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Mary Washington Healthcare Oral History Project

Barbara Kane

Interview conducted by
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in 2013

The Mary Washington Healthcare (MWHC) Oral History Project began in 2013 and recorded 100 hours of interviews over the next two years. The project was designed to document the history of MWHC's expansion and record the recollections of people involved with its transformation. The oral history interviews were with board members, administrators, physicians, nurses, social workers, and community members. Beyond a story of expansion or a single organization, the interviews record successes and ongoing challenges with the transformations in health care and hospital-based medicine over the last thirty years.

Oral history is a method of documenting the past through recorded interviews. The interview is between a narrator with firsthand knowledge of significant historical events and an informed interviewer. The goal is to expand the historical record, record firsthand accounts of social, cultural, and political changes, and preserve the recorded interview. The recording is transcribed, lightly edited for clarity, and reviewed by the interviewee. The final transcripts are archived in Special Collections in Simpson Library at the University of Mary Washington. The interview transcripts are available to researchers through the library and the project website, mwhchistory.com.

Oral history is a primary source and is not intended to provide the final, verified, or complete history of events. It is a spoken account, often recorded in a single interview. It records and preserves an interviewee's memories and narration in response to questions by an interviewer. The interview is reflective and irreplaceable.

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Discursive Table of Contents

00:00:00
Carrick:
Can you start by telling me about your first day of work at Mary Washington?

00:00:04
Kane:
I came in September of 1972. My first day was a little bit exciting because I had interviewed with the director of nursing and I had a lot of experience; we moved around the country a lot. She said that she needs someone who can work 11:00 to 7:00—11:00 to 7:00 to us at that time meant nights. I said, "No, my husband is overseas and we have three children." [She meant 11am-7pm] She said, "How about 10:00 a.m. to 6:00 p.m., during the day." I said, "Well, that will be just great." I was happy to be able to have a job that would meet my family needs as well. This was actually my first position that had an orientation. Most of the time in the places that we went— we traveled around with the Marine Corps—the orientation was that you came to work, a nurse on the unit showed you around the unit, told you the policies, and so on. It gave me the idea right off the bat that the organization really cared about how you would start out here. I was not assigned to a specific unit; I floated. I floated to several medical units, but mostly to the Emergency Department. In 1972 it did not resemble anything that our emergency departments look like today. It was an exciting time. I will say that this was the first time I ever got paid for going to orientation. Day one was really day one of work. That is what I recall about my first day.

00:02:09
Carrick:
Can you tell me about what it was like working in the emergency department early on?

00:02:14
Kane:
Early on in the Emergency Department we had three stretchers. It was in this building [2300 Fall Hill]. If you go right now to where the Chamber of Commerce is located, that dock was the emergency department. We had three stretchers. We had a GYN [Gynecology] exam room and across the hallway we had an orthopedic room. We could put on casts and do things like that. The attending physicians came to the hospital to see the department patients. You would have a patient come to the emergency department and you would have to assess the patient. Then you would call the attending physician; they were in their office and it was very different than it is now. [03:00] Eventually we got the concept of the emergency department physicians, and emergency physicians as a specialty grew. I do recall, because I did work a lot of 3:00 p.m. to 11:00 p.m. shifts as well, that the doctors from the Naval Hospital at Quantico would work overnight. They would come at six o'clock p.m. and they would work throughout the night. It did get some of those regular physicians a break. After six o'clock you had a doorbell, and the patients would ring the doorbell. [laughs] It was very different than it is right now. Then it grew in this building and obviously changed a whole lot when we moved to the other hospital.

00:03:50
Carrick:
What was it like when you moved to the other hospital?

00:05:02
Kane:
At that particular point in time, when it moved to the other hospital—we go from 1972 to 1993 when we moved. We started designing in maybe 1988 or 1989. I had gone from being a staff nurse and I had done quite a few things. When we moved to the new emergency department, I was the director of the emergency department. It was probably about three times as big as the space that we left here, which as I said had grown. It was about three times as big and was adjacent to the radiology department and the lab. Those are the main services that you use when you are in the emergency department. We were in that space from 1993 until it became apparent, probably in 2000, that we couldn't treat the number of patients that we had. Remember, we were the only emergency department in this region.

We began to design the current emergency department. We went around the country to look and see, how do you build a huge emergency department that has fifty rooms? There are probably only about one percent of the hospitals in the country that have emergency departments that big. It was an interesting thing to go and see how they were built. I collaborated with the physician chief of the emergency department, Clif Sheets, and we led the design team for that space. It has been modified somewhat over these years. [06:00] It opened in 2001. It's serving the community. We were very close to seeing 100,000 patients a year in that facility when the design for Lees Hill started, the freestanding emergency department.

The things that we did in the emergency department were much different as we've grown. We now have a trauma service. In the years gone by, many times our patients—some of our trauma patients and some of our severe cardiac patients—were transferred, mostly to Richmond, sometimes to Fairfax, but mostly to MCV (Medical College of Virginia). We now are caring for our community and we provide those services in our community. On any given day, the emergency department is a place where people come because they feel they need to be here. Sometimes it's not very obvious why a patient is here and the role of the physicians and the nurses in there is to determine how can we give you the best possible care for exactly what you feel is wrong with you today. It was very interesting.

00:07:38
Carrick:
What are some of the core values of Mary Washington Healthcare?

00:07:42
Kane:
Our core values now are very well publicized and we use the ICARE acronym for our values. Now, our ICARE is very well organized as a framework to be used all the time. Over the years, the core values that are there—Integrity, Compassion, Respect, and Excellence—they have always been part of what we have done. In some periods of time we've articulated those values in different combinations. For me, the difference now with ICARE, is the A; the A is the Accountability. When you have the integrity and the compassion to care for patients, and you respect patients, and you want to deliver excellence, you then become accountable for what you are doing. You become accountable for the role that you play, for the things that you commit to. "I can do that, I can do that." [09:00] Then somebody would check back and say, "Was that completed well?" "Well not exactly." That's not accountability. I think in society we see sometimes now about the need for accountability from people. If you say you're going to do something, if it is a part of your job, even if it is going that little extra mile, it is that value that I think we have now really focused on a little more. Others were there over the years, but ICARE brings it together for us in a very good way.

I want to say one other thing about values. In the course of my time at Mary Washington, I've had the opportunity to be at different levels making decisions. I can tell you that we have used values in decision making for a project or a service. If it doesn't meet our values the way we've articulated them, then the decision has been made not to do it. It is not only a phrase that's on paper, but it's personified. You can see it at every level.

00:10:21
Carrick:
How were these values developed and sustained through the expansion projects?

00:10:28
Kane:
They become the guiding principles. If you are going to do any kind of an expansion project and I can use any number of them. Let me pick cardiac surgery, which started probably in about 1994. Even though I said that ICARE was really brought together and articulated in the past several years, the values of our organization, quality, respect, and excellence, were part of building the cardiac surgery program; the needs of the patient were always first. What that says is that you start with the values and you take the needs of the patient as they relate to those values. Then you build the service. And when you build the service, if you have integrity in your service—that means that we've thought out what we're going to do and we do what we say we're going to do. When we were building the whole cardiac surgery service, it was all about buying the right instruments, opening the surgical intensive care unit, and hiring the right people. [12:00] We hired people who had a desire and some experience for taking care of the cardiac surgery patient population. Then we tested the system and we drilled. We went to the table in the OR, we opened the instruments and asked "is it correct?" While you don't say them or articulate them every day, it is really those things that are the

underlying principles. Why would you keep on practicing until you get it absolutely correct? Well there's a patient we're caring for, and that is the center of everything that we do.

