

# OREGON HEALTH & SCIENCE UNIVERSITY ORAL HISTORY PROGRAM

a project of OHSU's Historical Collections & Archives

an interview with:

**Virginia Tilden, Ph.D., R.N., F.A.A.N.**

interview conducted on: October 27, 2017

by: Michael Garland, D.Sc.Rel.



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Interviewee: Virginia Tilden  
Interviewer: Michael Garland  
Date: October 27, 2017  
Transcribed by: Teresa Bergen

Michael Garland: Okay. I'm Michael Garland. I'm so happy to meet you, Dr. Tilden. And this is September 27—

Morgen Young: October.

Virginia Tilden: Close.

Michael Garland: October 27, thank you. So scrub that. October 27, 2017. And an interview for the OHSU Oral History Program. And I'm delighted to be here. Looking over your impressive CV, which I didn't print out, because I don't have that much ink in my printer. But really recognizing that you have really been at the forefront and at the heart of a major transition of the profession of nursing, I think. And you're probably one of the early pioneers. The suggestion was that we start with you as a child. But I know where we want to get to, which is the incredible achievements that you've accomplished. What is it about your childhood that got you this way? Or is there anything?

Tilden: I think there might be. Thank you, Mike, and thank you so much for doing this. You're someone I love having conversations with, so I am looking forward to this one as well.

Garland: Well, it's a mutual love fest, so this will be fun.

Tilden: Childhood. Well, I'll just do the sort of short version of that. I grew up mostly not in the United States. My family was in the Foreign Service. My father was a Foreign Service Officer. And I was born overseas and didn't live in the States. And we would visit, we'd come home and visit relatives. But I didn't live in the United States until high school.

I think there was sort of early shaping of my sense of a pretty large world, and the suffering of many people.

Garland: Where in the world were you most of the time?

Tilden: But I would have to say we were mostly in sort of the British Commonwealth, it was called at the time. And then in the Far East. But I was aware of a number of things. I was aware of my privilege of being an American citizen. I was aware that the world is a big and diverse place, and aware that many people are left out of the benefits that I had. I think that that was a progression for me into wanting to go into a profession where I helped other people.

Garland: That's interesting. That really lays down some tracks that can take a lot of different ways. And yours eventually took you into nursing.

Tilden: Yeah. It did.

Garland: How did nursing pop up on the, “Oh, I think I’ll do that?”

Tilden: Well, I always cared a lot about people and their suffering. I also cared a lot about animals and their suffering. That’s a very strong element of who I am is an advocate for animals.

Garland: You have taken care of some rescue dogs, as I recall.

Tilden: We rescue dogs. I volunteer at the Humane Society. I sent money to Houston. You know, I don’t want to sound as though I do what Jane Goodall does, or what could be done. I fall far, far short. But it has always been a very strong interest. I thought about being a vet. The ‘50s, when I grew up, and in the ‘60s, when I was in college, was not a time when women felt that they had a lot of access to much in the way of professional tracks. Nursing, teaching, and secretary, believe it or not.

Garland: That’s right. Mm hmm.

Tilden: Do you remember that, Mike?

Garland: Oh, I do.

Tilden: But those were sort of the approved pathways. Those were the more common pathways. And it’s not that women didn’t find their way or beat down a door. But there would be one woman in the vet school. There would be one in a class of medical students. I was enough of a rebel that I should have been that one. But I wasn’t. With the coaching of my high school counselor and my father, who was a very traditional sort of, loving but paternalistic kind of influence, I went in a more common path.

My father and brother were graduates of Georgetown. And Georgetown had an excellent nursing school. And I sort of fell in.

Garland: You must have been living in the DC area.

Tilden: We were living in the DC area. Yeah. Yeah. My father was in the State Department at that time.

Garland: So you, but you did a BS in nursing.

Tilden: I did.

Garland: At a time when a lot of nurses didn’t do a BS degree.

Tilden: That’s right.

Garland: That was really the early years of getting college degrees going beyond an RN to be a nurse.

Tilden: Right. It's true. I never, I would not have gone into nursing if it couldn't have been a university degree. I wouldn't have gone to a hospital training program. I mean, I always knew I loved the academic environment. And I loved Georgetown, visiting Georgetown. As I say, my father and brother were graduates, so we were on the campus from time to time. And it just felt like that's where I wanted to be.

Garland: And how would you look back on that training in those years? You graduated in '67.

Tilden: Late '60s. Yeah, '67. Well, I look back on that and a little bit shake my head.

Garland: That those were the early years.

Tilden: They were the early years. They were the early years. And you know, it was an excellent education. I chafed at it somewhat. I was always a little bit of a rebel, and it was very traditional. It's a Jesuit university, so that was the confines, right, of the thinking then. And nursing was very traditional. It was very much subservient to physicians. I was very much follow orders. You know, that would make me bristle. Follow orders? Wait a minute. I mean, so that was a challenge for me. Why I stayed was I loved psychiatric nursing because it was where I could connect with people, with their suffering, with their limitations.

Garland: You were able to track into that even in the undergraduate years?

Tilden: Well, not exactly. I thought about it my junior year. I thought about leaving nursing and going into a psychology program. Because I had discovered, right, that what I really loved about connecting with people was what made them tick. And I thought about transferring. And in fact, I applied to the University of California in Berkeley and got accepted into their psychology program. And I was sort of ready to go when I discovered—just interesting how fate comes along—that my psychiatric faculty instructor, who I liked a lot, had nominated me for a National Institute of Mental Health traineeship. And it gave me a full ride for the rest of my Georgetown tuition and expenses. And it was very hard to turn down. And I was only a year away from a bachelor's degree, so I stayed.

It's interesting, because the NIMH award also obligated me, kind of a moral obligation, to get my master's in psychiatric nursing.

Garland: That's why you—

Tilden: Even though I might have anyway, yeah, I paid a lot of attention to that because I'd accepted this financial award that paid for the rest of my undergraduate. And then I knew I would go and get a master's in psychiatric nursing.

Garland: And so that was out at UCSF.

Tilden: It was.

Garland: And so what was it about UCSF that attracted you, apart from the hill and the city and all that? Clear across country.

Tilden: Clear across the country. Clear across the country. Well I have mentioned I was a little bit of a rebel. And I had found the confines of the traditionalism of Georgetown, of nursing, and in a sense of the east coast, confining. And so I went to as radical a location as I could think of, which was San Francisco in the 1960s.

Garland: With flowers in your hair?

Tilden: Well, I actually lived in the Haight-Asbury.

Garland: Did you?

Tilden: I did. I had an apartment on Asbury Street, just two blocks from Haight.

Garland: That's great. And we, I think, almost overlapped. I left there in, or I came there in '73.

Tilden: Oh. Let's see, '73—

Garland: And left in '77.

Tilden: Yeah. I was there, right? Because I had finished my master's degree in '71, and then I was asked to be on the faculty as a clinical instructor. And I worked as a clinical instructor with undergraduate students in psych units. And then I started the doctoral program in '78, finished in '81. Seventy-seven, I think '77. Started the PhD program. Yeah, so we did overlap.

