OREGON HEALTH & SCIENCE UNIVERSITY
ORAL HISTORY PROGRAM

a project of OHSU's Historical Collections & Archives

an interview with:

Rosemarie Hemmings, Ph.D., L.C.S.W.

interview conducted on: November 1, 2022

by: Susie Goolsby, D.D.S., M.S.H.A.

Interviewee: Rosemarie Hemmings, Ph.D., L.C.S.W.
Interviewer: Susie Goolsby, D.D.S., M.S.H.A.
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Susie Goolsby: Okay. All right. My name is Dr. Susie Goolsby, and I am interviewing Dr. Rosemarie Hemmings for the OHSU Oral History Program. It is November 1st, 2022, and we are recording this oral history digitally through the services of the BICC Library. So Dr. Hemmings, what a treat and pleasure to be interviewing you today. We've had a chance to chat some, and I think the listeners will really enjoy hearing about your background and the things that you do and how you see healthcare. So, I would like to start with your early life. So, describe your childhood and education, your trek to Portland and your work here in social work, if you will.

Rosemarie Hemmings: Okay. So, I'm from New York, which I think most people will pick up from my accent. Actual New York City, the heart of New York in terms of Brooklyn, that's where I grew up in a predominantly very Caribbean diverse culture, but very Caribbean household. My parents were Jamaicans. I saw the movie *Till* this weekend and, you know, there's a, Emmett was sent down south because he was in Chicago to spend some time with his family. And it triggered a memory for me growing up in the city where when summer came, a lot of my friends were sent down south, right, for the summer to be with their grandparents, aunts, and uncles, where I was sent to Jamaica for the summer, right?

I didn't like that idea. Because I really wanted to stay in Brooklyn to be with my friends that didn't go down south. So yeah, I grew up in New York, in the city, very diverse. Went to undergrad and grad school in New York. And I would say I spent most of my life there until I think around 2004, I relocated to Florida, southwest Florida. And I spent ten years in Florida before relocating here to Oregon. And what brought me to Oregon was I came out here to work with the VA system in Medford area. And after about a year, I relocated to Portland because once again, searching for more diversity, right? And that's kind of, you know, my story around that.

Goolsby: I want to return to the Jamaican summers part. And I wonder how that informed your trek in life, your decisions to go into social work.

Hemmings: Yeah. You know, looking back, I would say that my mother really, this is myself and my younger brother who's about a year and a half younger than I am, would probably saved the entire year, from summer to summer, to be able to send us to Jamaica. Because I think in her mind it was cheaper than keeping us here all summer, right? She's working, having to be concerned about what we are doing. And I think it also gave her a break. But I think there was another piece of that where she wanted us to connect to our heritage, to our roots, and to have an appreciation for that part of who we were.

And my summers there was varied. I mean I would stay with different family members. Some were more well off than others. So I had an opportunity to stay in the country with people who didn't even have electricity, right? And to really begin to appreciate what I had. And also, it was a very – a lot of my family members there were very Christian. So we spent a lot of time

going to church like almost, I felt like every day of the week. I didn't actually like that. So in terms of just shaping who I am today, I think it has helped me in terms of being able to understand the varied lived experiences of people, understand the different cultures that make someone who they are. And also just how important it is to have roots, to know where you came from. And that part of your identity is very important. And also, what it's like to live in different worlds, almost. Very different experience there. Most people think of Jamaica, and they think, oh, Negril, Ocho Rios. All of that.

My summers was spent really learning. I had one of the family members I stayed with was an educator. So I actually had to do schoolwork while I was there. It was required. And the schoolwork there was a lot more advanced than what I was doing here. So it helped me even in terms of academically. I would come back and I would be way ahead of my other classmates. But it grounded me. And I think that's the thing. It grounded me and humbled me in terms of really understanding who I am. And Jamaicans are a very proud people. We're feisty and we tend not to really allow others to step over us. And I think people who know me at OHSU knows that about me, right? But I think that experience of growing up, my childhood I think is what people see now when they see – and I'm always willing to step out and look out for people who I feel are not being treated well. So, yeah.

(00:08:18)

Goolsby: That's a beautiful personal history. Thank you for sharing that. So what actually inspired you to pursue a career in social work, though? Or who?

Hemmings: Yeah, so my mother was a nurse's aide in a nursing home, I guess all of my childhood. And she would come home, and she would talk about stories about her patients. And she would always talk about the social worker. So that stuck in my head. But if I'm going to be honest with you, I went to college to major in music. Because I played the clarinet and I played several saxophones, the alto sax, baritone sax. I wrote music, transcribed music, I played in the state band, I traveled, and I went to college because I wanted to be a conductor.

I wanted to major in music. And my goal was I wanted to stand in front of an orchestra and be that person who conducted the orchestra. And I remember my mother saying to me, "What are you going to do with that?" And I didn't care. So I went to college to major in music. And I share this with teenagers, like high school kids, when I do my talks around my journey. And my first semester I didn't go to my music class because I figured, I went to like the first two classes. And I was like, I know this stuff, I don't need to go. So I didn't go to class. And what do you think happened? I got an F. Because I just showed up for the exam and failed. So I got an F, my first and only F. That ended my music career. So that was freshman year.

And then I couldn't, didn't really think about what I was going to do after that. I just took classes, hung out, you know, friendships and social circle was the most important thing for me. I pledged a sorority. And then my sophomore year I had work study. So I was working in the office of academic affairs. And my supervisor there was a social worker, which was unusual because academic affairs, most people there weren't social workers. And she was also Black. And I went to a predominantly white school. And she mentored me as my supervisor and as this young Black girl who just seemed so lost and didn't know what she was doing.

And she sat me down and she said, "What are you going to do? What do you want to do?"

I was like, “I don't know.”

“Well, you're a sophomore. You have to declare a major before you turn into your junior year.”

I was like, “Oh, I don't know what I want to do.”

And then she said, “Have you considered social work?” And she had heard about my petition. I had started petition on campus to allow homeless people to attend the university. Because there was this homeless guy that was on campus. And people would mistreat him and treat him so badly. And so I started a petition. I would go around to get students to assign this petition to allow him to attend classes. And she'd heard about that, and she says, "You seem to have a heart and a passion for people. Have you considered social work?"