00:12:48
Carrick:
What new practices had to be implemented in the transition from being a small community hospital to a more diverse regional medical provider?

00:13:01
Kane:
So many things. If you had speed photography, you could show a blooming flower. It was so many things. I'll start with the nurses. The nurses first of all had to have more depth, more education, and practice caring for perhaps a more acute patient population. Nurses are known for compassion, for kindness, and things like that. But nursing is a knowledge profession and we have our own body of knowledge. We have our own body of research. We are a bona fide profession. We really try to articulate that and focus on those areas where we need to broaden what we know, create more depth of what we know, and increase our competencies as we go along.

Our hospital supported us in terms of things that are nursing specialties. We have clinical specialists. Those are masters prepared nurses who go on to be clinical specialists in a particular area. For example, Mary Jane Bowles is in the intensive care unit. Natalie Root is the clinical specialist in the emergency department, for all the emergency departments. Their expertise is at such as high level that their role is to maintain the currency and the competency, and to challenge the nurses who provide the care for an increasingly acute patient population. [15:00] On the nursing side it was creating that breadth and that depth.

On the physician side it was really a lot about what is it that our patients are going to other places for? How do we meet the health needs of our community? I already mentioned cardiac surgery and basically touched on trauma services, but it is more than that; there is neurosurgery, thoracic surgery, and the NICU. I'm very proud of our new neonatal intensive care unit. Years ago, well twenty plus years ago, the need for neonatal intensive care unit was identified. A group of nurses stepped up to be specially trained to care for this, which takes a special population; it is intensive care for newborns. That meant that now mom with this newborn baby who needs intensive kinds of care, that baby doesn't go to Richmond and mom is here. It meant that all the maternal bonding and caring that we care about could happen. Recently, our nurses said, "You know, we really are very good at what we do in the NICU, and we are regionally excellent. We need to be able to transport patients into our NICU." For example, I'll use a baby from Tappahannock or maybe from Culpepper or another outlying hospital; we need to be able to transport that baby here. That's a whole new ballgame when you go there and pick up a sick baby and you bring it to our facility. We partnered with Children's National Medical Center and nurses trained at Children's. Children's came down here, the physician neonatologists trained, and we opened our neonatal transport service. Now we not

only have a unit, but we have the nurses who are transporting. You know who's transporting today because they have their boots on and they have a different shirt when they are on the transport team; if the call comes, they go. [18:00] It's just like you see on television. [laughs] It's really quite an experience to watch them bring in a baby. It is very touching to know that nurses provided that particular service.

Regional provider—it's about nurses and it's about physician specialties as well. Then it is everybody who supports the patient. Remember, there is always a patient here in the middle. It's the lab. What kinds of tests does a lab need to do? What kind of pathology will the pathologist be looking at when they have these advanced surgical procedures? It's radiology. We have one of the finest labs and radiology departments in this part of the country. Our radiologists are very highly trained, as are our pathologists. They all had to say, "Okay, what's coming?" We have neuroradiologists and those who specialize in the trauma. It involves building and laying a foundation for a new, great endeavor. If you don't have a good foundation things will get wobbly as you build the top part. It's all the services and includes nutrition and infection control. You go across any service and I had to look at what we're doing and where are we going. How do we structure services to get there?

00:19:40
Carrick:
You talked briefly about all the changes that we had. Can you tell me in the past twenty-five about some of the most significant changes in the nursing department at Mary Washington?

00:19:51
Kane:
I can, and a couple things will come to mind. I already mentioned the NICU, and the things that our nurses did with the NICU. Another nurse driven project is in our atrium. If you're walking into the front door in the atrium, you will see on the right hand side an organ donor garden. The building didn't look this way when it first opened. The atrium was not there; none of the atrium was there. You drove up Circle Drive and where the information desk is now is where you entered the building. As they were building this atrium in this wonderful space, one of our intensive care nurses had this great idea. [21:00] I was in the leadership position at the time and I said, "Amy, what is your great idea?" She said, "You know we need to have an organ donor garden right there, right in the atrium where people can see how important organ donation is." The nurses in the intensive care unit are probably closest to the act of organ donation of anybody in our hospital. They have seen trauma happen and they have seen the end of life approaching with no other hope. They have seen families making decisions to donate organs, or to carry out the wishes of their loved ones. It is a very touching experience to go through. What we have found in the nursing research is that it is reassuring to the families in the long run. Tragedy happens. Can you find anything good out of tragedy? That is where organ donation is so very important; lives that are saved by organ donation. Back to the organ donor garden. I was the clinical director at the time and my boss was the nurse executive. I went to the nurse executive and I said, "I have a suggestion." She didn't say, "What are

you thinking?" She said, "Hmm, that's interesting." From there we went on. That particular nurse executive had gone on to do greater things and left the organization before we actually got it done. Today it is one of the finest tributes to organ donors. Every year for the past twelve years on the Friday before Thanksgiving, we have organ donor family recognition. We invite the families back for an organ donor recognition ceremony. We used to have it in the atrium with a few chairs and sitting around. Everybody comes. We are so big now that last year the whole ceremony happened at the Fick Center. The only lighted Christmas tree inside the building at Mary Washington is the organ donor tree. [24:00] At the ceremony each family has the opportunity to hang a crystal ornament on the tree. Although we had the ceremony at the Fick Center, our friends at materials management figured a way to get the tree back over into the atrium and to get it standing again. It has grown and it is so meaningful to all of the families. The point I'm trying to make is that as the goals are set and as you set your sights on being the star, other feelings and other ways of doing things also open up. You have to be more receptive and have to be accountable.

The highest thing is probably the Magnet award: in 2009, Mary Washington was designated as a Magnet hospital. What that means is that American Nurses Credentialing Center conveys upon a hospital the highest award a hospital can get on behalf of its nurses and on behalf of the quality of the nursing staff. At that point, we really recognized how truly professionally we had grown. There is a lot of work that goes into applying. First, you have to be in that kind of a profession with those kind of nurses, and then you can apply. The application process is very lengthy and very grueling. Then, if documents are accepted, there is a survey. When the surveyors come in, they talk very nicely to all the leadership and everything, but they spend time around the clock with the nurses. They talk to the nurses. They get a feel. At that time, there were 340 hospitals internationally that were Magnet hospitals. I don't know what the number is right now. I know some hospitals were designated since then. That probably is the biggest validation of where we started and where we are has changed. We have grown in competency and leadership. I've always believed that the nurses are the leaders, and that's probably the biggest thing. [00:27:00] It is all about nurse input; nurses drive the care on the unit.

