

Caring

November 15, 2001

HEADLINES

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Standing room only, standing ovation, for Sue Briggs, MD (left), Marie LeBlanc, RN, and the entire DMAT Team, for their presentation, "To New York City and Back" (See page 4)

MGH Patient Care Services

Working together
to shape the future

A grateful hospital says, 'Thank-you!'

Celebrating five years of collaborative decision-making

On Wednesday, October 10, 2001, Patient Care Services celebrated a milestone in the evolution of our professional practice model. Five years earlier, we had come together to align our work. In our hearts and minds we were already a united multi-disciplinary team. All we needed was a plan that would allow us to think together, strategize together, and craft our future together.

Six goals helped us articulate our work:

- Enhance communication to promote understanding of organizational imperatives and their involvement in clinical decisions affecting practice.
- Promote and advance a professional practice model that is responsive to the essential requirements of patients, staff, and the organization.
- Assure appropriate allocation of resources and equitable, competitive salaries.
- Position nurses, therapists, social workers and chaplains to have a strong voice in issues affecting patient care outcomes.

- Provide quality patient care within a cost-effective delivery system.
- Lead initiatives that foster diversity of staff and create culturally-competent care strategies supporting the local and international patients we serve.

From our goal to develop a professional practice model, emerged four key questions:

- *Delineation*: How do we acknowledge and capture clinical expertise?
- *Description*: How do we create an environment for learning and capture opportunities to teach?
- *Identification*: What systems need further refinement, and what resources are needed for the development of expertise in practice?
- *Definition*: How do we acknowledge, celebrate, and reward clinical expertise?

No one can really 'define' professional practice model. It is a framework that guides, supports, and helps organize our work. You, the decision-makers, are the backbone of our professional practice model.

The model has nine components:

- *Values* that affirm our work
- A *philosophy* statement that synthesizes our beliefs
- *Standards of practice*
- *Decision-making* that empowers clinicians
- *Professional development*, including career-advancement programs
- *Patient-care delivery system*
- *Privileging, credentialing, and peer-review systems*
- *Research-based practice*
- *Theories* from profession-specific experts

The milestone we have just achieved is about your work, about our work, around collaborative decision-making. Collaborative decision-making places authority, responsibility, and accountability for patient care with practicing clinicians. And we have been successfully utilizing collaborative decision-making in our practice for five years now.

Our collaborative governance committees have brought this aspect of our professional practice model to life.



Jeanette Ives Erickson, RN, MS,
senior vice president for Patient Care
and chief nurse

- The Quality Committee safeguards and ensures the very reason for our existence
- The Professional Development Committee challenges us to talk about our practice and recognize the excellence of our work
- The Ethics in Clinical Practice Committee provides a forum for us to discover our collective wisdom and then use it to advance quality patient care
- The Patient Education Committee informs and empowers patients
- The Nursing Practice Committee gives us a voice and strengthens our influence over important practice decisions
- The Nursing Research Committee brought life to our spirit of inquiry and supports our movement toward a more research-based practice
- The Patient Care Services Diversity Steering

Committee taught us to see the good in ourselves and in our society

● The Staff Nurse Advisory Committee brings recognition to Nursing and strengthens me as your leader

We have come a long way from where we started five years ago. The Staff Perceptions Survey tells me we are making great strides in changing our culture for the better. But we still have important initiatives to discuss, consider, develop and implement.

Collaborative governance is still young. But with every passing year, we are weaving our committee work into the fabric of Patient Care Services. All members of Patient Care Services are accountable for an inclusive decision-making mechanism that works to better serve our patients, their families, and staff.

I thank all who have
continued on next page

Collaborative Governance

The Fielding the Issues section of Caring Headlines is an adjunct to Jeanette Ives Erickson's regular column. This section gives the senior vice president for Patient Care a forum in which to address current issues, questions, or concerns presented by staff at various meetings and venues throughout the hospital.

Question: What is collaborative governance?

Jeanette: Collaborative governance is the communication and decision-making model that is employed within the structure of our professional practice model. It places authority, responsibility and accountability for patient care with practicing clinicians. Collaborative governance is based on the belief that

- participation is empowering and contributes to a broader knowledge base

- individuals make appropriate decisions when they have sufficient information
- a shared vision and common goals lead to productivity and commitment
- individuals are accountable for their own practice

Question: What committees are included in collaborative governance?

Jeanette: Eight committees comprise our collaborative governance structure. They are: Diversity, Nursing in Clin-

ical Practice, Ethics in Clinical Practice, Patient Education, Nursing Research, Professional Development, Quality, and the Staff Nurse Advisory Committee. All committees are chaired by clinicians, and each committee is supported in its work by a coach who is a member of PCS leadership.

Question: What are the responsibilities of committee members?

Jeanette: Members are responsible for attending committee meetings;

communicating information back to managers/directors and colleagues; and bringing to the committee the thoughts and comments of their co-workers. Members are also responsible for actively participating in meetings, initiating discussions, asking questions, and problem-solving.

Question: How long can a person serve on a committee?

Jeanette: Co-chairs and members rotate every two years so that all staff have an opportunity to participate. These appointments are staggered to maintain the necessary experience level within each committee and to allow experienced members to mentor newer members.

Typically, opportunities to participate on committees arise once a year.

Question: When do committees meet?

Jeanette: Times and frequency of committee meetings vary, so check with committee leadership for specific scheduling information. If you're interested in participating on a committee, there's an annual report available through The Center for Clinical & Professional Development that may assist you in selecting the committee of interest to you. Speak with your manager or director to ensure your participation is supported. For more information, contact The Center at 726-3111.

