Interview with Steph Walters

Brooke Offenhauser, Interviewer

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Cottage Grove, Minnesota (interviewer) and St. Louis Park, Minnesota (interviewee), via Zoom

[00:00]

BO: Hi, my name is Brooke Offenhauser, and I'm a senior at Macalester College. The date is April 19, 2021. I'm speaking today with Dr. Steph Walters, Medical Director in the Hamre Center for Health and Wellness at Macalester College. So Steph, I want to ask you some questions about your experiences during the COVID-19 pandemic. You are welcome to answer in however much detail you feel comfortable sharing, and you can always decline to answer by just asking to skip a question. Before we jump in, I would like to ask your consent to record this response as a part of Macalester archives to be saved and shared for future Macalester members and historians.

SW: Yes. No problem, you may record.

[00:51]

BO: Great. So, thank you for taking the time to share your experience with me. First, can you just tell me a little bit about yourself? Your hobbies, things you like to do, your family.

SW: Yeah, so I'm Steph Walters. I've been at Macalester for 11 or 12 years. And I am Zooming from home today. I live in St. Louis Park across the street from the elementary school where my

kids both went. Now they are in middle and high school. My husband is working from home in the other room. It's a Monday. We have all managed to be healthy. And our hobbies have evolved in this pandemic year. I have two dogs, one of which Brooke knows very well, and that's a nice connection to have as we reflect on the year. And I've always liked spending time with them but like many folks who worked from home -- for me especially because my commute is 30 minutes both ways -- that was suddenly an hour a day plus the maybe ten or twenty minutes I used to spend putting on' real clothes' or 'real pants.' So I do have a little bit of a gift of time when it's not a very busy workday. And my favorite hobby has become a longer morning walk with the two dogs. And sometimes a separate walk because Kevin, who the campus knows really well as a therapy dog, is a golden retriever -- nine years old but still pretty spry -- and likes to go for a one-hour walk. Wednesday the Newfoundland prefers about a three-minute, half a block walk. So it's nice to have time to do them separately.

[02:34]

So, let's see. You asked about hobbies, where I live, my family. I think I mentioned we stayed healthy. The kids, like many in Minnesota, had been all remote and then hybrid. And then they had the option just recently of either going back to full-time school which my tenth grader did opt-in. Learning from home wasn't a great fit for him, and he said as much. And my youngest, who's a seventh-grader, opted to stay at home. One of my favorite comments when she went back to school for hybrid, she was like, 'the desks at school are really hard compared to my bed.' [laughter] So she prefers to Zoom from home and was able, partly because the demands of middle school are just less, to keep up with her work and not struggle too much with the self-motivation that was much more challenging for my high schooler with different styles. So now she is at home every day. He is getting dropped off at school. As I'm being interviewed today,

I'm fully vaccinated. My husband is fully vaccinated. Most adult loved ones and close family in my life are fully vaccinated. My high schooler has his first vaccine. So we are starting to tiptoe back into a little bit more normal-ish or post-pandemic normal life. And that feels really good. Starting to anticipate some travel. We have done a few trips just to visit other vaccinated folks and hug my parents. That kind of thing. It's been good.

[04:11]

BO: That sounds great. Do you want to talk a little bit about your job? You mentioned how long you've worked there. And then maybe why you started as a physician?

SW: Yeah, I'd be happy to. So I grew up in the Twin Cities, and everyone in my family is in education. My sister and her husband are both in education, but my two parents, now retired, were both teachers as well. And even as a young person or college student, I really liked teenagers and what was energizing to them. And things in that life stage that are frankly off-putting to a lot of folks, I always found very energizing. And I really didn't like many of the stereotypes around young people, so I thought I would do something with young people. But it wasn't until well into medical school that an adolescent health doctor came and spoke to us, and she talked about adolescent medicine as a specialty. And it was the most alive I've ever felt in an otherwise kind of boring year with biochemistry and some physiology. Anatomy was fun. And it was great because for the first time I was like, 'okay I sometimes worry that I just went to medical school because it felt like the right thing to do, or I was a relatively high achiever and motivated and didn't really have many other paths.' But then when she spoke I was like, 'that is what I want to do.' So fast forward to an adolescent medicine fellowship where we are

