INTERVIEW WITH GARY KOSKINIEMI
ISHPEMING, MI
JUNE 9, 2009

Subject: MHS Project

START OF INTERVIEW

MAGNAGHI, RUSSELL (RMM): Okay first question I have Gary is your birthday?

GARY KOSKINIEMI (GK): December 15, 1952.

RMM: Okay and we will be talking about the start of your career when you first started working at Marquette General [Hospital]. That will be the general gist of the interview. Could you tell us a little about your background, where you're from? Are you from the Upper Peninsula?

GK: I was born in Calumet, Michigan and I went to [Calumet] Sacred Heart Central School for my elementary grades and for high school I went to Calumet High School. From there I attended Michigan Technological University from 1970 to 1976. I left there with an associate's degree in nursing [and] at the same time I started in the National Guard in 1971. By the way, I'm retired from the National Guard [having served] 23 years. I'm a retired captain of the combat engineers in the 107th battalion. That's the U.P. battalion. After graduating from Michigan Tech in 1976, well, in about 1975 I married Donna Rogers who's now Donna Koskiniemi, of course. We graduated [in] '76 from tech and moved to Marquette, Michigan, where I found my first job with Marquette General Hospital working on the Medical Floor, the unit for general nursing. I worked there for about a year and a half and from there (the medical floor) I moved to a "step down" area (intermediate care unit), still at Marquette General. I was the first nurse to work the first shift when it opened. It was part of the open heart surgery package they were putting together for the hospital. Then, after about a half year of that, I went to their intensive coronary care unit (CCU). I was there for three years. From there, I left and came to Bell Hospital (Francis A. Bell Memorial Hospital) in Ishpeming. I worked there for 9 years as the head nurse of their intensive coronary care unit. From there, I left in 1991 and went to Munising Memorial Hospital (in Munising, Michigan). I went to Munising Memorial Hospital and I was the director of nursing (DON) there for 17 ½ years. Then I came back to Bell to be their clinical quality director and that's where you find me now.

RMM: Going back to when you got started, what were your memories of activity at Marquette General when you arrived? Were things developing, the different units, the intensive care units, were these things in place? Were you there when they were unfolding and developing?

GK: It seemed like it was in the earlier stages. Now, intensive care units, especially coronary care units came into being in the early 1960's. I started there in '76, so they did have established small units, a 5 bed intensive care and a 5 bed coronary care unit. This was barely in the young stages for intensive care units. There were two hospitals in Marquette [prior to 1974]. One was St. Luke's and [the other was] St. Mary's and they sort of converged and though I don't know the exact date when that happened [St. Luke's and St. Mary's Hospitals merged in 1973 to form Marquette General Hospital] it always seemed like it was very fresh in people's minds, because they would still talk about it. So, there had been some

reorganization when I started there but [with] the units (intensive care units) still being fairly small. They were just really starting to get going with the coronary care unit. They really seemed to be getting into new areas with cath labs (cardiac catheterization labs) coming during the time when I was there and, of course, the open heart surgery [program] started really taking off when I was there. So, the intensive care units (ICU) and the coronary care units were seeing much more usage and starting to get more technical and high tech; high technology being incorporated.

RMM: Could you go back to just your memories and observations of the interplay of the two hospitals? They merged around 1972 [actually 1973], so you were there about 4 years after. You could still see some stress-strain?

GK: Yeah, you know, I never quite understood what was going on, but there would be comments that were made. Like, I would be sitting at the coronary care desk and watching the monitors of our patients, our heart monitors and things, and the nurse I was with (I remember one in particular, we'll call her Carol), she had been there for many, many years and she looked at somebody that had just come through the unit, another nurse, and she said, "See her, she still doesn't like us". She said [that] ever since we moved and made the change, people still can't get together; they still are in divided camps. So, I don't think it was quite as noticeable to people who didn't know what was going on, but [to] the people who were involved in the move, there was still this feeling of division, of separate camps, of "us and them". An animosity was going on. Some of that stuff, especially for the older people, never quite went away while I was there. I was only there for 5 years, but in that 5 years time - it wasn't enough time for it to dissipate. Everybody was still thinking about it. They were still thinking about it, maybe not paying as much attention to it, but still it was-

RMM: So, this would come up in comments?