And I was like, “Yeah, my mother would talk about social workers at her job.” So I went and I did some research. And I looked at what was the field going to look like twenty years from that time. So this is 1980s, right? Early ‘80s. What was the field of social work going to look like? Was there going to be a demand? What area of social work would be the most profitable, right? So I did that, looked up, did some research. And I saw that because of the baby boomers, the aging population, and a need for healthcare, that there was going to be a tremendous need and growth in the field of social work twenty years from that point. And that the area to concentrate on was working with the elderly or in healthcare.

So I came back and I said, “Yeah, I think social work will do.” Plus, I also found out that once you had a degree in social work, you could work anywhere, that there were so many different areas of social work.

So then she looked at my transcript, my courses, and she says, “Okay, you have this, you have this, you need this. So this is what we have to do.” She sat down and she says, “You need to take this course, this course, and this course.” I remember economics was one. I was like, why do I need to take economics for social work? Because SUNY at Stony Brook, which is where I went, had a school of social work, bachelor of science in social work. That was part of their health science program. Once you got into the program, you did your two years, you graduated and you have your BSW, Bachelor of Science in social work. If I decided to go on for my master's, I could get into a one-year master's program instead of two.

So she says, “This is what we're going to do. Work on your essay.” And she worked with me. I did the classes she told me to do. Passed them. I had to get, I think, at least a C or B, whatever it was. Did well. And did my essay, did my interview, and I got accepted into the school of social work. And there started my social work journey. I went in saying, hey, I want to work with the elderly because you have to do an internship. I want to work with the elderly.

And instead, I ended up in mental health in a locked ward, a psychiatric unit. All I can remember is the keys. (laughter) And here I was young, I was probably like, what? Nineteen, twenty, right? Psychiatric unit. Didn't know what I was doing. Persistently psychotic people saying that they're Jesus Christ, the whole bit. And being locked up with these folks and the smoke. They smoked a lot. Anyway, that was my first field placement. And just being very scared being in this locked psych ward for my internship.

And then I got out of that. I can't remember what other placements I had. And then I graduated, and I applied for, that's when I applied to NYU, too, and I got accepted into their one-year advanced standing program, which is very clinical in practice. So after graduation, moved back home because Stony Brook was in Long Island, lived on campus, moved back home and went to NYU for grad school for a year. And that's where I got my wish to work with geriatric population.

And yeah, that's how I got into social work. It was kind of like... And that's why I say it's so important for representation. Representation matters. She saw something in me, maybe saw herself in me and saw what I was doing and pulled-- She didn't have to, right? Pulled me and said, “Hey, what are you doing? What are you doing with your life?” And had she not done that, I probably would've been like a lot of my other friends who didn't graduate in four years, just kind of fluttered around and trying to figure out what they were doing. So she really helped to guide me. And that's one of the reasons why I mentor today. Because I just think that was so valuable for me. And I just see how important it is to mentor others in any way that you can.

(00:17:04)

Goolsby: So on that mentorship piece, I know exactly what you mean. I've benefited from them from an early age as well. But I also enjoy mentors at the professional level. Can you talk a bit more about maybe people that you have actually asked or considered mentors to you in your professional life?

Hemmings: Only one person comes to mind. And Dr. Sullivan was my—So, after I graduated from grad school, I started working with the county hospital in their geriatric outpatient clinic. And I left that after six months. And then I went to work in the school system with kids. And then I left that, and I went to work with in home health, home care, as a social worker where I would make home visits to patients in their homes. And then while doing that-- in New York back then, to become a civil service employee, you would take these civil service exams. And sometimes you would wait a year, two years, before you got called. So I had taken a civil service exam to be a supervisor in the city, in this civil service job. And then I got called.

So at about the age of twenty-three, give or take, I became a supervisor in a mental health clinic on the Lower East Side of Manhattan, working with primarily Asian and Hispanic clients, right? Lower East Side. Huge Asian community, Hispanic community, Jewish community as well. And my supervisor there was Dr. Sullivan. And she was an African American woman. And I just looked up to her. I remember her saying to me once, and here I was twenty-three and I was supervising psychologists, supervising social workers, interns, who were all older than I was. And I came in and I had the attitude. And she really took me in under her wings. And she said to me one day, she says, “You don't do well with people in authority over you, do you?” (Goolsby laughs)

I was like, “I hadn't really thought about it, but now that you say that, no.”

And she says, “We need to work on that.” But she was-- and that was six years I did that work with her. And she really guided me in terms of how I practice. She was a family systems framework, that's what she worked with. So through her, I went on and got a certificate, graduate post grad certificate, in structural family therapy. I really honed in my clinical skills under her. And also, she taught me how to relate to others as a supervisor, right? I wasn't much like her because she was a lot more reserved. And I was still, got that edge to me. I still have it today, that's just who I am. But really helped me a lot as it related to how to be a supervisor, how to mentor others. So I would say she has had the biggest impact on me. Even today, I'm still in touch with her. She's moved on to bigger and better things in the state of New York. But yup, Dr. Sullivan. That's who I give credit to.

Goolsby: Well, I had to laugh because I've been told the same thing in my youth. (laughter)

Hemmings: She just says, "You don't do well with people who are in authority over you, do you?"

And I was like, "Nope."

"We've got to work on that."

Goolsby: You were bringing too much of that Jamaican summer mixed with-

Hemmings: Oh, yeah. Oh, yeah. Yeah, yeah, yeah, yeah.

Goolsby: So let's see. So you worked as a social worker and you kind of touched on it a little bit, but I'd like you to go a little bit more into describing how you came to OHSU and how your career has evolved here.

Hemmings: Yeah, so as I said, I came to work for the VA, right? That was in the Medford area. Relocated to Portland, just looking for more diversity. So I had a private practice while I was in Florida. And then when I moved here to Portland, I resumed my private practice seeing clients individually. In addition to, I've always been interested in my PhD, my research is actually around violence against women, but it's looking at teens. But that's a whole another story I'll get into in a minute. But I did some work around working with women who batter. Yeah, I would do groups. I did groups here in Portland for a while. Women who were mandated, who were batterers. And oftentimes women who batter, they have children and usually sometimes there's child abuse involved. So I did that work.

I did a little stint at Providence while I was doing my private practice. And then I ended up, I think at CareOregon as a health analyst around population health. And part of my work there with CareOregon was working with OHSU and some of their contracts, right? And so I got familiar with OHSU and the work that they did around the members from CareOregon. I would come to OHSU to meet with medical teams around more of the members of CareOregon that had a higher risk score. So I was familiar with OHSU in that way.