Jeanette Ives Erickson

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participated on collaborative governance committees, including outgoing committee leaders, Regina Doherty, OTR/L, Karen Hopcia, RN, Barbara Cashavelly, RN, Kristin Parlman, PT, Clare Beck, RN, Ed Burns, RRT, and committee coach, Donna Jenkins, RN. And welcome to those who are just beginning their membership terms. We look forward to helping you and working with you as we move forward.

Updates

- I'm pleased to announce that Mary Coughlan Lavieri, RN, has accepted the part-time position of critical-care clinical nurse specialist for The Center for Clinical & Professional Development. Mary will support the North Shore Cardiac Surgical Program, working closely with Donna Perry, RN, and the cardiac surgical and peri-operative

nursing teams, and will support the continuing development of critical care initiatives.

- On Monday, November 19, 2001, Jill Nelson, RN, will assume the position of oncology inpatient nurse practitioner within the division of Hematology/Oncology. This is a one-year pilot program funded by Oncology Clinical Performance Management. Goals have been established to help evaluate the effectiveness of the pilot, including: decreasing

length of stay; effecting a smooth transition to the next venue of care; improving patient- and family-

satisfaction; and improving communication/collaboration among the entire healthcare team.

Rewards for PCS employees who recruit or refer clinical staff for hire within Patient Care Services

- PCS Referral Program rewards PCS employees who refer individuals for hire into specific roles between now and December 31, 2001
- All current PCS employees are eligible (excluding directors, leadership and HR staff)
- \$1,000 will be given to employees whose referrals are hired into PCS clinical positions of 20 hours per week or more

For more information, contact Steve Taranto at 724-1567

Special Teams

DMAT Team presentation: “To New York City and Back”



Members of the DMAT team (seated) listen as Marie LeBlanc describes their journey to Ground Zero.



Ives Erickson introduces team in a packed Ether Dome

“This is a proud and historic moment,” said Jeanette Ives Erickson, RN, senior vice president for Patient Care, as she introduced Marie LeBlanc, RN, nurse manager and DMAT supervising nurse, and her presentation, “To New York City and Back: Our Mission to Ground Zero.” LeBlanc narrated a riveting photographic essay of the DMAT team’s deployment and work at Ground Zero. Before a backdrop of stunning images, LeBlanc spoke about the speed and efficiency of the team’s response; the changing focus of their mission driven by the changing reality at Ground Zero; the enormity of the destruction; and the incredible and unwavering support they received from fellow team members and from other DMAT teams who had been deployed from all over the country.

Bob Droste, RN, and Sally Morton, RN, described what it was like to be part of the second wave who helped staff the Cornell Burn Center at the New York Presbyterian Hospital. They spoke about having to quickly learn new equipment and technology, the high level of security surrounding the hospital, working long hours, and the incredible outpouring of support from the community, including cards and posters sent to the hospital by school children and others.

LeBlanc recognized the New York City police and fire fighters as the ‘real heroes,’ but applauded the “high level of organization, and the strength, spirit and courage exhibited by the entire DMAT team.”

DMAT nurse says, ‘Thank-you’

I would like to take this opportunity to say thank-you to all the brave ‘unsung heroes’ who characterized the MGH community in the aftermath of the September 11th tragedies. The unsung heroes are those of you who performed with dignity, caring and courage, the most difficult task of all, the job of staying behind!

In recent times, much has been written about the power of positive energy. Many religions testify that grace and prayer can create change, promote healing and move mountains. Nurse theorist, Martha Rogers, described human and environmental energy fields as open, infinite and integral with one another. James Redfield, in his book, *The Celestine Vision*, talks about a ‘responsive’ universe made up of an interconnecting web of energy relationships.

If we believe that we are all connected by energy, the terrible destruction generated by the terrorist attacks in September was offset, repelled, and in many ways, neutralized by the outpouring of positive energy from the MGH community! That healing energy was created by prayer, by covering a shift for a colleague, draping flags on office doors, talking with children, appreciating your family a little bit more, juggling your schedules to fill a sudden gap, making a donation to a meaningful charity, facilitating a debriefing, making a welcome-home sign... by asking, “Are you okay?” and listening to the stories, and by keeping the everyday routine at home and at work on track.

By doing these things, you have defended our way of life and operationalized the words of Buddha: “Hatred does not cease by hatred at any time; hatred ceases by love—this is the eternal law.” Please know that you all have made a difference during these difficult times. Please know that you all are my heroes!



Mary D. O'Brien, RN, MS, CS
pediatric trauma nurse coordinator

Mary O'Brien

MGH celebrates Latino Heritage Month

A number of special events made it possible for staff, patients and families to take part in October's celebration of Latin Heritage Month at MGH. Presentations, Nursing Grand Rounds, and a Latino Health Resource Table provided educational materials and information, while a Friday afternoon 'fiesta' supplied food, fun and frivolity!

The theme of this year's celebration, "Paving the Way for Future Generations," was evident in many of the presentations, including, "Why Healthcare Needs the Foreign Language Interpreter Law,"

"Care of Latino Patients," and "An Inside Look at the Latino Culture, Heritage and History at MGH and Beyond."

Among those who shared observations were

Allison Rimm, vice president of External Affairs, who spoke about our many advancements in diversity as an institution; Win Williams,

MD, of The Multi-Cultural Affairs Office, who spoke about the importance of increasing opportunities for Latino clinicians and increasing the number of Latino and Latina professionals in our workforce; Ernesto Gonzalez, MD, stressed that it's every-

one's responsibility to improve services to our Latino patients and embrace opportunities for advancement; and Carmen Vega-Barachowitz, CCC-SLP, director of Speech-Language Pathology, shared some personal experiences about what it was like for a Latina woman coming to America for the first time. She spoke of the different influences that contribute to diversity within the Latino population, and of the similarities. Said Vega-Barachowitz, "There are common threads that run through all of us—the importance of family, religion, community, our way of communicating, our shared sense of 'struggle.' This is a time to celebrate our similarities!"

