

Ep.3-Frontline-in-a-Pandemic.mp3

[music]

Karly McGibbon [preview]:

I'll tell you the story about our first COVID clinic in Sudbury. I got a call on a Sunday night, from my manager, to say, "Hey, Karly. The vaccine is coming to Sudbury and I need you to go get it." And it was like, "What?! Vaccine is coming to Sudbury. Oh my goodness."

And she said, "You need to go, at four o'clock in the morning and pick up the vaccine at the airport. Don't tell anyone where you're going. Don't talk to anybody. Don't stop anywhere. You need to go to the airport." Umm, and at the time we didn't have the big freezer, so she said, "You're going to bring it to the local hospital. A security guard will be waiting for you. This is where you park. You're going to park. You're going to open your trunk." Like it was all written in sequence. "You're going to carry the vaccine. You're going to take *this* elevator with the security guard."

I went in the dark to the airport and waited for the plane to land. And then, you know, they gave me the cooler. I had to put it in a seatbelt in my back seat. And I felt like a private agent. I felt like I was in a movie.

[clip of fictional movie set instructions]:

(inaudible) thirty-six, take one. Marker. (inaudible) mark. (inaudible).

[music]

Maureen Cava:

Hi, I'm Maureen Cava.

Susan Blue:

And I'm Susan Blue.

Maureen Cava:

This is *Stories From The Field: Public Health Nursing in Ontario*.

Susan Blue:

Today we're talking to Karly McGibbon, a public health nurse who has worked in the Sudbury area for 17 years. Since the beginning of the pandemic, Karly's work has focused on supporting Public Health Sudbury and District Health Unit's response to COVID-19. And that important work will be the focus of today's conversation.

Maureen Cava:

Karly was introduced to public health between her third and fourth year of her nursing program at Laurentian University. She was hired in the summer student program to provide prenatal, breastfeeding, and parenting support to childbearing-age families, in

the Healthy Babies, Healthy Children program. This summer job opened a whole new area of nursing for Karly. And she loved it.

Six months after her graduation, the Health Unit called her, offering her a position with the family health team. After about a year-and-a-half, Karly was ready for a change and was offered a position in the immunization program, where she has worked for the past 15 years.

When COVID started, Karly was redeployed to the area of case and contact management. And, of late, she has been the lead public health nurse for the Health Unit's immunization and vaccination program.

We're really excited to learn about Karly's experiences during this unprecedented time.

But first, we'd like to acknowledge and thank both the Lawrence S. Bloomberg Faculty of Nursing and the University of Toronto. Funding from the Verna Huffman Splane Endowment Fund enabled us to produce the podcast series. A public health nurse who lived to be 100, Verna's legacy donation supports education that promotes public health nursing.

[music]

Maureen Cava:

I'm wondering if you can take us back to March 2020 when you first learned about COVID. Can you describe for us what happened in the health department and, more specifically, what happened to *you* as a public health nurse?

Karly McGibbon:

Sure. Well, I remember it so well, so I'll tell you. I had just gotten back from a trip to Disney World—my favourite place to be. So I was certainly coming into COVID well-refreshed and well-rested.

And I remember in Sudbury, here, our first case was on March the 7th. And I remember being in the office and, you know, there was of course early March there was all this buzz about COVID. And things usually happen in Toronto first, before they happen in northern Ontario. So we were all kind of waiting. And of course nobody knew how big COVID was going to be. So, "Do we think we'll get a case? Will we get a case?"

We had this one fellow, and he was our first case. And I wasn't the nurse who spoke to him during the initial call, but we were all kind of gathered around that girl's desk. And then I remember this particular gentleman had been to a conference in the Toronto area, and presumably that is where he picked up COVID, so, but not knowing, as a community, you know, "What do we do next?"

We had put out a media release. And the next morning our lobby was full of people who had a wife who had a friend, who had a neighbour who knew someone who went to the

conference. I mean, we had *everybody* coming in to the lobby, and of course grave concern in the community.

And I remember going out to the lobby and just talking to people, and wearing all this PPE because we weren't sure what we needed or didn't need. And at that time in Sudbury we didn't have a testing centre set up, so we were sending them to the local emergency department. And lots of whirlwind, but I just remember feeling like, you know, this is the emergency department of public health, and we're right in the middle of it and in the thick of things.