When I was the CNO [Chief Nursing Officer], I would say to the nurses, "You don't want me. I do have a lot of clinical experience. But you don't want me making policies back here for the patient at the bedside. You're the professional and you can do that. You have that responsibility." It's kind of a shared responsibility with me because I'm responsible overall for what we provide at the bedside. There is a lot of nurse decision making. Maybe you have or haven't seen lots of nurses; there is the whole manner of scrubs for nurses these days. Nobody wears the formal white uniform and cap like I did when I was nursing. At one point our patients could not tell who were the nurses. We had Spongebob Squarepants, scrubs that looked like camouflage, and we had cartoon characters on scrubs. You name it and we had it in scrubs. We asked our research committee to do some research and see where the nurses were. The committee said, "Yes we could go to one color, but it would have to be by division—cardiac division would want their own color." I said, "Wait a minute. The patient starts in the ICU with nurses in black and white, and now they're over here and nurses in red

and blue. So how do we meet our goal of being able to distinguish the nurses?" We would wear a hang tag that would say RN so they would know that we are nurses. I said, "Okay. We will try that for a little while." Then we polled the patients, and the patients still couldn't tell who the nurses were. We got it down to two colors and there was still a lot of consternation. I said, "If I make the decision, we'll go back to white. How about that?" To make a long story short—navy blue was an acceptable color. It did take a bit of leadership and real involvement and directional planning. The nurses are in navy blue or white, or a combination of navy blue and white. [30:00] But no white sweatshirts; you still have to look professional. That has really helped. What happened since then is the rest of our colleagues in the pharmacy, radiology, and respiratory departments, have also all picked colors. We are a very color-identified group of caregivers. I'll tell you where it helps. It helps the nurses know who the players are in the unit. If you have a code you know who's around the bedside. The patients know and the families know. It's been helpful and kind of fun.

00:30:55
Carrick:
You spoke earlier about your leadership role. What kind of planning projects were you involved in with Mary Washington Healthcare?

00:31:06
Kane:
I was really lucky enough to be involved in so many different planning projects from the service perspective, like cardiac surgery. I was the clinical lead for cardiac surgery and I worked with OR lead and our cardiac surgeon. I hate using the term "I," because "I" is never one person in the health care setting. It is about the "we" that come together. It is everybody. If you don't think about everybody when you are doing a project, then you are going to miss something big. It goes from those services' perspectives right into the planning of how do we care for the patient? How many nurses will we need? How many patients will a nurse have to care for? How many will they have to take care of in a shift? What will the nurses do? What will be the components of their care be? Those are the kinds of questions we have to ask.

When we built the hospital that is currently Mary Washington, I had director responsibility for the ICUs and design responsibility for the ICUs and the parts of the medical surgical units, but not the emergency department. Before it was all over and we moved in, I was the director of the emergency department. When you look at it with an architect on a sheet of paper and you see these are the columns and here are where the windows are going to go. [33:00] Okay, let's design it. You think about flow, about footsteps, and how far will the nurses walk. Where are the supplies? Where will we take the dirty things? It's the how, what, where, when, and why of those. That was a lot of fun with the current Mary Washington Hospital.

With Stafford hospital I was really on that because, by that time, I was the Chief Nursing Officer. I worked with the executive team that made a lot of the final decisions. We were involved with the

nitty-gritty of designs and we made some of the final decisions. After looking at the plans for so long and then as I walked those units and look at how it turned out, I see we did a great job with Stafford Hospital. We considered the technology and what we found out with Mary Washington hospital; care advances and technology grows. Where are you going to put it if your room is so small, which has happened at Mary Washington. Sometimes we have so many things we need to care for the patient that the rooms seem small. And yet, when we moved from this building [2300 Fall Hill] we were so excited. In this building we had semi-private rooms. The first thing you had to do when a patient was going to come up from the emergency department is figure out do you have a female bed or a male bed. Then you started moving people around. Patients could smoke. They were smoking in the rooms. You had to do smokers and non-smokers. Everything is relative. Coming from this hospital to the new Mary Washington was wonderful. And now these many years later, there are advancements that have just been recently made: the pharmacy is huge now because of the things that the pharmacists need to do. The lab is now expanding again, and it has expanded several times. In order to be able to care for this, they have made some modifications.

Being on those teams—an example of how our organization identified needs early and the second generation of growth is our cancer program. [36:00] There was a cancer center on Route 3, where they are doing all that construction. It served us well for many years. As cancer technology changed, as radiation oncology changed, and as our desire to be a leader in this part of the country grew, our need for different buildings changed. Now on the campus are our cancer radiation center and the oncology center. We had leaders on the top for many years who were futurists of sorts. They said, "How do we grow? How do we continue to meet the needs of our community when we don't even know what our community is going to be like twenty years from now?" Lots of credit goes to some really early thinkers. I think we stand out in the country as far as a health system goes. That's pretty much how things have evolved. It is the services and the places, and then it is the specialties. We have wound care specialties. We have nurses who do wound care and work specifically with diabetes and pain management. I mentioned the clinical specialists already. The nurse practitioners were an integral part of our palliative care unit. Some services on that unit have changed as I understand it. It's the buildings, the services, and being involved in getting the specialty people in there as well.

00:38:02
Carrick:
How has health care as a political issue impacted the practice of medicine?

00:38:08
Kane:
Wow. [laughs] You know if you look back as far as I go back, I think it's helpful. Pre-Medicare the doctor provided the care and the patients and the physicians decided on the bill. The hospital charged a certain amount. We are one of the few enterprises—health care as an enterprise—where you come in and you have no idea how much it is going to cost. [39:00] If you go buy a car, you know how much the car costs. If you buy a dress, shoes, or you name it, you know how much it is

going to cost. A phenomenon happened as insurances grew and as insurance companies made deals and made arrangements with hospitals and health care organizations. Here's an insurance company, and to the hospital it says, "I'll pay you this amount of money for this procedure." It is a negotiation, a contractual arrangement. We got further and further away from understanding, at a grassroots level, the cost of health care. There were always people who could not afford health care. And sometimes the people who could not pay for some of those contractual arrangements, helped to make up the deficits. I don't really know. I do have an MBA, but the insurance side was never really my area of expertise. Medicare came along, and seemed like a fine idea at the time; let's provide health care for seniors. Look back to when it started in the 1960s. People weren't living as long as they are right now. With Medicare, people are now outliving the actuarial tables that were first used to construct Medicare. It is happening with Social Security as well. The cost went up; did we have the controls that we needed in place? Maybe we had controls, but the controls are different now. The controls are different now, and we talk about accountability and penalties for non-accountability. There are some quality measures that now drive how a health care organization gets paid from Medicare. And very soon, it will happen with regular insurance companies as well. For example, is ventilator-acquired pneumonia. Medicare or an insurance company might say, "You know if you have ventilator-acquired pneumonia we might not be paying you because your patient got ventilator-acquired pneumonia in your ICU." [42:00] The same could happen with catheter related blood stream infection. We might hear, "You should really have been better than that. So we are not going to pay you for that. Or a pressure ulcer; let's not pay you for those." Quality is what we always espouse to. The demands to demonstrate it nationally make it very different. It takes it us from "We had two ventilator-acquired pneumonias this quarter," to a "What happened?" review for prevention. We have a very precise process for looking at that and now we have to justify that. It has made us more accountable. What's going on in health care right now— we can promise a lot of things to everybody. Isn't it a shame—and I'll show my political bias—isn't it a shame that we passed a law and we had to pass it in order to read it. What we are reading right now and the way laws go sometimes is, the law is written and then the regulations get written along with it. The how to do this gets written later, by whomever had this great idea. What a great idea. Now that is where we are. We didn't know what was in it to start with and now as the regulations are being promulgated. The regulations, if you are a thinking person and you read them, some make absolutely no sense and are absolutely not achievable. How do you do this? Let's take some money away from the physicians. Right, that's not going to work. Let's take away some nurses from the bedside because the revenue is getting tighter and tighter. Wait a minute; we are talking about quality. It's poorly designed. Do I have some better answers? Probably. [45:00] If the push to have a significant piece of legislation had not happened, I think we would be in a whole different place right now. The push and the pressure were unbelievable and now we have what we have. [laughs].