Deborah Washington, RN, director of the PCS Diversity Program, shared that with all the Latino festivities going on, she really felt part of the Latino community. "Wouldn't it be nice," she said, "if we could make that feeling last all year... not just for the month of October!"

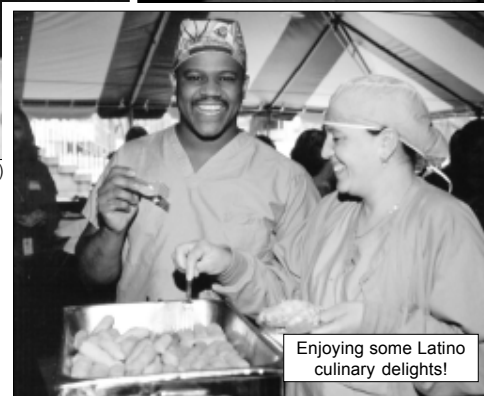
The Latino Heritage Month Planning Committee, chaired by Elena Olson, was a multi-disciplinary, multi-cultural team that included employees from Interpreter Services, AMMP, The Multi-Cultural Affairs Office, and Food & Nutrition Services (who prepared an authentic Latino fiesta from recipes submitted by committee members!)



(Photos by Abram Bekker, Bulfinch Photo Lab)



Carmen Vega-Barachowitz, CCC-SLP



"Wound & skin care: common problems, common products"

Program is designed to enhance participants' knowledge of latest developments in skin care and wound management. At completion of program, participants will be able to assess, implement, evaluate and document care for a range of common wound and skin-care problems.

**Friday, December 7, 2001
7:30am–4:15pm
Training & Development
Charles River Plaza**

Please bring challenging cases for discussion by panel

Contact hours will be awarded

For more information, call Joan Gallagher, RN, at pager #2-5410

Marie C. Petrilli Oncology Nursing Award

Congratulations to Laura Ghiglione, RN, staff nurse, Ellison 14, and Nancy Schaeffer, RN, Medical Oncology nurse practitioner, the recipients of this year's Marie C. Petrilli Oncology Nursing Award. The Petrilli award is given annually to recognize the caring, compassion and commitment of MGH oncology nurses. The award ceremony has been rescheduled for the spring; Ghiglione and Schaeffer will be formally recognized at that time.

Collaborative Governance

Past-year accomplishments and goals for the future

On Wednesday, October 10, 2001, Patient Care Services celebrated another year of collaborative decision-making as the annual collaborative governance presentations and dinner were held in O’Keeffe Auditorium and the grand ballroom of the Holiday Inn. Committee leaders were asked to summarize the work and accomplishments of their respective committees over the past year, and share their goals for the future. An overview of their reports is included here.

Ethics in Clinical Practice Committee

- Played leadership role in development and implementation of Life Sustaining Treatment policies
- Increased staff awareness around ethical aspects of care
- Provided education on ethical issues to MGH community

Future goals:

- Continue to develop interdisciplinary ethics resources
- Expand collaboration with other committees regarding the intersection of ethics with other committee charges.

Nursing Practice Committee

- Revised Nursing Assessment Sheet
- Developed a One-Time Medication Sheet
- Revised Nursing Procedure Manual
- Evaluated new and current products for efficiency, cost, effectiveness, and safety

Future goals:

- Support development of computerized, on-line nursing record
- Continue to work with Materials Management and front-line evaluators to review new products.

Professional Development Committee

- Developed guiding principles
- Used clinical narratives to identify uniqueness of MGH clinical practice
- Described four levels of practice:
 - Entry
 - Clinician
 - Advanced clinician
 - Clinician scholar
- Identified themes of practice:
 - Clinician-patient relationship
 - Clinical knowledge
 - Teamwork/collaboration

Future goals:

- The Professional Development Committee has completed the work of its original charge; it is currently awaiting its next charge.

Patient Education Committee

- Established ‘on-demand’ patient education
- Made educational videos available on televisions at patients’ bedside
- Retained programmer to assist with expansion of Patient Family Learning Center website for MGH-specific patient education documents



Collaborative governance committee leaders report on their work and accomplishments at recent annual collaborative governance event in O’Keeffe Auditorium.

Pictured (l-r) are: Regina Doherty, OTR/L, Jennifer Kelliher, RN, Pam Wrigley, RN, Anne Cassels-Turner, RN, Barbara Cashavelly, RN, Clare Beck, RN, Susan Jaster, RN, and Firdosh Pathan, RPh.



Future goals:

- Continue to work on the PFLC webpage to provide easy access to patient-education documents for bedside nurses
- Improve documentation of patient education
- Continue search for diversity-related and culturally sensitive materials



Diversity Steering Committee

- Had strong participation in the creation of annual Diversity issue of *Caring Headlines*
- Coordinated Black History Month Pinning Ceremony
- Was instrumental in creating and displaying multi-cultural holiday banners
- Held successful holiday gift-giving event to support the families of the HAVEN Program

Future goals:

- Continue to hold 'big events' celebrating diversity
- Present at Nursing Grand Rounds
- Develop more culturally competent care informational resources

Nursing Research Committee

- Initiated "Did you know?" research-utilization posters on patient care units
- Designed and presented Research Poster Preparation Workshop (now an on-going offering of The Center for Clinical & Professional Development)
- Expanded Nursing Research Day poster session to two weeks
- Added more research-utilization resources to Nursing Research Guide

Future goals:

- Increase collaboration with other committees
- Support and consolidate "Did you know?" poster topic-development
- Get research webpage up and running

Quality Committee

- Assisted in implementing improvements in medication administration
- Collaborated with director of Quality to assist with JCAHO preparations
- Worked with Nursing Research Committee and Occupational Health Services on issues related to employee back injuries
- Collaborated on implementation of hand-disinfection program

