CONTINUUM HISTORY AND RESEARCH: TRANSCRIPTION

INTERVIEWEE: Bob Zylstra

SUBJECT: Whidbey Island Hospital District

NUMBER OF TAPES: 2

DATE OF INTERVIEW: January 20, 2000 INTERVIEW NO. 1

LOCATION: Whidbey General Hospital, Coupeville, WA, 98239

INTERVIEW CONDUCTED AND TRANSCRIBED BY:

Theresa Trebon, author of *A Common Need: Whidbey General Hospital and the History of Medical Care on Whidbey Island, 1850-2000*
Continuum History and Research
10619 Sterling Rd.
Sedro Woolley, WA 98284

Bob is the great-grandson of Riekele and Liske Zylstra who came to the United States from Holland in 1880. The Zylstras moved to Whidbey Island in 1896. Riekele and Liske had nine children, one of whom was Ralph. Ralph had a son named Hank. Hank married Gertrude Nienhuis and they had four sons, one of whom was Bob, born in 1934 at the Arnew Hospital in Oak Harbor.

SIDE A

B: **Bob Zylstra**
T: **Theresa Trebon**

T: What I would like to start with is a little bit of your background in terms of going back to your great-grandparents, the Zylstras, who I understand came here in 189...

B: 6. [1896].

T: Originally from Holland?

B: Originally from **Holland** and they came as far as the Dakotas for a year or two. I'm not exact on this. But they were in the Dakotas for a short time, over one year or two years.

T: I understand Charles Mix County?

B: Oh really?

T: How do you pronounce your great-grandfather's name?

B: Ree-kle.[1]

T: It says here they were in Charles Mix County in South Dakota which was where my grandfather came to from Holland.

B: Really! So you're a dutchy too. But they didn't stay long, ours didn't. A year or so. They had other contacts or friends and people that came out here earlier.

T: To Whidbey?

B: Yes. And they wanted to get to a more moderate climate and more what they were used to so they moved on to Whidbey Island in [18]96. And they homesteaded and here's where I'm not the best historian. I have a cousin who has done a lot of research on our family but the general part of it is that my great-grandfather opened, he had a real estate business in Oak Harbor, and he was a county commissioner for a period of time and he brought his father over here and his father is even buried in Oak Harbor. And all of his children grew up in the area. Either in Oak Harbor or, one of his children, James, who was an attorney, his family grew up in Coupeville.

T: And your grandfather was Ralph?

B: Ralph.

T: And he married...?

B: He married a Hoffman. A lot of Grandma's family lived in the area.

T: Were they related to the Hoffmans up in Clover Valley?

B: No. That's different. The Clover Valley Hoffmans, I think, were German.

T: How many kids folks did your kids have?

B: My brothers and sisters?

T: Yes.

[1] Rickele and Liske Zylstra are pictured on p. 167 of *A Common Need.*

B: My [grandfather] Ralph had two sons and three daughters. And my dad was Hank, Henry. And I had three brothers, so there was four of us. My mother was a Nienhuis.

T: What was her first name?

B: Gertrude. And her father lived here in Coupeville. They grew up, more or less, in the Coupeville area. And my mother had two brothers and four sisters. Big family.

T: What was her parents' names?

B: Richard Nienhuis.

T: When your parents got married, where were you brought up at?

B: I was born at Oak Harbor in a **maternity home** that's there... the home is still there, it's a private home now.

T: Which maternity home?

B: I don't know the name of it. It wasn't Kruick and it wasn't Harpole.

T: Was it the Arnew?

B: Could've been Arnew.[2]

T: Where was it located?

B: It was located... do you know where the Whidbey Medical Clinic is?

T: Yes.

B: It was a house, just the next corner over.

T: Okay. That was the Arnew.

B: That's the Arnew? And that name kind of rings a bell.

T: What year were you born?

---

[2] For photos and information on this maternity home, see p. 111 of *A Common Need*.

B: [19]34. And the only thing I remember, and I don't know why it sticks, but my mother, and another aunt of mine and another good friend of ours, the Fakkemas, this happened to be Della Fakkema, were all in the maternity home at the same time. And they were there for ten days! So it was like living in a hotel.

T: Party!

B: Yes! They didn't get home very quick. But Chuck and Jeannine and I, our birthdays are all within a few days of each other. One of them was my cousin and the other was just a friend. Oak Harbor was small. I can still remember when Oak Harbor was less than a thousand, maybe, five, six hundred people living in Oak Harbor. And Coupeville and Oak Harbor were about the same size. And then when the Navy came in 41, of course, Oak Harbor started to blossom.

T: Who do you remember your mother taking you to see to the doctor when you were little?

B: Our doctor was **Doctor Henry Carskadden** and he was the only doctor in town and his office I remember vividly because of an injury I had when I was about five or six. It was on the main street. The building's torn down now. Right on Pioneer Way. His office when I was a child. On Saturdays we would go to catechism at church and then sometimes she'd [my mother] go visit her sister Grace Jensen, who lived right next to that maternity home, and they had a bathtub. And after catechism we'd take a bath. Our Saturday bath. I slipped in the bathtub, it had a porcelain spout, and I cut myself just above my seat, across my back, so they took me to Doctor Carskadden because it was quite a deep cut. My dad was a mechanic all his life and the Ford garage was across the street. It's where the Pioneer Building is now. But he heard me crying, hollering, in that office. The stitches scared the heck out of me. And he came across the street because he heard it! It was that small a town. The window must have been open or something! [Laughs.]

T: "That's my kid!"

B: So I remember Doctor Carskadden very well. Whenever he was getting serious about doing something, he'd bite his tongue like he was going to bear down on you. He was a very nice man. Then he moved to a newer office from there. And I think he brought in Doctor Bailey after that. But at that time, when I was a child, Carskadden was the only doctor on the island for a while. And he'd do house calls all the way up and down the island. He had diagnosed my mother with appendicitis, he just threw her in the car and drove her to Everett. That's where he did his surgery, was at Everett General.

T: Not at Anacortes?

B: No. Anacortes was a very small community hospital at that time run by a doctor and a nurse I think. It was not a district hospital at that time.

T: Was it more like a house or was it actually a building?

B: No, it was a little hospital but they didn't do surgery. I don't think they could support a surgical service of any size. I'm just speculating. Even Mount Vernon's hospital was quite small at that time.

T: Was Burlington's hospital still going?

B: The old Burlington Hospital? I don't know. I just remember him driving my mother to Everett and doing surgery on her. Hers weren't ruptured. She did fine.

T: He just took her on down eh?

B: He just closed the office and took off. They put in long hours, it isn't the way an office is set up today.

[Bob was suffering from a cold and cough during this interview. Tape is momentarily shut off so he can get some water.]

97

T: Where was your parents' place at in Oak Harbor? Was it outside of Oak Harbor?

B: Now it's within the city limits. We owned a little home, right at the corner of Scenic Heights and Highway 20. It was torn down a couple years ago. Just east of it now is condominiums. Right on the corner, I think if you look down over, they've built the highway up there, but we lived right on the corner property. We had two acres. We had a little barn where we raised a cow and pigs and Dad was a mechanic in Oak Harbor.

T: Were your grandparents still living out on the place past Monroe's Landing Road [and its intersection with S. R. 20]?

