Department of History and American Studies
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Mary Washington Healthcare Oral History Project

Mary Katherine Greenlaw

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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00:00:00
Rigelhaupt:
Today is October 9, 2013. I'm in Fredericksburg, Virginia doing an oral history interview with Mary Katherine Greenlaw at her office in the mayor's office in City Hall. And to start, I wanted to ask you about early memories. And when we spoke earlier you said you grew up around Mary Washington Hospital. Your father was on the board, your mother was on the Auxiliary Board. And if I could ask you what some of your earliest memories are of Mary Washington Hospital.

00:00:35
Greenlaw:
My very earliest memory is when I was five years old. I cut my leg very badly and it was stitched up in the old hospital down on Sophia Street. That's my earliest association with Mary Washington Hospital. As I said earlier, my mother loved working in the gift shop. That was her favorite volunteer activity and she did it up until she was well into her eighties and could no longer walk the hill up to the shop. And my father served on the board. I don't remember what years that was. It's always been an important community asset, if you will. It is something that the community felt very proud of. It was considered a privilege to be asked to serve on its board and certainly men and women equally volunteered to be part of the auxiliary. The Auxiliary is large and one of the strongest in the state today. It's just been part of my life.

00:02:05
Rigelhaupt:
Did your father ever talk with you about how he became involved with the board?

00:02:08
Greenlaw:
I don't recall that specific conversation. I can recall his interest in certain things. He served on the building and grounds committee. I know he was extremely interested in the hospital's business relationships with groups of physicians and how those worked because my father was a businessman. But I don't recall how. He was on the board of one of the banks in town and that may have gotten the attention of the folks who nominated folks for the Hospital Board.

00:02:47
Rigelhaupt:
And your mother. Did she talk with you about how she became involved with the auxiliary board?

00:02:54
Greenlaw:
No, not specifically how she became involved. But my mother was a volunteer extraordinaire. [03:00] She was always anxious to serve where she could help. She was chairman of the school board in the city for a number of years.

00:03:12
Rigelhaupt:
Do you have memories of some of the things your father was most proud of in terms of working on the board? The buildings and grounds committee? Things that he was particularly proud of achieving in terms of the hospital and his work on the board?

00:03:31
Greenlaw:
He was very proud of being on the board and of our hospital. I cannot recall specific achievements. I know they had a big project and I know that one of the members of the committee was Betsy Houston. I can remember his praising her and her work. I might add that this would have been, I guess, late-1950s or early-1960s when Daddy served on the board. I can't remember when men first started serving on the board. But the hospital—the funds for the original hospital were raised by women and the hospital was governed by a board of lady managers for many years. It was a long time before men actually showed up on the hospital board. I don't remember what year but it would have been sometime probably in the-1940s. But I don't remember those dates. I do know that for many years it was exclusively a board of women who served the hospital.

00:04:56
Rigelhaupt:
Let's switch gears a little bit in terms of your involvement. How did you become involved with the board in 1978?

00:05:06
Greenlaw:
I was put on the board to be a mental health activist. A friend of mine who was on the board, Dr. Robert Wheeler, and I were active in the local and state mental health association. And at that time, and to tell you the truth to this day, we struggled to be adequately served with mental health professionals in this area. The hospital had no dedicated psychiatric beds, nothing that was labeled as such. There was a wing in the hospital that kind of became that. It was to increase the awareness and the service to mental health patients that Dr. Wheeler recommended that I serve on the hospital board. That was 1978. Harry Bach was the manager. [06:00] I will tell you that we had luncheon meetings. We would get to the meeting and a notebook would be placed in front of us which had all the agenda and all the information and everything. During our lunch we would vote on everything in the notebook and then we would leave and the notebook would stay there. After a few months of this, DuVal Dickinson, who was also on the board, took me aside and he said, "You know, Mary Katherine, we really don't need to be a rubber stamp. I don't think they even need this board. I'm thinking of resigning because I've got other things I need to do with my time." That's how little the board was involved. It was not long after that that Harry Bach resigned or retired that we had a search for a new president or chief officer, and we hired Bill Jacobs. I was on that search committee.

The first thing that he did was to educate the board. Immediately he sent a bunch of us to a conference in Washington on long range planning. I remember going, I think with Dr. Ray Jones; Raymond Jones I believe was with me. I remember that one of the presenters was from Booz Allen consulting company and they made the comment that corporate restructuring is the designer jeans of the 1990s. And sure enough, it wasn't long before Bill Jacobs and I are driving down the road to talk to the hospital in Norfolk—that has now become Sentara Health Systems—about how they restructured. We went into a restructuring process. I had the good fortune to serve on that committee. A former judge here in town whose name is escaping me at the moment, it will come back to me, said that it was the most fascinating thing he had ever done in his life. It certainly was an extremely interesting process as we considered the various ways of restructuring the hospital. Some people were making their foundation the umbrella organization and everything fell under that. We did not choose that model. We created MediCorp. I think it was just called MediCorp. The name's been changed since. Pete Hearn picked the name of MediCorp. But at any rate, we created a corporate structure with corporations underneath as an organization to run the hospital. I was one of the first chairmen of MediCorp. [09:00] It has now evolved into MediCorp Health, or Mary Washington Health Systems. Yes. Somehow we kept the Mary Washington, the name now. I forgot. It was MWH MediCorp. That was the name we chose because we wanted to keep the Mary Washington in it. That was a very interesting process, to say the least. It was a very necessary process. But along the way, one of the things that Bill Jacobs did as president of the hospital was to constantly educate his board. It was very valuable to me personally. I feel like I gained more than I gave as far as a volunteer is concerned, with the experiences that I had and have had. In 1994, I think it was, I found myself in a true conflict of interest. I was working at that time for a developer in office parks and I found myself on the opposite side of a COPN, a Certificate of Public Need application. I was working with a physician who wanted to open an ambulatory surgery or have some ambulatory surgery rooms in his building and the hospital was opposed to it. I was very uncomfortable with that. I resigned from the hospital board because I feared that my work would put me in other conflicting situations. After a few years, the Foundation Board, which is separate from the Health Systems Board, and the operational arm folks, asked me if I would serve on the Foundation Board. It is a true labor of love because the Foundation Board does so much good, gives so much money away in this community, and supports so many health activities in the community. I did accept that and actually have had no conflicts of interest since that original one that made me nervous. But, at any rate, today I serve on the Foundation Board and actually serve as chair of the Foundation Board. But that's my history with Mary Wash. It's evolved in a very interesting way. I had the good fortune to serve on the committee that picked the location for the present hospital, which moved over to that location in 1993. We came very, very close to putting it in Stafford County, where Servicetown is. [12:00] But the demographic center at that time, in 1993, was actually right about where Route 3 and Route 1 intersect. The Route 1 bypass—where Williams Street runs under the Route 1 bypass was almost the demographic center of the area. A decision was made to keep it within the city and to keep it there. We moved across the street because we had an opportunity to buy that property. Of course, there was considerable discussion of what to build, how big to build, and what to anticipate. I can remember someone, and I believe it was a physician,