Future goals:

- Collaborate with Diversity Committee to foster strategies for culturally competent care delivery
- Focus on systems improvement to enhance patients' access to quality care

Staff Nurse Advisory Committee

- Made good use of time spent with senior vice president for Patient Care discussing issues related to environment of care
- Promoted recruitment and retention initiatives through open houses and the Employee Referral Program
- Provided input into documentation of care initiative and educational calendar
- Addressed issues important to staff (such as parking)

Future goals:

- Continue open dialogue on all issues of importance to clinical staff
- Support legislative and public-relations initiatives



(Photos by Paul Batista, Bullfinch Photo Lab)

Inter-disciplinary collaboration, effective communication result in timely discharge

Mr. G is a 57-year-old man who was transferred to MGH from a rehabilitation hospital in February. He had multiple medical problems, including bilateral below-the-knee amputations precipitated by severe vascular disease, diabetes, and renal failure requiring hemodialysis and frequent hospitalizations. Mr. G also suffered from severe depression, which caused him to attempt suicide by overdosing on insulin.

For this hospitalization he had been transferred from a rehabilitation hospital with a diagnosis of abdominal pain and sepsis. Mr. G underwent surgery and because of his fragile health, his recovery was long and challenging. Mr. G was a brilliant man, but had a very strong self-destructive streak. Growing up he was poor but received a full scholarship to an Ivy League college. He soon dropped out and began a slow decline into alcoholism. He found work in construction but continued to drink despite marrying and fathering two daughters.

We met Mr. G when he was transferred to White 8, two months into what would become a nine-month hospitali-

zation. Lisa was Mr. G's primary nurse; Karlene was his case manager. Little did we know the journey we would be taking together.

Mr. G's long illness and frequent hospitalizations robbed him of his sense of control over life. This was manifest by his refusal to eat after receiving insulin. While we all understood his need for control, we were concerned about his falling blood-sugar levels. His labile blood-sugar readings caused not only serious medical problems, but also many missed therapy sessions. After working with him for a little while, we realized there were certain things he could control; but we couldn't let him put his life at risk.

Lisa would stand in front of him and say, "You have to drink this orange juice," and he would drink it. We changed the time his insulin was given so that he wouldn't receive it until breakfast. Slowly, a relationship and a trust developed. We realized he needed to retain some independence, so with the assistance of PT and OT he was able to shower independently, get in his wheelchair, and travel the hallways of MGH. Mr. G was a frequent presence at Coffee

Central. Lisa would put a note on his chart alerting others to contact his nurses if they were looking for him—we knew all his favorite haunts.

It is challenging to care for patients who have struggled with substance abuse and adherence issues in the past. Being able to remain non-judgmental allows the patient to feel valued and cared for. But as challenging as it is for clinicians, it's harder for families who often must reconcile painful memories with the demands of a frail husband or parent. Mr. G's family struggled with a complicated history, and we frequently consulted social worker, Marilyn Wise, MSW, who had known the family in the past.

Mr. G's recovery was slowed by infections, primarily related to his dialysis catheter. It became necessary for us to place a permanent access device in his arm, but due to his vascular problems, we had to place it in his (dominant) right arm. Mr. G refused. He feared something would go wrong and he would lose his right arm, and with it, his independence. He asked Lisa what to do. It is a great responsibility when a patient asks for this kind of guidance, so Lisa spent



Lisa Wright, RN, staff nurse, White 8
and Karlene LeMieux, RN,
case manager

time talking with him about his options and his trust in the surgeons. Ultimately, he decided to have the graft placed in his right arm.

When Mr. G returned from surgery, his arm was cool and the pulse from the graft was weak. He developed difficulty moving his hand. We carefully monitored his condition and worked with the whole team involved with his care. Everyone had an opinion but no one was doing a very good job of communicating with each other or with Mr. G and his family.

We decided we needed a family meeting so that everyone's concerns could be addressed. The team was going to meet 15 minutes before the meeting to prepare; we met for 45 minutes. Lisa forcefully advocated for Mr. G and the need to establish a concrete plan to deal with his graft and discharge plans. Karlene helped us look at all of the conflicting views

involved in the case.

Then we met with Mr. G and his family.

Things could have gone very badly at this meeting—complex family dynamics, unresolved issues about the best way to treat his graft, and a myriad of unknowns about the future. But it went well. The team was united, and Mr. G and his family could see that we were working together to do what was right for him. The next day, tests showed that the graft could not be saved, and it was removed. Occupational therapist, Tricia Cincotta, OTR/L, and physical therapist, Bob Dormund, PT, aggressively worked with Mr. G to maintain function of his hand.

Mr. G's long journey was drawing to an end. He told us he wanted to return home. We all understood, but we didn't want him to fail once he got home. To prevent that, we felt he needed the expertise of a rehab-

continued on next page

Case Management Week at MGH

MGH observed National Case Management Week, October 9th–12, 2001, with an information/educational booth in the Main Corridor, raising awareness of the MGH/MGPO

Case Management Program to all who stopped by. Patients, families, staff, and visitors had an opportunity to learn about the role of case managers and the impact they have on patient

—by Hilary Levinson, RN
case manager

care at MGH.

The Case Management Department, under the leadership of Nancy Sullivan, originated six years ago with the consolidation of Utilization Management and Continuing Care. Case managers work to ensure that patients receive quality, patient-focused care that meets each patient's specific needs in a timely, cost-effective manner. At MGH case managers are

registered nurses who are well versed in all aspects of insurance coverage.

One of the primary goals of case managers is to work with the healthcare team to devise a comprehensive discharge plan for patients. Case managers assess, implement, coordinate, monitor and evaluate all of the options and services necessary to meet patients' healthcare needs.