B: He had that farm when I was very young. And then when my grandmother died of diabetes, he didn't live there much longer than that. He moved out on Oak Harbor Road and had, when the Navy came, he owned some cabins there and he rented them to Navy families. Small little homes, little cabins, they're still there. And one of his daughters lived right next door.

T: And then did he sell his farm?

B: Yes and I don't know the circumstances. Well, after Grandpa moved off of that then the other brother, my dad's brother, Richard Zylstra, I don't know if you've hear of Ted, he's an attorney, but his father [Richard], they lived out there for a while. And when they bought it from Grandpa, and then sold it, I'm not sure of the circumstances. Ted knows a lot of the history of our family. And his father was the mayor of Oak Harbor for a period of time. He was a builder, built homes.

T: Well the Zylstras certainly are an important family on Whidbey Island.

B: Especially the north end. They were quite involved with the development of the north end.

125

T: Well, so you went to Oak Harbor High School then I assume?

B: Yes. I went through the school system in Oak Harbor and went to Whitworth College in Spokane. And then I went in the Army for a couple years, and back to Whitworth. So after I graduated [from high school] in 52, I was just home summers. And then I was married in 57 while I was in the Army. After I got out of college I started in small loans career. Banking and small loans. So we lived in Spokane a few years, then in Anacortes, then back to Spokane before I went into the health care field. Changed careers after seven years from the small loan business.

T: So you were in Spokane when you changed careers?

B: No, I was back in Anacortes. It was a company called Capital Finance. They had 300 and some offices around the country. It was considered a fairly large small loan corporation. They had a branch in Anacortes so I was there too. But I wanted to change careers and the business office manager for the Island Hospital came open. So I took a look at that and talked to the administrator and took that job. That was in [19]66, when I started my health career change.

T: And they had only been, at that point, a hospital district for...

B: Three years. Well, they were open... our daughter was one of the first children, the first year, after it opened. It may have opened in 62. She was born in February 63. It was a brand new hospital.

T: Was it on the site of the old one?

B: No. The old one is the library now. Downtown further. Our one daughter was born at the old hospital and the second daughter was born at the new. And I don't know when the district was formed and when it became a district hospital.

T: I talked to them... I think it was 62.

B: Around that time. They bought out the old hospital, ran it for a little while, then built a new one.

T: So you got into the hospital business at the same time, basically, they were trying on Whidbey Island to get it together to...

B: Yes. They were trying to get a hospital established here. And as you know, there were two districts for a while [on Whidbey Island] and the south and the north came together and formed one district. They were working on that... I wasn't really aware of that or really involved with that until 68. The board here had been negotiating with the Anacortes Board of Commissioners... They needed some expertise in getting this project off the ground. And so they signed a **Shared Service Agreement** with that board and the administrator and I then, helped with the bidding process. The hospital was already designed so there wasn't much we could change. This one. But the bidding process and seeing it constructed and the hiring of people and all of that we did for the next two years.

T: Was that exciting?

B: Yeah, that was really a fun experience. And then we also had our responsibilities at Island Hospital. I was the assistant administrator at that time.

T: Of Island?

B: Of Island and then of Island and Whidbey when it opened. And we thought it would be good if one of the administrators lived on the island. Well, that was nice for me because I was coming back home. So it was logical I guess so I moved back to Whidbey in July of 70 and the hospital had opened in March of 70. So there was a presence here of one of the administrators. So we continued that shared arrangement for a period of time. For a few years.

184

T: You know, I was able to track that [shared services arrangement] up until [19]74.

Do you think it went much beyond that?

B: No, not in administration. The administration part, we could tell, it just didn't work. There wasn't enough identity for this "baby" hospital so to speak. They always felt like they were not getting the attention they needed here. Island was more mature as far as a hospital by that time. After Whidbey opened, about three years, it was decided to split, it was decided we needed a full-time administrator here, and a full-time administrator, of course, at Island. And this board opened that position while maintaining other **shared programs** with Island. We did that for a number of years beyond.

T: Okay. Like equipment and...

B: Equipment and the head of our Physical Therapy Department, the head of our Respiratory Therapy Department. Our Chief Engineer... they were all shared department heads. And we had workers, skilled people, in both hospitals that did the day-to-day work. At that time they did patient care too. But they managed those departments shared. And our **medical staff** was a joint staff which kind of put some glue to the program. And rather than have one medical staff, because so many of the Island Hospital doctors, people from Anacortes, did part-time surgery and physician coverage over here. So rather than duplicating their time for two meetings, and two of this and two of that, for a few years, we had a shared medical staff. And then, through growth and other conflicts, I don't mean conflicts in a negative way but you know, scheduling of things and with the growth of both medical staffs, it was decided to split that again. I forget when that happened.

So when the full-time administrator position opened here.

T: Was that after **Jerry Koontz** resigned?

B: Jerry Koontz had already left and we had Bob Jacobs for one year about. And he was still sharing and I worked under him. He had a parting of the ways and moved on and at that time, when Bob left, is when the board decided to split the position. So they were hiring a new administrator for Island Hospital and a new one for Whidbey. And I was accepted here. So, I'm guessing now, that was about April of 74.

T: [Trebon, checking her files.] Good memory!

B: Was it?

T: Yes. It seems like there was some opposition by some folks to moving into more of a... I know like in [19]72, when it was proposed hiring a full-time accountant

and purchasing agent for Whidbey, Doctor **Gabrielson** opposed it saying the board should encourage expanding patient coverage as opposed to the administration.

B: I don't remember how strongly he opposed it. Some of the physicians, I believe, felt, and that's been historically true, they feel the hospitals get too top-heavy and not enough of the people really care for patients. I think he was sort of in that camp. Whidbey was growing and at that time we had a shared purchasing agent between the two hospitals. And when I say shared, I mean they didn't have much help under them. They were doing two jobs for two organizations that were growing with fairly large budgets for that period of time. And with growing pains in both communities we felt we needed a purchasing agent who was responsible for a lot of dollar flow and equipment supplies at each hospital. It wasn't working.

You grow out of some of those shared programs is what I'm saying. And there was some opposition but I think all of the decisions that we made to gradually split away from the shared employees were supported by the board and recommended by administration. And even though there may have been some opposition, it was the right decision. And I think Doctor Gabrielson or anyone else who might have opposed that, at that initial time, could probably could see later that it was best.

The shared program was a good way for Whidbey General to start. Because they had experienced people. I mean, it's one thing to move from an old hospital to a new building when you've been operational for a number of years. This was a first on Whidbey Island.

T: A big change.

B: A *big* change! And no one had the experience of managing or operating or even being the decision makers of a hospital, including the board. To get that experience and knowledge from Island Hospital made Whidbey General successful from the get-go. Even though we opened knowing that the reserves we had were next to nothing. We opened this hospital going on what they call registered warrants. Which means that we were paying bills, and borrowing from the county, to pay the bills. We weren't generating enough revenue to pay for the daily operations. So after about a year, year and a half, I forget...

T: [19]71.

B: Yeah-in a year. We had to go back out to the community for a levy to cover the operational debt and also get enough money to carry us through so we wouldn't have to do that again. And I can say from that levy, from 71 on, we've never been on registered warrants again. Never. And for a small rural hospitals that's a real

victory because many of them were on registered warrants for years and years and years. What that means is, it's a new debt you have. So you gradually pay that off. But it says right on the check that this is a registered warrant at an interest rate of such and such and it's covered by the county.

T: But then you have to pay the county back, with interest.

