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

Linda Koch

Interview conducted by
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in 2014

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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00:00:06
Rigelhaupt:
It is April 18, 2014. I'm in Fredericksburg, Virginia in the pharmacy offices at Mary Washington Hospital doing an oral history interview with Linda Koch. To start I was wondering if you could describe your first shift at Mary Washington Hospital.

00:00:27
Koch:
I was on night shift in the ICU. It was a very busy night and I was the new person. There were a lot of senior nurses and they really took me under their wing and we made it through the night.

00:00:52
Rigelhaupt:
So if you could walk me through that first shift. You walk in, you check in at a nursing station and then in terms of treating patients and working with new nurses, how did that go?

00:01:09
Koch:
We got report form the off-going shift and we were assigned two patients. I had my two patients and there some were on ventilators and some were awake. You go in there and do a head to toe assessment and you check on them every one to two hours and provide them with whatever they need.

00:01:37
Rigelhaupt:
How was that first shift in the ICU similar or different from where you had worked as a nurse previously?

00:01:46
Koch:
It was similar. The hospital I had worked at before was a community provider like Mary Washington and it was fairly similar.

00:02:03
Rigelhaupt:
So what made you choose to accept a position at Mary Washington Hospital?

00:02:07
Koch:
My husband got transferred to this area and it was the only hospital in this community and I didn't want to commute to DC or Richmond.

00:02:17
Rigelhaupt:
So thinking back to 1979 and that's a couple of years ago—

00:02:23
Koch:
Thirty-five. [laughs]

00:02:26
Rigelhaupt:
—and this may be a hard question in terms of remembering back that far, but could you describe what you saw as the hospital's core values when you first began?

00:02:37
Koch:
I think the core value was taking care of the community because we were the sole community provider and that is where the focus was. Even the mission was to improve the health status of our community.

00:02:58
Rigelhaupt:
Again, was that something similar to the hospital you had worked at? [03:00]

00:03:03
Koch:
Yes.

00:03:07
Rigelhaupt:
Speaking of the previous work in terms of the other hospital, could you describe your nursing career before you started here?

00:03:15
Koch:
I graduated from a community college in 1977. Then I worked a month on med-surg and then they had an opening in the ICU and I went to the ICU. I really wanted to be an ED nurse, but they told me I needed a year of med-surg; then they put me in the ICU and that's where I worked for quite a few years.

00:03:39
Rigelhaupt:
What was the hospital you worked at previously?

00:03:41
Koch:
Memorial. Memorial Hospital in Maryland.

00:03:47
Rigelhaupt:
So when you first got here in 1979, what did you see as the strengths of the nursing program in the ICU where you worked?

00:03:56
Koch:
The people that I worked with cared about the patients and really worked as a team. For instance, when we would get an admission, and if it was my admission, I would have everybody on the staff coming in and helping get the patient set up, doing the assessments. It was really a team effort.

00:04:16
Rigelhaupt:
Early in your career were you assigned a kind of mentor or someone to show you the ropes in terms of a new ICU unit?

00:04:24
Koch:
Now we have a very formal orientation for any new associate. Back then what they did on my first day was they put me in a room with policies. I read through them and then the rest of my couple-week orientation they just put me with a nurse. It could be Mary one day and Suzie the next. What I found was some nurses do things a little differently; there wasn't a lot of standardization back then.

00:04:48
Rigelhaupt:
What were some of the things you saw in terms of the differences that you thought went particularly well, or maybe you saw as you were learning that you thought you may do differently?

00:05:11
Koch:
I think I wanted to know how to do it right. Sometimes things morph over time, but I think it was also different ways to do things.

00:05:53
Rigelhaupt:
Did you notice any areas in terms of the nursing program that you saw as potential areas for improvement when you first started? [06:00]

00:06:04
Koch:
There was not a lot of autonomy. What the physicians said, we did. I remember one night we had an emergency surgery come back and the physician ordered a particular drug. When I calculated it I didn't get the same thing he did, and he would not back down. He said, "No, that's not right." And I said, "This is the way it's calculated." I was correct but he was not receptive to that at all. Nowadays they would say thank you.

00:06:23
Rigelhaupt:
Was that typical or atypical of the kind of dynamic between nurses and physicians?

00:06:29
Koch:
Nurses and physicians nowadays have for the most part a very collaborative relationship. When I first started my nursing career when they walked into the nursing unit and if you were sitting there and there was no other chair, you gave them your chair. What they said, you did. Working in the ICU, you developed a little closer relationship and trust factor and they may be a little more receptive to what you suggested, but it was pretty much you do what they said.

00:07:03
Rigelhaupt:
So it was a hierarchical relationship?

00:07:04
Koch:
Right.

00:07:07
Rigelhaupt:
So thinking about those first few months that you were on night shift in the ICU, what was the most exciting part of your job?

00:07:18
Koch:
It was watching people who were critically ill and doing interventions and seeing them improve. With somebody coming in with a heart attack, you would do what you needed to do and they survived. That was exciting. Also never knowing what would happen—a patient could be stable and the next thing you know their heart is stopped and you've got to do that intervention. Not that that is exciting for the patient, but it kept me awake at night.

00:07:54
Rigelhaupt:
So thinking about the ICU space at 2300 Fall Hill, could you put in your mind walking in as you would on a shift, where you would go, and where the patient rooms were and describe the space and how the nurses and patients interacted in it?

00:08:14
Koch:
It was kind of a rectangular configuration. There were two double rooms and then the rest were private rooms. You would walk in and there were rooms on both sides; in the middle of the rectangle was the nurse's station and behind the nurse's station was the med room and the nourishment room. You would come in, get reports, and then go to your assigned room. There was a lot of running back and forth to the supply room and to the med room. Nowadays the meds are in the room in the ICU, so a lot of improvement that way.

00:08:51
Rigelhaupt:
How many beds were there in the ICU at this point?

00:08:53
Koch:
I think there were 13. [09:00]

00:09:01
Rigelhaupt:
So again thinking about those first few months working as an ICU nurse, what were some of the challenges about the work that you might have only learned after you started?

00:09:14
Koch:
I think one of the challenges was that there weren't twenty-four-hour ancillary services. There was not respiratory. They were on call. I remember a particular night a patient had to be put on the ventilator and we had to call the respiratory therapist from Richmond to come up and put the

ventilator together. The physician and I kind of said we can't wait because essentially you would have to stand there and manually ventilate them for that hour; so we put the ventilator together and put it on the patient. I think that was probably the night they realized that they need somebody in-house. I mean we didn't even have a cafeteria; we ate out of vending machines at night.

00:09:59
Rigelhaupt:
So the hospital itself really transitioned in terms of activity from day to night.

00:10:05
Koch:
Right.

00:10:07
Rigelhaupt:
Comparing again to what you said was a relatively similar community hospital, was that also the case where you had worked, that a community hospital in the late '70s might have really been different between days and nights?