And then the manager, I think she was director, director, manager of the social work program at OHSU was leaving to go to Providence actually, to be a regional director. And I saw that there was an opening, I applied for it, came in, interviewed, and that's how I ended up at OHSU in January of 2017. In January of 2017. So that's how I got to OHSU.

So I started out my career at OHSU on the healthcare side, in charge of all the social workers within the care management team. Which at the time and still today has the largest number of social workers within OHSU. And that's how I got to OHSU.

Goolsby: Wow.

Hemmings: Because I moved to Portland. I didn't know anyone here. So I just had to find my way and just did different things. And that's the thing, once again. In social work, you can do so many things. And I made use of that until I found my way into OHSU.

Goolsby: Well, with the specialization in working with women who batter, I would imagine that takes an emotional toll both whether you're in private practice or you're working with it here in

Oregon. So how do you care for your own mental wellbeing while working with all of these heavy populations?

(00:26:17)

Hemmings: Someone once asked, when I was thinking about what I wanted to focus my dissertation on and I wanted to do rape as a weapon of war. And that was because while I was in college I had a group of friends, very close friends, even to today, some of them were my son's godparents, who were from Liberia, West Africa. And Liberia had fourteen years of civil war. And this was happening during while I was in college. And I remember meeting some of my friends' family members who had escaped the war, right? And they would talk about the things that they experienced as women, and how the fighters would break in to their homes and they would assault them. And not just the women, but the men, also.

And there was just something about that, that just pulled me. And just thinking about like, so, who is helping these people? Does this country have the infrastructure to actually work with these women on a population health level? How is this being addressed? So that was in my head from undergrad. So when I started thinking about my PhD and my dissertation, I wanted to actually do my research around that. And someone once asked me that is just so deep and dark, just like what you said. Where is that coming from? And then I kind of thought about it and-- I spent a lot of my career around in hospice during AIDS/HIV crisis in the '80s. That's where my career really started. I did a lot of work, and I was always very comfortable around death. I've always felt that it's a gift when you can sit with someone who's dying and watch them transition. And I think it just, there's something I guess out of my childhood where that comes from. So I'm comfortable around those sorts of feelings that most people are not, right? Very weird, strange, but that's just who I am. And maybe it comes from a spiritual place.

So when it comes to dealing with batterers, rape survivors-- Actually, when I did that group, it was very stressful for me to sit and listen. As a mom, a mother myself, right? And to hear the things that these women did. But it was always important for me to be able to take some time after each group to just sit and meditate. And I think self-care is very important. But I think for the most part, the biggest self-care for me is recognizing and looking at changed lives. And seeing the transition that people make out of these dark places and move into spaces that are much healthier for them. And being able to be a part of that, where people invite me in to share that part of their journey without judgment, gives me a sense of-- just feel as if I'm fulfilling my purpose. And it's not for everyone. I wouldn't recommend it for everyone. But there's just something about me that allows me to be able to be in those spaces with people who have had very dark experiences or have themselves contributed to the dark experience of others. And I don't really question that much. I just see it as something not everyone can do, and I am able to do that. So why not?

And processing is important. Having someone that you can then--Your own therapy is important, so that you have a place that you can actually process the stuff that comes up. And while we're at it, I'll just share with you because I think this might be interesting. I didn't do my dissertation on rape as a weapon of war. Because my dissertation advisor looked at me and said, "So, how are you going to do this?"

And I said, "Well, I'm going to go to Liberia, and I'm going to stay there for three months or whatever, and do my research."

And she says, "Okay. Are you independently wealthy?"

And I was like, “Actually, I hadn't thought about that.” So I didn't end up doing my research in that. I ended up doing it around team dating violence, bullying, which was kind of my way of still staying in looking at primary prevention of violence against women. But not necessarily what I wanted to do.

Goolsby: But still critical-

Hemmings: The goal was to finish. And she made me recognize that. She said, “The goal is for you to finish. When you're finished you have your PhD, do can whatever you want to do.”

Goolsby: Well, and you gave a great service to people in your own backyard. So it ended up working out. Do you plan on making that trip out to Liberia or have you since?

Hemmings: Yes, I do plan to, but not to do research.

Goolsby: Okay.

Hemmings: Yeah, I was actually on my way when COVID hit. So-

Goolsby: Oh my goodness.

Hemmings: Yeah.

Goolsby: Okay.

(00:33:17)

Hemmings: Deferred, not denied.

Goolsby: Exactly. (laughs) So, what challenges do you think public health practitioners face in Oregon?

Hemmings: Yeah. One thing we didn't cover, and I think I should pivot to that, is how did I go from social work to public health? My master is in social work, but my PhD is in public health. How did that happen? And then I can tell you about what I see in terms of Oregon. Spending so many years working with individual lives, whether it's in private practice or in organizations where people are coming in, they're in the stress, you help them, you patch them up, you send them back out. And just this one offs. I just got to the place where I was like, you know what? I'm just so tired of helping individuals. And still seeing the same thing over and over again. And then I was like, this is a much bigger issue. Because what I was seeing is the systems, the policies, the social determinants of health, the spaces in which people were living, where they were working, where they, even the church, right? These were the things that were adding to or creating what I was seeing in individual practice, right? In organization.

And I said, you know what? I want to do work on a macro level. I want to work with how do we prevent what I'm seeing here on this level from happening? How do I work with policy makers, legislators, who make these laws that I see how they impact, how resources are

allocated? Because I'm seeing the impact on the health of individuals. And I wanted to look at it on a population level. And that's why I decided to do public health rather than social work for my PhD.

So when I think of Oregon, I don't think that we can look at public health, look at the health of Oregonians, without looking at the history of Oregon. And that history, the racial history here, and also when you look at rural communities as well, I think that those are very significant impacts in terms of public health here in Oregon. And the discussions that are happening now within public health nationwide, but let's talk about Oregon, because Oregon's discussion is a little different than what's happening on a national level. And Oregon, I think, has began to acknowledge that the policies that has driven public health here excluded a whole huge segment of the population, right? And we're seeing, and we're reaping the benefits of that exclusion.

And I sit in on the public health advisory board. I'm actually on the data subcommittee in Oregon. And I sit in a lot of these different OHA, Oregon Health Authority, different committees. And the conversations that are happening are kind of all the same about power, the power dynamics. Who gets to sit in? And not just sit in. Who do we allow to participate and provide information, and who do we listen to? And are those people really reflective of the people who need this the most? And that's the struggle, and that's the rub, right? Because when you start to have these conversations, they become very uncomfortable for some people. Because sometimes it means relinquishing. And recognizing first the power that you have and that you bring to that space, and then being willing to relinquish it in some way, share that space. And that's not very comfortable to be. And that's where I think health discussions, public health in Oregon, that's the kind of conversations that they're having that they're struggling with, right?

