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Interview with Margaret Caddy

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**Texas Medical Center
Women's History Project**

Margaret Caddy

Interviewed by: Darra McMullen
Date: January 29, 2016
Transcription: Darra McMullen
Location: Margaret Caddy's home

DM: Okay. We are now in the home of Margaret Caddy. It is Friday, January 29, 2016. I am Darra McMullen, the interviewer, and I am here with Margaret Caddy to interview her about her life's story.

Okay, we'll begin with the first question.

Where were you born?

MC: I was born in Hickory, North Carolina.

DM: Hickory, North Carolina, Okay, and were you raised there also, or did you move?

MC: No, I lived there until I was about seven years old, moved and lived in Mississippi for about a year, was raised in north Louisiana – West Monroe, and remained there until I was 18, when I moved to New Orleans to go to nursing school.

DM: And did you have siblings?

MC: No siblings; I am an only child.

DM: An only child, Okay.

And what did your parents do for employment?

MC: My mother was a librarian, although she spent most of her life in charge of a bookstore in West Monroe, and so, she worked in retail more than that, except for

volunteer librarian for the church library, which she complained bitterly that people didn't read enough. And my father was a salesman – various types of industries, but basically a salesman all his life.

DM: Okay. Did your parents or other relatives in your life influence your decision to go into the medical or health fields?

MC: Yes and no. My mother always thought that I should go into nursing because she admired nurses so much. She thought nurses were just wonderful, and she really wanted me to do it. And I think in some way because I was an only child and wanted to please my parents, I decided that that would make her happy. I was also interested in the medical field, so it wasn't totally her, but certainly her influence in that way probably helped make the decision.

DM: And were there any other relatives that had any influence at all?

MC: I had an aunt who was a nurse and admired her a lot; she was one of my favorite people growing up, and someone whose house I loved to go to because she always let me do things my parents wouldn't and spoiled me, and since as you know, I am a cat person, she lived out in the country and had lots and lots of cats, and when I would go out and visit, I would be allowed to take home a few cats and play with them for awhile and then return them and get two more, and so it was kind of like a "rent cat" center. We had a lot of things in common, and she had been a nurse, and I think I wanted to be like her growing up, so there's probably some influence there.

DM: Okay. What is your earliest memory of thinking that you wanted to go into a medical or care-giving role?

MC: Probably, oh I would say in maybe junior high age. I really was trying to decide

between – at one time I wanted to be a missionary, or thought I did. Thought I would like to be a medical missionary. So I think I was focusing really on the missionary role rather than the medical role, but it all sort of came out in the end.

DM: All right. Can you think of other childhood influences or experiences of some sort that helped to lead you into a medical related field?

MC: Ah – not really. I worked as a volunteer in a hospital – a candy striper type experience when I was in high school. I think I related very well to most of my teachers in high school that were in the science department. I did a lot of things like science fairs, and always, always focused on the medical side. I liked biology and liked that side of things. So, probably just the influence of them and being inspired by what they did sort of enhanced that interest in medicine.

DM: And where did you go to middle school and high school?

MC: Both in West Monroe, Louisiana. Middle school was actually only the seventh grade at that time. One through sixth was elementary. Seventh was middle school at that particular time, until they built other schools and rearranged everyone. And then actually eight through twelve at that time was in high school because there was a new high school, and they had more room for the eighth graders while they were adding on and building the new schools. That was the reason there. (Phone busily rings in background; DM and MC discuss need to answer phone and decide against interrupting the interview.)

DM: Did you have any extracurricular activities as a teen that helped to lead you to a medical career?

MC: Probably by working in a hospital or by volunteering in the hospital did. Lots and lots of church activities that sort of put me in contact with all sorts of different people.

Lots of school activities that really weren't related to medicine, but I would say that almost everything that I did revolved around helping people in some way. And so that was kind of where my natural tendency was, and that was where I kind of gravitated to doing that.

DM: Okay, all right. Tell me a little bit about your educational background and why you chose the particular schools and programs that you chose.

MC: I went to school in New Orleans. The name of the nursing school was Touro Infirmary School of Nursing. It was, at the time I went into nursing, the most common type of school, [which] was called a three-year diploma program. The four-year Baccalaureate programs were really just beginning, and there were, maybe, two in the state of Louisiana, and so, they were considered a little bit experimental at the time, and the school in New Orleans was considered one of the best in Louisiana.

DM: It was well established.

MC: It was very well established. I can't remember when it was established, but it was many, many years [ago] and had a very good reputation, and at the time, if you graduated from Touro you were pretty sure to get any type of position that you wanted. So I applied, and it was accepted. There were only thirty-six students in my class. It was a small school, and we only graduated with eighteen because it was a very strict school. Anything below eighty on a test was failing.

DM: Oh! My goodness.

MC: And we had quite a bit of clinical experience, which is what, at that time, the Baccalaureate programs were lacking. They had lots of college and theory, but they didn't have much practice experience, and that's what the hospitals and everyone was

looking for at that time was more the experience. You could always go back to school and get a degree. So, I chose to go that route as opposed to the Baccalaureate. Also, the cost of the school – it was a heavily endowed school. It was, if I remember correctly, \$406.00 for the entire three years.

DM: Oh, my goodness!

MC: Those were all summers. That was three – not three academic years, but it was a three solid calendar years, so it was almost a four-year program.

DM: We'd be really happy to see that price today!

MC: They [nursing students] would! That was at Tulane for our academics, such as our chemistry, biology, and microbiology, and so forth. So, it was a year at Tulane, our residence at the dorm, all of our meals – three meals a day plus a snack in the evening, which the chef from the hospital brought over to us, membership in the New Orleans Symphony or tickets to be able to attend the New Orleans Symphony.

DM: Oh, my goodness!

MC: And all kinds of other perks; it was a heavily endowed school, and then I won a – at the first of the year, we had our capping ceremony it was called. We had awards, and I won the award for the outstanding student for that year, and the prize, along with the certificate, was \$100.00. So, that took some money off [the tuition expense], and then, we could work on weekends for \$10 a day at the hospital, which you know no one would do anymore, even on an hourly basis for a nurse, but we did a lot of that to earn extra money.

And then at graduation, we also had some awards, and I won four awards at graduation. Each was \$100.00, and plus, if you stayed in the state of Louisiana for a year

and worked, you got an extra \$100.00. So, I made money on my nursing education.

Plus, having a private room in the 5th floor of the dorm that overlooked the Mississippi River and of that, I was completely spoiled in terms of my dorm experience in college. Those things don't exist anymore, and it was just wonderful to have that experience at that time.

DM: And I'll bet it was a beautiful view.

MC: It was absolutely gorgeous – over the Garden District and on to the – it couldn't have been a prettier view in New Orleans, and the hospital and the school was in the Garden District; [it was] very safe and lots of fun to walk around, and all kinds of fun experiences at school in New Orleans.

DM: That must have been something!

MC: I was very fortunate!

DM: Okay, well while you were a nursing student, what was your plan for your career? What did you want to do? How did you have your life mapped out at that point?

MC: I wanted to do – I didn't really want to do regular “bedside nursing”, so to speak; I really wanted to be a nursing instructor.

DM: Okay.

MC: Teaching was something that's always been a passion of mine, and I really think had I not decided to go into nursing direction, I would have gone into some type of education.

DM: Right.

