VOICE EXPEDITION INTERVIEW TRANSCRIPT
The Oral History of Nephrology
PATRICIA MCCARLEY, RN
Interviewed by Dugan W. Maddux, MD
MAY 24, 2017

DWM: (0:04 - 2:20)
Well, today is May the 24th, 2017 and I'm here in Nashville talking to Patricia McCarley. So Trish, thank you very much for being here with me today and to be a part of the Nephrology Oral History Project. So I wanted to start with where you were born and where you grew up and how you ended up going to nursing school.

PMcC:
So I was born in Morganville, Kentucky and I'm a twin, so it's a real small town in western Kentucky. And I grew up in middle Kentucky, also the town Kentucky, which is right outside Louisville. Spent most of my, all my years there until I went to college at Vanderbilt.

And I think I became a nurse. My best friend, we lived in a little cul-de-sac and my best friend's mother was a nurse. And I think although I didn't really realize it, I think that was really my motivation.

She just was a, you know, we always, we had a carpool and she took us to work, took us to school and on her way to work. And I just was always, you know, just enamored and impressed with her. And it was more, I never saw her at work or doing anything.

I think it was just her personality of just positivity and everything was always going to be okay. That just sucked me into her and being a nurse, so. So that's fascinating.

DWM:
So you never saw her actually being a nurse, but it was just her person that influenced you. Very interesting. So in your mind, do you think you felt like nursing embodied that sort of positivity?

PMcC:
I must have because I did do some candy striper stuff. So I think that probably gave me some, you know, first-line impressions of nursing. And then probably just based on that and her personality.

It just kind of like, that's where I want to be.

DWM:
So when you went to Vanderbilt in undergraduate school, did you do nursing then?

PMcC: (2:20 - 2:23)
Yes. Into the school of nursing.

DWM:
Yeah.

PMcC: (2:24 - 4:48)
And the first couple years, I actually was doing some pre-med too. I thought about possibly going to medical school. But, you know, really decided nursing was the place for me.

DWM:
So stayed there. So once you really got into nursing, nursing school, what is it that made you think this was the right thing for you?

PMcC:
I think what did it then and what continues to do it now is just the impact you can have on people's lives.

I mean, that's why I'm still doing. I mean, Christy was saying, why aren't you retired? Guys, I still think I'm making a difference in patients' lives, in nurses' lives, in trying to help them do a better job.

And so it's very motivating for me. I like it. I feel like I have really a passion that just is still driving me to help patients and nurses.

DWM:
Interesting. So you come to Vanderbilt. You're in school of nursing.

What happened then?

PMcC:
You know, I finished and my specialty was neuro.

DWM:
So did you have to declare a specialty?

PMcC:
Yeah, well, no. Your senior, your last semester as a senior, you picked an area that you wanted, a clinical area that you wanted to concentrate on. And I was neuro-orthopedic.

And actually, I worked with spinal cord victims, long-term people that were actually comatose, but living on respirators. Just really sad cases, to be honest with you. Some good cases, but we had a lot of sad cases at Vanderbilt.

And I did my specialty there. And I worked in that area for about a year. And then I got married and had a baby and moved to, that was in Nashville, and I moved to eastern Tennessee to Knoxville.

And I found this job that was going to be three days a week. My husband was going back to school at UT to finish up his degree. And I had this new baby and he was going to be in school in the morning.

And I could work in the afternoon at this dialysis clinic three days a week. And I was like, wow, this is just perfect. And so that's how I fell into dialysis.

So it was kind of quite by accident that I got into it. But then once I got into it, I really liked it.

DWM:
So what year was that that you fell into dialysis?

PMcC:
That was 1976, September.

PMcC: (4:48 - 4:49)
1976.

DWM: (4:50 - 9:58)
So what was that first dialysis clinic like where you fell into it and you were working three days, three hours a week?

PMcC:
It was a DCI. And it was right across the street from the hospital.

And you know, I don't remember, I remember a lot about the technology, but it was pretty much your, just kind of your typical dialysis clinic. We had nurses, technicians. You know, actually, I really ran into the nurse that hired me.

She was working for Fresenius. Like, you know, 40 years later, I ran back into her that we were both working for Fresenius. But just kind of a typical unit, just with not the the high-tech stuff we have right now.

DWM:
So tell me about the technology. What was it exactly like? What was it like to put a patient on what equipment?

PMcC:
Yeah, so we built our own dialyzers. We had Kiil boards and actually built dialyzers. And so that, you know, the dialyzers were about three by five feet or so.

And you know, you would tilt them up and down depending on if you're returning blood. And, and, and we actually built them, you know, so that it was, you know, all completely different. We didn't have any of the, you know, the safety systems that you had, in terms of no UF control.

You know, we would, we were dripping saline, you know, trying to control patients' volume losses. So it's a much more, I would say, intensive process than it is right now.

DWM:

So a Kiil board, tell me what, what, what did it look like to build a Kiil board?

Where did you do that in the dialysis facility? What equipment did you have to have? How long did it take you to build a Kiil board?

PMcC:
So the Kiil boards, there's two boards, and inside the boards are cellophane. And, and, and then a blood chamber that, so you have two pieces of cellophane. You have a Kiil board, two pieces of cellophane, a Kiil board, two pieces of cellophane, and a Kiil board.

And then it's all locked together with little screws, like little clamps. Kind of a, kind of a shell, a metal shell that they all fit into. And at the end of those pieces of cellophane were your blood ports, where your lines connected to.

And you would just, you know, put your Kiil board down, then your cellophane, your blood, blood port, your cellophane, Kiil board, and on up, and build. And then you'd crank it all down, and then that would be your ?doctor. So as a nurse, you were building a Kiil board to dialyze every patient.

DWM:
And how long did it take you?

PMcC:
Gosh, I can't remember. I just remember building those things.

You know, probably not very long. It was kind of a system where everything was laid out, and boom, and boom, you know. And it was part of a change of shift.

So that morning, we probably had built them the night before, had them all out for that morning shift. We would dialyze everybody, you know, take those kill boards down, and they would be getting cleaned up, and the new ones would be brought out, and set up. And I don't remember too much about that.

I just remember those dialyzers.

DWM:
And was the kill board heavy?

PMcC:
Oh yeah, they were heavy.

They stood upon a stand. So you had this stand with this metal bracket that these kill dialyzers sit down into when you build them. And so, and this stand and bracket, you would crank it up, because when you were returning the blood to the patient, you're going to crank it up and let the gravity pull the blood out.

And then you would crank it back down and take it back to get it cleaned up and ready for the next patient.

DWM:
So, yeah. So what kind of pump machine were you using?

PMcC:
You know, I remember Drake Willock then, as part of that system, and with no safety devices. So you didn't have a clamp that if you got air in the system, that would clamp off. You know, you had saline drips.

But I remember the Drake then, in that clinic, the Drake Willock. I don't remember Century II's until a little bit later on when I got to the VA.

DWM:
So when you walked into that dialysis facility, what did you think seeing all those Kiil boards?

PMcC:
Yeah, I remember, you know, the first thing I remember, really, from that clinic was the day I walked in and I was going to be the charge nurse after just, you know, being one of the nurses. Because someone had sewed up and I was like, oh my god, you know. Now I'm in charge.

And I don't think it was very long into my work there that they were all of a sudden, I walk in and, okay, you're in charge now. And that was really a big, vivid memory for me. Like, okay, hell brother.

And today, if a new nurse came to work in dialysis, they go through a big training period.

DWM: (9:58 - 9:59)
What was your training like?

PMcC: (9:59 - 22:24)
Just on-the-job training. You know, you just got it there. I remember one of the nurses that, what was her name?