B: You've got to pay it back! With interest! So we got rid of that after we really felt we were operationally able to meet the budget each year, after one year. But we couldn't do it, and take care of that past debt. So we went out for an operational levy and that was the only time we had to do that.

In fact, we didn't even open the hospital when it was finished. It was actually ready, we could've accepted patients by about the middle of 69 or early 69, but we had to go out for a levy for supplies. The construction of it used up all of the Hill-Burton funds and the bond issue and so it was a nice beautiful looking building, but we weren't able to equip it. Because it had drug on for so many years, from the time of the original bond issue, with the fights they had with Hill-Burton and getting the hospital approved, that the inflation caused that bond issue to not meet the total financial needs. Yet, they went ahead, knowing that, and finished the hospital, but didn't have enough money to equip it. So wasn't there another bond issue in 69?

T: There was one in 69, the fall of 69.

B: And then we had to come back out in 71 and say, "Hey, we need some more money."

T: How was that?

B: Well, the people supported it. We presented it in a way I guess that they understood that that was a good business decision. And they wanted the hospital badly, the people really felt they wanted it to succeed. Beyond that, the only time we ever went out for a bond issue was when we did major expansions. Two or three times over the last twenty year period. Or, the ambulance levy, and that's the way ambulances are operated. That's a separate issue. But the hospital itself, it has always been able to meet the operational needs, with increased rates, of course, and putting money in reserves for day-to-day operation.

331

T: So basically then, once this 1971 levy happened and you went on from there, your

income comes from being reimbursed for patient care by Medicare and private insurance companies?

B: All insurances, and private.

T: So that's one source of income.

B: That's the majority of it. For our daily operations.

T: And then the millage?

B: The millage hasn't changed. What happens is what we call the M & O, maintenance and operation levy, which is the millage, the cents per thousand keeps decreasing as the assessed value goes up. Because they capped it at 106%, the state did. Unless you went out for a special levy to increase that back to the maximum, let's just hypothetically say at 25 cents a thousand [dollars assessed value].... We were down to 10 cents a thousand because the assessments kept going up, we could only increase it to 106% a year...

T: Per thousand dollars property value?

B: Say you were getting a thousand dollars of millage, it could only go up to $1060 dollars. You couldn't go up more than 106% per year. Well, inflation and everything else went up much faster than that. The assessed values went up much faster than that. So the amount of levy required to hit that 106% became less and less and less. So we're down now, but I bet it's under 10 cents a thousand. But we never went back out to say we want to get our millage back up to whatever the maximum was. It started with a maximum of, I think, 25 cents a thousand at that time. I'm not positive of that, but there was limit.

But that millage, even today, with a thirty to forty million dollar operating budget, it's thirty million, is a couple hundred thousand dollars, two or three hundred thousand dollars. Very small percentage of the millage goes into the daily operations of the hospital. Small dollar amount. And a little of the millage is tied to cover the bonds for the South Whidbey Clinic. But all the other... on our tax statement where it says, "Hospital-$30.00 a year" or whatever it might be, a portion of that is for the millage, a portion is for bond issues that were approved over a twenty-year life, say, bond issues, like paying off your home, so part of that millage is to pay off past bond issues, and part of that millage is to pay for the ambulance service. Three different pockets.

But getting back to what revenue do we generate for the daily operations, 99% of it is from patient revenue. Small amount is from the millage, and a very small

amount from donations. The foundations and stuff, but most of that's for equipment. But from the revenue that we generate, and the cash we take in for operations, we are also building a reserve for the future. We fund the equipment budget and the day-to-day operation from that, so you know, that's why its very important to collect as much as you can from the bills. And there's some bad debt, write-off for charity. And the insurance companies are paying much, much less today than they used to pay on the dollar. So it's a tightrope.

401

T: So, how does the hospital resolve that? That's one thing I noticed, starting in the 80s, the amount you were being reimbursed for actual service was just starting to drop. So how do you make up the difference in that?

B: Unfortunately you inflate the charges. The differences are picked up through two things. One is, you charge more for those who aren't under those regulations, like Medicare. Medicare is your regulating thing and they pay less than cost. All the government programs pay less than cost.

T: In 1984 it says, "Beginning this year, the state designates 468 different categories, each containing a fixed amount that the state will pay no matter what it costs to treat."

B: That's right. That's what we call **DRG's** in Medicare. At that time, let's say you had a gall bladder surgery, they would pay X dollars for that gall bladder surgery, no matter whether you had complications or what [edit: B. Z. "not"]. It was passed on a blended formula for the northwest, regardless of what our costs were, or Mount Vernon's costs were or Anacortes's costs. We all got the same basic dollar amount and then they blended in some additional costs based on your own experience. The point is, whether that was enough to cover that surgery or not, the [Edit: B. Z. : "hospital performed the surgery and cared for the patient."

The question was what do you do? You raise your rates. At that time, over 50% of the revenue was still generated from other types of insurance programs and the private sector that would pay, literally, cost. At that time. That has decreased all along. And now the majority of insurance companies and the federal government programs are regulated in a way that they only pay, they negotiate a rate. And it doesn't always meet costs. That theory of raising rates so you can get more money from the private sector doesn't fly anymore.

So the other thing you got to do, is just negotiate the best you can, to get the best rate you can, and then you got to keep reducing costs, expenses. So the hospital

works very hard at being as efficient as they can in order to not have red ink at the end of the year. They've done fairly well there. There are hundreds of hospitals who've gone under since all of this happened. Hundreds and hundreds across the country and even in this state, some hospitals just couldn't make it under this formula for reimbursement. But this hospital has been successful. And I think it will continue to be. Not that some day it won't become part of a larger group or something. It's like any industry, there's fewer and bigger. And that may happen.

But it's been a real successful hospital that we can be proud of for a rural area. We've been, I think, on the cutting edge of new services, and quality services, all the way along as best we can. We can't do everything here. But we've added some services over the year that have made us a very attractive rural hospital. You know, when they started home health, and the ambulance service, and then oncology... one of the best things we ever did was start our medical oncology program. Everybody had to go to [United General] at Sedro-Woolley [Edit B. Z. "or hospitals in Everett and Seattle"]. And that was fine because it wasn't too far but that's a hard day's work when you're sick. And when we started the medical part, not the radiation part, over here in conjunction with North Puget Oncology, the patients just loved us for doing that. It wasn't a big costly thing to start. You got to have the docs though. You have to have the oncologists to do it. To come here. It's a wonderful program.

T: Do you have any idea when that started?

B: No.

T: Unfortunately the scrapbook from 1992 until present is gone. Nobody knows where it is.

B: I don't think we did much scrapping did we? I don't think we did a very good job from that point on. Whether it would be us or the auxiliary of keeping that up. That's sad. Either Amy [Ayers] or Renee Yonkee, who runs the department, can tell you when the oncology program started here. We call it medical ambulatory care but oncology is the biggest portion of that.

T: Okay... 1992-expanded medical ambulatory care. That's it?

B: Yes, and that's probably when oncology started. But that was a wonderful program. **Home health**, and Hospice is probably the most... we don't see it here because they're out in the field all the time. But they do so much for the elderly and people who can stay at home, providing them care. We bought that from a private agency that started here. They were connected with an agency out of Everett I think, initially. And they struggled because it was a small agency. And

our theory, our philosophy, here was if there's a service need in the community, and we feel we can provide it as well as, or better, than anyone else, we should try to do that. And so when it appeared that that was going to fail we kind of bought them out. By that I mean we took the employees and we probably paid them something for their equipment, and we started Home Health. Early 80s.