GK: Just passing comments, yeah. Someone would make a comment about, "Oh yeah, she worked at St. Mark's or St. Luke's, rather, [St. Luke's] or St. Mary's." To me it was all Marquette General.

RMM: What were the conditions like in terms of, I guess to give it a sense of contrast, how would some of the facilities you were working at then compare to what you encounter today in terms of the intensive care unit and so on? In terms of being large or small or were they in the process of growing? I guess one of the key figures there was Dr. Hunter (Alan F. Hunter, MD, cardiothoracic surgeon at Marquette General Hospital).

GK: Well, Dr. Hunter played a really key role in the education and moving our units ahead. I know I was there at a good time, because their heart program was just kicking off and getting going, so you had to make sure to take care of these new patients that were going to be seeing you. You had to make sure that the intensive care nurses were trained to take care of these people right after surgery and that there were people to take care of those patients once they got through [with their stay in] intensive care (the ICU). Then they needed a step-down unit, so they had to be specially trained RN's to make sure those patients were receiving the proper care and the proper assessments to [keep them] out of harm's way. So, Dr. Hunter put together an extensive training program for all the nursing staff to make sure of that and all the other ancillary services to make sure we all understood what our roles were, what we had to do, what we had to be prepared for. It was very intensive. It was grueling. It lasted; it was probably a couple month processes. It wasn't short by any means and when I left the medical unit it was [done on] the medical floor. We went right into that training and we did that training until it was time for a step-down unit to open up. So, we received a lot of great training and it prepared us for taking care of these new high tech patients that we started seeing (patients on ventilators, people that had just gone through [coronary artery]

bypass surgeries). We also had to be prepared to help out other intensive care units if they needed it, so we receive really great training.

RMM: Now, they had this special training program, because at that point they were utilizing personnel that were in the hospital that weren't? For instance, you didn't get any of this training when you went to college?

GK: No. Usually with college you find they teach you enough to pass the state boards (licensing examinations for nurses) and to have the basic information you need for nursing but the real training and the real education comes once you graduate and you've been on the floors [the hospital patient-care areas]. Now you start taking care of patients and you have to do a lot of studying, a lot of reading, on your own. You've got to be up on all the medications that your patients are receiving now and all the procedures that [they] are going through. Every day's a learning event for you. Even today, thirty years later, there isn't a day I'll come to work and I won't learn something. It's intense; it's very gratifying and rewarding. It's (nursing is) a great occupation.

RMM: Now, as time moved forward then and when they began to hire new people, would they be trained or did they have to be specially trained in the procedures of Marquette General?

GK: Well, when they came in they would also be trained in the procedures of Marquette General. It was an evolving program so it wasn't always Dr. Hunter doing the training. Later on, other people would take over that role but we had the prototype. We knew what had to be taught and how it had to be taught and people were hired to do that, to develop the education course.

RMM: As teachers?

GK: As teachers.

RMM: Then, that became a common procedure, the training procedure or at some point, today for instance, would they train them that way or do people come out of nursing school today with that background?

GK: Even today I think there is a trend for people to get more clinical [practical training] in schools, because there have been complaints again about that system, the educational system, not having [not providing] enough clinical [training] for their nurses when they come out (graduate). We always have to, we feel like we're training them from day one. They haven't had to learn anything. I think the nurses coming out now are receiving much better education [in] that way, but still, when they come out they are not prepared for intensive care certainly. Usually, we don't even like to bring them into intensive care unless they have a few years of experience on the regular floor. That's really where we're at right now. People coming out [of nursing school] are still requiring training. What you see in smaller hospitals: we'll take brand new nurses but they'll have maybe the "buddy system". Smaller hospitals won't have a huge education department. But they have a smaller class, so they [new, inexperienced nurses] just marry up with somebody [with experience] and that person will take them through the normal processes and procedures and answer all their questions and make sure they're comfortable and [then] turn them loose.

RMM: Now, when you were down at Marquette General did you see things expanding, the intensive care units, various care units, were they sort of knocking out walls and going from two or three beds to more?