The MGH/MGPO Case Management Program covers inpatient units, primary care practices, the Emergency Department and Admitting. Case managers work collaboratively with patients, families,

and the entire patient care team.

As specially trained nurses with expertise in all aspects of insurance coverage and non-acute services, case managers:

- facilitate and communicate treatment and discharge planning with patients, families and all members of the healthcare team
- facilitate consults and testing for appropriate services and specialties
- clarify health-insurance issues, and explain the intricacies to patients and families
- make recommendations to expedite appropriate care and discharge plans
- coordinate insurance benefits with treatments and procedures necessary for a timely discharge

A luncheon reception was held to recognize the invaluable services provided by case managers throughout the hospital. Speakers included: Jeanette Ives Erikson, RN, senior vice president for Patient Care; Elizabeth Mort, MD, assistant chief medical officer and director of Decision Support and Quality Management; Brit Nicholson, MD, chief medical officer; James Richter, MD, medical director of the MGPO, and Peter Slavin, MD, chairman and chief executive officer of the MGPO.

For more information about Case Management, call 6-3665.



Greenwood fields questions from MGH visitor



Staffing the Case Management educational booth are (l-r): Claudia DeLucia, RN, practice-based case manager; Karlene Lemieux, RN, acute-care case manager; and Christine Greenwood, RN, Emergency Department case manager

Exemplar

continued from page 8

litation hospital, and he finally agreed.

Throughout his stay, Mr. G and his family worked with three case managers. All encountered difficulties as they planned for Mr. G's discharge. Karlene was finally able to get the Gs to agree on a few facilities and then advocated for his admission. She enlisted the assistance of MGH therapists to talk to therapists in these facilities. The attending physician made phone calls.

Mr. G was screened and rejected by all of the facilities to which we applied. It was not going to be easy to place Mr. G with his complex medical needs. Finally, our persistence paid off when he was accepted by two rehab hospitals.

The family refused one of the options, and Mrs. G expressed anxiety at the prospect of the other, saying she didn't think it was a good idea. Knowing her, Karlene reminded Mrs. G that this had been their first choice and was probably the

best place for him. Perhaps because of what we had been through together, she agreed.

The rehabilitation hospital wanted to transfer Mr. G that day right after his dialysis
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The writings of Miss Georgia Sturtevant, MGH's 'last untrained nurse'

—submitted by Martha E. Stone, MS, AHIP

In my capacity as coordinator for Reference Services at Treadwell Library, I am sometimes called upon to research various aspects of the history of nursing at MGH. Occasionally, after I've answered a specific question, I'm so drawn to the subject that I pursue it further for my own interest. This was the case with a question I received about Miss Georgia Sturtevant, the last 'untrained nurse' at MGH.

Georgia Sturtevant began her career at MGH in 1862 as an assistant nurse, and after two months was put in charge of a men's surgical ward. During that time—the Civil War era—male wards were filled to capacity because no soldier was turned away if there was an empty bed. Sturtevant was appointed hospital matron on July 31, 1868, upon the death of her predecessor. I found it particularly interesting that she was also placed in charge of Treadwell Library, which at that time was located in the Bulfinch Building. In her position as hospital matron, Sturtevant was the only female of all the officers at MGH. The stereotype of hospital matrons at that time, in the words of a 21st century British writer, was a 'tyrannical, starched battle-axe.' By late 1873, preparations had begun to open MGH's training school for nurses.

After 32 years of service, Sturtevant retired, in 1894. She was given a gift of \$1,000 (the equivalent of \$18,482 by today's standards). She began writing a series of articles on "Hospital Life Before the Days of Training Schools," for a nursing journal called The Trained Nurse. The fourth installment of her article, published in the April, 1896, issue, struck me as so contemporary, I thought Caring Headlines readers would enjoy seeing it. I have edited it for length, but the essence and emphasis (italicized words) remain Miss Sturtevant's.

The writings of Miss Georgia Sturtevant: a 19th century 'exemplar'

"Human nature is a complex problem at best, and *sick* human nature is sometimes incomprehensible. A nurse has two distinct conditions to consider—the individual and the case. She has not only to watch the physical symptoms, but the moods, and frequently the personal eccentricities of the patient as well, and sometimes the latter is much the hardest task of all. She is always in a state of expectancy;

always on the alert for some new development. Sometimes tokens of gratitude, in the form of kind words, come back to her from appreciative patients or their friends, and again, where she has done the most and endured the most, she receives only censure." (Sturtevant continues with the narrative of a nurse whose name is not given; possibly, it was Sturtevant herself.)

"Willie C, a poor,

haggard, emaciated boy, worn out and fractious by long years of sickness and intense suffering, was brought to the hospital. We looked upon him as a *boy*, though against his name we read 'Age 22.' The case was that of a 'bad knee' and it proved to be very bad indeed, and after some weeks of treatment, it finally came to amputation. It was a long, tedious case, and the nurses were quite worn out



Martha E. Stone, MS, AHIP
coordinator for Reference Services
Treadwell Library

with Willie's almost ceaseless, fretful demands upon them during the many weeks that lengthened into months that he was under our care. Even the patience of his mother, who had remained with him for a time, was finally exhausted and she left him in our hands.

"But there came a day [about six months later] when Willie was discharged. We brought out his clothes and we brushed his hair, and put on his *one shoe*. We wrapped him in warm blankets, and the strong ward tender took him in his arms to the carriage, and as the carriage drove out of the hospital grounds we drew a breath of relief. Yes, we were glad that Willie was gone, and yet we were *sorry* that we were *glad*.

"[After he had gone] we missed his peevish calls, and his pale face

haunted us. We would ask ourselves, 'I wonder if we were patient enough with Willie?' and then the consoling thought would come, 'But even his mother got out of patience with him.' And we would fall asleep, to be wakened by the night watcher's call, 'Quarter of five!'