[music]

Susan Blue:

Contact tracing for public health is a little like detective work. Public health nurses will interview people who've had a positive test for COVID-19, to figure out who they may have been in contact with. Then they contact those individuals and potentially ask them to quarantine. And this way, the disease hopefully can't spread any further.

So we asked Karly to explain contact tracing in simple language.

Karly McGibbon:

We would get a phone call from the local lab. And they would say, "Karly, I have a positive lab report." So then my job would be to call the client. We would disclose the diagnosis. And then I would say, "Okay. Our first step is to figure out where you picked this up. So tell me everywhere you've been in the last two weeks." And usually people were fairly confident on where they picked it up. "Well, oh yes, I did go out of town" or "Oh yes, I was at a large gathering." So that part was easy.

The tricky part for contact tracing is, "What have you done in the last 48 hours?"—like from their symptom onset. So you know, let's say it's a Wednesday and they got sick on Tuesday, I would say, "Okay. Start with Sunday morning, where have you been?" "Okay, you went to the grocery store. Well, which grocery store? Which aisles did you go down? You know, who were you with?" "Oh, then you went to Tim Horton's. Okay." That's big—that's big up here in Sudbury. "Well, which one did you go to?" because there's one on every corner. "Then you had dinner with your family. All right, who lives in your household?" "The next day you went to work. Where do you work? Who's in your office? Do you work alone? Do you have a door on your office? How often does your office get cleaned? Did you use the photocopier? What is the likelihood that you transmitted this to anybody?" So if they said, "Well, you know, yeah, I had a three-hour board meeting and there were six of us and we were in a small room without masks," well, that gives me a pretty good indication that there may be some potential transmission.

Because, of course, we can't close down every business or every grocery store, so we really need to take a look at what's high-risk, what's low-risk. Those are all kinds of questions that would help build our case.

Maureen Cava:

So you were looking, really, for the close contacts.

Karly McGibbon:

Yeah. So we would almost split them into three groups. So we would have what we would call our “high-risk close contacts.” So those are your family members, your best friend, your close work colleagues that you were, you know, more than 15 minutes, less than 6 feet apart—those people who we really felt, you know, that these people are at risk and they need to isolate.

We also had, ah, low-risk close contacts. So let’s say, I went to the gym and I was working out, you know, from two to three o’clock. So we.... But I was alone and I was wearing a mask. So then what we would do is maybe send a letter to the gym and say, you know, to the 100 people who were in there at that time, “Heads up. There’s been a case of COVID. We don’t really think you’re a contact. But you don’t need to isolate. But if you do develop symptoms, please go and get tested. So your risk is very, very low.” We just, you know, we called it “the heads-up people.”

And then we also had what we called “the transient people.” So you know, “You shopped at Walmart on Sunday night and someone there Sunday morning had COVID.” So we wouldn’t even notify those people. We likely wouldn’t notify the store. We would just report it as a transient interaction. And then we would know all of a sudden if, you know, we get seven cases linked to a grocery store, you know this is an issue.

Maureen Cava:

It may be difficult for people to feel comfortable talking to a nurse as they ask questions about where the person has been and who they were with. How does Karly build trust quickly, so that she can get this information in order to stop the disease from spreading?

Karly McGibbon:

When we call people to disclose, we certainly had a lot of people who didn’t believe that we were public health. And they said, “I don’t believe you. This is a prank. There’s no way. I wasn’t in contact.” And what we would often do in that situation is say to the person, “Here’s my number. Here’s my extension. You know, call me right back. And then you’ll know you’re calling public health, and that’s where I am.”

And, I mean, understandably it’s a shock for people. So once they sort of got over the initial shock, and I like to tell them, “Listen. This is going to be a 30-minute call,” just to get them prepared. “I’m going to ask you everything about, you know, your last trip to the bathroom, to where you worked, to how much you weigh, to any health conditions. I need to know all these things. And the reason I’m asking is, you know, so we can come up with a treatment plan that’s best for you and we know what to watch for.” And then I would say to them, “I’m going to be calling you every day. So you know what? Let’s make this work. And this is how it’s going to be for two weeks. And then you don’t ever need to speak to me again.”

So we certainly had some people who were not buying in. But I have to say, most people were scared, and they were happy to get the call from us. Because, like in today's day and age with technology, by the time we called them there *were* a lot of people who said, "Oh, I already know." You know, "I checked my results online." Or, "I already know that my best friend is positive." Or, "I already know that my father's positive." So a lot of people were relieved to get our call, and had a ton of questions.

