

Caring

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HEADLINES

Winter 2002

Macaluso Awards

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Once again, expectations were high. And once again, The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Awards delivered.

On December 12, 2002, senior vice president for Patient Care, Jeanette Ives Erickson, RN, welcomed members of the MGH community to O'Keeffe Auditorium for the 10th

presentation of the Macaluso awards since their inception in 1998. This year's recipients: Kathryn Best, RN; Jennifer

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Senior vice president for Patient Care, Jeanette Ives Erickson RN (center), with Macaluso award recipients (l-r): Carol McSheffrey, LICSW; Jennifer Kelliher, RN; Judy Lynch, RN (summer Macaluso recipient); Jean O'Toole, PT; Michael McElhinny, MDiv; and Kathryn Best, RN.



Kathryn Best, RN
unit nurse leader, Oral & Maxillofacial Surgery

About Katie...

A graduate of Bristol Community College, Katie has practiced at MGH for 14 years, most recently as nurse leader in the Oral and Maxillofacial Surgery Clinic. If you had visited the OMS Clinic before Katie started, you might not recognize it now. Katie's presence and leadership have transformed the unit. Through her tireless pursuit of excellence, Katie has helped to create an environment that focuses on the patient. She implemented systems that allow anesthesia to be more readily available to patients; she has worked with support services to ensure that supplies and equipment are easily accessible; she was instrumental in developing educational tools that give patients a greater understanding of how to care for themselves post-operatively. Perhaps her greatest achievement has been the development of a cohesive team that works together collaboratively and goes the distance to ensure that patients have everything they need. They do this because they are skilled professionals, and because they have a role model for excellence in Katie.

Clinical Narrative

It certainly was not the diagnosis Mr. M had expected. True, he hadn't been feeling well. He had been tired, listless, and wasn't eating well at all. Then, there was the 'sore on his tongue.' But he was a smoker and felt it was from all those years of abusing his body. Why not? He drank and smoked more than he cared to admit, and as a result had managed to lose touch with his friends and family over the years. But at 73 years of age, these things happen. He would go to the doctor, get a prescription, and that would take care of it. Everything would be alright. He would quit smoking and drinking! This was enough of a scare—kind of God's way of telling him it was time to slow down. Not a problem.

Problem! In the spring of 2000, Mr. M presented to the MGH Oral & Maxillofacial Surgery Department with a chief complaint of a sore on his tongue. It was somewhat painful and was starting to interfere with his activities of daily living. Because chewing and swallowing had become a problem, he had lost a significant amount of weight. He was sick and tired of feeling sick and tired! Upon examination, Mr. M was noted to have a lesion under his tongue. His clinical findings painted a morbid picture. The lesion had been there quite a while and was working its way through other areas of soft tissue including his throat and neck. An incisional biopsy was done, and Mr. M was diagnosed with squamous cell carcinoma of

the tongue. There was an incredible amount of soft tissue invasion with nodal involvement.

Mr. M decided to call on his family, two brothers, James and Robert. It was difficult for Mr. M to admit he needed help from his family after so much time had passed. It was also hard for his brothers to step in for what was probably the most stressful, uncertain time in Mr. M's life. But, they were willing to do so, no holds barred. After all, "blood is thicker than water."

It was at this juncture that I decided one of my roles as unit nurse leader was to make this journey as smooth and emotionally safe as I possibly could for these three men. Although none of them knew what was in store for them or what they would

have to overcome, they were definitely going to do this together. Mr. M needed love and help in dealing with his fear, and his brothers needed guidance and support in dealing with their fear and confusion. As much as the three of them were willing to go the distance together, they could certainly not do it alone. Also, based on Mr. M's diagnosis, there was a crucial need to consult Oncology, Radiology, and vascular surgeons from the Massachusetts Eye & Ear Infirmary. The strong possibility of increased confusion existed for Mr. M and his brothers. There would be more people to listen to and keep track of now.

In all my years as a nurse, I have felt that a key responsibility of nurses is that of liaison. A patient will listen to

his physician and hear most of what is said... *most!* It has been my experience that not all patients will ask for clarification. It is here that the nurse steps in, understanding that his/her role is not to overshadow the physician in charge of the patient's care. A tenuous distinction at times, but when performed professionally it can reap incredible benefits for everyone concerned.

Mr. M's brothers did not live locally. James lived in the western part of the state and Robert elsewhere in New England. Neither was familiar with the layout of MGH. In providing optimal care for Mr. M, we needed to run the standard battery of tests in various areas all over the hospital as well as at MEEI.

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The CT was an absolute must. Then there was a chest x-ray, blood work, specific facial films and bone scan. It was a lot for these men to digest considering the fact that Mr. M was healthy, or so they had thought, just a week ago. And why did he have to go to another clinic?

My first job was to schedule the CT scan, the blood work, the chest x-ray and bone scan. Hopefully, this could all be accomplished in the same day. Success! Because Mr. M knew where the Oral & Maxillofacial Clinic was located, it was decided that everyone would meet here. I had never met the brothers before, but, in speaking with them over the phone, it was apparent that they wanted to be part of all aspects of Mr. M's care. The morning of these tests was difficult because James and Robert 'didn't know what they didn't know.' They didn't know what they could or could not ask. They would soon reach a comfort level as far as that was concerned.

That morning, we all met in the clinic for introductions. They were introduced to Dr. Janice Lee, the chief resident in the clinic who had originally examined Mr. M and who would prove to be very instrumental in determining and providing Mr. M's treatment throughout his time with us. We were on our way for a day of test-

ing. I had planned my day to allow time to be tour guide of the different testing areas, counsel for the 'whys,' and interpreter for our medical jargon. The good news was that the day went beautifully. The bad news was that I was scheduled to go on vacation in two days for two weeks. At that point, there was a trust relationship. James and Robert felt comfortable calling me with questions. They asked, and I agreed, that we continue this level of communication while I was on vacation. They had my office number and were comfortable leaving messages for me while I was

away. If they wanted an answer, they would leave a call-back number. Most of our communication had to do with explanations. What will this test show? Why does he have to have the dye? Will the test hurt him? Will he feel pain with these tests? How long has he had this? Is it from smoking... what if he stops smoking now? Other messages were to let me know how Mr. M was doing. They were extremely appreciative when I called them back. Mr. M would conduct most of his questioning through his brothers.

As time moved on, things progressed quick-

ly for Mr. M, and it always seemed to be for the worse. He lost more weight, his testing confirmed the worst, and the consultation with the Oncology physicians at Massachusetts Eye & Ear Infirmary revealed what we as a team had predicted. Mr. M needed extensive surgery, sooner rather than later. A feeding tube became necessary as well as a laryngoscopy. But, due to Mr. M's deteriorating medical condition, the laryngoscopy was never done. He could not have tolerated it. In a perfect world, there would have been enough time to prepare everyone for the inevitable. But ours

is not a perfect world.

During Mr. M's hospitalization and what ended up being a prolonged death, James and Robert would stop by to let me know how things were going and sometimes to ask me to simplify things for them in a way they could understand. Although communication and trust were always present between these men and Mr. M's physicians, it seemed just a little more personal when I was able to sit down and speak with them.

