

Department of History and American Studies  
University of Mary Washington

Mary Washington Healthcare Oral History Project

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Interview conducted by  
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in 2013

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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](http://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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00:00-15:00

Nurse Hiring Process—Community oriented—Differences between old Fall Hill facility and new MWHC facility, in terms of care and interpersonal interactions—Brother's job at Fall Hill vs. job in the new hospital—Expansion of specialties and ICUs—Cardiac ICU—Flexibility of nursing career, especially at MWH—MWH support of continuing education for staff, both financially and professionally—Physical move to the new hospital—Gradual expansion of staff—Community needs reflected in expansion

15:00-30:00

Community needs reflected in expansion—Close ties between community and Hospital—Staff reactions to expansion—Effects of expansion on the hospital staff—Challenges with new services and technology—Keeping up with technology, policies, procedures, and education for all staff members—Change in requirements change hospital procedures

30:00-45:00

Requirements and standard changes to improve medical care—Discussion of political impacts on health care—Diversity of community—The Affordable Care Act—Discussion of hospital values, regardless of political factors—Policy changes, especially those that affect nurses—Changes in the 1990s regarding the new hospital—1990s changes focus on planned growth, using staff and patient perspectives—Hospital goals of growth to benefit community

45:00-01:00:00

Discussion of senior staff—Fred Rankin's influence—Technology and new equipment in furthering the expansion of the hospital—How other hospitals and health care facilities compete with Mary Washington Hospital—Competition among hospitals—Current responsibilities at the hospital—Organ donation council tasks—Ethics committee responsibilities—Outside factors that contribute to ethics at the hospital—Patient input on health care—Ethical changes at the hospital

01:00:00-01:15:00

Ethics committee formation and structure—Services of the ethics committee—Changes in understanding of ethics and applying them in practice—Changing role of physicians—Changing nurse roles and practices—Pros and cons of specialization in the hospital—Challenges in expansion and with technology—Emergency Preparedness Committee

01:15:00-01:26:39

Emergency Preparedness Committee—How to deal with large scale emergencies?—Reasons to form these preparedness plans—How the hospital adapted to changes in the community—Funding and financial growth—Predictions for the next few years in medicine

00:00:21

Simonpietri:

Do you just want to go ahead and tell us about your first day at Mary Washington hospital?

00:00:28

Brothers:

My first day at Mary Washington Hospital. We had come up from Florida to visit my brother in law and he said, "They are hiring over at Mary Washington. So why don't you go over and see what's going on." I came over here not really knowing anything about the hospital, or the background, or really that much about the area. I came in and went to human resources and they called up to the ICU. The ICU manager came down and met me and took me up for a tour of the ICU. By the time I got back to human resources I had been hired for the job, gotten a raise, and I hadn't left the building yet. We made plans to move up—of course I had to get a license in Virginia since I had never lived in Virginia. That took a few weeks. It was probably about eight weeks from that interview to the day that I started, which was in October of 1986. We were across the street here at 2300 Fall Hill, an entirely different facility than we are in now. It was a very close knit group, very community oriented, everybody knew everybody, and everybody worked together. Then I worked nights on top of that, so it was even a smaller group. And it was really easy to get to know everybody and to feel like you were a part of the group.

00:02:21

Simonpietri:

So can you tell us a little bit more about working at the Fall Hill facility? Maybe compare it to the facility that you are working at now?

00:02:32

Brothers:

The Fall Hill facility, I think, before I came here was even smaller. There were more spaces that were designated for things other than patient care. The rooms were set up entirely differently. The rooms at the new facility are all private rooms, and over there we had some rooms that had four patients in them. [03:00] That's kind of unheard of over here; people would just have a cow if they knew they would have four people in a room. In fact, there was a period of time where the census was really high and we had to pair up a couple of people on different floors in order to accommodate all of the patients here in this facility. It was not well received; people are used to now having their own private rooms. But over there we had rooms. I think almost all the floors had like a four bed unit in it, in addition to most of the other rooms that were two to a room. Only in ICU were there private rooms. An occasional room on the floor was private, but that was for those patients who had an infectious disease or something along those lines and where they couldn't be in a room with somebody else. When I started over there we had in the main lobby vending machines that vended cigarettes. You could get soda and cigarettes. At one time it wasn't unheard of, nurses having cigarette breaks in the nursing lounges and things like that. It is totally unheard of at this current

environment and, certainly, people are not encouraged to smoke, not patients or staff. In fact this is a smoke free campus. Entirely different from what it was over there. The cafeteria over there was in the basement and it wasn't as restaurant like as the cafeteria is over here. A lot of people congregate here; families come here to the cafeteria. It didn't have that much space over there, so it was sort of hard to have lots of outsiders. Certainly we have lots and lots of people who come to the cafeteria or atrium. It was a very close-knit group though across the street and we had less staff and less specialties. There were a lot more transfers. Now instead of transferring out we get transfers in. Now that we are a trauma facility we get lots of patients that are flown in from car accidents or from outlying areas that come in here for lots of different specialty treatments. We have grown and grown to meet the needs of the community so people don't have to leave this area in order to get the care that they want to have.

00:05:58

Simonpietri:

What did you do at the Fall Hill [hospital]? [06:00]

00:06:03

Brothers:

I worked in the ICU. I worked mostly nights and there were three of us usually on, sometimes four depending on the acuity of the patients that were there. I was a staff nurse and a charge nurse. Then the day that we moved over here—that was certainly a day—I was one of the last nurses left over there as we moved all the patients over here. I still was in the ICU at the time and when we moved to this facility. Over there we just had one ICU. Over here we had the medical ICU, the surgical ICU, and the cardiac ICU. I was in the cardiac ICU when we came over here.

00:06:59

Simonpietri:

So it sounds like your job really changed. Did it really change with the different kinds of ICUs at all?