Garland: Yeah. Yeah, I think we may even have walked up and down the same hill, because Third Avenue was the hill. And I think there was a nursing unit, Virginia Olesen, which was there.

Tilden: Yeah. Virginia Olesen was one of my faculty. And that was the Social Behavioral Science group, was Anselm Strauss, who became quite the guru in qualitative methods, and Leonard Schatzman was a protégée of his.

Garland: Yes.

Tilden: And then Virginia Olesen was a sociologist. There were others, but those are the three that I can think of right away. And I took courses from them and learned qualitative methods from them, and admired their thinking and their insights.

Garland: Anselm Strauss used to take some of us out to lunch. And as we walked around the neighborhood, he would say, "Now, you can only lift your foot three inches off the ground because there's some problem that you have." And we'd come to the gutter and he'd say, "Now step up onto the curbing."

Tilden: Oh, my.

Garland: Three inches. No, you can't get up three minutes. It was his sort of object lesson in what it is to live with a disability.

Tilden: What a powerful memory you have. That's a great way of—

Garland: Yeah, yeah.

Tilden: Were you a student or a post-doc?

Garland: No. I was sort of half faculty there at the Ethics Center.

Tilden: At the Ethics Center.

Garland: Yeah. Ethics and Public Policy.

Tilden: Was that—

Garland: Al Jonsen was there.

Tilden: Al Jonsen was there. Yeah. I should have remembered that you would be faculty, but I didn't know whether you'd done a fellowship or a post-doc of some kind.

Garland: No, I had done my doctorate elsewhere. Back to you. And we have Anselm Strauss, but all of that world was very influential, I think, in the sort of shaping of your thinking.

Tilden: Mm hmm. Very much so.

Garland: It was a separate world. And also at a time when the field of medicine and the field of nursing and the field of dentistry were all kind of changed trying to redefine a lot of relationships.

Tilden: Absolutely. Absolutely. What I remember about the master's program so vividly is that at Georgetown, my perception of nursing was that it was very rule-based and procedure-based. There was nothing in our curriculum about teamwork. There wasn't a whole lot about problem-solving and independent decision making. It was much more here are the orders, here's the rules, here's how you do it. And while I needed to learn that, I was glad to break out of that. And what I found at UCSF was a much bigger horizon for possibility. And much more of an environment for saying we have common goals for improving the patient's condition with the other professions. How can we align what we do? But we weren't saying "teamwork." That word didn't come along until later.

Garland: Not quite yet.

Tilden: No. It wasn't quite there yet.

Garland: Interdisciplinary—

Tilden: Yeah.

Garland: Interdisciplinary, we used to joke interdisciplinary used to mean surgeons talking to internal medicine people.

Tilden: Yeah, right? I know. What we meant was sociology and nursing and medicine and epidemiology. But that's right. Medicine defined it differently.

Garland: This is my curiosity. But I assume that in that world of here are the orders, you just do it and make sure it gets done according to—

Tilden: Yeah.

Garland: —that there must have been a sort of informal world of this is how you get messages back up to where they ought to be, without being invited exactly to send a message up. Can you explore that a little with—

Tilden: Yes. And I railed against that. But you're absolutely right. It was the hidden something, hidden curriculum, hidden way you got things done. It bothered me because it wasn't transparent and it didn't seem honest. But nursing justified it because it was the way we provided better patient care.

Garland: The patient.

Tilden: Yeah. If you have your eye on what's best for the patient, you'll figure out how to do backdoor end runs, whatever it takes. And that's the way the system was then. It was a very rigid system. And there was one dominant profession. And everybody else figured out how to work around that.

Garland: Let's move you up to Portland. How did that transition occur from San Francisco to OHSU? Then it was Oregon Health & Science University.

Tilden: Right.

Garland: No, was it still University of Oregon Health Sciences Center when you came?

Tilden: No. It was OHSU when I came. I came in '82. But I don't think it had the ampersand. That came later. I don't remember. I think it was Oregon Health Sciences University. But the ampersand, anyway, well, here's how that happened. I did my master's degree at UCSF. And I got excited about research, because my faculty mentors were all doing research. They all had doctorates. And that was a big eye opener. My faculty at Georgetown didn't.

Garland: And those were, it's a doctorate in nursing. It's not a doctorate in something else.

Tilden: Well at that time, many of my faculty at UCSF had doctorates in something else, because there had been a federal government scholarship program for them called the nurse scientist. There weren't very many doctorate PhD programs in nursing. They were, of course, older than me. And in their generation or cohort, I guess I'd say, to get a doctorate and to figure out how to get the government to pay for it, you got your doctorate in anthropology or sociology or psychology or basic sciences or physiology or something else. Most of them didn't have doctorates in nursing. But they had doctorates and they were doing research. And that really lit my fire. The whole world of research opened up. And Anselm Strauss, with his amazing ability to teach us how to observe the human condition with these qualitative methods, so that's where my incentive came to go on and do the PhD.

Garland: It's a PhD in—

Tilden: In nursing.

Garland: In nursing. It is in nursing.

Tilden: Yes. At the time that I did it, it was a DNS. It was, DNS because when the program had opened in, I think, the '60s or late '50s, in the wisdom of the Board of Regents, there was not understanding that there could be a science of nursing. It was assumed it was a clinical applied degree, so it was the doctor of nursing science. But when that was changed, even after I graduated, because our curriculum had been a PhD curriculum, completely, I did a full dissertation, the whole thing. The whole nine yards for the PhD. Then we were grandfathered into the PhD.

Garland: What was your dissertation?

Tilden: It was the psychology of the transition through the year of pregnancy and childbirth.

Garland: Oh, interesting. Oh, wow.

Tilden: It was the mental, it was the psychological journey that a woman goes through from conception to postpartum.

Garland: Fascinating. Yeah. Probably fun and fascinating to do, wasn't it?

Tilden: Yeah, it was.

Garland: It was interview research?

Tilden: Uh huh. And yeah, it took me a year to collect my data. When I see students do a survey that they get back in three weeks, I think why didn't I think of that? But no. I collected, I was in the OB clinic. I had them fill out forms. The variables were, I can't remember them all. But I was very interested in sort of the stressful aspects of accommodating to a pregnancy. And then I did a sub-study of single by choice, so very early in the time in which it could be socially okay for a



woman to be alone during a pregnancy, to have no partner. By choice. I located a sample of women who were willing to talk to me about how they had made that decision.

Garland: Yeah, very early, pioneering work. We have to get the magnet from Portland drawing you up here.

Tilden: Right. Getting to OHSU. Well, I would credit Carol Lindeman. She was the dean of the School of Nursing at the time. And she held high value research, and high value, she had great vision for the science of nursing and building that and what it would take to build that. And she knew that most of us had been educated by nurse faculty whose doctorates were in other disciplines. And there's richness there, because we'd then been influenced by all of their fields. But how did we put that together into the science of nursing? That's what she cared about, so she recruited people like me to come. I had two small children at the time, and Portland seemed like a good place to bring them.

