing, but you've ceased to follow a path that leads to a different or another element of the team, you've simply become a junior member, and maybe not even a junior member, of the initial team?

Gilliss: You know, I hadn't thought about it quite this way before now, but just as I talked about creating that ladder that starts at the entry-level and goes on, in some ways I think nursing could create a ladder that articulates with medicine. That is not to say that nursing is something less than medicine, but in terms of your description of it as levels of education and levels of skill-building and levels of information, yes, maybe the nurse practitioner is one route that ultimately intersects with preparation for a career in medicine.

However, I would argue that nurses are generally different from most physicians in that they view the health problem in the context of a person's life, as opposed to a problem to be cured.

The tradition in nursing is to locate health/illness problems in a context that's about family and community and individual life. That's where, if we were to do a better job of creating a single health professional, nursing's value would outshine others.

Mullan: As we look at programs that were nurse practice programs largely of the earlier epoch, that were more community-based of creating nurses from a local community, emphasized training in that community with appropriate links to university-level training, awarded certificates, and basically provided a dramatic upgrading of skills in a given area, often a rural and often an underserved area, that model has been largely extinguished. Is that a problem? Is that a lost opportunity?

Gilliss: I think it's been reborn, and the work that we're doing in the Fresno area is a good example of how it's been reborn. We're supported by a Robert Wood Johnson grant out there, the Partnerships Initiative, to co-prepare PAs, midwives, and nurse practitioners for service in the San Joaquin Valley. We hope to recruit students from the San Joaquin Valley, prepare them there, keep them there, and yet we from UC-San Francisco are involved in that training program and will be. We'll send our students there. We'll offer degrees to people who are enrolled in our programs out there. We now have technology that will enable us to participate in the educational program in the sites where the training should happen.

Mullan: As in telecommunications?

Gilliss: Yes. I think it's a mistake to go back to the certificate-type preparation. I mean, it's truly a Bandaid, because after you teach somebody how to do four things and to do them pretty well, then how is that person going to continue to solve the new problems that come up? And that's where I think you want to have people who have graduate or advanced-thinking preparation and not just information. There's probably not just one model for that. There are probably other ways to do it too.

Mullan: Most physicians in the community are not solving new problems. They're filling a service need, in fairness. I mean they may have been trained at the doctoral level, etc., but they're grunts.

Gilliss: I'm glad you contributed that part to the interview. [Laughter]

Mullan: That's not coming from me. I mean, in fairness, you know, the academic view of the world, which is people's minds should be prepared to meet new challenges, is not the reality in vocational training for how most of the trainees ultimately make their daily bread and spend their--

Gilliss: So maybe there's an opportunity for a differentiated model where some of those people do get that kind of training,

and then there's some other people who have a different kind of training. One of the things that we talked about last June at the Pew-sponsored nursing workforce seminar, the invitational seminar that was out here, was whether all these disciplinary boundaries might disappear and we would truly have a single mid-level professional, and I think that's possible. I think it's very possible.

I also think, although let's get this one on the record--I also think it's possible, though politically probably not feasible, that advanced-practice nurses could work in tandem with physician specialists and that there would be no need for primary care physicians or a greatly reduced need for primary care physicians. I mean, there are a lot of ways to put the model together, and that's why nursing got into the trouble that it did. There are six million ways to enter nursing because we don't force everybody to do it one or two ways, but there are many, many ways that we can organize care, organize teams and deliver care in communities where people need services.

Mullan: Let me ask you to crystal ball. We have ever more physicians coming into the workforce. We have expanded numbers of nurse practitioners now graduating and we have the shifts in the requirements for clinicians largely driven by managed care and its somewhat diminished requirements. How do you see thinks breaking in the future in general and specifically for advanced-practice nursing, including nurse practitioners?

Gilliss: I think there are two things. One is contracts, and the other is salary. First of all, nurse practitioners are only going to be competitive if they stay below the physician salary ceiling, and that may drop a bit from where it is, because as we see physicians taking lower salaries to do what they want to do, we'll probably see nurses stay a little bit underneath the physicians.

Mullan: What are your graduates able to command in salary?