Pull that up. One of the trainers. But you just learned, you precepted with someone and trained and learned to set up and then, you know, took care of the patients, learned cannulation.

And then from there, you just kind of went out on your own.

DWM:
So how big was this unit?

PMcC:

You know, I think it was probably about, I don't think it was any more than about 15 stations.

So fairly small. And three shifts on, I know it had three shifts on Monday, Wednesday, Friday, and I believe on Tuesday, Thursday, we just had two shifts.

DWM:
Okay. Tuesday, Thursday, Friday. So do you remember the patients? What kind of patients you were dialyzing and how were they doing in 1976?

PMcC:
I think they were, in general, they were doing fairly well. But one specific patient really came to mind. And it really helped to form my attention to all patients all the time.

So this patient walked in and, you know, he had a headache. That's kind of what we remembered. He had a headache.

And he didn't say it was the worst headache he'd ever had, but he had a headache. And, you know, we, oh, he had a headache. Let's get him some Tylenol.

We started the procedure and, you know, he got his usual dose of bolus of heparin. And he had a big infarct on the machine that day and he rolled out and never, you know, didn't survive. And it just really imprinted on me and has always stayed with me the fact that this procedure seems really routine, but it's not.

It's not routine at all. And how important that assessment of the patient is prior to the treatment, because it can kill people if it's not done, if it's even done when it shouldn't be. And so because that happened so early, I just never took it as a routine procedure ever, that going forward.

It never was routine for me. Every patient's complaint was something serious that needed to be evaluated before we proceeded. And, you know, it was just a big thing that happened at that clinic that I'll just never forget, probably.

And I can still see that guy right now. Those are the kinds of events and then feeling like you've got to be vigilant all the time that can, I think, wear people out.

DWM:
Did you feel stressed or burned out at all working?

PMcC:
No, I don't think I did. I just always, from that point on, just knew that every patient was going to probably present a learning opportunity for me, either for my own personal growth or for my professional growth. And I think that's one thing that has kept me in the business, is that my own personal and professional growth has really been propelled by my patients.

DWM:

What a great thought.

PMcC:
Yeah, I mean, I can just tell you who I am because of them. You know, it's what they taught me.

You can just learn so much from people, just about, even about raising your own kids, about things you do in your life. I remember a guy at the VA was telling me, you know, Trish, don't split the small stuff with your kids. Really focus on the big things and then they'll listen to you.

If you really focus on little things like pick your shoes up or do this, they're not going to listen to you. And I took that advice he gave me and actually transformed the way I was parenting. And to this day, it made a big difference in my kids listening to me and the people they became.

Because I didn't, I quit, you know, messing with the small stuff and really concentrated. So I just tried to always learn both, again, professionally on taking better care of patients and what they told me, and then just personally on how I could do better in my own life. That's wonderful.

And that's why I'm still in nursing, because I like it. I really, I love it, you know. I still enjoy that contact with the patients and it's just, you know, it's just, it's fun for me.

DWM:
So in 1976, you get a convenient job that allows you to work three afternoons a week.

PMcC:
Right.

DWM:
So how long were you in that clinic and what was that, what happened to your career during that time?

PMcC:
So I was in that clinic a couple years, and then we moved back to Nashville. And I was thinking, okay, back to Nashville, I was thinking, do I want to get back in neuro-orthopedic again, where I'd started at Vanderbilt. And that was kind of one of my loves.

But again, a job opportunity. I had two kids then, and a job opportunity opened up at the VA in their dialysis unit. And again, it was three days a week, kind of an evening shift, that 10 to 4 shift.

And I was like, oh, I'll just kind of stay in it. And when I got to the VA, it was just quite the opportunity there. Bill Stone was the head of the dialysis clinic, and he's just an excellent clinician and educator.

And that's where I would say I really started to learn and really become more knowledgeable about the patient on dialysis, nephrology, just the whole, that whole area.

DWM:
So what kind of things did you learn from Bill Stone?

PMcC:
You know, he is, I don't know that I've met a better lecturer that really can take you through this is the acid-base balance.

You should hear a lecture on that, you know, you know how complicated that is. But if you just go through it with him, you'll understand it completely. So, you know, we went to the grand rounds.

We were always associated with the fellows. The fellows were always over in our clinic. And so we were, we just had a lot of opportunity to be exposed to, not just the dialysis procedure, but all the rest of the care of the patient and understanding what's going on, and the physiology, the pathophysiology, and understanding really what you're doing and why you're doing it.

And so, you know, to me that's always, you know, as a being, getting a degree in nursing, I wasn't just learning how to do procedures. I was learning all the patho. And so that, we just continued that with Bill Stone.

He just continued to be sure we were, I mean, he came and made sure the nurses got a lecture on different things. So he was quite, I mean, that, that, the clinicians at that clinic, and it was all RN staff at the VA, they were very, very well educated about the nephrology patient.

DWM:
So what was the technology like at the VA?

Were you still using cue boards?

PMcC:
No, no, they had the dialyzers. They were just flat plates at the time.

So we had started to get the Gambro flat plate dialyzers, and that's where we had the Century, Century II machines, to tell this funny story. So by then we had the, the, the clamp below the blood chamber. So if you got air in the blood chamber, the clamp would clamp, but the blood pump wouldn't stop.

So you, if the clamp clamped and the blood pump didn't stop, which happened occasionally, you could, you would blow dialyzers up. So the VA, we had quite a few blow-ups, you might say, you know, where air got in, it clamped, and the pump kept going, and so we blew the whole system up. So I remember quite vividly, and then Century II, which was made by Cobe

and Drake Willock, they all learned pretty quick, okay, when that clamp clamps, we have to be sure it gives a signal back to that blood pump to stop, so that we don't have all these situations.

But we started, that's where you really started to see the, the systems evolve and, and change and get more, you know, more sophisticated. And it was when I was at the VA that we actually got UF control. So where you didn't have to drip saline in and, you know, have a venous pressure clamp.

That's how we control pressures. We didn't have any kind of negative pressure, so you controlled it with a clamp. And if the venous pressure was already too high for that patient, then you'd have to drip saline in.

So it's always really a guess on how much fluid you're going to get off a patient, and kind of what was going on. So, you know, take, checking blood pressures. We didn't have automatic blood pressures.

Everything, you know, you would actually take the blood pressure. So a lot of more hands-on was going on in assessment of the patients.

DWM:
What do you think the technology did?

Did you, could you see any change in the patient quality of care? Like when you went from not having a UF control to having a UF control, did it look like that made the treatment better for patients?

PMcC:
Oh, I think the UF control definitely made it better for patients, where you were able to dial in the amount of...

What was happening to patients before you had that? Before we had that, they were just crashing, you know. You might not have caught the blood pressure falling down or the heart rate going up, and so you didn't give them enough saline, and then they would just, you know, have a hypotensive event, and then you'd catch up.

Or we'd get them off, and they were way below what we thought their dry weight was. So it was just always a big... You just had to be much more vigilant in watching them, because you just, you were stuck with this venous pressure.

You were dripping saline. You were really trying to control things that you had no idea of what they were doing.

DWM:
Yeah. And did you like the flat plate dialyzer?

PMcC:

Oh, you know, I don't think there was a pro or con to it. They had a lot more blood volume out to get the surface area.

So again, that's another thing you were dealing with, a larger blood volume that came out on those patients. And so I remember that specifically. Once we got to the smaller dialyzers, less blood volume out, smaller lines, that made a really big difference.

DWM:
And were your patients different, the patients you had seen before, when you had been in the DCI clinic in Knoxville?