concurrently getting our Masters in Public Health (MPH). So I was starting to think about the big picture, upstream, systemic, sociological model as opposed to just one-on-one care. So that really energized me. And then they send fellows in almost any specialty out to any clinic that's relevant to them. So I went to a bunch of teen clinics and one college health clinic. St. Kate's would host fellows from the University of Minnesota. And that person had done the same fellowship as me, and I started chatting with her. What is college health? Why do you seem like you're having so much fun? Very few doctors that host fellows are as happy as you in your job. And she has since become both a mentor and a friend to me.

[06:34]

And that's when I reached out to Macalester. The rest is history, so to speak. But in some ways, to be honest, there's a lot about this COVID year that I didn't like about my job. It wasn't energizing because what I really like doing is more around sexual health and health promotion and mental health and reducing barriers to access and having one on one appointments and care. And for COVID, it was frankly a lot of meetings, a lot of planning, a lot of thinking about systems -- so there was a part of my brain that was really activated by that MPH part. But, by this time, you Brooke and others have seen that it's like looking in the sun for nine months straight or drinking from a hose. It just is ever-changing. Always. A lot of work; shifting sands. And at the same time, recognizing that if that mix between boredom and not liking my job as much or feeling uncertain in that role is the worst thing that happened to me this year, lucky me. So both recognizing the privilege and also taking a deep breath. And like any one of us involved in COVID care, however you define care, it was and still is a lot of work. Especially as we're getting ready to plan some vaccine clinics on campus, finally! And that's in some ways nothing compared to people who were on the front lines of care in emergency rooms and hospitals. And

the exhaustion. I didn't very often feel, to be perfectly frank, that my life or my family's life was at risk. Because I work in a small clinic, and we were able to do a lot of it remotely via telehealth. We had very structured COVID clinic afternoon testing, so it always felt very separate. And when I had to see an ill patient, we had enough personal protective equipment (PPE) to do it. So, compared to many in healthcare that I think probably felt vulnerable -- crossing their fingers, reusing their masks -- that whole time, I and my staff were relatively distant from that. There are people that worked in the lab that suited up in PPE every day to take swabs, so I can only imagine for them it was much more top of mind like that they were at risk. But for me it was a little bit of just rooting for them, rooting for patients, wanting to do the best by our patients but also being aware of resources.

[09:23]

Blah blah blah blah. [laughs] I will just say that when I get glimpses of what my job was before COVID, I am reminded like, 'oh no Steph, you *really* like your job.' I've had a couple of patient interactions recently that were tender and raw and beautiful in the fullest sense of the word. And a couple of meetings lately that reminded me sometimes you get to talk about diet culture and fat phobia and eating disorder prevention and other times you get to talk about sexual health and other stuff. And I was like, 'okay, it's coming for you. Get through this.' But yeah, it was a lot of soul searching. There was a big change in leadership at the college this year, a big change in the world. We've said this before the pandemic of COVID, there are ongoing pandemics of racism and transphobia and all the other things. So I think anyone who doesn't feel a little bit tired after this year should do that soul searching like, 'what do I really value? Where do I want to spend my energy? Where do I spend my time?' I think if my job was always COVID like this all the

time with this level of that type of stress, I wouldn't want to keep doing it. That's where I am today, anyways. But now I see a glimpse of the old job returning, so I'm excited for that.

[10:51]

BO: Yeah. Thank you for sharing that. I do want to get more into your experiences about your role as medical director, but first thinking back to like early 2020. How did you first learn about COVID-19?