And I would also say, something so interesting with the contacts is it really depends on the age of the client. So anybody maybe from about 50 and older absolutely kind, and concerned, and buying into what we have to say. And you know, they're making notes. "And when do I go for testing? Absolutely." And they're willing to do whatever it is that we're asking of them. Fantastic.

When you get into the younger demographic, people start worrying about, "Am I going to get in trouble?" People start denying the fact that they were there. "No, I wasn't at that house party, Miss. I didn't go there. I'm not a contact." People starting to say, "Well, you know, yes, I—I did have ten people over for dinner. Am I going to be charged because I was only supposed to have five in my house?"

So we really had to say to them, I said, "I'm not reporting you to the police. There's no enforcement piece here. I need to know exactly who you were with, because I need to make sure that we get them the best medical care and we can nip this in the bud and stop it. I don't want all these people continuing the spread."

So we really had to, with the younger demographic, say, "You're not in trouble. Just please be cooperative and, you know, we're going to help you." That was something that we noticed absolutely a difference with the ages.

Maureen Cava:

So, as you said, you were collecting data, you know, as you went, during COVID—you know, how many people were positive, how many people are negative. Can you tell us how collecting that kind of data might impact marginalized or vulnerable communities?

Karly McGibbon:

Yeah. We had sort of pockets of cases. So we certainly would have—I mean, COVID doesn't discriminate. Right? So we would have someone from a homeless person to a very affluent business person. I mean, they're all getting COVID. So it doesn't discriminate. But what we did see were higher cases in marginalized populations. And we had two sort of big clusters in Sudbury.

And one was a group of international students from one of our local colleges. And so, these were international students that came. And there's quite a large population of them. But they don't have any money. Right? So they live, you know, six to eight people in a one-bedroom apartment. So we had *big* outbreaks in this student community. So they didn't live *on*-campus because it was too expensive. A lot of them lived off-campus.

You know? And there was a language barrier. These people are really afraid to lose their status. And they're afraid that they're going to get kicked out of school and get sent back.

And so there was a lot of work around gaining trust. Because you would call one day and, "No, ma'am, it's just me and my one roommate." Then you would call the next day, there were six roommates. Then the friends from southern Ontario were here visiting. And so it was really hard to gauge what exactly is happening in the situation.

So we had a couple weeks where we had big, big clusters of cases in this population. And of course, a lot of them, they don't have a driver's licence, they don't have an Ontario Health Card, so it certainly just makes everything a little bit more difficult. They don't—you know, all their friends are isolating, so there's no one to get them groceries. They don't have any family here to help them. That sort of thing.

Maureen Cava:

Karly shared another story with us—this time, regarding a case that started within a school and spread throughout the surrounding community. Connecting marginalized individuals and families with resources and supports was challenging, complex, and absolutely essential.

Karly McGibbon:

So a teacher had COVID and spread it to the school. So that's how we believe it got into the school. I'm going to say, this is a school of maybe 250 children. And we ended up with about 100 cases stemming from that. So they weren't all kids but they were parents of kids, siblings of kids, grandparents of kids, partners.

So we really trickled through the community. But these children were from housing projects and low-income neighbourhoods. So it really was hard for them. They couldn't get groceries. They couldn't go for food. Their neighbours didn't have vehicles, so they couldn't pick things up.

So we were able to connect with things like Meals On Wheels to provide them groceries. We were able to set up, you know, the YMCA if they needed childcare to attend these appointments. Because the other thing is, we would say, "You need to go for testing." And they would say, "Well, I don't have a car. And you only have drive-through testing sites." So we connected with our local paramedics, and they went in and did testing in the home for these communities.

And we absolutely had to help them and make sure, "Do you have enough food? Do you have medication?" And a lot of times it was, "Do you have someone to watch your child?" because we had.... I remember this one young—young mum, and was quite symptomatic, and she needed to go to the hospital. And she said, "I need to go to the hospital. What am I supposed to do with my son?" And her son was also positive. "You know, what am I going to do with him?" And—and I think she had a friend, or something, that was able to come. But originally we had said, "No one in your home.