PMcC:
Well, of course, in Knoxville we had, you know, male and female were pretty equal, and more, you know, just that Eastern Tennessee is just different than Middle Tennessee. So we had that.

Then at the VA, you know, they were all vets. We had very few women. We had a couple of women, but very few.

And one of the things that was really unique about the VA was we had a huge home program, one of the biggest home programs in the whole United States. We had over a hundred patients on home dialysis. And that was because we had this VA, but there weren't any other VA dialysis centers anyplace else.

And Dr. Stone, we just had this huge home dialysis program. And they were all on home hemo. They had their water systems at home.

And again, we had over, and this was in the mid-80s, we had over a hundred patients on home dialysis out of our, yes, out of our program. It was just unbelievable. Now, that number dwindled as we got more and more clinics that were available.

DWM:
But what really spurred that home dialysis program was there weren't any clinics available for these patients. And they were not on PD.

PMcC: (22:24 - 22:26)
No, they were on home hemo.

PMcC: (22:26 - 23:30)
And they were on, most of, a few were on drugs, quite a few were on drugs, because that was the first machine out. But then when we got the Century 2 Cobe, they all liked that. So they all wanted that.

So a lot were on that. But no, home hemo. We had PD.

We did have quite a few patients on PD. But this was home hemo. One of the biggest, at the time, it might have been one, I know it was the biggest VA program.

It might have been one of the biggest in the country.

DWM:
How were you managing to train everyone on home hemo? And home hemo training is pretty long.

PMcC:
Yeah, it was a six-week training period. So they came in, and they actually had classes. We had such a big program.

They would have at least two and sometimes three in a class back in this separate area. And they, you know, they came in, stayed there. Their wife came, and they were there for six weeks learning the whole process.

But it was very quite successful. And we just didn't really have that many failures. We didn't have people burning out or quitting.

You know, it was a really thriving program.

DWM: (23:31 - 23:34)
Yeah, that sounds very remarkable.

PMcC:
Yeah, for sure.

DWM: (23:34 - 25:24)
So you came into the VA, and how long did you stay there?

PMcC:
I stayed there till about in the 1990, 1991. I believe that's when I left.

DWM:
So that's been a long time.

PMcC:
Yeah. Eventually, I came there as a nurse, and then I eventually became the clinic manager.

And that dialysis clinic, we actually had outpatient. We did acute. We actually started a plasmapheresis program there.

We also did some research programs there. We treated, what's that called? We treated scleroderma with plasmapheresis, this whole process.

So we had a lot going on there in that program. So it was really, really within the VA, which can be kind of a frustrating system and the staffing levels on the floors. In that dialysis clinic, we were really well staffed and had a really great program.

So it was kind of unique within that. And then again, we have, we trained all the nephrologists that were over at Vanderbilt just love to come to the VA because they had got this really wide range of experience. They got outpatient, they got home, they got PD, they got pheresis, you know.

So they all love their, you know. They actually, the fellows actually, as part of their fellowship, they actually had to work in a dialysis clinic one of their months. So they actually had to do, you know, build, set up dialyzers.

They kind of had to do the whole process. So I think that was a really good part of the fellowship back then. So it was a really, you know, just a, it's just a great environment to work.

DWM:
So tell me about the plasmapheresis. How did that come around? I mean, that was pretty new technology.

PMcC: (25:24 - 25:25)
That was new.

PMcC: (25:25 - 32:46)
That was toward the end of the 80s and, you know, it was extracorporeal therapy. So like, who's the best group to do that? And you know, our team was always like, okay, we'll do it.

And so, you know, we kind of just took it on. And it was, we had a separate unit. And then nurses were dedicated to that.

And we actually did it as part of, we did it with dermatology because we were treating a couple of dermatologic issues. And I have to go back and look exactly which ones we were treating. But it was kind of a collaboration with them.

And so it was really pretty interesting. But then it just gave nurses an opportunity to do something a little different. And a lot of the nurses had been in the dialysis unit 30 plus years.

So, you know, they were, okay, here's an opportunity. You can do something a little different now. So, yeah.

DWM:
And were you all doing a lot of other clinical research?

PMcC:
Yes, we were. In fact, we were part of the study of epogen.

We were one of those seven sites in the U.S. for phase two. So, you know, we were really on the forefront of that. Lo Binkley, I don't know.

She's died now. But she was actually the head of that research for Amgen. And well, she was our VA.

And then she went on to work for Amgen. But yeah, we were one of the seven sites that did the phase two studies. So we were always part of a lot of big research projects.

DWM:
What did you think about EPA?

PMcC:
You know, it's kind of strange. We noticed early that we did notice that the hemoglobins went up and it was great.

But we also noticed some of the issues that came about later with the higher hemoglobins. So we noticed patients who normally, you know, because their blood was so thin, that immediately when they got those higher hemoglobins, they might have had a stroke, or they might have had some circulatory issues. So we, we noticed that as a nursing group, but we got a kind of got poo pooed about it.

Oh, no, you know, but it's kind of when that a lot of the things that were found in the higher hemoglobin, we saw that just anecdotally in our patient, gosh. And one of the things interesting things prior to that, we were given large doses of iron for a reason. I can't remember why.

But we noticed that those large doses of irons that are in that patients were getting like a gram of infed, they just didn't tolerate it anymore, when they were starting to receive epogen, it just like we had to get that dose way down. So that was another thing that kind of happened around that time. But the things that we saw that were actually seen in the higher hemoglobin study, higher hematocrit study, we saw those anecdotally, and nobody gave us even though we were kind of saying it to ourselves.

No one paid any attention to it, I guess.

DWM:
So how, as a nurse during this time, which is like the late 80s, early 90s, or even earlier when you started dialysis, were your nephrologists, what did the multidisciplinary team look like? How did the nephrologist come relate to you as a nurse and to how did your multidisciplinary team function?

Was it any different in Knoxville than it was at the VA?

PMcC:
I don't even remember much as a social worker and dietitian in Knoxville for some reason. I do remember the two at the VA, because they weren't part of our, unfortunately, in the VA, they weren't part of our dialysis group, they were, they served several.

And so they weren't as integrated into our structure, so it was quite frustrating. And actually in the VA, the way the clinic's set up, I ran the nursing group, but all the other tangential people that were part of our team were supervised by someone else. So it was really a challenge to get the technicians to do what they were supposed to do, to get the social worker.

We had a great dietitian, and generally, I think in dialysis, you have great dietitians, but I think it was really a challenge. We had Dr. Stone was always our attending or chief, but even toward the end of my career, there was some thought that he should rotate through. And actually, one of the doctors came over from Vanderbilt and said, I'm gonna be the attending this month.

And it didn't go well at all, I have to say. So we always had him as the connecting figure, but we would have a different fellow each month. But they were there to learn and usually listen very keenly to the nurses, and we were pretty...

We knew what was going on with our patients pretty well. So although we lacked some of that interdisciplinary team, I think the nurses were able to drive and get what we needed from the other groups, even though it was a challenge. Once back out into the private sector, I went to another DCI clinic here in town in Nashville, that multidisciplinary team where I was in charge of everybody, the social worker, dietitian, everybody reported to me.

It was much easier to make the team be cohesive and work together.

DWM:
Yeah, makes total sense. Yeah.

So how long were you at the VA?

PMcC:
I was there between 78 and 91.

DWM:
Did you like being a clinic manager compared to being a staff nurse or charge nurse?

PMcC:
Yeah, I think I did. I think it's always an opportunity to make a bigger impact, make things happen, try to keep things going in a positive direction. So I think you just...