The last time I saw James and Robert, they had come to tell me what I already knew, that Mr.

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Katie Best, RN (front and center), with clinical support staff (back row l-r): Maria Pierre, Emma Gulick, Kimberly Perry, and Christine Emma. (Front row): Byron Hernandez and Allison Goddard.



Jennifer Kelliher, RN
staff nurse, Bigelow 9 Respiratory Acute Care Unit

About Jenn...

A graduate of The Reading Hospital School of Nursing, Jenn has practiced at MGH for nine years in a variety of settings including the Vascular, Trauma, and Thoracic units. Her practice is driven not only by knowledge and skill but by incredible curiosity. Jenn has sought out opportunities that challenge her, whether as co-chair of The Nursing Practice Committee or as a member of the Magnet Steering Committee. Jenn currently practices in the newly created Respiratory Acute Care Unit (RACU) where her expertise is tapped daily as patients and families arrive on the unit acutely ill and emotionally drained from their hospital experience. Jenn is frequently confronted with ethical issues that challenge patients, families and staff in their decision-making process. She organizes ethics rounds to help everyone involved frame these issues in a way that facilitates optimal patient care. She constantly challenges conventional thinking about patient management. Jenn's limitless enthusiasm, compassion, and curiosity have created an environment of excellence for patients, families and colleagues.

Clinical Narrative

Close your eyes and imagine that you're lying in your nice, warm, comfortable bed at home. You're able to get up and go where you want, when you want. Now imagine that you're only able to shrug your shoulders, and wiggle your nose when you need something. You're totally dependant on someone else for all of your care. You have lost the use of your arms, hands, and legs. And worst of all, you can't talk because of the breathing tube in your throat, and you're hooked up to a ventilator. This is it for the rest of your life, and you are only 22 years old.

I tried to put myself in this scenario, and it frightened me. I couldn't imagine not being able to move, walk, or

talk. From that moment on, I knew I had to take this woman as my primary patient. The story that follows is the journey of a courageous young lady, who, no matter the odds, fought to the end.

Marie was what we all would have considered a normal, healthy teenager. She was the middle child in a family of three children. She was able to do all of those wonderful childhood things we all do. She could play with friends, run and jump, and go to the mall. Life was normal for her until age 13. Then she began having difficulty walking and became very clumsy. After a lengthy work-up, she was diagnosed with Pompe disease. This would change her life forever. Her parents tried to

provide her with as normal a life as they could. As her symptoms became worse and Marie was unable to do things for herself, her parents became her caregivers. They assisted her with all her activities of daily living. From the age of 13 until I met Marie, she accomplished many things. She graduated from high school; she attended classes at a local college; she met her boyfriend; she became actively involved in the Pompe Disease group; she was able to travel in the United States quite a bit; and she gained the love and friendship of many, many people.

I was lucky enough to meet Marie when she was 22 years old. She was a very attractive young woman who had beautiful flowing red hair, lovely ivory colored skin, and a smile that

would light up a room. She had been vacationing with her family in Florida when she developed an upper respiratory infection. She was hospitalized for a few days and then flew home to Massachusetts. Within days of returning, her breathing had become labored. She was admitted to a hospital near her home. While there, her breathing deteriorated, and she needed to have an endotracheal tube placed to assist her breathing. Her infection had become pneumonia. Marie and her family made the decision to have her transferred to MGH. Marie was admitted to the MICU.

During her time in the MICU, attempts were made at extubation. Unfortunately, they were not successful. Luckily, we have a

relatively new service available to patients who are having a difficult time weaning from the ventilator. My unit, the RACU (Respiratory Acute Care Unit) provides specialized, expert care to difficult-to-wean ventilator patients. Marie was a perfect candidate. We received the consult and were preparing for her arrival. Through the consult process, I was able to gather information about Marie's medical history, social history, and any other special concerns we may need to know to care for her in the RACU. I came across a phrase that needed definition. Even after dusting off the cobwebs in my brain, I couldn't remember what Pompe disease was. This was pivotal information. How could I

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care for this young woman, without knowledge of her disease? Luckily, that information was only a click away.

I found out that Pompe disease is a glycogen storage disease (GSD) that results in the absence of an enzyme needed to produce or breakdown glycogen in the body. It normally affects liver and/or muscles. I found this information on the Association for Glycogen Storage Disease website. Marie had all the muscle and nutrition involvement I had read about. She had been using a wheelchair for two or three years. She had hypertrophic cardiomyopathy, WPW, and she had had a pacemaker placed at age 15. She had the diminished function of her respiratory muscles and had to be on BiPAP (a ventilation support system that is delivered via mask) at home.

Upon arrival to the RACU, I could see how advanced her disease was. She weighed only 85 pounds. She looked tiny and helpless in the bed. Little did I know how wrong I was in that assumption. Marie was scared, and so were her parents. They were on the edge. They needed someone to be not only their advocate, but their friend. I made a silent promise to do everything in my power to fulfill their wish to get Marie home.

I knew we had many issues to sort through. This family needed a supportive medical team. After only a few days, a family meeting was called. We discussed a plan of care with Marie and her parents, and assured them that we all shared a common goal: to get Marie home. We encouraged her parents' input. Our first obstacle was to provide proper nutrition. Marie hadn't been able to maintain an adequate caloric intake at home because her swallowing muscles had weakened and that was causing aspiration. She had an NGT in place, but it couldn't stay forever. The GT issue had been brought up in the past but Marie did not want one. What 22-year-old would want a tube coming out of her stomach? This was someone who went to Florida at least once a year. How could she wear a bathing suit? It took time and many tearful hours for Marie to make the decision. I reassured her that she should still be able to go to the beach even with a tube. She also needed to understand what the tube was, how it would feel, and how it would be placed. I explained all of this to her, with many re-explanations. I reassured her that I'd be with her throughout the procedure to hold her hand, and I promised her that she'd have adequate pain relief after the procedure. Marie agreed to have a GT

placed. She tolerated the procedure with the strength of a lion. And even better, we could see more of her face now.

Throughout this time, I knew it was important to give Marie and her family adequate time to digest all the information we were giving them. I also gave them time to ask their questions. It was during this time I felt like I'd

become part of their family. I had been able to establish a level of trust and friendship that made the days easier for them. This would become more important than I could ever have imagined.

Our next hurdle was Marie's breathing. Communication was difficult at first, but we eventually devised a system of shoulder movements and facial expressions

to communicate with each other. Extubation had not been successful in the MICU. So we provided the best possible conditions to ensure Marie could remain extubated. She received her prescribed dosage of IV antibiotics. We provided her with pulmonary toilet. The only things we couldn't fix were her muscles. Marie and her family under-
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Bigelow 9 staff nurse, Jennifer Kelliher, RN, helps patient, Jennifer Jackson, prepare for a short walk around the unit.



Michael McElhinny, MDiv
oncology chaplain

About Mike...