Gilliss: Well, depending on what they've done before, there is a range, and a lot of ours go into public care. If they're in public care they're not going to get a big dollar, but they can probably get $65,000 right out the door, and in a couple of years they might be getting $85,000. It depends a lot on whether it's public or private. But you can see, as soon as you get somebody who's at $85,000 and the productivity ratio gets calculated in there, then you start to wonder whether you should have a physician or should you have a nurse. So they're going to have to stay underneath that ceiling, that critical salary ceiling. Or they could demonstrate the added value of their services.

But the other place that nurses in primary care are going to face hardship is if they can't be listed on panels and have their own contracts within managed care organizations. That's one of the things I've run into in my pediatric practice.

In the state of California, it has been the practice that contracts can only be with the physician. So the salaried

pediatrician who works for us half time in our pediatric practice is the one whose name is on the contract. The nurse faculty over there are giving virtually all the care, and consulting with him as it's appropriate. We're sort of over a barrel. If this were not a person we really trusted, the contracts are not in our name! If we don't make some legal headway around the country on that issue, then nurses will be confined to salaried position, which isn't their death and demise, but it's going to--

Mullan: Well, what you're saying is that independent practice will be truncated by the--

Gilliss: Yes.

Mullan: You're not saying that the nurse practice role will be eliminated, but--

Gilliss: It will confine nurses to salaried positions, limiting their practice possibilities.

Mullan: But I would think in capitated situations, a provider group that's looking to provide efficient care within a capped dollar would look to a rich mix of physicians and non-physicians which provides it to be [unclear], depending upon how the group organizes itself, but it's like everybody would be on salary, I would think.

Gilliss: And in that case, why should a contract just be to a physician? I mean, it depends a lot on the needs of the population group that you're contracting to serve, home-bound elderly, for instance. Some groups that have a high amount of need for health education, more social service, more problem-solving, more educational. Why should that contract necessarily be a contract that has to be signed by a physician? So it is something of a labor-rights issue. I don't think it'll totally freeze us out of the market, but it's going to limit the ways in which we can diversify our practice.

Independent practice for me is not really about "Let's show them we don't need them." There are times when, in any group, it's obvious that somebody would take the lead or somebody else would take the lead, and we're slow to recognize that in our relationships between nursing and medicine. Traditionally this is one of the things we fight about, and I think if we'd just give it up, we'd find that there are some very creative and worthwhile ways that we could organize together.

Mullan: Certainly teams are the way of the future. I think probably the teams [unclear].

Gilliss: Yes, but now, I've heard you say that the physician should be the team leader under all circumstances, right?

Mullan: I'm not sure I've said it quite that rigidly. On the other hand, the thing that I find a little hard, I think medicine

has rigidified itself and been uncreative and moved in a direction which I've spent a fair amount of professional effort trying to reverse and that the values that nurse practice espouses in terms of holism and in terms of community orientation and in terms of primary care should be a more prominent part of the family of physician disciplines, physician training, physician practice. And frankly, I think if the house of medicine, as some of my colleagues are fond of calling it--I always snicker--when the house of medicine can't manage that, it deserves, and it will lose, the generalist function. I think nurses are well poised to take that on by a sort of a graduation of functions, which is in a sense what has happened. The notion that nursing, of itself, has an entitlement to that, I'm not so persuaded by. I think nursing has a terribly important role in health care in this country. I worry, and I particularly worry with leadership colleagues in nursing, that there is a preoccupation implicit, and I think often not borne consciously but deeply embedded in the history of nursing, that they want to escape finally from the domination of doctors and hospital, and to do that is become a doctor on their. But pharmacists want that, too, and psychologists want that, too. There's a sort of desire to get as high on the feeding chain as possible, and there may be reasons for that.

The notion of a hierarchy of training, where people who are trained longer and in greater thoroughness are, in fact, in the lead. I mean, you'd have a captain on a ship who is the senior officer by dint, usually, of training and experience, is a role

that makes sense to me. I think it's not in every case and it shouldn't be rigidified, but if you say, well, we ought to throw that out and we ought to have the ship run by a committee or have the ship run by people who have less training and have the most senior people working for them, that just doesn't conform to my experience in life in general, forget about in medicine, where it doesn't conform either.