00:07:08

Brothers:

It does. Now in the surgical ICU we have a lot of neuro cases, a lot of neuro trauma, a lot of motor vehicle trauma, and all of those pieces to the puzzle. We have the open heart team, and that's a specialty unto itself. Each one of those segments, trauma, neuro, and the open heart surgery: those patients need very specialized care. The cardiac unit focused predominantly on those patients who camopen-heartad MIs—heart attacks—and that needed to go to the cath lab. The medical ICU predominantly had those patients who had pneumonias, were on ventilators, or having strokes; those kinds of things that wouldn't require surgery and weren't cardiac in nature. It is a big division as to who goes where. I went from the staff in charge nurse position to at one point managing the cardiac intensive care unit. The greatest joy about nursing is you can move from place to place and your job changes. It's like a whole new career as you learn different parts. You can also change,

depending what is going on in your personal and family life, and you can make nursing work for you. The hospital has always been very supportive of people going their own way, supporting you, and making sure your needs are being met as well as the hospital's. [09:00] When my kids were small, I transferred out of the ICU environment and worked in the outpatient surgery division so that I was working when the kids were in school. I could drop them off at school, go to work, get out of work, and pick them up. They were both on the swim team and I would take them to swim team practice. That part of my life was very supported. Not only was I able to maintain my career, I was also able to maintain the family life. A work life balance is an important piece to what goes on here.

00:09:41

Simonpietri:

Did continuing education, was that required to change your role within the hospital?

00:09:50

Brothers:

It's not required, but it's certainly encouraged. They have tuition reimbursement and they recognize any certifications that you get for the specialties that you are in. We have lots of those specialties and they are very supportive. In fact, since I've been working here I went back to school. First I got my associates. I was already had my RN. In order to gain a broader base, I went back to school and first got an associate's degree in general studies, went to get my bachelor's in health administration, and then went to UVA and got my master's in clinical ethics. My role has changed with the different education opportunities that were afforded me.

00:10:44

Simonpietri:

Did the hospital help you with that at all?

00:10:47

Brothers:

Yes. At the time that I was going to school I went through a program that was a tuition pay-back program. For every month that you worked you were paying off credit; I didn't have any out of pocket costs for going to school. I was supported. Plus, they helped work my schedule around when I had to go to school, which was extremely helpful.

00:11:25

Simonpietri:

Can we go back, you said that the day that you transferred from the old hospital to the new hospital, that it was an interesting day, can you expand on that a little bit on how that went?

00:11:37

Brothers:

Yes. It was months and months and months in the planning. As the building was going up, there were all these background plans on how do you have the new facility open and running and still have the old facility open and running. They both had to be open until you can get them all in to one place. [12:00] We had the entire nursing staff that was involved in planning unit by unit. Who was going to be where? Who's going to receive the patients? Who's going to send the patients and how is that all going to be coordinated? We had an administration group that was already over here in the new facility and there was still administrators that were on site and available at the old facility. Each one of the floors had a receiving staff and a sending staff. We had ambulances lined up to transport the patients. The ambulances would pick them up here and take them over there, get them registered over at the new hospital and then come back. It was just a repeating cycle until we got all the patients out of here. Of course they had tried to limit the number of elective things that were happening, in say the week before. This was so that the census was not through the roof—as much as you can predict a census. Because certainly anyone who came to the E.R. and needed care, they came in regardless. Anything that they could be put on the back burner for a moment or two while we got the transition done, that's what we did. It was a huge effort for the organization and also for the community because the fire department was involved, the police department was involved, and the ambulance crews were all involved. Of course anybody who worked in the organization was all involved.

00:13:46

Simonpietri:

How long did that—did you get that done in a day?

00:13:49

Brothers:

Yes.

00:13:49

Simonpietri:

Wow.

00:13:50

Brothers:

All in a day.

00:13:51

Simonpietri:

How did the new, you said you had a tight knit community at the Fall Hill hospital, I'm sure you had to acquire a lot more staff for the new hospital?

00:14:05

Brothers:

It was a gradual growing. Certainly, when we first moved over here we didn't suddenly have all new departments. We grew them. It was timely. It was spread out over a timeline. We had the ability to look for the staff that we wanted and they knew what specialties they wanted to bring in to the area to meet the needs of the community. Certainly the neurosurgical piece was a big piece. Open heart surgery was a huge piece. Up until the time we had our own open heart surgeons here, the only places people could go were north, to Inova or Washington Hospital Center, or South to Richmond, or out to Charlottesville. [15:00] That's a big commute if you are trying to get to somebody every day that you care about and has had a huge surgery. Moving in that direction was always done with the community in mind. What needs do we need to meet for the community? The cancer specialties have certainly grown, with the cancer center and the radiology and chemotherapy. All of that is now available within the community. Developing that staff—again there are certifications that are involved. The hospital did exactly what it needed to do to support the staff that were interested in going in to those specialties, to get them certified in the appropriate different medication delivery systems, and all of those systems that go with that. It's been an ever growing, ever changing environment that we work in.

00:16:04

Simonpietri:

So, you would say that the growth of the hospital reflects the growth of the community?

00:16:10

Brothers:

Yes. And I would say that this organization in particular is very much in tune with the community. They have the community action committee that meets, and they are very interested in having a say in where the hospital is going, what direction it takes, and what specialties we need to have in the area. There are community members on the ethics committees within the hospital in order to maintain that balance and to have different opinions that can certainly drive the culture of the organization. They have been very much geared toward listening to suggestions from the community. And listening to how we can do it better and what we need to have to make it better and more beneficial for the community. We have the Moss Free Clinic and we have other services. We work with Micah Ministries and all of those pieces to reach out to the community. We have a speakers bureau here at the hospital. If any group wanted to have a speaker on a particular subject they can call and ask and then people will go out and talk on whatever the subject matter is that they wish to hear about. We then can help them gain some insight in to whatever that situation is.