Anytime you have a chance to make more of an impact, it's good.

DWM:
So what happened after 1991?

PMcC:

So one of the fellows, they were finishing up and they were gonna open a clinic here in Nashville and I was a little burned out on the VA, just the lack of ability to control people that...

Not control them, but have any authority over people that were working in your area and weren't doing a good job. And I just felt frustrated by that lack of ability to... A technician wouldn't be doing their job, but I had no control over it or the social worker wasn't helping me.

I couldn't do anything about it. So I just felt frustrated and so they said, Well, we're opening a clinic, we'd like you to be a clinic manager there.

PMcC: (32:46 - 32:47)
And so I was like, Oh, okay.

PMcC: (32:48 - 35:23)
And so I just kinda jumped at the opportunity to go back to DCI. I like that company, they're a very... They're a non profit.

I knew... Actually, I'll tell you about this later, but I worked at their camp for kids here in town and so I knew I'd stay connected to them. So I just thought, Oh, I think I'll go back and work for DCI.

So I went and did that.

DWM:
So in the early 90s when you moved back out of the VA, what was the technology like in the dialysis facility then?

PMcC:
It was pretty much what I remember now.

We started to have the hollow fiber kidneys. We were starting to get... I believe that's kinda when UF control came into practice.

Water systems got sophisticated and the whole... We started to have more patient care techs involved in taking care of patients and it was starting to shift toward what we see now in the 90s.

DWM:
Okay.

And how long were you there?

PMcC:
I was there till 2001 and again, just got a little frustrated with DCI, my medical directors, and I just... My kids had just graduated from college and I saw an opportunity.

Ray Hakim had started Renal Care Group and Rebecca Wingard, one of my best friends that I'd worked with on a couple of things, said, Oh, why don't you come over and work for us? And I wanted to go back to school to be a nurse practitioner. And again, my kids were in college, just finished college, and I was like, Okay, wow, this is all lining up here perfect.

And so I just kind of went on and worked in their quality department for a couple of years. What kind of lives to finish up my MP and doing that.

DWM:
So what was the quality department at renal care group doing at that time?

PMcC:
We did a lot of education and Ray was just... Had his thumb on quality in all the clinics. He was really...

We had a quality meeting that all the clinic managers attended every single month to talk about outcomes. And we did a lot of education. So we monitored quality, but a lot of what we did within that department was devise education and tools and systems for clinics to use to improve outcomes.

DWM:
What kinds of things were you all looking at for quality?

PMcC: (35:23 - 35:27)
We were looking at vascular access, believe it or not. Still. Yeah.

PMcC: (35:28 - 41:36)
And I have some stuff from there that I pulled back out to say, Let's start to see if we can use this. Yeah. So we were looking at vascular access, fluid management, just all the same things that we're looking at now, actually.

Anemia management. So vascular access was...

DWM:
What were the big concerns in the early 1990s about vascular access?

PMcC:
I think we focused... I don't remember as big a push about catheters because I don't remember that catheters were as big an issue then. We were getting fistulas put in and grafts.

So it was cannulation. So the big focus was on cannulation, being sure you didn't cannulate the same one side itis, rope ladder, monitoring and surveillance. And we did...

The transonic was the first monitoring device. And I actually wrote a paper within Kidney International on the transonic because we used it at our clinic in a CQI project. And we're

able just to reduce our clottings on both our grafts and fistulas down to practically nothing, because we had interventions.

We followed it closely. We did it every month. And so we didn't have catheters.

We had grafts and fistulas and we focused on surveillance.

DWM:
So describe the transonic.

PMcC:
So the transonics does flow.

Gosh, I can't even remember exactly how it worked. But it just did access flow, basically. Similar to what you do with the dialysis, with the Fresenius machine now.

But we just measured access flow. And just based on that trend of declining access flow, we refer patients for interventions. And we worked...

We had a real close relationship with the surgeons and the interventional radiologists at our clinic so that we would call them up. We have a decreasing access flow on this patient. We need to get it taken care of.

And I remember specifically, we had this one patient. He was down to his last vessel. This is it.

If we can't keep this, we'll have to have a catheter. And the catheter then, we didn't even have permacaths. They were straight caths.

That's why we didn't have them. So that was like a death sentence. And so we were able to keep this guy basically alive because we were so vigilant on his referral for interventions.

So as soon as we saw a stenosis coming, he was out the door. That got the angioplasty back in and done. So it all focused on...

Because we didn't have permcaths. That might have been the worst thing that ever happened in dialysis was the permcath.

DWM:
Actually getting the permcath.

PMcC:
Yeah, really. Now that you think about it, because I really hadn't thought about catheters coming in to be permanent access until we got the permcath, because you couldn't have a straight cast and for very long. You had to get something.

DWM:

When thinking back about the patient population you were dialyzing then, were you dialyzing older patients, sicker patients?

PMcC:
I can't say that they look much different than what we have now. I think the VA group was definitely unique.

It was a younger population than... Although we had our share of older gentlemen, but it seemed to be a younger population there than what we had. But actually the DCI clinic, we had the only PEDS clinic in town.

Vanderbilt at the time didn't wanna have any kind of outpatient dialysis facility. So we had all the pediatric patients in our clinic. So we actually had PEDS clinics on an adult floor.

It was quite the challenge, but our clinic embraced it and the adult patients loved it. They loved their little kids. And if we were hurting one of those little kids, we got in big time trouble.

It was just quite the... Seeing that relationship between our little pediatric kids and our adult patients, and it was just really quite joyous, how they loved each other and took care of each other. And we had one of the first evening shifts.

We had a waiting line for that evening shift because all those patients wanted to work. And we just always, at that clinic, always just... We had a huge home program.

The medical directors were really into home, and we had about 40% of our patients on home, and a lot of PD patients, and we had a lot of PD kids. So we were always... That clinic was really a big clinic for DCI in terms of just doing a lot of different things.

DWM:
Yeah. Interesting to have that all together. All together.

PMcC:
You wouldn't see these now with adults, but it was quite... It was a great learning experience, too. I actually had to learn a lot about PEDs and had to be sure we were prepared.

It's a different dialyzer, different lines, a different emergency cart, different treatment for hypotension, different amounts of fluid. Just a whole learning experience. So it was a challenge, but one that we kind of embraced.

DWM:
So... And also thinking about the quality stuff from... What were you doing about fluid management and anemia management?

What were those like from a quality perspective?

PMcC:
I remember, I guess, the anemia management, that which kind of came out in... Was it in the 80s that we did it?

DWM:
Late 80s.

PMcC: (41:36 - 41:37)
Late 80s.

PMcC: (41:37 - 42:28)
I remember it kind of in the early 90s. And I remember so clearly where we were... The nephrologists were handling it, and it was just so off the cuff, unorganized, that we said, okay, we gotta get some protocols going, because this were...

These hemoglobins were just going everywhere. And that was really the start of trying to get a more consistent pattern of changing doses so that you would see a stable hemoglobin, because it was just so willy nilly. And so that's really what I remember about anemia management, is really trying to find a protocol that would work for your patients so that you kept those hemoglobins in the target range.

So that's really what we were focusing on, on quality.

DWM:
What does that anemia management look like? Beginning to write protocols.

PMcC: (42:28 - 42:28)
Yes.

DWM: (42:28 - 52:02)
Which would have been a new thing, to manage a medication by protocol.

PMcC:
Right, exactly. Yeah.

But we saw it really quick. We've got to... This is...

This one doctor's saying, do this. This one's saying, do this. And it's so everywhere.