SW: Funny -- I think the way I first learned about it was not at work. I think like all of us, you were seeing these little blips. And anybody who's a medical director with an MPH, we're getting daily emails. We're on multiple listservs, so sort of seeing that. But the first time I think I heard the word COVID was from a friend of ours who's a total prepper. [laughs] They were like 'what is this COVID thing?' And I was like, 'don't worry about it. It's going to be similar to the flu. Novel viruses come and go.' I think I really dismissed it. And he was like, 'I don't know.' He's on some aspect of the internet that isn't me, and that's very funny that he was the first person to be, 'I don't know if you should dismiss it that quickly.' Shortly thereafter, it became a bigger topic at work. Then my memory of this, and granted it's through my brain over 12 months ago. I think there's an email chain that will get us there. I think I emailed Denise Ward, who's my boss, and maybe DeMethra LaSha Bradley, and was like, 'we need to meet about this. Tomorrow.' And they were like, 'really? Like this week?' I said, 'this week. And help me think who needs to be part of it.' We were just brainstorming what eventually became the Infectious Disease Task Force. But it had representatives from senior staff, Coco Du from residential life. I can't -- now we're going on memory, and for the archive someday somebody could dig into it.

But I remember DeMethra being like, ‘did you really mean that we need to meet about this by the end of the week?’ And I said, ‘I really mean we needed to meet about this by the end of last week.’ And I think that was late January or early February. And I take no credit for that. I don’t know if the difference between meeting end of January or early February set us up for any more success than somebody that was meeting about it on February 15. By March, it was clear to everybody what a big deal this was going to be. But there was that sensation of like maybe I didn’t get it as soon as my prepper friend did. But feeling a little alone -- not alone, but in a small group of people who understood what this could mean. And understood how underprepared the world, the country, our little pocket was and how much work there was to do so.

[13:49]

So as you know, the president then was President Brian Rosenberg. And a couple of memories from that moment was he asked me to start coming physically in a little boardroom to senior staff meetings. That was back before we were masking or distancing, and [COVID] was just this thing that was out there. I don’t remember how that lined up with the first case confirmation in Minnesota or what the timeline of that was. But I went to senior staff meetings and they met every day from 10 am to noon for a little while. And Karine Moe, Provost, and whoever else was in that room -- I remember saying something like, ‘if it can be done remotely, it should be done remotely. And if it can’t yet be done remotely, the planning for doing it remotely needs to start. So it’d be a *really* good time for professors to know this and start planning to teach their courses online even if they don’t have to.’ And Karine Moe -- her job is to think about academics and faculty representation. Her job isn’t to think like an MD/MPH and she kind of was like, ‘I mean if we don’t *know* we have to go remote, that’s a lot of dual planning. That sounds like a disaster.’ It just sounded so awful. And I was only the messenger, but I can only imagine how tough that

sounds. And then Brian would pose a question, and I was sitting right next to him and I said something, and he probably didn't like the sound of it. Nobody did at that point. You're talking about closing campus and sending people home. People in that room, understandably, need to think about money and impact and hustle and longevity of the college and messaging. And I'm just thinking about public health and health. That's why they brought me. And I remember I must have said something that nobody wanted to hear because Brian just kind of laughed and looked at me then looked around. And he was like, 'I'd like to hear from someone other than Steph on this topic.' [laughs]

[15:50]

And that was kind of fun. I don't know if you know this but Brian's wife is a physician -- I want to say internal medicine. Recently retired. So he had a little bit of that lens and knowledge which was really helpful. I remember we went to an in-person faculty meeting in Kagin and all the faculty are sitting there. He wanted me to come and share with people what I knew, what I was learning, what [Michael] Osterholm was saying -- who I was quoting probably six times a day back then. And we tried to reassure them and say this is what we know, this is what we don't, this is where we think we're heading. And those are just early memories of both the innocence in it and the like -- something big is coming and you couldn't have predicted where it would go. And just the quaintness of these in-person, non-masked, non-physically distanced meetings is such a strong memory. I'm sure I have lots of other things that bubble up. But it took a while before we had the semi-permanent members of the Infectious Disease Task Force. What voices do we need at the table? I'm not nearly as savvy as most people in the college about academic roles and hierarchy in higher ed and how these things happen. I was just like 'we've got to start talking about this.' And normally a task force is *literally* tasked by the President or by somebody

that says, ‘here’s what I want you to do, here’s who I want on the thing, here’s how I want you to report back to me.’ None of that happened. It was almost like we all came together and started chatting. Then, senior staff came to an infectious disease meeting -- again in person. This one was in the Campus Center. And we’re all standing or sitting around. The Infectious Disease Task Force -- the group of us had met maybe three or four times so we were a little thicker into it, a little bit more cognizant of what was coming. Senior staff was starting to get on board. Brian was very much on board. But there was still a lot of, understandably, disbelief and resistance. Like, ‘really? That would be really tough for the college.’ So it was a real evolution.