I remember, because as I said, I've done a lot of work in palliative care, hospice. There isn't a population that I haven't worked with. But when I was on the healthcare side, I went to the Palliative Care Advisory Committee on the state level. So this is the committee that advised the governor around policies related to hospice and palliative care. And I attended one of their meetings as a public member because they have public comment period. And I went in person, this is before COVID. And they were finalizing the policies that they had come up with and the rules that they were going to share with the governor. And I sat there in the meeting and I listened to them talk about everything that they had. They had been meeting for some time. And I didn't hear any mention, and there was nothing in their policies or rules, that specifically addressed Black and brown people. How our needs may be different when it comes to palliative care, advanced directives. We tend to not have advanced directives, if we even have a will, right? How do we feel about hospice? And then there was also no mention about the LGBTQ community.

So when it came to the public comment period, I said to them, I said, "This is my first time here. I really don't know how much work you have done. But in this discussion as you're finalizing this document," I said, "I don't see anything here related to the unique needs of these particular populations."

And they said, "Oh, we hadn't thought about that. Thank you for bringing that to our attention."

And that made me realize, well, I knew this before, but it helped me to actually see. So when you have people who are sitting at these tables, who are making these decisions, and they need to have the lived experience or they need to have someone who's there who can share information about things that they may not be thinking about. This gets passed onto the governor

and it becomes the policy that the entire state follows as to how we conduct and do palliative care and hospice care in the state. And I said, how many of us actually even know, I have the privilege of knowing about this committee. But regular Jane, John, have no idea how these decisions are being made, right?

(00:41:40)

Goolsby: Yes.

Hemmings: So I think Oregon has a lot of work to do. I think they have recognized that. They're starting to look at that. COVID, as we know across the country, I think revealed issues that were there. And public health here in Oregon is attempting to look at equity. And remove the blinders that I think has been around for far too long.

But once again, we have to go back to the history of the state. And we have to remember and look at how that has shaped who we are and how we determine who gets what and what we do. And we have to acknowledge that. And be consciously aware of our ineptness. And acknowledge that. And allow other people to come in who may not necessarily have the same education level, but they have the lived experience.

Goolsby: Right. When you're serving on those committees and you may be that one voice in the room to present this other side, as time has changed, as people's opinions have changed, as their knowledge has increased, do you ever find that being that voice sometimes you're not heard because those people feel that they are so well informed that they know how these other communities would feel?

Hemmings: Yep. Yes. That comes up a lot. And there is this sense sometimes that I get, but that in itself is part of the problem in terms of power. Because that means that I need to, not me, but individuals who don't have the lived experience that I've had may feel that they don't necessarily need that. But because of their level of education, where they live and because they understand the inner workings of policies and health, that they don't necessarily need that piece. And it's almost a way of dismissing. And it's about power. Because if I step back and say, "Well, that is something I don't know," then it diminishes my power, right? It diminishes my relevance on this committee. Which isn't true. But that's kind of what's going on subconsciously. It's not necessarily conscious. But subconsciously it's kind of like well, I need to stay relevant. And sometimes that means being dismissive, or being able to show, and use sometimes book knowledge. You know, "My education, my research that I have done about these people. And I have that and I can come from that perspective. I don't really need to have the lived experience to know, right? I've read enough books to understand what Black, indigenous, Latino people need, LGBTQ need." And it's very frustrating for me. And sometimes I just sit back and I'm quiet. And people on these committees I think know me well enough now to know that when I'm not saying anything, I'm saying a lot.

(00:46:24)

Goolsby: Okay.

Hemmings: So they will say, “Oh, Dr. Hemmings would love to hear what you think.” And I said, “Do you really want to know what I think?” And I don't mince words. And I'm going to go back to, “Well, there was a discussion in this committee where we talked about power dynamics, and about the importance of lived experience. That's not what I'm seeing here right now, right?” Okay. Yeah. New York. I've learned to be assertive, not aggressive. As a Black woman, you’re always seen as aggressive. Yeah, I'll go back to, “Well, did we talk about that we wanted to move in this direction?”

Goolsby: I see.

Hemmings: We're not really going there, right? Once again, we're still having these struggles, these issues around what the research says. Evidence-based practice. Whose evidence? Who was participating in that? How many people who looked like me was in there, in that study? When you say “evidence-based,” what does that mean? Whose evidence?

Goolsby: You're making me lose track of the questions now.

Hemmings: Okay. I'm sorry. Go ahead.

Goolsby: (laughs) I'm over here. Shout and preach. I think it's important for the young people that are listening to this or anybody listening to this to know this is how we do advocate when we are in those situations. So thank you for sharing that.

Hemmings: I do not mind. To whom much is given, much is expected. So when I'm in these spaces, I am always thinking about the people that I am seeing, the stories that I have heard. And I'm bringing that in and I'm saying, “Hey, look at this.” Because I recognize here in Oregon that oftentimes those faces are not represented. Those lived experiences are not represented. Always feel that, that's my work. That's why I'm there, right? To remind people, “Hey, you got to think about this over here, these folks over here.” And they're like, “Oh, yeah, yeah, yeah, that's important.”

Goolsby: Yeah. So I want to go back to the questions, but I also wonder how do you just maintain your emotional, mental health when you have to be that person in the room, making sure that these policies reflect the needs of people who otherwise would have no voice if it weren't for you?

(0:49:37)

Hemmings: Oh, that's a good question. It's fuel for me. The fight is fuel. But I have to be honest, in December of last year, I got to the place where I said, I've got to stop. I've got to release my fist and I've got to stop fighting. And because of that, I withdrew myself from a lot of the extra things that I was doing at OHSU. Because I realized that it was taking a toll on me. I felt like I was always wound up. And I was like, why am I doing this? Is this really my fight? And what was it doing to me? Because now the people that were in my personal life were being impacted by it. Because I couldn't turn it off. I was always on fight mode, right? Always had my fists

clenched, ready to fight. And so I decided, well, what was I willing to give up, and what would I still keep? Because I knew I couldn't continue the way in which I was going.