T: [19]82.

B: And that's been a wonderful program. Difficult to make it pay, but it does so much.

T: Is that because of Medicare?

B: Yes. They just keep tightening the screws down on it.

T: And then the next year, you started the Hospice Care through Home Health.

B: Yes, which is wonderful. Good program. I know Scott, our son, even experienced Home Health. I'd always heard so much from patients and families, how great it was. And seeing those people work.... I never got out in the field and watched them work. But when they came to your home, it was just tremendous, what they do. It's a great service.

543

T: So.... 1970s you're kind of getting on your feet, getting going here.

B: The hospital?

T: Yes.

B: We opened March 10. And we had hired the core staff by then and the state had given us our license.

T: Is that accreditation?

B: No. Accreditation you have to be open 18 months I think.

T: Because I saw the first was [18 months later] I thought "How could they open without being accredited?"

B: Well how you open a hospital or any health care organization, is you're licensed by

state, by statute, you're licensed. You don't have to be an accredited hospital, ever. There's some in our hospital that aren't accredited. Accreditation is like the Good Housekeeping stamp of approval and the highest standards that are set for hospitals in the country, nationwide. And that accreditation is important. Medicare looks hard at accreditation. If you're not accredited, they have to come in and do an audit every year and see how you're managing your departments and things. When you're accredited, they accept that accreditation as their standard. A lot of insurance companies would balk if you're not accredited. It says you're doing things as good as any other hospital in the country so to speak. You're meeting those standards at least. And you couldn't become accredited until you're open 18 months. And we applied and I think we were accredited in 72?

T: Yes you were. And you were number 2 out of 90 hospitals.

B: Yeah... and we've never not been accredited. For a while it was every two years, now it's every three years. And we've always met the [standards]... we've had some deficiencies here and there that we've corrected. Some of its paperwork, not care.

T: Who accredits the hospital?

B: It's called the... I can't think of the name of it. I'll show you.

[Bob walks out into the hall to bring in the hospital's framed Certificate of Accreditation. It is provided by the American Hospital Association.]

END OF SIDE A

SIDE B

000

T: Is it a government agency?

B: No. It was actually started by the American College of Surgeons to make sure the hospitals they worked in had the highest standards of care. And then the American Hospital Association went together. It's a private agency. And we invite them in. It's not a mandate at all. We don't always like their standards but we have a voice too. There's people in our industry who are on their boards so we can argue with some of the standards. But overall, if you didn't have somebody looking over your shoulder, things could slip. Even though we complain, "Here it is time to do the Joint Commission Survey again." You got to kind of get geared up. If they weren't

around, I think some hospitals would let things slip. So it's good. It's good to be accredited.

T: Even though it's a stressful process probably.

B: It is. Horrible.

T: [Laughter.] It's funny, when I read the coverage after your first time going through it, you could almost hear sigh of relief.

B: That was a big event. Because not only could we say we were accredited, many hospitals back then didn't make it the first time.

T: So you did, and you came out number...

B: Well, I don't know what that...

T: Let's see. You were number 2 of 90 hospitals in Oregon and Washington. First time out.

B: Okay. Well, that was good. We did all right.

T: Real good. You had your **disaster drills** in 72.

B: Well, disaster drills are part of the accreditation process. They require you to meet their standards for emergency preparedness. To have two disaster drills a year. And you have to document that. It means you have to have a design, drawn-up plan as to what you do when there's a disaster. That could be a natural disaster to an accident to whatever. Then you have to use that, follow that plan. So the hospital does into a different mode of operation that you call a disaster. Then the disaster, if it was a real one, would be called by the administrator and that brings in... you have to have a telephone tree to bring in extra help because it usually means you're going to get more patients. Or, it could be a disaster when all the lights went out and its twenty below zero. That's a disaster too. It could be a natural thing or an earthquake or something. But usually it's from an accident so all of a sudden your emergency room's going to be inundated with twenty patients. Normally we see twenty patients in an hour.

So you got to have a method of bringing in extra people, extra doctors, and you go into a different mode and still take care of the people that are in the beds. So every year we have... sometimes we've done just a telephone... the biggest concern we had was making sure we could get people in from all parts of the island. So we do a telephone check and make sure everybody was home, and yes you could come

in, or no, they weren't home so they weren't available. Whose available at any given moment. That's kind of important. So I'd do a telephone tree check and that was enough. But every year we do a live disaster drill where you'd get kids from the school and demonstrated a bus accident, and the ambulance goes to wherever the accident is and pick up these people and bring them in and we had Army cots and gurneys that we'd put them on and set up different triage stations. They still do that every year.

T: And that's part of that accreditation?

B: Part of the accreditation, it is. It could even be part of the requirements for licensure, I'm not sure. Every hospital does that. And we do it now, not each time, in conjunction with the Navy hospital and other emergency agencies on the island, the county and so forth. We do a broader report, every once and a while, every couple years.

57

T: So, in 1975 you go and expand for the first time. Was it pretty obvious that you had to make that move at that point? Five years after the hospital opened?

B: Yeah. We were running out of space, the lab for example was literally about as big as this room, and a little extra L. [Bob is referring to the small meeting room we are in... large enough to accommodate a long table and about ten chairs around the table.] The major part of our lab wasn't any bigger than this. That room isn't there anymore. The lab was running out of space. We didn't have a physical therapy department but physical therapy was booming already. We were using two patient rooms for physical therapy. OB was in very close quarters, and surgery and all. I forget what all... and Central Supply was short of space. We had to expand in five years and yet we didn't want to overbuild. Sometimes you can overbuild but it is also costly to underestimate. To think ten years out is really a maximum. However, the lab we built in 75, although we've added a little bit to it, that 75 lab is still functioning today. So that was kind of a good one. It was very obvious we needed to expand in order to grow with the requirements of the patient loads that we had. [Editing change by B. Z: in order to provide services for the increasing patient volumes.]

T: It must have been hard too, because in 76, as your expansion had been completed, you're quoted as saying, "The population is increasing but the average length of the stay is decreasing." So that must have been a real tricky thing to...

B: Well, it is! But that's why we didn't add beds. We may have in 75 yet...

T: I don't think so. I think you did in 81...

B: A few beds in 81. If you look at the volumes of patients we see every year today, compared to what it was in the 70s, you'd think well, how could you not add beds? Well, the obvious reason is, is that lengths of stays kept declining, only back then about 20% of the surgeries were done out-patient, and 80% in-patient. So you were in bed everytime you came in for surgery. Now, over 50%, the majority of surgeries are done on a one day, in-and-out-the-same-day stay. So you don't need more beds. You need more support for whatever services you're providing. So you need bigger and better recovery rooms and you need physical therapy and you need services that treat people on an out-patient basis, whatever those services are. So that's where the growth has really been in the hospital since that 75 [expansion] when it kind of brought us up to date for lab and that type of thing. That wasn't our emergency room. We didn't increase our emergency room until 80 I don't think.

But the point is, it is kind of tricky to know where to build, and how much to build. Some hospitals erred by building too many beds. The bigger hospitals. Their wings, a whole floor is setting empty all the time. That's a waste. We tried to maximize the use of our space and yet we didn't want to underestimate. Well we did that probably in surgery and ER. In our last expansion, we had to cut back in order to stay within our budget.

