SUNNI LEVINE

Dr. Fitzhugh Mullan,
Interviewer

Mullan: We are in Jacobi Hospital in the Bronx, New York, with Sunni Levine. We are in the pediatric outreach office, a place in and around which Ms. Levine has worked for a number of years.

What we want to do is start back at the beginning, and why don't you tell me a bit about how you got into nursing, I presume, first or into health care in general.

Levine: Mom pushed me into it. Mom said, "You like children, you like biology. Nursing would be a good way to go." I really didn't have aspirations to be a nurse as a child. There was no Florence Nightingale or Clara Barton kind of story. I started going to school right over here, at the nurses' residence.

Mullan: Where did you live? Where did you grow up?

Levine: I grew up in the Bronx, was born and raised in the Bronx, right around here, Pelham Parkway, and actually just left a year and a half ago.

Mullan: When were you born, could I ask?

Levine: 1946. The Bronx was not a prairie then.

Mullan: What was it like?

Levine: Small. There were some private houses coming up, some apartment houses, pre-war buildings. This area was mostly Jewish and Italian. Park Chester was Irish. There were some minorities around but minimal. It was a nice, safe, old-fashioned kind of neighborhood with a sense of tolerance where you could leave your doors open and not worry about anything. School went up to the eighth grade, and then you went to high school. There were lots for children to play in, you know, tires strung up as swings, life the way it should be, in my perspective, anyway.

I went to all the local schools, and the local nursing school was Bronx Community, right here on the grounds of Jacobi.

Mullan: You went out of high school?

Levine: Yes. I was in the degree program. Actually, the first year I went at night, and I worked here at Jacobi Hospital in the laboratory part time, first filing, then spinning blood and working with the autoanalyzers. It was the period in lab medicine when technicians were going from the traditional Bunsen burner tests to these fancy machines.

Mullan: What years are we talking?

Levine: We're talking now 1967. No. No, no. I graduated in '64. '65. 1965. The experience of being in a hospital was exciting. I got up to go around to the wards and deliver lab test results--in those days they had a double slip of paper with a piece of carbon in it, and the electrolytes, BUN and all other results were written there. You'd rip the slip and file half,

and then go around to the floors to give out the other half. And just going to the services. It really turned me on. I was initially going to go for labs. Mom wanted the nursing part, it was unusual for Jewish girls to go into nursing in those days. So I did it. I really think that she thought I might marry a doctor. [Laughter] It didn't work out that way.

So two years, Bronx Community, and then my job in Basement South, which was then a communicable disease unit. I started on the tail end of an era--I guess polio had just finished. But pertussis and meningitis remained--we isolated everything in those days.

Mullan: [Unclear] diarrhea as I recall.

Levine: Yes, respiratory infections and diarrheas. And I was down there as a staff nurse under the direction of Miss Kolter. I don't know if you remember her, an older woman, previously an Army nurse. After a couple of years I took on the role of assistant head nurse. In 1974 the position of head nurse opened up in the intensive care unit on the eighth floor. Although I had never worked in the ICU, Ms. Michaels, who was the supervisor at that point, felt that I had leadership skills, and they needed somebody to lead. So I made my way up to the eighth floor for about three and a half years. Just about the time I was burning out. As far as I'm concerned, any normal person can't hack it for more than a few years.

Mullan: "It" being ICU.

Levine: The ICU. Yes. It was too much, too much death, too much of the minute they got a little bit better, they were out the door. And I realized I was missing the continuity, really getting to see kids get better. The nurses were very stuck on not having moms in there, you know, that elitist mentality, and it wasn't my cup of tea, it really wasn't. If the kid wanted to have his bear, I thought the kid should have his bear, and if Mom wanted to be there, I thought Mom should be there. And the nurses really had a hard time with that. It was too much to fight after a while.

It was during that time that I was exposed to the nurse practitioners who were working for Dr. Ruth Stein in what was then the pediatric home care program.

Mullan: Which year are we in?

Levine: This was between 1974 and `77.

Mullan: So these must have been the earliest generation of nurse practitioners.

Levine: You got it. Yes. Ruth ran the program here.

Mullan: And had she trained them?

Levine: Yes. She had a training program here. In fact, Pat Donovan was in the first program--I was in a later program. The initial program was a two-year work study program. I think it was really the best. They got their didactic and clinical here,

and they got paid while they were doing the training, two full years of it. It was more like an internship. The second program Ruth ran was a one-year program, where you had to take a year of educational leave. The first four months were didactic followed by eight months of clinical here in the institution. I believe certificate programs are much better than--today's master's programs. Masters students don't get enough of what they really need.

Mullan: What's the distinction there?

Levine: If you go to a master's program, the amount of clinical hours you have comes nowhere near the eight months of clinical hours that I had. You just don't have the experience. Todays new grad is thrown into a managed care world and expected to be a revenue producer. How is somebody coming out of a master's program who's had limited experience in the provider role supposed to start seeing eight patients in a three-hour period of time? It's a little stressful.

Mullan: What you're saying is that the current trend towards master's programs, which are stronger on the classroom and less on the experiential, is not as efficient or as effective as the more clinical exposure that you had in both the longer program and a more intensive clinical program?

Levine: Yes. Another difference is establishing clinical placements. The certificate programs provided continuity with respect to classroom and clinical teachings. The needs of the

students were built in as not to put extra demands on preceptors. Approximately 80 percent of the practicum remained with the institution.

Todays masters students have to search for clinical placements. Practicing nurse practitioners must maintain productivity. Providing a quality preceptorial experience is difficult under the pressure of productivity. The nurses practitioners at this institution have drastically reduced the amount of clinical placements previously provided.

Mullan: Tell me what you thought of seeing nurse practitioners, the transition in your thinking between what a nurse had been and what a nurse might be?

Levine: Nursing is limited. There were certain things that were just taboo. In those days, you couldn't put an NG tube in. There was only certain information you could share with the family, and then you had to get the physician to do the rest.

Mullan: Were nurses doing IVs in those days?

Levine: Sneaking. The beginnings of sneaking to do it. A lot of the stuff just doesn't make sense. You know, anybody can learn a skill, but they had these rules. The thing that I liked about nurse practitioners, not even so much the skills, was the intensity of the relationship that they had with the family. They really knew the families, they felt comfortable with them, they could be there supportively, and they were going to be with

them again once the kids got out of the hospital. So there was always somebody there for a family to rely on. It was real nice, it reminded me of old-time family docs, you know, the type I had when I was growing up, they knew every aspect, and you didn't have to tell the story again. They knew you. They knew where you were coming from. The family knew them, and it made for clinical care in a nice supportive relationship. I've always felt that you need to know what's in somebody's head to treat the whole body. And how do you get into somebody's head but have a longstanding relationship with them? The nurse practitioners made home visits, so they got to see how the family was functioning in their environment. The whole thing just excited me. So I said, "Okay. Time to go on." And I applied for one of the newer, later programs and got into it.