00:10:19
Koch:
Yes. Because the patients weren't as acute and didn't need those services—the cafeteria, respiratory. We did have lab at night. I don't remember if there was radiology available but I do remember that respiratory was not available.

00:10:46
Rigelhaupt:
I want to ask you a couple of questions about nursing leadership. I don't have a perfect way to ask you how to break this up in terms of years, I was thinking maybe the first five years, but you might break it up more organically based on your jobs. But thinking of those first few years you were here, how would you describe the nursing leadership and the way they worked with staff nurses?

00:11:10
Koch:
I think early in my career, especially working at night, I didn't have a lot of interaction except for in the morning I saw my nurse manager. I didn't really see the CNO. I remember when I first started all nurses had to wear their caps and it's kind of hard working in the ICU with IV poles hitting it. When the Chief Nurse Officer got wind that night shift might not be wearing their hats all night, that's when we saw her. [laughs] Nowadays, the CNO is very interactive and the nursing leaders are more in tune with their staff and empowering the staff to make decisions. I remember calling out—

you feared it because the leader you were calling out to would give you the tenth degree. [12:03] If you didn't have a fever, you'd better get in here. It was more aristocratic also.

00:12:27
Rigelhaupt:
When do you remember that dynamic changing?

00:12:34
Koch:
I think probably in the '90s. I attribute it to when we moved here. Maybe I'm more aware because I was in management and I had more interactions with the senior nursing leaders.

00:12:56
Rigelhaupt:
Would you be willing to describe the nursing officers through the first decade you were here? Who were they and what were some of the contributions they made?

00:13:16
Koch:
Dorsye Russell was the first Chief Officer when I was there and she was very involved with the community. I think there was some turnover like the first ten years. I think then Barbara Kane, who I reported to numerous times from the '90s until the early 2000s and she elevated nursing. We even had a nurse on the board. I think Barbara Kane throughout her forty-something years here really elevated nursing.

00:14:14
Rigelhaupt:
Could you describe some of the ways that she elevated nursing?

00:14:18
Koch:
I think she got the respect of the CEO and physicians. She was able to represent nursing on different hospital and organizational based committees and she was always an advocate for nursing.

00:14:43
Rigelhaupt:
And she played an integral role in the process of the hospital achieving magnet status for nursing?

00:14:48
Koch:
Yes. Her and Eileen Dohmann.

00:14:51
Rigelhaupt:
Would you be able to talk about what you saw and experienced in terms of the hospital achieving that status?

00:15:00
Koch:
I think it was a group effort and taking a framework of what we already had and then enhancing some of the things that we needed to enhance. I was in the atrium the day we got the call that we achieved the magnet status. We had tried previously under a different CNO. It was very exciting for me personally because I had seen so many positive changes over the years.

00:15:37
Rigelhaupt:
What would you point to as some of the positive changes that made it possible to achieve that status?

00:15:43
Koch:
I think shared governance is the nurses making decisions collaboratively at their practice, their environment, and for patient care. I happen to be on the chartered committee of clinical practice. I facilitated that as a manager and a director. It was exciting to see the nurses from different units sitting there and saying, "This is what I think we should do." And then it being approved; because early in my career what doctors said and what the CNO did was what you did. There was no empowerment. I think with magnet, and probably in the last decade, we have been empowered to take control of our practice.

00:16:35
Rigelhaupt:
So the magnet status came a number of years after this facility opened. But it sounds like earlier you said that some of these processes were underway when the new hospital opened.

00:16:48
Koch:
Our chief nurse officer then was Shirley Gibson and she was a big advocate for nursing and helped us get shared governance. One of the things we had was a central nursing office, so if you called out or needed nursing resources it was one area. We decentralized so that units had their own and were responsible. We saw our call-outs go dramatically down because the nurses were responsible to each other. When we moved here it was almost like there is a new building and now we're going to have a new nursing practice.

00:17:51
Rigelhaupt:
What are some of the ways your perspective changed as you changed positions in terms of what you saw in hospital? [18:00] Because you've gone from night nurse in ICU, then a charge nurse in ICU starting around 1987. How did you see the dynamics changing as you took on more responsibility?

00:18:19
Koch:
I think as a staff nurse working nights, you didn't. You only knew your own little area. What we knew was communicated to us through staff meetings. As I became involved in leadership, you see the organization a little bit differently. But also the organization was changing because we went from a sole community provider. We added a nursing home and other businesses. We became a corporation and not just a hospital.

00:18:58
Rigelhaupt:
That was actually one of the things I was going to ask about so I'll jump ahead there. So during your first decade, Mary Washington Hospital became MediCorp. How was that perceived by the nurses in terms of a name and corporate structure?

00:19:19
Koch:
I think for the general nurse I don't know if it made a difference to them. But I think it helped us with our financial viability and that's probably what they understood.

00:19:39
Rigelhaupt:
So it was not something that was talked about among the staff? Maybe the corporation name changed on your badge.

00:19:45
Koch:
No.

00:19:47
Rigelhaupt:
Okay. But you mentioned the expansion of the facilities also during your first decade here. The medical centers in Stafford, Bowling Green, Dahlgren. You opened the ambulatory surgery center. Was that expansion talked about among the nursing staff?

00:20:08
Koch:
I think it was exciting because we were growing and it also gave nurses other opportunities. Some of my colleagues could no longer work nights and it gave them other opportunities while staying in the organization. Also our family members didn't have to go to Richmond or DC because some of the services were now provided.

00:20:48
Rigelhaupt:
So let's jump back again to when you first started. What was your impression of the physician community? [21:00]

00:21:02
Koch:
When I first started? Some of them were collaborative and some of them were scary. [laughs] You know, as a new young nurse I would have to call them and tell them that someone pulled their line out or they took themselves off the ventilator. Are they going to yell at me? Also now we have hospitalists and the primary physicians do not come in at night. But on the night shift back then you would have your primary physician so they could be up all night and be up all day. They cared about their patients and I think that was a strong point. But it's a lot more collaborative now.

00:22:03
Rigelhaupt:
What were some of the things that have happened that have made them more collaborative?

00:22:09
Koch:
I think nursing being elevated and being able to sit at the table. Also, having physician leaders in the hospital who can advocate for the patient and for nursing. I don't remember in the early years having a lot of physicians on staff in leadership roles.

00:22:36
Rigelhaupt:
Are there physicians that stand out to you who have been strong advocates for the nursing program?

00:22:41
Koch:
I think Dr. Fuller. When I was working with the medical units he was the Chief of Medicine. He was my go-to person and he was always receptive to anything I needed and he was a strong nursing advocate.

00:23:11
Rigelhaupt:
When do you remember the first hospitalists coming on staff? And not that you have to answer with a specific year but more about did that begin to change some of the relationships between nurses and physicians?