And you're seeing all these hemoglobins. So if the nurse is new really quick, we've gotta figure out a way to get control of this, because we're just getting all these different orders that don't make sense. So let's figure out what this looks like so we can get the physician buy in and get it off their plate.

They don't wanna have to answer our questions about this, and they want the same thing we want. So it was an easy sell to them. They were...

Sometimes you can't let physicians... Get physicians to let go of certain things, but this was more an easy sell, I think, because the protocol usually proved really quick that it worked better, and we had more consistent outcomes, and then it was off their plate for them to concentrate on other things that were more important.

DWM:
No, exactly right.
So, and what about fluid management? What were you thinking and doing about fluid management?

PMcC:
You know, it doesn't come to mind as much to me that it was as much a focus.

And I even told this story just the other day. I do remember at our clinic, we put a limit on how much we would take off, and it was five kilograms, period. That was it.

That's the most you can take off. And it didn't matter. We weren't really concentrating on whether a patient was large or small.

Five kilos, that's it. We don't care what your size is. That's all you can have taken off.

That's all they gained when we put that rule into effect. So I was telling the clinic just the other day, you know, funny thing, about 25, 30 years ago, we told the patients, this is the max. Guess what?

They quit gaining. Nobody gained any more than that. They wanted their fluid off, and that rule that came out from the doctors, that was the rule.

That was it. Nobody gained any more than that. So I think that we ought to do a little bit more of that, probably.

That's all we're taking off. We're trying to protect your health.

DWM:
Today?

PMcC:
Yeah. So we... Today, we have electronic systems to capture data, we have lab data, and all that stuff.

DWM:
So how in the world were you all keeping up with all of this?

PMcC:
Everything was on paper. I can laugh about this, because Rebecca Wingard and I, when we were writing the paper on transonics that got published, we were in an office with all our pieces of paper, pulling out our flows, doing our percentages.

We finally got a statistician to help us with the final paper, to look at some of our numbers and stuff. But it was all on these little pieces of paper that we were using for our CQI and our QAI process.

DWM:
And were you all doing a...

Did each of the clinics do a CQI or a QAI? Meeting?

PMcC:
Yeah, I can remember our QAI meetings and discussing issues, and I guess I remember not as much, probably the CQI meeting, as much as the plan of care meetings.

They were... They went on with, for sure.

DWM:
Did patients come in for their plan of care meeting?

PMcC:
No, I don't remember them being involved in them at all. But it was definitely the entire interdisciplinary team sitting down and talking about patients. And really, what was going on with that patient, and how could we help them, and stuff like that.

DWM:
So how was it working in the quality department at Renal Care Group?

PMcC:
Oh, it was great. Ray Hakim is quite the personality.

We can always do better. That's what his main line is. You can always do better.

We can always do better. Or what can we do to do better? There's something, always doing something better.

But a great learning experience for me. I've been a clinic manager, administrator, ran a couple of clinics for DCI, and then came over into this group where we really were starting to... I learned to do public speaking and develop processes on a bigger scale for more clinics.

So just a great learning opportunity for me to be a part of the organization and try to help clinics and nurses do stuff. And actually, I have to say, Becky and I wrote the CQI boot camp that became part of Fresenius, the CQI boot camp. That's the boot camp we wrote.

And we actually did... We had a boot camp where we, with RCG, we would go to an area, the whole interdisciplinary team would come, the physicians would come, we would run a boot camp with the physicians there and doing CQI meetings. And we actually brought their problems in.

So when they were at their table, they were working on issues based on data from their clinic. And I'll have to say that was probably something that we need to replicate through many organizations so that people learn what the CQI process is about and what your CQI meeting should look like.

DWM:
Yeah, so describe the boot camp.

What's that mean? What was the boot camp?

PMcC:
Well, so the boot camp was really...

The first half was kind of explaining CQI principles. But then the afternoon, and we dressed up in fatigues and really made it look like we were getting on. But the afternoon, when they sat down to really learn how to run a CQI meeting, they were essentially having a CQI meeting at their table with us, actually mentoring and coaching them on looking at their data, writing action plans.

And they left that meeting there with action plans to follow up and hopefully completed that process over and over again at their clinic, month after month after month. So it was really learning how to do quality improvement in an interdisciplinary team and how to replicate that month after month to change the outcomes in your clinic.

DWM:
Was it enough to give them one session's worth of mentoring through CQI?

PMcC:
You know, I think it probably was. If we could have followed up, it probably would have been great. But we did have follow up calls, so we would be asking them questions on what's going on with...

What's your action plan? So all in our quality calls that we had with each group, it was, what's your action plan? What have you learned from it?

What are your best practices? So we were following up and away with them on what they were doing.

DWM:
And you got the physicians to come?

PMcC:
Yes, we did. And I would say that was the power in the whole boot camp, is that they really became part of a team. Because their leadership in the CQI meeting is really necessary.

And their input... I mean, unfortunately, CQI has gotten to be just spitting out data and everybody looking at the data. And nobody does any problem solving or any problem identification.

And the physician doesn't lead the group in a different direction. So it made a huge difference. It really did.

And I think they... Once they came and saw the power of it, they embraced it. And I'll have to say, I'll have to share with this about history, but I was just in a clinic last year for six months trying to help a team that was infectioning very well.

So I was asked to go to the clinic and I went every other week for six months to try to help this clinic. And I just had forgotten, again, the power of the interdisciplinary team in changing practice, changing outcomes, changing the whole picture of what a clinic looks like. And once again, I got into this clinic and that was our big focus.

Everything we did, we did as an interdisciplinary team. And I just was... And one of the biggest areas that we had to impact at this clinic was fluid management.

And so we approached it as an interdisciplinary team. And we went from having about 30% to 40% of our patients off the chart and fluid gain down to about 10%. But it was...

Again, I was so... It was the power of that interdisciplinary team that I'd forgotten about, how everybody brings such a different perspective, and how each person's perspective, either on a patient situation or on a clinic problem, each of those perspectives brings such power to the whole process that that's why it succeeds. And it just slapped me in the face again.

I was just like, oh my God, the interdisciplinary team is just incredible. People just forget about the power of that. And all those different voices bring in together this solution that's valuable.

DWM:
Amazing.

PMcC: (52:02 - 52:03)
Yeah, it is.

PMcC: (52:03 - 52:15)
It was amazing. I brought it from way back. We've been preaching it for 40 years, right?

We're still preaching the same thing. It's gotten lost somewhere. It's gotten lost.

DWM: (52:15 - 52:15)
Where?

DWM: (52:16 - 52:57)
Where did this happen?

PMcC:
I don't know where it got lost. And people don't believe in the power of it.

But I think if we could reinstitute it on problem solving, and people see that power, they'd be like me, where I was like, oh wow, oh my goodness, it's the interdisciplinary team. That's why this clinic turned around. We didn't have any new...

We had some new people on the floor, but we had a lot of the same people. We just brought them all together to problem solve and approach, get everybody's viewed and get everybody's buy in on what our solution was gonna be. That's how we turned the clinic around.

DWM: (53:00 - 53:00)
Totally make sense.

DWM: (53:00 - 1:13:41)
We should go back and just visit your history in the room. I need to go listen to all the history so I can bring more stuff to the forefront. So you were at DCI, which is a non profit, and moved to Renal Care Group, which was for profit.

Did that feel any different to you, look any different to you?

PMcC:
I wasn't as exposed to it there at Renal Care Group. I didn't feel anything any different there, no.

A lot of that was going on. It just... It didn't...

Over in quality, it just didn't seem to... I didn't feel anything there at all.

DWM:
And did the clinics look the same to you, the DCI clinics and the Renal Care Group clinics, as far as patient care delivery?