Mullan: That was here?

Levine: That was here in 1976, '77.

Mullan: Associate degree was acceptable as an entry level at that point?

Levine: Yes. They probably would have taken, I think, diploma grads, because they knew your clinical work here. They knew your experience. They had the advantage of seeing the kind of nurse. They advertised all over. Anybody could have applied for the position, but the thing that was good was they knew who they had grown here as nurses, and it didn't always work to your advantage. I didn't get in the first go-round, but the second

go-round I did. I always felt that a nurse practitioner was something a registered nurse worked towards. You took a nurse in pediatrics and then took him or her onto newer levels. You know, they have this new entry into practice--do you know that?

Mullan: Yes.

Levine: Somebody with either a bachelor's or a master's can go into a program. If it's a bachelor's, you just take what you need as far as nursing to get the bachelor's of nursing, and then they pop you right into the master's program in like a two-year period.

Mullan: This is somebody with no background in nursing?

Levine: No background in nursing, and not necessarily in health care at all, they make you a nurse practitioner.

Mullan: In three years?

Levine: That's if you need the bachelor's. If you already have a bachelor's or you have a master's, you can go into something else. You can go into a master's program and do it in a year and a half or two years, get your RN license while you're in there. They throw you into a couple of clinical settings as a nurse. That's not to say that some of the nurse practitioners that I've met that come out of these programs aren't good NPs. They don't understand the in-patient part of nursing. We actually hired

somebody who does the HIV program with Pat. She's excellent, her name is Marina Lugovoy.

Levine: I can't think of the mom's first name. Her mother works with Henry Barnett in the Children's Aid Society.

Mullan: Henry Barnett is still active?

Levine: Yes. And so Marina came to us having graduated from one of these family nurse practitioner programs. Prior to that she was a forest ranger. She really had nothing to do with health care. And she's very good. A couple of years after she was here, the nurses on the in-patient unit were saying, "She's not that friendly," you know what it was? She had never really been on an in-patient service, and she was terrified up there and really uncomfortable and just didn't know the workings of it. So I think there's something to be said even in being able to provide for a child if you can anticipate, the experience, for the parent of what a hospitalization is going to be like.

Mullan: You entered the program here?

Levine: I entered the program here.

Mullan: What was it like?

Levine: Scary, but we were learning all these physical assessment skills and differential diagnosis and history-taking. All the pediatricians that I knew, Andy Mezey and his cohorts,

were, you know, our teachers and our consultants, and it was wonderful because they really understood the transition. You know, they could help ease us into it. But it was very scary because suddenly you don't turn around to the doctor anymore. You are the front line. I wanted to be able to do more, now suddenly responsibility was on me, and it was really frightening in the beginning. Well, I'm talking about eight or nine years. It takes a long time to really transcend that gap. But it was fabulous. It was probably the best thing I ever did. I really feel that I have impacted and made differences in people's lives. Of course they make the big difference.

Mullan: And this was a pediatric program strictly?

Levine: Yes. Strictly peds.

Mullan: And it was two years?

Levine: One year. I was in the one year. I was in the second go-round. One year.

Mullan: And you got a certificate at the end?

Levine: Certificate at the end.

Mullan: And what happened then? What did you do?

Levine: There was a position in the pediatric home care program, fortunately, which is chronic illness and home visiting, and I

was accepted into it, working with, to me, the dinosaurs of nurse practitioning. I was really being challenged and learned a lot. I had my own caseload of patients.

Mullan: You were doing home visits as opposed to seeing the kids in the office?

Levine: Yes. Both. We would see them in the office, this actual office. You would do your initial intake either on the floor, I mean on the wards, or in the office, try to connect right away and follow up with home visits and do as much of whatever it was you were doing, whether it was health education or examinations or follow-ups, as much as you could in the home. In those days it was real safe. We weren't dealing with crackheads.

Mullan: And what sort of conditions, what sort of diseases?

Levine: Everything from diabetes to sickle cell to congenital hypothyroid to--oh, God.

Mullan: You were actually managing medication decisions?

Levine: There was a child by the name of Brenda Castro, who's no longer with us. I think everybody who ever worked at Jacobi knew this kid and her family, and she had some sort of autoimmune process going on that knocked out all of her hormones and her glands. Aida LiBasci was taking care of her, balanced everything, all her meds, all her lytes. It was just incredible.

But you learned that once you got into caring for the kid and really knowing every aspect of her, it could be done by a nurse practitioner. I mean, she really got to know the ins and the outs. When the kid would come into the emergency room, the house staff would panic because they didn't know what to do first, and Aida would go along and just, you know, help them get her stabilized. Whatever it was that needed to be done.

Mullan: And you worked in the home care program for several years?

Levine: Up until about, I guess, about seven years ago.

Mullan: Ten years that would make it, from the late seventies to the late eighties?

Levine: Yes. I became the supervisor of the home care program when the supervisor left, and my patient panel got smaller. When the supervisor for the clinic left, and there weren't enough nurse practitioners in the clinic to warrant hiring another supervisor, I took over the responsibility for the NPs and the clinic also.

Mullan: This now is on the hospital-based side, ambulatory?

Levine: Ambulatory.

Mullan: So you were supervising them as well as continuing to do home visits?

Levine: Right. My administrative responsibilities grew when we got a new director--actually, we got a new director of nursing who was wonderful. She was just becoming familiar with what a nurse practitioner was, did her homework and saw that this was the wave of the future, and helped me to apply for the state for rate appeal money to educate our own nurses, for funds to send them to Columbia. Actually, the first rate appeal was for Cornell. Cornell had a neonatal nurse practitioner program, an eight-month training program. Andy Mezey had already started bringing nurse practitioners into the in-patient service. Andy had this telescope that saw what was coming down the road and knew that the training program was going to have a reduced house staff. He started by bringing in the nurse practitioners in the newborn nursery. That was the first inpatient NP that we had. Eventually we increased to three of them. With the changes in graduate medical education, primary care and managed care, we knew that we were going to lose house staff, and we thought that they could be replaced by bringing nurse practitioners.

Mullan: What year are we now?

Levine: Early nineties. The NPs that we brought into the newborn nursery were excellent also, and we started gearing up to bring them into the--NICU (neonatal intensive care unit).