T: This is the one in 90-91.

B: Yes, 90-ish. See, they're already now in this plan... [Bob points to a blueprint on the wall for the hospital's next expansion.] they're looking at increasing the emergency room.

T: That's currently going on right now?

B: Yes. That's their master plan. They haven't gone out for the money yet but it's going to take 4, 5 million dollars to do that. So they've got to find the money but that's their plan. And the big blocks are all out-patient services. Here's the patient wings... see, these haven't been touched for years. You just don't need more beds but that stuff is all out-patient, but the ER, even though we spent a lot of money building that emergency room ten years ago, it's too small. But you don't want to build a Taj Mahal, you can't.

T: Well, it sounds like you were smart, I think it was the expansion back in the 80s, you had walled off space, you put the space in...

B: That was the best thing we ever did. And we didn't actually fill those spaces in

until about close to 90, the 90 expansion. That was all the OB area. This whole wing here, this part, was all just shelled in. And then the basement under some of this was all shelled in. Then we finished that off. That was smart. That was a good thing we did that because the cost of construction is so horrific.

T: So now, the next expansion then will be to enlarge emergency?

B: They'll enlarge emergency, diagnostic imaging, that's another big area that keeps growing with MRI. We had all this portable stuff. Portable MRI, portable CT, portable everything. And that was the best way to start because somebody else owned the equipment, they rolled it up here every couple days and you didn't have to spend a couple million dollars on one piece of equipment that you couldn't afford.

T: You did that in conjunction with other hospitals?

B: Yes. They went here today, and Anacortes tomorrow, and Arlington the next and back and then you need two days a week, and then the next thing you know you need three days a week and then it's time to get your own. And now CT is in house, and they're going to be bringing MRI, it is still out on a portable, and they're going to be bringing that in-house when they get this done. So it keeps growing. I think the hospital has grown in a systematic way, to not over-tax the district and the public who has to support it, but has also been able to increase its services based on new technology and new ways of caring for people. It's never been a static type program here. It's moving.

I remember our first **medical staff meeting.** Our old meeting room was our old library and it was a little bigger than this room and all the docs sat around here, five of them, or six of them, and the administrator and I, and that was the first medical staff meeting. Now we have 40 or 50 or 60 doctors.

152

T: How does that work? Are the doctors paid by the hospital?

B: No. Most of them aren't.

T: So they are basically independent. And they contract with you?

B: No. They apply for privileges, based on their specialty. They say, "I'm capable of ___ and I want to do this and this. There's a whole laundry list of procedures or services that they provide in their specialty. Whether it's family physicians or a

general surgeon. Much of it overlaps. But they check off everything that they want to do and then there's a committee of doctors called the Credentialing Committee that credentials them and says, "Yes, you can do this." Sometimes they question it, "Now, why did you check this off? Most general surgeons don't do hysterectomies." You know what I mean. So they explain why or they say, "No, I don't do those."

So the **medical staff** has their own governance and their own way of monitoring themselves and that's the final authority with the board. So a doctor applies for staff privileges at Whidbey General, the medical staff recommends and approves what privileges they have here, what they can do here at this hospital, and then the board approves that. It's not rubber-stamped but it's not too often that they would question the recommendation of the staff. So then they're a member of the medical staff and they're required to be on committees, they have to make the medical staff meetings or they'll be kicked off the staff. It's kind of like belonging to a country club I guess, but there's more teeth to it. And yet, they're all independent physicians out in the community except for the E. R. docs... they could be employees of the hospital but they're not, they're employees of a large emergency room physician group and we pay to have their physicians here.

T: Same with OB?

B: No, OB, all the surgical specialties, all the family practice, all internal medicine, they're all private physicians.

T: Good explanation.

B: And then there are some hospital-based physicians that also are not employed, they're allowed to work here in anesthesia, radiology. We have contracts with them but we don't pay them. They're paid through their own fees, but they're allowed to do their specialty here and they're required to meet some certain things that we require.

T: Does it cost money to have privileges? Is there a fee?

B: There's a fee. Every year they charge them fifty dollars or whatever it is just to redo the paperwork. But they don't pay the hospital anything significant partly because we expect work out of them. They *have* to belong to certain committees, which means a meeting a month and maybe some preparation for that. It was only about two years ago that we have provided a stipend, and most hospitals do now, because there's more work to be done and it takes time away from their office and they're having the same problems as hospitals of getting enough reimbursement. The reimbursement for their work is being squeezed down all the time. Like the

chief of staff, and certain key officers, who have to spend more administrative time here. We're paying them a little stipend, $500.00 a month or something.

T: Is that recent?

B: Yes, last couple of years. And that's very common today in hospitals.

207

T: Speaking of staff, I know there's been a few **controversies** over the past thirty years. There was an incident in 78 with a doctor disconnecting life-support on a patient. Have there been many things like that that have been big hurdles?

B: Major hurdles? No. Really there's been very few of those. For the most part the medical staff has worked well with the hospital and its staff, there's been few major care-type challenges that the medical staff has had to deal with. And that was a philosophical thing but at the same time it was major enough that they kicked that doctor off the staff. That was the outcome of that. And the docs really agonize over that because its a peer review process, it's their livelihood that your talking about but they felt there was enough other things related to that that they felt he shouldn't be allowed to have privileges here. Doesn't mean he couldn't go somewhere else but now there's what's called the Databank for Physicians. It's run nationally, where anything like that happens, the hospital is required by law to send that incident into this databank. So if that Doctor X applied for privileges somewhere else it would be shown, and they bring that data forward to their hospital, that he had a problem somewhere. He or she.

T: So basically then, anything like this that happened was more an incident with the medical staff as opposed to the hospital?

B: Well... I say they're self-governed, they are, they have their own set of **by-laws** and all but it all ties back to the hospital. The hospital board approves the medical staff by-laws, their working by-laws, how they're structured, and so they are the medical staff of the hospital but they have their own set of officers to work from and their own set of standards. So it does reflect on the hospital when something like that happens because it's the medical staff of the hospital. It's Whidbey General Hospital Medical Staff.

The doctors are very conscientious about making sure its a safe place for patients. That's number one. And there's a high quality of care being delivered. There may be conflicts sometimes about what that means... some doctors feel that they're being scrutinized too closely, I mean, there's different ways of skinning a cat,

different ways of caring for people. So sometimes within their own committees there can be big debates. But when it gets to that serious of a problem, after all, we don't want to be sued either, so the doctors help us with the quality of care issues. But those major things like that, where we had to really restrict the privileges of a doctor, or actually deny them privileges, over the thirty years? Two or three times. Very minimal. Usually what happens is if there's that type of peer pressure to change, and you don't want to change, they move on.

259

T: There was an incident with a baby that died or was brain-damaged. I'm not quite sure.

B: Yes, that was one of our only **court cases** we ever had.

T: What was the outcome?

B: It showed... the doctor had already settled so they couldn't bring up the doctor in court, so all the jury was hearing was what the hospital did or didn't do appropriately. And the jury couldn't know how much that they had settled for with the doctor's insurance company, which was different than the hospital. Because it was obvious it was a bad decision on the part of the doctor.

T: And they couldn't hear that part?