00:23:25
Koch:
The first hospitalist I remember is Dr. Kin and he was the head of the hospitalist group. We were excited because it was somebody who was accessible. A lot of times when you had to call a physician they could be in their office or they just went to sleep and this was somebody who was here working with you side by side. Dr. Kin was always very collaborative. [24:00]

00:24:07
Rigelhaupt:
Another big part of the hospital is the administration. What was your impression of the administration the first couple of years that you were working here?

00:24:20
Koch:
The first couple of years, like I said, being on night shift you had very little interaction with the administration. You knew who they were. Nowadays the administrators round. They could pop in at 2:00 a.m. or pop down here to the pharmacy and they always had an open door. Back then, there were fewer and there was a different philosophy. Because they were here during the day, I really didn't have a lot of interaction with them.

00:24:55
Rigelhaupt:
Do you have any recollections of Harry Bach who was the Chief Administrator when you started?

00:24:59
Koch:
I remember when he retired because there were pictures in the paper and stuff like that.

00:25:10
Rigelhaupt:
Do you have any recollections of some of his contributions to the hospital that stand out?

00:25:17
Koch:
It's been such a long time.

00:25:24
Rigelhaupt:
Well what do you remember about Mr. Jacobs starting?

00:25:28
Koch:
I remember Mr. Jacobs being very personable and that he took the organization to the next level because he was the one that started with the other businesses. By that time I was working day charge and had a lot more interaction with him. He was always open door, very personable, and always open to any suggestions.

00:26:03
Rigelhaupt:
It was a period of growth in the first decade. How was some of the growth communicated to the nursing staff? Were you likely to hear about it at work before it made the local paper? Did you find about it at the same time as the general public?

00:26:23
Koch:
Probably a lot of rumor mill back then because we didn't have email. [laughs] I think it was more the rumor mill or during a staff meeting that our nurse manager would tell us what was going on.

00:26:40
Rigelhaupt:
So other than the expansion and Mr. Jacobs being open and personable, were there other contributions from his time that stand out in your memory?

00:26:52
Koch:
I think also nursing taking a larger seat at the administrative table and just continuing to be the community provider. [27:08] We were always looking at what can we do next, what are people in the community traveling for that we could provide here?

00:27:22
Rigelhaupt:
Do you remember new programs or services that were implemented while he was CEO?

00:27:30
Koch:
The cardiac surgery program stands out in my mind, and I'm not sure whether he was the administrator at the time. It was probably Mr. Rankin. I was working in the ICU when we moved to the new facility and it was exciting because we were going to do cardiac surgery and our patients wouldn't have to go to Charlottesville, Fairfax, or Richmond. It was kind of scary because it was something new and we were going to have to get a lot of new equipment and a lot of extensive training; that particular program stands out in my mind.

00:28:13
Rigelhaupt:
Well what do you remember about the transition from Mr. Jacobs as CEO to Mr. Rankin—he had been here as President of Mary Washington Hospital while Mr. Jacobs was CEO so you knew him. But do you remember, and thinking about nursing staff, a sense of change when he became CEO of what was MediCorp at the time.

00:28:37
Koch:
I know myself personally when Mr. Jacobs was going we were all very sad because he was a great asset to the organization, but we really embraced Mr. Rankin because he was personable, he was an advocate for nursing, and we knew that he was going to be able to take our organization into the future. I remember being in a manager's meeting and he was talking about the ten-year goal for where we were going to be in 2013; the organization had never set goals like that. That really has been our recipe for success. This is where we want to be: we want to be the best in customer service, the best in quality, and it really has driven all the other initiatives.

00:29:41
Rigelhaupt:
In your recollection from talking to other nurses, was there a sense of excitement that there was going to be this ten-year plan.

00:29:49
Koch:
Yes. Nurses like to have things organized and things in direction. It was very exciting. [30:00]

00:30:03
Rigelhaupt:
So one of the ways hospitals are run is kind of a dynamic between the administration, the board, and physicians. Did you have a sense in the first few years that you were here what that relationship was like between the administration, the board, and physicians?

00:30:33
Koch:
I think the first couple of years, just being a staff nurse, I don't think there was an awareness of the board. I don't think there was a lot of awareness except that there was a CEO and physician group and that they worked together. Not a lot of awareness about what the board did or what the board was.

00:31:02
Rigelhaupt:
It sounds like there was a change at some point and that you became more aware of the role of the board.

00:31:07
Koch:
As a nurse leader, I sometimes would have to present things to the board. It made me aware. Sitting in our leadership meetings we would know what the working relationships or the expectations were.

00:31:27
Rigelhaupt:
Could you describe the first time you presented to the board?

00:31:31
Koch:
The first time was I had to give a report on a project. I was scared to death but they were very receptive and it was like they're normal people! [laughs]

00:31:49
Rigelhaupt:
Do you remember the project?

00:31:51
Koch:
I don't. It's been so many years ago.

00:31:54
Rigelhaupt:
Do you remember a project that you were particularly excited to present to the board?

00:32:02
Koch:
There were a couple process improvements: one was decreasing restraints and another was decreasing pneumonia rates and some interventions that we had done for that. Some clinical projects that I had worked on had been recognized. The board is very interested in knowing what we're doing for our patients and for the community.

00:32:38
Rigelhaupt:
How did you respond to the board being as interested in clinical patient care? Was that something you expected as you became aware of it?

00:32:53
Koch:
I think so because our leaders would always say, "The board is very interested in this." They're community members and they want to know how we're treating patients. [33:00]

00:33:11
Rigelhaupt:
Did you get a sense talking to other nursing colleagues from other hospitals that this was a relatively normal practice that the board would be that engaged with clinical practices and bedside patient care?

00:33:28
Koch:
That's kind of hard to answer because I've never really discussed it with any colleagues outside.

00:33:42
Rigelhaupt:
Okay. Thinking of when you became more involved with the board and more aware of it, are there board members that are particularly memorable for their response to your projects or really being advocates for nursing?

00:34:00
Koch:
I think Mr. Fick and some of the board members that have rotated off were very interested in some of the clinical projects. I think the board as a whole advocates not only for nursing, but for the associates of the hospital.

00:34:35
Rigelhaupt:
So speaking of programs and clinical practices, what would you cite as the most important clinical practices or programs that have started since you began here?

00:34:51
Koch:
We have quality indicators and I think that CMS dictates that we do certain things. You give certain antibiotics and you give certain drugs to prevent blood clots in the legs. I think some of those programs have been very important because I remember as a night shift nurse, there were always patients arresting at 6:00 a.m. We couldn't figure out why. What was happening was we would get the patient up and they were throwing clots from their legs. Research showed that they needed to have their blood thinned. Every patient that comes into this hospital, if they're going to be on bed rest or have restricted mobility, we make sure they either get a drug or some other kind of device to make sure that they don't develop clots. I think over the years we have learned that some things that we did or didn't do adversely affect patient care and we are now making sure that we standardize care. Does that answer your question? [36:00]

00:36:06
Rigelhaupt:
Well and in terms of programs, I was thinking of things like cardiology, neurosurgery—

00:36:20
Koch:
Being a trauma center, like you say, cardiac surgery and neurosurgery, which we didn't offer before. I was director of the medical care center when we got our stroke designation. That was exciting because we didn't standardize our stroke care and with that designation it gave us the infrastructure to make sure that if you had a stroke, you were getting the best care and the best outcome, hopefully. That was exciting for me because I was intimately involved in getting that designation in and setting up that program.