Mullan: Before we do this, let me ask about the decade between the late seventies to late eighties and your experiences in there. How did the role perceptions, acceptance of the nurse practitioner evolve during that time, as you saw it?

Levine: You have to remember that this was a really special place. This is a hospital that ran training programs for nurse practitioners, that had the earliest nurse practitioners running them, okay? So we had some of that, "Who do they think they are? They think they're doctors practicing medicine. They don't have a license." There was some of that but not much--and, you know what? It was within nursing, not within medicine, because we had the support from the pediatricians. They trained us. They were not threatened by what we were doing, we worked well with them, but nursing had a problem with us. When I first came out of the program, although I worked for the city, there was no supervisor for me in nursing, and we were kind of out there by ourselves.

Looking at it now from their perspective, they didn't know how to supervise us. What were they supposed to tell us to do? They weren't even sure if what we were doing was legit. So those were very exciting years because our senior people, Doris Lovejoy and--I don't know if you remember Rachel Kolb--Doris had been in Vista, so, you know, Doris was a real change agent and very politically involved and was going to make sure that we were allowed to do what we were supposed to be doing, this was what we trained for, and the medical board wasn't going to get in our way, and nursing wasn't going to get in our way. So us babes were really exposed to a group of politically savvy senior NPs that really helped transcend those early years, which were difficult. And I think because I was exposed to them, I didn't know any other way but you band together, you group together, and you teach the world what it's all about. And that's what we did here.

So, yeah, there was a little bit of that, "I'm not doing your blood pressure. I'll do the doctor's. You're a nurse; you can do a blood pressure." But very quickly, I guess, as I started getting into the administrative part of it, we'd been around enough at that point that we were able to just make the changes as necessary.

Mullan: So acceptance grew?

Levine: Yes.

Mullan: What about with younger nurses coming along? Did the role model appeal? Did you see more interest?

Levine: Yes, I guess there was some, because some folks started going outside to programs. There were no more programs here. A lot of people would say, "If you ever bring it back, let me know. I want to be a nurse practitioner." But, I guess more so, people just were able to be in their roles and work together accepting one another. I was not the kind of person that thought that just because I'm a nurse practitioner I'm better than. To me, a good staff nurse is a good staff nurse, and you respect that. Your role is just different than mine. And most of us were like that. These were our roots. This is where we came from. We were just doing something differently, but we respected the people we worked with, and we depended on them. So many of the people that are still here, like Pat and myself and the folks that were in the late sixties and early seventies, we've never had a problem with that in nursing.

Mullan: What about the development of the clinical nurse specialist, which I gather took place over that same period, in this case, nurses who are developing advanced but highly targeted specialty practices? Were they trained here, and how did you relate to them?

Levine: They were master's-trained. There was no training going on here. In the early days, particularly the clinical specialist, which was a clinician here, was a nurse who had gone back for her master's, who did the education of the staff nurses. That's how it ran in the earlier days. Later on, when they changed from clinician to clinical nurse specialist, most of the folks that we had here wanted to function the way they were in the privates, where you had the enterostomy nurse or the diabetic nurse. This hospital didn't hire folks like that. It was a loss.

Mullan: How about in the CCU? Were there CCU nurses or --

Levine: Yes.

Mullan: At the clinical nurse/specialist/master's-prepared level?

Levine: No. They were CCU nurses that took critical care courses given at Jacobi--

Mullan: So OJT as opposed to master's training?

Levine: Yes.

Mullan: So within nursing, I gather, during the late seventies, late eighties, there was a growing acceptance, at least here, of your role. The clinical nurse specialist wasn't too much of an issue one way or the other.

Levine: No. They did their thing, and we were really very separate.

Mullan: And were there a lot of nurse practitioners functioning throughout Jacobi, throughout the Bronx? I'm not clear how much is your experience, how much is generalized.

Levine: Right. Well, when I got to really know what was going on around the Bronx is in 1987, when New York State passed a certification process where if you wanted to work in the state of New York you had to register as a nurse practitioner. And they had criteria. It's somewhat changed since then, but we applied, you know, with proof that we graduated from the program here, and we were licensed. I carry two; one's actually a certification, one's a license. I have my RN license.

Mullan: Both from the state?

Levine: Both from the state. When the law went into effect, what it said was that in order to practice in the state of New York, you had to be in a collaborative practice agreement with a physician and work from protocols. The way the law was really

set up was for people who were out in private practice, and I don't think there were many out in private practice. Most of us were working in hospitals or clinics. So the networking started. "What does it mean?" "What do we do?" "How do you set it up?" Who's running the collaborative practice?" And of course, I was going to wait for the Health in Hospitals Corporation to give us some direct input. It was clear that they didn't have a clue to what was going on.

So I got the law, and I read the law, and we developed collaborative practice agreements in every area where there were nurse practitioners, in the medical clinic with the medical director, in the pediatric clinic with the pediatric medical director. Those were the first two. At this point I realized I had some political savvy because I could read a law and do what I needed without direction. And the protocols, of course, became an issue, because nobody wants to spend time--doctors didn't like, then, the idea of following protocols. They certainly didn't want to write protocols for somebody else to follow. The state actually came up with some books that were acceptable, national protocols. One of them is the Harvard Community Health Plan. Those were acceptable. To be honest, you know, in an inpatient setting, those things don't do much, but the state wouldn't accept those little spiral books that the docs use, because there weren't protocols on them, so they tell us what we should use, we tell them that's what we're using, and nobody checked, and everybody gets good care. But, you know, this is a bureaucracy.

But it was the networking at that time that I really got to talk with folks to find out, actually in the Greater New York

area, what was going on. And at that point--that was 1987--NCB, North Central Bronx and Monte [Montefiore] had a substantial amount of nurse practitioners. We've lost numbers over the years. But Comprehensive, the Russo Building over on Morris Park Avenue, had a nice cadre of nurse practitioners. I don't know how many are there anymore. We've kind of lost ties with the place. There weren't a lot in hospitals, at least in Peds. I can't speak to the adult services, but I think we had the greatest amount, at least in a hospital, certainly a city hospital, and it started growing. As Andy dictated what the need was and we realized what the need was in Peds the need would be in medicine also, we started advertising for inpatient--NPs.

Mullan: That's a very important story. I want to get that. That comes after '89, is that right? There would be a few other things in that period. As you began to network more and get a sense, tell me a little bit about what I'll call the culture of master's-prepared versus non-master's-prepared, and how has that played out for you?

Levine: Okay. At that point, the certificate programs were almost nonexistent.