MC: So, I had decided nursing education or nursing administration was what I wanted to do, and um, I knew that in order to do either of those, I needed to continue my

education and get a degree. So, anyway, that was sort of the way that I was going. I was also interested in nursing research. It was just about the time I graduated that in the nursing industry, nurses were beginning to branch out and to become more leaders in the medical industry, as opposed to just doing what doctors said and just being more what a nurse's aid position is now. But they were in the leadership, and I was interested in where the industry was going and wanting to be in some part of the leadership role in making it happen.

DM: Good. Good. Well, as you progressed along in your career, did your goals change, or your views of how the industry was changing, did that cause you to change?

MC: It caused me to change a little bit; it was more life circumstances that changed along; as soon as I graduated, I enrolled in LSU New Orleans to get a degree; at that time, it would have taken two years because you would have been allowed credit for your nursing degree, and then it would have been a Baccalaureate degree in nursing.

However, I finished a year of that while working part-time at the hospital. And then, got married and moved to Houston. Went to work at Hermann Hospital, before it was Memorial Hermann, when it was just Hermann.

DM: I remember that too.

MC: And went to work on the –

DM: Excuse me just a second to interrupt. Did you come to Houston to work specifically at Hermann?

MC: No, no. I got married; my husband got a job in Houston, and we moved here because of his job.

DM: And what did he do?

MC: He was an engineer, a chemical engineer and worked for Fluor Corporation.

DM: Oh, okay.

MC: He worked there his entire life.

DM: That used to be just down the street from where I live!

MC: Yes, yes, yes. It did; I know exactly [where the Fluor building used to be]. It moved out to Highway 6.

We came here really for his job, and I interviewed at a few places, and I went to work on the pediatric floor at Hermann. Hermann, at that time, had a main building and a charity building, and I worked in the main building and had been there about three months, and one of the staff nurses said, "I've been asked to find out if anybody is interested in teaching a course in pediatrics to the licensed vocational nurses that they have at the school at Hermann." They had a school for RNs and a school for LVNs at that time. They wanted somebody to do that [teach], and I said, "Oh, I'd like to do that." And [I] had never taught before anything, and they interviewed me and said, "Well, you can try it; it's only six weeks." And I think they thought, "How bad can you mess things up in six weeks?" So, I went over to the school, and they gave me the textbook and so forth, and I taught the six weeks course and did the clinicals for them and so forth, and just absolutely loved it.

And so they said, "Well, we have an opening that's going to be starting in -." I can't remember now if it was the fall. We moved here in June, so I think it was the September class, and they said, "It's to teach medical/surgical nursing, and would you be interested in trying that?"

And you could, at that time, teach according to the state regulations if you were

working toward a degree if you had an RN. Of course, I had my RN, so I went back to school at Sacred Heart Dominican College, which was on the corner of Alameda and Holcombe, which is now still owned by the Catholic Church but is more of a nursing home type of place now, but it was a college back in the early '60's.

So, I was going to school there at night and accepted this teaching position, and again, just absolutely loved what I was doing and decided combining my interest in teaching along with the medical field was exactly where I wanted to be and what I wanted to do. So, I was quite happy at that time, and I had about a semester to go in terms of finishing up my degree there. Of course, I had – it was going to be a little bit longer because you had to go back [and catch up on new things at a new institution]. Every time you start a new college, of course, you have new things to pick up, which I had to do there, but was enjoying every bit of it, and my husband was transferred to Germany.

DM: Wow!

MC: Oh, I can't miss the opportunity of living in Europe! And so, I talked to the college, and they said, "No problem; we'll give you an incomplete for this semester. When you come back, we'll give you some make-up work, and you can take your test, and then, you can finish your last semester, etc."

And I thought, "This is great!" We went to Germany. We got there in October of '67 and stayed until May of '68. We took a month off before coming back, and we bought a car over there and toured Europe, and it was a wonderful experience. I also discovered I was pregnant at the time. So, when I came back, I thought, "Well, I'll –"

DM: Did you have the baby over there?

MC: Did not. Had the baby over here. Came back here. We came back here in May. The baby was due in November. I thought, “Well, I’ll wait until the baby comes, and we get that settled before we go back into the education part of things.”

DM: Right.

MC: So, I did go to work that summer in a nursing home because I also liked geriatrics. And I told everybody if you could do geriatrics and pediatrics, [then] that meant you could also take care of men because they fit into one of the two categories.

DM: Laughter (robust)

MC: That all worked out together, but I’d always liked geriatrics. So, I worked there for about four months, and then the baby was born, and then I didn’t work for a year or two and just stayed home with her. Took a part-time job somewhere in there for the Houston Independent School District, teaching nurses aids that one course that they had, pharmacology, and some other skills. That was just sort of a part-time position there. About the time I was ready to go back to school and see if I could finally finish up this degree, the school had closed.

DM: Oh, no! Oh, no!

MC: So there really wasn’t an opportunity to do that, and we had decided that I was going to be a stay-at-home mom, and so, let’s just get this part done, and then we’ll worry about that [finishing the degree] another time. Sara was born in ’72, and Steven came along in ’76.

DM: And the year [again] of your first child?

MC: Sixty-eight. They’re four years apart.

DM: I’m [born in] ’66, so we’re very close in age. (Laughter)

MC: So we were just getting everybody kind of settled when David got transferred to California. So we moved there in 1980 – August of 1980, so we could be there to get the kids all in school and whatever. So, for about the first six months there, I was busy getting them settled, getting used to where we were living, that sort of thing. We were renting a house. We decided if we were going to be there for three or four years, we'd go ahead and buy a house.

So, we bought the house, re-moved; by the time we got everybody settled, it was almost the whole first year of that, and [I] started looking around [to figure out what came next]. Steven was getting ready to go into kindergarten.

And [I was] thinking, “Okay, what else do I need to do?” And I discovered the community college close by, which was Mission Viejo Community College, had a two-year degree program in geriatrics, or gerontology, and most of the teachers in gerontology came from the University of Southern California, where is the national headquarters for studying gerontology. And I thought, “Well, gerontology is my second love, and so this is a wonderful opportunity.”

So, I went and talked to them, and they accepted quite a bit of my class work and whatever and welcomed me in. And I decided I would take the two years; maybe I could actually finish that one (laughter) without getting blocked along the way.

I did; I finished that, and I finished a two-year course in business, and while we were out there, 1983 came along and David was transferred back to Houston, so we came back here, and by then, all the kids were in school, and I decided [to redirect my energies]. Amy was in the first year of high school, and I thought, “I need to go back to work; we need to start thinking about college and other things.”

This [next story] was while we were in California. A very close friend of mine – we lived across the street from each other for years – and she had gone to work for a lady who was working in hospice. And when I told her I would be going back to work when we moved back, she said, “Well, we have accumulated enough money in hospice now to hire somebody. Would you like to apply for the job?”

Now, I was packing everything in California, and all my resume stuff was something I didn’t think I’d need for the next two months; it was already packed. “I’m sure I don’t have enough background and information to work in hospice, but I need some interview experience, so yeah, I’ll send you my resume, etc.,” [Margaret replied to her friend]. So, I dug everything out, updated it, had a friend’s husband’s secretary type it because I didn’t even have a typewriter there then. I had sold it because we were moving back, the one I had used for schoolwork. Sent it in and set up an interview for when I got back to Houston.

Met with the board [of directors] and knew about hospice from my studies in gerontology, but only the basics. I didn’t know very much at that time.

So, they interviewed me, and the lady who – Bernice Moncrief – who had started Houston Hospice, her husband worked for Fluor also. I knew her somewhat, but her husband worked way up in the administrative area, and so, we knew each other, but we were not really friends. But she had talked to me about it and so forth, and she told the board, “This is whom I want.”