00:37:02
Rigelhaupt:
Could you talk about your contributions to that? What you did and who you worked with?

00:37:07
Koch:
We worked with nursing and administration and said, "We want to do this." I had a nurse manager who was passionate about it and we designated that particular unit for all the stroke patients to go there. We got a nurse who was also passionate and she kind of ran that program to make sure that they were getting this medication at this certain time, and they were getting rehab. We also worked

with a neurologist to set up standardized order sets. It was a multidisciplinary group, and it's still going on. I think they've recertified; they'll probably be going on their third set of recertification. It really has served the community well because if you have a stroke and you get to our facility within a certain amount of time we can give you that clot-buster and you'll probably have a better outcome than you would have if you went to a hospital without that program.

00:38:09
Rigelhaupt:
Who were the nurses? You said there were a couple that were very passionate about the program. Who did you work with?

00:38:14
Koch:
Jackie Thompson was the nurse manager. Eleanor Redmond was our stroke coordinator and still is today. Dr. Alattar was the medical director, the neurologist. It was definitely a team effort but it was exciting results.

00:38:35
Rigelhaupt:
Is starting a program like the stroke center and having that designation as a team effort as you described it, has that played a role in developing more of a collaborative relationship?

00:38:49
Koch:
Absolutely. Especially with the physicians; we had never seen physicians. When the Joint Commission came in to do the one-day survey, that physician was sitting with the surveyor all day and was part of the team. [39:00] The nurses developed that rapport so that if they had a stroke patient and they had a question, they collaborated with that physician and the physician was receptive. You're absolutely right. It also led to other designations for other diagnoses, like hip and knee, to be best in class.

00:39:41
Rigelhaupt:
If I'm not mistaken the cardiac surgery preceded the stroke center.

00:39:52
Koch:
Cardiac surgery did. That was probably in the mid-'90s and our stroke designation was probably 2000s.

00:40:11
Rigelhaupt:
In your experience did you see some of that collaboration between physicians and nurses starting to develop through the implementation of the cardiac surgery program?

00:40:21
Koch:
Yes. Because you were working with one physician—you spent a lot of time with those physicians and their patients and it did help develop that relationship.

00:40:39
Rigelhaupt:
Has that been true with the expansion of the cancer programs that Mary Washington is offering?

00:40:47
Koch:
The cancer program is very exciting and I happened to be there for that too and it was one of the first service lines that we developed. We met with all the oncologists on a frequent basis to develop how we wanted the cancer program to look, and we developed radiation and surgical oncology. It was a very exciting collaboration.

00:41:18
Rigelhaupt:
Could you talk a little about your contributions to what you worked on in terms of starting the cancer program?

00:41:23
Koch:
I was the director at the time and I had a nurse manager in oncology and a nurse manager for radiation oncology. With all the physicians we also had a tumor board—which that particular manager helped build—with the three nurse managers, and all the oncologists, and all the ancillary. To set up a program you need dieticians, you need radiology, physical therapy, etc. I kind of did the coordination and the support but the team really did the work. [42:00]

00:42:09
Rigelhaupt:
Who were the nurses?

00:42:13
Koch:
Renee Shank, Diane Tracy, and Colleen Blankenship were the nurse managers.

00:42:32
Rigelhaupt:
It sounds as though teamwork has become a more prominent part of patient care and practices here. But on the other side, as it has grown considerably in size, was some of the more informal discussion, because it was just much smaller when you started, beneficial to patient care?

00:43:07
Koch:
Can you kind of restate the question?

00:43:11
Rigelhaupt:
The opportunities for discussions, knowing the staff more, much smaller—was there a way that information was exchanged informally that as the growth of the organization has just made it harder in terms of size?

00:43:29
Koch:
I think when I first started there were fewer people and fewer departments and fewer hoops to jump through. Now because we're such a complex organization, it may take a little more time. But also you have to keep in mind if I do this, if I start this program, what else does it effect? I think as you become more complex the communication and the processes become more complex.

00:44:08
Rigelhaupt:
So one of the phrases you've used a couple of times has been standardization. I'm wondering, is that related to ideas about evidence-based medicine?

00:44:19
Koch:
Absolutely. I think now we base our practices more on evidence-based practice and standardizing. For instance, charting and the expectations for nursing—way back when we had a piece of paper and you wrote down whatever you did. Now the nurses have computerized charting and it prompts you to make sure that you're covering and standardizing your charting. But we have a lot of standardized order sets and protocols, but it's based on evidence-based practice.

00:44:47
Rigelhaupt:
Could you describe the process by which evidence-based practice became part of patient care and work at Mary Washington? [45:00]

00:45:06
Koch:
I think some of it was government driven. When the government realized if you treat this patient with pneumonia with this antibiotic, they have a better outcome so we're going to mandate that. I think then we said, "Hmm." Then also people starts questioning, "Well, why are we doing that?" Just because we used to do it that way? Why don't we see what's the best way to do it? I think the emphasis on quality has also helped with that. We don't start anything anymore without saying where is the literature? Where are the studies? What else can we benchmark with somebody else to see if this is the best practice?

00:45:55
Rigelhaupt:
Was there any friction created when you tried to implement evidence-based medicine?

00:46:09
Koch:
All the health care providers need to be convinced and sometimes it's, "I just want to do it this way." So yes, there has been friction, but I think once you show people the data, you sometimes just have to say this is the way it's going to be because evidence shows it.

00:46:38
Rigelhaupt:
If you can recall, are there ways in which you as a director and other nursing leaders made a concerted effort to share the evidence-based medicine best practices through the nursing staff and how that was done?

00:46:53
Koch:
I think Magnet really brought to focus evidence-based practice for us. We have shared governance, and part of that is when we make changes or suggestions we use evidence-based practice. Like I said, before we implement or change anything we're checking to make sure it's best for our patients.

00:47:25
Rigelhaupt:
Costs are a big idea in terms of medicine at this moment in time and I don't think that's always been the case in terms of the acute awareness. Thinking about your career as a nurse here, can you think of the year in which the nursing staff became more aware of considering cost?

00:47:50
Koch:
I think probably not until the last ten years that even nurse leaders—when I first started as a nurse manager I didn't have to worry about the budget. [48:00] Somebody else worried about that. We just gave the care and nobody had to worry about using too many supplies or using the most expensive drugs. But over the last ten years, we've had to make that focus because of payer changes and administration can't do it alone. We need everyone to buy into it and give feedback and sometimes the best ideas come from the people doing the work.