Mullan: By the late eighties they had given way to the master's program?

Levine: Yes. Cornell had the neonatal nurse practitioner certificate program, one of the last certificate programs.

Mullan: The master's program is certainly all over the country, supplanted--so today there are very few certificate programs.

Levine: Yes.

Mullan: What I'm asking about is, how did that manifest itself in terms of your role, and did it become more burdensome to only have a certificate within--

Levine: Well, I'm probably not a good example. Having been born here, having grown here, I was judged on what I did, not what paper was hanging on my wall. I'm going to be honest. Again, the physicians never asked. It was nursing who always asked. Now I was entering this dinosaur era as being one of the oldest--you know, it's weird--and really knowing a lot just in terms of the law and the protocols, you know, I was now becoming the maven here. It wasn't an issue for me. Had I gone elsewhere, probably it would have been. I got my bachelor's in 1989. I realized that my administrative position required credentials to back it up. As matter of fact, I just got my master's this May, at Columbia.

Mullan: Great.

Levine: It was a completion program. They accepted my certification. They gave me fifteen credits for that, and I did the completion.

Mullan: So it's a master's in nursing?

Levine: Science, master's of science.

Mullan: And where did you do your bachelor's?

Levine: Mercy College. I picked the fastest thing. They had three sessions a year. It was in behavioral sciences and community health. I needed to get the papers. I was in and out.

Mullan: So I asked about how credentialism and how it related to you when you saw it develop.

Levine: I saw what was happening, and whether I believed it was the right way or not, nursing as a profession decided--well, they'd been battling it for years, really, you know, associate degree, bachelor's. They've been fighting for years, and they'll never clear it up, that to be a professional nurse, you know, the only way to do it, especially as a nurse practitioner, was to have the masters' degree. Now, this was the decision they had made. I could argue the point that they're opening up schools and nobody's checking the quality of the education or the quality of the preceptorships, and what were we really doing? Just because you've got the letters after your name doesn't mean that you're the best we have to offer.

Mullan: But that's what was going on?

Levine: Yes, that's where it's at now.

Mullan: You mentioned the issue of a more explicit but also arguably a more limiting law, i.e., the protocol, the physician collaborative practice, etc. How was that greeted by the nursing community, and has that evolved on in New York State?

Levine: It was limiting in the sense that we would have to work from protocols, and the law also limited prescriptive privileges, I'm only allowed to write prescriptions for patients within the collaborative practice. If you asked me for a prescription for yourself or your son for Amoxicillin, I'd be breaking the law to do that, unless your son has Jacobi chart number. My own feeling was, "Big deal. I don't want to be writing prescriptions for folks that I'm not treating anyway." So I don't have an issue with it. And the reality of the protocols is that the state has limited resources and can't check on their use. That's the reality. They don't know what's going on. They just don't have the funding to check to see what people are doing. I think institution by institution, we have to monitor what we are doing through a QA process and chart reviews. We should be responsible for that. We really shouldn't be leaving it to the state. We do that here (QA).

That's the law. So it gave us the ability to write prescriptions. So that was good. We don't have to get co-signature anymore. And legislatively, they continue to work for direct reimbursement. There are groups. There's the Coalition of Nurse Practitioners, NAPNAP, which is the National Association of Pediatric Nurse Associates and Practitioners. They work on the legislative policy. So they're always working for us to make sure that we're in the arenas where we need to be.

Although it may have seemed initially a little limiting having a law, we needed to have some structure. I mean, you just couldn't have people graduating from any old school, going out there, and not have some kind of consistency in what people were doing across the state. So from that perspective, I understand it. Everybody should be at the same level, at least on paper, and there should be a standard. And that's what they're aiming for.

Mullan: How about, again, the eighties, the specialist versus generalist, primary care versus non-primary care thinking? Did you see yourself as a primary care practitioner?

Levine: Yes.

Mullan: And realizing you--you [unclear] pediatrics always, right? I mean, you always were a pediatric--

Levine: Right.

Mullan: How did you see that, and particularly in this generalist/specialist work?

Levine: I really always felt that we're the primary providers, we should be working in consultation with all the specialists. They should be advising us on what to do. They should not be seeing the patient in isolation. We've had some issues around here. Diabetes was the big one, because they were growing and moving and changing, and they really felt that they provided

primary care, but I think their sphere was a little bit limited in comparison to ours. And I saw myself as a generalist. Even though my area of expertise was chronic illness, my focus was the child in the broad sense and the family.

I have to tell you that I also think that, to be honest with you, there are some specialists that I've worked with in this hospital that are wonderful primary caregivers. Dr. Maria Santorinean, who's a hematologist--

Mullan: She's still here?

Levine: She's still here. If a patient with a hemo problem is followed by her, that would be enough, because she's making sure that the immunizations are up to date. She's involved socially, psycho-socially. So it depends on the person.

Mullan: Sure. But you're speaking now not only in terms of your experience, but as you have seen the nurse practitioner move into--

Levine: They consider themselves primary providers.

Mullan: Certainly in surveys and other kinds of querying that have been done in the nurse practitioner community measuring has suggested that the identity of the nurse practitioner in general is largely as a primary caregiver or a generalist, whereas the physician assistance has tended, as that movement has grown, to be in larger numbers specialty-focused. Any sense of why within nursing the generalist mission has remained paramount?

Levine: Because I think we see ourselves as holistic and really believe that if you're going to treat and care for and educate, that's how you do it. And we learn that as nurses. So you just carry it over into nurse practitioner. But the difference with PAs, physician assistants, their training is very different. They get a six week rotation in each area, medicine, surgery, OB, peds, etc. They don't specialize in either pediatrics or medicine. So although they do believe they come out, some of them, with a primary focus, they don't have the intensity in that one area.

Mullan: Would it be fair to argue that the clinical nurse specialist is something of the analog of the specialist in the medical model?

Levine: Absolutely.

Mullan: Well, let's move into the late eighties, early nineties, when some major changes started to take place here at Jacobi. Tell, both for me and the record, updating a little bit, what kind of institution Jacobi is and has been and then what changes it went through at that point.

Levine: Well, we were, I guess, in the beginning, a 700-bed level one trauma, 911 receiving, city, public hospital, and a training institution in affiliation with the Albert Einstein College of Medicine.

Mullan: With large numbers of house staff.

Levine: Huge. Huge.

Mullan: House-staff-run, as I recall.

Levine: It's a house-staff-run hospital, actually. For me, the change took place when they split and they became a combined program with Montefiore.

Mullan: Saying what? You mean split?

Levine: Well, Jacobi Pediatrics used to be here.