00:17:53

Simonpietri:

How do you think the community's feelings about Mary Washington have changed over the past twenty-five years since you've been here?

00:18:04

Brothers:

I think that most of the community now recognizes that Mary Washington has done a lot for the community and for growing the specialties that the community was asking for. I think that when I first came here people were not so much on board with Mary Washington. They were more likely to say, "Take me to UVA or VCU or Washington or to the big hospitals." I think that was sort of a trend. There are lots of small community hospitals and people ask, "Is it the best? Can I get the newest possible things at that facility?" They look to have all that. They hear it on the news. They see it in some specialty or there's this huge new machine at Washington Hospital Center. They have this trauma team and they have this and they have that. Over the twenty-five years, it hasn't been only they have that; it's we have that. I think that there are positive interactions with the community with the speaker's bureau and from having community members on committees within the hospital. I think the word gets out that, yes, this is a facility that is here for them and that is working to make things better for the community that it serves.

00:19:55

Simonpietri:

What has Mary Washington Healthcare meant to its employees internally, and to the community externally and has this changed with the expansion?

00:20:10

Brothers:

I think it has changed. As employees at 2300 [Fall Hill] there was a camaraderie, a family centered feeling about the entire workforce. As we have grown and expanded to not one hospital but two, with a separate free standing emergency department, with another separate surgical outpatient department, the staff is physically not as connected. [21:00] People can say that I work at Mary Washington, and I might never have seen them. In the past, when we were smaller that wasn't the case. Everybody knew everybody even if you worked on a different shift. There weren't so many locations. There's positive and negative to all of that. Sometimes when everybody knows everybody that you work with, there's a lot of gossip and there's a lot of family feuds because you are like a family. When you are in a bigger facility there are more places and different people that you are working with on a day to day basis. There are a lot of different departments and it's not the same people you are working with over and over again. I don't want to call it in-fighting, but that sort of familiarity is gone. And so there is a more formal presentation because you don't know everybody that you are working with or you haven't worked with them at all before. It does present a different front, I would say, than that close knit everybody knows everybody.

00:22:37

Simonpietri:

What challenges were faced with the expansion of new services and technology and how were they overcome?

00:22:45

Brothers:

The challenges were education. Making sure that everybody who is going to be impacted by whatever the new service is—whether it's a new piece of equipment or an entirely new service that we are offering—that the people who are going to work with it or with that program have the education and resources so that they can move forward. And they aren't feeling like, "I'm floundering out here and nobody seems to know." They're acutely aware of those kinds of changes and they try to make sure there are resources available to everybody when they need them. If it's a computer change that there is somebody, a trainer, to make sure that people are educated while the changes are happening. They can put them out on each one of the floors so there is a support system in place. They make sure there are courses that are offered, classes that are offered. It is either within the organization or they have to send somebody out to get a specialty certification. [24:00] They are willing to do that in order to make sure that we are meeting requirements for that new equipment, or new ideas, or new standards of care.

00:24:15

Simonpietri:

Had that always been the case while you worked here? Like at Fall Hill, did they have the same kind of attitude towards continued education like that?

00:24:27

Brothers:

Yes. I would say they had the same attitude toward continuing education. I just think that because it was smaller, it was not so specialized, and we didn't have so many departments that it might have seemed less obvious. Even then they supported people going back to school and getting high degrees and going in to specialties that they wanted to go in to. It's just that I don't think we were having as rapid a growth and change that you need to educate for. It is important to make sure that you are maintaining regulatory readiness because there are a lot of different agencies that look at a hospital. You have to make sure that they are doing it by the best practice, that it's the best way, that this is the standard of care, and that all of that is being met. You need to make sure that the staff is educated to what those requirements are and that they are able to maintain those standards. You need to make sure they are willing to take it on, learn it, embrace it, and sometimes it's a hard sell.

00:25:55

Simonpietri:

How do the physicians, RNs, and other providers keep up with the latest practices and technology?

00:26:04

Brothers:

For the most part if it's some new procedure or something, the physicians will go and seek out the experiences so that they can master those skills, new pieces of equipment, or whatever it is that they are trying to advance. They bring to us new ways to do things all the time. The nursing staff will get sent to national meetings or there's a lot of webinars now so that you can stay in your own facility but participate in that educational opportunity. [27:00] The Joint Commission and the Centers for Medicare and Medicaid produce the standards of care and the national patient safety goals come out annually. We look to make sure that our policies and procedures meet those requirements on an ongoing basis. If there are any changes in the law or any of those requirements, then we educate the staff. It can be going to staff meetings, having a one-on-one, or we do computer-based learning; we have CBLs, computer based learning tools, that address very specific educational needs that exist for everybody. We have an orientation program. Whenever anybody starts working in the organization they go through the orientation program so that they have that floor of education and they know what the expectations are from the get go. They maintain a system so that when there is something that needs to get out right away they have a mechanism called the "Info Express," which is passed out through the computer. It's just a one page document that says, "Here is the problem, here is what we are doing, and here is the solution." It is all on one page and that ensures that everybody is on the same level of education as we move forward.

00:28:44

Simonpietri:

Have you seen the regulatory, processes and standards—has the impact they have had on the hospital changed over the years?

00:29:00

Brothers:

I don't know that the impact has changed, but certainly the direction that regulatory requirements have taken us have changed. The Joint Commission certainly comes in and does their surveys on a regular basis. Their expectation is that their requirements are met and that everybody is aware of what those requirements are. I think that that has been the floor, where you want to be here it is. This is the basis for where you want to be and I think that that part has not changed. That is still the truth, and the way that they want hospitals to operate nationally. [30:00] It is not just a specific hospital; they want to raise that floor and they want to raise the level so that health care is improving with more safety and higher quality. Whenever it seems like they are coming, they produce a whole new sets of standards and it feels like, "Oh my gosh, are you kidding? We just met all these standards and now you have changed it to X." Then you feel like, did we miss something? Did we

not start this soon enough? You are always challenged by those regulatory agencies to stay on top of the game.