A graduate of the University of Massachusetts, Mike received his master's degree in Divinity from the Weston School of Theology. For more than four years he has been the Oncology chaplain ministering to patients, families and staff throughout the hospital. A cancer diagnosis can cause individuals to question the meaning of their lives and the existence of God. It can cause many to turn away from their traditions altogether. How do you comfort patients and family members who are going through this experience? We are lucky to have Chaplain Mike as a spiritual leader and compassionate guide. Mike is fully present, open and honest. He is accepting and gentle and intelligent. Those who work with him tell us he has the uncanny ability to appear at just the right moment; he knows when to talk and when to listen; when to comfort and when to give space. At those times when we worry that we're not enough for our patients, we turn around and there's Mike.

Clinical Narrative

I met Mrs. B in September of 1999 in the Blake 2 Infusion Unit. She had been referred to me by her nurse and her oncology social worker. I followed her for almost two years until she died. Mrs. B had breast cancer, which would later spread to her brain and various bones. This disease would rob her of more than half her life. Radiation therapy and various chemotherapies were unable to keep her cancer in check for very long.

As I got to know Mrs. B, I quickly identified three challenges that could prevent her and her family from experiencing a peaceful death. First, was Mrs. B's growing sense of guilt at having contracted the disease and for

being a burden to her family, especially her husband. She was a key figure in her family, but now she was gradually doing less and less for them. Second, Mrs. B and her family had a strong Roman Catholic faith. It was 'the resource' of her life. She and her family had a strong belief in miracles and knew that somehow God would cure her, no matter what. Mrs. B's job was to keep fighting with healing masses, holy water, and a special cross. Third, Mrs. B and her family were of the Cape Verdean culture. An important element of this culture is not discussing death in front of the patient for fear she will lose hope, and death will result.

As a chaplain, I try to look at the patient and family 'where they're at' and work from there.

I don't want to impose my views or diminish their beliefs. I knew the solutions to the three challenges that faced Mrs. B and her family would be found in their faith in God and in their deep love for each other. Nothing else would touch them on the deep spiritual level of the heart. Over time, I got to know Mrs. B and her family as best I could. I hoped that our relationship, formed by almost weekly outpatient visits, might help them to listen more openly to me when the time of her death arrived. I have learned that if I can be patient and control my desire to 'fix things,' God will provide marvelous opportunities for healing growth.

An opportunity to address the first challenge to Mrs. B experiencing a peaceful death

occurred in May of 2001 in a private room on the Infusion Unit. No other family members were present that day, which seemed to give Mrs. B permission to speak honestly.

"I'm getting nothing but bad news," she said. "I'm scared. I'm mad at God. I don't want to die and lose my family. And I'm no good for nothing!" And she cried many tears.

I affirmed her feelings and her tears. After a good nose-blowing, I asked, "Who made you, Mrs. B?"

She smiled broadly and said, "Chaplain Mike, you know it's God!"

"And did He make you good with special talents?" I asked.

"Well, of course He did."

"And, haven't you been using those talents

to serve God and your family as best you can right up until this very moment?" I asked.

I gave her several examples from our conversations of what she had been doing for her husband and family with God's help in spite of her disease. Her face lit up as her spiritual meaning and worth became visible to her.

"You know," she said, "I *have* been doing good, haven't I?"

"And don't you ever forget it," I said. We both smiled.

At the beginning of August, Mrs. B was admitted to the Ellison 14 Oncology Unit. While it was clear to staff that Mrs. B would die there, her family was still hopeful for a miraculous cure or another medical treatment. As I entered Mrs.

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B's room one Friday, her family left so we could talk privately. It was time to face challenge number three, the Cape Verdean view of not talking about death.

"I am so scared of death, Chaplain Mike," Mrs. B told me. "I need to talk to my husband, but I just can't. It would be too hard for him."

I later shared this honest statement of Mrs. B's feelings with her medical oncologist. We decided to speak to her and her husband together about this issue. The oncologist described the Western practice of talking with patients and their families about death, to which Mrs.

B's husband responded, "This is not the Cape Verdean way."

Addressing Mrs. B's husband, I spoke of God as, "a loving builder of bridges between Himself and His people," and suggested that "we could build a bridge between the Western and Cape Verdean views of discussing death based on the deep love that he and his wife shared."

He slowly nodded, so I quickly asked, "Are you aware that your wife is very afraid of dying?"

"No," he whispered.

"Do you know she fears you're upset with her for having this disease?" I continued.

"But, I'm not," he said.

Mrs. B's eyes widened with hope and she and her husband began a much-needed conversation to say good-bye to each other, which lasted for most of the next two days. This led to a request for DNR/DNI status, comfort measures, and the involvement of the Palliative Care team. Mrs. B's oncologist and I planned a family meeting for Monday.

Some of Mrs. B's siblings were pleased that Mrs. B and her husband had talked, but her mother and other siblings were not. This attitude was clear to the oncologist and me as we

started the family meeting. But after the oncologist gave Mrs. B's medical report, no one in the family continued to believe that the conversation between Mrs. B and her husband had made her condition any worse. But the last challenge of God's power remained.

"God could still perform a miracle," one sister said.

"Yes, He could," I agreed, "and I know you all have a powerful faith in God."

"We do," she said, "and it could still be God's will that she be cured."

"It could," I repeated. "So let's let God's

will be done and prepare for it as best as we can. For with God on our side, we have nothing fear."

"And we don't want our sister to fear or suffer," her sister added.

I suggested we all pray for that. Since all agreed, we did just that. Arrangements were made to give Mrs. B the Sacrament for the Sick in the presence of family members who wished to be there.

The three challenges to Mrs. B's peaceful death had all been faced with spiritual resources and love from the heart. Mrs. B died comfortably the next day with her *continued on page 13*



Oncology chaplain, Mike McElhinny (left), in the Blake 2 Infusion Unit with patient, Rita Qualters and her husband, Tony.



Carol McSheffrey, LICSW
clinical social worker

About Carol...

Carol received her BA and MSW from Smith College and completed two post-master's training programs in Family Therapy at the Family Therapy Institute of Cambridge. Carol has worked at MGH for 11 years. She is a clinical social worker on the Primary Care Team in the Outpatient Mental Health Service. Carol's work focuses primarily on couples' therapy. When the pressures of life, work, and relationships become too great and/or are coupled with poor communication, substance abuse, violence or a myriad of other factors, all members of the family are affected. When this happens, families are lucky to find their way to Carol. With a combination of tenderness and determination she works with families and individuals to heal. She walks with them through the complex dynamics that often define families. With great sensitivity, she questions, probes, reflects, and teaches in a non-threatening, non-judgemental way. Carol is allowed into the inner sanctuaries of families in distress because she has earned their trust and respect as a gifted social worker.

An Interview

Carol's clinical narrative could not be included here due to issues of patient confidentiality. To showcase her practice, we asked Carol to talk with us about her work as a clinical social worker. The following is our interview with Carol.

Caring Headlines: Carol, what was it that attracted you to social work?