Mullan: So it was an Einstein-affiliate program but was separate from the Montefior program.

Levine: Yes.

Mullan: So at some point they combined them?

Levine: At some point they combined them.

Mullan: When was that?

Levine: I'm not sure on the dates. The day we became two campuses, we lost the Jacobi family, which is too bad. That was the end of it, as far as I'm concerned. It was just too massive, and house staff weren't here all the time, the house staff was split between two sisters. It was difficult for the patient to access them, for us to access them. Continuity was gone.

It was happening for a reason. There was a plan here. You know, I wasn't privy to it, but I remember in my younger years, talk of Dr. Cherkasky, Dr. Martin Cherkosky wanted to build an empire at Montefior. And I was young, and I didn't pay much attention to the talk in those days. But even during my time as a nurse practitioner, we started losing census and numbers of particular types of patients, certainly the patients with the tracheotomies, we weren't getting that many referrals. That's because ENT had moved their offices. They were either at Einstein or at Monte, but people were leaving this place.

Mullan: So the intensity level in this place became less?

Levine: Yes. If you sat back and opened your eyes, you, you could see what was happening. How long are you going to run a pediatric service without neurosurgery or ENT being right here? So I'd seen it happening, pick, pick, pick, little, by little, by little.

When I left the ICU, there generalists who were running the ICUs. They didn't have intensivists then. After I left, intensivists came in. If you didn't have that intensivist, you couldn't run a unit. So we lost the intensivists. We lost the unit here.

Mullan: Were the number of beds falling at Jacobi [unclear]?

Levine: A little bit.

Mullan: And this was going on in medicine and other services as well?

Levine: Yes, but it hit Peds first.

Mullan: So what happened then in terms of house staff?

Levine: They started to reduce numbers. Well, there was the other part. They weren't meeting their match, and there were a couple of years there where the quality of the house staff was not the historical great Jacobi house staff. And I think they made a decision one year--I don't remember the year--that rather than try to fill, that they would level off, that they weren't just going to take anything. It was just getting too difficult. So we had a few years there where there were diminished numbers, and then for whatever the reason was, the allure for Jacobi Peds and the quality started increasing again.

Mullan: I'm going to turn the tape over.

[Begin Tape 1, Side 2]

Mullan: This is Sunni Levine, tape one, side two, continued.

Levine: From the nursing perspective, you know, just sit back and talk to the nurses about, "What's the house staff like?" As the years went on, they didn't trust anymore. You felt it was a house-staff-run place, but it started getting scary because the quality had dropped, and has never come back up.

Mullan: It was a separate program still from Montefior? It was a separate [unclear]?

Levine: No, it was a combined program.

Mullan: So the diminished quality is part of the overall--

Levine: Yes.

Mullan: What happened in terms of phasing out? I gather the pediatric house staff program has been phased out.

evine: No, not completely. We lost the house staff completely, Lalmost completely, in the newborn nursery. We only have one resident who we're losing at the end of this month. The NICU, we lost all of the residents--about four years ago, the entire house staff. That's why we did a "grow your own" neonatal nurse practitioner. We got the State support and sent our nurses off to Cornell. So we had PAs and neonatal nurse practitioners running the NICU. This year we're probably going to lose the fellows--this year has been a real disaster year. I don't know what's going to happen. But the census has dropped dramatically. Had it not, we probably would--we had to drop it at times by ourselves because we just didn't have the manpower to provide care.

Mullan: Why has the census dropped?

Levine: I don't know. I don't know if it's the managed care. It's unclear.

Mullan: What is the patient population?

Levine: Mostly Medicaid. Some will argue that since Medicaid is being taken all over the place, why should a woman come deliver here and be in a six-bedded room, when she could have privacy at our Lady of Mercy, Einstein? So I don't know that anybody's really studied it to know.

Mullan: How many beds does this hospital have now? You said it had 700.

Levine: Well, it had 700. I think we're about down to 600, but the truth is we're going to 300. We have a new medical director, a new CEO, and the plan for this hospital was to make it a 300-bed community hospital. A year from now, it's not going to be anything like what I've known it as. At first it was the medical realm that was affecting us. It was the funding, losing the funding, the consolidation of services, the move towards primary care, and the decrease of specialties. That was initially what was affecting us.

In there was managed care drawing out--you know, the contracts happening much more quickly all around us. The city's very slow at getting anything. So we were losing our census. They were actually going to the welfare centers, these HMOs and managed care programs, and enrolling folks. A patient would come into clinic and the financial counselor--bet you never heard of

one of those in a hospital--would say, "We're sorry. We can't see you here because your managed care organization won't pay."

Mullan: As the nature of the hospital has changed and as the nature of the house staff for related or unrelated reasons has changed, the role of the nurse practitioner on the inpatient side has become more prominent. Tell me about that.

Levine: We thought we would be able to run the inpatient pediatric service with NPs and PAs and going for a model where they would run it and the house staff, the limited house staff, would come in and just have a different experience of working in a multi-disciplinary setting with the NPs and attendings, and have their rotation here. It didn't pan out.

Mullan: Why not?

Levine: We were unable to attract enough nurse practitioners to man the floor, basically. You know, I think by the time you become a nurse practitioner, you're well into your career. The last thing you want to do is start going back to rotations, which I guess we really didn't think of initially. The role of a ▒perpetual▒ intern is not what NPs have in mind.

Mullan: The labor intensity of it, rotating call schedule, crisis orientation was not appealing at all.

Levine: It wasn't appealing at all. So we lost folks faster than we could bring them on. We never had the numbers that we needed. For some reason, [unclear]. We couldn't pull it off here in pediatrics. And there were conflicts between the house staff and the nurse practitioners. Interestingly, once the nurse practitioners got their feet on the ground and they really felt like they knew what they were doing, they only wanted to work with the attending. They really didn't want to be advised by the house staff, what if a house officer was telling them to do something that was inappropriate? It's a different generation now. Even with the house staff, it's very, "me, me." The commitment is not there. I think the Bell Commission and the 405 regs impacted immensely on the way house staff provides continuity.

Mullan: For the record, though, the 405 regs were the ones that limited house staff working hours?

Levine: Yes.

Mullan: And the Bell Commission?

Levine: It was Burt Bell working with Axlerod. That was the Bell Commission--Committee, we're not supposed to say commission--Committee that set up the 405 regs. It was probably good for the lifestyle of the house staff, but it destroyed the care.

Mullan: Really?