[18:12]

And then by that spring and throughout the summer, we continued to meet once a week. And the Infectious Disease Task Force in its full group has never met in person. And so just in those Zooms getting to know people so well week after week after week. I’m not sure I would recognize them if they walked in front of me. I don’t know how tall anybody is. We’re just sitting in these Zooms. So we do joke about how nice it will be at the end of it -- anyone who’s been through this but that group in particular. Having made connections with people I’d never worked with before, being able to sit together for coffee or for a beer or for lunch. To just reflect on all that we did and talked about during that time. I look forward to that because I do think that’s potentially coming, too. Maybe this summer.

[19:08]

BO: Yeah. So you talked quite a bit about the Infectious Disease Task Force. You are currently the co-chair of that if I’m correct.

SW: Right, yeah.

[19:19]

BO: So you talked about how it was formed and how often you met, but can you talk a little bit about what your primary tasks were? Or primary role?

SW: Yeah, you're like, 'even if you invented them yourself and weren't given them.' [laughter] Well, I do remember when President Rivera joined and she came remotely to one of our meetings. And I did ask her like, 'we just started meeting, and we kind of know what we're doing, but we were never tasked for understandable reasons. I mean everyone's just working a mile a minute. But what do you most want from us?' And again, this is my memory -- I don't have a transcript. But I think she was like, 'oh, I want this group to give the best public health advice and recommendations to senior staff.' I'm paraphrasing, but that's my memory of it. So, I did co-chair that with Paul Overvoorde. They assigned Paul, very smartly. This was such a Herculean task that you couldn't have somebody that also had a day job do this thing. So I think he was previously Assistant Provost and then he became just Director of COVID Operations. So this is his full-time job. Unless we put everything else in Hamre Center to a screeching halt, that couldn't have been anybody from our staff. There's not the bandwidth for that. And I already am doing way less than what I was doing in the Hamre Center. I probably only saw a quarter of the patients I normally did this year. Among some other things that we just let go or postponed or put off for another year. So having him in that role -- that meant he could take on a lot. Most of the campus-wide emails have come from Paul. If they're more clinical, then me. And then Jen Jacobson too, I pulled her on I think this summer. As soon as it became clear that our role was to

advise on public health, but no one else in that room had any public health experience, I was like, 'I need another person who just thinks like this.' Like public health is about making the healthy choice the easy choice. That making rules and incentives and decisions are not the same as behavior change. And knowledge is not the same as behavior change. Things that I think Macalester did really well, whether because of leadership or senior staff or the privilege we had of being a relatively well-funded college, who knows why. But I'll just say things. They listened to an Infectious Disease task Force recommendation to have single occupancy dorm rooms, and that was not without a financial blow to the college and significant disappointment.

[22:54]

The other thing which I am a part of is the COVID Case Management team. Single occupancy dorm rooms meant that an exposed person could quarantine in place, whereas at other colleges -- I don't know if you have friends, but like I talk with other COVID case managers. The shuffle of people in and out of rooms or fielding phone calls from a parent being like, 'my kid just said that their roommate was exposed to COVID, and they're going to be staying in the room with them this whole time.' We didn't have to deal with that on campus. And so it allowed us some bandwidth, as opposed to just dealing with the immense shuffle of people from one place to another. Or the general angst of feeling like your roommate was a danger to you and 'I don't even know this person.' It's one thing if a group of seniors decides to live together in a house and have a shared commitment about how they are going to approach COVID. Well, that's another silver lining -- communication and everyday consent. So I'm *very* happy and proud that Macalester chose that route. I don't think it was the only key to our success, but it was one of them. And then the other thing is that unlike some schools, which were very punitive or assuming that their students were going to fuck everything up and flout the rules and party

anyways, I feel like Macalester took a very realistic understanding. And I give a lot of credit to student affairs professionals. I'll say for myself it was the thing I was most consistent on. Just reminding them harm reduction -- these people are human; we have to be aware and honest that there's going to be slips. But we also *cannot* send the message out there that we assume you're going to mess up, and you'll be punished if you do. That just doesn't build community. For me, it felt like, on average, Macalester's vibe was very, 'this is no fun, but we're in it together.' We know what it means to sacrifice for the greater good or protect the most vulnerable.