B: No. It was obvious the hospital nurses hadn't done everything exactly the way they could have but at very little risk or damage and certainly to this patient who was born very crippled, because of loss of oxygen, that really the hospital or the staff, really wasn't involved. And so the end result of that was that the jury awarded X dollars for that patient. Well, the doctors insurance had already paid that so the hospital didn't have to pay anything after three weeks of court. Well, the judge didn't like that and I didn't know that he could do this but he arbitrarily said, "No, the hospital's got to pay something." So, we ended up having to pay a little bit on that. Not much. But baby cases are tough because there's such an emotion there and such tragedy. We've settled some other cases out of court where the hospital's been sued but they've been minor. That was the only one that really hit the newspapers. That baby case. And they brought the child into the courtroom, he's still living, but he's in a wheelchair and he doesn't have use of his limbs. It's sad.

304

T: What about the decision to offer **abortions** here, was that a controversial thing in the community?

B: Yes, it was. It didn't hit the paper so much. I received a lot of letters from people who didn't feel it was right that we did abortions here. Whether you agree with that or not, as a district hospital that's chartered to provide care to its community, whatever community it is, you can't deny that. If a doctor is qualified to do something that is legal, you really can't stop that. Employees who have convictions about that were given the opportunity not to provide care to that person. If you're a surgical nurse and don't believe in abortion, you didn't have to scrub in on that case. But it wasn't a big outcry. I got letters from several people that said it wasn't right that our hospital did that. Well, what has happened over the years is that our doctors, I don't know if there's any doctor here that does them now. Where people go for them, I do not know. It's just a rare occasion, if at all the last few years, that abortions were done.

But Roe vs. Wade came into play, early on, when hospitals were trying to figure out how to deal with this law and the rights of the community, and mothers, are, it wasn't a big issue.

T: I was just wondering if you had demonstrations outside...

B: No, we didn't.

T: Has there ever been anything like that? What, in your recollection, has provoked a huge public response one way or the other?

B: A couple times it did. One was around this doctor. His patients were very loyal to him, the one that was kicked off the staff.

T: Morloch.

B: Doctor Morloch. There was a lot of newspaper, and letters to the editor, letters to the board. And of course, the administration takes in the neck during those situations too. His patients were very loyal to him. They liked Dr. Morloch. I went to high school with Dr. Morloch. And I knew him very well. So it hurt to have all that happen. I certainly agreed with the decisions that were made. But that was kind of a public outcry.

But the biggest one I would say, and it was prompted by one or two people, our **billing department** was not being managed very well. You trust your people but you do need some checks and balances, and it was brought to my attention that we had not billed for about a half a year of Medicade billings, which is the welfare

program for the state, and there's a limit after the date of services as to how long you can bill, otherwise they're denied. And it's like six months or something. But anyway it was a significant number of dollars that we had to write off. Like a half a billion dollars worth or something like that. Big amount. Well, some people in the community felt that that was mismanagement and we should have known. And what the outcome of that was, we had a specialist come in and look at our billing system and make some recommendations to where it's working great now. And reduced our counts receivable, [it was] a lot higher than it should be. And now its down to where its one of the lowest accounts receivable around.

But the point is, that really hit the newspaper. They wanted my neck and all of that. And that only happened just about five years ago. In the nineties. And that's when I replaced our CFO at that time. And Doug Bishop came in.

T: CFO?

B: Bob Maxwell.

T: What is...?

B: Oh, Chief financial officer. Because that was under his watch and that was a stressful thing. And the public... black eye so to speak. It was a financial matter, not really a care situation, nothing to do with care. But you know, when the taxpayers own you, they have a right to tell you what they want and they have the right to expect us to do things the right way. And you feel an obligation towards that, I always did. I always told people when they were hired, every month, we had new employee orientation, I said, "We're not just providing a service to the people of Whidbey Island. They own us. And we're carrying out their work here." Because they paid for these buildings and so forth. I suppose that's the way school districts feel and other.

But there haven't been... I'll tell you, when you sit at the Northwest Council [of Hospital] meetings, and listen to the other administrators. And part of the value of this **Northwest Hospital Council** I work for, is administrators have a safe place to get together every month and share some of the things that were going on in their lives and hopefully we can support each other. It's kind of our own support group. Our AA meeting I guess. And when you hear some of the problems and challenges that some hospitals have, I've always felt over the years, that Whidbey was really pretty fortunate.

T: It says that in 76 you were the president of the Northwest Hospital Council.

B: Oh yes. A couple of times over those thirty years.

T: Is that when you began working with them?

B: No. The Northwest Council was already in existence when I started. But each year there's a new set of officers from the sixteen hospitals that are members. Not all of them participate at that level. But I think that was the first time I was president of the council. And I did that 1 or 2 more times during the twenty-some years. And then at the state level I was chair of the District Hospital Association one time, or twice I guess, and on the board of the State Hospital Association. I wasn't an officer but I was on that board. And the presidents of the council are automatically members of the State Hospital Association Board. Nine members. I've always enjoyed participating in our industry beyond just the local level.

T: You said you're still involved with that. What are you doing now?

B: The Northwest Council? Now I'm the paid... I get paid a little bit for setting up the meetings and getting education seminars every month. This is the agenda for our next meeting. We meet once a month, so I'm going to send that out.

I'm the staff person for this little organization. It's kind of small but there's the membership.

T: [Theresa reads a list of hospitals in the Northwest Council]: Anacortes, Arlington, Bellingham [St. Joseph], Bremerton, Coupeville, Edmonds, Stevens Health Care, Ellensburg...

B: Yes, there's one across the mountains. The rest are all northwest.

T: Everett, Mountlake Terrace, Everett-Providence, Puget Sound Kidney Centers, Forks, Monroe General Hospital, Mount Vernon, Sedro-Woolley, Port Angelas, Port Townsend.

B: It's a pretty big group. So that keeps me involved.

T: One thing that's really impressed me through all of the material I've read about the hospital, is your dedication, your awareness of the community. You have always been very aware of that. You said in 1980 that the hospital's been successful because "We meet patients individual needs. It takes not just equipment and skilled technicians but sensitive and concerned support personnel."

B: That's been my strong conviction all the way through my career is that the equipment and the building doesn't do anything. That isn't what carries the people. It's compassion and having dedicated and well-trained people to meet their

personal needs whatever they are. And that's not just fixing the incision, there's spiritual needs, there's family needs. Whatever we can do, or should do, while they're here, is to meet those needs. Physical, emotional and all. If the community feels that their hospital has treated them that way, then we've been successful. Otherwise we've just fixed an....owie. [Laughs.]

T: And sent 'em back out.

B: Yeah. That doesn't mean too much.

498

T: In your career here, any people that stand out as people that should be included in this history? As deserving recognition? I know everybody's worked hard and worked as a team.

B: The other thing I've always done is tried to recognize it is a team and it isn't any one person. I feel just as proud, and it's shown with the patients too, of our housekeeping department and the services they provide as I do with a lab tech or an R. N. or anyone. They're all important people, they all have an important job to make the community feel good about their hospital.

T: I thought it was neat, your first "Most Valued Employee" was a member of the housekeeping staff.[3]

B: Was it? And that's true. People have said that. I got feedback from patients that, unfortunately we didn't always have a way to share all these things, but you get letters back or a note from a patient, saying, either the admitting person, or the housekeeper who came in an cleaned their room, or whatever, was so nice. "They talked to me," so it wasn't just a sterile experience for them. To me, that's important.