Carol: Well, I guess you could say it's a family tradition. Both my parents are nurses and very committed to helping people. Perhaps in a display of youthful rebellion, I decided I wanted to do something else... but really, nursing and social work are not that different—there are a lot of similarities.

I was a Psychology major in college and very interested in neu-

rosience. After college I had a lot of different jobs that involved advocating for children and adults with developmental disabilities. When funding was eliminated for one of the projects I was working on, it seemed the timing was right to try something new.

I got a master's degree in Social Work from Smith College, and I felt like I had arrived at what I was really meant to do.

Caring Headlines: How did you come to practice at MGH?

Carol: I was very interested in family therapy. I did a lot of work and training at the Family Institute in Cambridge. And then in the late 80s an outpatient psychotherapy position opened at MGH. I applied, and I've been here for eleven years.

Caring Headlines: Do you have a particular specialty?

Carol: Yes, I specialize in couples' therapy. I work with couples when they're unable to resolve their differences despite their best efforts. Sometimes couples present in crisis; sometimes one partner is considering leaving the relationship; sometimes couples just feel like they're drifting apart, living like strangers in the same house.

Caring Headlines: That sounds like very challenging work.

Carol: I think the most challenging thing about working with couples is seeing how profoundly hurt and misunderstood they can feel in a relationship.

Caring Headlines: Where do you begin?

Carol: I usually meet with couples together the first time. I see how each of them describes the problem, find out how long it's been going on, and get a sense of their ability to communicate with each other.

Then I meet with each person individually; find out a little about each partner's history, establish a relationship with each of them separate from their partner.

Then we come together again and after presenting my impressions and recommendations, we discuss whether it makes sense to continue with couples' therapy. If it does, we come up with a collaborative plan on how best to proceed. Sometimes the decision is to continue meeting as a couple and sometimes the decision is to con-

tinue therapy but meet separately.

Caring Headlines: Is there a standard approach to couples' therapy?

Carol: My primary goal is to understand how each person feels misunderstood. I try to do that in a way that causes each person to be curious about their partner's pain. And I try to help them do that in a way that's non-defensive and non-judgmental.

Couples often slip into habits or routines or ways of relating to each other that are problematic. And they do it without even realizing it. Together, we try to untangle that. We try to see where each person may be accidentally stepping on the others' toes, and what we can do about it.

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Caring Headlines: Can you give us an example of some of the interventions you use?

Carol: One of the simplest interventions is shifting the way that couples relate to each other; changing their behavior in certain situations.

For example, we probably all know someone who doesn't listen well, or who dismisses comments as unimportant or without value. That kind of behavior is counter-productive in a relationship, so I might suggest that that person listen more actively and

not feel compelled to respond to what he or she hears, not judge the person who's speaking.

John Gottman is a well-known researcher in couples' therapy. Gottman reports that two thirds of all issues that arise between couples are un-resolvable. In his opinion, what's important is how couples manage the inevitable conflicts that arise. Finding ways to accept their differences enables people to stay together and work on the issues that are solvable.

Caring Headlines: What would you say to peo-

ple who are reading this who might be having problems in their relationship?

Carol: I would say that there are lots of ways to be a couple; every relationship is different. The important thing is to find a way to preserve your love and the friendship that brought you together in the first place. If you think you may need the help of a professional, don't wait! A good therapist can help you navigate the difficult times without losing the love you have for each other.

Caring Headlines: You sound very passionate about your work.

Carol: I have to say that couples' therapy can be very painful and challenging work. But intellectually and emotionally, it is so rewarding and satisfying.

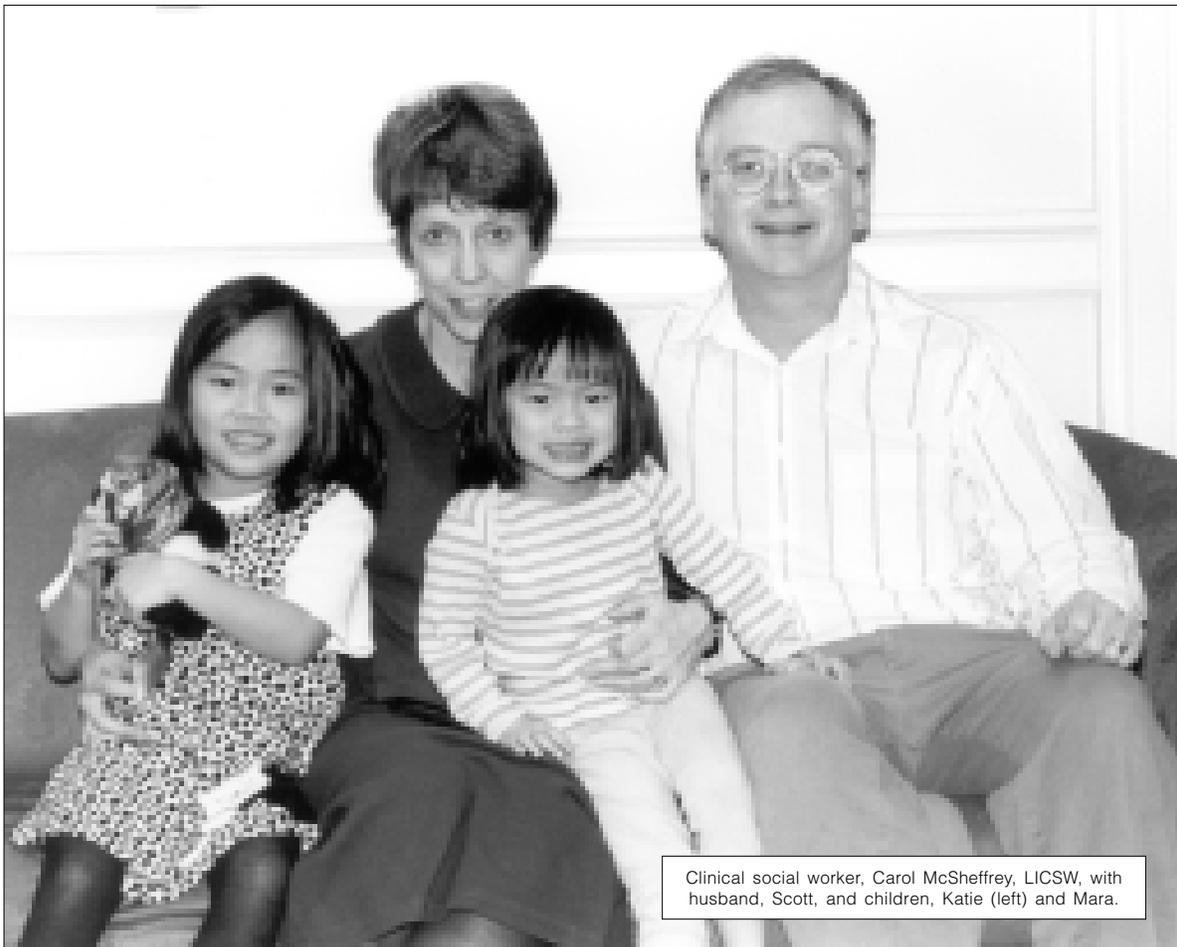
Caring Headlines: Is there anything we haven't talked about that you'd like to add?