00:45:22
Carrick:
How has the bureaucracy affected your ability and other nurses; abilities to practice the profession?

00:45:33
Kane:
I like to think of bureaucracy in terms of internal and external. I've already talked about some of the external bureaucracy. But internal bureaucracy—our organization is much more open to understanding complexity. When it gets too complex or when a process gets too complex, that's for me a real signal that there is some real bureaucracy in there somewhere. Somebody said, "No, you have to do it this way." And I say, "This is the way this process has to be done. And by the way, I have a piece of this process and this is the way I say it had to be done." Before you know it, is so complex that you almost can't figure it out. We have some complexity in our health system. We have an openness to try to remove those barriers and to make things a little bit simpler. In the *Wall Street Journal* about two weeks ago they had an article about complexity. One of the places I follow a lot, mostly because we are from Cleveland, is the Cleveland Clinic, which is kind of a trend setter in just the opposite: simplicity. They've made it an organizational goal to simplify things. When you start trying to simplify things somebody will say, "What about my stuff?" It takes everybody to build a bureaucracy and it takes everybody to take it apart. There are some very complex systems on the internal side that could be simpler.

00:47:58
Carrick:
How did the expansion of HMO's in the early 1990s affect the core values of Mary Washington? [48:00]

00:48:08
Kane:
Let me think about that one. First of all, let me talk about our core values. Our core values are our core values and they about our relationship with our patients and our community. The HMO impact on core values? I can't really draw that direct link. HMOs? I think about Kaiser when I think about an HMO. Kaiser has been known for being able to build some very good systems. They have very good linkages. They are very much an outpatient, keep-people-well kind of a system. Then Kaiser watches very closely when someone transitions into an acute system, like a hospital. I will say that I believe that in planning—and perhaps it impacted our planning the new hospital, the current Mary Washington Hospital—the national prevailing wisdom was we are going to keep people out of the hospital. People are going to stay so well that they just will not have to be in the hospital. They will only see specialists occasionally. Did it make an impact on what we did as a size of a hospital? I don't know; it may have. I wasn't at the executive level at that time. I was about a couple of rows underneath that executive level, so I wasn't in there on that decision. It could conceivably have some impact on the size of the hospital that we created.

00:50:24
Carrick:
How will the Affordable Care Act (ACA) affect Mary Washington Healthcare?

00:50:33
Kane:
I talked about the regulation. Every regulation is probably going to impact us in some way. It is either going to be demonstrate this or it is implement this. I do know that the electronic medical record is part of the ACA. We've got many parts in a total electronic medical record up and running, which is quite admirable. [51:00] I can say that in many occasions, it takes longer to do it electronically then it does on a paper chart, but we realize what has to be done and we have the future in mind. The ability to care for—we will always care for people who can't pay. Whether you have insurance or you don't have insurance, you are always cared for at Mary Washington. I think it's going to be the regulations that are now written in relationship to the Act that will impact it. Not the least of which is the revenue regeneration.

The revenue we generate—we are not-for-profit organization, which means we don't sell stock and we don't have stockholders that we have to pay dividends. The revenue keeps our business going and it keeps us developing at a higher level of expertise and technology. Anything that impacts revenue or spending—if your revenue is not coming in, then where do you spend? What many organizations did in the last two years was to begin planning for this and they took out caregivers at the bedside. They took out people who are directly closest to the patients because they are the most expensive group; the largest groups are the people who care for the patients. What's happened is they are putting them back at the bedside because it is about quality and outcomes. It is about quality and it is about how you care for patients.

The demand now to help the patient transition out of the hospital is greater than it has ever been. We have been in home health care for years and years; again we are trendsetters there. How do you transition the patient out of the hospital and help them—even if you don't have your eyes on them—to follow their medical regimen so they don't come back to the hospital? So they don't get readmitted. Because remember I said, "You don't get paid for that." You don't get paid if the patient comes back to the hospital within thirty days after you've discharged them. [54:00] Those are demands on the system. How then do we do that?

I can tell you that on the cardiac side, one of the things that is probably the most difficult conditions to manage is congestive heart failure, especially as the heart gets weaker and weaker. Patients that have congestive heart failure have so many things to watch and manage—they are often elderly—that they keep coming back to the hospital. We have a nurse practitioner run clinic for heart failure patients that has wonderful stories about keeping patients out of the hospital. Keep in mind that the hospital's goal is keeping them healthier and as healthy as they can be; so they are able to do things

within their own activity tolerance and it really is something to watch. It's going to be keeping up the care. We no longer can say, "Hello, we're here to care for you. Goodbye, have a nice day." It is not like that anymore. It has to be a real partnership with the physician and the community when a patient gets admitted to the hospital, cared for by the hospitalist, which a specialty in medicine, then discharged back to their own physician and back to the community. It links the continuum of care. It is really a nice health care model and something that has always been on our radar screen.

00:56:03
Carrick:
What changes have you notices with the respective presidents over the past twenty-five years, most specifically within Mary Washington hospital?

00:56:14
Kane:
Let's see. I can tell you that during times historically as the hospital progressed, did I relate it to who was the president or not? Maybe not too much. I do know that when—this is my personal belief—when people are working, when people have a job, and when people feel they can care for themselves, I think the health care that we provide is more timely. [57:00] When people struggle with finances, maybe do or do not have a job, do or do not have health care, they tend to manage right to the edge. We see patients that are sicker than if we could have intervened a little bit sooner. I'll tell you what people do. We've known this, it all depends on how you talk to your patients; you find out a lot when you talk to your patients. People on fixed incomes, toward the end of the month, will start cutting their medicines in half to make them last. Sometimes that can work to get them through and sometimes it doesn't. With things in the community that we support like the Moss Free Clinic; the pharmacy there can help people with that. As the economy goes, so goes the health of the country.

Unfortunately, as we look at obesity and as we look at what is happening in our country, we see the dramatic increase of diabetes related to obesity and high blood pressure. You put all these things in this bucket and the impact on the patient is throughout their whole body. Their vascular system gets impacted by high blood pressure and the ravages of diabetes. As a nation, we have to try to help people eat healthier. I think sometimes we throw money at this project. Now communities are getting much more organized, and are looking at what's our community struggling with? This is what we are doing too, meeting the health needs of our community. When we look at what are our biggest health care issues in the community. We do find obesity and diabetes. We've got the top ten list of things. And then we ask, how do we help treat those things?