00:30:54

Simonpietri:

How has health care as a political issue impacted the practice of medicine at Mary Washington?

00:31:10

Brothers:

I think the whole political climate around medical care has changed. I know there is a lot more conversation. In the past, I can't say that I noticed nurses sitting around talking about how X bill is going to impact what happens to us. I have not in the past heard nurses talking about, "what is the pair mix? Do we have enough people paying for this to take care of these people?" That whole situation of, does socialized medicine win? Is it the insurance companies that are going to win? And how are the patients going to be impacted? That's all part of a conversation that seems to occur on a fairly regular basis; that wasn't true in the past. I also think that from the political climate from when I first started here—it was sort of like the cultural diversity in the area was there were those people who lived in downtown Fredericksburg and everyone else were farmers and that was the cultural diversity. Now you know we have a refugee center, a large Korean community, a large Russian community, and a large Mexican community. All these different cultures are converging and we are adapting; we are adopting policies that will address their cultural issues as well as being able to meet their need and to have the political voice that goes with each one of those cultures. [33:00] Their cultural needs are new.

00:33:08

Simonpietri:

How will the Affordable Care Act impact Mary Washington Hospital?

00:33:13

Brothers:

I'm sorry?

00:33:14

Simonpietri:

How will the Affordable Care Act impact Mary Washington Healthcare?

00:33:20

Brothers:

I think it will change the way we do things. Whether it's because we will address things to do, maintain the same quality of care, and do it in a more expeditious manner. We will have to make sure that quality doesn't get compromised and to do more with less. We will have to be as lean as we

possibly can with getting the same job done, while delivering the same kinds of care and doing it as economically balanced as you possibly can do it. I think it's difficult to know in advance. It's sort of like back when they were putting DRGs, Diagnostic Related Groups, in place. People were asked, "What's that going to mean to health care?" You don't really know until it's already happened. The language almost changes. Before DRGs nobody would have even had a clue what Diagnostic Related Groups were, let alone what outliers were or what this was or what that was. I'm not sure we know what the full ramifications of that whole new process is going to bring to health care, but I think that, there is going to be a broader base and perhaps more outpatient kinds of things. I know even now they are already looking at making sure that you aren't needlessly admitted, and that you are not in the hospital lingering longer for not a good reason. I remember way, way back even before I was here that there were times when people would admit grandma to the hospital because they were going on vacation. There she would sit for two to three weeks with really nothing wrong with her. "She's having her annual physical." Really? And it takes three weeks to get that done? [36:00] Then she would be discharged when the family came back from vacation. Those days aren't here anymore. As those changes happen we will adapt to that. And adapt in what way? I am not really sure.

00:36:21

Simonpietri:

How did the expansion of health maintenance organizations (HMOs) in the 1990s and more broadly managed care programs impact the core values and business model of Mary Washington Healthcare?

00:36:41

Brothers:

I'm not sure that it did do anything to the core values. I think that the core values of then MediCorp and now Mary Washington Healthcare are based on the philosophy of the organization and not from external sources. They have been committed to making sure that it's an ethical climate, that it's an ethical business and working organization, and that it is transparent. It can speak openly to the community and say that the mission is to provide quality care to the communities that we serve. They are dedicated to making sure that that mission is fulfilled. I think the HMOs changed the reimbursement, but it didn't change the core values of the organization.

00:38:07

Simonpietri:

What have been the most important policy changes in the past twenty-five years?

00:38:14

Brothers:

Wow. Policy changes related to staff or patients?

00:38:26

Simonpietri:

Whichever one you are more comfortable answering, or both.

00:38:36

Brothers:

There have been many policy changes that have come along related to time and shifts. I think all of that has a big impact on the availability of nursing staff. When I first started here almost everybody was doing five eight-hour shifts, and that has changed over time. [39:00] We have some— actually very few who are doing five eight-hour shifts a week. More often you see three twelve-hour shifts. Some people split it up and do two eights and two twelves. They have looked at overtime. They certainly don't want you working to the point of exhaustion, so you are not making good decisions; that impacts the safety and the quality of the care that you are delivering. The focus on the human resource policies have impacted the staff that works here. I think that some people are very comfortable working within the confines of the human resources policies. They find almost a comfort in knowing that they are there because it fully informs you of what the expectations are of you, the employee. Also, they inform you of what you can expect from your employer. I think that a lot of people are very comfortable with that; they don't necessarily like flying by the seat of their pants and not knowing what may or may not happen. They like to be able to flip open a policy book. If anything changes within that policy, and it certainly has with sick time and whether you get. At one point in time we had a sick bank, we had a vacation bank, and then they merged the two of them together so that now it's up to you the employee. Are you calling out sick or are you going to save that day and use it for you vacation day? Those kinds of give and take, I think, impact the staff. It promotes a cohesive staff because there is an equity and a fairness in whatever is going to happen. They know that if they do something that violates a policy there is a disciplinary process that can happen.

00:41:20

Simonpietri:

What did the new, in the early 1990s, senior staff bring to Mary Washington health care?

00:41:28

Brothers:

First, I have to think about who that is and the early 1990s.

00:41:35

Simonpietri:

I guess the new hospital?

00:41:40

Brothers:

I know that what they brought was a different look. [42:00] I think that when we moved over here it was a different approach to access, from community access to us and to our interactions with the community. I also think that there was a focus on how do we grow from here? There was an open arm approach to what are we going to take in and what are we going to do? How are we going to do it and do it well? How are we going to maintain the quality and expectation and grow that feeling of I want to go there and I want to be a part of this. From a staff perspective and from a patient perspective, how do you attract those people? What do you do to maintain that quality? They soon put in place the different pillars; there was an identified as a service, finance, growth, community, or is it the people. There were identified pieces to this quality and service. The customer service initiative has grown and grown over the time we have been here.