"No tidings came back to us of Willie. But a reckoning day came when we least expected it. 'A gentleman in the reception-room to see you,' was announced one morning by the porter [five years later], and an uncomfortable presentiment of coming disaster took possession of me. I arranged my hair with trembling fingers—no *caps* in those days, unfortunately, to give dignity to one's bearing and confidence as a badge of office will—

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Building bridges: a nurse's passage to India

—by Donna Perry, RN,
professional development coordinator

I recently returned from a trip to India, where I was part of a cardiac surgery team deployed to help develop a cardiac hospital in Punjab, India. The team included five staff from Brigham and Women's Hospital, and was a tremendous opportunity for multiple disciplines from two different hospitals to help bridge the cultural gap and bring healthcare services to a place where those services are desperately needed.

Landing in Delhi was like entering another world. Your senses are overwhelmed with a barrage of new sights, sounds, and smells. Men in business suits and brightly colored turbans stride down the sidewalk. Women in beautiful saris sit sidesaddle behind their husbands on motor scooters as they zip down the street. Often they hold one or two children as the small scooters provide transportation for the entire family. Bicycle rickshaws rush by, laden with people and parcels. Cows wander freely

down the middle of the street, stopping to graze on the side of the road. Cows are revered as sacred by the Hindus so they are allowed to graze undisturbed. The aroma of home cooking permeates the air as many people live on the side of the road in tents or makeshift huts.

And everywhere is the blare of horns. The sound of honking is constant as all the different vehicles vie for space on the crowded roads. One driver told us on the first day, "You need three things to

room contains a small bed next to the patient's bed for a family member to sleep. In India, it's customary for a family member to stay with the patient as a personal-care attendant. The hospital is kept scrupulously clean by houseboys who seem to be constantly sweeping and mopping.

From the moment we arrived, our visit was a whirlwind of work-filled days followed by evenings of warm Indian hospitality. We were invited to several homes for dinner where

The public perception of nursing in India is very different from the US. Nursing is seen as a low-status job there, and their role is very task-oriented... So we looked at this as an opportunity to influence the development of professionalism among nurses in India.

drive in India: a good horn. Good brakes. And good luck!"

The hospital itself was located in Mohali, Punjab which is just outside the state capital of Chandigarh. It is a spacious facility with state-of-the-art equipment. Each patient's

we were treated to sumptuous feasts of Indian delicacies such as Tandoori chicken, and our Indian hosts were so gracious.

At the hospital, we found nurses to be very sweet and enthusiastic to learn. They had a good knowledge base about their patients but

were timid about expressing opinions to physicians. Over the next several days we worked with the nurses and observed their care. We found them very receptive to our suggestions, but reluctant to initiate a primary role in planning care.

The public perception of nursing in India is very different from the US. Nursing is seen as a low-status job there, and their role is very task-oriented. A public relations consultant described the public's view of nurses as, 'two arms and two legs.' So we looked at this as an opportunity to influence the development of professionalism among nurses in India.

Each afternoon one of our team members lectured on a particular topic. I gave a presentation on the importance

of patient education. About 70 staff, physicians and nurses, came in on their afternoon off to attend the session. Patient-education is not a major aspect of care in India, but it is an area they want to improve on as they develop a more patient-centered philosophy.

I felt fortunate that MGH has such a well articulated philosophy of nursing. I was able to share our strong emphasis on patient-focused care and our belief that every action is guided by knowledge, enabled by skill, and motivated by compassion.

My presentation included photographs that have appeared in past Nurse Week issues of *Caring Headlines*. These photographs showed MGH nurses in action, and caring and compassion were evident in each picture.

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Donna Perry, RN
professional development coordinator

MGH celebrates Respiratory Care Week

October 21–27, 2001

On Tuesday, October 16, 2001, staff of Respiratory Care Services offered a day-long educational booth in the Main Corridor. Respiratory therapists were on hand to educate people and answer questions about the many services provided by their department, including: mechanical ventilation and airway management; bronchoscopy assistance; asthma care and education; extracorporeal life support; as well as a number of consultative, research-oriented, and community-service activities. For more information, please call 724-4480.



Laura White, RRT, and Bill Perry, RRT, answer questions for passers-by



Staffing the Respiratory Care Week educational booth are (l-r): Laura White, RRT, Bill Perry, RRT, Pam Brown-Early, RRT, and Mike Underwood, RRT.

Miss Georgia Sturtevant

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for even a nurse, an *untrained* nurse, cannot control her emotions under all circumstances. I went down the long flight of stone stairs, and as I opened the door of the reception room a gentleman advanced to meet me. His stern face added greatly to my discomfort, and my self-control nearly deserted me. The gentleman asked, 'Are you Miss -----, and did you have the care of a patient by the name of Willie C? Was he very troublesome?'

"I answered in the affirmative as calmly as I was able. The picture of indignant parents, sympathizing friends, and the 'family physi-

cian,' whom I had every reason to believe was standing before me, passed rapidly before my mind. But though my hands had grown absolutely *clammy* by this time, I determined to defend myself and regain my self-control by talking very rapidly, and I answered, 'Yes, he certainly was very troublesome indeed. We knew that he had suffered a long time, and we really pitied the boy very much, and we tried to be very patient with him, but his fretfulness did at times seem almost unbearable. Even his mother—'

"But what a remarkable change had come over the stranger. His

stern features had softened and a smile transformed his face, as he answered, 'Yes, even my *mother* couldn't stand my nonsense. For I am Willie C, and I have come back to apologize for my bad behavior.' And he held out his hand, and I noticed for the first time the artificial leg that he had learned to manage with perfect ease. Here indeed was a case of gratitude we were wholly unprepared for."