saying that Mary Washington Hospital would never be a trauma center. Never. Bill Poole must have been chairman at that time. I do remember that Bill Poole and I were pretty much lambasted for spending too much money and building a hospital much larger than the city was going to need. Of course, it immediately was added on to. The interesting thing is the emergency room doubled in size when it moved across the street and immediately had to be added on to again. It was like where have these people been? You can't sit halfway between the nation's capital and the state capital on one of the busiest interstates in the entire nation and not assume you're going to have patients and be busy. That decision proved to be wise, both in location and in size because the location and the amount of ground they purchased enabled them to be able to expand and to put things on the campus. There is a cancer center and ambulatory center, those things. One of the things I'm most proud of is that this hospital has maintained its independence, has maintained its community status, and has maintained its not-for-profit status. That is not easy to do in today's world. It may not be able to continue to do so, but it has always been so aware of its community benefit, the fact that it is very much a part of the community, and that it very much has to support other organizations in the community that support the health and welfare of our community. Of course, that's a large part of what the foundation does. But the health care world has changed. It was evolved dramatically since I first went on. When I first went on the board of the hospital in '78 we had primarily small physician practices, independent physician practices taking care of folks. [15:00] Some of the specialties were in groups like radiology. Today the whole reimbursement is so different and so difficult. Of course, the federal government is so involved that it's a whole different world. It's very difficult to maintain that independence. But we have managed to remain—the hospital's operating board has managed to keep it financially strong and very much a benefit to the community. I appreciate its quality. People do not realize the talent that we have here. It's like the cafeteria at school. Everybody complains about the cafeteria food until you go somewhere and compare it to something else. [laughter] That's a capsule of my involvement in the history as I recall it. We did a lot of traveling around and visiting other hospitals before the '93 hospital was built. But it's constantly changing.

00:16:36
Rigelhaupt:
We'll definitely get to the '93 expansion. But if we could go back to '78 and coming on the board. What do you remember learning about health care and had you had a lot of experience? Or some of the things that you learned immediately about hospitals and health care when you came on the board?

00:17:04
Greenlaw:
I hadn't had a lot of experience. Definitely. I think that the primary thing that any board member learns or is shocked by, regardless of the timing of when they come on a hospital board, is how hospitals are reimbursed and hospitals' and physicians' relationships. People want health care to operate in the marketplace like any other business and there's no way that it can. It is so regulated, and the changes in programs like Medicare and Medicaid and how they reimburse and what they're

willing to reimburse for. [18:00] I can't remember when the term DRGs came in. But one significant change in reimbursement practices was how hospitals became reimbursed—there would be a certain amount of reimbursement available for like an appendectomy and it didn't matter whether your appendectomy was complicated and you needed to be in the hospital five days and somebody else needed to be in the hospital two days. An appendectomy was an appendectomy. I'm grossly oversimplifying this. These are the kinds of things that the hospitals and physicians have to work with in their reimbursement from federal programs, state programs, and private insurance companies. There's a real balancing act. That I think that was the greatest learning curve: how the finances work and how significantly they have changed over the years. It takes quite a lot of time on the hospital board to really grasp that. And by the time you grasp it, somebody passes a new law and changes something. I think people don't realize that hospitals and physician practices have to negotiate with companies like Anthem. They negotiate the discount and Anthem is like the great big gorilla in the room. It's like, "I'm only going to pay you 50 percent of what you charge or I'm only going to pay you 60 percent of what you charge." People don't realize that these companies actually negotiate a discount. One company pays this and another company pays that. If you're paying out of your pocket you're paying more than those insurance companies are paying. Now, all of that is a huge balancing act for maintaining the quality of service, maintaining the very expensive equipment necessary, and keeping a really strong medical staff in place.

00:20:30
Rigelhaupt:
Was the hospital in sound financial shape when you joined the board in 1978?

00:20:34
Greenlaw:
Indeed it was. Indeed it was. It has always been one of the stronger independent hospitals in the state. I don't know how many independent not-for-profits remain but they're dwindling in the state. But I don't know the number. Yes. I agree. I think it's only five or six. [21:00] I remember when we joined at some point an organization called Voluntary Hospitals of America. That was an attempt, back probably in the 1990s, to assist not-for-profit voluntary hospitals to remain strong or remain independent. I don't know whether they're still active with that or not. I don't remember when I went on the Foundation Board, but for the last ten or fifteen years my involvement with the hospital has been with the Foundation Board and not on the operations board. I've been more involved with the community benefit aspect of things and ways in which the foundation board can assist the operating board. I've involved with activities like raising money for the Moss Free Clinic, which is a great asset to this community. We raised ten million dollars to build that clinic and the foundation continues to support that clinic. We currently are raising money for a regional cancer center primarily for the ancillary services that are so important. When you get cancer, you don't go to one doctor. You have four or five different doctors, and you have all these other things that are very important to you, like yoga and massage therapy. Various holistic treatments are part of the total package that a cancer patient needs and the support that the family needs. Those are the kinds of

things that we are raising the money for now, so that our regional cancer treatment center can be a full-service center. That's what I've been focused on, like I said, for the last ten or fifteen years. I'm aware, because the foundation board receives reports on the operations of the hospital, but I'm not involved in it in a detailed way.

00:23:28
Rigelhaupt:
What do you remember about, and again going back to the '70s, what do you remember about the need for the expansion in 1979?

00:23:36
Greenlaw:
That's right. They expanded the 2300 building, didn't they? My father died in 1972 in Mary Washington Hospital. [24:00] He was admitted. He had a stroke, and then he had a cerebral hemorrhage. ICU was full and he was in the hall. He died very quickly. I do recall that very vividly, of course. Yes, I'd forgotten about that expansion. You may not be aware also that the location of the 2300 building; that property was part of what was supposed to be the property belonging to James Monroe High School. James Monroe High School was built in 1952. At that same time, they were looking for a location to build a new hospital and to move the hospital from down on Sophia Street. The city council agreed to sell a portion of the land that they had purchased for the high school to the hospital. My mother was chairman of the school board at the time and she was furious. The school board gave the council holy heck because they never intended to leave the playing fields at Maury. They intended to develop all the playing fields, the football field and everything. This council left them a little short of ground by selling part of it to the hospital. I think the hospital actually may have been built before the high school but it was very close in there, '51, '52. It was not long then that they had to put—I'd forgotten about that addition. I don't recall much about it. What year was that?

00:25:51
Rigelhaupt:
'79 I think—

00:25:51
Greenlaw:
'79. It would have been soon after I came on the board. I don't recall much about it, to be honest. The emergency room moved. That emergency room entrance was—yes. I do remember that. I do remember that.

00:26:18
Rigelhaupt:
Well, part of the reason I ask is that in reading the book Edward Alvey wrote, *90 Years of Caring*, he described it—if memory's serving me correctly—as about fifteen and a half million dollars, which probably in 1979—

00:26:34
Greenlaw:
Huge amount of money.

00:26:37
Rigelhaupt:
And I'm not sure it was the first time, but he noted that bonds were issued to the Fredericksburg Industrial Development Agency. I'm not sure if I have that term exactly right. But was there a sense from the board that this was a new model? The need to issue bonds.

00:26:58
Greenlaw:
I don't recall that. I don't. I simply don't remember much about it. [27:00] I do not know. Yes, it would have been the IDA at that time, the Industrial Development Authority.

00:27:13
Rigelhaupt:
And, again, part of the reason I'm asking is this moment in hospital history. In the 1970s, a lot of community hospitals can't raise the funds through auxiliaries and are issuing debt; it's a different model and necessary for the equipment that you've described. I'm wondering if you have memories about if there was any apprehension from the board that this was a different model, that this might affect the community relationship, the questions of bonds and indebtedness. Would change any of the core values of Mary Washington Hospital?