PMcC:
Yeah, pretty much the same. Yeah. Pretty much the same, yeah.

I wouldn't have been able to tell a difference if I'd walked into one or the other.

DWM:
That's interesting. Yeah.

So you're in the quality group, Renal Care Group, what happens?

PMcC:

I get my NP license and finished, ready to go out to be a nurse practitioner. And I had gotten divorced, and my boyfriend at the time was out in California, and a couple of the fellows that I'd worked with at the VA were out in California in a practice, and they were in his city.

And so I saw one of them at ASN, and I was like, where are you, Walnut Creek? Walnut Creek? Oh my gosh, my boyfriend's out there.

I just finished my NP. Well, we've been thinking about hiring an NP. So it just was like one of these lucky things.

I went out there, I was their first nurse practitioner, and they had six nephrologists, and I went out and gotten to practice with them. And it was one of just a great experience. The best I've ever had.

DWM:
This was in 2001. And so if you were their first nurse practitioner in 2001, what tasks did you take on? What part of the practice did you do?

PMcC:
Well, so we had quite the group of patients that were managing their anemia. So that was kind of my first task, was taking on those patients. And then...

DWM:
And those were CKD predialysis?

PMcC:
CKD predialysis, all getting dosed in the office. And it was a huge...

We had a huge group. So that was kind of my first task. And then as I...

I did rounds in the dialysis clinics. So... And we had six or seven dialysis clinics.

So I went to all of them, at least once a month, doing rounds. And that was before the MCPs and the requirements of four rounds a month. So they would get there once a month, and I would get there once a month.

And I was quite popular with all the nurses, because here was now an NP that they could approach and call and ask questions too much easier, learn from and everything else. So then I did the dialysis clinics and mostly the anemia management. And then we got a second NP and a third NP.

And then I kind of started to do more management of chronic kidney disease patients, their fluid management, hypertension. We have a huge office practice. And to be honest with you, a lot of the management of chronic kidney disease can be managed by an NP or a PA.

So I actually saw more patients in the office than any physician, because it was just... They would do the initial diagnosis. I didn't see any patient initially on their referrals.

They would do all the work up, but then following that, I would just follow them and manage their meds. And if they were in for a shot, I'd do that and that. And then I did do some stuff in the hospital.

But the hospital out in California was a little bit... Every NP note had to be signed within 24 hours by the physician. So it just didn't make logical sense.

It was kind of a waste of time for me to see patients in the hospital, and then they had to go. And then I'll have to tell you this story too about being an NP out there. We had this one internist that was really...

He was one of the best internists in our area, but he wasn't so sure about nurse practitioners. So he was always telling his patients, now I want you to see that nurse practitioner. I want you to see the doctor.

And I would always send the patient back, now I want you to be sure to tell Dr. Strauss that you saw the MP, that you didn't see the doctor. So one specific... I don't know if it was a Friday afternoon or something, he needed to get something done in a dialysis clinic.

And all the doctors were off, but the nurse practitioner. So he had to call the nurse practitioner to get an order in a dialysis clinic, because he didn't have any privileges there. So he had to call me.

And from that point on, he wanted every patient to see a nurse practitioner. So it was slow going out there and trying to get the cardiologist and get the internist to see that you could help manage their patients on visits and between them. But, you know, if you just kind of let it work, it's, you know, let your...

how you treated patients and the patient's input and how they landed back at their other doctor's office, if you just let that do the speaking for you, then slowly, you can turn that around. But this practice was a great practice for me to be in. And, you know, I got a lot of just unbelievable experience there, just really loved it, actually.

And so was out there about 12 years. I want to go back to this comment you made that the nurses were happy to see you around.

DWM:
So what was it about you beginning to interact with the nurses in the dialysis clinics that was good for them?

What do you think it was that made that good or useful to them?

PMcC:
I think although our physician practice, I will say, when they did rounds in a dialysis clinic, they spent the whole day there. So they were very approachable.

I think it was just having a colleague, someone they saw as a colleague. They just felt easier asking questions of me or asking me for something or asking me to explain something. It was just more of a, again, a colleague, not the physician.

So they felt like they could approach me or ask me a question about something. And I would even, I was well versed in dialysis, the dialysis procedure, too. And so I would teach them things.

I remember teaching a nurse and a patient care tech recirculation, where, you know, you see the saline coming right back out the arterial needle. And I said, this, this is recirculation. Well, nobody ever showed them that.

So it was just like someone who could also teach them some things about the dialysis procedure, because I had so much background in that. And, you know, questions about, you know, just different things about the procedure. I think that's just what they liked, because they all were really wanting to learn.

I think in general, people want to know more and understand more. It's just, and I saw that actually out in the clinic I was in in California. People were just, we did a lot of education out there.

That's what I did a lot of and people that had been in dialysis 10 and 11 years, were just sucking it up. They wanted it. They wanted the assessment skills I was teaching them.

They wanted things I was, PowerPoints I was bringing to them and things we were teaching them about pathophysiology. They wanted it. They were just like, yes.

DWM:
Interesting. So you did that for a while and then what happened?

PMcC:
So I was out in California and I was having grandkids.

So I was recruited by a company, RAI, to come and be their vice president of clinical services. And I was like, Oh, okay. And at the time, my husband and I were kind of thinking about transition out of California.

And so he said, Well, we'll just go for it. So we did a little bit of long distance, but I came here and then right after I joined RAI, Liberty bought us and then Fresenius bought us and we became part of the bigger organization.

DWM:
And what do you do now?

PMcC:
So now I've had multiple jobs within Fresenius. I've probably had about 12 jobs or 15 since I've been there. But right now, I'm leading actually a kind of a quality mitigation team.

We have seven managers that are all nurses. We go into clinics who have performed poorly in the one the five star program or the QIP measures. And we just go in and really just help look at we do a review of their processes and help them get some action plans going and just help them do process improvement, kind of teach them how to get their multidisciplinary team involved and then just get them on the right track of trying to solve their own problems and do process improvements and improve their outcomes.

And our goal is really not the numbers. It's, you know, getting the catheters out of patients getting better adequacy for patients getting lower calcium. So our goal is really to get better outcomes for patients.

DWM:
So you've been in quality a long time. So how does five star and the QIP fit into the quality work that you have done over decades?

PMcC:
Doing the same thing we were trying to do.

You know, we're trying to get patients well dialyzed. We were trying to manage fluid. You know, we've always been trying to manage hyperphosphatemia and bone disease.

So that's, that's always been a big focus. So I think they're focusing a lot on the same things that that we've always focused on. And, and, and again, the catheter thing is kind of a new thing with the perm cath.

It wasn't an issue way back in the day because we didn't want those straight catheters. You know, they were such a risk.

DWM:
So have we made progress with quality if you think about bone and mineral metabolism and fluid and have we made progress with quality over these years?

PMcC:
Well, we certainly have made progress with any knee management. I think I think clearly, we're doing a better job there. Adequacy, definitely.

We've made huge quality. I think patients were not as well dialyzed. But because we've done so much better in adequacy in shortening dialysis times, that's really impacted our fluid management.

So the longer treatments that we have, you know, five and six hours when we have the bigger dialyzers that weren't clearing as well, we didn't have as many issues, I think, with fluid. So I think where we've improved in some areas, that's led to worsening situations for fluid management. Bone and mineral, I think it's improving.

You know, that's a hurdle to get over because just like fluid, it involves the patient. So anemia management, we can take care of because it doesn't involve the patient too much, we can manage that. You know, adequacy, if we can get them to agree to time, we can usually manage that.