And so I decided to give up a lot of things that I was doing at OHSU that were not part of my job. Just like all these different committees and advocacies. I still continue to mentor people there. But then I switched my focus to, I think, more so on the community legislative level and continued with those committees, national committees. I think because I felt that I could be more, it's weird, but I felt that I could be more impactful on the state level than I could at OHSU, which is really interesting. So I had to decide where do you think that you can have the most impact, where you don't feel like you're hitting your head up against the wall all the time. And so I continue to do that work. And even I've dropped out of some few things here and there on the state level, but I felt like I could be more impactful there. And once again, go back to be more impactful on a much larger scale, right? Because the work there eventually will affect OHSU.

Goolsby: Right.

Hemmings: Right? And I had to take a break. I had to take a pause. I had to just kind of, I stopped everything for a month and just took deep breaths and really process what's important? Where do you feel valued? That's important. Even though I do this work because I enjoy it, it's my passion, but at the same time I'm human and I want to feel valued. So, yeah.

Goolsby: So you decide to stop paying the tax?

Hemmings: Yes, yes.

Goolsby: That many of us women and people of color in academics end up paying. The things that don't progress our careers, but serves others.

Hemmings: Right, right. Yes, yes. You get it. See, and this is it, right? This is the kind of thing where you can talk to someone, and you don't really have to explain what you're saying. They get it. The same with clients in my practice. They come in and they say, “Yeah, I had a therapist before, but they just didn't get me.”

Goolsby: Right.

Hemmings: “I could just talk to you and I don't have to explain what I mean when I say this or I say that.” It matters. Representation matters.

Goolsby: It does, it does. So your current work involves developing and teaching an innovative interprofessional curriculum related to social determinants of health within the School of Dentistry, which I applaud you for. What does that curriculum look like and what does it hope to achieve?

(00:54:26)

Hemmings: So I was recruited, well, hired by the previous dean, Dr. Maruca, who had this vision to address the code of standards around teaching students how to relate and work with

diverse communities, population, as well as the non-biology type psychological issues, right? He hired me, brought me in. He knew what he wanted. He had the vision, but he didn't really know how to operationalize, how is this going to work? Because he's not a social worker, he's a dentist. But very much into public health, though.

So he brought me in. And I came in and there were two social work interns there. I started November. Two social work interns had been there since September with really nothing to do, no supervisor. So I came in and quickly, my first thing was to get them set up. So creating a way for them to be able to document, creating what the criteria would be for which patients who would see. How would we get referrals, working with our EHR, axiUm dental records? How do we put notes in there? Where should they go? Building that infrastructure and setting, what do they need in terms of space, supplies? Where should they sit? How are we going to see patients? Where are we going to see them, in person, over-the-phone?

So all of those logistics. So building out the social work program and introducing the dental students, faculty, to social work. What is social work? What do we do?

And then the other part was to develop a social determinants of health curriculum for the dental school in alignment with the CODA requirements. So I did a presentation at the curriculum committee, got their approval, looked at which current courses existed that we could fit in. Because at this time, we weren't thinking about having an actual course. It was just going to be how can we work this into these different existing courses that existed, right?

So looked at those courses. And then I believe the first summer was, I did like three lectures, ninety minutes, to the first-year dental students on social determinants of health, right? Was part of their professional, what's that course? It was just part of another course that they did the summer when they came in. I just did it for three times and it was ninety minutes. No big deal.

And my background as a social worker, public health, my passion around inequities that exist in health does not exclude dentistry, does not exclude oral health. Being in healthcare for thirty years, and as a social worker, honestly, we didn't really think about the mouth. When we would do our assessments and we would ask our patient, when was the last time you saw your doctor? We may even get into various tests if you had these tests done. But we don't usually say, “When did you last see your dentist?”

So this was something new for the field of social work. And even schools of social work that I would reach out to and say, “Hey, we have a social work program now in the School of Dentistry, I'd like to bring in social work interns. It's part of your master's program.”

And they would say, “Dentistry? What would our social workers, what would they do?”

And I would say, “No, nothing. No, they wouldn't do anything different than what they do on the hill in the healthcare, in the hospital. It's health.”

And they were like, “Wow, hadn't thought about that.” So we got social work students from all over. You know, Boston, Pennsylvania, Arizona, whatever.

But when you look at the patients which is what Dr. Maruca I think saw, huge Medicaid population, uninsured. And you think of social determinants of health. Who's more impacted, right? And you think about if I don't have money to pay my rent or I'm homeless, or I've got some mental health substance use disorder issue, right? My electricity, I can't figure how to, do you think I'm thinking about my teeth? No.

So when the patients come into the school and they're meeting with their dental students and the dental student is saying, “Well, you need to have this, this and this.” Yeah, cost is important, but also can I fit this in? When you're telling me I need to brush twice a day, I need to

stop eating the things that are easily accessible, affordable to me. I'm just like, mm hmm. Do I come back if I don't feel comfortable, if I don't feel that I'm capable of doing the things you're asking me to do, do I come back? Do I follow up with treatment? Do I do what you tell me to do? You're not asking of me about me, holistically. You're just focusing on my teeth. And that's the last thing I'm thinking about, right? I just need you just to take care of this. Or maybe I'm in pain.

Goolsby: Right.

Hemmings: Right? So how do we treat the whole person, right? How do we teach our future dentists that when that person sits in your chair, they're human beings with lives. And those lives—wherever they live, wherever they work, play, worship—impacts what you're seeing in their mouth. And you have to take that into consideration as you're providing care. And there goes social determinants of health, health equity and social justice, right? Because I also wanted dental students to feel empowered that they, too, can advocate for their patients. Not just within the school, but on a much population level. Legislatively, right?

The students every year I think would go to Salem. They have this legislative day thing that they do. Great. But I wanted them to think about, okay, so you're going to open up a private practice when you graduate. Do you think that the people that you're going to see, just because they have commercial insurance and they have money to pay that they don't have other issues? And I would say to the students, "How many of you know someone who's been divorced? Who drank maybe a little bit too much, use other substances, had their heart broken? Suffer from mental illness? Those things don't discriminate based on your socioeconomic status." Yes, if you are on the lower socioeconomic, you have a greater impact. But everyone in all walks of life have other things going on in their lives, right? And therefore they too should be knowledgeable about what resources exist that they could tap into for their patients, right?

So the social determinants of health became an actual course over time. To now it's a full course, six weeks, four hours a week, for all incoming dental students. Where students learn about people who they've never really necessarily engaged, encountered personally, right? Their subconscious, their biases comes to the forefront where they can address them. They learn that you can't necessarily get rid of your bias, but you can work to mitigate them and think about how those biases might show up in their work with the patients, both now and in the future, right? And to begin to think differently from how they were raised, how they grew up, right? Because oftentimes it's been at a distance that they have seen those people. They haven't really had to engage and interact with them in such a close personal level.