They really were not clear about what all of this was going to entail. It was the very beginning of that hospice, and people knew very little about it. And they said, “Well, Okay, if you want the job, it is fine with us.” So, that was really the basis of my

interview. It wasn't very much.

"I'd like to work for you."

"Okay, that's fine. Now, what's for dinner?" That's how the interview went. So, I came home and thought, "Okay, I think I've accepted a job, and I have no clue as to what to do."

So, the next week, I went on a Monday to meet Bernice and her secretary, who was my friend, at the office, which had been donated, which was one room. An office on the Katy Freeway had been donated by Red Adair. Remember the fire fighter in Houston?

DM: Yes, I do.

MC: His office was in that building, and he donated the office. And they had a filing cabinet, and a desk, and a telephone, and a coffee maker, but nothing else, and so, Bernice met me and said, "Here's the key to the office, and we're looking forward to you making us a hospice. And we have an appointment; we're leaving." And they left.

I looked around. There were no books; there was nothing. I did find a yellow tablet and a pencil, and I thought, "Well, I can make coffee. I'll make a pot of coffee, and I'll sit down and write a letter of resignation because I don't know anything about what I'm supposed to do. Whatever made me think I could do something when I don't even know where to start."

So, while I was drinking coffee and thinking what I was going to do next, a lady with tons and tons of energy bustles in, loaded down with boxes and whatever and introduces herself as Betty Evans, and she said she was the volunteer director of Houston Hospice, and she had all this information, and we were starting a class on training

volunteers the next week, and she had me down to teach classes two, four, and seven, and here was my material, and here was everything about hospice, and she'd see me later.

Well, at least now I had boxes and something to do, so I pulled it all out and started reading, and there was a tremendous amount of material there. So, you know, I spent a week devouring what all of this was, and that was in September, and the National Hospice Organization - .

DM: And what year was this [all taking place]?

MC: This was 1983. The National Hospice Organization was having their national meeting in November of that year, and Bernice said she wanted Pat, her secretary, and I to go.

And so, they had a pre-conference seminar called "How to Start a Hospice." I thought, "I think that one has my name written all over it." (Laughter from both)

It was an eight-hour course, and it was, absolutely, still today, the best course I ever took, taught by some wonderful people, and I came home with tons of ideas, volumes of notes, and kind of knew where I was going from that point on. At least, I knew where to start and where resources were. I knew kind of what I needed to do.

So, the volunteer director and I began to kind of put some things together, along with what they were doing. They were taking care of some patients, but only offering volunteers to those patients, and they were kind of making it up as they went along.

Also, in 1983, was when Medicare added the hospice benefit to the Medicare benefit. So, I got all that information during the rest of the conference, when I was there.

I came back into the board [meeting] and said, "If we want to build this program and move forward, we have to be licensed." But to get licensed as a Medicare program,

you were required to have quite a bit of capital in the background, because you had to do a lot of contracts or whatever. You just needed working capital, like you would to start any business.

DM: Right.

MC: And we didn't have that. So, we decided the best thing we could do was to get a license as a home health agency, and then, we could actually earn and do a few things while we worked toward getting the hospice license.

Well, I'd never worked in home health. I didn't know how to do that either, but I wrote a letter to the state and asked them how you do that, and they sent me about nine boxes of material, and [the state] said, "Follow these directions, and we'll come out and survey you, and you'll do this." And so, that took us, basically, until May of 1985 to get licensed as that.

In the meantime, we were working on all kinds of things from fund-raising to building the board to doing what we could for people to whatever, and it was basically me, and I had still the director of volunteers, who was a volunteer and didn't earn a license, a doctor who was volunteering his services.

DM: Wow!

MC: And finally was able to hire a part-time office person to begin to help us with some of the administrative things that we needed to do.

DM: Right.

MC: So, we got our home health license, and then we could see patients from a medical standpoint, and that meant me because I was the only nurse in the office.

So, I had, in that time, made friends with people in the industry. They had sort of

taken me in; they let me go out with them. We had a few home health agencies that were interested in what hospice could offer. Wonderful friends along the way – that I got to the point of saying, “I don’t know what that means; can you help me?” And they would always answer questions for me. It really helps if you’re not real smart because then you know you don’t know anything, and you’re not afraid to ask questions.

DM: (laughter)

MC: So, we had a wonderful board of directors, a lot of absolutely talented businessmen who could help with all the things that we needed for business plans and contracts and whatever, and a few people on the board that actually –

DM: And fund-raising too!

MC: And fund-raising. Lots of wonderful people who helped with fund-raising, and then we had several people on the board that were actually working in the health industry that knew a lot about the regulations and whatever, and could at least point me in the direction of what I needed to do. So, we spent quite a lot of long hours getting that up and going.

At that time in Houston, there were three hospices. There was the hospice at the Texas Medical Center, and they had started with a lot of money and with the medical model, and only with the idea of being a full-service hospice, and they wanted an in-patient unit, etc.

The Visiting Nurses Association had a hospice program along with their home health program – basically a hospice team, and then there was Houston Hospice, and we were on the west side of town, and we were considered at that time, a community based hospice. So, there were those kinds of models, and there was one in Galveston, but there

were only three of us for the whole [Houston] area.

DM: Wow!

MC: So we met; we got to be friends. We kind of divided the city up. The medical center hospice, which was called New Age Hospice in their first days, basically kind of took the medical center and inside the Loop. We took the west side [of Houston], Sugarland, down Fort Bend way, and the north part of Houston. VNA was everywhere with all of their teams and so forth.

DM: Because they could just travel.

MC: They could travel. We really had no problems with areas. We could be friends; we could share information; we could learn and have fun.

DM: Are there more hospices now?

MC: Oh, yes (Laughter from both)! Those [times] were the fun days; nobody bothered you.

In the meantime, the state of Texas was becoming active in the hospice industry. We had the Texas Hospice Organization, which was the state organization that kind of “oversighted” everything. I became very active in that, and made friends with directors in hospice all over the state and really could get lots of information from them; went to all of the meetings, and so forth, that they had.

This all was working fine until I decided we weren’t going to move forward anywhere without that hospice license from Medicare. So, I figured out one night, about 3 a.m., about how much money we were going to need and wrote it out on a napkin, and we had a board meeting the next morning at seven [o’clock], and I took my napkin in and said, “We’ve got to become a Medicare certified hospice, and I didn’t have time to type

this because I did it at 3 a.m., but this is my budget. This is how much money we need, and they laughed at me, and one of the doctors on the board was also very instrumental in our foundation, and he said, “We’ll give you the money. We’ll meet with you. I’m sure we can. Let’s meet with the people from the foundation.”

DM: That’s good.

MC: So, we did, and they said, “Well, let’s do it this way; let’s kind of give you a line of credit that you can draw down on, and if you don’t need the whole amount, then don’t take it, and we’ll kind of do this.”

I said, “That’s fine. What I need is to kind of get started.”

We got all our contracts; we got our license; we got everything done, and that was in 1988 that we finally got our Medicare license, somewhere in the middle of the year. We had both of our licenses; we were beginning to grow; we could now accept hospice patients, and we began to grow our staff and that sort of thing.

So, the other two hospices were doing the same thing, and then in 1990, we had a new hospice that came to town, and they were a for-profit hospice, and we were just highly insulted. We were all non-profit, and we thought that’s how hospices ought to be in terms of taking care of people, and that was kind of a new wrinkle, and they began to use really naughty words like “market share” and “marketing” and “return on investment”, and all these words that we didn’t think belonged with hospice.