GK: Actually, when I was there, they weren't [expanding] at that point for the intensive care. I did see the expansion with the cardiac cath lab. That was expanding. Also, for the surgical department, though I don't know if they knocked out any walls, just the fact that they were adding this new product line of [coronary artery] bypass surgery. Cardiovascular surgery was definitely changing their landscape. The intensive care unit did not really expand when I was there. They were utilized, fully utilized. The intensive care unit was almost always full and the intensive coronary care unit was very busy also and the cardiac cath lab was right next to the intensive coronary care unit, so that patients coming out of there would go right into [through] double doors and be right there. It was that close. It was interesting too, being in the intensive coronary care unit I had the opportunity to go into the cardiac cath lab and assist them in procedures. I'd be the nurse watching the monitors and treating arrhythmias that they have. Just being someone that was there to help out.

RMM: So, that was just a total learning experience for yourself?

GK: Yes.

RMM: Then you stayed there until what year?

GK: 1981, I left.

RMM: Now, by that time had it, because it started with Al Hunter, so you were kind of in the midst of that development. Then by 1981 had it come to full bloom at that point? Were they still....?

GK: By '81, as I recall they, I know he had a partner and I can't remember the guys name but he had a partner and they were busy. It was probably, I don't know if I can say it was at a peak, but probably - they were very busy. It was heyday for them. It was like, the people coming in for [bypass surgery] if they were in need, if they had a narrowed artery or a blocked artery, bypass was very popular. There were a lot of surgeries going on. I think [in] that way it was a big success. It was being utilized and it was. I remember hearing stories of how it was the new popular appendectomy all popped up but now it was the bypass surgeries. That was the new kid on the block.

RMM: Does that continues or is that pulled back, bypass surgery? They continue doing it but…?

GK: Actually, with what's happening now, with all the new innovations in the medical field and the surgical field, bypasses are not a thing of the past but [are] heading that way, because there are just so many other options now for people. Even the surgeons themselves don't have to be as invasive. You don't always, necessarily, have to crack [open] the chest anymore because of the endoscopy equipment or the scoping that they can do. They go in with a little tube, look around and then they go in with another tube and they can actually do some cardiovascular surgeries without having to crack the chest. They can do things through [in] their cath lab now. They're putting stents into arteries that are narrow. The stents are like little spring-like rotor devices that can actually spread the arteries open and hold them open. They've got little drills now that they can go in and actually drill through clots. I mean, it's amazing the things they can do and they're just getting going on it. So, because of that, what you are seeing now is heart programs are not seeing the bypass volume [the number of surgeries] they used to see, because bypass was [a] cash cow. It made a lot of money doing that and they are very expensive surgeries. Now, with the advent of the cath labs and what they call angiosuites (angiography suites) we can do a lot more without being so invasive. It's going to become more and more like that and less of the cracking the chest and opening the rib cage.

RMM: Then I guess the earlier procedure, designed to be painful, would take a longer recovery time?

GK: Well that's the way we thought it was going to begin. It's really amazing. [During] The time I was there, I can't quite recall if it was immediate or not, but I know it was always amazing that they got to that point, in just the short time I was involved with the intensive care area. How the patients would be up in the chair, extubated, because you know they were on a ventilator and they had a tracheal (endotracheal) tube in and [had been] extubated [and] up walking the next day. You think of the assault onto the body. The assault of the surgery, yet they found that it was just quick [to get] up. By the time I left Marquette General there were patients that seemed like, memory sort of plays with me, but it seems like it was, like 3, 4, 5 days later they are going home. They'd been already walking and so it was, but if you think about it, though the surgery might seem harsh, what it was doing for the body was just making it stronger and better, because now you're giving the heart a fresh blood supply so it can work and be efficient and giving more energy and therefore more strength, more ability to heal and move. Of course, the body always reacts better the quicker you move after surgery. Movement, the body was made for movement. So, when you're just moving, the sooner you can get up and walk and be moving after surgery the better your body is going to be able to adjust to it, heal, and it just makes all your systems work better.

RMM: Now today with the more sophisticated processes that they have, where they can go into the heart and so on. Can some of that be done in an office or a clinic or do people have to come to the hospital to get some of that done? Or does it depend on the situation?