00:48:34
Rigelhaupt:
Are there ideas that stick out in your mind that nurses or colleagues of yours have brought to the administration?

00:48:43
Koch:
One thing was we have bag baths. They look like baby wipes and someone said, "Why are we using those? Why don't we just use washcloths?" Some of the things they've talked about is linen. You don't change your linen every day at home, should we change just Monday, Wednesday, and Friday? Those were just some of the ideas that were talked about. They usually come from staff.

00:49:23
Rigelhaupt:
Do you think the conversations would have been as open without some of the teamwork that had been built up years before this in terms of bringing ideas to the administration and leadership?

00:49:36
Koch:
No. Teamwork and collaboration have been essential to that. Because essentially it's, "We're all in this together." We know we can do it and you at the bedside know how to do it best.

00:49:53
Rigelhaupt:
Do you feel like there have been strong advocates from the administration for really pushing that idea about teamwork, that we're all in this together and really making sure that from staff to nurses to physicians are trying to deal with problems collaboratively?

00:50:08
Koch:
Absolutely.

00:50:10
Rigelhaupt:
Who were some of the administrators or nurse leaders—?

00:50:14
Koch:
Our CNO previously was Eileen Dohmann. Marianna Bedway. Barbara Kane. Nurse leaders and even our administrator of the hospital Kevin Van Renan. It's we're all in this together and they are very open about what we need to do and take suggestions. They say, "Yes, we can do this. Or, no we can't." Or if you want more nurses—I remember Eileen saying I can't give you any more nurses, but I will help you be more efficient and give you more time back to the bedside. [51:00] There was a project called "Transforming Care at the Bedside," which looks at inefficiencies. They looked at how far nurses had to walk to get linen. Maybe they might want to put linen here and here? That gave the nurse thirty minutes back in her day that she can spend at the bedside and not feel cramped. Resources weren't available to give you more, but you can use the resources you have better.

00:51:33
Rigelhaupt:
So part of what you're describing is a clear sense among nurses and hospital administration staff the importance of collaborative teamwork based practices, but as you described earlier when you started physicians weren't necessarily used to practicing that way, late '70s. What have you witnessed in terms of the medical staff from the physician perspective and how they perceive the emphasizing of teamwork?

00:52:04
Koch:
I think starting with our physician leaders they have, over the last ten years, been real advocates for nursing and teamwork. Knowing that we're working side by side and having those hospitalists; they're here twelve hours a day and you get to know them and know the expectations It really helps because you're calling maybe one or two hospitalists instead of five or six different primaries. I think that has supported nursing and teamwork too.

00:52:41
Rigelhaupt:
And less likely to have to drive in at 3:00 in the morning when you call them.

00:52:44
Koch:
Right. Because they're here. If a nurse says, "I don't want to call that doc at 3:00 am." Then we might not have so good of a patient outcome because she doesn't want to wake the doc up, but the hospitalist is right there and we can get that so it doesn't get any worse.

00:53:09
Rigelhaupt:
So the new Mary Washington Hospital that we're sitting in—despite it having celebrated its twentieth anniversary—what if you can go back and think about when you first starting hearing about it as possibility? Was there water cooler talk about building this new facility? What do you remember hearing about what you would describe as the rumor mill?

00:53:34
Koch:
The rumor mill was we were told that they weren't going to build any more beds than we already had. And we were like, "Hmm. Why are we doing that?" It was scary because it was like, "Oh my goodness." I remember the first day walking into the new ICU: it was like a new job because we didn't know where things were. Even the lab wasn't where it used to be. It was a little scary when we first went in, but it was exciting because everything was new. It was clean, shiny, and bigger. The staff was involved in the planning and I remember they gave hardhat tours open to all the staff; it was more involvement with the staff. I think they were really engaged and excited. [54:00]

00:54:09
Rigelhaupt:
So again it even sounds like building this facility involved more collaboration.

00:54:37
Koch:
It did.

00:54:44
Rigelhaupt:
Were there things you remember in terms of either meetings or the tours, as the construction was underway that you as a nursing leader at this point were advocating for and wanted to see at this new facility?

00:54:57
Koch:
I remember doing the hardhat tour thinking, "Wow. This is really neat." We could go back to the staff who hadn't had a chance to take a tour and say, "You need to get over there. It is really nice!"

00:55:13
Rigelhaupt:
Could you just, if you can remember the last time you walked through this facility when there were no patients but right before it was probably set to open? What was it like?

00:55:27
Koch:
It was very quiet and just serene. And you kind of imagine, "Next week it's going to be hustle bustle." [laughs]

00:55:41
Rigelhaupt:
And you were involved with the move over?

00:55:42
Koch:
Yes.

00:55:44
Rigelhaupt:
Could you describe your involvement?

00:55:45
Koch:
I helped staging because I was still working in the ICU. We needed to make sure there were nurses in the new ICU and nurses in the old ICU to take care of the patients; we had to double up. It was a concern because moving ICU patients, except for mothers delivering babies, they're more sensitive to being moved. We had a patient that was not doing well that day and we thought, "How are we going to move him?" Then he kind of stabilized. But it was just the coordination of being here in the new facility and saying, "Okay, bring the next patient over." Then once we got here it was going back to the old facility because it was empty and there were a few things left there. It was sad but exciting.

00:56:51
Rigelhaupt:
What was that like to walk through where you had worked at that point for almost twenty-five years, seeing hundreds if not thousands of patients and then it was just empty? [57:00]

00:57:01
Koch:
I know. Like I say, I just remember having that scary feeling when I walked into the new ICU: you lose your comfort zone because it's new. It was kind of sad because there were a lot of memories in the old facility, and a lot of relationships. And there were some of the good things because it was like, "New cafeteria!" [laughs] And expanded services.

00:57:40
Rigelhaupt:
What were some of the most exciting new programs or opportunities for nurses in the new facility?

00:57:47
Koch:
I think some of the new equipment like automatic blood pressure cuffs, automatic thermometers, and new beds that weighed patients. As an ICU patient, you had to get them up on a sling to weigh them. It was just the technology that made our work a little easier.

00:58:30
Rigelhaupt:
Were you aware as this facility was being talked about and being opened that it had the potential to become the base of a regional medical center?

00:58:41
Koch:
No. I think at the time that we were discussing it and building it because it was such a big project. I had no idea that we would grow as much as we have.

00:58:59
Rigelhaupt:
What are some of the reasons that you think, MediCorp then, Mary Washington Healthcare has been able to grow so much since this facility opened?

00:59:09
Koch:
I think because our leaders had a strategic vision and also the community support. With our mission of ensuring that we were meeting our community needs, I think the two of them combined helped us make us what we are today.

00:59:35
Rigelhaupt:
And a similar question I asked about this facility, the water cooler talk, what do you remember about the first discussions of the possibility of Stafford hospital?