Carol: Actually, I would like to acknowledge the members of the reflecting team, a professional consultation service in the department of Psychiatry led by Dr. Anne

Fishel. So much of my work with clients is done behind closed doors. It's invaluable to have this team of professionals as a source of guidance and support. We all act as resources for one another, constantly learning from each other, and our patients benefit tremendously from our interactions.

Caring Headlines: Carol, thank-you for taking this time to share your practice with us. Congratulations.

Carol: Thank-you.



Clinical social worker, Carol McSheffrey, LICSW, with husband, Scott, and children, Katie (left) and Mara.



Jean O'Toole, PT
physical therapy clinical specialist

About Jean...

Jean received her BS in Physical Therapy from Northeastern University and her MPH from Boston University. She has practiced at MGH for 15 years and has become a clinical expert in the area of upper-extremity and shoulder dysfunction. Jean initiated a two-year investigation to identify the various classifications of shoulder dysfunction, descriptions of each classification, possible treatment, and frequency. She has given countless presentations across the country and around the world on shoulder dysfunction, and she is constantly sought after for consultation by therapists and physicians at MGH and other institutions. But to really understand Jean's practice you would have to see her in action, doing what she does best, treating patients. Concern and compassion are at the core of Jean's practice. It was that commitment to patient care that caused Jean to spearhead a customer service initiative in the Physical Therapy Department. She has energized all members of the Physical Therapy team to better understand their role in the patient-care experience.

An Interview

Because Jean's clinical narrative contains sensitive patient information, the following interview is offered to provide insight into Jean's practice.

Caring Headlines: Jean, you're a physical therapist...

Jean: Yes, I've been a physical therapist for thirty-two years. I've practiced at MGH for about fifteen years.

Caring Headlines: Can you tell us what made you choose physical therapy as a profession?

Jean: My mom was widowed when she was thirty years old. She didn't have a college education, and she was raising three young girls. She really struggled. She was determined that when we grew up we would be able to

support ourselves. Education was very important to her. But as I got older, nothing really called me as a career choice.

My mom introduced me to a friend of hers who was a physical therapist. She really enjoyed her work, so I decided to try that path.

That push to go to college was definitely from my mom. I'm not sure I would have done it without her insistence.

Caring Headlines: Do you have a specialty within physical therapy?

Jean: I specialize in upper-extremity dysfunction. At one point in my career, I treated many patients with hand problems and had every intention of getting a master's degree in hand therapy. But short-

ly before leaving for school, a friend who worked at MGH mentioned there was an opening for a senior therapist on the upper-extremity service, so I came to work for MGH instead.

It was a transitional period for me. I started treating more and more shoulder problems, and really have focused predominantly on shoulder problems ever since.

Caring Headlines: Do you think you've found your niche?

Jean: At this point, my real passion has become treating patients with upper-extremity and shoulder problems following treatment for cancer, most commonly, treatment for breast cancer.

Frequently, there are changes to the soft tis-

sue in and around the shoulder girdle following radiation, surgery or reconstruction.

Swelling is also a major problem for this patient population. In March, I plan to begin a special training program for lymphedema (swelling) management. This will be an important service to be able to provide. The more I can learn about how to manage swelling, the better prepared I'll be to help other patients, as well, not just post-cancer patients.

Caring Headlines: What is a typical day like for you?

Jean: The majority of my time is usually dedicated to treating patients. But as one of the clinical specialists, other responsibilities include visiting the health

centers, clinical teaching with staff, and consulting with colleagues.

Caring Headlines: Has much changed in physical therapy during your career?

Jean: Absolutely. One change is the onset and growth of managed care.

What makes MGH such a great place to work is that the emphasis has remained on the *patient*. The bottom line is quality of care and providing a positive patient experience. Unfortunately, that's not the way it is in all hospitals. I credit the leadership of MGH and Patient Care Services, and Mike Sullivan, the director of Physical Therapy, for creating a work environment that encourages autonomy and allows us to use our clinical judgement.

continued on next page

I have to say, our department has a wonderful staff with clinicians of all ages and backgrounds. And we have an incredible support staff—without them we could not function. Stacey McGlame is our wonderful office manager. Kathy Ashman is our great transcriptionist. And the special Wilma Short is our glue! No matter how busy they are, they never say ‘No.’ With our front-desk staff, insurance coordinators, aides and co-op students, our work day is much more manageable.

Caring Headlines: Is there anyone you look to as a mentor?

Jean: Yes. I have been so fortunate in my career to have multiple mentors and role models. I really feel that so much of who we are and what we do is the product of good opportunities. When I think of the opportunities I have been given over the years, I feel very rich.

But when you asked me about a mentor, I must mention the late Birte Thomasen. She was my first real role model. She was the senior physical therapist at Lahey Clinic, which is where I worked immediately following graduation. She was very strict but very patient-focused. She used to say, “If you’re going to do something, do it right!” Of course, looking back, that was a good lesson to learn.

There were many times when what I thought was my best, was not good enough. The charge was clear—figure out a way to make my best even better. I owe a lot to her.

Caring Headlines: Whom do you go to when you have questions now?

Jean: I turn to my peers and colleagues. We have strong relationships with the shoulder physicians and primary care physicians. They are very willing to help me, even if it’s not their

patient. I really value those relationships because, you know, you can’t treat a patient by yourself.

And the younger staff—they challenge you with their questions, and that’s a good thing! I’m constantly learning from them.

Caring Headlines: It’s a shame we couldn’t publish your narrative. Is there anything you’d like to say about it?

Jean: My narrative was not so much about a clinical-care situation

as it was about what you can learn by listening. An important thing for me is that first interaction with a patient. You have to really listen with every part of you—you have to hear what they’re saying and what they’re not saying. Patients need to be allowed to be honest with you and still feel safe. They have to know that you value them, that you respect them, and that you’re not judging them. To me, that is the only way to begin good patient care.

I look at my relationship with every patient as a partnership. Because when all is said and done, I am only a facilitator. We can only succeed if we form relationships in which we are equal partners. Actually, it needs to be much more about them than me.

Caring Headlines: Jean, thank-you so much for talking with us. Congratulations.

Jean: Thank-you. I feel very grateful for this award.



Physical therapy clinical specialist, Jean O'Toole, PT, with patient, John O'Leary.

Exemplar (Kelliher)

continued from page 5

stood this, and were willing to give extubation one more chance. It was a very emotional time for everyone. Unfortunately, her muscles were just too weak. She was only able to tolerate a few hours without the breathing tube. Even the BiPaP didn't help. Marie had to be re-intubated. This was a huge blow to Marie. She did not want a tube.

After she was re-intubated, we talked about a trach. We had talked about this in the past, but Marie and her family had hoped she wouldn't need it. I spent many evenings just sitting and holding Marie's hand and letting her cry; reassuring her that we would do whatever she wanted. We discussed all the positive and negative ramifications of having the trach tube placed. I even

brought in a tube to show her what they looked like. She understood that she couldn't live without the ventilator, and that BiPaP would not be effective for her. It really took a team effort to help Marie arrive at a decision. After hearing all the information, she consented to having a trach tube. Two hurdles were behind us; the biggest were yet to come.