EAP Resource Table

"Stress and the Holidays"

Many of us look forward to the holidays, but for many others it is a time of conflicting demands and stressors. Visit the EAP Resource Table for suggestions on how to manage stress, set realistic goals, and take better care of yourself during the holiday season.

December 6, 2001
11:00am–1:00pm
Eat Street Cafe

December 13, 2001
11:00am–1:00pm
Building 149, Atrium Lobby, CNY

For more information, call the Employee Assistance Program at 726-6976

MGH celebrates Pastoral Care Week

In celebration of National Pastoral Care Week, October 22-26, 2001, The MGH Chaplaincy sponsored a much-needed session of spiritual renewal and comic relief in the form of stand-up comedian, Jackson Gillman. Gillman, who prefers the description, 'stand-up chameleon,' because he changes his voice and appearance to create a host of 'supporting' characters, used song, poetry, skits, and mime to deliver a message of love and hope.

Gillman reminded listeners of the spirit and tenacity of a childhood friend with the familiar lyrics: "The itsy bitsy spider went up the water spout. Down came the rain and washed the spider out. Out came the sun and dried up all the water. The itsy bitsy spider went up the spout again!"

"Just like that little spider," said Gillman, "we must all... rise again!"

Evelyn Bonander, ACSW, director of Social Services and the Chaplaincy, took the opportunity to thank MGH chaplains for what they do every day, and especially for what they have done since September 11th. Said Bonander, "Thank-you for planning this session—I think we all needed to



(Photo by Abram Bekker, Bullfinch Photo Lab)

Comedian, Jackson Gillman

remember how to laugh!"

Reverend Mary Martha Thiel, coordinator of the Chaplaincy, introduced members of the Chaplaincy who were present, noting the great diversity of cultures and origins represented. Said Thiel, "Our hospital boasts a rich diversity of traditions, cultures and languages from all over the world. But as different as we all are, there is a palpable sense of unity for which we are all grateful."

The Chaplaincy can be reached by calling 6-2220.

Exemplar

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treatment. Lisa was off that day, and Karlene wasn't there when he left. While we both wish we could have seen him before he left, we realized that after our long journey together, nothing had been left unsaid.

The entire team had a great feeling of accomplishment at finally getting Mr. G into an acute-level rehab facility, when so many complications could have prevented it. We felt like this might be Mr. G's last chance to regain his independence, return home, and perhaps

start picking up the pieces of his life. Mr. G's case is a powerful example of what can be achieved when all members of the healthcare team come together to advocate for the patient and his family. While the trip was far from easy, we reached our final destination, and it was, indeed, a beautiful conclusion.

Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

What impressed me about this narrative was that the accountability of each discipline overlapped the accountability of other disciplines. This was truly

a collaborative approach. Case managers assist patients and families in developing and implementing discharge plans, but as this narrative so beautifully demonstrates, nurses, therapists and social workers all play a key role in ensuring the success of the plan.

In caring for this medically complex patient, nurses, case managers and the entire healthcare team worked together and communicated effectively to advocate for Mr. G and his family. In the end, a timely and satisfactory discharge took place because of their efforts.

Thank-you Karlene and Lisa.

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Publisher

Jeanette Ives Erickson RN, MS, senior vice president for Patient Care and chief nurse

Managing Editor/Writer

Susan Sabia

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or by e-mail: ssabia@partners.org

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December 6, 2001



Physical therapists celebrate National PT Month by sharing blood, sweat and years of experience

What better way to celebrate National Physical Therapy Month than sharing knowledge, information, and injury-prevention strategies with staff, patients and visitors to the MGH community? Well, giving blood was one way. That's what a number of physical therapists did on Tuesday, October 16, 2001.

The department had originally wanted to donate blood right after the attacks on September 11th, but were asked to defer their donation to a later date because of the huge number of people flooding the Blood Donor Center in response to the tragedies. So therapists decided to combine their 'group blood donation' with their celebration of Physical Therapy Month. On Wednesday, October 17th, it was back to business as usual as therapists took turns staffing an educational booth in the Main Corridor.



Photos (clockwise from top left):

1) Physical therapists (l-r): Maria Fitzpatrick, PT, Laura Kastrenos, PT, Diane Heislein, PT, and Michael Tiffany, PT, staff educational booth in the Main Corridor.

2) Tiffany, gives blood; Gail Fennessy, LPN, is the technician.

3) Fitzpatrick, spends time educating a visitor.

India

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One photo was of a nurse holding the hand of an intubated patient and talking with her. I told them that education was an important part of ongoing care. The message was very well received. The senior cardiac surgeon asked me to reemphasize the importance of talking to

patients. He felt this was something that really needed to be developed.

Later in the week, some of us were invited to a press conference about nursing. We were very excited but nervous because none of us had ever been involved in a press conference before. We met with representatives of a public relations firm to help prepare us to talk

to the press. We met with reporters from the largest newspapers in India. One was from a Hindi-speaking newspaper so there was a bit of a language gap. But overall, it went very well. I gave an opening statement describing our philosophy of nursing and how nursing is a respected and trusted profession in America. It was a wonderful opportunity to represent

nursing and hopefully elevate the public perceptions of nursing in India!

One reporter asked what we had learned from nurses in India. After some reflection we talked about the respectful way that staff had treated each other and the great kindness that had been shown to us by virtual strangers. We witnessed how important the family unit

is in India. With all of our technological and economic advances, sometimes we lose sight of the importance of human connections. Perhaps our visit to India taught us to stop worrying so much about the future and start enjoying each moment as it comes.

Life is short, and in the end, it's the human relationships that make it all worthwhile.