Garland: Did you react positively to Portland? What time of year did you first come to Portland?

Tilden: You know, I interviewed in the summer.

Garland: In the summer. We'll trade stories.

Tilden: Okay.

Garland: I came on an absolutely beautiful fall day.

Tilden: Oh, did you?

Garland: And I said, "Oh, boy, this is fantastic." But back to you.

Tilden: Yes. I interviewed in the spring, in the early spring, and thought it was so beautiful. I think I came in August, and it was still beautiful. And it was beautiful for, you know this story, two or three months. And then a Portland winter descended. And I was a runner. I would, every morning I'd put on my running clothes. I was getting the kids to school and so forth. But I'd put on my running clothes and I would look out the window. And here was the rain. And it was just, that first winter was hard because of the gray and the rain and the constant rain. I mean, rain's fine. But when it's all the time, and the drizzle. Until I learned, by the following winter, I learned to get GORE-TEX, and that here people run anyway. You just run. You just go out and run. And you wear the right stuff, right? So how was your first winter?

Garland: Well, I had lived in Strausberg, I did my doctorate in Strausberg, which is just like Portland. The winters are rainy and they don't see the sun. We used to joke about the sun was this unidentified flying object.

Tilden: That came by occasionally.

Garland: It kind of fitted in. I had some parts of my psyche. And the San Francisco winters are not like that. Because some of those are some of the finest days in San Francisco.

Tilden: Absolutely. It's the summers, as you know, in San Francisco that are cold and foggy.

Garland: And you came in and was part of Carol Lindeman's agenda, which was at that time, it was the transition of the School of Nursing faculty to doctorally prepared faculty, which it hadn't been.

Tilden: Yeah. Doctorally prepared. Yeah. She was visionary that way. Doctorally prepared and willing and committed to continuing to do research.

Garland: We used to, I always enjoyed medical school class on sort of the social dimensions of medicine, and worked Carol into our lecture schedule. And at the time, the book *The Social Transformation of Medicine* by Paul Starr was a very big thing. I had said to Carol, "Can you give us a one-hour lecture on the social transformation of nursing?" Which she did. It was a marvelous lecture.

Tilden: I can imagine that she would be very good at that. It's an interesting history, beyond what we can, I think, touch on probably in any depth. But it's a very old profession, nursing, very old profession, but a very young science. But there have been nurses as long as there have been monks. Because the first nurses were men, and they were in religious orders. Florence Nightingale had a sense of the importance of data. We credit her with being the first nurse researcher. In the Crimean War, she was so influential on the health of the patients because she insisted on a lot of public health practices, opening windows, getting people better water, getting them better air. They were in fetid sort of underground hospital units, if you can call them that. And she had data that showed that people did better if they had basic, what we might call kind of public health environment. And she was quite the tyrant about that. We credit her with caring about data and using data as a powerful way to influence change, to bring about change.

Garland: Yeah. And I think, as I recall, one of Carol's dicta was that until, so it was part of essentially a social and political transformation of nursing into an independent profession. But it could not achieve independence until it owned its own science.

Tilden: Good for her.

Garland: I think that vision was part of why she built up a faculty that was composed to people like yourself.

Tilden: Absolutely. It's an interesting paradox because medical orders are legal, medical orders. They must be followed. And they should be. There has to be this sort of okay tension between following medical orders, but still knowing what part of your practice is really independent judgment and decision making that you can make. And now we're in an era where we realize that the best care to patients happens when the team works well together. This hierarchy of just, I'm going to write this order, just do what I say and don't question it, is fortunately over. And it's not because nursing toppled it. We certainly didn't topple it alone. You know what toppled it was

the IOM, with their quality chasm series. And the evidence that that hierarchical, that strict, unquestioning hierarchy is a big reason that we have the error rate in this country, and that we harm patients with medical errors. Working in teams, collaborating, communicating, figuring out, putting our different disciplines together for the welfare of the patient, that's very different than just following a scripted set of orders.

Garland: Let's talk about your own research as you got here at OHSU, that you both continued to do your own research and stimulated research projects of students. How soon did you become the director of nursing research?

Tilden: Quite a few years later.

Garland: Oh, it was later.

Tilden: It was later. Chris Tanner was here, and she was the director of the Office of Research. I don't think there was an associate dean for research. But there was a director of the Office of Research, and it was Chris Tanner. I came in '82. I became the associate dean for research in, gosh, we might have to look, but I think it was '89. And I was in it for twelve years before I left to become dean.

Garland: So your research, your own research—

Tilden: Yeah, my own research.

Garland: You were focusing on?

Tilden: Well, one of the things I found on my study of women during pregnancy was a troubling trend of family violence and abuse. So—

Garland: Because I think that's where you and I first connected was, you and Barb Limandri were doing a lot of work on abuse.

Tilden: Right. Yeah. Abuse of women.

Garland: And we got connected there. But go ahead.

Tilden: I wouldn't say, it's not like I discovered high incidence. What I discovered is that that year of pregnancy and childbirth is stressful for everyone, for everyone in the family. And in families or in couples without good coping skills, the stress of the gestation and then the newborn can trigger abuse. And that was really very fascinating to me. To find out more about that, to understand that better. This was also now a time when the women's movement was quite strong. There was this sort of we're not going to take it anymore sort of culture. I think my first studies when I came to OHSU were around family violence. It's hard for me to even remember exactly what they were. You and I would have to look at my CV together. But yeah, I worked with Barb Limandri I think several others as well. We did some good studies. Oh, and one of them was in the emergency room, where we worked with the clinicians in the emergency room,

and those who identified injuries, a woman's injuries, as resulting from an abuse episode. And then we interviewed those women.

Garland: Interesting. A whole lot of stuff we could go into.

Tilden: Yeah.

Garland: So the faculty is building and developing here at OHSU and you're moving into the position of sort of being the promoter, the encourager, the developer of research wherever you could find it and support it and encourage people to find the money to do the research.

Tilden: Right, right. It turned out I liked grant writing, which is an asset, because it turns out you need money to do research. And I kind of fell into that and turned out to like grant writing. I liked teaching grant writing. And the other thing that happened, thanks to Carol, I came in 1982, and part of Carol's vision was to open a PhD program in nursing. And the school didn't have one. They had the baccalaureate program and the master's program, but no doctorate. And, of course, I look back at it now and chuckle because I would never again come to a university that didn't have a PhD or didn't have a doctoral program for nursing. But then, back then, they weren't that common.

Garland: No. It still was a transition.

Tilden: It was.

Garland: A development.

Tilden: Nurses got doctorates, but again, they got them in other fields. I came in '82, and our doctoral program opened in '84, I'm pretty sure, '84, '85. When I came, I was right away kind of ushered in to the planning for our PhD program, and then taught in that program, which was a wonderful experience, a wonderful privilege.