[25:14]

And I know there are individual exceptions to that, and pandemic fatigue hit all of us no matter how altruistic or well-intentioned. So I chat with medical directors at local schools all the time. Compared to what I was hearing from my colleagues, the students had a lot of buy in for this. They wanted to do the right thing. It wasn't always fun, and they totally sometimes made mistakes. But it never felt like we weren't going to be able to contain something because there was nobody out there not believing in COVID or anti-science or super individualistic like, 'I don't care about protecting other people. How bad can COVID be?' That just never -- it's just always felt like folks were sort of in it, and that made doing the work a little easier. Just like that united focus. So that part I really liked.

[26:30]

BO: That was great. Thank you for sharing your journey through that and your roles and experiences. Thinking more about your role as medical director, can you talk about how COVID-19 changed your day-to-day?

[26:52]

SW: Yeah! So the biggest reason is obviously location which is reflected by how we are doing this interview. So I'll just speak from a very personal level. I'm 0.75 full-time equivalent (FTE) 12 months out of the year. So what that basically means is that I was working roughly four days a week and not on one day a week. So what that meant for my day-to-day during the school year is that four days a week, I was getting in my car and driving to Macalester. And I had a mix of seeing patients, some meetings, supervising residents and fellows. Just a crowded, busy, vibrant clinic which you've been in as a student worker there. And that all changed. So especially back when we weren't vaccinated, the way we decided to do it was one of the three medical providers with advanced degrees -- that would be me, Brian Bradway, and Ellen Giere. So me, physician assistant, and nurse practitioner. We were going to take turns being in-house provider so that there was never more than one of us trying to share space and see patients in person. The other two would see patients remotely or be doing meetings from home. So, they both had two days a week in clinic; I had one, and that makes five total. Because I was the one with the most meetings and the most ability to Zoom from home. And they have always had a little bit higher patient volume and not as many meetings. Counseling was almost entirely remote as you may know. They have five full time staff but nine total. And there was only ever one counselor in the clinic. They would rotate through, and everybody worked remotely. So that was the biggest difference. Just the entire structure of my day changed. The work of COVID -- because of our patient population -- 17 to 25, roughly pretty healthy. Unlike being a medical director of a nursing home or something where you'd be very actively thinking about the medical impacts on your individual patients, that really never surfaced very much for me. I didn't have to think that carefully about staying on top of COVID management. Steroids or antibodies or blood or

anything like that. Which anyone who is caring for more elderly or vulnerable people would. Their COVID work was keeping up with this brand-new player on the scene of like, 'how am I going to manage that for my patients?' Mine wasn't. So I would say that what felt like the bulk of my COVID work was Infectious Disease Task Force stuff as medical director.

[30:02]

Torri Lattimore, the operations manager, and I had to figure out like a clinic flow and a procedure. We had to get everybody on HIPAA compliant Zoom. We had to teach people how to schedule their own stuff who never had because they would always go to the front desk to schedule things. We had to get up to speed with COVID testing options and protocols. We had to figure out a literal flow of how to get one sick patient in the clinic, get their test, and go home as soon as possible. So there was definitely that. But I spend more time thinking about the medical management of depression, anxiety, and STIs honestly. Like I never really had to dive into the medical parts of COVID. A little more on a personal level for loved ones or making sure my parents had access to it, but like this was really a public health exercise. At least for my job and my experience. I did give up this year hosting and teaching residents from the University of Minnesota. So they would come, and they would spend full two days and clinic with me. And what they really liked learning from us was mental health, young adult, adolescent health management. And for sure in the shutdown of last spring and then early fall when there are so few people on campus, we just didn't have the volume. And some things just are like, 'okay I can do this via Zoom,' and other things like, 'I can't. I can't figure out how to have the resident see the patient, but then I have to join the Zoom meeting and see the patient, too. Then I have to sign off. None of us are in the same place. They don't know how to use our electronic health record (EHR). Like, I can't.' And it was fine because there was a time when medical learning

was really limited too. they didn't allow medical trainees to see and be at risk for COVID, so it's just like a pass. But when you ask about my role as medical director, what do you what do you mean or what are you curious about?