00:27:50
Greenlaw:
I do not recall any decisions along those lines. They might have taken place but I don't recall anything about it. I do know that there was considerable concern about the amount of debt that the hospital was taking on to build the '93 hospital.

00:28:09
Rigelhaupt:
We'll definitely get there. What do you remember about Harry Bach's decision to retire and the plans for transition?

00:28:18
Greenlaw:
It was considered timely that he retired. We definitely felt we needed more up to date management and leadership. He was a wonderful man and he had been there for a long time, but everybody was ready for him to retire. That's what I remember.

00:28:37
Rigelhaupt:
And you were on the search committee that eventually made the decision to hire Mr. Jacobs?

00:28:43
Greenlaw:
Right.

00:28:44
Rigelhaupt:
Could you talk a little bit about that process and how the board came to the decision to offer the position to Mr. Jacobs?

00:28:52
Greenlaw:
I can't recall the other candidates. I do remember the first time we met. I do remember we were very pleased with his vision. We were very pleased with what we felt was more in touch with contemporary issues. Like I said, this whole business of educating the board was something that was discussed in the hiring process, I remember, on Mr. Jacobs' part. I do believe that he was clearly the preferred candidate. Basically, that's it.

00:29:48
Rigelhaupt:
What were some of the first things you remember him doing in terms of educating the board?

00:29:54
Greenlaw:
As I said, he picked out conferences for us to attend to learn about various things. [30:00] When I first went on the board, the hospital board had very few standing committees; it had had at one time a long range planning committee, which had not operated for years. Joe Rowe was chairman of the board at that time. Joe appointed me chairman of the long range planning committee. That was why one of the first things that I did after Bill Jacobs became president was to go to a planning meeting. I remember it was in Washington, and I remember we drove back and forth. We were always so conservative about spending any money. Eventually we planned a retreat. It was a big deal. We went to this modest little motel in Harper's Ferry because nobody wanted to spend any money. We had

this nice meeting. But we got the clear indication afterwards that if we were going to have another retreat we had to go where there was a golf course. [laughter] We stepped it up a little bit. We had some retreats down at the Tides Inn. We stayed in the lodge. That was one of the first things he did: he got the board off where it could focus on planning or specific issues for the hospital, and had speakers and what have you.

00:31:45
Rigelhaupt:
Do you remember some of the first things you identified as goals or changes you wanted to make in terms of long-term planning when you became chair of that committee?

00:31:59
Greenlaw:
One of the first discussions we had was the shortage of primary care physicians and whether the hospital should get involved in recruiting physicians. That was a very touchy subject, a very touchy subject. In fact, I had one meeting that practically blew up because the physicians on the committee felt that the hospital should have nothing to do with recruiting physicians. But eventually, of course, the hospital did. They do now actively recruit necessary specialties and what have you. Even today we still have a tough time with primary care physicians. Of course, what has happened now, primary care physicians no longer serve their patients in the hospital; they're taken care of by hospitalists primarily. There are just a very few primary care physicians that keep hospital privileges anymore. But at that time, that was one of the first things we identified. The other was the lack of psychiatrists. [33:00] This was part of the '93 planning. We built the Snowden Hospital along with the other hospital. There was an interesting discussion at one of our early long range planning meetings, and I'll never forget this. I brought up that there was this newfangled thing called hospice. They were doing it in England and there were some people in Fredericksburg interested in it. People were saying, "Well, how's it working? Isn't that interfering with the physicians and so on." But at any rate, hospice eventually became part of medical services in Fredericksburg. I think Saint George's Church was actually the spearhead or one of the beginning local groups that got hospice and that concept involved. But I remember that was one of our early discussions. One of the first things and one of the early things we needed to deal with was territory. Potomac Hospital purchased some land in the northern part of Stafford. The decision was do we let that go or do we put a toehold up there? We decided to open a clinic on Garrisonville Road to preserve what we considered, rightly, Mary Washington Hospital's territory. I remember a meeting with the Potomac Hospital board. It was a very interesting discussion with members of their planning committee, our planning committee, and the directors. Eventually Potomac did not choose to locate a satellite in Stafford. The building where Mary Washington Hospital placed a clinic and had a number of physicians was sold just three or four years ago to a private owner. But for years MediCorp Properties owned that building and leased it to physicians from Fredericksburg who had practices there. I can't remember when that happened. But that was one of our early long-range planning discussions. What is our territory? Where do our

patients come from? That's number one: you find out where your patients are coming from. And, number two, you find out what do you need to do to serve those patients.

00:35:51
Rigelhaupt:
So from my understanding, hospitals, particularly nonprofit community hospitals, they're run on a kind of tripartite system with a board, administration, and physicians all invested. [36:00] How would you describe the working relationship between the board and physicians and administration? Particularly after Mr. Jacobs came on and, as you described, was educating the board more and bringing it up to more contemporary standards?

00:36:32
Greenlaw:
There's a natural tension between physicians with their private practices and their businesses and hospitals. It's just inevitable because the physician group—for instance, you take a major group that is absolutely wedded to the hospital, like anesthesiology or radiology. They have their own independent business and their own independent income, but it's absolutely dependent on a hospital that provides them with the working environment that they need. The hospital provides the physical environment, the operating rooms, and the equipment. There is a natural tension there and over the years it has ebbed and flowed. It has been dramatically affected by the reimbursement practices of insurance companies and Medicare and those things. I believe Tom Ryan was the first to hold the position of director of medical services. I'm not sure we had that position until he assumed that. Prior to that, the chief of staff, who was more or less elected by the physician group, would more or less serve as the liaison with the hospital administration. I'm leaving the board out of this because the board is sort of tangential. They're more closely aligned with the administration because they meet with the administration. It has always been a goal to have physicians on the board. There's been, I think, a concerted attempt—and there certainly is on the foundation board today—to see that physicians in various kinds of physician practices are represented on both the operating board, the health systems board, and the foundation board. [39:00] That relationship is one that evolves and has evolved, and at times it has been more tense and at times it's been less tense. I can't describe it in more detail than that. Like I said, at one time when we were building the '93 hospital we actually had physicians angry with us because they felt like we were building too big. I had someone say, "We'll never have neurosurgeons at Fredericksburg. We'll never support neurosurgery here." We had varying opinions of what might be necessary. What I have seen happen, and I think this is irrefutable, is simply that there are fewer private practices and more physicians working for hospitals or working in a large group that has a defined business relationship with a hospital.

00:40:21
Rigelhaupt:
And part of my asking was—as you mentioned, there was the decision I think in '84—

00:40:26
Greenlaw:
Is that when it was?

00:40:28
Rigelhaupt:
—to open in North Stafford. And was there a sense from the physician community that the hospital was going to start opening practices that might be in competition with some of their practices?