DM: Market share of dying people!

MC: In the meantime, hospice was growing all over the United States. We were seeing more and more for-profit hospices coming in, along with the non-profit, and so we started seeing the growth of hospices in the Houston area. In the meantime, as the budgets began

to grow and Medicare began to say, “This isn’t just going to be a little, small part of Medicare,” they began to put more and more rules and more and more quality assurance programs in, and it became instead of a little, small local program over here, and now a line item in the Medicare budget, and that meant all kinds of other things were happening.

We became – somewhere in the nineties – we got heavily regulated, and we just had all kinds of new hoops to jump through; we needed to be accredited. That was another whole thing. Was it going to be JCAHO or CHAP, or what was the accreditation going to be?

In the meantime, because we had so many more for-profit hospices starting, the non-profits in the state got together and formed an organization that we called the Texas Non-Profit Hospice Alliance, and managed care was coming into our world about then, and we needed to have contracts with hospice because hospice was small, and they wanted somebody that could serve the whole state.

Well, it didn’t make much sense for me to have a hospice in Dallas and San Antonio and El Paso, and the hospice in El Paso to have one all over, so with this organization, the way we legally formed it, we could get a contract to then service the whole state through this organization. So, that’s when I started learning a lot of legal things and a lot about what you could and couldn’t do from a legal standpoint and so forth. And we realized we had to have somebody that could work with all these managed care organizations, and be a contract person for us and learn how to manage those contracts.

So, I had a young man that was working for me that I felt like could do that. So,

he started working part-time for Houston Hospice and part-time for the Alliance. So, now we were into the big business as far as billing and working with Medicare and all of those kinds of things.

With both state organizations, I became an officer in both of them and president of both of them at different points in time. And also [I] worked with the medical director of Blue Cross Blue Shield in South Carolina, who was our fiscal intermediary for hospice in terms of all kinds of new rules that he wanted to put in place for hospice. So, I learned to volunteer for those things because if you got in on the ground floor, it was the best way to learn them. Learn it as you went along, rather than learn it all at the end, and you had to absorb all of it [at the end].

So, we were moving along with all of that until 2002, and we were beginning to think at Houston Hospice that we had grown. We had established an office in the northwest part of Houston; we had acquired an office in El Campo that was closing, so we had an office down that way. We originally had an office in Richmond that we had moved to El Campo. So, we had three offices; we had a pretty large territory. That was when we went to the seven counties.

We had a pretty good staff, but we realized what we were going to have to have was an in-patient unit. We had used hospitals for that fairly successfully, but it wasn't ideal. And so, we were exploring where we wanted to grow and how we were going to manage this in-patient unit.

I had been out-of-town and came back from a short vacation, and got a phone call from the president of my board, that says, "I'm coming over to your office; (I was in my office.) clear your calendar." And I thought, "My goodness, what happened? What did I

do?”

So, he came over and closed the door, and he said, “I’ve had a call from the president of the board at the hospice at the Texas Medical Center.”

By then, they had grown; they had built a facility on Holcombe, the in-patient facility that’s over there; they were larger than Houston Hospice was in terms of patients and so forth. They had failed their licensure survey and were having their license pulled.

DM: Oh dear!

MC: This was a much longer story; I’m sure you’re not interested in that. They had three choices. They could close down for six months and apply to reopen; they could just simply close period, or they could essentially choose to give their program to someone else.

They really didn’t want to close with everything they’d built and their reputation and so forth, and so, they were interested in working with us on that.

DM: Wonderful!

MC: And so we – I said, “Well they have an in-patient unit, and I need one.

(Laughter)” And besides, they were a great program; I just couldn’t see them closing. There was too much the community would lose as a result of that.

I said to the president of my board, “We acquired the hospice in El Campo, but that was real easy; that was seven patients, three employees, and a cat. They had an office cat.” (Laughter from both)

“We’re talking about a whole lot more with this one, and I don’t know, legally, how to make this happen. I’m going to need a whole lot of help with that.”

And he said, “Well, there are three others on the board that we have done many,

many acquisitions, and we know what questions to ask, and we'll help you."

And I said, "Okay, if you'll promise to help me, we can do this." And so, that's when we – this was September of 2002 – and we got everything done and finished; to the community, we said it was a merger. It was actually, because of legal things, an acquisition, and we made that happen on the day before Thanksgiving of 2002.

I've since learned you can't do that in that short a time, but since nobody told us you couldn't, so we just did it. It was, of course, 18 hour days from September until that time, and a whole lot of work, and we got everything signed, and then I went over and looked at the building and thought, "My goodness; this is like a small hospital; I don't know how to do this!"

DM: (Laughter)

MC: And I was standing outside looking at the big oxygen tank, wondering, "How does the oxygen get from there into here?"

One of their staff came outside and said, "Are you Okay?"

And I said, "I think so; I'm just curious about your oxygen tank."

And I think it was at that point that they said, "Oh dear! This is not going to work."

DM: We have a newbie here! [With very amused laughter]

MC: [Laughing in agreement, repeats] We have a newbie here!

But we now had two entire hospice staffs, two entire boards of directors, and one of them which was really, our hospice going, "How are we going to do this?" And their hospice [was] saying, "We just lost everything." And they were just in a state of grief.

And we had two boards that operated entirely differently from a whole different

philosophical perspective, and so then, I spent the next year combating all of that.

DM: Wow!

MC: We knew that some people would not be able to be with us, and that some people would. Then, we had dissolved both hospices and formed a whole new organization, and so when licensure came around, if we didn't pass that licensure survey, both hospices would be gone.

DM: Would be gone, right. So you knew you had to get it right.

MC: We knew we had to get it right the first time, and the people at the medical center hospice were nervous because they had failed those licensure surveys, and they didn't know if they had a lot of confidence in us or not, even though we had a really good history with the state. I discovered one of my talents was handling state surveyors really well.

DM: Oh, well that was needed!

MC: Time came for the state survey, and a new state surveyor came in that was a very unusual person, and we did not know from beginning to end whether we were doing good, bad, or what. I had no clue; I could not read this person. I finally said that we've got to do the best we can, and I had no idea about her.

She was asking for the most bizarre things and asking for the strangest things, and I had never been through a survey like that. And so, at the end of it, she was ready to give us her findings, and so, I called all the administrative staff in with all our hearts beating about a million times a minute. And she said, "I've looked at everything; I've looked over everything." She drew this out you understand.

DM: She's probably enjoying this! (Laughter)

MC: She finally said, “I can find no deficiencies.”

I said, “ I think I’m going to cry.”

One of the guys who was kind of second in control says, “Is it permissible to hug the surveyor?”

We absolutely couldn’t believe it. We thought she would find, definitely, some things that went wrong, but she didn’t.

So we were off and running, and so then, we spent the next few years combining the organization, building the organization, trying to repair the community sales, trying to raise a bunch of money because they were in a whole lot of debt. So it became a much bigger organization with a bigger business plan.

I had planned to retire in 2003, and stayed on because I felt like I needed to get that organization firm and on its way. And so, we started with just me as the only paid employee and a lot of volunteers, and when I left, we had three offices, seven counties, 200 employees, and a patient census of about 250 a day.

DM: Wow! You made a big difference!

MC: It did. So I kind of started this with an interest in medicine and teaching because there was a ton of teaching I did in hospice along the way that I also discovered after I did all these courses in business that I really liked the business angle of it.