01:00:00
Carrick:
What are some of the primary policies of the nursing department at Mary Washington Healthcare?

01:01:16
Kane:
I would say first is our philosophy that we are here for the patients. There is a patient at the center of everything that we do. That's the top. The next would be care for the patient in a competent manner. Do not go ahead with anything if you're not sure about. Ask. Like the gut reaction, there's some research on that too. The gut reaction is very real; do not ignore your gut. When your gut is going, "Hmm. Something is going on here. Time out." It is time to stop what you're doing. I think one of the important policies is that we have experts around you. We have teams that respond to obviously a cardiac emergency, such as a cardiac arrest. We also have a team from the ICU that responds to the nurse, when the nurse says, "Something is just not right with my patient. Let me dial up my experts." They come and they assess the patient with the nurse.

When we think about policies, we think policies are, "Here's how you document a medical record and here's how you do procedures." But policies that I've just mentioned are the broad base of care for our patients. We use a short version of patient care. The short version of patient care is: "Cure me, don't hurt me. Be nice to me." The nurse is doing everything and understanding that patient. When a nurse links with a patient, nine times out of ten, they've never seen that person before. Now they are going to care for them at a vulnerable time in their life. You have to engage with the patient. You have to look at them with compassion. You have to put yourself in the patient's shoes and you have to know what does the patient want. [01:03:00] What information do you need? Where are you right now? I can tell you what we're planning for you and to take care of you. I need to know what concerns you and what scares you.

01:03:27
Carrick:
Was there ever a time when you were a nurse or the chief nursing officer that you had to act outside of policy, or someone that worked for you had to act outside of policy?

01:03:42
Kane:
I think if you are acting outside of policy then something is not right. If something is going wrong, acting outside of policy may be first providing for the safety of the patient, before I'm going to do something. "Wait. I need to do something. The patient is not safe. So I'm going to step out and care about the patient's safety first." Sometimes it is ethical decision making. Sometimes the patient has made some decisions, or somebody has made decisions for the patient. Really understanding when you need to step outside policy—I'm watching this reaction and I may not like what I'm hearing here. Yes, this may be the person who can make the medical decisions for the patient, but I'm watching the patient and the patient is still competent. I might intervene, and say to the patient, "Here is what I just heard. Is this the conversation we are having here?" When you are stepping out of policy, you are stepping out because of safety first. It is always about saving a patient's life.

01:05:47
Carrick:
Was there ever a conflict if a patient needs care but can't afford it?

01:06:00
Kane:
We have a clinical ethics committee. I would say that probably there are some times there might be something. I'll just make something up. There might be a patient who can't afford care and who we have cared for in the ICU. Maybe we have done a cardiac cath (catheterization) and some processes and cared for the patient the way they should be. Maybe there is a technology that would certainly—or at least gives us reason to believe—that it would prevent this from happening again, but it is very expensive. The decision is not made based on the expense of the technology. The decision is made based on the care of the patient and what the patient also wants. Just because they can't afford their care, does not mean they can't participate in their care and that they are the owners of their care. Should things get to the conundrum, the clinical ethics committee is available for those kinds of discussions.

01:07:45
Carrick:
What kind of patients normally come in to Mary Washington for care, such as socio-economics?

01:07:55
Kane:
We see everybody in the community. We are the care providers in this community. I think if you go through the hospital— I made rounds on a very routine basis to see the nurses, patients, physicians, get a feel of how we are really doing. As you move from room to room, everybody does not wear a finance tag and you can't tell who maybe can afford to pay for their care. I think after you perhaps talk to the patient for a while, yes then you would know. If you looked at Mary Washington hospital, I think you would see the cross section of our community. Again, what county are you from? I think we mirror the county images in terms of socio-economic status. [01:09:00] I think if you look at Stafford Hospital, we mirror Stafford county and the patient population that is in Stafford County. Stafford county tends have more federal or military, those kinds of workers in that area; we are likely to see that kind of split in the status. We do display that on an annual basis. We look at the groups that we care for, their socio-economic status, and we are very in tune to people who can't afford care, as soon as it becomes obvious to us. We have charity care policies. Depending on what federal poverty guideline that patient and their family meet, there are different levels of payments or non-payments as the case may be for your economic status. That just goes along with our charity care policy, which we've had forever and as long as I can remember.

01:10:30
Carrick:
Have ethics in the hospital changed over the years from when you started until you retired?

01:10:40
Kane:
In ethics? Maybe in terms of end of life decisions and some beginning of life decisions. The things that we are faced with are people living longer and people cared for by others. People who are still physically in pretty good shape, but become mentally incapacitated, for one reason or another. Alzheimer's is where that really comes to mind. Alzheimer's creates a lot of different dynamics and families create a lot of different dynamics as well. The patient decides, the patient has rights, and the patient decides in their competent state, what we as health care providers need to do. Sometimes the family doesn't have to be very large for one side of the family to say, "Momma would want this, and daddy would want this." And another side might say, "Oh, no they wouldn't." [01:12:00] There are very specific levels of decision making, and things like that that go on. Which is why the discussions that go on in families with their matriarchs and patriarchs, and anybody in the family needs to know: "Here are my wishes and this is what I have documented as my wishes should I not be able to act on my behalf. Here is who I want to act on my behalf." Those are very hard discussions. For us sometimes it seems fairly easy. We can help people to come to those discussions, but for some people it is really difficult to do and they don't want to go there. The decision has gotten very challenging.

01:13:13
Carrick:
Have attitudes about right and wrong in the hospital setting changed at all over the years?

01:13:18
Kane:
To say right and wrong; no, I don't think so. What was wrong years ago is still wrong. What is right, again I focus on the patient. Right and wrong—no I don't think they've changed. What maybe has changed is yes and no in an area of grey, as things begin to take some shape. Right now I can't think of an example. If somebody is very black and white in the way that we deliver care and in the health world today—sometimes you have to be a little grey. The grey is open up and listen to others because you may not have thought about that. But the right and wrong part, I don't think so.

01:14:58
Carrick:
What sort of responsibilities did you have as the chief nursing officer? [01:15:00]

01:15:03
Kane:
Leadership has been my focus forever. I have always been a student of leadership. Many times I had the opportunity to say to people, "My role is patient care. My role when I graduated from St. John's hospital in 1960 was patient care. I do it in a different way now." The responsibility of the chief nursing officer is the care that is provided to the patient. When you are about several levels removed from actually putting your hands on that patient and being able to care for them, then what you do as a leader is be sure that systems are in place to support the education and knowledge of the one who is at the bedside. You have to go and see what is happening. You can't be a leader without going to see where your product is being produced. I don't care what industry you're in—if you don't know what's going on and where the action is happening, then you are at a bit of a deficit. And so it is that. Then it is being able to ask the questions. You might be going around and you'll start noticing a few things. Then you start asking the questions about things and might hear, "Well yeah, we've been doing that for a while." If we've been doing it forever, there is bound to be something that changed because change is constant here.