00:40:45
Greenlaw:
Yes. In fact, interestingly enough, when the hospital started its home health agency there was that concern. In fact, Jeppy Moss, for whom the Moss Free Clinic is named, came to visit me to talk about that very thing. Jeppy was a close personal friend of my family and Jeppy said, "I'm concerned about this development of a home health agency because I think they're interfering with physician practices." And I said, "Jeppy, how many physicians in this community, other than you, do house visits, home visits anymore?" He admitted that he was probably the only one. The physician coming to the home was dying at that time and is, of course, now gone. It never happens. I remember Jeppy, he was a wonderful man and wonderful doctor and a good friend of mine, being concerned about the home health agency interfering with doctors practices. Anything that the hospital did was questioned along those lines for a long time. [42:00]

00:42:02
Rigelhaupt:
And from my understanding, a lot of physicians, or a physician community broadly defined, might not have been concerned purely in financial terms but the question of interference between—

00:42:20
Greenlaw:
It was definitely not purely financial. It was a question of whether an institution like a hospital could do as good a job and whether the personal relationship with the patient would be there. It was definitely not as much a financial concern as, what's the best way to take care of the patient? Yeah. You're absolutely correct on that. For instance, those concerned about the hospital getting too big or it never having neurosurgery were not so much saying, "We don't want neurosurgeons here because they are competition to us." But rather, "We don't want them here unless they're busy enough to do a really good job." You do not want a specialist who does three things a month, as opposed to somebody who does three a day. It's that simple. You've got to have enough volume to attract the quality of care. The concerns of the physicians usually were not so much financial competition as what is the best way to take care of people.

00:43:35
Rigelhaupt:
Can you remember, and again, trying to maybe stay with your first decade on the board, '78 to '88, just roughly in that time period, physicians coming to the hospital or coming to the board and saying, "These are some areas that we think would better serve patients in the community and these are some areas we think the hospital could expand or try and bring new practices or programs," and really trying to drive the hospital or take it in new directions in terms of patient care.

00:44:11
Greenlaw:
I can't recall that. I can't recall physicians coming to the board. The way that kind of concern would come to the board would probably be through the administration and through the medical staffs' communication with the administration: "This is what we need to do and what have you." Although we were expanding greatly at that time, where this was coming from—it wouldn't have been purely administration because we would have had physicians requesting special equipment and special services in order to do this or that. I can't give you specific examples. [45:00]

00:45:04
Rigelhaupt:
But with, say, special equipment, would the financial—and risk isn't the right word—but investment, however you want to think about it, would that primarily have been the hospital backing it or would physician practices have shared that?

00:45:20
Greenlaw:
It would have been the hospital backing it. Although there's an early example of the hospital choosing not to do something that is interesting; I don't know the years. I can't put the dates on this. When Amos Willis first started doing laser eye surgery—he was one of the first in the state—and he came to the hospital and asked the hospital to buy the equipment for him to do it. The hospital chose not to. And so he went on his own and a lot of people thought that was a major mistake on the part of the hospital. He went on out his own with a large surgery center. He was one of the first in the state to do the laser surgery on eyes and that's an instance where the hospital said, "Oh, no, we're not going to go out on a limb and buy this stuff." They probably missed the boat. But that's one instance where it didn't happen. Now, it is the da Vinci robot. There's an instance where the hospital went out of its way and the Foundation Board held events to raise funds and everything else to fund that piece of equipment. And the early cancer center—I can't remember what the big piece of equipment is right there. I don't remember. We raised the funds for that.

00:47:08
Rigelhaupt:
So earlier you spoke about the corporate restructuring in ’82 and ’83 and I’m wondering if you could reflect back on how it was set up then and why the board made some of the decisions that it made.

00:47:25
Greenlaw:
We had an attorney whose name I do not recall who specialized in that. The two primary models that hospitals were using, and most hospitals were restructuring themselves, were either to make—I don’t remember the legal and tax and reimbursement ramifications of the different decisions. The two main models were either to have the hospital’s foundation be the corporate umbrella and everything flowed from that. [48:00] We chose to keep this foundation as a separate arm. It proved to be a very, very wise decision because today the foundation serves as its community benefit wing, which is a very important thing to us in maintaining our not-for-profit status actually. We separated out services and medical properties. It seems like to me there were five subsidiary corporations at one time under MWH MediCorp, the hospital being one of them. MediCorp Properties still exists as a separate entity. One of the easiest decisions we made—absolutely the easiest decision, I think it took maybe all of thirty seconds—was to decide whether or not the members of the board of directors—I believe they were called that, and not trustees at that time—would be paid or not. Most were. It took us about thirty seconds to say no. It’s always been considered a voluntary position and an honor to be asked. I do recall that was the easiest decision we made. I don’t know how it is today, but we discussed at some length term limits and how they should work or not work. I think they’ve been adjusted since then. I know there are no term limits on the Foundation Board. Every year you sign a statement as to whether you’re willing to serve again or not. It rotates itself pretty healthily without having term limits on the Foundation Board. There’s always a little turnover.

00:50:18
Rigelhaupt:
So in the corporate restructuring you mentioned MediCorp Properties and sort of the smaller organizations under MWH MediCorp. Now, some of those are for profit.

00:50:29
Greenlaw:
Correct.

00:50:31
Rigelhaupt:
And how did that decision come about? That some of the entities under MWH MediCorp, which absolutely maintained its not-for-profit, would be for profit entities?

00:50:51
Greenlaw:
Obviously when you own buildings and you're leasing them you have a business enterprise. [51:00] I'm not sure I can give you a good answer to that question. It is all related to tax consequences. The Stark regulations—the Stark laws that had to do with conflict of interest really dictate how a not-for-profit hospital interacts with its physicians and with its other entities. It has to be extremely careful about that. I'm sure that was part of the decision making process.

00:51:47
Rigelhaupt:
Part of the long history of Mary Washington Hospital is a close connection to the community, from the women's auxiliary that ran it to the commitment to the volunteer status from the board. And I'm curious if there was any apprehension from either the board or the community that the corporate restructuring, even just the language of that corporate restructuring, raised any fear that this was becoming a different kind of organization that might change its relationship to the community.

00:52:27
Greenlaw:
It definitely did. A lot of people were put off by the idea of a corporation period. People didn't like the name MediCorp because of the reference to corporate. That concern existed. I don't know whether it exists as much today. But it definitely was a concern in general population, and in physician population that the hospital's become a big business and people don't like to think of it as a big business. Unfortunately, it is a big business. With my mayor's hat on I can tell you it's a driving force to our economy and a very, very important part of the economic development of this community, with the spin-off. The hospital itself pays no taxes but the spin-off of all the services and the physician groups and what have you is huge. It's one of the biggest employers, if not the biggest employer. It is the biggest employer in the city of Fredericksburg. But yes. There was considerable concern and a dislike of looking at the hospital as a business or having the hospital act like a business. [54:00] There were those who considered it too aggressive by locating other clinics and buying nursing homes and locating nursing homes. There were those who considered it too aggressive as a business. Those concerns definitely existed. To a certain extent exist today. But as I said, there's a natural tension between private and independent health care givers and the big health care system.

00:54:50
Rigelhaupt:
Do you recall any specific effort by the board around '82, '83 or the few subsequent years to try and address any concerns about the corporate restructuring and to demonstrate its ongoing commitment to the community?

00:55:07
Greenlaw:
One concern was to keep the MWH in front of the MediCorp. There were was a concern to keep the hospital, Mary Washington Hospital, in the forefront of all of our literature and of our PR. I can't give you specific examples, but I do remember it being discussed more than once and in more than one situation regarding public relations and advertising and how to present the hospital, and how to remind the hospital that it was a community enterprise. Not too long ago there was a benefit, a fundraising effort that did a roast of me. Fred Rankin was one of the speakers. I was one of the first people he met because I served on that search committee also. I didn't realize this at the time, but he said my conversation with him as a prospective president of the hospital—we were interviewing him for the job—was different than the other search committee folks he met with because I talked about Mary Washington Hospital's relationship to the community and significance to the community and importance to the community. I was very pleased that he recalled this. [57:00] He said he's never forgotten that the community is a very important part of Mary Washington's mission. It is a community benefit. It has been a constant effort to balance that concept with the concept of medical health systems as this huge business and this huge corporate structure. At times it is very aggressive, at times very aggressive. When HCA decided to build a hospital in Spotsylvania, Mary Washington immediately went out to Lee's Hill and set up an emergency clinic and a whole bunch of stuff out there to service that population. It has not been shy about protecting what it considers its territory.