DM: Really?

MC: And I also wanted to work in medicine where I could still keep the patient and family needs as forefront. I needed to have that service and that mission part of it, and it all came together for me in hospice. And while I was there, I always made sure we kept the patient and kept the family as forefront, which is what hospice is supposed to do, but

we managed to do that, and we had to use good business practices even though it was a non-profit.

Certainly, there was a lot of teaching, and it was a medical learning experience because of what was going on. So, I think all of the things that I did, even though it didn't quite go the way that I thought it was going to, all worked out as it was supposed to in the end, and so I retired, and went to work for a company part-time doing some consulting for them for some other hospices.

Enjoyed it when I was there, but decided consulting wasn't for me, mainly because of the schedule. You'd get everything set, you'd get the cat-sitter for the cats, and get all your pre-work done, and then, they'd call and say, "We don't want you to come."

I was going to all kinds of different states and flying, and it just got to be –
DM: Too much trouble.

MC: Too much trouble. I wasn't earning enough money to totally disrupt my life, so I began working with another group of people working on – at Fort Hood [they] wanted someone to come in and help them train their casualty assistance officers when they needed to go out and tell the family that the soldier had been killed, and they [the casualty assistance officers] had never had training in that. They didn't know how to do that. They didn't know how to handle that. They were getting lots of flack from the community and the soldiers' families on that.

So, we created a bereavement program, and went to Fort Hood and a couple times a year taught the soldiers, and that was really different to be in front of a group of 100 of these strong soldiers, as opposed to a group of little old hospice volunteers. [Laughter

from both]

So it was a different experience, but one that was extremely rewarding. We learned that those people just needed someone to talk to.

DM: To talk to, yes.

MC: You would be in your car driving away, and they would be running alongside you asking you one more question.

DM: One more question, yes.

MC: I think we felt like we did as much for them just listening to them. So, we did it only to establish it, model it, and then they were taking it over. It wasn't going to be a long-term thing; we were doing this as volunteers. So, it was a short-term project.

About the time we were finished with that, the guy that had taken my place [at the hospice] decided he needed to resign because they really wanted to move out of state. They had adopted a child, and their life had changed, and they called and asked me if [I] would come back for a couple months and kind of baby-sit the organization while they looked for a new CEO.

DM: Right.

MC: And that was in 2008, and the economy was doing all kinds of dreadful things.

And you know it wouldn't be bad to have a few more coins in –

DM: My pocket. (Laughter from both)

MC: My bank account with what's going on, and so I went back [to the hospice], and they said, "You don't have to do much; the organization's pretty –

DM: [Interviewer's note: Side A of cassette gets to the end of tape here; there is a brief break in the interview while tape is turned over to begin on Side B.]

DM: Okay. Go ahead and finish up what you were saying about the history of hospice, and then, when you get up to the present on that, stop, and we'll re-start with the rest of the questions.

MC: Okay. There was only about two more sentences. Anyway, that turned out to be eleven months, not three months, and it was the year that the federal government changed all the rules for hospices for the first time since 1983.

DM: Oh, no!

MC: So, every policy, every procedure, everything, had to be re-written. We also wound up, just a month before the new person came to take over, with a survey that was our accreditation survey, but the accreditation bureau was surveyed once a year by the federal government to make sure they were doing their job right. So, I had surveyors surveying the surveyors, and they wanted to do it really right because they wanted to pass their survey.

DM: Right.

MC: We also had the state surveyors come in at the same time because they had some questions about an incident that came in. So, I had the state surveyors come in, and then, we had a third set come in. So, at that point, I was just, "Everybody tell me what you want. I have no idea how to handle this."

So it went on in kind of a high note of saying, "Well, at least I'll never have to go through another survey again!" Everything went Okay. It was all passed and accredited and whatever, but it certainly was not a year of babysitting; it was one of the hardest years that I had.

DM: But at least it all turned out well.

MC: It all turned out well. The accreditation was done, and the gentleman who took my place is still there. They have made great strides in continuing to build on the program, and so it is nice to hear about [how] the successes have continued along that way.

You asked a question earlier, “Are there other hospices in Houston?” To my knowledge, today there are about 75.

DM: Wow!

MC: And that sort of includes the whole area that I talked about. There may be more. There have been many that have come and gone in that timeframe.

DM: Are many of those for-profit?

MC: They’re almost all for-profit. The VNA that I spoke about earlier closed their hospice at some point in time. Houston Hospice and the TMC hospice became one; we became Houston Hospice at the Texas Medical Center. That was the official name. The Galveston hospice is still there. St. Joseph’s hospice was a non-profit, and I believe they have closed. Memorial Hermann has a hospice now that I believe is non-profit status because of being part of the hospital. I’m not sure of the status of the others because I’ve lost track of all of them. That’s a national trend, that most of the hospices now, and certainly, the larger ones, are the for-profit entities. That was a change, because in the beginning, they were all non-profit. That was a change that I saw over my 25 years or so in hospice.

DM: And all of this got successfully concluded in, did you say, 2011, when it was all finally finished?

MC: I left in 2009.

DM: Two thousand-nine, Okay.

MC: I went back in the fall of 2008 for that extra year, and so, from '83 to 2009 were my years in hospice. I did a little volunteer work after that, but not really very much.

DM: Not very much, Okay.

Let's back up quite a bit in the questions. How did you land your first job in nursing, and did you have a job in nursing before the Memorial Hermann job in Houston?

MC: I did; I was working in New Orleans, and I was working in the same hospital that I graduated from, so, basically, if you graduated from the hospital, they just kind of gave you a job. The only decision was where in the hospital do you want to work? And I wanted to work nights because I was going to school during the day, and there certainly were a lot of openings on a regular medical-surgical floor at nights.

DM: Okay. As your career continued to progress over many years in different areas and different things that you saw with regard to hospice, or nursing in general, what were some of the most important things that you learned about how to be successful? What do you think was really critical to you being able to pull all of this off?

MC: I think a lot of it was realizing that you can't do it all and being very, very open and honest about what you needed to know. I found that people were more than willing to help you if you really wanted to learn, and you were sincere, and if you were willing to listen. So, I think the ability to listen to other people was probably the real key to my success.

DM: Did, at any point when you were younger, and in the nursing area, did you ever have any dreams about "Oh, I want to start a hospice!"; did that ever occur to you, or did you just sort of fall into it?

MC: I just kind of fell into hospice. I always knew that I wanted to be in charge of something. I thought for a while that I would open a nursing home. When I was particularly interested in geriatrics, I thought about that. There were some other areas that I thought I might be interested in doing, but basically, I always kind of wanted to put something [in place] that I could be in charge of how it was run, how it was implemented, and again, just because I saw so many people that had a goal of, “How much money can I make in this?” [that] I just always felt like medicine needed to be all about the –

DM: Care!

MC: The care, the patient, and the person, not the money. So that was my reason, really, for wanting to do something like that.

DM: What would you say were the greatest challenges to the hospice in recent years? Are you still in contact with the people there?

MC: I am; I am.

DM: And do they tell you what their challenges are there now?

MC: The challenges right now are the fact that there is no – oh, I can’t remember the right name - Certificate of Need in the state of Texas. So, anyone who follows the rules and applies for a license can open a hospice.