Educational Offerings

October 4, 2001

When/Where	Description	Contact Hours
Nov. 28, 8:00am–12:30pm November 30 (Exam) 8:00–9:30am	Transfusion Therapy Course (Lecture & Exam) Bigelow 4 Amphitheatre	---
November 28 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
November 29 8:00am–4:00pm	Clinical Evaluation of the Electrocardiogram Stearns Auditorium, New England Medical Center	TBA
November 29 and 30 8:30am–5:30pm	Advances in the Management of Polytraumatized Patients Training Department, Charles River Plaza	TBA
December 3, 4, 5, 10, 11, 12 7:30am–4:00pm	Critical Care in the New Millennium: Core Program Brigham & Womens Hospital	45.1 for completing all six days
December 3 8:00am–4:30pm	Diversity Within Cultures: Implications for Health Care O'Keefe Auditorium.	TBA
December 4 7:30–8:30am	On-Line Patient Education: Tips to Ensure Success Patient Family Learning Center	1.2
December 4 8:00am–5:00pm	Chemotherapy Consortium NEMC	TBA
December 6 1:30–2:30pm	Nursing Grand Rounds O'Keefe Auditorium	1.2
December 6 7:30–11:30am 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
December 6 8:00–11:15am	Intermediate Arrhythmias VBK 601	3.9
December 6 12:00–4:00pm	Pacing and Beyond VBK 601	5.1
December 7 8:00am–4:30pm	Wound & Skin Care: Common Problems, Common Products Training Department, Charles River Plaza	TBA
December 10 8:00am–4:30pm	Care of the Respiratory-Compromised Patient O'Keefe Auditorium	7.8 (RNs) .6 (SLPs) certificate of attendance for OTs and PTs
December 12 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (contact hours for mentors only)
December 12 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
December 12 5:30–7:00pm	Advanced Practice Nurse Millennium Series O'Keefe Auditorium	1.2
December 13 8:00am–4:30pm	Preceptor Development Program: Level I Training Department, Charles River Plaza	7
December 17 7:30–11:30am 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
December 17 8:00am–4:00pm	2001: A Diabetic Odyssey O'Keefe Auditorium	8

For more information about any of the above-listed educational offerings, please call 726-3111.
For information about Risk Management Foundation educational programs, please check the Internet at <http://www.hrm.harvard.edu>

Halloween

November 15, 2001



Volunteers, Jack DiBona and Christina Friel (back), with Dalmatians (l-r): Gayle Gastineau, Maureen Forbes, Ellen Millea, and Heather Peach.

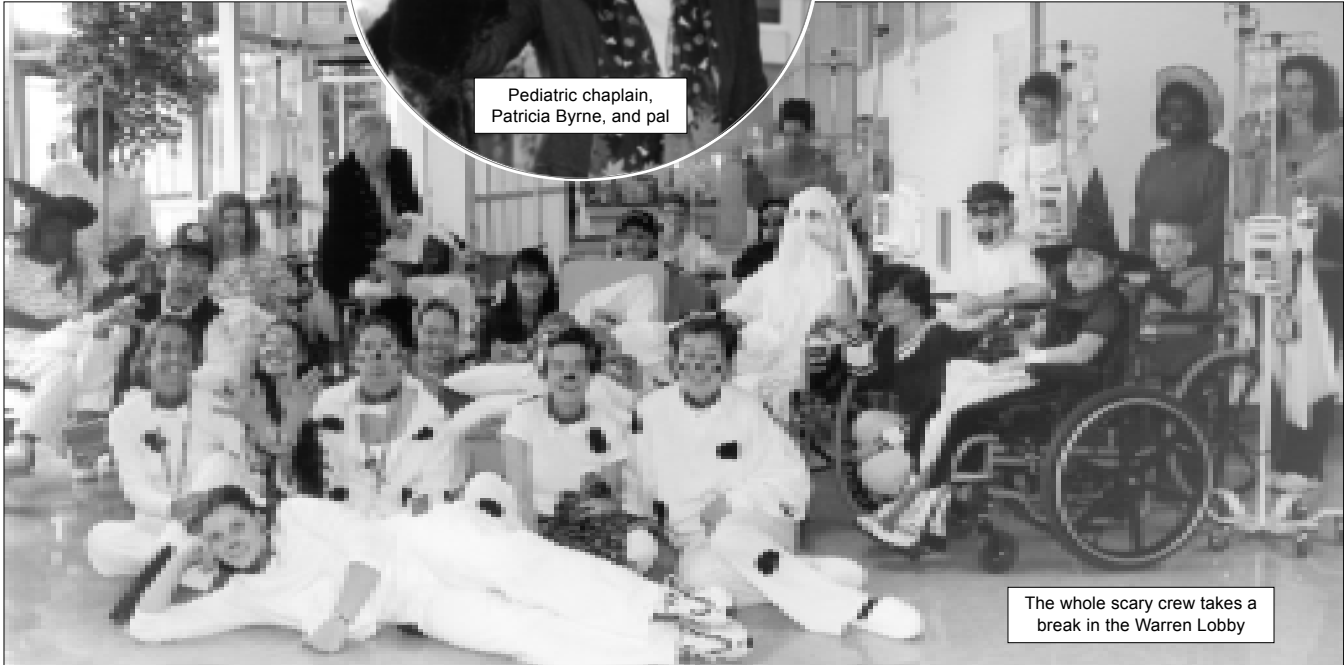


Tracie Grant helps 7-year-old, Felistus Kangethe, celebrate her first Halloween in America!

Halloween—Because MGH child life specialists and pediatric caregivers take Halloween v-e-r-y seriously, once again children on inpatient units had the opportunity to trick-or-treat in full Halloween regalia to the delight of staff and visitors! All 101 (or 102!) Dalmatians couldn't make it, but the ones that did make an appearance were a-d-o-r-a-b-l-e !



Pediatric chaplain, Patricia Byrne, and pal



The whole scary crew takes a break in the Warren Lobby

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