Marie's 23rd birthday was approaching. Her mom and I planned a party. Her mom was going to bring in a cake and party favors. My job was to keep Marie occupied until everyone arrived. It got to be late in the day and no one had arrived. By 1:00pm, I received a call from Marie's mom. It was not good. Marie's father had been taken to the hospital with chest

pain. He was having an MI. He was brought to MGH for treatment. Mom arrived and we discussed how to tell Marie. I knew Marie was very close to her father. We had to tell her the truth. The worst part was that it was her birthday. I entered the room with mom and we very gently broke the news to Marie. She was very upset and blamed herself. I explained that her condition was not the cause of his heart disease. I used simple definitions to talk about the heart attack. But it only helped a little bit. Marie wanted to see her father. I promised her that after he had his tests the next day I would arrange it with the CCU.

The next afternoon, Marie, her mom, the respiratory therapist, and I went to the CCU. Father and daughter were reunited. Marie could see that he was alive and okay. The visit was short, lasting only a half hour, but it made Marie feel better. Her father underwent a cardiac procedure and did very well.

Our next outing was to a place that not many vented patients go: the MGH Gift Shop. Marie had asked if she could get a gift for her father. So, I called the director of the Gift Shop and arranged to take Marie to the Gift Shop before it opened in the morning. I coordinated the visit with our resource nurse and respiratory

therapist. It was fun! It was the first time in a few days that Marie smiled. After that, we took more 'road trips' out under the Bulfinch tent. It was nice for all of us to get out in the fresh air.

Marie had a few setbacks in the weeks that followed. She started to feel overwhelmed with her situation, as did her parents. We consulted Social Services and the Psychiatric Department for guidance, and they were very helpful. Things were looking brighter. I had begun teaching mom how to use and care for Marie on the trach tube. I made her a model to practice on at home. She started giving Marie meds via the tube within only a few days. I taught mom how to suction via the trach tube. She was uncomfortable at first, but eventually, she became a pro. She was already adept at Marie's physical care, so we concentrated on the tubes, troubleshooting, and the care they would require.

Eventually, Marie's discharge day arrived. I came in to help transport Marie to rehab. It was hard for me to say good-bye. I had made a new friend and gained a new family. But I felt better knowing I had seen the place where she was going and I was able to give the nurse there a clear and concise picture of Marie and her family and their needs.

Marie did make it home after about a month at rehab. I kept tabs on her to see how things were going. Marie came to the realization that she did not want to live on a ventilator for the rest of her life. What a profound decision for a 23-year-old to make. A group of professionals from our Palliative Care team visited Marie at home to help her work through this decision. After careful consideration of all the factors, Marie decided to remove the ventilator, knowing she would cease to live. During this time, she and her mom made all the arrangements for after her passing. Marie decided she didn't want to be at home when she passed. She was admitted to MGH for pain management, emotional support for Marie and her family, and to be removed from the ventilator. Marie's family was kind enough to allow me to be part of her last few hours. I was able to say good-bye and thank Marie for all she had taught me in the short time she was in the RACU. I was also able to try to comfort her about the afterlife and what a peaceful place that I thought it would be for her. It was comforting to see such a loving, involved family. I watched Marie as she looked at her family; she seemed to be trying to take a little piece of them with her. It was good to see that her

continued on next page

The MGH-Timilty Partnership seeks science fair judges

The MGH-Timilty Partnership is looking for volunteers to judge the annual science fair at the James P. Timilty Middle School in Roxbury February 10-13th from 9:00-11:00am.

No science background necessary!

Round-trip transportation from MGH to the Timilty School will be provided. Bi-lingual (Spanish-English) judges are also needed.

For more information, please contact Wanda Velazquez at 724-3210 or send e-mail to: Timilty@partners.org.

Exemplar (Kelliher)

continued from previous page

parents' fears regarding the tubes and vent had disappeared. They were as proficient at suctioning, feeding, and maneuvering them as anyone I've worked with.

Marie passed away that evening. She was comfortable and at peace, with all the people who loved her. I was unable to attend her funeral, but her mom told me how nice it was.

I wrote to Marie's mom two months after Marie passed to catch up with her and to let her know that my life had changed. I was expecting a baby. During our conversation, she told me she had gotten a sign from Marie: a rainbow. She knew that Marie was doing well. Coincidentally, I had seen a rainbow the week before, and now I knew why.

Marie was a very special person. I think of her often, and try to remember all she taught me.

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

This beautiful story really makes us think about quality of life, and about all of Jenn's interventions to make the quality of Marie's life better while she was in her care. Right from the beginning, Jenn saw

Marie as a person, not a patient. She saw beyond Marie's illness to the beautiful, strong-willed but physically frail 23-year-old girl.

Jenn was present for Marie on so many levels—helping her with difficult decisions, educating her, empowering her, making special arrangements with the Gift Shop to take her there before it opened, and ultimately, comforting her as she approached the death she chose for herself.

This is a powerful narrative and an incredible story of the journey Jenn took with this family. There are lessons here for all of us. Thank-you, Jenn.

Exemplar (McElhinny)

continued from page 7

husband and many of her siblings present, as well as her nurse, and a palliative care fellow. We prayed and sang in faith as Mrs. B would have wanted. Some members of her family couldn't bear to see her die and decided to go home. I affirmed their feelings and prayed with them before they left. Mrs. B and her family are powerful

signs that faith can take many roads and still reach the same goal, when it remains open to God's love.

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

"If I can be patient and control my desire to fix things, God will provide marvelous opportunities for healing

growth." Wow. What a wonderful message. What a wonderful approach to pastoral care.

I was struck throughout this narrative by Chaplain Mike's ability to accept and affirm Mr. and Mrs. B's attitudes and beliefs and still be present for their needs. He identified three challenges that stood between Mrs. B and a peaceful death, and then one at a time surmounted those challenges with love and understanding. Chaplain Mike did indeed build bridges between people and between cultures.

Faith *can* take many roads when our hearts and minds remain open. We're fortunate to have Chaplain Mike as our spiritual guide on those difficult journeys.

Thank-you, Mike.

Ethics Forum

"Privacy: It's Everybody's Business
HIPAA, Ethics and You"

Friday, January 10, 2003
12:00–1:00pm

Sweet Conference Room (Gray 432)

For more information, e-mail mwise@partners.org
CEUs will be offered

The Employee Assistance Program

Work-Life Lunchtime Seminar Series
presents

"Basic Budgeting"

Presented by
Consumer Credit Counseling

This seminar will offer guidance on how to assess your current financial situation, gain financial control, and get out of debt.

Thursday, January 9, 2003
12:00–1:00pm

Wellman Conference Room

(Repeated January 15th at BWH)

For more information, please contact the Employee Assistance Program (EAP) at 726-6976.