But, saying that, there are some people probably, who have done a lot to shape who we are. One person who I think has done an outstanding job and is probably as dedicated a health care person as any hospital has and that's **Amy Ayers**. The Assistant Administrator now. She came here as Director of Nursing but now she's the Assistant Administrator for Patient Services and beyond. She's the most tenured assistant administrator here. She's been very dedicated and she knows how to work with employees. She's had some jobs that have taken a lot of heat but she is also that just puts the patients first, and worries about the consequences later. I think she's done a lot to shape and mold what this hospital is going to be

[3] Anna Youderian. For more information, see p. 169 of *A Common Need*.

remembered for. Amy is one.

But you know, it depends on what category you put these people in. They're some doctors too that have put a lot into this place. **Ed Sherman**, who's passed on, I think he was our longest tenured board member, about 17, 18 years. I think he's somebody to be remembered. Tom Vader, one of our anesthesiologists, has been here twenty years. **Neil Manor**, who is currently an ear, nose, and throat specialist, was the family doctor in Coupeville when the hospital opened. I think he's the only physician that's still on our staff, even though he was in a different specialty at that time.[4]

T: Did you know **Charlotte Dower**?

B: Charlotte was our first volunteer coordinator I think. Not too long, her health was starting to, you know, she was getting older. But she was some head nurse at the university, of one of the big hospitals in Seattle. Lived on Whidbey but she was a sharp person, I remember that, and helped establish our volunteer program.

T: **Mary Jane Geddis**, she was the first Director...

B: Mary Jane Geddis was our first **director of nursing**. I'll tell you another person though, when you start thinking of names like Charlotte who is still around and still actively involved, and was involved prior to the Hospital District even being formed, is **Wilma Patrick**. She has done probably as much as anybody and has seen and worked through all of this of any person. She was part of the original Parent Guild, when they had all the fund raising events. She was one of our first chairpeople of the auxiliary, and she was a hospital volunteer every week, and here, she's still involved. I mean, a year or so ago, she was president of the auxiliary again! I don't know if it's a third life or what! But, she is so dedicated. As far as a community member, she has to be right up, one of the top.

T: Is Doctor Mark Gabrielson still alive?

B: No. He died. He was on the board when he became ill and he resigned just prior to his death. He was one of the doctors who was practicing prior to [the hospital opening.]

[4] Dr. Neil Manor died in May 2001.

END OF SIDE B

CONTINUUM HISTORY AND RESEARCH: TRANSCRIPTION

INTERVIEWEE: Bob Zylstra

SUBJECT: Whidbey Island Hospital Dist

zylstra2
c:everything\
oralhistory\misc\

NUMBER OF TAPES: 2

DATE OF INTERVIEW: January 20, 2000 **INTERVIEW NO. 1**

LOCATION: Whidbey General Hospital, Coupeville, WA, 98239

INTERVIEW CONDUCTED AND TRANSCRIBED BY:

Theresa Trebon, author of *A Common Need: Whidbey General Hospital and the History of Medical Care on Whidbey Island, 1850-2000*
Continuum History and Research
10619 Sterling Rd.
Sedro Woolley, WA 98284

Bob is the great-grandson of Riekele and Liske Zylstra who came to the United States from Holland in 1880. The Zylstras moved to Whidbey Island in 1896. Riekele and Liske had nine children, one of whom was Ralph. Ralph had a son named Hank. Hank married Gertrude Nienhuis and they had four sons, one of whom was Bob, born in 1934 at the Arnew Hospital in Oak Harbor. As this tape begins, Bob is discussing the various doctors that were in practice prior to Whidbey General Hospital opening.

SIDE A

B: **Bob Zylstra**
T: **Theresa Trebon**

B: [**John Teays**] started his own clinic. But Teays, he spends most of his live on the road with his R. V. But [Doctors] Goetz and Bailey still live in Oak Harbor. Goetz and Bailey didn't really support Whidbey General being built.

T: Now why was that?

B: They were the only two that had [hospital] privileges only in Mount Vernon. They were loyal to that hospital. And they also were part of the Oak Harbor camp that said the hospital shouldn't be built in Coupeville, it should be in Oak Harbor. So there was some of that. But it wasn't, but a few months went by, and they applied for privileges [here.] For a couple reasons. One is, that 36 mile round trip every day is a bummer and the patients wanted to support their own hospital. So I think

they were getting feedback from patients. And they were very loyal supporters after that. It was not a big deal. At first they were still dragging their feet.

Now John Teays and Mark Gabrielson had their privileges in Anacortes, they were on our first medical staff, and very involved from the get-go. And Teays, they actually sold their home in Oak Harbor when he retired, bought a $100,000 set of wheels and they live on that sucker. They go all over. When they come back home, they park down at the beach or wherever they park. And that's where they live. But Bob Goetz would be a good person to talk to. He would probably give you some time. Doctor Bailey doesn't communicate as well as Dr. Goetz.[1] Goetz is a very 1-2-3, bang-bang-bang guy. He's still active in the community. Not practicing medicine, but very sharp. Doctor Bailey has quite a few more health problems than Doctor Goetz.

T: What about when efforts started coming in to **unionize** the staff? That was in the late 70s. Was that a difficult period of time?

B: It was. Because I felt it kind of drove a wedge between the management of the hospital and the employees which I never liked. I've always felt it was sort of a defeat for me because I've always been proud of the fact that I knew all the employees and I thought a lot of them all and I liked the relationship that we had prior to that. And it almost made me feel that they didn't trust us. And there's some of that. There would always be some of that. It was a growing pain more than that really, in fact, we were growing. A much larger staff and probably we were making some decisions on the wages and benefits that some didn't agree with.

One of the reasons that they started unionizing as that Island, a lot of our employees were tied to Island Hospital, either because they had worked in both places, or, that was kind of our "sister" hospital. They started unionizing before we did. When I say that, the nurses were part of what they called the **Washington State Nurses Association**, which is a professional organization, but they also made the labor contracts so they were the union for the nurses. They were already unionized when we opened. We accepted their contract. But the rest of the hospital staff weren't unionized. And I always felt that was healthy. When Island started unionizing, some of our counterparts here, say, like our professional-technical group, the first ones to unionize here, they were worried that what happened at Island Hospital, where they kind of took everybody and put them in one big pot in that union, that that would happen here. They wanted more of a voice, more of a professional-technical union here. Not with all the other departments of the hospital. So they wanted to protect themselves from that

[1] An interview was done with Dr. Robert Goetz and is part of this oral history collection for WGH.

happening here and so they unionized as a professional-technical group. And then the other departments, the housekeeping, engineering, all the support departments, stayed non-union.

But it was partly the growth... of our industry being unionized, you just kind of get caught in that wave. And we finally got caught up in that wave. I always felt, though, that we continued a good working relationship with most of our employees, and the groups, and with the unions. We tried to maintain a civil thing. So there was only once or twice over the past fifteen years where we went to impass and outside arbitration. But I've always told people, of all the jobs I was responsible for, negotiating contracts and having my employees of a certain group sitting across the table, and developing sort of a wall or some hostility even at times maybe, wasn't a good feeling. That was the worst part of my job even though I knew it was necessary, responsible. I did the best I could for the employees and yet still, had to look at what could the hospital afford or what was right. It wasn't a pleasant thing because it puts us in different camps and I don't think of us that way. I think of us as part of the service organization. But that's the nature of the industry. But that was kind of difficult.