And that then doesn't translate to how they build that rapport with the patients when they're sitting in that chair. And you see a patient whose oral health is just really, really poor, what assumptions do you make? You got to check that, right? You look at this person and think, wow, who wants their teeth to look this badly? No one does. So there has to be a reason. What's the story, right? And a lot of times they feel ill-equipped, they're like, "Well, I don't really, that's not really my area of expertise." Right? But it's important to learn how to communicate and listen to their patients. And oftentimes that's all they have to do is listen.

(01:05:10)

Goolsby: Right.

Hemmings: Right? And then be able to say, “Okay, we have this resource here.” This is where the social work piece comes in. You know, “I have colleagues here that are experts in this area. Is it okay if I refer them to you? Can I go get them to just talk to you? Are you okay with that?”

Goolsby: This sounds like a unique course. I just got back from a dental educators meeting and I've been at another school. And I would wonder if you have a course like this in other dental schools, anywhere else. This sounds like having someone who both has the social work and private practice as a social worker background, plus the PhD here in public health has contributed to a very unique and extremely relevant, currently relevant course for the dental students.

Hemmings: So I'm a part of the dental school social work group, I guess it's called. So there are other dental schools that have a social work program, but their program is not as robust as the School of Dentistry. And oftentimes they're only like, they may have interns that are just working with the peds, pediatric department. They don't do the educational piece. So School of Dentistry social work program, and the social determinants of health curriculum is unique, as you just said, right? And in addition to the social determinants of health, CDEN 705 course that the first-year dental students take, they also meet with me again in their second year just before they go into the clinic where I do introduction to social work practice. And in that course, I have the social work interns in the class role playing with the dental students about how do you assess for suicidality. If a patient says to you, “I'm thinking about harming myself,” what do you do with that?

Goolsby: Right.

Hemmings: If a patient talks to you about substance use, how do you utilize a screening tool to assess what the risk level is for that patient, right? So role play with the social work interns who have the expertise and the language. And those students are able to role play with them how to do that. So I'll have one person who's playing the patient, one person who's playing the dental student, and then the social work student also observes, right? And I'm also there.

They also learn how to communicate with their patients about social work. So one of the things that I created when I built the social work program was a social determinants of health screening form. Because what I quickly noticed when we started a social work program, that we weren't getting a lot of referrals. And then I realized that we were dependent on the dental students and the faculty to determine who needed social work and refer them, but they didn't necessarily have the language or the expertise to really know what to look for. Or they may not have been comfortable with even getting into those issues with the patient.

So I said, hey, why don't I take it out of their hands and put it in the patient's hands? So I created a social determinants of health self-screening tool where every new patient would check off on this form if they met, had any of these issues, social determinants of health issues. And then would also say, yes, I will, I want to talk to someone about this. No, I don't.

So what do you do as a dental student if a patient's checked off all these different things but then says, “No, I don't want a social worker.” So role play with them on that. How do you address that with the patient?

So they have me their second year just before they go into the clinic. And then once they're in the clinic, they're working with me and the social work interns with their patients, right? Would I like to see social determinants of health, health equity woven more into the curriculum in other areas? Yes. But I think what we have right now is a lot more than other dental students have.

(01:11:31)

Goolsby: Absolutely. Where else do you see the potential to place pieces of this in the curriculum?

Hemmings: There used to be, and I don't remember what course it was, where it's the one where the dental students would videotape themselves doing their very first intake with admission, right? And I would sit in with the social work interns, with the other dental students as we watched the video. And we would provide feedback to the dental student about what they did well, what are some areas they could work on. And I would focus on the communication. I would focus on look at the patient's body language, what is that telling you? If a patient mentions substance use and the dental student just glossed over it, I would say, "Okay, we want to pick up on that, right? What else could we have asked around that?" They don't do that anymore. And I think that was very important. And I think right now they're in the process of trying to recreate it but using the, what do you call it, patient? I forgot what the word is. There's like a simulation lab or something that I think they're looking at. So I think that's a big component. Yeah. So that's one piece that I think would be important. I think the first two years are crucial, right? And then once they get into the clinic, they should have that foundation already if we're able to bring it into each term.

Goolsby: Right.

Hemmings: Yeah.

Goolsby: So let's talk about your research a little bit.

Hemmings: Yeah.

Goolsby: Your research has often explored socioeconomic barriers that individuals face in accessing healthcare, including access to care providers and issues of affordability. Could you describe how these barriers impact communities, patients, and providers?

(01:12:25)

Hemmings: Well, one, I often think access. We don't necessarily always include racial, ethnic, ethnicity when we think about access to care. We think of rural communities. We think of how many providers are available when we think of inequities. But more and more, especially in mental health, but I think in all aspects of health and wellbeing, I think that there is a tremendous inequity that exists in terms of providers of color. I mean medicine all the way down.

And I think it impacts health outcomes because oftentimes patients may not necessarily feel comfortable, right? There's this issue of trust. So they may be less likely to go, like I talk about, to show up. They may be less likely to follow whatever instructions they were given, right? And then that of course impacts their health outcomes. And I think for providers of color, I could speak for myself as a mental health provider. We become overwhelmed because there are just so few of us, because of the inequities that exist.

And there's just more people that are looking to us to help them, to work with them. And we can't. We can't take everyone on. Because there's just so few of us. And I can say that from personal experience.

One of the things that I did on the legislative level was work on a bill to address the inequities that exist amongst mental health providers of color. How can we work to eliminate or reduce some of the barriers that exist for people who look like me to actually get their degrees and then get licensed, right?

So this bill created funds to help pay for student loan forgiveness program. I have some of my mentees who actually just got approved for that. And how do we eliminate the barriers that exist in terms of getting your license, right? And that's inequities. We're not looking at equality. Because what I say is that there are a lot more people who don't look like me providing mental health services to a population that is majority of people who don't look like me, right? So that's taken care of. The inequities exist and we don't have enough providers who look like, **t**here's not enough providers period, I would say that. But there's more of the majority than there is the minority, right? And that's inequities.

And we see that shows up in what we see in terms of health outcomes, where we have more people who are in distress showing up, needing much more severe treatment because they weren't able to access the preventative care, right? Now, some might say, "Well, why would they need to see someone who looks like them?" Just because of what I said before. Lived experience, being able to be with someone who you can feel comfortable with, is an important part of your health and wellbeing, right? That's just real.