You know, you cannot have a friend in your home.” But then it got to the point where she said, “I need to seek, you know, emergency medical attention, and what do I do with my kids?” Or, “Okay. Well, what are we going to do with the kid?” And then if we get the friend, then the friend is going to need to isolate once she leaves, because now the friend has been exposed and *she* has children.

And it really is a whole trickle effect of, you know, how do we care for these families? And it just—it really shows you the difference.... And even I wasn’t aware of how your income impacts your health, like so when we talk about the social determinants of health.

Early on in COVID we got a lot of return travellers. Right? People coming back from cruise ships, and airports, and all those things when COVID first hit and the government said, “You need to come home now.” And so people would say, “Well, I’ve just been on a two-week Caribbean vacation, and now I have COVID.” And we would say, “Well, you need to isolate.” “Well, that’s no problem because it’s just my husband and I. And we have a four-bedroom house with four bathrooms. And we’ll just order in meals every day, because that’s no problem. And you know, we’ll leave our fancy cars in the garage, no problem.”

And so it really, really showed you a difference in affluent families. They all had the same illness and, you know, they all had similar symptoms and were dealing with similar things, but your income and your money really did make a difference.

You know, and we would see these families and they would say, “Oh, no problem. I’m going to order in a cleaning service, and they’ll have my house cleaned from top to bottom.” And then we had other mums saying, “Well, I can’t afford Lysol wipes. I just—you know, my whole family is going to get COVID because we only have one bathroom, and I can’t clean it because I don’t have cleaning products.” So definitely people tugging at your heartstrings, for sure.

[music]

Maureen Cava:

Shifting gears a bit, Karly described how the vaccination clinics got started, and how the distribution happened in the Sudbury region, knowing that there are both rural and urban communities that are being served.

Karly McGibbon:

I also did the first clinic. So our first clinic here in Sudbury was actually about two hours out of town. It was at a local native reserve, and we did the nursing home. And it was just the same thing as when we got our first COVID case. So just so exciting, and exhilarating, and just so cool to be part of this. And you know, this is the vaccine olympics.

And I remember driving there and stopping on the side of the road and checking the temperature on my coolers. And I mean, I've transported vaccine tons of time but never this important or never this far. And it kind of felt like, you know, all eyes of the city are on *me*. And it was the same thing: we didn't want to tell anyone we were coming, but the news was kind of getting leaked out that it was here. And the drive, I say, felt like when you're coming home from the hospital with your newborn baby and you've never driven so careful; that's how it felt.

And just the joy that it brought to people when we pulled up with the cooler, and they knew that in that cooler was hope. And that was really how the day rolled out. It's like this is giving these clients hope. And it's hope for the whole city and whole north that, you know, the vaccine is here, and this is a possibility. And you know, we're turning a corner here; this is a step in the right direction. And this is something tangible that we can do to make it better. And certainly one of the proudest moments of my nursing career.

Maureen Cava:

Vaccine hesitancy can be a real concern, especially if people don't have good information about the importance of getting the vaccine. We know that education, as well as bringing clinics where people live and work, can make a real difference in getting people vaccinated. We asked Karly if this was an issue for her Health Unit.

Karly McGibbon:

I will say I'm pleasantly surprised there hasn't been a ton. An interesting fact is, when we did our first mask clinic—so our first, you know, 2,000-person clinic at an arena—we had security outside because we were anticipating we may get protestors, we may get people who really feel this is not a good thing and really want to say their piece. Luckily, we didn't.

Most of what I encounter now, because I'm working frontline at the clinics, are people who want to be there. So a lot of what I see is elatement, excitement. People are so happy to be there. You know, this is something that they can do to make it better. COVID is coming to an end. They're doing their part.

Susan Blue:

We asked Karly to share any challenges she's faced with overseeing the vaccine clinics.

Karly McGibbon:

Well, there are many issues. I spend my days putting out fires. Although I will say, we've come a long way in the six months that we've doing clinics, as have our staff. Because, of course, we couldn't do this alone. And we've had to hire a ton of people who vaccines are probably not their first line of work. And so there was a learning curve at first. Things are going well.

I would say two things are coming to mind. One is supply and demand. And so we will get people coming into our clinics. So they're, you know, city-run arenas—they're open to everybody. People come into the clinics and want vaccine—so the opposite of vaccine hesitancy. They're wanting vaccine, and we just don't have doses for everybody. We can't do everybody at the same time.