Gilliss: But the longevity in training also has to do with what's the training end, and that's where I think we haven't been as open to the leadership possibilities as we could be. If the problem really is a medical problem, then I think there's little doubt that the most sophisticated medical training is with the physician. A lot of the problems that we deal with, and especially in primary care or in the community, are problems that relate to a medical problem, but they are problems of coping, adjustment, making things work, figuring out how to. They're not medical problems. They're life problems as opposed to medical problems. That's where I think there is some opportunity for people other than physicians--not exclusively nurses, but social workers, psychologists, vocational therapists--to participate, or lead the team.

Mullan: Since I'm a little worried about time and also I'm about to run out of tape here, what I'd like to do is get any comments that I haven't gotten, just sort of free thoughts on your part, if there are things--I mean, there are many things that we

haven't touched on, but I will leave a moment here for you to reflect or comment.

Gilliss: I'll tell you about one experience I've had very recently. I've been co-teaching with Emilie Osborne a seminar for very beginning medical students. This is part of our generalist initiative, and it's been a very important professional experience for me to be with six of the brightest, most altruistic, excited-about-starting-a-career people that I've seen in a very, very long time. And I look at these six people, people of color, men and women, the oldest is forty and the youngest is twenty-two, and they're clearly very capable, having been admitted to this medical school, and I kind of want to watch what happens to them over the next four years, and I worry a little bit. I'd like to watch because I don't know what happens, but I've seen this eagerness, this openness, this excitement, this clumsiness, too, and those aren't the kinds of students I get anymore.

It's been a very revitalizing image for me to think about how we take this kind of talent and what we do with it and how we really put it to good use, good use in collaboration, in collaborative education, which I think is the way of the future, and how we turn these people out so that they understand what people need. They're going to be good scientists, there's no question about that. But how do we turn them out, too, so that they know how to work with other people, including their colleagues in the health-care field, and work with people?

One of the students was role-playing how you would ask a question to a teenager about drug use, and it was just hysterical. I mean, the student felt clumsy, and the classmates realized that the question wasn't being asked correctly. This person is going to be very good in time. I'd like to be a fly on the wall and watch the whole journey, but it has renewed my respect for medical education.

I have been involved on this campus in the last year as a co-convener of the Chancellor's Task Force, chairing a task force on primary care collaborative education, and we've recommended the development of a center. We, Goldman and I, did this together, recommended the development of a Center for Collaboration in Primary Care. It's got to happen. It's got to happen. That is the last word.

[End of interview]

Index

American Nurses Credentialing Center 31

Bateson, Mary Catherine 24

Catholic University (Washington, D.C.) 4, 11, 12, 13
Crede, Bob 18

Donnelly, Rosemary 16
Duke University 7, 8, 14, 15

Ingels, Thelma 14
Engel George 17, 20
Ford, Loretta 18

Gortner, Susan 21, 23
Griner, Paul 17

Managed Care 37, 38
Martin, Joe 41
Martinson, Ida 23
Mausch, Ingleberg 18
Murphy, Marion 12

National Center for Nursing Research 23
National Council on State Boards of Nursing 31, 32
National Institute of Mental Health (NIMH) 8, 10
National League for Nursing 31
National Organization of Nurse Practitioner Faculties 27, 29, 31
Nurse Practitioners 14-18, 22, 23, 26, 28-35, 37

Osborne, Emilie 40
RWJ Partnerships Initiative 35
Physician Assistants 14
Primary Care 18, 22, 29, 30, 36, 38-41
Primary Care Fellowship Society 27

Robert Wood Johnson grant 35
Robert Woods Johnson Nurse Faculty Fellows Program 5, 15, 16, 18
Roberts, Brenda 22

Sonoma State University 23
Stead, Eugene 14, 15

University of California-San Francisco 1, 19-21, 24-26, 28, 35, 40
University of Maryland at Baltimore 12
University of Portland 19

Veterans Administration Hospital (Washington, D.C.) 8, 10, 12