GK: Well, they have stand alone surgery centers that you can go to. But as for going to a doctor's office - when you're talking about putting stents in, and things, you really still need an ambulatory surgery center that's well equipped and with the ability to monitor patients afterwards. To have an intensive care unit close by is always essential. Patients, after those kinds of surgeries, might need that assistance for an overnight [stay] or for a day or two so you have to have the ability to take care of them. I do have to say, "I don't know a lot of the organizational standards for a stand alone ambulatory surgery [facility], but I haven't heard of any who do cardiovascular stuff like we do here". For this size hospital we had to make sure we had an intensive care unit with trained nurses that are ready to go. It requires ventilators and respiratory therapy staff and you have to be able to support these patients because not everybody is going to have an event (complication) free procedure.

RMM: So I am kind of coming at it as, you know, a layperson so that's why…It's still a type of surgery that the physician people have to be concerned about?

GK: Bypass surgery?

RMM: No, no, no. What I mean is some of the things that have replaced bypass surgery.

GK: Well, they all have their risks and benefits. You just have to weight them. For the most part, what I think you're seeing industry-wide is that the alternatives to bypass [surgery] are definitely being done more [frequently] than bypass now. So, you'll see, in places like Marquette General, where, because their bypass program has not produced [the number of surgeries] like it used to, it is affecting their income and their bottom line. It definitely was a revenue producer.

RMM: How many hospitals in the Upper Peninsula today can perform bypass cardiovascular surgery?

GK: One. That would be Marquette General [Hospital].

RMM: Is there anything you would like to go into?

GK: I was going to say that if you're going to do any of the other things (cardiac procedures) like the stents and things, you still have to have the capability to do bypassing (cardiac bypass surgery). When you're doing these things (cardiac procedures), which is probably why I haven't heard of any ambulatory surgeries (cardiac procedures such as stenting), is because if you're doing a stent or any other kind of cardiovascular interventions, if something goes wrong then we have to be prepared to go to an open case. By open case I mean opening the chest, going in, and doing it "old school".

RMM: So, when something like this is being done there are people in the hospital close by that could come down and take over in order to go into a more complicated surgery?

GK: Either that or they are already in the room.

RMM: Well, they would actually keep them there?

GK: Well, yeah, or close by. That stuff would probably be done in the cath lab or somebody would have to be prepared to just whisk them to the operating room, so you can't wait for people to be coming in at that time you have to be ready, you know.

RMM: I'm kind of asking and getting clarification because if somebody is listening to this in the future that isn't familiar with some of the procedures, then they will have a better idea of what is going on here. Were there any other physicians or people that you remember at Marquette General that played a role besides Al Hunter in terms of some of the nursing staff and other that were the leaders at that time?

GK: Well Dr. LeGalley (Thomas G. LeGalley, MD, cardiologist), who's still a leader in the community today, definitely played a key role in the cardiac cath lab being started. He had a partner, Dr. Patrick (George Patrick, MD, Marquette's first cardiologist) who is not there (in Marquette) now, but also played a [role]. They were the first two cardiologists [in Marquette] that [and] worked together in the double cardiac cath lab and the cardiology side of the bypass surgery, as you have to have a cardiologist involved. It was fun working with those guys and watching them help develop their programs and they just helped out the nursing staff too. They worked very closely with us, because they were cardiologists and I worked in [the] intensive coronary care unit (CCU). They were our medical directors. They were right over us. They made sure we had the education we needed.

RMM: You were talking about LeGalley and Patrick?

GK: Yeah. They worked really hard to make sure that we were up to speed on everything and they also helped with the advanced cardiac life support (ACLS) certification that we had to have to work in intensive care, so that was good training for us. It was just interesting to see what medications would come out. IV drips and things to help the cardiac patient. They were always on the forefront of education because we would have to deliver and assess the patient and monitor the patients as they were receiving all their medications. It was excellent training grounds.

RMM: Were there any other, in terms of the nursing staff, were there any kind of leaders that were involved in that?