00:59:46
Koch:
I think it was like, "We were having bed crunches." I mean we were boarding patients in the ED and it was like, "Oh yeah, we really need more beds." [01:00:00] I think most of the discussion was where it was going to be? Is it going to be down in Spotsylvania or Caroline County? I don't think anyone really realized they were going to put it at Stafford. Staff talk was, "Where are they going to put it. Everyone agreed there was a need because we were doubling patients up in single rooms. We were using endo and PACU to board all these patients. I was director of the medical unit and they were mainly medical patients and we were putting them in every corner of this hospital.

01:00:42
Rigelhaupt:
So it was clear you needed—

01:00:44
Koch:
Yes! Come on Stafford! [laughs] Since Stafford opened, we have not had to put people in cubbies.

01:00:54
Rigelhaupt:
Were you involved in the planning process of Stafford as well?

01:00:57
Koch:
Yes I was. It was a very collaborative effort: nursing staff and every discipline. For Stafford, it was exciting because we got to pick the palettes of the colors, what type of med carts, and what kind of nursing model they were going to do. It was going to be brand new. It's probably an experience that not many nurse leaders get to experience, starting a whole new facility from scratch.

01:01:39
Rigelhaupt:
What were some of the things you learned from having opened this facility that you applied to Stafford?

01:01:47
Koch:
I think just keeping everybody informed and always be prepared for the unexpected. When you think you've got everything covered, there's always that little detail. But I think it's just involving all the stakeholders. I think that's probably the biggest.

01:02:16
Rigelhaupt:
What was it like to build a nursing program from the ground up at Stafford?

01:02:21
Koch:
It was collaboration with the nurse leaders. There were some discussion of, "Okay, should we do it like Mary Washington? No, let's do it this way. What's the CNA/nurse ratio? What should the CNAs do? What should the nurses do?" It was very interesting. We were trying to benchmark what does this facility do? We were trying to also enhance customer service because Mary Washington had always struggled with customer service. Could we do something differently at Stafford that would enhance the patient experience with the nursing model? [01:03:00] I mean everything from drug distribution. They have two sets of med machines where here at Mary Washington they only have one. Does that help? Probably just details like that; just thinking out of the box.

01:03:26
Rigelhaupt:
Were there things you learned as you were planning at Stafford that you then implemented here?

01:03:32
Koch:
Yes. And vice versa. I mean we've learned from one another over the years. From my pharmacy experience I learned that pharmacy from Stafford was not overseen by the same person at Mary Washington. There were some other departments like that; practices varied. By having the same oversight you're able to make sure that there's some standardization with that. And I think the same goes with Stafford every time Mary Washington learns something nursing-wise—for instance if a regulatory body comes in and says you need to be doing this differently—that learning is also carried over to the other facility. Or if somebody comes up with an idea and says, "Let's do it this way." We always share that back and forth.

01:04:15
Rigelhaupt:
So one of the other things I want to ask about is the community benefit, the Community Services Fund, which are a big part of—well MediCorp then, now Mary Washington Healthcare. From your perspective as a nursing leader, what were some of the things that stand out about how you became

aware of some of the community benefits in terms of things like the Moss Free Clinic and those sorts of things?

01:04:33
Koch:
Sometimes I think nursing isn't aware of everything the organization does. I think probably over the last five or six years the organization has done a better job of saying this is what we do and this is how you can participate. Like the Moss Clinic: we need nurses to help volunteer. We have more health fairs, and getting nurses involved in those.

01:05:08
Rigelhaupt:
Are there community benefit programs that stand out to you as most beneficial to the community?

01:05:16
Koch:
There are numerous ones. I think the Moss Clinic really stands out in my mind as serving that population that can't afford their medications or their medical care. I think just some of the things that they do: women's services and care for babies. [01:06:00] Even to the point of making sure that they're fitting into their car seat. Their bereavement program. Our foundation and some of the grants that they provide for different needs in the community.

01:06:20
Rigelhaupt:
Are there ideas that you can think of or maybe had discussions with in terms of they became grant-funded or made it up to administration in terms of community benefit that came from nurses and what they were seeing on the floor and with patients that you shared?

01:06:40
Koch:
I can't think of anything right now, but if there is a need they usually let somebody in leadership know. Then if some funding for the foundation and the foundation is always very accommodating.

01:07:06
Rigelhaupt:
I think I'll pause there and then maybe—I'm just going to say this for the transcriptionist. A second interviewer is going to start and her name is Dana Nordling and for the purposes of transcribing her last name is N-O-R-D-L-I-N-G. Dana is going to take over with some questions.

01:07:38
Nordling:
So I want to turn back now to your education. So you said you had done a nursing program with your associate's degree. What was that nursing program like?

01:07:54
Koch:
It was focused on clinical and it was a two-year program. It used to be a program run by the hospital, a diploma program, and then the community college took it over. I went straight out of high school. A lot of my classmates were second career so they were older and it was pretty intense because we went all summer to get our associates in two years.

01:08:32
Nordling:
What made you want to be a nurse?

01:08:37
Koch:
I always liked the excitement of helping people. I had some relatives who had been terminally ill and the nurses were wonderful and I thought, "I want to be like that. I want to help people." [01:09:00] As a matter of fact, three of my best friends and I all became nurses and it was because of the experiences we had from other nurses.

01:09:15
Nordling:
So the associates nursing program, when you finished that were you an RN?

01:09:31
Koch:
Yes.

01:09:40
Nordling:
But then you went back for your bachelor's down the road?

01:09:42
Koch:
Right.

01:09:43
Nordling:
So that was to get your BSN?

01:09:45
Koch:
Right. I was working full time. In nursing it was you had your diploma or you had your associate's degree, but then we ratcheted it up and then we said bachelor's and now master's. There weren't a lot of bachelors programs and it wasn't the expectation. When I became a nurse leader I wanted to get my bachelor's. I went to Old Dominion while working full time; I was taking a class here or there. But I felt that it was more beneficial because what they were teaching I could go back to work and experience that real time.

01:10:36
Nordling:
So I know now that there is a shift towards all nurses having their bachelor's. How will that impact nurses here at MWH who don't have a bachelor's?

01:10:51
Koch:
I think it will positively impact them because I think the bachelor's program not only gives you a little more clinical expertise, but it also focuses on leadership and as a nurse you've got to be a leader. You have to be a leader of your patient and coordinate that care. The organization is very committed to helping people in that situation. There are scholarships, and the University of Mary Washington will have a program. There are a lot of online programs. It's easier now to get your bachelor's. When I went there were no special online programs or RN straight to master's programs. It was more traditional.

01:11:41
Nordling:
How have nursing programs changed from the time that you did yours in the '70s to now with the content or clinical aspect of it?