In Florida, that’s not true. In Florida, you, for example, can only have so many hospices per certain amount of population, or area, or whatever, and what that does, it gives you that economy of scale that you can get from a big business, and certainly, when I saw the hospice industry sort of explode, you would lose one patient here and one here and one here, and your census would go down, and it would be very difficult to predict and manage your budget from that standpoint, and then, that hospice would close and

you'd get them back. And so, it was a juggling act, a lot would [not make it], like any business that would open and fail, and it wouldn't work out for a whole variety of reasons. So, I think that [economic issue] still, today, remains one of the biggest challenges.

The other thing is – it's so much better than it was in the very beginning – but you still have a bit of reluctance from the medical community on accepting hospices. We had lots of physicians that because of being afraid of legal retributions, wanted to treat that patient for as long as they could. So, they'd decide hospice was Okay and then send them [patients] to hospice maybe two days before they actually died.

DM: Right.

MC: So, your higher costs are for your patients at the very end of their lives – the beginning and the end – and you kind of needed that middle to spread it out because that's how hospices are reimbursed. They're reimbursed on a per diem basis, not a fee-for-service basis. You get a lump sum of money, and you kind of manage it out. So, the economy of scale is very helpful.

So, I think the economics is – and again, when I first started in hospice, I did lots and lots of public speaking, and I'd say, "Do you know what a hospice is?" And you'd get one person or two who'd raise their hand. Now, almost everybody does, but they want it very differently. Also, hospice was founded on the premise – and I know you don't have the time to listen to that whole history – founded on the premise that a group of professionals would teach a family how to care for a person who was ill.

This was back in the late '70s when people wanted to care, wanted the experience of caring for someone at the end of life. They just didn't know how to do it. So they

needed people to come in and teach them, and then, they would actually provide the care, and then you would change the plan of care [as needed by the patient's condition]. That is what it was set up for.

That economics and the way hospices are paid hasn't changed, but now, we have everybody going to work, and now, nobody has time or can afford to stay home and take care of Mom and Dad or Grandmother and Grandfather, so they want someone to do it for them. So you've got all kinds of changes in society that's happened, so making the hospice program fit with the current society is a challenge that remains today.

DM: That kind of looks like that puts the hospice in a bad situation because they get people right at the end of life, and then, they can't get reimbursed monetarily, and they're caught sort of in the middle because maybe the family would have preferred that they [the patients] go into hospice sooner, and the doctor kind of didn't release them sooner, or something.

I wonder if the motivation of the doctors – is it just financial, or do doctors feel if they keep trying, maybe –

MC: I think so.

DM: Maybe they don't want to admit defeat.

MC: I think it's monetary for some of them. For others, it's, "Well, if I quit too soon and then the patient gets better, then I haven't done my job, and then, I might get sued because I've not been a good physician." As some of the legal aspects changed in Texas, that made that better, but that was a problem for a bit of time. It is just concerns, and again, everybody getting used to some of the changes on things.

In the early days, a lot of physicians didn't want to turn patients over to hospice

because they didn't really – they weren't trained to know how to provide the adequate medical oversight for end-of-life care for pain control and for the various symptoms, and so when we had individual doctors writing all those orders, there was a lot of training and begging. [For example, hospice staff might say,] “Well, we found this works really well; would you consider ordering this?” [A doctor might reply,] “No, I wouldn't; I want to try this.” There was a lot of that.

Hospices now, certainly Houston Hospice, when I left, we had a staff of seven physicians so we had a medical group we were running as well. But the doctors were willing to turn the patient over to the hospice physician to do the orders and to manage that and keeping them informed about what they did, but they understood that the [hospice] doctors now have a specialty in palliative care where they're trained in medical school and in residency how to manage patients, so they [regular doctors] had more confidence that the [hospice] doctors were going to do what needed to be done. They [regular doctors] didn't have to deal with it; they could still continue on with what they were trained to do.

DM: Right.

MC: So, when they were able to let go and form a partnership, the patient won – at the end of that. But it took time; you know change is hard.

DM: Get everybody pointed in the right direction.

MC: That's right! (Laughter)

DM: I understand.

What have been your greatest challenges, just for you personally, in your professional life? What would you say were the hardest things for you to deal with?

Things that took the most out of you to overcome?

MC: I think a lot of it was just realizing that when the challenges were ahead, and you absolutely, in the beginning, kind of didn't know where to start, to have the confidence that you could figure it out. It might take a few starts and stops and changes along the way, but basically, as a person, I'm really kind of introverted, and so, to be able to step out and have to be that forefront of the organization and be the one who fought for [things] and made those things [happen was difficult]. And [another challenge was] dealing with things like the state legislature with the Medicare System and with the people in the medical community, like the Attorney General – not the Attorney General – I can't think of the name, but anyway, the legal part that dealt with Medicare and going into those meetings and thinking, "Oh! My goodness, I'm not going to be able to be "on par" with those people just because of not having "grown up" [with] or having had a basis of say hospital administration or some of the other things like that." So, I think those were the hardest things to overcome.

It was also very difficult to have to say "no", when you simply didn't have the funds or the resources and be able to handle that, to be able to get what you needed for a patient, regardless of managing all of that and just get what you needed, and yet knowing that with good business plans and business management, you have to have a reserve fund. You can't spend it all on one patient just because you feel sorry for them. It has got to work out that way, but it was still hard to have to say "no" in some cases.

One of the things that we started in hospice in the beginning was the pediatric program – back to my pediatric roots – because no one in Houston was taking care of children.

DM: Oh, wow.

MC: And that became difficult because it was difficult to convince my staff that they wanted to take care of children that are dying. Because that's not the natural order of things; it's hard or whatever.

DM: It has to be really hard to watch.

MC: It is very challenging to do that; so, I took the first couple of years of being the nurse for the children, since I had a pediatric background, and learned a tremendous amount from the children and from the families in doing it. It was really very rewarding, but it was also very hard to do.

DM: Very hard to do; I can imagine.

MC: But was really still glad to have the pediatric program up and going; it is called the Butterfly Program because the butterfly has a short but beautiful life, and that's what we felt like applied to those children.

DM: Oh! That's a good thing.

MC: So, that was kind of a challenge.

DM: Okay. Does the hospice still cover a ten county area? I read it covered a ten county area.

MC: Yes, yes.

DM: Is it more than ten counties?

MC: I don't think so; I think the Houston Hospice is ten.

DM: And what services does the Hospice sort of "export" from its primary location on Holcombe?

MC: The hospice team, and a hospice team is made up of a physician, a nurse, a social

worker, and a chaplain and volunteers, and then, any individual patient might have other things added to that team, such as a physical therapist, an occupational therapist, a nutritionist. We always have these people on contract; we don't always use them very often, but sometimes, we do need them. Occasionally, we would have volunteers for art therapy or music therapy or a child life specialist in the case of our children's program, but again, that was a very rare occurrence as opposed to anything else.

DM: Right.

MC: The rules state that the team must be managed by a hospice nurse. So, it was a matter of going out and visiting a patient, assessing a patient, and determining what the needs were. Home health aids were almost always a part of that team for personal care.

DM: Right.

MC: And then that changed. They have team meetings every week to go over the patient's plan and care and see what needed to be changed as a result of that.

That team, in addition to providing the care, based on their discipline, their training and education, also the hospice provides all the medicine for the patient that they need for managing a terminal illness, all the equipment, and all the supplies.

DM: Right.

MC: So the nurse, the team also has to assess what medicine, equipment, and supplies are needed as well and also what level of care. Eighty percent of the patients on the census on any one day in time should be home care patients, and 20% can be in-patient. So again, that is something that has to be assessed and managed on a routine basis.