The role is patient care. The way you do it is as a leader, as a really true leader. There are some times where when you are with the board of trustees and the focus is on the patient care. That is where the rubber meets the road and where it is a description of the quality of what we have accomplished, which is not the processes and not all the stuff that we did. What were our results? This is why I always say the ventilator-acquired pneumonia, the blood stream infections, and things like that—I was proud of the progress that we really made. [01:18:00] We did some phenomenal things and wiped out patient occurrences that we hadn't worked on as diligently in the past and we focused there. Or for one reason or another there seemed to be more of something. It is a privilege to be at that level, to be included at the chief executive level with the chief finance officer and the chief medical officer, and to bring the nurses' perspective to the table. In the past, the table did not include nurses. The nurse has a very important role in the care of patients: we are the ones in the room with the patients twenty-four hours a day. It is quite an honor.

01:19:06
Carrick:
How has technology changed in the past twenty-five years or so?

01:19:11
Kane:
First of all, there wasn't—there pretty much wasn't technology or technology was very basic. We had a thermometer that took your temperature that had mercury in it. We had a sphygmomanometer that we could use for blood pressure, which had mercury too. We know about mercury these days. There really wasn't technology like you think about technology today. It has changed in that it does provide us with more information. We have information that is just abounding. If you don't take the information and make something of it, it just continues to be technology.

I'm a graduate of George Mason and an article in our alumni paper just recently from the nursing program was a project that the doctoral program is doing about diabetes and about electronic monitoring of diabetics. It is about communication, but it is tools that the patient has to transmit their results to the nurse practitioner at Mason who can say, "Okay, you're doing good. Here you are in your kitchen or wherever, and I can see your results." [01:21:00] It is the use of technology and the application of technology that will get cooler and cooler. The iPhone is going to be incredible, you watch. The iPhone right now has a module that clamps on to the back of it; a physician in his office can snap in a lead to the patient's chest and do a cardiogram right there and see it on his iPhone and the drop it into the patient's record. It is what we are going to be able to do with it that is really going to make the difference. I think we haven't seen anything yet.

01:21:50
Carrick:
Is there any technology that you've used, or seen used, that has made a major difference in the nursing department?

01:21:58
Kane:
I guess the technology I'll go back to will have to be cardiac monitoring; then some of the other monitoring that can be done, and other wave forms that can be done with those pieces of equipment. In the nursing department we are using the monitors to monitor the patients' blood sugars. I mean that is an everyday kind of thing. The computers that the nurses are documenting on—all the medicines are on the computer. What I might think would be very cool and very neat technology may be a difference of opinion depending on where the nurse is and what the nurse is practicing. It would be different from the NICU than it is from the medical unit that cares for the pulmonary and renal patients; it would be different from the step-down unit of the ICU, and different technology in labor and delivery. I just did a consulting contract for a period of time in a perinatology practice, which involves caring for pregnant, high-risk moms. The technology that they use to look at the babies biophysical profile, the heartbeat, and certain other things can be monitored is not only in the office, but can be looked at in labor and delivery and vice versa. If a perinatology patient presents in labor and delivery then the records can be viewed. The point I'm making is that nursing is as specialized as the physicians are. [01:24:00] The technology that you use the most frequently is the best for you. I do a lot of things, and did a lot of things rounding with my iPad. As I was rounding, somebody might have a question about something and we can pull up some research that shows something on sepsis and different things like that. The technology you have depends on where you are. It goes back to the patient.

01:24:44
Carrick:
How did the community influence decisions at Mary Washington health care?

01:24:51
Kane:
First of all, we have a very good link with the community and a formal link with the community. They pretty much will express their thoughts about what they think we need. I think the best example is driving to somewhere else because their loved one had to go somewhere else. What they said to us is they don't like driving: "I had great care in the cardiac intensive care unit, and you want me to go *where* and have heart surgery?" It was the same before the NICU started and the same for neurosurgery before that started. It is about our linkage with the community and to improve the health of the communities we serve. Subsequently, the community is telling us here's what we think we need, can you do this?

There have been some things to which we said, "No, maybe we can't do that." The response was from either our values perspective or because we didn't have the expertise for doing it. I'll give you two real quick examples. One is the rehab nursing facility, the nursing home. We built that nursing home twenty plus years ago; it was a stellar nursing home in this community. The rules and regulations for long term care are astronomical; they are very tight and very tough. And if you really don't know that whole long term care business and regulations, then it gets very difficult to manage. We reached our conclusion in 2007 and 2008 with our nursing home. [01:27:00] There are organizations that have many nursing homes and they know how to run nursing homes. It is not that we couldn't, because we did it, but it got to be too complex. We said, we can't be in this business anymore. What is our core business? Our core business is patient care and more than that it is probably acute patient care. It is the more acute patient population. We sold the nursing home.

A second example is we provided a school associated with Snowden, our psychiatric facility. It was a school for the children because they could no longer be in their local schools while receiving psychiatric treatment. It was a good idea at the beginning, and then it got a little challenging because it's regulated by the state Department of Education, and we're in health care. Education is changing, everything is changing—and so we partnered with our community and said, "You know, we think we are not experts." If you are going to do something, you better be good at it; you better be the experts at doing it. With those two things we had to say, "It may be needs for the community, but it's not our expertise." If it falls in our expertise and meets our core values, we obviously do consider it.

01:28:39
Carrick:
What has competition meant for Mary Washington Healthcare with hospitals in DC, Fairfax, and Richmond?

01:28:47
Kane:
We've always had competition. Now our competition—the closer we get the more we can see it with

Spotsylvania Regional Hospital, part of HCA. Some of the changes are now in Northern Virginia. It makes you look at where's our game the best? Where do we see opportunities for development? It is not really crystal ball gazing—but boy there's a little bit where a crystal ball would help sometimes if you had one—because you're really thinking about how the service is going to grow with the population. You have to speculate what the population is going to be. What is the traffic pattern? You really have to consider all things. [01:30:00] And sometimes you really do have to partner with another agency to have the real market on a service and keep it from some other competition coming into that market. You have to be on your game all the time. The competition is getting tighter and tighter. You just have to keep focused on the patient and be excellent in what you do. And if you do something and think, "Well, this is a great idea." After a very short evaluation period of time and you may say "this is not good"—then have the courage to get out when you know you need to. We've done some of that too.

01:30:59
Carrick:
Have there ever been issues for funding for the nursing department?