Garland: Right. I'm just chuckling about the getting degrees in other fields rather than in nursing. I think Carol may have stimulated PhD programs down at PSU like nobody's business. Because the faculty of the School of Nursing—

Tilden: The faculty needed doctorates.

Garland: —were told—

Tilden: Yeah, go get a doctorate.

Garland: A lot of them hustled down to PSU.

Tilden: That's right, they did. And the Center for Aging there. Yeah. Yeah. You're right. A lot of my faculty colleagues were students at PSU in the doctoral programs. Absolutely.

Garland: Let's see. Shall we slide forward to the formation—well, you and I, and everybody in the field of ethics got together. Oh, wait, there was an intervening period that you and I were both involved in, which was the Nurse Ethics Resource Program, I think. You were a moderator for that group as well, weren't you? Or am I projecting Caroline White onto you?

Tilden: Caroline White. Yeah, you might be.

Garland: Ranata Niederloh, though, had this group going over in this hospital. And it was a group of nurses—

Tilden: Right.

Garland: —that had petitioned for an ethics committee and kept getting an answer, “Yeah, that's a good idea. We'll get around to that.” It never happened, so they created on their own this thing they called the—

Tilden: I remember.

Garland: —ethics resource nurse. And it was, the idea was that they would meet regularly and have these discussions and build up the capacity to guide and evoke ethics discussion on various words.

Tilden: But I didn't get involved in ethics until about 1989, or 1988, '89. I don't think I did. I was always interested in ethics. And when I was at UCSF, Al Jonsen was there, as we've already mentioned, but his home was in the School of Medicine.

Garland: Yes.

Tilden: And he did ethics rounds. But they were open, and I went to some of those. I could have been involved with Caroline White, Ranata Niederloh. But I'm not sure, I'm sure I wasn't a leader, because it's not standing out in my mind. But in 1988 or '89, I was due for sabbatical. Or I should say, I was privileged to be qualified for a sabbatical. How's that?

Garland: That's very good. Yes.

Tilden: You know, they don't happen much anymore.

Garland: That's right. Yeah.

Tilden: I was very privileged to have one. And I think it was nine months long. And my memory of that was I did two training programs that I wanted. I wanted additional training. And one of them was in ethics. It was the University of Washington certificate program. And it was located in the School of Medicine at the University of Washington. And it was led by Al Jonsen. It was a year-long program, and anchored by two sort of in residence periods. And then in between, I was in Seattle for the two anchors at either end of the year. But in between, the work was paper

writing and doing research. I don't mean data-based research. I mean reading and seeking kind of background literature to help with the production of papers. We had to write a case analysis.

Garland: People like me think that reading Plato is actually research.

Tilden: Oh. See, we're using that term in slightly different ways. Right.

Garland: I know. Yes, yes. It's not data. But anyhow, it's ideas.

Tilden: I did that, I remember I did the paper every month and sent that up. And then went up for the second anchor. And that really changed my life. Well, let me just say, the other training program I did at about the same time was at the Family Therapy Institute here in Portland. And I studied for roughly a year with—I'm going to block on his name, but it will come to me in a minute. He's not from OHSU. He's a well-known, well regarded family therapist in the community. And so, I trained with him. We were a group of about six clinicians. And the others, I was the only psychiatric nurse. Others were, I think, psychologists, social work and psychology. We trained with him, and that was very interesting.

But it was the ethics training that changed my life. And here's why, Mike. You know, I had this interest in families during gestation and childbearing. And then family violence. And I remember sitting in a class at the School of Medicine at the University of Washington. The lecture was being given by an attorney, and the whole two hours she focused on the Nancy Cruzan case, which had just made its way from the Missouri Supreme Court up to the Supreme Court. And the Supreme Court during the year that I was in this program made its ruling. And you know, but I'll just sort of again remind us that Nancy Cruzan was a young woman who had fallen into a persistent vegetative state. I've forgotten at the moment whether, I think it was an auto accident.

Garland: I think it was auto accident, yes.

Tilden: It was an auto accident. And she survived. But she was in a persistent vegetative state, so she was medically sustained on life supporting treatment. But she never woke up, so she had no real cognitive function. But she, so she was in a hospital and then she was sent to a nursing home. She was transferred to a nursing home and she was maintained on life-supporting treatment for some years. And finally the family said enough. They wanted to withdraw. I think she was only on a feeding tube, so she had a fair amount of function. She just didn't have intellectual function. But physiologically, she still had a fair amount. But she could not have survived without a feeding tube and there may have been some other somewhat minimal life-supporting treatment. The family wanted it withdrawn. The nursing home said no, that they had to protect the patient, that that was their obligation was to protect the life of the patient. The family said, "We can speak for this patient. This patient would not want this existence."

It made its way to the Supreme Court. I can't remember, you probably remember, what the Missouri Supreme Court said, who they ruled for. In any case, whichever party was not in favor with the Missouri Supreme Court pushed it up to the federal Supreme Court, where it was finally decided that the family had the right to withdraw life-sustaining therapies and allow Nancy to die, but only if there was clear and convincing evidence that this is what Nancy would have wanted.

And as someone with a sort of family therapy background, I was fascinated that the family had been dragged through this. And really, whose right was it? Who had the authority to speak for Nancy? It seemed to me the family did. But I also understood kind of the other side as well. It's a terrible decision to have to make. I was very interested in what that family went through. And as a result of that, I kind of moved my research program to trying to understand what families experienced when they went through ethical dilemmas.

When I came back from that program, I had gotten to know you and Susan Tolle and Gary Chiodo and we began talking about the creation of an ethics center. This is my memory of it, and I'd love to hear yours, too. My memory was that when Susan found out that I liked to write grants that we set about, she has great vision. She had come back from her post-MD ethics training at the University of Chicago. And she's a very ebullient, inspiring person. She said, "Well, let's write a grant. Let's get somebody to fund an ethics center." So we did. I'm sure you contributed. I think it was the four of us sort of bringing our four different professions together and crafting this idea of what an ethics center would look like. What would it do? Where would it live in the university? And we sent it to Robert Wood Johnson and they funded it. And it was \$500,000, which seemed like so much money then.

Garland: Yeah. Yeah.

Tilden: Pretty sure it was, it might have been five years. Five hundred thousand over five years, something like that. And Susan with her persuasive powers got the provost and the president to see the advantage of this ethics center not living in any one of our schools. There was, I think the assumption of the university was that it would be in the School of Medicine.

Garland: Yeah.

Tilden: Do you think?

Garland: Well, I think that may have been. They just didn't know where to do it, where to put it. Sharing our perceptions, recognizing that Gary was dentistry, you're nursing, Susan was medicine, and I was this world elsewhere.

Tilden: You were the only one with any real ethics training.

Garland: But what we felt was needed was to acknowledge that the provision of healthcare really occurred across these disciplines, and that the ethics would be best rooted in all four of them simultaneously. We were pretty fiercely interdisciplinary in a very wide sense of the word in creating that program, which then put it in that odd place. It didn't belong to any one of the schools, because that would distort it.