Nursing Career Expo

Human Resources invites you to learn more about nursing at MGH, including opportunities for staff nurses (experienced and new graduates), clinical nurse specialists, patient care associates, and surgical technologists.

Thursday, January 16, 2003
1:00–7:00pm

Wellman Conference Room

The Center for Clinical & Professional Development will provide a one-hour continuing education session to participants of the Expo.

The session is free, and 1.2 contact hours will be awarded.

For more information, contact: Megan Brown (mcbrown@partners.org) at 726-5593 or fax: 726-6866.

Exemplar (Best)

continued from page 3

M had died. It was then they told me that Mr. M had said, "Thank-you." He had been afraid of dying alone. Thankfully, James and Robert were able to be with him that last day... as a family.

Writing this has forced me to look at what has always been the most important aspect

of my life... my family. I am extremely lucky to have had a fantastic relationship with every one of my four brothers as well as my parents. It has always bothered me to see a breakdown in the family network, for whatever reason. The fact that Mr. M was willing to call on his brothers in a time of need, regardless of the damage that had been done, and that James and Robert were imme-

diately responsive, giving 100% of themselves, proved to me that as long as you are willing to try to forgive, only good can come out of a situation. I truly felt that making myself available to them was the least I could do to help them achieve that goal.

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

This narrative shows Katie going beyond her role as unit nurse leader to help this estranged family through a very difficult time. She became the liaison, not only for members of the healthcare team, but for these brothers who had a long, unsettling history and a strained relationship. By making herself available to all of them, she made it possible for them to be available to each other.

The brothers' trust in Katie was so strong, she agreed to let them contact her while she was on vacation. She continued to support her patient and his family even as she took time off to renew herself and spend time with her own family. Talk about multi-tasking.

This is a wonderful example of commitment and excellence in clinical practice. Thank-you, Katie.

Past and present Macaluso Award recipients

September 5, 1996
First recipient:
Stephanie Macaluso, RN

July 2, 1998
May Cadigan, RN
Pat English, RRT
Valerie Fullum, LICSW
Sarah Rozehnal Ward, CCC/SLP

December 17, 1998
Maureen Beaulieu, RN
Tessa Goldsmith, CCC/SLP
Diana Grobman, RN
Karen Lechner, LICSW
Donna Slicis, RN

July 1, 1999
Rochelle Butler, LPN
Alice Chaput, RN
Diane Plante, PT
Louise Sethmann, RN

January 6, 2000
Elizabeth Johnson, RN
Sucheta Kamath, CCC/SLP
Sandra McLaughlin, LICSW
Fredda Zuckerman, LICSW

June 15, 2000
Emilyn S. Bellavia, RN
Mary Elizabeth McAuley, RN
Diane McKenna-Yasek, RN
Marica Wasenius Rie, PT

December 7, 2000
Gae Burchill, OTR/L
Pamela DiMack, RN
Claire Farrell, RN
Marie Elena Gioiella, LICSW
Irene Giorgetti, RN
Lisa Sohl, RN
Susan Thel, MSW

June 21, 2001
Neila Altobelli, RRT
Constance Dahlin, RN
Sylvia Gordon, LICSW
Catherine O'Malley, RN

December 13, 2001
Clare Beck, RN
Anita Carew, RN
Robert Goulet, RRT
Kristen Jacobsen, SLP
Thomas Lynch, RN

June 13, 2002
Sharon Brackett, RN
Marguerite Hamel-Nardozi, LICSW
Mary Lou Kelleher, RN
Judith Lynch, RN
Kristin Parlman, PT
Debra Smith, RN

December 12, 2002
Kathryn Best, RN
Jennifer Kelliher, RN
Michael McElhinny, MDiv
Carol McSheffrey, LICSW
Jean O'Toole, PT



About the Award

January 2, 2003

History and background of the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

In August of 1996, Jeanette Ives Erickson, RN, senior vice president for Patient Care, formally announced the creation of the Excellence in Clinical Practice Award (originally called the Expertise in Clinical Practice Award). The purpose of the award is to recognize direct-care providers whose practice exemplifies the expert application of values put forth in our vision: practice which is caring, innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of leadership and entrepreneurial teamwork.

The first recipient of the award, in 1996, was Stephanie M. Macaluso, RN, thoracic clinical nurse specialist. In honor of the high standards she set as an expert caregiver, the award is now known as the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award.

Macaluso embodied the qualities and characteristics of an expert practitioner. She was known for her strong knowledge base, and intuitive skills. She knew when a clinical situation was changing even when common indicators remained unchanged. As an expert coach, she was one on whom peers relied and to whom physicians responded immediately because of her solid, proven track record of sound judgement.

Macaluso did not stand outside of a patient's realm of experience in her role as clinical teacher. Instead, she truly stood alongside patients conveying empathy and genuine

concern. Macaluso's ability to be with patients in a way that acknowledged their shared humanity is the basis of a caring practice.

Macaluso understood the relationship of health, illness and disease. It was this understanding that led her in her caring work to seek patients' stories. She knew that every illness had a story—relationships were disturbed, plans were thwarted, and symptoms became laden with meaning as to what else was going on in a patient's life.

Macaluso had the uncanny ability to put herself in touch with others and bring the encounter to an intimate level. It's hard to express how she made this contact with patients; maybe it was the way she approached them, the questions she asked, or the language she used. But somehow, they trusted that she knew what she was talking about. This trust and understanding allowed her to connect with patients and promote a sense of caring.

Macaluso had a keen ability to nurture staff and enlist them in her love of patient care. She epitomized the essence of what nursing is truly about.

We continue to celebrate expert practice throughout Patient Care Services. The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award is now given twice a year. Registered nurses, occupational therapists, respiratory therapists, physical therapists, speech-language pathologists, social workers and chaplains who provide direct care are eligible for the award and may nominate co-workers whose practice exemplifies the standards described earlier.

Clinicians who are nominated submit a professional portfolio which is reviewed by a selection committee comprised of clinicians, administrators and MGH volunteers. To assist recipients in achieving both personal and professional development, recipients receive tuition and travel expenses to the professional development conference of their choice.

The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award allows us to publicly re-commit ourselves to the highest standards of care we hold for our patients, and contribute to the on-going professional development of the clinicians within Patient Care Services.

Educational Offerings and Event Calendar now available on-line

The Center for Clinical & Professional Development lists educational offerings on-line at: <http://pcs.mgh.harvard.edu>

To access the calendar, click on the link to CCPD Educational Offerings.
For more information, or to register for any program, call the Center at 6-3111.

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Articles/ideas should be submitted in writing by fax: 617-726-8594 or e-mail: ssabia@partners.org
For more information, call: 617-724-1746.

Next Publication Date:

January 23, 2003



Macaluso Award Ceremony

continued from front cover

Kelliher, RN; Michael McElhinny, MDiv (the first chaplain to receive the award); Carol McSheffrey, LICSW; and Jean O'Toole, PT, were joined by PACU staff nurse, Judith Lynch, RN, who was a recipient in June but was unable to attend the ceremony at that time.