But fluid and volume, how much they drink and phosphate, phosphorus, you know, that involves them. So you have to get their partnership in trying to improve and sometimes that's a challenge. So and I think that's what I saw with the fluid when our interdisciplinary team was working on fluid management with this, you know, clinic that was really doing poorly is we weren't going to make any improvements unless we got the patients on that interdisciplinary team.

So once they, we saw that it took them, we had to partner with them. And once the interdisciplinary team saw that, and we had to figure out why, why is the patient drinking too much? What's the reason?

Not they are drinking too much, but why are they drinking too much? Once we had to drill down on that, and again, that just required me coaching a team. Okay, why are they drinking too much?

Let's figure out why so we can address it. Once once they saw that, then we were able to help the patient. So I think that's the same with phosphorus and those things that are more challenging to us right now.

They require the patient to partner with and often we take this approach with patients where we're taking them to task and directing them on what they have to do. And it's not the partnership, it needs to be the patient centered care that we all talk about, but we often don't exemplify in our practices. If you embrace the patient centered care where they're part of that, and they're finding a solution, you will get to it.

But if you don't, you won't. So I think that's the challenge today is that we've gotten easy stuff out of the way. The stuff we can manage, we're working on that harder stuff that really requires a different approach.

DWM:
Well put. That's exactly right. I think that's true.

So if you think back about the patients that you were caring for 30 years ago, have the patients changed over the last 30 years that you're the patients you're seeing today, the diseases, the types of patients or are you if you walk into a dialysis facility, do you see the same patients that you felt that you were caring for before?

PMcC:
Oh goodness. I remember more my VA patients.

I don't remember those patients as much at DCI. But I definitely remember my VA and my DCI Med Center patients. They seem the same to me in a way.

The patients I was a nurse practitioner to out in California, I had a lot of younger patients there that really I didn't see that in DCI or the VA. I had a, you know, some patients in their 20s. That really impacted me in terms that that's really where I got involved in partnering with patients, because you aren't going to get anywhere with those, those patients at all, unless you had a partnership with them.

And they really impacted me in terms of that younger group, teaching me that I had to go about it a different way, if I was going to help them. Whereas the older patient is more amenable to doing it like you have to tell them to. It was that older generation.

Okay, my doctor says to do this, I'm doing it. This younger generation and the kind of the older patient that we're seeing now, they've grown up with a different mindset that you don't tell me what to do. And so I think that's what we're, we're trying to see and deal with that's a little bit more challenging.

DWM:
So it is a little bit different patient. Yeah. So you're describing a little bit that the multidisciplinary team has to change its approach a little bit, you think from before?

PMcC:
Yes, definitely. And, and I think people get assumptions in their head about things. And you have to, and that's the interdisciplinary team.

So they get these assumptions about patients, but you have to coach them to get that assumption out of their head, and go out and find a real reason. And here's I'll give you this perfect example. And actually, one of the doctors found this out.

This patient was drinking a lot of fluid, a younger patient. And we were, you know, in our interdisciplinary team trying to figure out why. And so the doctor was taking this patient on that was going to be him.

So he went out to talk to her. Well, come to find out she was drinking a lot of hot tea because her heat had been turned off. So we're all younger patients, she's just drinking a lot, eating a lot of salt, you know, everybody's doing their assumption.

But what we needed to do was get a social worker in there, get the heat fixed. She quit drinking hot tea, and we take care of the fluid problem. So that was that specific case to that whole interdisciplinary team was really like an eye-opener.

It was the one that like Joel doesn't fall. And everybody's saying, Oh, my goodness, we were making this assumption about this patient. And it and it was causing us not to give her any credit or try to help her with what her real issue was.

And so once that we have that patient, everybody on the interdisciplinary team, they thought we're gonna find the problem. And we would divide and conquer the patients off,

you know, but everybody went about it getting that assumption out of their head. And let's figure out what the reason is so that we can we can help.

DWM:
You know, good. Yeah, yeah. But a doctor doctor found out.

So if you take a big step back and look at just your experience in dialysis from 30 years ago to today, what's what struck you? I mean, we've talked a lot about some of the details, but what's happened in dialysis, the good the bad over the last 30 years?

PMcC:
Well, I think the good is the technology.

I mean, you can't what has gone from what I described as the Kiil boards that were building in, you know, for 30, you know, 20 years later, we had dialyzers, and we had machines. I mean, all that is just so much better. But I think the challenge has been just the whole challenge of healthcare is the cost and trying to do more with less, you know, have less caregivers have less qualified caregivers.

We have, you know, technology, but it's still the assessment of the patient's the same. You know, we have a great machine up here that runs, but you're still talking about the same patient that needs that same assessment. So that patient that came in with a headache, that's the same patient.

Nothing about this technology is going to help that patient if we don't do the right assessment. So I think that we've fallen. Like, we were leaning on this technology to kind of take care of a lot of the things that were issues in the past.

But that same patient with the headache is sitting here right in front of me. And nothing about this technology is going to change that. And we've lost the piece where we really train, train, train, and depend on that, that nurse to be sure that patient to get done, get put on the machine.

So I think that's the caveat. That's what we've lost. That is really frustrating.

DWM:
Yeah, I agree. So when you first we first started talking, you talked about really, your career centered a lot more like things that you enjoyed about it were leadership kinds of things that you became educated yourself, you have joy in your practice of medicine, and then you are began to educate other people, and also write articles and lecture.

PMcC: (1:13:42 - 1:13:49)
Yeah.

DWM:
So how do you think of, were you thinking when you were in nursing school about leadership?

DWM: (1:13:49 - 1:21:00)
And how has leadership been a part of your career?

PMcC:
I didn't think anything about it much in nursing school, I guess, a little bit we we did have a because I was on this neuro orthopedic board. And I worked on that word for six months as my clinical nurse clinical senior clinical, we ran the floor for a shift.

But I never thought about, you know, going into the leadership part that I never got training or really thought about it. And really probably could use some training, self trained on leadership. But I don't know that I really thought about that.

Oh, gosh, someday, I'm gonna be a clinic manager. That really never entered my head much.

DWM:
Do you feel like a leader?

PMcC:
Yes, I guess I do. I guess I see myself as a leader. And certainly in areas there that I'm asked to take on.

Within our company, someone says, Can you take care of this project, I can lead the project and, you know, get to where the place we want to be. And I like to, yeah, I guess I, I see myself as an innovator and kind of creator of even leading our company on trying to change the way we think sometimes about approaching different things. Like, let's think a little bit differently about this, you know, and I think because people, they feel my passion when I talk about patients.

And I like that's in a big company. That's one of the things I always try to bring it down to is, and that's always what I do at the end of the day. You know, you'll get criticized, or you'll get someone say, Well, guys, why'd you do that?

And, you know, I measure myself on whether I was doing something that was going to be beneficial to patients. And so at the end of the day, I never, I go to sleep, because I always have that patient in my head. I see that patient, and my decisions are based on patients, that patient that I was taking care of.

And so I'm never I never second guess myself on stuff. And even though I may rub people the wrong way. And I may say something in a corporation that maybe shouldn't have been said, I really, I sleep well at night.

Because I my my leadership comes from always putting the patient first. So that that's where I think I lead. I just try to bring people that sometimes these we get so far away from the patient that we lose sight of that, that I've been actually blessed enough to always be in contact with patient.

And like I said, I was asked to go to California for six months to be in a clinic. And that we, you know, I've been out of the clinic for about four or five years, running on patients. And that was just, oh my gosh, it just brought it all back to me again, and revitalize that passion.

And we've got to do what's right for the patients, so that I could be that voice. So that's the way I see myself as a leader. It's being the voice of a patient.