Tilden: Right.

Garland: And it seemed very useful not to have it in the School of Medicine, because that reaffirmed that whole hierarchy that you'd been saying from the beginning that I was worried about that.

Tilden: Right. Yeah.

Garland: I think that's where it went. And we were very fortunate that there was a model, there was a Center for Aging that preceded us. So then it was rooted in the provost office and the—

Tilden: Oh, I didn't know that.

Garland: —was receptive to saying we can use that model and set this here. For quite a while, and I think it continues to be independent of each of the schools, a separate entity.

Tilden: I think that's true. I think that's true.

Garland: But part of that whole intent was to have a structure that was true to the vision of interdisciplinarity of the ethics commitment, which as you pointed out much earlier ends with, it doesn't end with, but it engages the patient in patient care.

Tilden: Right. Right. I hadn't known that there was a Center for Aging that was independent of any of the schools. But you know, I think of our collective, the four of us, collective success in making sure that it stayed, reporting up through the provost and then, through the provost to the president, rather than through any of the deans of any of our schools for the reasons that you've just explained. I think of that as early pioneer work that we were determined to have it be the face of all of our professions, and not be kind of collapsed into any one. That we knew we could not be effective if it were, had it been. Then that was the beginning of all of our work. And the four of us, I think, had a wonderful time.

Garland: Yes. Yes. Did a lot of good work together.

Tilden: Yeah.

Garland: And you know, with the four of us, we also had our sort of separate interests so that my main interest was healthcare and financing and access to healthcare. And you and Susan, I think, got very deeply into death and dying care, which indicated, was triggered before the Ethics Center by your study up at UW.

Tilden: Right. Right. Right. Exactly.

Garland: Thinking about the Cruzan case and rooting way back into your own research into family and violence and so forth.

Tilden: Exactly. You know, the Supreme Court decision that there needed to be clear and convincing evidence for what Nancy's wishes had been, or would have been, was really the power or the rocket behind advanced directives. You know, living wills had been around forever, but nobody paid much attention to them. But with that decision, that Supreme Court decision, they suddenly became much more important. And the language around them changed from living will, which was kind of a lay term, to advanced directive, which implied that each of us has the right, while we are mentally competent, in advance, to lay out a directive should we lose our



cognitive ability, this is what we would want our medical professionals to do; empowering our future medical professionals to provide the care that we can shape while we still can. I found that really, really interesting. Very, very interesting. And I was excited to see the kind of the national movement towards making advanced directives more in the public eye. And in fact, shortly after that, a federal law passed. Do you remember this? The Patient Self-Determination Act. And as you know better than I, Mike, most healthcare is not dictated at the central level. You know, there's the ACA, the Affordable Care Act. There's Medicaid and Medicare. I mean, there's certainly federal. But at the level of directing care, that's not so often a federal legislation. But the Patient Self-Determination Act was federal. And what it did was require any hospital that received federal funds of any kind, which is most hospitals, to have advance directive forms available and give them to patients on admission.

Garland: Well, I'll give you a footnote to that. You described Oregon, which passed a special law about actually giving the advanced directives to patients. The federal law said you have to tell them that they have the right to do this. It was a little bit like what do they do to criminals, you have a right to an attorney—

Tilden: The Miranda?

Garland: The Miranda.

Tilden: Yeah.

Garland: Well, doctors or hospitals had to Mirandize the patient, saying you have a right to do one of these. This is what's available in your state without having to put the—

Tilden: Put it in your hand?

Garland: —the piece of paper in your hands. And Oregon said we're going to put the piece of paper in hand.

Tilden: Oh. That's good to know.

Garland: Do you remember Bob Shoemaker?

Tilden: Yeah, I do.

Garland: He was in the legislature then. And that was one of his strong points.

Tilden: Good for him.

Garland: He pushed that idea through. Oregon got a little further than many other states. But it does create this world of advanced directives and the fact that, which was in the authority of the patient or the family, actually the patient, and they should inform the family, these are my wishes.

Tilden: Right.

Garland: But it ran into a problem that led to the creation of POLST.

Tilden: Right.

Garland: That you were engaged in the research following it, and even in the creation, probably. Talk about that.

Tilden: Right. I was involved in that as well. Right. one thing that was soon discovered about giving, as you've explained, giving all Oregon patients the advance directive form when they come into the hospital, is that those forms often ended up in the trash, basically. When you're coming into the hospital it's a stressful time. Somebody hands you a lot of paper, you put it in the drawer by the bed and that's the end of it.

And we in the Ethics Center were particularly concerned about long-term care facilities, where typically, not always, but typically elderly people live the last X years of their lives, that this act, Patient Self-Determination Act, really would not reach them, would not benefit them. They needed something that was different. And that led to this sort of birth of the POLST. POLST stands for Physician Orders for Life-Sustaining Treatment. At the beginning, it was designed to be filled out when a person entered a long-term care facility, like a nursing home. At the time of admission, the social worker or whoever was doing the admitting of that person would sit around the table with them and talk with them about what would you want us here at the nursing home to do if this happens, if this happens, if this happens. And you know, in the past, what nursing homes would do if a patient let's say had a stroke or had a bad fall and appeared to be seriously injured or, I should say, appeared to be at the end, the nursing home would just call 911 and the ambulance would arrive and an elderly patient would end up in the ICU, which is a very, which is a very difficult place to end up, and often not what people want. They want to be managed in the environment that they're used to. They want their pain to be managed properly, they need comfort care. They may need short-term hospitalization to fix a broken hip. But they don't want to just be in an intensive care unit for a long period of time and not benefit from it and in fact be suffering. And we know that intensive medical care also has its own downside, particularly for the elderly. Skin breaks down, so they end up with difficult decubiti. And when there's no mobility, it is a very bad place to be unless you have an acute condition that can benefit from that kind of acute care. Anyway, the POLST was intended to help prevent that. Because what's different about the POLST compared to an advance directive is that it is signed by a physician or a nurse practitioner.

Garland: And it's orders.

Tilden: And it's orders. That's exactly right.

Garland: Yeah. First is the Advanced Directive, which is an expression of my values and my wishes from the patient's side of view. So that took care of the Nancy Cruzan problem of what would she really want?

Tilden: Right.

Garland: That you have this evidence. Well, we know what she would really want.

Tilden: Right. This is what she said.

Garland: But I think the POLST ran into a legal problem that the EMTs arrive because somebody needs more care than they can get in a nursing home. The EMTs have a protocol which puts them in touch with an emergency room physician. They were not able to interpret the advanced directive and say we'll do what the advanced directive says. They had to follow whatever the emergency room physician said. The emergency room physician felt stuck because they wouldn't make a decision about a patient until they saw the patient.

Tilden: Over the phone. Right. Exactly.

Garland: This was all intended to give a legal solution to that total dilemma.

Tilden: Yeah. It's a medical order. Absolutely. That was quite revolutionary, that it became a medical order.