[32:14]

BO: I think what I was mostly wondering about your day-to-day changed, but also how, if it all, did your quality of care that you felt like you were able to give like students change? And then also, connections with students. I know that you connect so widely across campus. How did that change?

SW: Yeah, that's a great question. A lot of those heart, 'keep me going throughout the day' connections were honestly with Kevin. You know, therapy dog. Just being able to sit with him for an hour. And you've been there, and you've seen that. I think for anybody that works in the student clinic, one of the things that we really miss and once we get it, we're like, 'oh yeah, that's so important to remember,' and it's one of the things I value in our relationship, Brooke, is that if you're only seeing students in clinic, you're, on average, seeing them when they feel they're worst. Their sickest, their saddest, their most lonely. Not always. Study away physicals or general birth control -- there are times when you're seeing them feeling good. But you can get this skewed vision that people aren't thriving. And the things that helped us pop out of that were like stuff with Kevin or going to talk to a team about something or walking by one of the tables that Health Promotion was doing or going to a women's soccer game. Like talk about thriving! Just like seeing people. Or theater! I think I saw you at Rocky Horror. And those things weren't available. So in terms of quality of connection, certainly affected. I think there are pros

and cons to telehealth. I love it from a universal design and access standpoint. I love being able to Zoom with a patient and seeing their cat or their pet, or the drawing that their niece drew them behind them. Or just getting a glimpse -- so leaning into that bit of like, 'oh, it's easier to see them as a whole person in their natural habitat.' And maybe a little bit for them too. Sometimes folks *loved* when Kevin would boop into our appointments or Wednesday. Or just both of us Zooming in sweatpants and not apologizing for it, not that you would see the sweatpants. Like it was probably clear from the hoodie there wasn't anything formal under that. [laughter]

[34:57]

So that part was nice-ish but nobody would want that to be the only option. So I love that every clinic in every setting was forced to get on telehealth. I love that it forced insurance companies to recognize that this could be an effective way of care. So I just like it as an option because I think some people will truly like it better and will never go back to in-person unless they have to for a shot or labs or an exam. And other people hated it and or are like, 'everything in my life is on Zoom I don't also want this appointment.' So, the quality of care -- it's a really good question, Brooke. I think that it kind of remains to be seen. And it's going to be so hard to measure because how do you measure the impact of seeing somebody on screen and being able to bond in that way. Versus not being able to listen to their heart right there in the moment when they're saying they're having palpitations. Like that it's a little stressful to not be able to examine them, but the bulk of my work really is about asking questions gathering information. And then, like if it's a sexual health visit, and they're interested in testing, it's easy enough to just be like, 'so you go to clinic tomorrow, your lab is all set up, then you'll leave your samples.' Because we were still able to do all the talking, connection, and history taking here. So, I'll say that for me, the jury is still out. It kind of remains to be seen. But I'm very happy that this is an option. I'm