00:58:01
Rigelhaupt:
I'm definitely going to come back to the community benefit and I have some specific questions on it because I think it's a core part of the history. But I guess I want to switch a little bit to the hospital and what I still call the new hospital. I don't know how many years—it has to be twenty—

00:58:27
Greenlaw:
It'll be the new hospital forever. [laughter]

00:58:31
Rigelhaupt:
I don't know what number it will have to reach. But what do you remember about the earliest conversations about the potential to need to or to think about building a new hospital?

00:58:43
Greenlaw:
Probably the earliest conversations were the concern about location. That was a really hard decision. Do we go for the right off 95 or do we stay in the city? We had all kinds of little focus groups and subgroups talking about services, neurosurgery being one of them. Do we ever anticipate being a

trauma center? That was one of them and mental health services was one of them. The mental health services conversation actually got spun off into a separate building, actually building a separate building. That's primarily what I remember. I don't think there was any debate about whether or not to build a new hospital. [01:00:00] We had done all we could in the present location, the 2300 Fall Hill location. At that time the Mary Washington Hospital Association still existed. Anybody who wanted to could pay two dollars and be a member of the association. In fact, when I was asked to join the board I said, "What do I need to do?" They said, "You need to be a member of the association. Pay your two dollars." You had to be a member of the association to go on the board, to be elected to the board. We had membership association meetings related to the decisions on the new hospital. I remember that. I don't remember any question of whether or not to build. It was just, first of all, where, and second, how large. How large was dependent upon the departments and the services, which meant what do you anticipate? We were told at the time by the consulting company—and I don't remember who that was—that health care was changing in such a way that patients in the hospital would spend less time there, and part of that was that DRGs and driven by reimbursement practices. The patients would be sicker and spend less time in the hospital. If I remember correctly, we chose to build more beds than the consultant recommended. We went against their recommendation because despite the trend we were in a community that was growing at a larger rate than the average growth rates for the state or the nation. We felt that that would overcome the trend and indeed it did.

01:02:33
Rigelhaupt:
Probably an argument could have been made at the time that 2300 Fall Hill was out of date, that it would have been almost the same price simply to renovate it as it would be to build a new building and that might have been part of the decision. [01:03:00] But why didn't the board simply replace that building with the same size community hospital?

01:03:14
Greenlaw:
As in tear down 2300 and put something in the same spot or make it the same size?

01:03:23
Rigelhaupt:
Let me rephrase the question. Was the goal in building to not simply replace one building with more or less the same thing in a slightly different place but in fact to build a regional medical campus?

01:03:50
Greenlaw:
That is true. That is true. How much we envisioned of what to do with that campus at the time I can't say. We definitely we needed more ground and we needed definitely a larger building. The emergency room was slammed and horribly overcrowded, and was again as soon as we moved. But

yes, there was an advantage of a campus. We made use of it immediately because we built the psychiatric building and the childcare center. Those were part of the original plan. There was not necessarily a plan. The ambulatory surgery center came along a little later. At the time we made the move we had an ambulatory surgery center located over on Princess Anne Street. We took advantage of the campus to give it a more convenient location and hook it up to the hospital. We did see it as a regional center. And there was, as I recall, never any consideration of trying to do anything more with the 2300 location. We had just totally outgrown it in every way, including the fact that the building itself was obsolete for today's medical care, or for 1993's medical care. [laughter] It changes.

01:05:30
Rigelhaupt:
So to build the new hospital, I don't know how much the cost of the property itself was. But to build the hospital was a significant financial venture.

01:05:47
Greenlaw:
My gosh. I remember Goldman Sachs was one of the ones we interviewed for the financing. Eighty-five million dollars. [01:06:00] I believe that was the original bond issued but I do remember. Eighty-five million dollars sticks in my head.

01:06:07
Rigelhaupt:
Was there any apprehension on the board about that level of investment and potential risk?

01:06:17
Greenlaw:
Obviously you were constantly getting reports from your financial advisors and everybody else as to what you could do. The board was convinced that the hospital could withstand that level of debt. But it was not a decision taken lightly, obviously. One of the more interesting decisions was private rooms, because we went from a hospital that had wards and shared spaces. That was the new thing, all private rooms. But it was something [that might make you hear], "Fancy hospital, a lot of private rooms." You would think about it because it was a change at the time.

01:07:14
Rigelhaupt:
And was that a decision that the administration felt was important, the board felt was important, physicians, nurses?

01:07:21
Greenlaw:
I remember it being part of the building committee and part of the decisions. It was considered the best practice for medical care at the time and the most practical because you can't put a woman and a man in a double room. You can't put an infected person, someone infectious with something contagious, in with a non-infected person. When you think about it, it was more practical as far as use of rooms is concerned. But it was a sea change from the old hospital.

01:08:00
Rigelhaupt:
You've mentioned neurology as a specialty. It sounds like it was being discussed even in the 1980s or it was part of the discussion about medical practices in the region. As the new hospital was being designed and imagined and ultimately built, did the board have a sense of which practices the new hospital might make possible or was that part of the discussion of if we build this it will make X and Y possible and we might be able to bring the specialties to the region.

01:08:37
Greenlaw:
Yes. And it wasn't neurology, it was neurosurgery. That was part of these small groups meeting and deciding what services would be needed in the future and that we should support. [01:09:00]

01:09:03
Rigelhaupt:
And going backward a little bit, it seems like some of the decisions to open North Stafford, Bowling Green, Dahlgren, and Ladysmith in the mid-1980s, those were primary care facilities.

01:09:21
Greenlaw:
Yeah, yeah.

01:09:22
Rigelhaupt:
Was primary care, not acute sick care that hospitals do, was that also part of the thinking? That this new facility might be able to support in new and different ways?

01:09:42
Greenlaw:
Primary care obviously is where medical care meets the patient most intimately. Primary care physicians are the gatekeepers both to specialists and to the hospital. Getting folks out where people need them is a legitimate mission of providing good health care for a community. From a business standpoint, primary care physicians are going to refer to a hospital. At that time Mary Washington

was the only hospital around to be referred to. You get very far down east of us, then those physicians up 301 can use the Richmond hospitals. But for the most part, those patients were coming this way; they just didn't have anybody to serve them in their community.

01:10:53
Rigelhaupt:
You mentioned earlier that some physicians were concerned about the size of the new hospital. Do you remember who any of them were or some of the specific things they said or reflections on the concerns before the hospital opened?

01:11:18
Greenlaw:
I won't name names. And the concern really was centered around the amount of money and the size. As I've said before, there were some physicians absolutely convinced that we would never be a trauma center, and that we could never support neurosurgery. How much? Are we trying to do more than we should? Should we be shipping all these people to MCV, UVA, and Norfolk and not trying to do so much ourselves? [01:12:00] There was the whole business of consultants telling us that health care is changing and our going out on a limb really and building a hospital a little larger than professional consultants advised. If I remember that correctly, and I think I am remembering that correctly, it mostly centered around those discussions. There are certain specialties who feel like other specialties interfere with them; orthopedists and neurosurgeons both do backs, for instance. But it was mostly a concern of not wanting to see the hospital bankrupt itself or a thought that we ought to be sending patients out of town to the bigger hospitals. All of that, however, I think has changed. I don't see that now. It was a huge decision. It was a huge amount of money to borrow and a huge decision to buy that land and build that big hospital. We are a community hospital and obviously the community got involved in the decision. There were those who liked it and those who didn't like it. We got a great big courthouse going up next door to us that the community had varying opinions about. Basically that's what I recall.