Garland: I think that you went on one of your llama hiking trips with one of the creators of the POLST.

Tilden: Well, I would go on my annual escape to the wilderness. Who did I go with on a llama trip? I remember my llama trip, but who was there?

Garland: I recall it being—

Tilden: Oh, Terry Schmidt!

Garland: Terry Schmidt, yes.

Tilden: Right. That's right.

Garland: You went hiking up on Mount Adams with two llamas.

Tilden: Yes, on a llama adventure.

Garland: I don't know why that stuck in my mind.

Tilden: Oh, good for you.

Garland: I thought it was so exotic.

Tilden: Terry Schmidt. A wonderful physician on the faculty.

Garland: She was deeply involved in that interface of the emergency room and the EMTs.

Tilden: Yeah, she was. Exactly.

Garland: And she said, “We’re just stuck.” And the whole POLST was to unstick that particular problem, which I think they very successfully have done.

Tilden: It became very successful.

Garland: And you’ve done a lot of research on how it works out.

Tilden: Well, some research. We did one study, Susan and I, and Pat Dunn may have been a co-investigator.

Garland: Yeah, he was one of those at the heart of it.

Tilden: Because he really should be credited, I think, with the vision for the POLST.

Garland: Yeah.

Tilden: This particular study that I’m thinking of, I don’t remember whether Terry was on it or not, foggy here, but it was a team of us. And we studied several nursing homes. I’ve forgotten, I think we had eight nursing homes in the Portland area who agreed to participate with us. And we tracked over a year what happened to nursing home residents who had the POLST and what happened to those who didn’t. It’s not required on admission to a nursing home that you sit with this nice social worker and fill out the POLST and then have it be signed by the MD or the nurse practitioner. It’s encouraged. But there were lots of nursing home residents who didn’t have a POLST. We tracked over a twelve-month period if it did make a difference. And we found that it did. That was some early kind of evidence that the POLST could be effective. And then I know Pat Dunn and Susan and others, I think, continued.

Where I went next, I had gotten then a big NIH grant to study what happens to families who make the decision to withhold or withdraw life-sustaining treatment for dying patients in the hospital. I was again most interested in the impact on families of having to make these terrible decisions, these just so weighty, difficult decisions. And Susan was a co-investigator, and Chris Nelson. Do you remember Chris Nelson?

Garland: Yes, I do. Yes. The great Chris Nelson.

Tilden: Yeah. The great, wonderful Chris Nelson. Couldn’t have, she was my right arm, couldn’t have done it without her. She was just terrific. We inducted into our study families whose loved ones had died within some framework, I mean, a time framework. I think within the last month. We were able to locate them through hospital records. We invited them to be in our study, to tell us what they had gone through. The patient had to have died in the intensive care unit, and the death had to have occurred because there had been a withdrawal of life-sustaining treatment. So those were the, that was the segment of patients we sought. And then we worked with their families and we collected data from the families at time one and then six months later. We were very interested in the grieving process.

And here's a couple of the key findings that I think have really influenced the field. First of all, it was a very, very difficult decisions for families. No matter how well the ICU team framed it for the family, the family felt that they were making a life and death decision for the person that they didn't want to die. It became worse for families if the clinical team phrased it as, "What would you want us to do?" That really shifted the sense of awesome, just too heavy a burden onto the family. But if it was a very skilled clinical team and they said, "Here's the situation. Your loved one will not come back in a way that you tell us he or she would want. We can continue this treatment, whatever it might be. We can continue the ventilator. We can continue the tube feedings. But we think your aunt or your mother is suffering. We see restlessness. We see evidence of pain. We're trying to control that. But it's only a matter of time. How much time is wise to continue this way?" With that kind of careful framing, the family didn't feel like they were being asked to just be the only ones making this decision. If it was framed as, "We can help you make this decision, it's kind of a team decision," that helped a lot. So just how things were worded made a big difference. And we published that. I think you were a co-author with that, Mike.

Garland: I was.

Tilden: Yeah, you were on that publication. And we published it in a medical journal, not a nursing journal, because we thought that we wanted the opportunity to influence the physician reader who would read it in that journal. I think it was *Archives of*, no—

Garland: It probably was. And what I think your research really does is it keeps putting those conversations and those encounters in a wider context than popping in and saying, "What do you want us to do?"

Tilden: Yeah. Right.

Garland: And then giving, I think, the language and the frame to say, "What do you want us to do to your child, your daughter, your wife, your spouse..." is actually the wrong question. Because the authority of the family is being a spokesperson for that individual's wishes—

Tilden: Right.

Garland: —and their sort of life trajectory.

Tilden: Right.

Garland: It has been a very important framing, and continues to be important.

Tilden: Yeah.

Garland: Continues to be necessary and hard.

Tilden: Yeah.

Garland: Sooner or later, somebody shows up talking with the family and how are you going to say it?

Tilden: How are you going to say it? The other thing we learned was that the clinicians want one spokesperson for the family. Understandably. You know, with the amount of heavy work the clinicians are doing, talking to a whole family is not always that easy. Just to have one, so they're speaking a spokesperson. The family in general, they didn't like the spokesperson language. It put extra burden on one person.

Garland: That one person, yeah. No, I think they're very rich findings.

Tilden: Right. Right.

Garland: As the Brits say, "Good on you."

Tilden: Well, good on us. You were in that team and you published that paper as well. Now I'm remembering, that was I think a small grant from NIH. That was an RO3 that you and I worked on. And then the RO1, which is the bigger grant, followed that one. And that was the study that we inducted families from the ICU and we followed them for six months. And I remember a finding from that study, we used a life stress measure. We asked them to fill out a stress measure. And the data showed that those families were more stressed than families of a Berkeley fire. That same tool had been used in the Berkeley firestorm. Do you remember that, that had gone up the hillside at Berkeley?

Garland: Oh, yes, yes, yes. Part of my life in Berkeley was within blocks of that.

Tilden: Oh, that terrible, devastating fire.

Garland: It was on the Oakland side, it was the Oakland hills.

Tilden: The Oakland Berkeley, yes, the Oakland hills had just gone up in flame in seconds, and people had lost their homes. And researchers had then studied those families and how much stress they had gone through. And we found that our families who'd gone through this ICU experience of a loved one's death coming from withdrawal of life-supporting treatment had higher stress scores. So just that alone was important, I think.

Garland: That's really pretty fascinating. I think we should look at, I want to highlight how central and important that kind of research seems to me to be, which is creating this context and then looking at comparisons. And think of all the stress that's going on right now in the world having to do with immigration and wars elsewhere and people having to come in, or being threatened with deportation, these kinds of stresses. And the look at how they're affecting the family, I suspect is going to trigger the minds of a lot of people coming along after you as all of this. So good for you. And excellent leadership. You really were, I think, the research guru for the ethics work. And deserve full credit for that. But somehow the University of Nebraska School of Nursing lured you away for a period. We should talk about that.