Levine: Oh, yeah. Yeah. The commitment is not there anymore. But the world is much different. What seems to be lost is the quality of the relationship once held by nursing and house staff. The NPs on the in-patient unit have had difficulty in developing routine collaboration with the house staff. The house staff are in training, the NPs are working shifts. This led to There were controversies of who's in charge, and who's doing what, and, "Why should they be allowed to leave at 3:00 if I have to stay here and finish my work until I'm done"

The NPs were pretty picky about the quality of the sign-outs that the house staff was giving and reported that some information wasn't shared with them. The only thing I can think of is the quality relationship NPs and physicians have had in ambulatory care is based on a relationship with attending physicians. If the in-patient NPs had worked solely with attendings, maybe it would have worked out better than working with house staff.

Mullan: What has happened to the service?

Levine: We're going to downsize the amount of NPs that work there now. We have four teams upstairs from the old Bronx Municipal Hospital Center, which is now Jacobi Medical Center, there's the BMH and C teams, each one with a team leader who's an attending, NPs and PAs and the house staff.

We're at the point now where the amount of providers that we have for the census is too great. The average daily census--maybe sixteen or twenty, on a good day thirty, on the best day

forty in respiratory season. The house staff can manage it, and we're probably just going to need one NP or PA per team.

Mullan: And they'll provide enough house staff to do that?

Levine: There'll be enough house staff. We have the house staff. Their involvement and the numbers went up again. As long as we can provide some kind of an experience, as opposed to what Monte's doing, and as this is a more ambulatory-based experience, we have the ambulatory care pavilion over at Van Etten a really hotsy-totsy OPD experience. We'll have something for a while to draw house staff, but my gut feeling is that Monte's like Pacman; it's eating up the Bronx. They are even inside of Jacobi. The Monte dental clinic is inside this very building. Employees discuss the similarity of the sign age color. Our affiliation with Einstein is likely to end and our new affiliate will be Montefiore.

Mullan: So in terms of the interplay between nurse practitioners, PAs, and house staff, it didn't go so well, and I understand the sign-out and the different understanding of what each is about.

Levine: Yes.

Mullan: What about an issue that's raised many times in many different ways about comparability of not [unclear], but it's said in some circles to replace a house officer you have to have three nurse practitioners. Now, that assumes the house officer

is working around the clock and is not taking elective months or research months or a variety of other things and that a house officer is like a second or third year, you know, fairly well fired-up house officer. I'll always believe that if you really take the total specter of house officers ranging from the wet-behind-the-ears intern, who is very slow and very efficient, requires a lot of supervision, to the third- or fourth-year very competent person and then you factor in the teaching time and the elective months and the research months and so forth, that the replacement requirements are not as hefty as some would say. What do you think about all that?

Levine: Remember the spectrum of NPs that you get is also variable. If we could hand select the NPs, in a year or two we could, we would have excellent clinical practitioners. If we could retain the experienced NP and find a group willing to work the off hours, we might stand a chance.

Mullan: I guess it would stand to reason that even with, say, a third-year resident and a seasoned nurse practitioner, the third-year resident is going to have more required hours on duty.

Levine: Right.

Mullan: So he or she is going to be cheaper in that sense. To replace him or her, you're going to have to have more than one nurse practitioner because they are working a forty-hour week, whereas the resident's working something approaching an eighty-hour week.

Levine: I think they thought it was going to be cost-effective. Maybe in a hospital in another community where you're dealing with fewer social problems, fewer economic problems, in one of those "white picket fence" kind of communities, maybe it would work. You get a kid in who's sexually abused here, and the nurse practitioner wants to stay, and you go into overtime, it's not cost-effective. The house staff is going to stay without overtime costs. Now, that's not to say that there are some of us who would stay and would not put in for the overtime, but as in medicine, there are nurses who may not have the type of commitment I have. I never watch the clock. And some people can tell me I'm a fool, okay? I never watched the contract. I just wasn't like that. And many of the people I grew up with were not like that. And if I had to stay because something was going on, I just stayed, and I signed in and signed out my regular time. The world is not like that anymore. There are a lot of folks who feel like if they're going to stay for their patients, they want to be compensated.

Mullan: It's expensive.

Levine: It's expensive.

Mullan: So let's go back to your story in particular. The last number of years, the late eighties to the present, you have been involved in overseeing and coordinating this inpatient activity?

Levine: Yes. Well, everything. If there was a nurse practitioner or a PA involved in it in pediatrics, I was

overseeing it, and basically we worked to educate neonatal and pediatric. I was associate director for the NPs throughout the hospital. We also sent off about fifteen adult nurses to become adult nurse practitioners. We were supposed to do the same thing in medicine that we were doing in peds. It just never happened, and I don't know why. The money was here for the pediatric people to take NP positions. I don't know what happened in medicine. Somebody forgot to send something out in the mail, but we graduated a whole lot of adult nurse practitioners and didn't have positions for them. It was really sad. We coordinated that effort.

Mullan: So what did they do then, went and got jobs elsewhere?

Levine: No, because they have a commitment to the city.

Mullan: So did they come back and work as nurses?

Levine: Well, they were here working as nurses. It was three years that they gave back as an NP and a year and a half if we couldn't get them a job. Most of those people are still here, and, actually, they're finding positions for them and creating positions now.

Mullan: As nurse practitioners?

Levine: Yes. In this new service line. Our graduate neonatal nurse practitioners came back and are now running the unit. We've had some turnover. The pediatric people came back.

They're all still here. The ones that we sent out are all in an inpatient unit right now. Some of them will be going down to the clinic, the outpatient department, and a few of them will stay upstairs, doing inpatient.

Mullan: But your job is largely to oversee these developments?

Levine: It was.

Mullan: Now it's changing?

Levine: It changed a year ago when we went service line.

Mullan: Which means what?

Levine: Which means that instead of having traditional Department of Medicine, traditional Department of Nursing, and Social Work, the hospital was rearranged by service. So medicine has nurse practitioners in it. The medical nurse practitioners went to the medical service line. Each service line is spearheaded by an administrator. It's not a doctor or a nurse. They're hospital administrators. There's Children's Health Service. There's Behavioral Services, which is Psych, Medicine, Surgery.

Mullan: What about the Pathology, Radiology?

Levine: That falls under some other service line.

Mullan: So it's an effort to break down the traditional cross-cutting chunks, docs, nurses, administrators, whatever?

Levine: Exactly. So Ruth Stein basically is in charge of the physicians.

Mullan: Within the pediatric?

Levine: Within the pediatric service line. And our service line is comprised of OPD, Peds, Emergency, the inpatient service, we have an AIDS day care center. They separated women and children's. So there's the Women's Health service line. So I get the children and my counterpart gets the mothers. So I have the NICU and the newborn nursery. That's our service line. The good part of that is we've really been able to facilitate getting admissions from the ER. We are really working very well together. So it works really well for the patient. The problem is, of course, the other lines, obviously, variations.