happy both for patients and that access piece, but I'm also truly happy for providers. I don't know how in touch you are with a sense of primary care clinicians really reaching a high level burnout. Less so in college health because we have different pressures than them. But in regular family medicine clinics, there's a notion of see patients faster, do more stuff to them, don't talk, don't take time. Then you couple that with the energy of commute and getting dressed. And now hopefully -- like who used to think a doctor could work from home one day a week you know or a nurse practitioner? And now people are like, 'oh yeah you totally could.' If you did all your mental health visits on that day, and all your staff meetings on that day, there is no reason you need to be physically present. And I get that's not the case for hospital-based practitioners, but for clinic? So maybe there's going to be a little releasing on that pressure valve for primary care clinicians or mental health practitioners. I like to think of that. Surely there are some silver linings we can keep around. Or just the forced quieting for all of us. Occasionally on a Tuesday lunch hour, I'm playing a board game with my kids. Like when did that happen before? Just being all around together. There's also obviously many a Tuesday's where you walk up and you look at your family and think, 'oh, it's you again.' [laughter] There's none of that separation. Or the gift of when you go away from your house if you have a safe and lovely home to return to, just that feeling of like, 'I'm coming back.' When you're there all day, it can feel more like a cage than a lovely place of rest to return to. So, both and. Now I'm just waxing poetic about work-life balance but a lot to think about.

[38:58]

BO: Yeah, I feel like there's a lot of that balance between like, 'I hate the space, I love this space.' So I definitely agree.

SW: Totally. ‘I love this person, I hate this person.’ Really getting on each other’s nerves.

[39:16]

BO: Yeah, for sure. And so, your other *very* important role on campus as the Pet Away Worry and Stress (PAWS) therapy pet program director and mother of Kevin. COVID obviously impacted the PAWS program in general. Could you just talk a little bit about that?

SW: It did so much, Brooke. And on multiple levels. Obviously the very physical. There were months where nobody could comprehend how in the world you could do a therapy dog visit. [Kevin] is such a magnet. Everybody hugs him, hugs each other, comes close -- that’s clearly not a COVID-aware thing. But it was also a bandwidth challenge. Like you, [the PAWS student coordinator], and me, Denise and [her therapy dog] Koski. And we did one, maybe two virtual events with Kevin, and I did try to have him pop into my Zoom sometimes if patients asked for it. But that is not the same as just a regular standing place where people can go. And you have been so instrumental in getting some of these PAWS events more solidified and more regular, but we haven’t succeeded in expanding it to more animals. And so that is something like I’ve been thinking about is that will be a goal. I realized Kevin is nine, and retrievers live 10 to 14 years. But they don’t usually do therapy right up until the end when they get trouble. So if he can’t do it in a year or two, and I don’t have another trained therapy dog, like I still want it to be really vibrant. And sort of then -- maybe Steph and Kevin are the founders, but we’re no longer the directors. Because you want somebody who is still actively doing it. So that’s a goal. Almost like a PAWS rebirth or a PAWS refocus or a PAWS expansion for non-COVID time. But it is

very sad. And I don't know how much Kevin or the PAWS dogs are still on people's radar. At first, I was trying to be more effortful -- you and me both -- about still posting a little bit on Instagram and stuff like that. But again that's bandwidth. There was *never* a day where something new related to COVID didn't come in. Or somebody emailed me personally a question about it. And those would come from faculty I've never met, from students certainly, from staff looking for advice. People who didn't get an answer they wanted from their doctor. But like, they're not my patient. They're an employee asking me, Steph, for advice. So I felt like I was carrying a lot of people's burdens, understandably. 'Should I get this vaccine or that vaccine?' 'I'm not your medical provider. I totally see why you would ask me, but I'm the Director of Student Health Services here's some resources.' So it was hard. Nobody on campus had ever asked me for medical advice before, and now a lot of people would. Sorry you asked about PAWS -- I don't know how we got here. [laughter] So, anyways, back to PAWS. We'll try to do something a little better. Stay tuned. There might be one more surprise in store with Kevin for seniors. I can't say any more than that, but maybe you've heard rumblings. You can't say any more than that either. Okay. [laughs]

[42:56]

BO Yeah, that was actually one of my questions if more people turned to you. So I'm glad that you brought that up.