GK: Well at that time, Bonnie Wanska was the head nurse of ICU. Janet Penhale was the head [nurse] of the coronary care unit. Both were instrumental in the training of the nursing staff. They had to teach us everything we had to know, from reading cardiac monitors to other medications and patient care. Those type of areas. They did an excellent job. On the floor, the medical floor, Hildur Nelson was the head nurse there and she did an admirable job to make sure we were providing all the basic nursing skills that we had to for patients. She was there for many years and every once in a while I hear her name come up in circles. I was at the gym the other day and Mazzuchi (Daniel Mazzuchi, MD, nephrologist) had mentioned her. He was talking about the old days and he said, "Did you work for her?" And I said, "Yeah I worked for her." "Wow." Those were interesting times. A lot of growth was going on. A lot was happening. There was some expansion with the hospital, but intensive care, coronary care, the real expansion there is what was happening on the surgery side, with the bypasses and the cathlab. The two units were just sandwiched in-between and were able to handle the load.

RMM: Okay, anything I missed?

GK: No I don't think so.

RMM: Well, I mean is there something you want to add?

GK: Well, when I think of Marquette General, just thinking back in time, I think of the union (The Michigan Nurses Association). The RN's belong to the unions there (Marquette General Hospital). That was interesting going and working for a union. I remember one time when they wanted to strike and it was all over just a matter of respect. Nothing to do with benefits or anything, they just wanted more respect. They didn't actually strike, but they were threatening very much for it. It just made me wonder. If you are going to have a thing like a union tell you that or if you have to go to a thing like [a] union to try and get respect, something is wrong with the system. First of all, people should be able command their own respect and then get it, because they're providing this service and because they're valuable. Marquette General was growing bigger and bigger. They were hiring more people. You were becoming a number, not an individual. It was tough. There was a lot of stress there. I still hear stories of how much stress there is there. A lot of it seems to be because they aren't being treated as individuals. That's too bad because they (the nurses) provide a very valuable service to us. We need them to be here. We need their services. We don't need [to be in] competition with them. We need them to do what smaller hospitals can't do.

RMM: Do you think part of the lack of respect, this working against this monolithic institution, as people perceived it [after the hospitals merged], as opposed to the little St. Luke's hospital, St. Mary's hospital. So, maybe in terms of your experience here do you think part of that was that it was growing as a…it wasn't just growing and modernizing but it was getting larger in terms of taking more patients and more room and so on. Do you think that was part of the problem? That it was growing very, very quickly and people were becoming numbers literally?

GK: I think it was. The growth was going very fast and probably some of it was because two smaller hospitals came together. There was always a lot of friction between staff members and between management and staff. It was tough times with the division of the two hospitals and that didn't help [improve] the division between the staff and management that you usually see.

RMM: Plus it was going through the whole growing process.

GK: Yeah, going through a growing phase. That's always tough too and new technology and pressure on everyone to produce and do more. Sometimes you see less...

RMM: Do you think this was part of the…you said there was this idea of stress. Was that the result of this development and...?

GK: Sure. There was a lot that was expected and it was all new uncharted ground. We were all learning and growing together and people's lives were on the line and you couldn't afford to make mistakes.

RMM: Now you don't, for instance, here at Bell Hospital, you don't have that stress, because you're an established hospital, you've come into a new hospital now but you're not going through a great deal of growing pains?

GK: Well, we're going through growth spurts. Actually very big ones but it's different. We have a different mindset. It's a different culture. It's a smaller organization which does make it easier to control, but there is a culture here of customer service and [among] our customers, our physicians, our staff, visitors, everybody. That's one of our product lines actually, customer service. We consider that a product line. Our two major ones (product lines) are surgery and customer service. That really is driven from the top, from our CEO [on] down. It starts with the CEO and he is driving the upper management and the rest of the staff. And it just spreads out from there. Because of the attitude of those key people, the organization is so much nicer to be in and to experience for everybody.

RMM: Now do you think that?

GK: What I guess I would say is that the upper management of Marquette General in the late '70's [was] perceived by me to be…I think they were actually trying to go in the right direction. Probably, if asked, they probably did care about the individuals. They were definitely trying to grow and at that time it seemed like they were trying to take over the UP and become the mothership to everybody else. There was definitely competition and they definitely wanted to be the big dog on the street. I think from that time to where we are today there has been a lot more research. And successful organizations that have gone the way that Bell is going now, they have shown that it can be done and is more profitable to do it the right way.

RMM: Good.

GK: Quality and customer satisfaction drive everything. The more you have of that the more successful you're going to be.

RMM: Okay.

GK: Thank you.

END OF INTERVIEW