Mullan: And they've got to communicate across.

Levine: For me it's [unclear].

Mullan: Surgical--

Levine: Surgical. But fortunately the person that's doing Women, she also happens to be a pediatric nurse practitioner. She was in my program, and we have a good relationship. So we

can work really very well together. The two service lines work well.

Mullan: That job is changing too, service-line job that you've had?

Levine: That's what I just took a year ago. So rather than just being in charge of the nurse practitioners, I'm now responsible for all the NPs, the PAs, and all of nursing in the service line. So it kind of quadrupled for me, the responsibilities. I had never done operational nursing before.

Mullan: Operational nursing?

Levine: Well, being in charge of R.S. and LPNs and nurses' aides. I've dealt with NPs since I graduated.

Mullan: How's it going?

Levine: It was challenging, to say the least.

Mullan: What about the NP versus PA functioning outpatient/inpatient primary care in general? What do you see?

Levine: There's only one PA here who works in primary care, and she works in adult medicine. She used to be a pharmacist. She works in OPD, medical clinic. To be honest, they do seem to want to specialize. Even though we see our PAs on the inpatient

services as primary care providers, they don't like to go to clinic. You know, they're supposed to follow their patients. They really don't like that. They want to be inside. It's almost like people who work inside the ICU, they just didn't want to go outside to work. They're really not interested. They see themselves as primary care providers, but they don't want to do the primary care in the clinics. They want to be where the action is, I guess. There are probably some PAs who are probably excellent primary care providers. I think that anybody that's got a background and wants to do it can learn how to do it. It's a mind-set.

Mullan: Has the interrelation between the PAs and NPs been okay?

Levine: Yes. They work pretty well together.

Mullan: Let me go to a few big-picture questions. One of the significant policy controversies, particularly in Washington--and I suspect in state capitals around the country, but certainly in Washington--over the last few years has been the question of the independent nursing or the degree of independence, with the nurse practitioner being in the lead. How do you see that developing, and where do you see that going? Is nursing ultimately going to be a separate, stand-alone profession as some nursing pundits would suggest?

Levine: You mean the NP part of it?

Mullan: The NP part of it being the kind of leading edge, but the way I've seen it anyway, with apologies for pushing my ideas, is that the nursing leadership that has long bridled at being under the thumb of doctors has seen the NP as the lead dog, if you will, or the lead agent for pulling nursing more out on an independent par with medicine and no longer being as responsible to medicine, or subservient to medicine, as they've been in the past. And at least on the political levels, those debates are hotly engaged. How do you see that developing here?

Levine: When I went into nursing, I saw my role as somebody who worked along with the physician for the patient, not at all subservient. I was never treated that way, and if I did I would deal with it just like a woman anyplace. I really believed that we had independent roles, but we worked together. And I know that my experience is very different than a lot of other folks have had. Nursing, I know, has fought to come out from under--you know, they see themselves as working under the physician. I think it's an individual problem. I think they've made it a professional problem. I think people lose perspective. I think we have to see ourselves as, yes, we're an independent agent, but we're a collaborative group working towards patient care--we have our own jobs. We have to work together. I think that nursing should dictate what the nursing profession is about, the same way physicians would not want another profession telling them how to do things. I think, for the nursing part of it, that we should be independent, but I think we can't lose perspective that we're all in the same arena--not the business--the health profession.

I resent the profession of nursing seeing the NPs as a leader to pull us out of this because I don't see the problem the same way they do. I think if you're an independent practitioner, you develop the respect from the people that you work with, that if we were all doing the right thing, the glory would come automatically. I really think that they get too stuck in politics sometimes. They have been fighting for years and years and years what the entry level should be. This has been going on since the day I became a nurse, and there are still associate degree programs and baccalaureate programs and master's programs. Let's work on the quality of what we are putting out there and not worry what the letters are--because they really are not concentrating on the quality--and, you know, get down to the meat of this stuff and make sure you have a good registered nurse out there. To be honest with you, I think they've blown it. I think they've worked so hard at offending the medical profession and pissing them off, you know--and I don't mean us. I mean those folks at the AMA, you know, the big boys' club. That's why all this patient care associate stuff is happening.

I think that some people have gotten to the point where they don't want to bother anymore and saying, "We can find somebody who can do it cheaper and will listen to us." And that's what's happening. You know, they're bringing all these non-licensed folks now to do the job, and they're saying, "Well, you know, you can teach the skill to anybody."

Mullan: Is that happening here in New York? Because I know that's the big deal in California.

Levine: Yeah, it's happening. And I'll tell you what's upsetting. My son had to have a minor surgical procedure at Einstein, and there was a woman in a lab coat who took his vital signs. That was the first time we were there. And the second time I was there, the secretary told her, "Well, you know, the doctor wants you to draw up the lidocaine," and she was getting me to sign the consent, and something just wasn't right. And I said to her, "Are you a registered nurse?" And she said, "No, I'm a medical assistant." And I was worried, I really was, because I don't know what their level of training is, and I don't know who oversees them. Why is she drawing up the lidocaine? Is she injecting it? You know, so, for me, on a very personal level, it brought up a whole lot of issues, and I think we need to be careful. But I think it's working to the detriment of nursing, I really do.

Mullan: Let me ask, if I might, on a more personal level. You've had a fascinating career that's bridged major changes in health care and major changes in the provision of care, major changes in nursing. How has that all embellished, enriched, or impeded your personal life?

Levine: My personal life?

Mullan: How has your career related to your personal life? Has it been enhancing or troubling? This is a question I often ask physicians.

Levine: I think the whole experience has made me a better person. I have two children. I have two boys. They're 13 and 16 now. In August, they'll all go up a year. I've been separated for ten years, so I basically have raised them solo. I think it's given them an experience that they would not have otherwise had. It has made them more sensitive.

Mullan: Because of what they know of your work?

Levine: Yes, because I've had them here, and I talk. Some of my patients have my home number. I've had people call me at home. You know, I've always believed that it takes two seconds on the phone for somebody to call me, whatever it is, and people never abuse it. And I can relieve a little anxiety, a little direction to somebody rather than having them have to deal with the system. In the chronic illness program, there are people who called pretty regularly, and I was nurturing the way I was with my own kids, and my kids got to know some of them, at least my oldest, it gave him an appreciation for what he has, because he saw folks in tough situations--in particular, this kid I took care of, he's in his early twenties now, Ralphie Diaz, who has Werdnig Hoffmans disease. It's a debilitative, degenerative neuromuscular disease. And Ralphie managed to get through high school at home and even with this, with a trach, he became computer proficient, is working for the *Times*, collecting the stats for their bestseller list. I would tell Ian about this all the time, and they met other kids with handicaps and they saw the challenge.