78

T: When the decisions were made to start opening **satellite clinics**, that appears to have started happening in the mid-90s, first you had North Whidbey and then you had South Whidbey... Actually, is there one in Langely and Clinton now?

B: No. South Whidbey clinic was opened first. The South Whidbey Clinic initially in Clinton, it is in Clinton, but what that was, was trying to do two things. One was to provide a space for specialists to go see South Whidbey people rather than them having to come to their offices in Coupeville. And so the specialists can rent it by the half a day a week or twice a month, or one day a week, or whatever. So we were the landlords for a specialty clinic. A rotating specialty clinic. And, at the time we did that, everyone that was going to have surgery the next day, for example, was supposed to come in and have some lab work and a chest x-ray, so they had to drive all the way from South Whidbey up here for that and then come up the next day for surgery. So we thought if we could put an admission processing down there and some lab draw and x-ray equipment, they could do their pre-admission work down there. So we tried to connect closer, bring the hospital a little bit closer, yet not duplicate expensive services.

So that's why we started the clinic at South Whidbey. But then, shortly after that clinic opened, we realized maybe we should be providing some of our hospital-based services out in the community rather than building expensive additions to

this buildings. And so then, about 96-97, we decided that physical therapy was busting at the seams here. Private physical therapy services weren't necessarily doing everything that should be done, we didn't feel for patients, couldn't meet all their needs, so we bought out the North Whidbey physical therapy private service, and at the same time we started a service, physical therapy, on South Whidbey. I forget which came first. That was probably the first major hospital-based service that we really expanded out in the community, was that.

T: The rehab.

B: The rehab stuff. I think that's another way that this hospital will really grow in the future, in providing services, the growth will be to provide services not just here in Coupeville at this building, but out. Whether that be the medical ambulatory care services or whatever. But then also, the clinic, the North Whidbey clinic, which was providing care to the underserved and low income people, was already in existence in Oak Harbor. The county had a contract with an organization from Bellingham to manage that. We took that over and that's a special type clinic for the low income people. You have to qualify to go to that clinic.

T: The one in North Whidbey?

B: Yes. And now, subsequently, they just opened the counterpart of that, down at the South Whidbey Clinic so part of that South Whidbey Clinic that we initially opened years ago, a portion of that, is for the low-income clinic.

T: Same spot?

B: Same spot. And then also, just recently, they opened a new family practice clinic in Freeland that the hospital district is renting to physicians from Oak Harbor. They put two new physicians down there. One change that hospitals have made over the last ten years that is significant is that they're getting more involved in hiring of physicians or buying out clinics. This district hasn't bought out practices where as Anacortes Hospital has bought out most of the practices. That's because physicians aren't making the income that they want and they have to leave and go with some larger group. In order to maintain good physician practices in the community, they've done that. Well, we haven't done that but we've subsidized some physicians coming into the community for a year or two until they got their feet on the ground, and then they're on their own. Or, we built the building, like we did in Freeland so they wouldn't have the capital, long-term debt, and then rent it back to them, and get paid that way.

But we don't own the doctors, we just own the building there in Freeland. But hospitals are having to get much more involved in the hiring of physicians and/or

putting in the right places, or actually taking over physician practices. That's the newest thing and that's largely due to reimbursement problems.

149

T: Speaking of reimbursement, you mentioned the DRG system. What does that stand for?

B: Well, it stands for **Diagnostic Related Groups**. So they group by diagnosis and there's 300 and some. And when we code in medical records, the DRG, as an in-patient, that means that's what you're going to get paid for. So the Diagnostic Related Groups are the nomenclature started by Medicare.

T: What do you think about the future directions of this hospital in terms of the **Planetree** idea, the patient centered care?

B: I think that's good. I always say well, we were doing a pretty good job anyway of reaching those needs. I don't think, we certainly didn't give the patients all the opportunities they have in the Planetree model, to be involved with their care more. And to provide maybe a little more, less sterile, family setting, and to be involved with their direct care. I think in the Planetree model, I haven't looked at it recently, I think they're more involved into what goes into their chart, they have library resources more available to them, it's more homey. I think that's all positive by the way, and I think that's good. The only thing I'm concerned about, with the reduction of revenue, or reimbursement for expenses, I think it's a more expensive way of caring for people and are we going to be able to sustain that?

But I think it's a positive thing, in fact, I think that and what you're also going to see the next ten years, more of, is the alternative care being part of traditional care. By that I mean, more involvement in the hospital with chiropractic care and naturopaths and some of the alternative diets and so forth. I think they're going to come together more with the traditional hospital-type services.

T: And you see that as a positive?

B: I think so, yes. I think there's a place for both, why not do it together? I think that's going to come about. But Planetree, going back, I think that's good. I think that people need, and want, to take more responsibility for what doctors are doing to them, and for them, and I think that's a way to get them more involved. They can feel like they've had some choices, they've made some decisions, rather than the old way.

T: I found this article published by the British Medical Journal and it said that medicine will change more in the next twenty years than it has in the last two thousand, because of **technology**.

B: I think so too, and I'm not a futurist, and I've heard a few of them talk about what they see medicine coming to, and it just blows your mind. I think it is going to change. I don't know what all of those changes are going to be, but I think that's true. This one guy said something about they're going to put a little chip in you and then...

T: They can scan you!

B: You can connect to the doctor right over the telephone. I suppose technology is going to really change. I suppose the way that we're doing medicine today will be, not obsolete, but an antique.

T: Well, that's why this is a good idea to get this retrospective of where the hospital is now. It appears to me, from talking to members of the community, that it's been extremely successful in its thirty years.

B: It has been, it has been. I think that our philosophy of trying to make sure that we stayed in touch with the community, and made sure we were giving them what they want, and whatever we did, doing it with the highest quality possible. And trying to broaden what the hospital district is doing beyond the four walls of this hospital, has made it successful. I think we've met all those things. Because, just to be a little forty-bed, traditional in-patient hospital, that isn't where it is today. And unfortunately, some of the smaller community hospitals couldn't get beyond that. They either didn't have the resources to get beyond it, or the vision to get beyond it.

I think, I hope, and it seems like, we've satisfied the majority of the people that we're doing a good job here, and have over the years. And I'm sure, the way it's structured now, that they'll react and meet the radical changes that are going to be made the next twenty years. I'm sure they will. Because Whidbey Island, there's going to be a hundred thousand people living on this island pretty soon. It's already up to seventy or so and that's unbelievable isn't it? I wouldn't say that's good but that's going to happen. If this hospital district is responsible for... the Navy, you can carve out a little bit [of that population], but for a hundred thousand people, they're going to have to stay on top of things. Make changes and I think they are.

T: Well, great! Anything else?

B: Well we're having fun aren't we?

T: You've got a good recollection of all this good stuff.

B: Well, there may be some other but if there is just e-mail me or give me a call.

T: What about **Polly Harpole** before we leave this?

B: The only way I remember Polly Harpole, and I've told this before, is that she was someone we were all afraid of because she was the Public Health nurse and she'd come in the schools. She was a big woman, had kind of strong eyes, I don't want to say beady eyes, but intense. And she gave us our shots at school. So we didn't like Polly Harpole. And of course and she was in OB and there's so many good stories about her but I guess she just did a wonderful job of providing that service on the island for years. But I didn't know her.

END OF SIDE A

End of Interview with Bob Zylstra