SW: Yeah, yeah. So now it's pretty out there -- like health response or COVID testing. There are these COVID-related emails. Because at first, most of the messages in the spring were coming from me, Dr. Steph, so all anybody has to do is just reply to that. [laughs] People that probably

didn't even know I existed or what we did in the Hamre Center. Because there are still a lot of misperceptions about what the Hamre Center *really* does. They would write back with this really heavy stuff. Like, 'I'm supposed to come to campus still, but my partner is going through chemo right now. I'm terribly worried about being a risk to them.' And that was so new for me to be trusted and held with this care. Which is a privilege, and I didn't want to disappoint, but also, I am not their provider and I'm also not the decider. Sometimes people misperceived and I would have folks being like, 'I've been told we can't open this facility because of COVID, and I'm writing to tell you that we should and here's why.' And I'd just say, 'oh I'm not the decider. I didn't even know that was on or offline.' Thankfully once Paul was more established in the role, he started so bear a lot of that stuff. So it's like anything. Both and.

[44:37]

One of my favorite things about having medical expertise is to be that medical interpreter for friends and loved ones. And I'm very good at boundaries. My loved ones know this. I'm like, 'if it's an emergency, yes call me.' Like my parents, of course; my immediate family, of course. But if you just have a question, text first so that either I can get in the right headspace or say, 'no, not now. I'm out to dinner.' Because when I *can* help them make a decision or interpret what their provider said, it's such a gift. I wish everybody had a medical interpreter in their life to say, 'here's how I'd think about it if it were me. It's your body, and everybody has different comfort levels with risk and uncertainty, but here's my comfort level.' Sometimes a provider will say with all their white coat authority like, 'you should do this.' And I'm like, 'well, the evidence, to be honest, is mixed. You have more choice in that than you think. And if I fully agreed with them, I'd tell you.' So I love that role. But, nobody could do that all the time or take that on. So, my feelings -- like most everything about COVID -- are mixed. Like it was nice to be asked, but

I really didn't have much I could offer folks beyond empathy and support and then a little bit of a redirection. But it was good because it would keep that empathy and angst a little bit more front and center for me. I remember once I said in a message that came from me or on a webinar -- I don't remember which -- something like, 'I don't pretend ten months into this that you aren't affected by COVID. You may have lost loved ones, and it's really important to validate that.' And a couple people wrote back like, 'that's the first time that we've heard the college acknowledge that.' And that may or may not have been true, but that was their perception. And they were just so thankful for putting that front and center. Because sometimes it feels like all the college communications are just testing on this day, dorms close on that day, academic update from Dianna Shandy. COVID is just this thing that we have to adjust to, and not validating that is a terrible thing. And that it has affected many people deeply, personally, tragically. So once I got that feedback, I tried to put it in all the messages that I could. But it was great that somebody was able to name that and remind me of the importance of it.

[47:31]

BO: Yeah, and remembering we're all human going through all of this. So, I know we're almost out of time. Is there anything else you want to share that we haven't talked about?

SW: Well, first, I'm not surprised that you and I are almost out of time. That's how our meetings always went because we always have much to talk about. [laughter] I'm really excited for you and other people going into public health. I think that's another silver lining that folks have started to think about the range that public health impacts. COVID kind of brought that up. The other thing is I know that this has been really tough on young people -- college students, my own

teenagers, kids -- and I validate that. But I also am very mindful of a narrative that focuses too much on loss. Like, 'we didn't get to prom, we didn't get to this, and we didn't get to have in-person graduation.' Again, all true and worth validating. But I think there's this cool thing, that if people get really reflective and think about, is worth ten of those. And your generation or my kid's generation of young people realizes now, early on, that we are all in this together in some ways. And that there are always people more vulnerable than you. It is just that notion of the common good or going through something big that does indeed take some sacrifice. I mean a lot of generations don't experience something like that until it's wartime. I hope there's a little gift in that -- some teaching or reflection for young, healthy people with relative privilege to just remember maybe that was a gift for these students that they had to slow down. They had to think about their place in the world, and what it really means to sacrifice and protect others. Maybe that will do something for the world. Yeah. I think that's about it, Brooke. Do you have anything that you want to say for the record?

[49:59]

BO: No. I really wanted to hear your experience, so I'm centering that.

SW: Fair enough.

BO: I just want to say thank you again for sharing your experiences. You had such insightful perspectives, so I really appreciate you sharing with me today.

SW: I appreciate you asking and thinking of me. Just another benefit of our relationship is that this got to happen. So thank you, Brooke.