They also see where I've gone so they know that it doesn't matter how old you are, you can accomplish at any point in life.

You don't give up. My oldest son was 16 when I got my master's, he came to the graduation. In school, he was writing a composition on "The person I most admire." He told me he was writing it about my brother, but he wound up writing it about me. So I feel like I gave them more than just the mothering part of it. I've been very committed to work, and sometimes it's very hard to balance. Often I've said--"I'm on the phone now." "This is really important. This is job-related." And in the last year my work hours have been outrageous, this last year. They know they're number one, but I'm sure sometimes they question it. The exposure it's given them and it's given me the realities of life, I think, really has just been the best thing I could have provided.

Mullan: And is your mom still alive?

Levine: My mom's still alive.

Mullan: Is she proud of what the decision she made?

Levine: Yeah. Yeah. My father died in 1990, and I'm sorry, you know, that he couldn't have seen, because he was an administrator over at Einstein. He worked his way up, just worked his way up by himself. He was just an eighth-grade graduate. I mean, for him to see his daughter in an administrative role I just know it would, you know, he just would have--"kvell" is the word in Jewish. It would have made him proud.

Mullan: Did your work [unclear] on your marriage? Was that an issue in the marriage?

Levine: Yeah. Probably. Not because of the work, probably its importance to me. He's a club date musician, a singer with a band. Really did not go on educationally, just got out of rehab. He just now at age forty-nine realized that he's had a drinking problem all these years. I realized there was a problem earlier. For a long time, we were in therapy. I guess I was a caretaker in the beginning. I was going to fix everything. I really think it was other things other than just the nursing, although I know that he would make remarks from time to time, you know, about professionals. I know it distressed him. But he had his own issues. So I don't know that it was just my profession. Thank God, though. I mean, it was this profession that got me through, really.

Mullan: To go back to the profession, your thoughts on the future, where do you see primary care going? Where do you see nurse practitioning going?

Levine: I think we're going to go back around again to the way things kind of used to be with more focus on the generalist primary care, because I think we're being forced to do that. I think we're going to have a complete cycle. I think they're going to diminish the subspecialists and then they're going to have to put them back out again. I don't see how this whole managed care/HMO stuff is going to make it, because of who's getting rich off of it. I think it's going just going to be a matter of time

until there's enough horrors out there, you know, patient horrors, then we're going to have to re-equilibrate again.

But I think primary care is important. I think there's a role for NPs out there. I think the government thinks it's out in the boondocks. That's really where they were hoping we would all go, and the doctors didn't want to go out there, to the areas that are under-served. I think if we don't price ourselves out of the market and don't overdo it, we have a chance. I think we're starting to get too many schools pumping out too many NPs, and there are too many folks needing to be primary care providers, as per the government--I think we'll have to find some other track to go in. But nursing is very creative.

Mullan: You're saying the market is getting saturated with primary care providers?

Levine: Yes. But you know, it's these markets, like the East Coast and the West Coast. I think there's a great need in between, but I don't think anybody's going to go there.

Mullan: But even the urban inner city market? Even in the Bronx where new nurse practitioners are having trouble finding jobs?

Levine: I think they're having trouble finding jobs because of the downsizing. We always worked in clinics, and they're just expecting to do more with less. That's what I see right now.

Mullan: Are nurses being laid off in general in the Bronx?

Levine: I just went through two weeks of laying off 100 nurses.

Mullan: In the pediatric--

Levine: It affected us here. We didn't give any lines up but civil service has a bumping process. So there's about thirty-five nurses in pediatrics that were affected by it. The least senior. My service had done a lot of hiring in the last year. I just had the ship ready to move out of the port. Everything was "go," and their last day is Friday. It's a sin.

Mullan: It's what?

Levine: The [unclear]. It's the best part. You know, the dead wood that's probably been here longer than me--

Mullan: Is staying.

Levine: Yeah. So I don't know. Especially with this place, you know. I don't know what's going to happen. I don't know. I'm not privy to the politics, but I went to a community board meeting last Thursday and somebody said publicly about Montefior taking us on.

Mullan: Any other aspects of either your career or observations you'd like to mention?

Levine: Because we live in very difficult times, and I am pained by what I don't see in nursing and medicine anymore, the care giving. It really distresses me. I am pained by NPs going into

a profession because they make good money, and, trust me, there are people who have gone into this profession because it's better bucks than some of the other stuff around. I mean, that really hurts me, because to me it was this real caregiving profession that I went into. It just changed over time.

So it's difficult. Every day is difficult, but every now and then there's a patient who comes back to thank you. Elvira Mahmatovic, who was congenital hypothyroidism, who had just come over from Yugoslavia, the mom didn't speak a word of English. The child lost a lot--mom wasn't giving her child her medication because she thought we were trying to poison her. She can speak English now, and she tells me what those early days were like, and comes in and says, "Thank you. You made the difference. If it wasn't for you--" Phil Candelario's [phonetic] mom, the worst two-year-old asthmatic on the face of the earth, who was intubated in the unit a million times, who is functioning now and doing really well, they had a difficult psycho-social situation, and she'll come back and she'll say, "Sunni, if I didn't have you then, I don't know what I would have done." She had what it took. She just needed the directions. And those things make up for every bit of pain, every horror that you have, because for somebody to think that you're that important, or really to have made that much of a difference to somebody, nothing, nothing on the face of the earth can equal that. And we still get that around here. You know, we've helped. And to me, that's what it's all about.

Mullan: That's great. Where did the name Sunni come from?

Levine: When I was in nursing school, I was Ellen, and there was a Helen. There was a Helen Sternberg, and I was Silverberg at the time. We both had long straight brown hair, because, you know, it was the sixties, long hair was in. And they kept mixing us up. Like I said, there weren't a lot of Jewish gals in nursing. They kept calling me Helen. They kept calling her Ellen. So we said, "Let's take nicknames." So being the fairly creative person that I was, I loved the Johnny Mathis song, "Sunny." And then there was that sixties hit song "Sunny." I never had a nickname. So I took Sunni, but I spelled it S-U-N-N and over the "I" I made a big sun. She took "Holly." And it just stuck.

Mullan: Great story. I think it's a good place to stop. Thank you.

Levine: You're welcome.

[End of interview]