Goolsby: And when you're working with the population of students as you're educating and you know when you can see the inequity and the providers that you'll be educating and sending out to work with populations, you encourage them to consider the human factor?

Hemmings: Yeah.

Goolsby: And so I'd like you to tell us a bit more about what considerate care looks like in practice?

Hemmings: Yeah. I start with my social work interns as well as social work students, dental students, is see the humanity in every person, right? I have this thing on my signature and my, it's funny, the dental students I've noticed have started using it in some of their writings to me. When I talk about how do you mitigate bias. In my signature, it says, "One way to eliminate bias is to ask what breaks your heart? What gives you joy?" Right?

And I notice that dental students in their write-ins are using that in their write- ins to me to say, "This is what I'm going to do, right? To kind of mitigate my biases, right? I'm going to expand my social circle because I really don't have any friends that don't look like me. Even here in the dental school. I'm going to befriend people who I've never really hung around with

before." And they also talk about, let me just say this in their papers, how they've noticed that there's certain segments of the population, ethnicity, race, that's missing in their class.

(01:19:05)

Goolsby: Right.

Hemmings: Yeah. But yeah, it starts with seeing people as human beings. What do you need to survive, right? What brings you joy? What brings you peace? What's upsetting for you?

The people who you're seeing have those similar needs, but also have some different needs because of their lived experience. And even though you don't have the lived experience that they do, just step into this space of humanity. See my humanity. See my worth, see my value. And within that, it creates a very different relationship. Compassion. How can you be compassion for someone that you think is an other? You can't. So you've got to step into that space of seeing this person as a human being. Seeing their humanity, their dignity, their value, their worth. Right? What breaks your heart? What breaks their heart? Right? What do they enjoy doing? Their life matters, whoever they might be. Same way yours does. And that is a message that I try to bring is what is the humanity? Where is the humanity? How am I any less than you because I look different? Because my life, my lived experience may have been different from yours? I didn't see a dentist until I was thirteen. Do you chastise me for that? What contributed to me not seeing a dentist till I was thirteen? Get my story. Hear the story.

Goolsby: That's extremely powerful. It's very important. So are there lessons you've learned from being a social worker that you try to impart to your students? Some of the things that you've said clearly are part of what you impart. But are there any other points?

Hemmings: One of the first things, and this is more so with my social work interns, is I say, and this goes towards self-care, is you have to know where you end and your clients, your patient begins. I ask social work interns, and I ask the dental student, I do this course for nursing school too, School of Nursing, I forgot about that. I do this for every incoming nursing class. But I ask a question, why did you choose this profession? And I also ask, where have you lived? Because that talks about what exposure. Exposure matters, right? So my social work interns, I usually say, "Well, why did you choose social work?" And oftentimes they will say, "Well, I wanted to help people." And I say, "I want you to think about that for a minute. And think about how selfish that statement is."

Goolsby: Wow.

Hemmings: "I want to help people." Included in that statement is, they need my help. Who says? We can learn as much from our patients and our clients as we can teach them. We learn by their experiences. Without them we don't know anything. All this research, where did it come from? People's experiences, we hope. So where do I end and my patient begins? I can't try to take over my patient's life or their problems and solve it for them and tell them what to do. What do I bring to the table? Where am I ending and where is it that the patient now has to pick up and take off with that?

The other thing that I teach both the interns and the dental students is, be consciously unconscious. Meaning, be consciously aware about how inept you are to really understand the life of the person that you're working with. Rather than being consciously conscious, which is be consciously aware how inept. You have no idea. You are not the expert in anybody else's life. Maybe your own, if you are lucky. So those are the two things.

(01:24:14)

Goolsby: That's huge. I was also thinking not only is that "I want to help people" selfish, it's also arrogant.

Hemmings: Yes. Yeah.

Goolsby: Yeah. Wow. I feel like I'm learning things. This is a master class. (laughs) Alright, so you bring a deep understanding, this is just obvious in all we've discussed with cultural and historical context to your work. How does that inform your practice and your work with other care providers?

Hemmings: I try and do my best to share and impart my experience in terms of what I have learned around the importance of cultural diversities, cultural differences. I think my presence alone, and this is arrogant, but my presence alone triggers the need to actually look at this in any space that I am in. Unlike New York, right, where there's a whole lot of people look like me. But here, my presence alone triggers the brain, I think, to begin thinking about, oh, this person is different. How do I relate? How do I work with them? So it starts with just being in a group with my coworkers.

And I think that also I think helps in terms of how does that translate into when I'm working with other people? Not me, but how my coworkers may interact with someone else who's like me or looks like me. And so even with coworkers, I bring difference. I speak differently. I speak from the patient perspective. I speak about inequities in what we're doing. I'm not afraid to challenge that we need to sometimes think and do things out of our comfort zone. My passion comes through. And I can say to someone, my coworkers, I can say, "Well, you're putting this material together and I don't see myself reflected in it. Who's the audience? I don't see myself or people who look like me reflected in it."

Goolsby: Do you find that the care providers you work with are a little less malleable or open than the students because they have their own unique experiences with patients and maybe drew their own conclusions?

Hemmings: I think I'm still tackling that. I think for the most part, I would say my coworkers will try to say the right thing. I'm not really sure if they're really putting it into practice, per se. But they will try to say what they think is right. But I've had faculty who've said things like, "I don't understand why we're doing this," you know, this whole social term. "I don't understand we're doing this. Why? What's wrong with the way we do things?" But you just have to keep plugging away at it. You have to keep sending the message, giving examples. The proof is in the pudding, they say.

[interview paused and resumed]

(01:28:50)

Goolsby: Would you like to share any memories of colleagues you've worked closely with at OHSU?

Hemmings: Oh, wow. Worked. I'm still there. I have a passion project that I'm currently working on. It's looking at bringing community health workers, offering community health workers as an employee benefit to help address unmet needs of some of the OHSU employees. And this started with doing a survey of AFSCME employees around wellness. And as you know, well, AFSCME employees have a high range, but majority of them are in the food service industry, housekeeping services, social workers are also part of AFSCME too. And a lot of our admin clerical staff are part of AFSCME. So lots of them are lower income in comparison to. So we did a survey, asked them about what they think that would be helpful for them. Because we found that they weren't necessarily using the EAP benefits, they weren't utilizing the benefits that existed. What are some of the things that stresses them out? And did a pilot study around, well, we want to do a pilot actually of it. And we're trying to get funding right now. And I work with Dr. Brian Frank, who is at family medicine, on this with a group, Shannon and group of other researchers.