There are two other levels of care; they can be on a continuous care, which is 24 hr. care in the home, but that is only meant for times of emergency and lasts only a day or

two usually. If it is beyond that, then they go into the in-patient unit, and then there's respite care, which is meant to give the families a break. Until recently, that didn't work very well because you had to move the patient in-patient for respite care, and they would want to stay at home, so that didn't work. Now, they've added to the rules "home care respite"; that was after I left, but that's working better I understand. So, those are the patient services that are managed.

And the hospice functions with a variety of teams based geographically, one team for inside the Loop, one team for Fort Bend, one team for whatever. From all of the three offices, they have multiple teams that go out and are managed. Because hospice is a 24 hr. per day, seven day a week service, you also have an on-call member of that team, and that's managed in a variety of ways. Sometimes, there's a full on-call team; sometimes there's a member of the team that's the on-call person.

DM: Is there a physician, an actual doctor, for each one of these teams?

MC: Yes, yes, a physician for each one – there was at Houston Hospice. You have to have that. You have to have a medical director, but a lot of the smaller for-profits will not have [everything Houston Hospice offers]. Our doctors did home visits; they don't all have – not all doctors do home visits.

DM: It has got to be hard to find doctors that are willing to do that these days, I would think.

MC: Yeah, I was very lucky to have a wonderful physician staff that was trained in palliative care. A couple of them were females that wanted a flexible schedule, with children. They didn't want to do an office, didn't want to worry about billing. So the hospice acted as their billing agent and handled all of that for them as well.

DM: Good!

MC: We did manage to find a good physician staff of people who wanted to do that. I think that's easier in Houston than it would be, say, in a small community.

DM: What advice would you give to a person looking to get into a medical or care-giving career? What do you think they should think of first?

MC: Well, I think they need to ask a lot of questions and visit and follow some people around. Ask if they can shadow someone for the day, whether it is a nurse or a physician or any kind of profession, just simply ask if they can do a "ride along" and sort of see what it is like. They should do some volunteer work in whatever area of medicine they were interested in so they get just a little bit of real world experience.

DM: A taste of it!

MC: A taste of it. Because you go into it, sometimes with all the T.V. shows and things we have now, with thinking it's going to be like that. And it may be very different.

And the other thing that I would say, because a lot of the medical programs now are very heavy on theory, and the thinking behind that is you'll get your experience when you actually go to work and be earning money at the same time, and I would encourage someone, for example, who is right out of nursing school to spend at least a year or two in just general, basic nursing to get your skills down, and then specialize or start your career from that point.

Because I've seen nurses who are extremely bright and talented, and they could go right into a Master's degree program or right into nursing administration; they know everything. They then get frightened up here because they haven't been grounded in the basics. So, I really think that to be long-term successful and feel good about what you're

doing, you need that basic grounding; so, that's what I always tell people. They don't usually take my advice, but that's what I tell them! (Laughter)

DM: Okay. (Laughter) What advice would you give the person out there who has a dream job or dream idea they would like to pursue, but they're not quite sure how or where to start pursuing that dream? What would you tell them is a good place to start?

MC: Oh, goodness! Well, once again, [I think a person can start by] sitting down and talking to someone about your dream job and having them help you reflect back on which direction to go, and maybe getting some really good questions to ask first and then figuring out how to proceed from that point on. Because sometimes in talking to someone with experience that may say, "In looking for your dream job, you need to ask these four questions," and because someone without experience may not even know to ask these four questions.

So, you need a good personal plan on how you'd like to go about it, and then [set about] finding a mentor that can put you in touch with someone who is working in that field that, again, might help you decide what the best option would be in going forward. Mentors are, I think, just wonderful when it comes to that.

DM: Good! What would you say would be the epitome of success for you professionally, and do you feel that you've gotten there yet, and if not, what are your goals?

MC: Probably so; I still like being involved with people. My professional life now has taken more of a voluntary role. I still have lots of friends who call and say, "Here's what's going on in my family. What do I need to do?" It's very rewarding to be able to talk to them, and at some point at least learn a little bit about it and tell them what their

options might be, and kind of try and point them in the direction that might work for them in terms of the care, and that's not just hospice. Medicine is so confusing today, and there are so many options with all the wonderful care that people just get overwhelmed with the amount of information that they are given, particularly at a specialty hospital like MD Anderson. Your head explodes with the information, and you absorb, when you're a patient, about 10% of the information anyway, and so, I think you really need to go through this [a time to sort through options with a knowledgeable person]. That's been rewarding.

As for my professional career, I'm obviously not going back to work full-time or anything, but hospice really brought, as I mentioned before, everything that I kind of had an idea I'd like to achieve in medicine. I kind of put it all together. I got to do –

DM: Pediatrics and gerontology

MC: Pediatrics, gerontology

DM: Nursing, teaching

MC: Nursing, teaching. I got to do a lot of counseling.

DM: Business

MC: The business side of things, the administrative side of things. I always had my administrative staff make a patient visit a couple times a year to remind people of why we were there. Not to let that get out of hand. And I did the same thing. I went on patient visits as well to talk with families. It was so much easier when I was at the Medical Center. The in-patient facility was right there; I could always find a patient or a family that wanted to explain what the experience was like. I always think that with any of it, you always need to go back to your basics. Why did I want to do this? Why am I here?

Have I gotten off track?

A few times, I think we did. And we kind of had to pull ourselves back, and say, “How can we make the regulations not throw you off track?” That became all consuming; you kind of forgot, “Why am I doing this?”

But yes, I’d say I met my goals. They took a different turn, but then hospice wasn’t around when I graduated from nursing school. (Laughter)

DM: Okay. Are you married now?

MC: I am not. I’m divorced.

DM: And you have three adult children, is that right?

MC: Uh huh.

DM: How many grandchildren [do you have]?

MC: Just one. Just one grandchild, and she is a sophomore at Texas Tech.

DM: Oh, Okay, big girl then!

MC: Yes, yes! (Laughter)

DM: Do you have any advice specifically for women in the workforce about how to be more successful in pursuing their careers? Anything that women in particular should know?

MC: I think it is such a good time to be in any type of medical work because I think women are accepted more in the medical field these days. When I was in nursing school, we still stood up every time a doctor came by.

DM: Right.

MC: I just stood up all the time; it was easier than getting up and down! (Laughter) We don’t do that anymore! I do think that women are well accepted in the medical field. I

think it's a wonderful career for a woman.

I think they do need to realize though that they do need to be as professional about it and to – they have a much harder time balancing the careers because they do have families, and they have things at home. So, in terms of being successful in the medical field, you have to figure out how to do that, and you can't – you have to stand up for your time that you need to be with your family, but you have to be professional about it.

I've seen a lot of women who do more whining than they do problem solving, and that's where they get pushed down a little bit professionally. We don't want to push you up because we don't want to listen to the, "I have to go home because my child needs me, etc.," and that may well be true, but sometimes, it's simply the way things are said, not what was said. I think that's hard for women.

I think the other thing I would advise women today who are really balancing those jobs with kids and working too is they also have to take some time for themselves. They have to find a way to replenish their own energy and their own drive, or else it becomes rote and automatic, and they're not a good mother or a good employee. So, I think it is hard for women, particularly, because we want to take care of everybody else, and we need to take care of ourselves better.