00:43:24

Simonpietri:

What were some new ideas, goals, or policies that you might not have mentioned?

00:43:32

Brothers:

I think the biggest goal when we came here was growth. The goal was to grow and develop those specialty areas so we could meet all the needs, not have to be transferring people all over the place, and have them far away from their families. The goals were to keep everything here, support the community as we endeavored, and provide them with that high quality of care.

00:44:00

Simonpietri:

What did the new senior staff, what effect did they have on the culture of Mary Washington Healthcare?

00:44:11

Brothers:

I think they brought back some of the family piece to the puzzle, certainly the commitment to the people. I remember at one of the managers' meetings and Mr. Rankin being in front of us on a couple of different occasions. At one of the occasions he said they had intentionally put the people pillar in the middle because without the people pillar— and the people being staff, physicians, and the community—that the rest of it wouldn't exist. [45:00] That was like very important. There was a connectedness to him. He was very visible and very significant in the day-to-day of the hospital. I also remember him at a different meeting when he was talking about the whole customer service initiative and why all of that was very important. He was telling a story about a boy at the beach and that he was picking up star fish and throwing them back in the water. An old man came by and said, "What are you doing that for? It's not going to make a difference. They are going to die." The boy

picked up a star fish and threw it back in the water and said, “But it mattered to that one.” That was the way I want you to be connected. I want you to care this much. It was that kind of a philosophy that drove everything.

00:46:05

Simonpietri:

What has been the role of technology in the expansion of Mary Washington Healthcare?

00:46:09

Brothers:

Big, big, big. We have new pieces of equipment all the time in radiology. We have new techniques in the cath lab. We have new surgical devices and new surgical pieces of equipment that get used all the time. There is different support equipment that is available on the floor. I think about the lifts in the patient rooms, different medications, different wound treatment plans—all of those things are based on new technology. I think that with each innovation, you feel like you’re one step closer to having the pieces of the puzzle and to doing it right. The ability to get the equipment, and have it here and available is very crucial to quality patient care.

00:47:18

Simonpietri:

Has competition affected Mary Washington at all?

00:47:24

Brothers:

I don’t know exactly how it impacts the number of patients, but I think that it’s never a bad thing to have some competition. Because then you want your goals to be even higher, you want your staff to be even brighter, and you want all of the things that you are striving to achieve. [48:00] You want to feel that much more commitment, and you work toward that—at least I do—because then I have that competitive edge. We have to fight this more. Mary Washington has been here for a long time and has been a supporter of the community. There are people who are committed to coming here, and you aren’t going to make everybody happy. People are going to choose where they feel best suited. Other than being a motivator to do things better, I can’t say that I think that it has truly hurt the organization. Having Stafford Hospital up the road has been a positive thing for the community because they don’t have to travel all the way down to Fredericksburg. They can partner with Mary Washington Hospital if there is a reason for them to come here for a higher level of service or something. Then certainly we can make arrangements to come here. For the most part, the competition in the area is a driving force to make us want to do better.

00:49:26

Simonpietri:

Can you tell me a little bit about the position that you are in now?

00:49:32

Brothers:

Sure. Right now I split my time— [phone ringing and recording paused]

00:49:46

Simonpietri:

So we left off with can you tell us a little bit about the position you are currently in?

00:49:51

Brothers:

I split my position: I work half time as the patient flow coordinator, which most people call the nursing supervisor, and the other half of my time I am a clinical ethics specialist. With the patient flow coordinator role, we do all of the patient placement. Whether they come in through the emergency room, direct admits, or they are sent in from another facility. We get them admitted and then we process any problems, issues, or concerns. We serve as a resource for the staff and the hospital and make sure that the patients and the staff have the resources that they need in order to move forward. In the clinical ethics position, I am a resource for the hospital. I serve on both the clinical ethics and the organizational ethics committees. I facilitate the organ donation council and one of the first responders looking at the charts of the patients who are potential organ donors. [51:00] We do all of the regulatory compliance. We do the policy and procedure development. We are part of the patient care consulting committee if issues arise as to whether or not here is an appropriate decision maker for a patient or if the patient is refusing X, Y, and Z and they need some input. We do the ethics consultations for the organization. We provide the education on ethics at orientations. Any policy changes or laws that get changed, we facilitate that educational component. That pretty well fills up my day.

00:51:58

Simonpietri:

How long have you been on the ethics committee?

00:52:00

Brothers:

Since 1990.

00:52:03

Simonpietri:

Have you seen any changes within the committee throughout the years?

00:52:11

Brothers:

You mean in the things that we address?

00:52:13

Simonpietri:

Yes.

00:52:14

Brothers:

Sure. It's sort of cyclical. Around the time of Terri Schiavo we had a lot of issues with feeding tubes and those kinds of things—not that they were issues, but they were questions. There always seems to be a tie to whatever is being discussed on the TV, to what is happening, and who has questions about this, that, and the other thing. We have always had a fairly large component in end of life kinds of things. Whether it is on a ventilator or not, whether it's feeding tube, or a trach [tracheotomy], or any of those kinds of things. Those questions come our way and that's been consistent across the board. Different technology has added different questions. We have had concerns after we had the open heart program. We've had some patients who have said, "No, I don't want to have open heart surgery. This isn't what my plan was." There are issues with the plan of care now that there are all these specialties and different physicians to deal with. Now we have a lot of physicians who come from different backgrounds, different cultures, and they have their own personal belief system. Trying to work with a physicians, patients, and families and making sure that everybody is on the same page and everybody is okay with the plan of care moving forward—that has been a more recent development. In the past you know pretty much the doctor said X and the patient said, "okay," whether or not they thought it was right, wrong, or were indifferent. [54:00] Now there seems to be a more give and take. There is certainly a more patient focused, patient driven plan of care for the individual patients.

00:54:15

Simonpietri:

Do you know how that evolution came about?