01:31:04
Kane:
Sure. You know we would like to say that we're special and here is what we need so fund us. There have been issues and we've looked at ways to work things out. Sometimes you say, "We can't do this right now." There were times when we put in—we didn't get as crazy as some of the hospitals did in the 1990s with really off the wall paid programs—sign on bonuses and incentives that were just unbelievable. First of all, they do not do what you want them to do and they cost a lot of money. We did a few things and had to pull back on some of those. Anytime that you look at funding you start to look at the bedside and you say "Okay, what do we need to do?" The amazing part is bringing a group of people together at the grassroots level, and you bring the people together and you say, "Okay. Can we do this exercise here? Here is what I want to know. As you go about your day to day routines here, caregiving to patients, what do you think is really stupid that you do?" [01:33:00] I mean this sounds a little crass, but what feels like such a waste of time. Do you have things like that? At first everyone will just look at you and say, "Yes, we do. Here, it's this." Anytime you can identify those things that just suck time—why do we do that? "Two managers ago, she told us we had to do that. So we just kept doing it." You take those things away, which cost time and money, and you have the opportunity to streamline a few things, and say, "Okay, then we don't need to do that." But if it makes the work easier for the nurses and then you get some things generated like, "What would make your job a little easier?" You might hear, "When I'm passing medicines at night and I get back at that side of the unit, it is really dark back there. I don't want to turn on all the lights. I need a little mag light." You feel like, "Okay, we haven't done that." Sometimes it is the simple things that make things go much smoother. There might be a pot of money you want, but there's always something that we can look at to say, "How do we discharge our responsibility as good

stewards of the organization and good stewards of the money that we're allotted?" Yes, there have been times.

01:35:01
Carrick:
Do the hospital's goals for expansions and improvements seem to be for the better of the community?

01:35:10
Kane:
I think we're always centered on the community. I don't think we go up, out, or anywhere without focusing on what's good for the community. How is our community going to grow? How will it be different? How will health care be different? The whole thing with a little more technology in the home or a little more decentralized technology—what is coming down the road? From a business perspective, it is the same as anything else—you wouldn't want to build a children's toy store in the midst of a retirement community. [1:36:00] Why would you do that? The same kind of thinking goes along with anything that we're going to do for our community.

01:36:16
Carrick:
What does the community think of the expansion?

01:36:20
Kane:
I think that our community has changed somewhat. We still have very many of the people who grew up here and who call this area their home. We also have lots of people who have discovered what a great area this is and have moved here. We have people who have moved their families, their elderly families here, so they can be closer. Our community—I would say different facets of our community might have different opinions. We ask our community what they think of us.

We've always done patient satisfaction surveys and things. About the three years ago, we changed to a version that Medicare and CMS (Center for Medicare and Medicaid Services) piloted for about three or four years. It's a totally different approach at looking at satisfaction. It is looking at it from a patient's perspective, instead of us saying "Was your food hot? Do we have foods that you like?" We do not set the questions. The questions relate to the patient's actual experience with the nurses, physicians, medications, and discharge. The way that the questionnaire is structured is that the answer choices are *not at all* to *always*. Like a scale, the only one that counts is *always*. Your score is represented in the score of *always*. "The nurses treated me with courtesy and respect." That has to be answered *always*. "The doctors treated me with courtesy and respect." *Always*. "The nurse explained the medications every time." *Always*. Now think about yourself going out to dinner. Is there any place where you can say always? I mean it is a very high bar.

We know what the community thinks about us and we try to do our PR. The marketing group is just stellar. [01:39:00] They do focus groups. They have the expertise and the science to dissect our community. If you're going to do an education program on high-risk pregnancy, then an OB doctor, a perinatologist, and a neonatologist are going to be the speakers. The marketing department knows how to segment the populations and the fliers only go to those regions which may have that target population living there. It is very cool; there is a lot of science behind it, but it is very cool. In doing all of these, we are always gathering information, formal or informal, about what our community thinks about us. I think overall, they're very supportive of what we do and proud of the facilities and the quality that we can deliver.

01:40:09
Carrick:
How have the community relations with the hospital changed over the years?

01:40:15
Kane:
When I first came here, many of our patients went to Richmond. First of all, the community went to Richmond to shop. They also went there for health care, or if you really needed something big you had to go to Richmond. That was the feeling in the community, which has changed over time. People experiencing our care now are saying, "Wow, this was excellent." My graduate thesis was on patient satisfaction. My conundrum has been when somebody tells me a story about their care, good or bad, and most of the times it's good; but sometimes I hear some other ones. I always now ask them, "Well, tell me about that. I'm interested in knowing because I want to do something about this." Six months or longer—this was in 1962, and so this is what happened. My conundrum is how do we bury the old stories that are folklore and have no bearing on who we are now and what we do now? [01:42:00] And the stories can get passed on. "You know my grandfather, had this and that." There's part of that still in the roots. When people come and experience—and even people who have had those experiences— it sometimes still gets to the "Yes, but, you know." I just don't know how to get rid of that. But I think people who experience us and know us are, by and large, very satisfied.

01:43:00
Carrick:
Was Mary Washington your first job in the health care system?

01:43:04
Kane:
No. We moved about thirteen times before we got here with the Marine Corps. My first job with the health system was at the hospital that I graduated from in Cleveland; I was a labor and delivery nurse. I started out in labor and delivery. Then we moved and I worked in a private psychiatric

facility. I was the night charge nurse in the psychiatric facility. I learned a lot there. Then I worked in ICU, and that is when I started my ICU and emergency department experience. It was ICU, then the emergency department. The next place was the same kind of thing. The only time I didn't work was when we moved to California when my husband deployed to Vietnam. The kids and I stayed in California, and that was the only time that I did not work at all because he was away.

I have had lots of different experiences and only one experience scares me to this day. I just can't be a nursery nurse in the nursery with sick babies. I've shadowed nurses as a nurse director and a nurse executive. I stayed with a nurse all day in the NICU and watched her care for her patients. [01:45:00] I'll tell you that baby was this big [as big as her palm]. I said "I have to have a way to tell how big this baby is." I just laid my hand next to the baby; it was about give or take about that big. I watched her position the baby so that the skin would be good. I watched her with nutrition, hydration, and medications; everything she did for this baby was in nanodrops. I said to her, "I'm just in awe. You are really good." She said that she just loved it. She said, "I'll tell you what, you can take those emergency department patients and you can just keep them. Just give me my babies."

The nice part about nursing is that nurses find their niche. When they find it, they love it. The nice part about nursing is you can also move around until you find your niche. And in that, you gain lots of experience. Those are my jobs in nursing. One thing I did here at Mary Washington that I am very proud of is I went to Tucson Medical Center and the University of Arizona. I took a wound and ostomy management nursing specialty course; I came back and for fifteen years I did part of that as part of my job as well. Working with patients who had ostomies, horrendous wounds—I loved every minute of the teaching that goes along with that, the people that I met, and it was wonderful.

01:47:04
Carrick:
How did working at the hospitals compare to working at Mary Washington Healthcare?

01:47:11
Kane:
I obviously didn't stay very long at all those other hospitals. There were lots of similarities. We came here in 1972 from Albany, Georgia, from South Georgia. I was the nurse manager of a cardiac step down unit. Patients came out of the ICU to that unit. We were already doing probably a little more cardiac measures. We had CPR, which was coming into vogue, and all the medicines for cardiac arrest. We probably were a little further ahead there than here, but we quickly came up to speed. [01:48:00] The part that I've always like about Mary Washington is listening to people say, "We did this here. So do you think we could do that?" And then seeing the willingness to do those things.

01:48:37
Carrick:
You said that you went to college at George Mason?