DWM:
A wonderful description, actually. Very nice. So tell me a little bit about I know you were involved in ANNA.

Can you tell me a little bit about ANNA?

PMcC:
Yeah, yeah. Um, so Lo Binkley, who was at the VA and was a leader in nephrology nursing, she got one of those.

DWM:
What was her position at the VA?

PMcC:
She was clinical specialist. And then she left the VA to work for Amgen and run, you know, she was really big in Amgen and ran roll out of Epigen.

She was kind of on the frontier of all that. She really pushed me to get involved in ANNA. And she pushed me to go to my first meeting that was in New Orleans.

And we had a group of three of us drive down there, you know, and What year was this? I think it was. So it was when I went to the VA.

So probably in the early 80s. And that's when I got involved. And she had me write a paper.

The first paper I wrote was on hereditary nephritis for the ANNA journal. And so so she just kind of was a mentor in terms of that she wanted all the nurses there to be involved. And that's where I got involved in ANNA.

And then you know, I was I kind of got involved. So I could go to meetings and volunteer. So I would get my _____ paid.

And so I started being involved in their educational program. And then Linda Smith was the director of education for ANNA. And I kind of got under her on her committees.

And I was always on the program committees. And the program committees at ANNA were just such a learning experience because we were looking at all articles, figuring out who we wanted to invite. We were always trying to kind of be on the forefront and being sure we were getting you know, and so it was just, again, just a way to just really get more knowledgeable and learn more and do stuff and then get my weight paid to the committee.

And so that's where I did most of my volunteer work was always on the program committee, always. And then I headed a bunch of a couple of program committees for for ANNA and just really enjoyed it. And then also I was on there.

When the CNN test was their certification, that was part of ANNA, I was pulled onto that committee. And so I did test writing, I actually went to New York to the board of nursing there, and they taught us how to write test questions. And that was a great learning experience.

And then on the journal, I actually got to be part of the journal board, and I wrote all the test questions for the journal articles. And so just a lot of great opportunities within ANNA again, to just continue to educate yourself, stay on the forefront, and just, you know, be associated with many nurses across the country, network, all those great opportunities.

DWM:
So is this a certification for nephrology nurses?

PMcC: (1:21:01 - 1:21:01)
Yeah.

DWM: (1:21:02 - 1:21:34)
Yeah. And so was that a pretty popular thing to do, to be certified? You know, I think it was certainly a lot of the companies, if you were certified, it showed a level of expertise.

PMcC:
So I think it was and then, you know, now PCTs are required to be certified. So I actually wrote the first PCT test with a couple of people for ANNA. So yeah, it's come a long way.

Yeah.

DWM: (1:21:34 - 1:21:35)
Very cool.

DWM: (1:21:35 - 1:29:32)
Yeah. So other than ANNA, were there any other meetings that you've attended regularly?

PMcC:
Well, DC, I would have a meeting we would go to.

And then I didn't start going to the ASN until I became a nurse practitioner very much, but I started going there to those meetings. But mostly ANNA meetings, or the NKF too, I think those meetings are really good. So those were the two meetings that we usually attended.

DWM:
So who have your mentors and heroes been?

PMcC:

So I guess my first mentor was my supervisor at the VA. And she was not in nephrology.

She was an ER nurse, and she ran the outpatient department at the VA. But she just had a certain way about her that, I don't know, it just gelled with me. She just had a calmness about her.

I was probably more excitable at that age. And she, you know, she just taught me because the frustration within the VA was you couldn't control other people. You couldn't control people that were even working in your area.

And she just helped me learn that, you know, you sometimes you just have to accept certain things and try to work around it or, you know, do your best. So she was my first mentor. My second was probably Linda Smith at ANNA.

She just really taught me so much about just running projects, putting programs together, learning, just, you know, she was really just wise and knew nephrology. And actually her background was critical care. But she came into this, so she was kind of a really important person.

And then I think Dr. Stone, just his knowledge of nephrology was just enormous, you know, and his way to educate people. I mean, his lectures were, he did hard work on it. They were planned, you know, and I learned you don't just get up and talk about something, you have to really work at it.

I mean, even today, I'm supposed to give a talk in the fall, I will be going to work on it. It won't, I just won't throw the slides together. I'll be pulling the latest research.

And you know, it's a lot of hard work. And always when you're asked to give a talk, you think, well, do I want to learn about this? And do I do want to do the hard work I had to do to put this talk together, but usually you learn a lot when you're doing it.

So he was a good mentor. And then now, my boss right now, probably is a great one to end my career. Because she knows how to handle me.

So she turns my passions and my drive, and it helps me control it somewhat. And so I've really, I'm really blessed that now that I have her, I'm down like, okay, I'm at the, you know, final ends of my career. And I've got another, finally, I'm circling back around to that very first supervisor I had really at the VA.

She reminds me of her so much that it's just like, circled back around to the same person who's really channeling me. And that drive I have to be sure it's going in the right direction. So that's kind of the mentors.

DWM:
So why is it important to control your passion and drive? What does that? What help is that?

PMcC:

Well, if it's not controlled and channeled, then it won't do any good. You have to move it where it's moving something. So you have to figure out where, how can I, I see this, I see we have a big issue here.

I want to get something done about it. How do I go about doing that in an advantageous way? Rather than just, you know, blowing smoke, you've got to make things happen.

You've got to get all the people lined up so you can make it make a change. Because what you're trying to do is make a change. You don't just want people to know about it.

And I'm like a dog with a bone. I've got a few things going on right now, but I'm not gonna let go of there. You know, people might have thought I've let go of them, but I haven't.

You know, there's there's still an issue here, and we're going to stay on it. And it's kind of the team what I'm integrating in my team. We're going out to clinics and seeing issues.

And we may back off from that clinic right now, we hand it over to somebody, but you're still on our radar. You're not at, you're still in our focus here. And I've got some things at our company right now that I think are issues that we need to address.

So they're still in my radar. And she's taught me maybe right now we can't quite do anything about it. But some things are coming.

So hopefully, well, it's on the radar and I'll get to make some progress.

DWM:
So what do you think is the future of nursing? Let's say nephrology, nursing in particular?

PMcC:
Goodness. I think the future is hopefully getting a little bit back to our past, where we become the leader in the clinical arena. And our leadership, our clinical manager is actually that a clinical manager, where she's actually a leader in the clinical care of the patient.

And what's happening to our patients. I think that's where we we kind of got to get back to. We've saddled clinical managers with a lot of administrative responsibility.

And we need that clinical leadership. So I think that's, that's to me where we need to get our future back to that to impact our patients. What do you think is the future of dialysis?

Yeah, I'm hopeful that we'll get it more to a wearable kidney. I'll go back to being a nurse practitioner and really managing a lot of patients that need to, you know, just be seen on a, you know, every month or so basis just to make sure all the things are right. We'll, we'll continue to, you know, push that self management.

But I'm hoping that the wearable more daily type thing where it's managed, not within a machine, but more, more on a day to day basis. I'm hoping that'll, I don't know if it'll be our lifetime, but I'm hoping that comes about. That'd be a big improvement for sure.

DWM:
Yeah, yeah. Is there anything that we have not talked about that you would like to talk about as part of this interview?

PMcC:
No, we talked about more things than I thought we would.

No, I think you helped me solidify some of my own thoughts about nephrology, nursing, and my role. And it's helped me think about what what it's meant to me. And so it's been enjoyable.

DWM:
Well, thank you very much for being a part of the Nephrology Oral History Project. I really appreciate it.

PMcC:
Thank you.