01:11:57
Koch:
I think there's a lot more diversity in their clinical. [01:12:00] It used to be in my program you go to the hospital and you go to the nursing home. Now they're going out to public health, the jail, infection control, and there are also different tracks. I run a pharmacy. In an IT meeting, I had a nurse who was working on her masters in nursing IT. There are all kinds of different focuses now and you can go to different tracks. I think it's still clinical, but more of a variety of clinical tracks that you can do.

01:12:51
Nordling:
Does Mary Washington help employees continue their education?

01:12:56
Koch:
We have tuition reimbursement; the foundation has scholarships and grants. They're very supportive. When I got my bachelor's the hospital paid for that and also helped me with my master's.

01:13:14
Nordling:
What is your master's in?

01:13:16
Koch:
It's nursing administration. I also have a certification in advanced nursing administration.

01:13:28
Nordling:
Another big theme in health care right now is the role of LPNs. Some places are kind of phasing them out, other places they're still going strong. I was wondering what you've observed here at Mary Washington Hospital with the LPNs?

01:13:47
Koch:
When I worked in the ICU when I first started, I worked with two LPNs who had been there probably ten, fifteen years. They were the best nurses I ever worked with. A lot of their experience came on the job. I think patients are so complex now and the expectations with medications and technology that I don't know—the LPNs don't get that foundation in their education. Our organization has provided opportunities for those LPNs to get their RNs. I mean they're wonderful nurses, but most of those programs are only a year and it doesn't give them enough of the information and education. RNs do the assessment and there are some medications that LPNs can't give too.

01:14:50
Nordling:
So when you transitioned from a nurse to charge nurse and then from there to a manager, how did you find that transition? [01:15:00]

01:15:03
Koch:
I went from night shift and then being the day charge and being the manager. I had worked in this unit for numerous years so I was now managing people I worked with, and that was a transition. But they were also very supportive. Nowadays we have a formal mentor and some leadership training. Back then my mentor was the psychiatric nurse manager and she said just call me if you need anything. Essentially the nurse manager back then was just a charge nurse and you had some extra responsibility. Now the nurse managers have budget and a whole gamut of things. They are their business manager and leader and CEO of their unit.

01:16:01
Nordling:
Do you think that having nursing experience makes you a better manager or administrator?

01:16:11
Koch:
Of course. [laughs] My role right now is pharmacy director, which totally has nothing to do with nursing, but everything I have learned in nursing I use on a daily basis. It is troubleshooting, conflict management, project management, and multi-tasking. I think nurses are the best multi-taskers.

01:16:49
Nordling:
So what was it like being a nurse at Mary Washington Hospital in 1979?

01:16:58
Koch:
It was rewarding. You came in and did your shift, took care of your patients, and there wasn't a lot of other career development or a lot of autonomy. I think nowadays you find your staff nurses are on committees, are developing their career, are involved in performance improvement, and they've got autonomy and they're empowered to make decisions.

01:18:00
Nordling:
I'm going to transition over to technology. How did the introduction of computer technology impact nursing here at Mary Washington?

01:18:18
Koch:
Some of the technology like I said before was the beds that you could weigh patients, which really made the nurses' day easier. Probably ten or twelve years ago we started with barcode scanning, which patients got a barcode on their arm and you scanned the med and the armband and the

computer says yes its right med, right patient. Nurses were a little apprehensive but that's part of their daily routine and it's really a safety feature. Probably in the last five, six years instead of paper charting it's all on computers and I think for the younger generation that are computer friendly, it's great. For some of the older nurses it was a little transition. I think sometimes as a nurse you have to make sure that you're not spending so much time charting on your technology that your patient perceives you as not giving them enough attention. I know sometimes when those systems go down, it's a mad scramble of how did we used to do it?

01:19:37
Nordling:
So going back to that struggle of maintaining your balance between patient care and other duties like charting on the computer. Do you think that is a big challenge that nurses face today with technology?

01:19:58
Koch:
I think it is. It's designed to standardize and expedite things. The barcode scanning slows the nurse down, but it's necessary and they realize that. So yes, I think it does slow them down. But if the charting decreases a couple of forms or duplicate charting, then they realize that. I think some of the technology too is drugs. You don't think of that, but when I worked in the ICU and someone came in with congestive heart failure we would put blood pressure cuffs on all of their limbs and then it would rotate. So then what it was doing was keeping the fluid from going to their heart and lungs. It was called rotating tourniquets. We don't use that anymore. We use a drug that does the same thing. I think some of those drug technologies have made the nurses life a lot easier. [01:21:00]

01:21:15
Nordling:
So going to the ICU, what is the biggest change you've seen in ICUs from the late '70s when you first started there to now?

01:21:33
Koch:
I think the biggest change is that we have such advanced technology and therapies that patients who would have died are now in the ICU. Those patients I cared for in the ICU in the '70s are now in the floor. I think that's the biggest change.

01:22:03
Nordling:
From what I understand, when Mary Washington Hospital became a trauma center that put additional pressure on the ICU here as well. So how did that play out after that opened up as a trauma center?

01:22:27
Koch:
I've not worked in the ICU since they became a trauma center because I was on the medical units, but I know just organizationally it creates different demands. For instance, the blood bank or the drugs we have to maintain. Also for nursing, it is that extra expertise and the therapies that are required for those patients.

01:23:03
Nordling:
So having different specialties like ICU, NICU, or cardiovascular and the introduction of those to Mary Washington Hospital, how did that impact the role of nurses?

01:23:23
Koch:
In the old hospital we did have some designations, but I think it's great to have those specialties. Studies have shown that patients do better when you have nurses that are dedicated to that particular specialty. It also allows the nurse—an ICU nurse's personality and what keeps her motivated is different than oncology. Having worked with both sets of nurses, they're completely different. [01:24:00] I think having those specialties is great for the patients and great for the physicians because the physicians are working with that core set of nurses. It is also great for nursing satisfaction and their expertise.

01:24:14
Nordling:
So you already touched upon this a little bit but I want to go back to it a little. How was patient care when you started versus patient care today?

01:24:28
Koch:
In what aspect?

01:24:29
Nordling:
Just bedside care and the role of the nurse; the daily role of the nurse then and now.

01:24:40
Koch:
In the '70s, the nurse took care of the patient and the orders; a nurse just implemented the orders from the physician. Very little input from the nurse on that plan of care for that patient. A lot less technology; a lot less complicated medications. Nowadays the nurse is planning that care with the

health care team. The health care team has expanded because you have dieticians, physical therapy, and respiratory therapy. I think even though the patients are more complex, the team has become more sophisticated. I don't even remember in the ICU if we even had CNAs. I don't remember having any CNAs. Now most units have Certified Nursing Assistants to help with some of that care so that the nurse can focus on some of those others plans of care that only she can do.

01:25:47
Nordling:
You actually just brought up, that was going to be one of my questions about CNAs and I was wondering if you remembered when Mary Washington Hospital started bringing them on?