I did not do that when I was there. I left with thousands and thousands of vacation days untaken and so forth, and when I look back, if I would change anything, I would have taken a little bit more time, and thought, "Okay, I'm gone during this crisis, but there will be another one when I get back." Somehow, you want everything perfect before you leave on vacation; it is never going to happen! (Laughter)

DM: What do you think needs to be done system-wide to make palliative care training

more widely taught in the medical schools? My understanding is that a lot of doctors are not really very well schooled.

MC: They're not, and the medical schools are all over the place in adding that to their curriculum. I've seen some of them really being interested in it and adding it as a special job. I would like to see – and we did a lot of this at Houston Hospice – our medical team made this happen. But we were able to have all of the medical students for a couple of weeks in their senior year, and it was part of their elective, but somehow, we managed to get quite a few of them there, and almost always, I met with them when they came in and when they left, and some of them were happy to be there, and some considered it a waste of time. But almost every one of them as they left said, "I wish I had had this in my first year of medical school; it would have made me a better listener for my patients." And we had several of them that changed their focus on what they were going to do, and decided to go back and specialize in palliative care.

DM: Oh, how neat!

MC: One moved to Iowa; one moved to other places, but they realized what it was all about. At some level – one doctor put it best when he said, "When I was a little boy growing up wanting to be a doctor, I think this is the kind of medicine I had in my head." Probably from Marcus Welby on T.V. or something. (Laughter) "But then when we got into medicine, we got so much into business and so much about regulations, I've lost sight of this, and for me, this is where I would like to be. This gives me the patient contact and the family integration that I want to do."

So, I would love to see medical schools be encouraged to have their students go through a palliative care program and a hospice care program. There's a pilot program

now that combines those two in terms of hospices being allowed to offer palliative care to patients that are still getting treatment. That's a study right now, and I've not read the 9,000 pages of regulations; I decided I did not need to do that. (Laughter) But it would be wonderful if that would happen because I think that would further it in all levels of medicine and certainly in the medical schools to be able to realize that they can learn more about palliative care.

But if they have students coming through the first year medical school and then again their third or fourth year, I think it would enhance medicine no matter what specialty they went into because it's a real different approach, and because hospices have the time to do that with them, whereas the hospital doesn't.

Why make the hospital learn something when they [hospices] can teach them [medical students] that? You've already got a system that can teach them the other, but I would love to see them be more exposed in a real world sense, not just the theory, but in being able to practice that [palliative care].

DM: What do you think needs to be done within the health care system to make the public more aware of what the end-of-life choices are, including hospice?

MC: I think it needs to be just tons and tons and tons of education, and again, when I was at Houston Hospice, I had a big education staff, and we did 400 programs a year in the community on this and just simply educating and talking to people about options and so forth, and that was not just about hospice; it was about advance directives; it was about powers of medical attorney; it was about getting your family together and deciding and teaching them or making suggestions on how the family can make this decision, because what I found in hospice is you have the two children who have been taking care of Mom

and understood and had watched her with the medical progression she had made and were ready for this, and then you have the daughter who has not been there in three years who comes in and is going to fix everything. How do you integrate that, and how do you keep the family from falling apart?

We also found as these families came together to make those decisions, they probably hadn't made that level of decisions together as adults, and they reacted about like jr. high. They were back to where they were back at home again, and kind of forgot they were adults at times. That's where the social workers and the family integration came into place, and so a lot of that and the education of how to make the decisions in the family, not just what decisions to make, but how do we come together and how do we get about it.

I got a little concerned back when the Affordable Care Act came in, and there was so much talk, if you remember back then of people not liking it because of the "death panels" that were out there, and we don't want to talk about it because the understanding that some people had was what they were going to do was say, "Okay. You get a heart transplant, and you don't."

It wasn't that; what it required was end-of-life counseling, and that's what we need.

I heard something on T.V. the other day, and again, this was the news, and I don't know how accurate it was, but they were revisiting some of that with a softer approach and with better understanding. So, some of the insurance things really turned out to be helpful because of the information that they sent out to people about their benefits, and we worked with a lot of insurance companies and talked to a lot of people about the

benefits and about what it meant. “Turn to page 45 in your benefits booklet, and here’s what it says, and here’s what decisions go along with that,” and so, I think the education needs to be on a variety of levels about the end of life; I think it needs to come from churches; I think it needs to come from society, from the medical field, from your provider fields. We need to get it from a much broader spectrum than what I see it today.

DM: I’m assuming the social workers spend a lot of time just trying to get the families to calm down and not attack each other, and try to work through this constructively as to, “What are we going to do about this sick person?”

MC: Yes, yes, right, a lot of that. We saw wonderful things. A lot of people say, particularly if you’re of the mindset that euthanasia needs to be available to everyone, but we saw so much healing happening in families when they were forced to come together and deal with one another, and they, when you have five children in the family who wouldn’t speak to one another in the beginning of this, and in the end, they’re all holding hands and standing around Mom’s bed as she breathes her last. You saw the family integration come together, and sometimes you have to face something serious to make yourself do that. It’s just not something you normally do after Christmas dinner.

There was a lot of growth that took place with families with this; so, if you had a society where, “Mom has cancer, and there is no cure, so let’s give her some medicine so she won’t suffer.” You don’t want anybody to suffer. There’s plenty of pain control now that you don’t have to suffer, physically. Spiritual suffering and emotional suffering have to be addressed, but you do need someone to say, “Is this the right time to end your life, or do you need to have all these things in place?”

And if you don’t, then you’ve got a family that feels guilty the rest of their lives,

and then, their lives are never the same thing. It's very much like you see in families where someone has committed suicide where they've not talked it through, and they don't have the closure that they need to go on and lead a successful life on their own.

There's lots that needs to take place, and again, back when I said doctors sometimes don't send patients to hospice until two days before they die, there's no time to do all that.

DM: No, no.

MC: And so, you wind up needing the bereavement programs that hospices offer because sometimes you have to do it after the fact in the bereavement program, but it is so much better [to do it before the patient dies].

When I first started in hospice, we got patients very often for about six months at a time, and that is about what it takes to get all those pieces in place, and the staff felt like they had accomplished something, and they had a great sense of accomplishment, and the families were happy. Everything was in place, and you came to the funeral, or service, or remembrance; people were sad, but they were joyful too. And I used to say to all the families coming into hospice and all the staff that I talked to, I want you to be able to say, "I'm glad I did," rather than "I wish I had".

DM: Rather than "I wish I had," exactly.

MC: However we need to make that happen, then let's go through it, and it's different for everybody.

DM: Different for everybody, Okay.

Is there anything you'd like to add, on any subject, that I've not covered in this interview?

MC: Oh, goodness! I can't think of anything, other than just to say how grateful that I am that I placed into this situation and landed in Houston in the wonderful medical system that we have here because there were so many more things to learn and so many more opportunities that people don't have and how grateful I was for all the things that people taught me, and hopefully that I was able to pass some of that along to all the students that we had coming through the program and to all the volunteers, and whatever else. I'm very, very fortunate to have worked in medicine when I did.

You know some of the changes that are coming are – you're just glad you don't have to be there to sort through some of them. So the timing and everything was right for me, but again, with all the talent and the wonderful resources that Houston has with our medical community is just –

DM: Mind-boggling?

MC: Overwhelming, and how much we should appreciate it and be grateful for it!

(Laughter)

DM: I guess that about covers it for me, unless you have something else to add.

MC: Okay, no I can't think of anything.

DM: Okay, well thank you very much!

MC: Thank you for listening; I enjoyed telling my story.

DM: It has been very informative; thank you.

END OF INTERVIEW