00:54:19

Brothers:

Painfully. Painfully. Doctors weren't very happy about giving up that, "Because I said so. This is what has to happen because I said so." Even today there are still some physicians who have issues with it. It is not so much with the patients driving the bus, but the issue is if it's a family member or somebody else who seems to be an outside influence that isn't committed necessarily to the plan of care. I think that is how it happened. There was the development of the Patient Self Determination Act, which passed in 1990 and a federal law that said patients have the right to make the decisions for themselves. Even if it means they may die sooner rather than later, as long as they understand

the consequences of the decisions that they make. In Virginia we have the Healthcare Decisions Act, which was adopted in 1991 and then we have had some changes especially in 2009. Both of those laws look at the patient's right to pick and choose those things that they want to have done or don't want to have done. Both of them addressed the whole advanced directive piece, where the patient gets to complete a document. Say if I have a terminal condition, these are the things I do or don't want to have done. Even if I don't have a terminal condition these are the things I do or don't want to have done. It allows the patient the opportunity to name somebody to speak for them at any time they can't speak for themselves; that person then has the same legal authority as if the patient were speaking for themselves. It addresses the organ tissue and whole body donation. Those laws coupled with patient awareness. I think the internet has had a big impact on what patients know and what patients think they know. Sometimes that's a good thing and sometimes it's not because they get part of the information from the internet, but they don't know how that relates to them. They may misconstrue information that is in there, which sets them up to be adversarial with the physicians unwittingly. [57:00] They end up having to have some sort of compromise that may or may not have been necessary, if they hadn't gotten any information from the Internet. Back before the internet was quite so popular, it was always what was in *Redbook* or *Family Circle*. They would do an article about, "I had some disease and they missed it diagnosing it for six years. So if you have these symptoms then you have this disease." And you know the next month you would have ten people show up at the emergency room saying, "I have this disease because I have these symptoms." Not necessarily so. That has changed and the internet has certainly impacted that, but I would say it's the laws and different cases. There have been a lot of precedent setting cases in the ethics arena that have impacted the patients knowledge of how the hospital system works and what they need to do to advocate for themselves.

00:58:12

Simonpietri:

Has ethics within the hospital, has it changed over the years, when you were a nurse?

00:58:22

Brothers:

It has changed hugely. It was the Karen Ann Quinlan case in 1975 that got the ball rolling. She was a young girl who went to a party and decided that drugs and alcohol did mix, and they didn't. She had a cardiac arrest and ended up in what we call now a persistent vegetative state. Of course, then it didn't have a name. We also didn't have advanced directives. There was not a lot of guiding forces as to how her family was going to deal with this. Her parents had to go to court first to be named her guardian, and then to be able to make decisions for her. That happened over a period of time. So what the court system said during that whole saga was, "We don't want every end of life case ending up in the court system. You guys in medicine need to do something to help these people make these decisions. As the technology advances, more of these cases are going to appear." There was a push for people to become actively involved in the ethics arena. It really wasn't until the early 1990s the hospital thought we better have a committee and we ought to have this to make sure these things

happen. When the clinical ethics committee started off here it was just a small group of people who met, and we didn't want to be like the ethics police. [01:00:00] We didn't want people to misconstrue our intention. That we were not out there trying to tell them how to practice, but we wanted them to know that there were some resources that were available to them, if they had any questions. It grew over time with different cases that came up. After Karen Ann Quinlan, it was Nancy Cruzan, who ended up in another end of life situation. Her case went all the way to the federal Supreme Court. As far as making decisions, the federal Supreme Court said that states could make the decision as to what evidentiary standard that they were going to require in order to believe people who said that this is or isn't what this particular patient would want. They put that back on the states, but they did say that feeding tubes, just like ventilators, could be withdrawn. That was another step. Then in Virginia we had the Hugh Finn case. His wife eventually was able to pull his feeding tube after an extended battle; it was not nearly as long as Karen Ann Quinlan because her court case went on for years. Once the court said that the family could take her off the ventilator it was another 11 years before she finally died of pneumonia. That case carried us in to the Nancy Cruzan case, which was in the 1980s. The Hugh Finn case which was in the 1990s, and now here we are in the 2000s.

01:01:51

Simonpietri:

So how did Mary Washington—how did it adapt to the different cases and the way ethics was evolving?

01:01:58

Brothers:

Like I said, the committee started very small and took very tiny baby steps. We just sort of put some information out there and then people started asking questions. Different cases that happened and we were available for them. There were always different people within the organization who had an interest in the ethical side of the case. Certainly when anything would happen outside of Mary Washington it was something to be discussed. We would talk about, "What does this mean to us and where do we go from here?" The committee started growing and we started adding other disciplines to the committee; we added physicians to the committee, we added community members to the committee. Whatever the issues were as they were arising, there was a group of people who could say, "Okay. Now what do we think of this?" [1:03:00] Clinical ethics answers to organizational ethics, and organizational ethics answers to the board of trustees. The information was flowing upstream. As those issues and how we were going to handle them evolved, it went all the way up to the board and back. It was always the input of the organization that moved things forward.

01:03:28

Simonpietri:

You receive the primary ethical issues?

01:03:36

Brothers:

Yes. Anybody can ask for an ethics consult. We encourage the staff to call somebody on the ethics committee if there is something that they think is in conflict. Whether it's the patient and the physician, or the family and the physician, or the family and the patient, or whatever the issue is. That if they think, or maybe they think, it's not the right person making the decisions for the patient, they will call somebody on the ethics committee. It's usually me or Dr. Bigoney. They will tell us what's going on, we will go up and review the chart, and find out if it is something we can just converse one-on-one with them; if it's a bigger problem than that and it needs to be a full ethics consult. Then the doctors involved in the care, the nurses taking care of the patient, the family, patient, if they are able, and members of the ethics committee all get together at large table and everybody has the opportunity to talk. We facilitate that conversation so we can make sure the patient or the medical power of attorney has heard the same information as everybody else. Then they can make the best decision for that patient moving forward because they have that information. And a lot of times it's not, "Okay. We've met and now we are done with this." A lot of times it is, "Let's talk about this piece of it today and tomorrow or next week we can talk about this piece of it." Sometimes it's a very traumatic thing that the family and patient are going through, and it takes more than just one sitting to work through all the issues.