01:13:45
Rigelhaupt:
What do you remember about the community input, about people who were very much in favor or people who might have had concerns about the change to this new medical campus?

01:14:05
Greenlaw:
There were some members, primarily older, frankly, members of the association who were opposed. They simply thought it was too big and too much money. There were focus groups on the individual specialties and services—like I served on the mental health one and it had community members on it. It wasn't just board and it wasn't just staff. We engaged the community to a certain extent in the planning. I don't remember who was on the building committee. The building committee may have

been exclusively board members. I think Hunter Greenlaw chaired it. I know Hunter Greenlaw was on it. [01:15:00] I don't recall all the members. I'm sure that's recorded somewhere.

01:15:09
Rigelhaupt:
As is true for every health care system and health care delivery in the United States in general, there are underserved communities. Do you remember discussions among the board or decisions in the administration that the new hospital might open up possibilities to better serve communities that are underserved in health care delivery in the United States?

01:15:38
Greenlaw:
I do not recall that specific discussion. Going in to the Colonial Beach area and going into outlying communities with nursing care and with supporting primary care physicians was specifically directed at meeting that need. The grants that the foundation gives every year—over $600,000 a year that we give every year to organizations—really have that as a mission. We will have small groups doing blood pressure checks and small groups or organizations doing free medical care. There are all kinds of things happening in the counties and in the school systems that we support as an outreach for community health benefit.

01:16:56
Rigelhaupt:
So I'm definitely going to still come to the community benefits. I have a number of specific questions there. But since we are still on the new hospital I'm wondering if you can describe the first time you went into the new hospital after it opened.

01:17:11
Greenlaw:
Oh, my goodness. I can't remember the first time. I really can't. It was pretty overwhelming. And, of course, it's changed. The atrium and all that's there now was not in the original building. I'm trying to remember the original building. I remember going into the emergency room and thinking how huge it was. I do remember the patient rooms were so much nicer, the way they were arranged and all. I can't remember other than that. [01:18:00]

01:18:11
Rigelhaupt:
Do you remember having a sense of any change with physician practices or change in dynamics between physicians, administration, and the board after the new hospital was open and running? Certainly from my understanding pretty early on it's going to show itself to be successful. How those relationships may have changed.

01:18:43
Greenlaw:
I can't say that I remember noticing that. I think the staff morale was high. I think that staff morale is something that the hospital has worked off and on over the years. At times it gets low, at times it gets high. They're always working on that, as in any large organization. The nurses really are where the rubber meets the road. When I was on the operating board and we would talk about budget, I would always talk about the ratio of nurses to patients; the simple fact of the matter is the bottom line is what happens when the patient pushes the buzzer for the nurse. That's always been a real ebb and flow. There have been times when nursing morale was low and then it improves. That's a whole other discussion as far as the operations of the hospital are concerned and physician relationships with nursing staff. That's not one I can really speak to. I just know that that's a dynamic, of course, in any hospital system.

01:20:05
Rigelhaupt:
What are some of the things that the board can do to sustain and improve morale among the nurses?

01:20:16
Greenlaw:
Obviously there's salary, and there's benefits. One of the things that Mary Washington has done is assist with scholarships and assist with training. And, of course, we try to recognize their worth in all the various ways that you can, such as nurse of the month or floor of the month. We recognize the contribution and then we just constantly work with the managers on scheduling and that kind of thing.

01:20:57
Rigelhaupt:
You mentioned physician-nurses relationships. [01:21:00] What are some of the things that came up at board meetings, that the board tried to work on to improve that relationship?

01:21:13
Greenlaw:
Actually, I don't think the board ever directly got involved in that kind of thing. Now, where it was a budget item or a consideration for scholarships and that kind of thing to assist your staff, yes that is something the board considered. But that's not something the board would get directly involved in.

01:21:48
Rigelhaupt:
Do you remember any change in that relationship between physicians and nurses after the new hospital opened? Things that maybe the administration brought to the board's attention at meetings?

01:22:02
Greenlaw:
No, I do not.

01:22:05
Rigelhaupt:
Just before the new hospital opened, the decision was made to hire a president in Mary Washington Hospital and you were on the search committee that eventually hired Fred Rankin.

01:22:20
Greenlaw:
That's right. Because Bill left. Did he leave before it opened? It was very much Bill Jacobs's project, but he left right about the same time, right?

01:22:35
Rigelhaupt:
I think Mr. Rankin was president of the hospital for a few years before Mr. Jacobs retired or resigned—.

01:22:44
Greenlaw:
Okay. I didn't remember that. All right.

01:22:46
Rigelhaupt:
He was hired first to be the president of Mary Washington Hospital.

01:22:50
Greenlaw:
Okay.

01:22:52
Rigelhaupt:
I'm curious what you remember about the search process. You spoke about a conversation that you had about the community—

01:23:03
Greenlaw:
I remember meeting him. I remember being impressed with his experience at the Allegheny Health System, which is a very strong health system in Pennsylvania. I remember that. I remember Fred's

wife Barbara and talking to her about the community. Basically that's it. Again, I have no memory of the competition. He came to us with really strong, strong experience and strong background.

01:23:48
Rigelhaupt:
And what do you remember about the process? And you may have left the board. It was right around '95 I think that Mr. Jacobs left. But do you have—

01:23:59
Greenlaw:
That's true.

01:23:59
Rigelhaupt:
Do you have memories of the decision to hire Mr. Rankin to be president of MWH MediCorp? [01:24:00]

01:24:05
Greenlaw:
I do not. And you're right. I think I left the board in '94. I believe it was '94. I don't remember when I came on the foundation board. I can't remember the date, the year. But I think I was not on the board at that time.

01:24:37
Rigelhaupt:
So earlier, while you were on the board, there was the decision by MWH MediCorp to create a Community Service Fund, which is now the Community Benefit Fund, but it was first called the Community Service Fund. What do you remember about the decision to start that fund and provide financial resources for it?

01:25:01
Greenlaw:
It was partly filled by the money John Lee Pratt left and I don't remember what year that was. But he left a considerable amount of money. It has evolved over the years, but it's really been a wonderful benefit for the community. It is very well managed in that organizations have to submit grants, and we actually have workshops to assist them in preparing grants. The grants are submitted, a committee reviews them, and actually visits the facilities. One of the things that is assisted by this is the FRED bus system, a nice public bus system here which is almost free. I think now it's gone up to seventy-five cents or something a ride. The Mary Washington Hospital Foundation is one of the supporters of that bus system, which enables folks who can't drive or don't drive to get to the hospital and to their doctor's appointments and what have you. I remember it being constantly tied

to the mission of assisting those who contribute to the health care of the community. We've been pretty strict on that. It's not just any organization. It's those that definitely have an effect on the health of our citizens.

01:26:52
Rigelhaupt:
So Mary Washington, the board funded the service fund and then that had a separate board that would ultimately give? [01:27:00]

01:27:09
Greenlaw:
It's not a separate board. It's just a committee of the foundation.