And it's just been such a—and it's one of the things that I kept doing after December that I didn't give up on. And it's been such a joy to work and continue to work on trying to get this done. And to work with Dr. Frank and Shannon, because they're so, they don't look like me, but they acknowledge that. And say, "You know what? I don't really understand this or that." And try to find out and get understanding. And really advocating for OHSU to actually meet the needs as reflected and as stated by the people who are expressing the need.

We have a habit of, we will ask people what they need. They tell us. And then what we do with that is we take what they told us and we tweak it and then we come up with a solution based on our interpretation and how we want to define the need. And then we roll this wonderful program out or service out. And then we do another survey down the road. And the same people are saying, "We need this. We're not happy with this." And then we say, "What's wrong with them? We gave them this."

So working with Dr. Frank, he gets that. And it's been great to partner with him and Shannon around this project. And fighting to have the voices of the people who we surveyed, who invested their time, took the risk to meet with us and share what they wanted and help design this program and trying to get it funded. So that experience has been, and working with family medicine too, it's interesting. So that stands out to me. I've done so many things. Yeah. But that's the thing that stands out most to me right now. It's just, you just never know who you're going to meet. And even, I'm trying to remember how did I even get involved in this? Oh, I got involved with the project because I voiced my concerns when they sent out the survey to the AFSCME employees.

Goolsby: (laughs) So, speaking up.

Hemmings: Yeah. Yeah.

Goolsby : But I'm glad it's been a good experience though. Oh goodness. Well, are there any questions you wish I had asked?

(01:35:05)

Hemmings: No, I can't think of any. I think you covered, you've covered everything. I think I did share about, and if I didn't, let me know. I think I shared the challenges. Because people often ask me this question and I'm actually doing a presentation tomorrow on social work practice within oral health. And one of the questions that comes up a lot is, what challenges did I face as a social worker coming into a school of dentistry and actually setting up the program? What were some of the challenges? And I think I may have mentioned that.

And for me, I hadn't worked in oral health. I'm not a dentist, I'm a social worker, public health, coming into a school full of dentists. And like, oh my goodness, even though it's part of OHSU, School of Dentistry is very different than the rest of what I was used to in the healthcare side. I've worked with interdisciplinary practice all my life, had not worked with dentists. So that was different for me. So I had to learn the culture. I had to learn the culture of dentistry. I had to learn the culture of School of Dentistry, right? Not just dentistry, but the School of Dentistry. I had to learn the culture of my department, community dentistry. There was a lot that I had to learn. And being humble enough to recognize that there's a lot I didn't know about the field. That's one of the first things I do with my social work interns, is I have them actually do training around dentistry, oral health. They see a lot of graphic pictures and things like that. Because you need to have a basic understanding.

I did always know though, that because of my own personal experience with my own oral health as a child, how important oral health was to the body. I shared with the dental students on my end because I didn't see a dentist until I was thirteen. And that was only because I could no longer go to school because I was in so much pain. I was carrying, there's this thing that you put on your tooth when it hurts, I forgot what it's called. I think it was with an A, I think, in my school bag. And I was using that because my tooth ached so much. And I was in so much pain that I couldn't go to school. And my mom took me to one of the free clinics. And had a really bad experience. They tried to save the tooth initially, but then just made it worse. I was in excruciating pain the next day. And so they had to do an emergency extraction. And I was traumatized by that. And I've never liked the dentist since, to today.

Yeah, yeah. And I say when I talk about privilege, I talk about my son. My son is twenty-six now. And he loves going to the dentist. Loves it. Me, I go every six months, but you've got to drag me there. And they talk about the difference in terms of the privilege that he had because he's always seen the dentist. And therefore he's never had a problem where he had to experience severe pain. So he has a pleasurable experience as it relates to his oral health. And I didn't. So when you think of a dental student, you get these two different people sitting in your chair. You have a me who have trauma around dentists. So I'm just like, I don't really want to open, very nervous. And then you get someone like my son who is just happy to be there, do whatever you want to do. And you have to know how to adjust and to recognize the difference.

So anyway, yeah, but I love challenges and I like to learn new things. That's why I think I've worked with every population. So dentistry was, and I'm always someone who's interested in things that people will think is just weird.

Goolsby: (laughs) Are you saying dentistry is weird?

Hemmings: No, but a social worker in dentistry is weird. So people say, "What? Even dentistry, what?" It's like me moving to Oregon, "You're moving where? Where is that? Is that, where is that?" But yeah, so I enjoy challenges and I get bored easily. So that challenge was great. And I was happy to take it on. There were other challenges in terms of getting folks on board with the idea of having social work, with the idea of why do we need to teach a student social determinants of health? How does this impact the work that they do? Yeah. So there's still, I think, work to be done around that area. There's certain departments at School of Dentistry that I think could still use a little push.

And also we do work with Russell Street as well. Before COVID, I had an intern that would spend half a day over at Russell Street Clinic. And the interns just love being there because it's a different space, but they feel more at home there at Russell Street Clinic.

So yeah, besides that, I think you've covered everything. I think, no one at OHSU knows most of the things that I have shared with you today. I tend to be a very private person. A lot of people will be surprised and shocked to know about the Jamaican heritage. I spent my summers in Jamaica. People know I'm from New York because I say that. And once in a while someone will say, "I hear something else besides New York. What is that?" And it's that Caribbean influence that's there. So yeah.

(01:42:37)

Goolsby: Well, Dr. Hemmings, I think that, I think that, I know for sure, that the oral healthcare workforce in not just the state of Oregon, but the Pacific Northwest, has benefited and will continue to benefit from what you have taught the dental students here. I applaud you. I hope to see you presenting on this at an ADEA meeting at some point in the future and spreading this word and getting this kind of program out nationally. To be honest with you, when I came here to interview for the job here and I heard about the social workers working in the pre-doctoral clinics with the students, I was astounded. So I applaud you. I applaud your efforts. The curriculum sounds amazing. And I thank you for being open and sharing so much of yourself with OHSU today. Thank you.

Hemmings: Thank you. And thank you for having me, and thank you for doing this. You made it easy.

Goolsby: My pleasure.

Hemmings: Thank you.

Goolsby: Thank you.

(01:43:48)
End Interview.