01:05:25

Simonpietri:

Prior to the forming of the committee at Fall Hill how were ethical decisions dealt with? Or issues dealt with?

01:05:37

Brothers:

I think pretty much it was the physician. They would call administration. There was no committee piece to it, so it would be pretty much the physician's view of what was happening. They would speak with administration. [01:06:00] In the past, there were lots of opportunities that might now show up at ethics that weren't even recognized as ethical issues back then.

01:06:12

Simonpietri:

So, the idea of what's ethical and what's not has changed?

01:06:17

Brothers:

Sure. Now just something as basic as who's making my decision—patients have rights and patients have the right to make these decisions. They have the autonomy to make the decisions. If we are encouraging that piece to the puzzle, then the role of the physicians has dramatically changed; because back in the day the physicians used to be the decision maker. It wasn't like, "I'm going to go

talk to Suzie Q and see what she thinks about this.” It was like, “No, I am the doctor and I know what’s best.” It was a very paternalistic kind of situation. The doctor would come in and say, “I’ve made this determination. You need to have this surgery and this and this. Then you are going to have this treatment.” And the patient would go, “Yes, doctor.” That’s all changed now. Even something as basic as that has certainly evolved over time.

01:07:19

Simonpietri:

I’m not sure if you can really answer this, but that got me thinking— so the role of the physicians within the hospital has changed over the years that you have been here.

01:07:32

Brothers:

Yes. Not just here; the role of the physician in general has changed. Neither one of you are old enough to know, but way back there was a show called Marcus Welby and he was a physician. I’m sure he had wings somewhere along the line because he knew everything about everything. There wasn’t a disease process that could happen that he wouldn’t know about. He would always make all the decisions for the patients; he would call up and talk to anybody he needed to about the patient. Patient confidentiality wasn’t a big deal then either. They could converse with anybody they wanted to about the patient and what was wrong with them in order to get to the answer. That certainly all changed as well. It used to be the physicians made all of the decisions about what medication to use, what equipment they are going to need for surgery. Now, because of different driving forces, the medications may not all be available in any given hospital pharmacy. They might have to adapt and use a different drug that does the same thing because that is what is available. [01:09:00] Or there could be a situation that they want to use Joe’s Splints, but the hospital has Steve’s Splints. There are reasons that those kinds of things happen, but it impacts the physician’s role and what they’re doing. They are still obviously assessing and making the decisions as to what the possibilities are, but it’s not that they get to go in and say this is what we are doing. They have to go in to the patient and explain the risks, the benefits, and alternatives to what it is they are offering. That’s all new and different too.

1:09:44

Simonpietri:

How has the role of nurses changed within the hospital since you have been working here?

01:09:50

Brothers:

I’m not quite old enough to remember some of the different campaigns. I do remember having a medication cart and all of the medications were on the cart. We would take the cart room to room, bed to bed, dispense our own medication, and give it to the patients. They would fall over if we did

that now. They all have to come from the pharmacy for a specific patient and go in to a specific patient bin. For the longest time the rule for an IV was don't hang anything that you haven't mixed yourself. Now, all of the IVs come mixed from the pharmacy and it's an entirely different process. There used to be a narcotic room and you would go in and count the narcotics. It was in a room behind a locked door and you would dump the pills out and count them. Now they come individualized and they are in a machine. You still count them and make sure the total number is the same, but it's a whole different process. It used to be you would chart on paper and write. That evolved over a period of time. First you went from writing these long narratives to things called soap notes. It was subjective and objective, and your assessment and your plan were there on soap notes; and now there are no notes. Now it's a computer driven thing, and it all gets entered and checked off. That impacts the time with the patient, the time with the computer. Yes, big changes.

1:11:51

Simonpietri:

How has the specialization and departmentalization of the hospital, how has that effected the hospital itself? [01:12:00]

1:12:05

Brothers:

I think on the good side it offers more opportunities; it offers specific skill sets for the people who want to work in them. On the negative side it silos people. It may be that you work in interventional radiology. You may not see anybody anywhere else in the hospital except the people in interventional radiology until you go to the cafeteria. For the most part, the divided departments separate the people, but it does give you more expertise in the area you are working in, which is not a bad thing.

1:12:52

Simonpietri:

What challenges were faced in dealing with the expansion of new services and new technology and how were they overcome?

01:13:03

Brothers:

Again I say it's mostly the education. I think that the organization assesses what new technology they are going to bring in and what the impact will be. How many of X we are going to need so that everybody is then offering the same level of care? You can't get one new defibrillator and stick it in ICU. They are at a higher level of care than the ER, OR, and everywhere else. You want to make sure its uniform across the organization. It involves making sure those pieces happen and making sure everybody knows how to operate safely and has the knowledge base that needs to go with each new pieces of equipment and technology. It impacts the patient because if it's a new process and the patient comes back to the floor and you don't know some of the possible side effects and you don't

know what to look for, then the patient could be in jeopardy. Making sure all that is communicated is extremely important.

01:14:25

Simonpietri:

Your resume it says something about emergency preparedness committee? Can you tell me a little bit about that?