01:27:12
Rigelhaupt:
Okay.

01:27:17
Greenlaw:
Ed Allison has chaired that for years.

01:27:27
Rigelhaupt:
What do you remember about the initial support from the administration for the Community Service Fund from—

01:27:37
Greenlaw:
It probably came from the administration. At any rate, it's always been there.

01:27:44
Rigelhaupt:
And do you remember how administrators have talked about it in terms of playing a supporting role of the mission of the hospital itself and the health care system?

01:28:07
Greenlaw:
It's evolved over the years to where it's become really integral. I'm trying to remember. There's actually an IRS document that we have to fill out every year, [IRS Form 990]. That the hospital [completes Form 990] every year. All of this community benefit has become part of that. It's become part of the whole tax exemption process and everything else. I'm not able to give you a

good definition of that. I can't remember the name of the form [IRS Form 990]. But any rate, it's actually now become a very important working part of what the hospital does and how it maintains its not-for-profit status and its independence and all of that. That's not to say its first mission is to assist the community. It is actually become part of what it's required to do over the years and the changing and tax law, and all of that.

01:29:39
Rigelhaupt:
Certainly one of the ways that the hospital provides a community benefit would be charity care.

01:29:52
Greenlaw:
Oh, my goodness. They have that. Now you really are getting into it. And I'm sorry. I should have refreshed my memory. I'm sure you have the statistics. It's huge. [01:30:00] It's almost like thirty some percent of Mary Washington Hospital's care is charity care. Regardless of the little bit of grants that we give, there's millions and millions of dollars of care are given away in this community because no one is turned away from the emergency room.

01:30:27
Rigelhaupt:
Well, and part of where my question was headed is that it would be a perfectly rational, reasonable decision to use the funds that Mary Washington Hospital gives every year to the Community Benefit Fund to simply reinvest in the organization because it does provide charity care. Part of its community benefit is unreimbursed Medicare—

01:30:57
Greenlaw:
That's correct.

01:30:58
Rigelhaupt:
—unreimbursed Medicaid. And, as you said, a significant amount of money. Why does the hospital and Mary Washington Healthcare continue to prioritize investing in the community benefit?

01:31:20
Greenlaw:
Because a healthy community engages in preventative health care. A healthy community is out there in the localities, in the rural areas, and in the city with the blood pressure checks and the opportunities for people to prevent major illness. We want to keep them away from the emergency room. That is a true community benefit. Anything we can do to do that ultimately reduces that amount of charity care. In the end, if you can help people to manage their weight, their high blood

pressure, or their diabetes—that's one of the reasons for the Moss Free Clinic. If you do not have a clinic where people can go, they're not going to go anywhere until they're so sick they call 911 and go to the emergency room, wind up in intensive care, eat up a half million dollar hospital bill that might have been prevented by some of these outreach organizations and these free clinics. It works both ways. The most important thing we can do for the health of the community is to provide that early preventive care.

01:33:00
Rigelhaupt:
I'm not trying to play devil's advocate but I want to ask a question that's the other way around. Because you mentioned earlier about reimbursement and DRGs and how hospitals get reimbursed for the care they provide. And is there a way in which keeping people healthy could ultimately reduce revenue?

01:33:37
Greenlaw:
It would obviously if we keep people out of the hospital and we have fewer people in the beds. Unfortunately we're not going to keep that many people out. So then it becomes the matter of maintaining a hospital that is the appropriate size for the number of sick people you're going to see.

01:33:57
Rigelhaupt:
And I wasn't trying to imply—

01:33:59
Greenlaw:
Yeah. No, no, no. You're absolutely right. You're absolutely right. On the one hand you're keeping people healthier. On the other hand you've got empty beds in the hospital. Unfortunately, there's always going to be a need for a certain number of beds and the trick is managing that. When we talk about reimbursement, I'll give you an example. Today one of the new wrinkles in the way hospitals are reimbursed is that if you're admitted now for observation you go upstairs to a bed on the floor, you have exactly the same care as every other patient, but when it's considered observation—like you go in with chest pain—that first twenty-four hours is reimbursed at a lower rate. You're not receiving any less service, but that's one of the new wrinkles in the way hospitals are reimbursed. This is the constant balancing act for the hospital operating board and is dealing with—it's incredible. But to get back to your point, the more people you keep out of the hospital the fewer beds you have in use. We have to hope that we don't make a hospital completely obsolete or we will be in trouble.

01:35:35
Rigelhaupt:
And part of where that question was leading is it's incredibly hard to get the balance right in terms of the amount of beds.

01:35:42
Greenlaw:
Absolutely.

01:35:43
Rigelhaupt:
Simply running a not-for-profit hospital in terms of taking care of sick patients is very challenging. And yet Mary Washington Hospital and Mary Washington Healthcare and MediCorp in between has maintained its commitment to preventative care and primary care outside of the hospital walls. [01:36:00] Who has been the most vocal champion of that commitment to preventative care and primary care in community health?

01:36:23
Greenlaw:
That's a very interesting question. I don't think you can say any one person. It's part of the mission. I think because we have voluntary boards the people change, but the commitment has never changed. I really think it has a lot to do with the fact that we have voluntary boards that are representative of our community. I think the smartest decision we made was not to pay the boards and not to offer compensation for sitting on the board. I don't know that it would make any difference whether I got ten dollars a meeting or not. It might make a difference if I got a thousand dollars a meeting. I don't know. I don't know that it would make any difference in the way I think. But somehow, because our boards have always been volunteers and always been committed to the community, that emphasis and that mission has held. That vision has held and they've held the staff to it. I think that Bill Jacobs was committed to it and I think Fred Rankin is committed to it. Despite the fact that they have to deal with really, really tough financial decisions and business decisions every day.

01:37:51
Rigelhaupt:
So looking at the Community Benefit Fund from another perspective as mayor and the way in which the Mary Washington Healthcare has maintained its commitment to community health, what are some of the examples you've seen that it has provided to the city?

01:38:15
Greenlaw:
The Moss Clinic is one. The support of the FRED bus system is another. I am trying to come up with examples. You look at so many different things that happen in town and you'll see Mary Washington Healthcare is one of the sponsors. That happens all the time. This has never come up in Fredericksburg, but in other communities it has. The fact is that the property up there and those buildings up there are tax exempt. [01:39:00] That could be very lucrative real estate tax if it were not a not-for-profit. This community has never, ever considered going after that. Other communities where they have a community hospital have. We never have because we've always considered the benefit of Mary Washington Hospital far exceeds the real estate tax we might make. If, for instance, it were bought by HCA it would go on the tax rolls. We would not consider it a benefit to the community for it to sell that to a corporate owner.

01:40:12
Rigelhaupt:
You talked about serving on committees related to mental health for a number of years. Is that another one of the ways in which Mary Washington Hospital and Healthcare has brought in a community benefit and a community service that—

01:40:30
Greenlaw:
Definitely. Snowden is an asset to the community. The hospital has maintained the Snowden Mental Health Hospital because that's been an area that's chronically underserved. It has relationships with the social services departments, the courts, the police department—it is definitely a benefit to the community. If it were not here, where would those people be? A considerable distance away.