Tilden: All right. All right. Well you earlier asked, I think you mentioned when did I become the director of research at the School of Nursing. I became the associate dean for research I think in the late 1980s, I think 1989. And then Carol Lindeman retired. And the new dean came, Kate Potempa. I had an opportunity to work very closely with her, because now I was in an administrative position. And I really enjoyed those years with Kate and I admired her leadership. I had admired Carol's as well, but I was much more distant. I was junior faculty with Carol. And when Kate came, I was more senior faculty. I'd worked my way up through the promotions, and I was professor and associate dean for research. I loved being the research dean. I think I was in that position for twelve years.

Meanwhile, I had discovered that I liked leadership. And I had taken some leadership training courses. I went to Carnegie Mellon and did a certificate in higher academic administration, where I learned budget. Hadn't known much about budget. Budgets are quite interesting at the university level.

Garland: Yes. Yes, at the university level. Different from budgets in a grant.

Tilden: Yeah. Yeah, different. Different from budgets in a grant. I learned fundraising with foundations. That was a whole interesting world, too, to learn something about that. I had that training. I had some more training in leadership through the American Association of Colleges of Nursing.

I was coming back from these training programs and Kate would look at me and say, "So you're liking administration and you're taking these leadership, so what are you thinking?"

Garland: Interesting.

Tilden: I said, "Well, I like being associate dean for research." I mean, I did. I was in it twelve years. And she said, "You know, you could do the next step." I don't think she was trying to get rid of me. But she had been a mentor. And I think she said, "You really should look at deanships."

And so I did. I think it was 2003. I looked at deanships and I interviewed and realized that it was a job I could do and that I would enjoy. I accepted the offer of the University of Nebraska Medical Center for several reasons. It's a very good university surrounded by a very interesting state, much more politically conservative than I am. But I have to rush in and say that the city of Omaha is actually quite blue. And in fact, during the presidential election for President Obama, Nebraska is one of the states that allows itself to split its electoral votes. And it only has three Electoral College votes. But on that, do you remember that big map on election night—

Garland: I do.

Tilden: —with the blue and red dots. Here's Nebraska in the middle of the country with two red dots and one blue dot. And that's Omaha. It's a wonderful university. We loved Omaha. There's a lot to like about it. And it's a very good university; smaller than OHSU, but fairly similar in that it's all health sciences. And the other arts and sciences are in Lincoln. So, law and business and English and so forth is fifty miles away in Lincoln, Nebraska. Lincoln's the flagship, but in Omaha is the medical center, very much like OHSU.

And the School of Nursing was very much like the School of Nursing here in that it had rural campuses around the state. I felt quite at home. And I liked the chancellor, and I liked the leadership team. I liked the School of Medicine dean and the other deans, medicine, dentistry, allied health, nursing, which was the position I was looking at. Medicine, dentistry, public health. I liked the leadership team so I said yes and moved there and enjoyed it very much. Did eight years. And probably would have stayed for maybe ten, but John [Benson] was ready to come back to the West Coast. He was associate dean for medicine the years that we were there. He liked his job, too. But after eight years, and all our kids are on the West Coast, and all our grandkids are on the West Coast. And the grandkids were being born. I was wanting to, I was jumping on planes to come back for that. After eight years it seemed all right to step down and come back. And you know, we could talk about those years more or the deanship more, but I'll just say that I thought I was going to retire.

Garland: From there.

Tilden: Well, I did technically retire. I did retire. But I thought maybe I would try fundraising. I like fundraising. I like grant writing, I like fundraising. We moved back and I kind of investigated a few things. But then I met the provost here at OHSU, Jenny Mladenovic, the provost at the time. And she said, "I have a job for you." And I kind of got swept up in her, and she had wonderful, exciting projects. And so, I got swept up in those.

Garland: And then back into the School of Nursing?

Tilden: Yes. One of the things that Provost Mladenovic wanted me to do, Jenny, she goes by Jenny, wanted me to do was chair the search committee for the next dean of the School of Nursing. And so, I did that. Had a great search committee. Wonderful people on it. Inter-professional, of course, from medicine and dentistry and pharmacy. The dean of pharmacy was on the committee. And we did a national search. It took us, we worked very intensely for around eight months, roughly. And Susan Bakewell-Sachs was one of our candidates. And it worked out that she was absolutely our top, well, you know how it is when you recommend, you have to recommend three, something like that, two or three. And she was in our top group. It worked out. And so that's how I'd gotten to know Susan even before she became dean. Then when she came and became dean, she said, "I have just the job for you." Yeah, research, right. While I was part time with the provost, I then ended up fulltime in the School of Nursing. I was part time with both for a while. And then became senior associate dean for research, my old job, which I know how to do.

Garland: Where is nursing research focusing now? Are you doing your own grants, or are you being the shepherd of, the shepherdess of—

Tilden: I'm being the shepherd. I'm teaching grant writing and encouraging grant writing and facilitating grant writing. I run grant writing groups, I run research mentorship groups. I do still write some grants. The last one I wrote and got funded was for inter-professional education, funded by the National Center for Inter-Professional Education in Practice. I don't write clinical research grants anymore. But you know, I still love it. But you know how you go through



different chapters in your career, so the chapter I'm in now is I facilitate the research of others more than do my own.

Garland: That gets us to the crystal ball which is right here before us. And you're going to observe from both the research you see going on now and your own instincts and intuitions, where's the world of nursing going?

Tilden: Well, let me just say that where the world of healthcare is going—

Garland: Maybe that's better.

Tilden: —is teamwork. I mentioned earlier the IOM, the influence of the IOM reports on medical errors, and how influential, they're called "Crossing the Quality Chasm." Do you remember one of the IOM's reports about healthcare? This would have been in the 1980s, was how much of a chasm we have between how much we spend and how much health results from our spending. And there's this chasm because we spend more than any other country in the world, but our assets, we have many, many assets. But the benefit to the large part of our population is not that great. And on many statistics, we do not do well. Or I guess I should say, many indicators. We still have a high infant mortality rate, even despite this great spending. The quality chasm series was a big wakeup call to all of us in healthcare that we have to do things differently. And a major way we do things differently now is we educate students, for portions of their training, we educate them together. When I was a student at Georgetown, it was all parallel play. I remember my patients and there'd be occasionally a medical student who would say, "That's my patient." I would say, "That's my patient." We had nothing to do with each other. Nothing to do with each other. It was so siloed.

Garland: It didn't occur that that's *our* patient.

Tilden: It didn't occur to us that it was our patient, nor did it seem to occur to our faculty that this was our patient and let's work together for the benefit of the patient. Anyway, so that was 100 years ago. It's very different now. It's very different. It's about educating students that they must work well together. I've been part of the driver. I've been one of many drivers now in what we call the Foundations for Patient Safety course that's required of all new students at OHSU, all new clinical students.

Garland: Very interesting.

Tilden: Not of the PhD students, but of the clinical students in medicine, nursing, dentistry, and pharmacy. And allied health, the nutrition program, the radiation technology program. There are a number of allied health, the PA program.