01:48:40
Kane:
I graduated from George Mason. Again you have to hear my story, because I use it for people who think they are too old to go to school. I graduated from nursing school in 1960 when I was twenty-years-old. I had a wonderful, hospital-based education. The best kind of education we could have gotten. For a long time that did fine; I knew what I was doing. There were a couple of years in my life where I do admit I was cocky enough to say, "What is a BSN going to do for me?" I was at a point where I was asked to step in for somebody who had to take an extended medical leave. I was asked to step in to be the Director of the Surgical Services; that was everything but the operating room and included the recovery, all the surgical floors, and all that stuff. I said, "Sure, I can do that." So I did, and I did it for a year. I worked very closely with the surgeons and we were doing some great stuff. It turned out that the person could not come back from her extended leave. The position was posted. Remember I'm a hospital grad, and the position was posted. I went to the Vice President for nursing at the time and I said, "I've been doing this job for a year now. And even some of the surgeons say I'm doing a good job. I would like to apply for the position." She kind of looked at me and she said, "Well I'm sorry. You don't have the credentials." I said to myself, "That will be the last time I don't have the credentials." I may not be the person for the job, which is what the true fit in a job is about, but I will have the credentials. [01:51:00] It was about eight years later that I finished my BSN at Mason. That was about eight years. Then I spent two years at Averett University for my MBA. I was fifty-one-years-old when I finished. So anybody that says "Well, I don't know if I can go to school." I say, "Let me tell you." Of course it is much easier now. I did most of my things that I needed to get into Mason—they accepted some of my nursing school credits because we went to a college and took some of the courses there. They accepted those, but I was I don't know how many hours shy of getting into Mason. I went to Mary Washington College. I took marketing at Mary Washington. I took medical sociology with a wonderful professor who has since deceased. A friend of mine and I talked to Dr. Scott in the chemistry department to let us just jump into second semester chemistry because we needed another semester of chemistry. I took history with Dr. Crawley. [laughs] I spent part of my time here. I took some at Germanna. Finally, I could transfer. Meanwhile, I'm working full time.

I transferred to Mason and then at Mason I had to take statistics and a couple things. Then I had to challenge my junior year. I was in the nursing program and I had to challenge my junior year. What that meant was you could take the syllabus for the course, study the syllabus, and take the final exam. It was not standardized; it was whatever any professor thought they needed to have. It is standardized now. Take the exam—if you don't pass the exam, you have to re-take the course. No pressure there. I passed all of those and I'm finally got into my senior year and graduated. Then I went right on to graduate school. I was like "I got this far." The point being, there are people in your

life who—and I call that surviving adversity—challenge you in a direct or indirect way and completely set your path somewhere different. [01:54:00] My kids were in college when I was in college, and the thing I worried about most was how to register. I graduated from Mason and I'm very proud of it. It is an extremely good nursing program at Mason. That was in 1989, and in 1992 I graduated from Averett.

01:54:28
Carrick:
When did you know that you wanted to be a nurse?

01:54:30
Kane:
You have to think about when I was going to high school. I was going to high school in the '50s. Women who worked outside the home were nurses, teachers, or secretaries. I knew I didn't want to be a teacher. Actually, I wound up teaching a good part of my life. I knew I didn't want to be a teacher. I didn't know about the business thing. I tried to do sciences to prepare, and I did the business stuff to prepare. Then my mother was a nurse, but she never talked about nursing very much. I kind of knew a little bit about what nurses did. I had an opportunity to watch some families care-give people in their families and young children. I thought to myself, "I think I can do that." You have to want to care about people. If you don't care about people, you can't do this job. It is not very glamorous. It is not a glam job. It is a wonderfully satisfying career; the people that I've met and the things that I've learned. You learn something every day. Then I applied to the program and got accepted into the program.

01:56:22
Carrick:
What was the process to getting to the position of the Chief Nursing Officer?

01:56:32
Kane:
The ways that I went—I started here as a staff nurse. The director of nursing at the time, Dorsye Russell, was a real mentor and was well known in the state of Virginia. She was our director of nursing. She said, "I need somebody to understand quality and maybe do some in-service education and to teach patients. [01:57:00] What do you think about that?" I said, "Sure, I can do that." That's how I got myself into a lot of stuff. I said, "Sure, I can do that." Then after that you get there you think, "Okay, well now. How are we going to do this?" So I said sure. I learned those things and that's how I began teaching. Prepare to teach—I always thought about myself in class. I thought you have to take pity on the people that are sitting in front of you and it has to make sense to them because clinical people will get you figured in the first two and a half seconds, whether you have the credibility or not. Some of the things I was teaching at the time were very new concepts: quality and auditing of quality in the hospital, never mind in nursing. I did that for a while.

I was also the Patient Care Coordinator. I did lots of stuff. Leaders said, "Maybe Barbara is out there doing this. Maybe while she's there doing this, she could find out about one thing or another." I did that, and Lord knows how long I was in that position. I did so many different things. I also moonlighted in the emergency department. I worked 3:00 p.m. to 11:00 p.m. in the emergency department for years while I was doing other things. I was doing that and then I had that interim director position; it was probably my first leadership of the division kind of thing. Then I started going to school. Even though I didn't have the credentials yet, the nursing director started saying, "Take this responsibility." We were starting to make some changes and we were going to break up clinical and administrative. You be the clinical director." So I said, "Okay, fine."

Things changed in that way, and with every change, I got to experience every service. I've been responsible for every service, except the radiology nurses. Then I was the Director of Clinical Effectiveness, which had to do with performance, quality, and processes across the health system for three years. Then I was asked to take the position of Vice President for Nursing at Mary Washington Hospital. [02:00:00] Then I was asked to take the CNO position for the whole health system. There had never been one for the whole health system; that was quite a privilege, and I was getting to know all the nurses. By the time I left, we probably had about 1,550 nurses across the health system. It was really very good. It was wonderful experience. I wouldn't trade it for anything.

02:00:36
Carrick:
What did you love about working at Mary Washington hospital?

02:00:40
Kane:
I loved the people and the patients and the physicians. The people who are here really bring the organization to life and they help us with our mission; no matter what they do, they help us fulfill our mission. There would be sometimes where you had a lot of administrative things to do; you might have been in the office a lot or in meetings of one kind or another. When something got canceled or whatever, the place I would be is out in the hospital. That is where I got my energy. Every once in a while my executive assistant Tammy Brady—who is now Fred Rankin's executive assistant—to me was like Radar was to the MASH unit. She just kept me ahead of everything. Every once in a while she would just schedule me some free time and some rounding time. It was some free time for me to just go see a lot of the nurses in the health system. I would go to ambulatory surgery, up into the OR, or to do those kinds of things. That is where you really see how good we really are, and how much the people one on one, the people really care about what they do. It is not a glam job. It's hard work, but the rewards are just amazing.

02:02:43
Carrick:
That was my final question. So is there anything that you wanted to go over before we finish up?

02:02:49
Kane:
Let me think. No, I don't think so. We touched a lot of things. You all are going have to have some chips and snacks when we play this because it is probably going to be long. [2:03:00] It has been a pleasure. It's a privilege to tell this story of our organization because there are so many good things that we do.

02:03:23
Carrick:
Thank you for your time.

02:03:24
Kane:
Thank you very much.