01:41:10
Rigelhaupt:
And on the other side, when you were on the board and the decision was made to build Snowden as freestanding building which involved resources, was this something—and profit isn't the right word but—

01:41:31
Greenlaw:
I know which way you're going with that. First of all, it's lost money for years and years and years and years and years. I think maybe now it's holding its own. It was always known that it would not be a cash cow. The cash cows of hospitals are the fancy stuff, open heart surgery and cardiology. Those are your cash cows. [01:42:00] The psychiatric hospital for years lost money. I think, like I said, it is now finally holding its own but it's an area. Pediatrics. Pediatrics isn't going to make you any money. There are some children's hospitals that obviously survive and survive well as exclusively a children's hospital, but the pediatric unit in a hospital typically doesn't make any money. It was

known from the beginning. When we originally built the freestanding hospital we were in partnership with a group out of Richmond and I can't remember their name. And eventually that dissolved—it's been various iterations. But you're correct; the state of Virginia has a COPN process. You're probably familiar with it. Okay. You have to go to the state to get permission to build medical things. When the state granted the permission for a new hospital in Spotsylvania and in Stafford, one of the things they made the Spotsylvania Regional Medical Center do was have some mental health services. HCA wouldn't have put it in if they hadn't made them because it doesn't make money. So yes, Snowden was done hoping that it would hold its own. It's necessary and we need to support psychiatrics and psychologists and all the various agencies. But it's not a cash cow.

01:43:56
Rigelhaupt:
If I jotted it down correctly, you began serving on the foundation board around 1995.

01:44:04
Greenlaw:
I don't think it was that long ago. I resigned I think in '94 or '95 from the hospital board and I was asked some years later—it may have been as late as 2000. I do not remember the year that I went on the foundation board. But there was an interval of a few years in there when I was not on any hospital board. I don't have anything here that I could look that up.

01:44:39
Rigelhaupt:
What if the question actually was not date specific. What I was going to ask is what have been the places that you think the Community Benefit Fund has done its best work in terms of grants to other organizations? [01:45:00] And particularly areas that you have tried to push or advocate for within the Community Foundation Board?

01:45:10
Greenlaw:
Supporting scholarships for nurses, supporting the Moss Free Clinic, supporting the FRED bus system, and supporting the other free clinics. Dr. Timothy Powell has a clinic right behind BJs. And then, of course, there are a gazillion little things like Shiloh Baptist Old Site, which has a health fair and things like that. I definitely think the support of the Moss Free Clinic is absolutely key because that is essential. We have so many uninsured people. Jeppy Moss used to call them the working uninsured, meaning these are people with jobs. They're not down and out. They just can't get insurance. It is very difficult to insure yourself when your employer doesn't provide it. I know because I've had to all my life. My husband and I have always worked for ourselves. I've never had a company benefit of insurance. You pay through the nose and it can be extremely difficult to get, even today with Obamacare. We see how hard this new system is to implement. At one time one in every seven Virginians did not have health insurance. I think today it's probably worse. Those are

the very people that show up in the emergency room with a crisis that could have been averted if they had been able to tend to the illness earlier. Those are the things that I feel very passionate about. Over the years we've been a big supporter of Germanna Community College's nursing program because it provides us with the help that we need. The nurses are well trained.

01:47:37
Rigelhaupt:
This is kind of a long question so bear with me. It's clear in our conversation, and in others that I've had, that Mary Washington Healthcare and the hospital, over decades as it has become a larger organization, has maintained a community focus. [01:48:00] And since the 1970s it's clear that hospital financing has changed in terms of needing funds in much larger amounts of money and debt; and that's a certain force, dealing with bond markets and financial markets. You mentioned dealing with insurance companies and reimbursement. You mentioned DRGs and certainly coming out of Medicare and now dealing with the Center for Medicare and Medicaid in terms of reimbursement. These are powerful external forces that shape the hospital and the health care system. And it's a big question and, as I said, it was a long question. But what are some of the key reasons that this organization has been able to maintain its focus on the community and community health even while negotiating very powerful external forces?

01:49:10
Greenlaw:
I think we've had strong administrators who have kept current. I think we've had strong physician staff who have been willing to work with the administrators and who are committed to the community. We have one large physician group, radiology that has had practically no turnover. I think both our physicians and our administrators are very strong. I think we have strong boards. We have people who inform themselves and remain responsible. I think we are in a fortunate area. We're in an area that's healthy economically. If we were in an area where the major industry had closed and half the population had gone, it could be a whole different story. The city itself is strong financially, as are the surrounding counties. We've been lucky in that respect and it's largely due to location. We have enough growth to keep things going and so far we've had strong enough leadership to manage the financial strain. The shape of health care, the delivery of health care has changed and will continue to change for the very reasons that you said. [01:51:00] They are very dramatic outside forces that, regardless of what you want to do, are going to change the way you do it.

01:51:16
Rigelhaupt:
From the perspective of the city, as mayor, would there be any effect of the Stafford Hospital drawing patients from the city or is that seen as benefiting Mary Washington Healthcare in general?

01:51:34
Greenlaw:
The Stafford Hospital is seen as benefiting. It's reaching out to an underserved population. It's pretty much growing on target. It hasn't attracted a large physician population to locate at Stafford Hospital, but it has attracted physician populations to serve that hospital. It's in a growth area. Its intent was to serve Mary Washington Hospital because Mary Washington is where the specialties are, where the more advanced surgery is, and the more advanced procedures are. It's a feeder in that respect.

01:52:34
Rigelhaupt:
Actually, to go back to when the new hospital opened. This was an era of another potential change in health care, particularly in insurance. Hospital opened in '93 and the Clinton Administration certainly—

01:53:01
Greenlaw:
That's true, that's right.

01:53:05
Rigelhaupt:
And I think what largely came of it was HMOs and a managed care revolution and obviously not national health insurance. What do you remember how that affected Mary Washington Hospital at the time?

01:53:26
Greenlaw:
I remember discussions and concerns with HMOs and managed health care insurance. The truth of the matter is they didn't materialize to the extent that people thought they would. You even see some very dramatic things happening, like Kaiser and Inova and the break there.

01:53:57
Rigelhaupt:
Interesting. [01:54:00]

01:54:00
Greenlaw:
That's very recent and that's huge that they're no longer serving Kaiser. It's just one of many things that had been discussed, about the way health care is changing.

01:54:22
Rigelhaupt:
Speaking of Kaiser, it's probably 2010, '11, that Kaiser opens a building on the Mary Washington Hospital campus. Was that part of what was imagined as the new campus was being designed and planned, that—

01:54:44
Greenlaw:
I won't say that's part of what was imagined. But obviously they chose to be there because they're going to send their patients over to the hospital and they have a relationship, as did the Veteran's Administration clinic, even though they send tons of patients, busloads, down to the VA Hospital. They wanted to be at Snowden Executive Center because it's right there at Mary Washington. Even though, like I said, most of the patients will use the veteran's hospital, they will still have some relationship there with the specialists in town.

01:55:19
Rigelhaupt:
But working with other health care systems was going to be—

01:55:25
Greenlaw:
Mary Washington has always had some kind of a relationship. Like right now, they have a very close relationship with UVA in cardiology. But they've always had some relationship with some of the larger teaching hospitals around, like MCV and UVA.

01:55:53
Rigelhaupt:
I think those are largely my questions. So the way I often end would be to ask if there's anything I should have asked that I didn't. Is there anything you would like to add?

01:56:10
Greenlaw:
[laughter] I can't think of anything right now. I cannot. I'm glad you are doing this.

01:56:18
Rigelhaupt:
I am as well. Thank you very much for the interview.

[End of Interview]