01:26:00
Koch:
Having been in the ICU in the old hospital and I don't know on the floors whether they—I'm sure they might have had nursing assistants. When we came here we did try a hybrid of a CNA/housekeeper/dietary person. They did everything from cleaning the room to taking care of the patient. We piloted it and we were trying something different. That didn't work because the patients said the person that is feeding me is cleaning my toilet. I think now the CNAs get standardized training and are really an adjunct to the patient care in collaboration with the nurse.

01:26:56
Nordling:
So when I was doing research to prepare for this interview, I got a nursing textbook from the library. [01:27:00] It was actually a really good one and I was flipping through and it almost completely skips the 1980s. It talks a little about the beginning of the '80s and then it goes straight to the mid-'90s and that got us thinking about what was happening at the time if there were no changes. So I wanted to ask you what was happening here at MWH during that time. Were there a lot of changes or was it a period of continuity?

01:27:46
Koch:
As far as I remember in the '80s—I don't remember a lot of changes, but it's interesting that the textbook, a historical perspective right? Yeah. Probably not.

01:28:13
Nordling:
So nursing is obviously a very female-dominated profession and I was wondering what your opinion was on how that has shaped the profession?

01:28:30
Koch:
I think probably early on it gave us a disadvantage because when it came to sitting at the table with other leaders we might not have had the credibility. But as I've said before, nurses have gained more respect. I think in all the culture—you see women as CEOs in the corporate world. I think nursing also kind of followed what the trend was in the community.

01:29:16
Nordling:
At Mary Washington Hospital have you seen an increase in the numbers of male nurses recently?

01:29:24
Koch:
Recently? I think over the last ten years I have, yeah. When I worked in the ICU in the old hospital we had no male nurses.

01:29:50
Nordling:
In your opinion, what qualities make a good nurse?

01:29:56
Koch:
I think being able to be empathetic. [01:30:00] Being able to know what that family is going through and what the patient is going through. I think empathy is the quality, and wanting to help people.

01:30:22
Rigelhaupt:
Can I ask a follow up in terms of the technology question and how it's affected nursing? I don't mean for this to sound too touchy-feely but medicine is both an art and a science.

01:30:42
Koch:
Absolutely.

01:30:44
Rigelhaupt:
Is there a way in which having automatic blood pressure cuffs are wonderful, but your hands aren't on the patient as much?

01:30:56
Koch:
Yes. I think that's when the nurse needs to understand that you know, I'm charting, I've got the pumps, I'm sticking the automatic thermometer in your mouth—just putting your hand on that patient, and knowing when it's appropriate to and just saying is there anything else I can do for you? It's just showing that empathy in the midst of all the chaos and technology. Or just the sound of your voice and eye contact.

01:31:36
Rigelhaupt:
Are there times you can think back over a very long career as a nurse of cases where you might have seen a patient and how they were doing change because you were watching them? Or you did have more of an opportunity to have your hands on them and that technology simply interferes with?

01:32:05
Koch:
I think that what I always tried to do was just make sure that they knew that I was available and that I cared about them. It was something that I said to them. If it was a patient that we were taking care of for several days, saying, "You know I noticed your daughter was in, how are things going?" And some people don't like hands-on touch. It's just making them feel that they are special and that they are a person. Because when a patient is laying in the bed, especially in the ICU, and they've got tubes and wires and everything and they're sleep deprived, they need to know that they're still a person.

01:33:00
Rigelhaupt:
Understanding that, was that something that's taught in nursing programs or was that something you gained through experience?

01:33:12
Koch:
I think that's something gained through experience. There's no special class for empathy and I think you just can't teach it. You can make people aware, like now they say don't put your back to the patient when you're doing your charting. Someone who has got empathy would know that, if that makes any sense. We give nurses tools so they aren't perceived as being tied up with all the technology. But I think there are those nurses, and probably ninety-nine percent who just by their demeanor, just by their voice, just by their mannerisms, that patient knows that they're a person and being cared for.

01:34:15
Rigelhaupt:
The commitment to patient care and high quality patient care is supposed to flow through the entire organization. Is there a way in which what nurses have learned through experience about empathy and staying focused on the patient, have you seen that move up through the culture of the organization?

01:34:41
Koch:
Absolutely. I think with having our goals and one of them is quality. We measure different things. It makes nurses aware that I've got this standardized care that I know will probably ensure my patient has good care, but also knowing that they're making an impact on their patient.

01:35:27
Rigelhaupt:
Those are largely my questions, any other follow-ups?

01:35:33
Nordling:
No. I skipped one that I could ask.

01:35:35
Rigelhaupt:
Okay.

01:35:38
Nordling:
Well I was going to ask you what are hiring practices like here at Mary Washington Hospital?

01:35:45
Koch:
Hiring practices have changed. It's an interesting story of how I got hired. I was moving to the area and my mother-in-law lived in the area. She came and talked to the CNO and said my daughter-in-law works in ICU, she needs a job, and she said okay just show up on this day. [01:36:00] I had no interview, no application, and I just came and was hired. Nowadays the nurses and all associates at Mary Washington Healthcare apply electronically. There is a behavioral questionnaire. Our recruiter does a pre-screening question behavioral based interview and then if everything meets our expectations then that application is sent to me if I'm hiring. Then what I do is I do another pre-screen telephone interview. We use behavioral based questions for the interviewee and we usually do peer-interviewing. When I was a nursing director and now in the pharmacy, I've always brought in either nurses or pharmacy techs and pharmacists to interview potential staff members. We've gone

from no interview. My philosophy is you can teach people the skills and you can teach people how to use computerized charting and our medication method, but you can't teach them integrity and you can't teach them compassion. We really put a big emphasis on our shared values and assessing that before anybody even gets an interview.

01:37:33
Nordling:
How do things like nursing shortages impact hiring?

01:37:42
Koch:
We may use different strategies to get the applications in, but we still stick to that behavioral based process. I mean early in my career we were trying to get nurses and we would "walk a mile in their shoes." Even if they came to the job fair we would give them a free pair of nursing shoes voucher. Seminars, door prizes—we've done everything in recruitment. We try to get innovative when there are nurse shortages.

01:38:30
Rigelhaupt:
So the way I usually end is to ask two final questions. One is there anything I should've asked that I didn't or is there anything you'd like to add?

01:38:45
Koch:
I think you've asked a lot of very—it's like wow I haven't thought about that for a long time. I just think being a nurse from the '70s to now we have gone a long way and the organization supports it. [01:39:00] I wouldn't have stayed thirty-five years if this wasn't a great place to work. They not only see me as a nurse, but as a leader and they've given me tons of opportunities that I would've never had elsewhere. I think nursing is a great vocation and every day there is a different path that a nurse can take—you can work in a doctor's office, home health, school nurse, or informatics. I mean it's just a great vocation.

01:39:40
Rigelhaupt:
That's a nice place to end. Thank you.

[End of interview]