So our clinics are strictly by-appointment-only. But, you know, you'll get people—umm, and some people are quite forceful. Some people are not. They're—they're not intending to be malicious. You know, they may be there with their 85-year-old mother and they thought she had an appointment but she didn't. And you know, it took so much work for them to get out.

And—and our doses are monitored so closely that there's no extra to go around. So we—we really do only have what we have for—for our appointments. And we can't—as much as we would want to, or as much as, you know, may have happened in the past with the flu vaccine where, "Oh, that's fine, you know, one more, because we have an infinite supply, it's no problem"—we really can't do that. So that's tough.

And then on the flipside of that, the other thing that's tough is at the end of the night, because vaccine is so closely monitored, and you have to dot all your i's and cross all your t's, there's no room for error at the end of the night. So we draw doses only for bums-in-chairs. And we have to really be careful. So if we're using Moderna, for example, there's eight doses in there. And if I only have five people in my clinic, I either need to find people really fast or I'm not going to open that vial and I have to go tell those five people, "I'm really sorry. I know you had an appointment *but* it's not going to happen today."

When we started with dose one, it was really easy because nobody was vaccinated. So I could call my neighbour, no problem. Or you know, we started with the 80+ age group. So we were all calling our grandparents and, you know, their friends, and, "Can you come to the clinic? Because if I open this I'm going to have four more. So could you get here?" And so we did that.

But as we progressed through dose one, and the eligibility became tighter and more people were done, well, it's harder to find people at nine o'clock at night to come. And so now we're okay again, because we're into dose two now. So you know, everybody still needs their dose two. So it's fine, I'm going to open it up; I'm going to give it to the five people in my clinic. We started creating a standby list. So I'm going to call six people off my standby list. They're all going to be here within ten minutes. And away we go.

But, I'll say as a nurse lead, the pressure of balancing those numbers at the end of the night is like nothing I've ever done before. And we make a lot of relations to flu clinics. And I'm now embarrassed to say how much flu vaccine I think we've wasted over the years by kind of looking at the bottle and saying, "Well, I think there's a dose. Nah, I think it's good. Well, let's throw it out." You know, whereas these—every dose that you

withdraw, they're all multi-dose vials—every dose needs to be accounted for, and documented, and the time you pulled it, and how much you pulled it. So absolutely, at the beginning it was very new and very, very different.

Maureen Cava:

COVID-19 has brought to light many things about our healthcare system. We asked Karly to comment on how the pandemic has highlighted the role of public health.

Karly McGibbon:

Before this, there was a lot of talk from the provincial government about grouping health units together. So I think we were going to go from 36 health units down to 10, and things can be streamlined. And I think there's certainly still a case for that, and there's areas of public health that we absolutely could share with other health units—more health promotion things.

So bicycle safety, and breastfeeding. And that is the same in North Bay as it is in Toronto or London or.... But there are so many differences at the local level. And so I think this is certainly shining a light. Like we see right now in Timmins they're having big troubles with outbreaks. The province as a whole, you know, things are looking up. And ah, but there's certainly still pockets of places where they're having a really rough go. So there needs to be continuously work at the local level.

I know from my clinic experience, like I said earlier, we've had to hire a whole ton of people. So we hired maybe 150 nurses, that came from all other settings in the community, who never dreamt about working in public health and who never knew what public health was.

So I think, you know, *they've* had this experience. Hopefully it's been positive and they'll bring it back to *their* workplaces and—and be able to talk to people in acute care, or people in long-term care, about the great work that the Health Unit is doing and what the opportunities are.

I can share that we've had some nurses who have said, "You know, is there any postings I can apply for? Because when COVID is done, I love this work, and I think I really want to work here." So certainly opened up the eyes of nurses, who even, you know, nurses who are well-seasoned who've never come in contact with public health, who have never had to deal with public health.

Public health is often there when there's a problem. This is what public health does. And this is why we're here. And I think it's shining a really positive light on the work that we're doing, and showing the importance of the work that we're doing.

I know I did a drive-through clinic with.... One of the area physicians had this brainwave that he wanted to do a drive-through clinic at his, ah, his practice. And so a few of us went. And you know, he wasn't super-familiar with immunizing. None of his staff were familiar with immunizing. And—and they didn't know how to use the computer software

and all these things. And so we showed up sort of like knights on a white horse and said, “Come on, Doctor. This is what we’re going to do. And we’re doing this and this.” And the clinic was a success. And he said, at the end of the night, “Wow, I couldn’t have done it without you.” And we sort of took a step back and thought, “You know, you really *couldn’t* have.”