Ives Erickson began by invoking the memory of Stephanie Macaluso as a long-time nurse, clinician, and friend. Said Ives Erickson, "We honor her memory with this award. I know she is smiling on us today and sharing in our pride."

Ives Erickson thanked the review board for their hard work and commitment in selecting clinicians whose practice exemplifies the attributes exhibited by Macaluso in her practice years ago. Past recipients of the Macaluso award have been invited to serve on the review board, which this year included:

- Trish Gibbons, RN (chair)
- Paul Bartush, Volunteer Services
- Gae Burchill, OTR/L*
- Ann Daniels, LICSW
- Robert Goulet, RRT*
- Ann Jampel, PT
- Liz Johnson, RN*
- Beth Nagel, RN
- Catherine O'Malley, RN*
- Suzanne Potts, Ladies Visiting Committee

- Steve Taranto, Human Resources (* indicates past recipient)

Before the awards were presented, Ives Erickson invited recipient, Kathryn Best, to dialogue with professional development coordinator, Mary Ellin Smith, RN, about the journey that brought her to be unit nurse leader in the Oral & Maxillofacial Surgery Clinic. Best described her experience beginning with what she thought would be a 'temporary' assignment, and ending with her as a confident, competent nurse leader, firmly ensconced in a practice that has tripled in volume since she first started.

Said Best, "Working on my portfolio (part of the nomination process) was a great learning experience. It gave me an opportunity to reflect on my practice and really see what I've been able to accomplish in my career."

As the first chaplain to receive the Macaluso award, Mike McElhinny was asked to share his practice with director of the PCS Diversity Program, Deborah Washington, RN. McElhinny spoke about the spirit of cooperation and collaboration at MGH as key factors in his decision to come to work here. He spoke

with pride about the Chaplaincy and the ability of MGH chaplains to stand alongside other disciplines in providing the best possible care to our patients.

As she presented the awards, Ives Erickson read briefly from each recipients' letters of nomination. Since Judy Lynch was unable to attend the last awards ceremony, she began with her.

Reading from a letter written by staff nurse, Diane Herald, Ives Erickson said of Lynch: "Judy's concern for her patients and their families is always of the utmost importance. Staff look to her for the highest standard in post-operative care, from pain-relief to the comfort and assurance she offers each patient during her time with them."

About Katie Best, Ives Erickson read from a letter written by Dr. Edward Seldin: "Katie's is a highly complex and demanding job that requires an individual of consummate dedication, capable of extraordinary attention to detail and hard work and possessed of highly refined organizational and interpersonal skills. Katie supplies all these attributes in spades."

Introducing Jennifer Kelliher, Ives Erickson read from a letter written by Dr. Robert Brown, saying: "Jennifer's devotion to her patients and their families is particularly

noteworthy. I witness regularly the strong relationships she forms with her patients. Her concern travels beyond the confines of the unit as she regularly visits patients after they've been transferred to other units and even other hospitals. Jenn has organized unit-based ethics rounds, which are particularly valuable to our patients, their families, and to us as caregivers."

Reverend Mary Martha Thiel, director of the MGH Chaplaincy, wrote one of McElhinny's letters of nomination, saying: "Mike approaches each patient with the wonder of a child. He builds relationships with each one. He sees their beauty. He listens more than he speaks. He is not afraid of pain, anger or loss of faith. He is faithful over time, seeing people through cure, or to death. I marvel at his ability to bring his patients to peace."

About Carol McSheffrey, Evelyn Bonander, director of Social Services, wrote: "Carol brings extensive knowledge, seasoned skills, an openness to learning and a passion for work with troubled couples and families. Carol's ability to assess complex relationships, engage and individualize each member, yet intervene with the whole unit and remain non-judgemental marks true practice mastery and

excellence. She is sought out as a consultant and supervisor by social work colleagues as well as psychologists and psychiatrists."

Director of Physical and Occupational Therapy, Michael Sullivan wrote one of Jean O'Toole's letters of nomination. Of Jean he said: "She is the 'clinician of choice' for many of our accomplished orthopaedic surgeons. Her expertise is derived from an extraordinary understanding of biomechanics, pathology and pathophysiology of the musculoskeletal system. Despite a level of clinical expertise that is evident to all, Jean energetically engages in self-reflection and consultation with peers around patient-management issues. Without her vision and steadfast determination, our service to patients would not be at the level it is today."

In closing, Ives Erickson thanked the award recipients, the review board, and all MGH employees for everything they do to make MGH the greatest hospital in the world. "Excellence in patient care is alive and well within these walls," she said.

The next Stephanie M. Macaluso, RN, Excellence in Clinical Practice Awards are scheduled for June, 2003. For more information, call Mary Ellin Smith at 4-5801.

Educational Offerings

January 2, 2003

When/Where	Description	Contact Hours
January 10 12:00–1:00pm	Ethics Forum: Privacy: It's Everybody's Business—HIPAA, Ethics and You Sweet Conference Room, Gray 432	TBA
January 14 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	---
January 16 1:30–2:30pm	Nursing Grand Rounds O'Keeffe Auditorium	1.2
January 16 10:00–11:30am	Social Services Grand Rounds "The Treatment of ADHD in Adults." For more information, call 724-9115.	CEUs for social workers only
January 16 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
January 19 1:30–2:30pm	USA Educational Series Bigelow 4 Amphitheater	---
January 22 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
January 24 8:00am–4:00pm	Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza	8.1
January 24 8:00am–4:30pm	Psychological Complications of Pregnancy and Postpartum Shriners Auditorium	TBA
January 27: 7:30am–4:30pm January 28: 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: VABHCS. Day 2: (VBK607)	14.4 for completing both days
January 28 and 29 8:00am–4:30pm	BLS Instructor Program VBK601	13.2 for completing both days
February 3 8:00am–4:00pm	Advanced Cardiac Life Support—Instructor Training Course O'Keeffe Auditorium. For more information, call 726-3905.	---
February 3 7:00–11:00am, 5:00–9:00pm	Congenital Heart Disease: an Overview for Nurses Burr 3 Conference Room	TBA
February 4 8:00am–12:00pm	Pediatric Advanced Life Support (PALS) Re-Certification Program VBK 601-607	---
February 4 5:00–9:00pm	Congenital Heart Disease: an Overview for Nurses Burr 3 Conference Room	TBA
February 6 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
February 6 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
February 6 12:15–4:30pm	Pacing : Advanced Concepts Haber Conference Room	5.1
February 6 1:30–2:30pm	Nursing Grand Rounds O'Keeffe Auditorium	1.2
February 7 8:00am–4:30pm	ICU Consortium Program (Topic TBA) O'Keeffe Auditorium.	TBA

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111. For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

Holiday Celebrations

Patient Care Services



Continued on next page

spreading good cheer for the holidays



Santa's helpers



PCS Diversity Committee's Holiday
Gift-Giving Event

Shining the spotlight on excellence!



Best and Smith



Lynch and Ives Erickson



McSheffrey



McElhinny and Washington



O'Toole and colleague, Diane Plante



Kelliher

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