01:14:35

Brothers

I can. The emergency preparedness committee has been around for, maybe 10 years; don't quote me on the ten years, but it's somewhere in that vicinity. Certainly it has taken on lots of new challenges with different things that have happened, with 9/11 and the bombing at the Boston Marathon. [01:15:00] All those things are emergency situations. Actually, this organization participates with the Northern Virginia Emergency Preparedness Alliance; there are 17 hospitals that are a part of that alliance looking at emergency preparedness for the entire area. It looks at all of the pieces. If somebody blows up I-95 how do you get equipment? Can Mary Washington share going across the state? Can we get a piece of equipment from Winchester, if we can't go north or south? What do you do when there are drug shortages? If you have listened to the news, there have been a whole lot of them lately. How do you decide who gets it and who doesn't get it? We plan for all of those pieces to the puzzle. Making sure on a day-to-day basis that if something were to happen, like maybe the generator explodes, what do you do in that kind of emergency? What do you do if there is a power failure and no electricity going to the computers? Do you have a backup plan to make sure that all the charting can get done and all the documentation can get done? Will there be a follow up so that it is not all just lost in cyber space? What do we do if those pieces to the puzzle happen? It's the whole hospital, the whole organization, how that marries with this alliance with northern Virginia, and what that impacts. For trauma there's Inova. They come down to us with the Pentagon—there would've been patients, had there been patients. There would have been patients that would've filtered down here. Are you prepared to receive multiple people, all at the same time? What is your capacity? We interface on the computer every twelve hours to make sure that there is an update that says, "We have these beds available in this care center and these beds available in that care center. We could open up two ORs if we had to. We have this many ventilators that would be available." There is an open communication with all of the people in the alliance so we know what resources we have available for any emergency that may arise.

01:17:43

Simonpietri:

So it's a fairly new development, the emergency preparedness?

01:17:50

Brothers:

It's been changing. There was a Joint Commission chapter—and this isn't my area of expertise—that fell under the environment of care. [01:18:00]It was about making sure you were prepared for whatever was going to happen. It grew and they broke it off by itself. Emergency preparedness is something that gets looked at from a separate menu now.

01:18:18

Simonpietri:

Do you know, was it 9/11 that really triggered like the split/growth or were there other?

01:18:25

Brothers:

No, I think it was more of the natural disasters that pulled it in that direction. Hurricane Katrina certainly contributed to all of that. There are a lot of things that came out of Katrina and allocation of scarce resources. What do you do with that? What if you don't have enough ventilators or all of the hospitals are under water? All of those pieces to the puzzle got looked at, but that came out of those natural disasters. What do you do if there's a 141 car pileup on I-95 and those people are all coming this way? We've had that in the past. Fortunately for us it was at a low rate of speed and there weren't a lot of victims. It was just a little glare ice on the road and everybody starts slamming in to one another. If you have people going at a high rate of speed, then you are talking about a lot of victims very quickly. We've had bus accidents that mean sixty people are coming in all at once. Can you handle that? Are you equipped for that? Do you have the medicine for that? Do you have the staff for that? How do you get the staff in? All of those pieces all feed in to it. Yes, I think 9/11 did have an impact on it, and certainly on people's attitude toward can this happen. The Boston Marathon is going to have the same impact—you get this many people together and this kind of thing can happen.

1:20:05

Simonpietri:

What would you say has been the biggest societal impact on Mary Washington since you have been here?

01:20:15

Brothers:

I have no idea. I would say the changing cultures in the community have had the biggest impact on the organization because it means that we need to have more awareness of cultural diversity. We need to be able to adapt the programs and policies we have to meet the needs of the different cultures in the area, their different religious beliefs, and how that impacts what they want and expect out of health care.

01:21:00

Simonpietri:

Can you give us some examples of how the hospital has adapted?

01:21:07

Brothers:

I'll give you one example. We used to have the Gideon Bibles in every room. That's all well and good if the population all believes in the Gideon Bible. When you have Mormons, people who want the Koran, or people who want to have the King James Version of the Bible, whatever it is. Now there is too much diversity to just offer one religious volume in any given room. Certainly you couldn't have one volume of every religion on earth with a book in a room in order to meet everybody's needs, but you can have them available in a centralized source. We have done that and gotten the information. If somebody comes in to the hospital and wants to have the Book of Mormon or the Christian Science Monitor or whatever it is that they want, we have access to that for them. We can bring that to them to answer those kinds of needs.

01:22:28

Simonpietri:

How has the institution balanced the social goal of providing the community high quality health care and the economics of health care?

01:22:40

Brothers:

I'm not a finance expert. I know that they have certainly looked at their investments and certainly looked at their properties. They have the financial division. They look at the pair mix of how many patients we have that are insured or uninsured or indigent; they look at how that is going to impact the inflow of money. They do have investments. What they are I don't know, but I know they have always been acutely aware of maintaining financial stability in order to be able to ensure the quality care that they want to deliver. Even if it impacts some plan they would rather err on the side of financial security for an ongoing commitment to the community rather than something immediate.  
[01:24:00]

01:24:26

Simonpietri:

I think that's about all I have for you. Is there anything you would like to add that I haven't touched on?

01:24:40

Brothers:

No. I can't wait to see what the next twenty years brings.

01:24:32

Simonpietri:

Do you have any predictions?

01:24:36

Brothers:

I think there will be a bigger outpatient department. More and more of the surgeries are getting quicker and quicker. I think that a lot of the surgeries that used to be done in the hospital and the patients would stay several days are now being done as outpatient procedures. I think that will grow. I think that they are doing a lot more of the surgery like in arthroscopy. They are not opening up your knee: they just go in with these pieces of equipment and they can just fix whatever is torn, ripped, or otherwise not supposed to be there. Now they can do that. They have laparoscopic gall bladders and appendix surgeries. That trend is probably going to continue. I think we will have a larger outpatient population and that the technology will continue to develop. Then I think there are going to be more and more decisions that patients and families have to make about is this an appropriate use of the technology for me, grandma, or whoever it is that, that may or may not benefit. There are going to be a lot more discussions about is it the quality or quantity of life we are looking to deal with? Then how do we help people make those decisions and what is right for them. There will be changes.

01:26:34

Simonpietri:

Okay. Thank you.

01:26:37

Brothers:

Thank you.