Garland: The Foundations of Clinical Care.

Tilden: No, I think it's Foundations of Patient Safety.

Garland: Patient safety.

Tilden: Right. It's the IOM report that said patients are not safe. When we don't work as teams, we fail the patient because we're not communicating well. In fact, data showed that the single largest driver of error is miscommunication, failed communication. We now have this foundational course that students take. And it's all of the students, the first-year students, all of the clinical students. And we have them for a whole year, fall, winter, spring, so the whole academic year. We work with them in small groups of about twelve students mixed up from the different schools. And two facilitators from different professions. This year I'm working with a wonderful physician. And we are the team that works with these twelve students. And we coach them about the importance of mutual respect, of having shared goals that are patient-centered goals, so it's not about any of us. It's about what's best for this patient, about communication and listening and how to work with each other when there's potential for conflict. How to do conflict resolution. We rely on the IHI, the Institute for Healthcare Improvement modules that are focused on all these patient safety issues. And the students on their own time study these modules and complete actually a sort of certificate program through IHI that they can put on their CV at the end of this. It's a foundation for these students that says, pay attention. We actually scare them with the data about how patients are the victims of our best intentions. We're all best intended. But of our mismanagement, because we don't know how to work together. We get their attention by how awful a medication error is, or a surgical error, or any error. And they read a lot about this. That gets their attention, too. I mean, we don't have to do a lot of the scaring. The scaring is in the IHI modules and in what they read.

But then they have to work together on patient cases, hypothetical. Many of them are actually real cases that are de-identified, of course. And they work together to solve these very thorny patients about what went wrong, how could it have been prevented, what systems could be changed. You know, the whole emphasis now is not on blaming the person who made the mistake. It's on trying to understand how there's a system failure. Most of the mistakes that happen are not because someone intended to harm a patient. It's primarily because of either miscommunication in what was supposed to happen, or missed opportunity for checking to see whether that's a correct dose for a medication. Alarm fatigue, too many alarms going off and not knowing which ones to pay attention to. There's a lot of system ways that patients get harmed not because we are anything but best-intended. So that, I'm an enthusiastic champion for that course.

Garland: I hadn't noticed.

Tilden: That doesn't come across? I'll have to pick it up.

Garland: And you should be. It seems to me that you just described what you could experience as really the result of a lifetime of, a professional lifetime of observing what's going on in this field that you love, the profession that you love. So, another good for you.

Tilden: Well, and you know, part of it comes, my passion comes because I made a medical error. I made a medication error when I was a very young nurse on a psychiatric unit in San Francisco. I gave a patient a medication he wasn't prescribed. And the medication was Cogentin, which is given to ameliorate the side effects of the phenothiazine. In that era, the class of drugs that was used for acutely psychotic patients were the phenothiazines. And they did a reasonable job of

controlling hallucinations but those drugs also made patients uncomfortable, with stiffness. My memory was that the major side effect was stiffness. And this drug Cogentin reduced that effect. And this, most of our patients were on Cogentin, but this particular young man was not. And I was the medication nurse that morning. And I pulled everybody's medications following the orders, following the orders. In those days, there was no pharmacist that pulled medications. We nurses stood there in the medication room with this huge closet of shelves of drugs. And you know, into medication cups. All that's changed now.

Garland: Those little cups. The nut cups.

Tilden: Yeah, exactly. The little white paper nut cups. And I just missed it. I just missed, because most patients were on Cogentin. So, after you pulled all your little white cups, you'd take your medication cart, it was on a cart. You'd go, these were psych patients, so they weren't in bed. They were all dressed. This was a locked psychiatric unit. And you'd go into the nurse's station and your cart was there. And the nurse's station had sort of a Dutch door, right? You could have the bottom part of the Dutch door closed and your cart was right there, and then the open part. And then patients would come by. And when they came by, you would check a wrist band and you would check your order and you would give your medication.

I can't tell you how I missed this, but I did. And within a minute of handing that man his cup and him taking it, I remembered that he should not have had Cogentin. I remember that feeling. I'll never forget that. Never. And it's four decades ago.

Garland: It's obviously written in big print right across some brain cells in there.

Tilden: Yeah. Oh, boy.

Garland: Very easy to call up.

Tilden: Yeah. I can still feel the pain of it.

Garland: I'll bet.

Tilden: I can still feel what happens to my heart, the squeeze on my heart. I immediately called my supervisor and said this is what I've done. And I don't remember all the details. But my big memory was of course she called the physician. And of course that patient then was taken to his room. And remember these patients are all dressed, so the doors are open to the rooms and the beds are made and everything. And he's watched, right? His blood pressure's taken and he's just monitored and watched. And of course, I felt just awful, awful, awful, awful. And what I remember that's so different now is then there was no root cause analysis done of how I had made this error. That's what I needed. I needed to debrief and I needed for all of us to say, "Let's go back. What distracted you? What did you miss?"

Garland: And why was it even possible?

Tilden: What was it even possible? Yeah, why were you distracted? What did you miss? None of that happened, because that was pre what we do now. Now we don't blame a perpetrator. We say

this happened. Our first attention needs to be for the patient. What's the welfare of this patient? Do we need to take the patient to the emergency room? Do we need to escalate the medical care of this patient, right? But then, once we've made sure that the patient's stable, we also go to the health professional. You know, in the language now, the health professional's called the second victim. The first victim is the patient, but the person who made the error is called the second victim because the sense of guilt and distress and pain over this is enormous. We go to the second victim and we say, help us now in what we call a root cause analysis. Let's find out what it is that went on that we could prevent, right, if we could understand how this happened, it will give us the opportunity to say, can we put some extra safeguards in place, and to involve the person who made the error in making sure it doesn't happen again for the next person. It's a much healthier process now. But back then, there was none of that. Fortunately the—

Garland: It just happened you made a mistake.

Tilden: I made a mistake.

Garland: You fessed up.

Tilden: Yeah.

Garland: Things happen.

Tilden: Things happen. We move on. Fortunately, it was not a medicine that would have a big impact, and this patient was fine.

Garland: But it was still, yeah, I can see that. It has motivated you nicely to keep moving in the direction and to sort of have what I call it a little extra pinch every once in a while if you get tired of this interdisciplinary stuff.

Tilden: By the way, I tell students about this. And I say, "What we say to you is not whether you'll make a mistake in your career. It's not if you'll make a mistake. It's when you'll make a mistake and how bad will it be."

Garland: And what will the circumstances be then. Yeah. That's great. Virginia, one of the things I know about you is that you're a marathon runner. And we have done a marathon.

Tilden: Yeah. This has been so fun.

Garland: Shall we say well done?

Tilden: Oh, thank you, Mike. It's such a pleasure to talk with you. We could do this all day.

Garland: I know. We could. It's a pleasure for me. I'm thinking of all kinds of follow-up. So, thank you. I enjoyed this enormously. I thought I would, and I did.

Tilden: Oh, my pleasure. My pleasure. Thank you.