And not to pat ourselves on the back too much, but the expertise that we’re able to bring to these sectors that is often overlooked is fantastic.

Susan Blue:

And on the topic of public health nurses making a difference, Karly related a story about a scared and highly anxious 13-year-old attending a COVID vaccine clinic that Karly was leading. Despite efforts by several health professionals, the young teen was very fearful about being vaccinated.

Karly McGibbon:

The nurse that we had was a hospital nurse and tried to immunize her and couldn’t. We had a paramedic on-site, so the paramedic gave it a try and couldn’t. And then the third nurse came in to give it a try, and the girl just wouldn’t. Her mum was in tears. She was in tears. She was so afraid. And so this nurse came back to my team-lead station and said, “I have this dose. I guess we’re going to have to waste it. You know, three of us have tried. We can’t get it into this kid. And I don’t know what else to do.”

And I said, “Give it to me.” So I grabbed that dose. I have a 13-year-old daughter. I’ve been immunizing 13-year-old kids for 17 years. Within 30 seconds I had the vaccine in her arm. As a parent, I felt for that mum so much. And I know what it’s like when you’re willing your children to do something and they just won’t do it. And, I mean, she’s a lovely child but she was just so scared.

And mum was, you know, “Is there something I could go to the pharmacy and get for her? Should I give her a sedative? Like what can I do?” And mum was at her wits’ end. And the child was at her wits’ end. And I was able to sort of use my expertise from the school program to immunize her. And it was just the best feeling.

And then the mum left after her waiting period, and she came to my table, and she said, “You know, I can’t thank you enough. And I didn’t think it was going to happen.” And they—they were teary again.

And I just thought like: that’s what I’m here for; that’s what public health nursing is about; that’s why I love it. It’s, you know, the thankys from parents. It’s the crying kid who tried three times and couldn’t do it, but then I was able to it. And you know, those are the moments that you remember. And those are the things that make this such a rewarding job.

Maureen Cava:

I'm just going to ask you one last question about what you feel most proud about in this current COVID work that you've been doing.

Karly McGibbon:

One thing is being accessible to my community—so kind of giving out my inside information to clients. You know, because this *is* my community, I can say, “Okay. Well, don't try to book into that big clinic, but there's a little clinic here happening on the outlying areas and if you don't mind driving an extra half-an-hour, maybe we can get you in here.”

So you know, those are little things that I can do. And—and you get, you know, gratitude. People are so appreciative and people are so happy. So when they get the COVID vaccine, I mean, it really is liquid hope. It's hope in a syringe and that this is going to get better. And everyone is doing their part to—to make it change.

And this has certainly been the longest year of my career but absolutely the most rewarding. I did some work in long-term care with the vaccine clinics. And—and I remember this bedridden lady. And her daughter came in, and she was taking pictures, and she brought balloons. And—and I immunized her mother, and she hugged me, and she was crying. And she said, “You know, now I can hug my mom again.”

You know, for all nurses, you can't ever think of it as just another day at the office. Like these are life-changing days for people. And I think we need to remember that. I mean, there have been bumps along the road, but when we look at how far we've come in the immunization program in the last six months.... You know, we started out documenting on paper, and now everything is electronic, and we've got scanners, and we've come so far, and our speed has picked up so much more, and we've trained so many new nurses and physicians to immunize. And we can see it; it's working.

The numbers in Ontario are going down. The numbers in Sudbury are going down. And you know, how do you not pat yourself on the back for that—when you say, you know, every early morning, every late night, every time I didn't have dinner with my kids, but it's working? Like it's really just incredible work to be a part of. I'm very, very lucky.

[music]

Susan Blue:

Thank you for listening to *Stories From The Field*, hosted by me, Susan Blue...

Maureen Cava:

... and me, Maureen Cava.

We are so grateful to the Ontario Public Health Nursing Leaders Association and the Chief Nursing Officers for their support in identifying public health nurses willing to share their stories.

Susan Blue:

This series is produced by Katie Jensen and Sabrina Brathwaite of Vocal Fry Studios.

Maureen Cava:

If you've enjoyed this episode, we'd love if you shared it with a friend and subscribe wherever you listen to your podcasts, because we have more stories on the way.

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