

Caring

October 7, 2004

HEADLINES

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Crossing the culture chasm

PCS Diversity Committee raising awareness at MGH, in the community, and beyond



Prior to blood-pressure screening, June McMorrow, RN, shares information with visitor to the New Bostonians Community Day event. Forty percent of the immigrants and refugees who were screened tested borderline for hypertension.

(See story on page 6)

MGH Patient Care Services
Working together to shape the future

Diversity in health care means better access, better business, better care for all

Sometimes change happens dramatically.

Sometimes change happens subtly, over time—we find ourselves in a new culture without even noticing the process that brought us here. When I look around the hospital and see the results of our commitment to making MGH a welcoming institution for all our patients and visitors, I can't believe it's been only seven years since the Patient Care Services Diversity Steering Committee began its important work.

This issue of *Caring Headlines*, our sixth annual diversity issue, is testament to the success that the committee and the MGH community have achieved in meeting our original goal to, "lead initiatives that foster diversity of staff and create culturally-competent-care strategies that

support the local and international patients we serve."

We have reason to be proud, but even as we celebrate our accomplishments, we know there is still much work to be done. As we continue to address challenges such as eliminating disparities in health care, recruiting more minority professionals, and improving access to care for all patients, we know that a racially and ethnically diverse workforce is at the core of our solutions. Increasing diversity in our workforce improves access and quality of care and promotes confidence among our minority patients; it attracts students of diverse backgrounds; it influences the direction of our research and resources; and it impacts health policy as we interact with and inform our local, state and national legislators.

At a recent Patient Care Services retreat dedicated to quality, safety, and customer service, some interesting observations arose related to diversity and our commitment to providing culturally competent care and retaining a racially and ethnically diverse workforce. According to a recent study published by the Sullivan Commission on Diversity in the Healthcare Workforce, "diversity and cultural competence are measurable attributes" of a healthcare system. One measurement tool recommended by the commission is a needs-assessment survey. In appraising the healthcare needs of a particular community or population, information on race and ethnicity can be captured enabling an organization to "approximate their workforce needs and ensure a critical mass of under-represented minority providers."

At the New York Times, senior vice president for Human Resources, Cynthia Augustine, employs a different kind of diversity measurement tool. She asks two questions: "Does your leadership team include a significant number of people from diverse backgrounds who are in a position to influence the company?" And, "Can people bring



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

their 'whole selves' to work or do they have to check their sexual identity, religion, or ethnicity at the door?"

DiversityInc magazine recently printed a tool for measuring how well a company's website reflects its commitment to diversity. It included questions like:

- Is there a link to diversity-related information on your home page?
- Does your website include multi-cultural images?
- Would a search of your website using the keyword, 'diversity,' yield significant results?
- Does your website highlight activities that impact diverse communities?

Good work is being done in many venues, and I think it's time we raise the bar again. It's not enough to develop and implement diversity programs and initiatives. It's not enough to incorporate diversity into our

strategic planning and decision-making. We need to be able to measure our success and hold ourselves accountable for meeting the goals we've set for ourselves.

We all understand and appreciate the need for diversity in health care. A diverse workforce ensures a higher level of cultural competence, which ensures a higher level of quality and safety for all patients. A diverse workforce brings skilled people from all backgrounds together creating a cross-cultural forum for creative thinking. A diverse workforce contributes to better access, better business, and better care.

I think you'll find this issue of *Caring Headlines* uplifting and informative.

Update

I'm pleased to announce that Coleen Caster, RN, has accepted the position of nurse manager on the Bigelow 7, Gynecology Unit. Coleen will start in her new role on October 12, 2004.

Celebrating Ramadan

In the spirit of unity and friendship, the PCS Diversity Committee, the MGH Chaplaincy, and Muslim staff invite you to Iftar, the breaking of fast during the Holy month of Ramadan. All Muslim patients, family members, staff, and friends are welcome.

Wednesday, October 27, 2004
5:15-7:30pm
Wellman Conference Room

For more information, contact Firdosh Pathan at 6-2503, or Lulu Sanchez at 4-0989

Diversity Committee answers frequently asked questions

Question: I wanted to join the Diversity Committee, but I thought it was only for African Americans.

Answer: The Diversity Steering Committee is comprised of staff from all backgrounds. There are no ethnic, racial, cultural, or religion-based prerequisites to join. In fact, membership of the committee is not predominantly African American; it is comprised of Christians, Jews, Muslims, Hispanics, African Americans, Asians, and people of many other diverse backgrounds. We all have one thing in common. We are committed to supporting and developing strategies that transform our work setting into a more inclusive and welcoming environment for staff and patients.

Question: What does the committee do?

Answer: The committee supports programs and events that promote the professional development of minority employees, student outreach, culturally competent care, and patient-education materials specifically designed for a diverse patient population.

Question: I've seen an increase in the number of Muslim patients we care for. But I don't understand a lot about their

religious beliefs. What is the basis of the Muslim faith?

Answer: The Islamic religion is misunderstood by many people. It is, in essence, the message that God revealed to His messengers and prophets beginning with Adam. Muslims pray to and worship the same God as others do (Allah is the Arabic word for God). Muslims accept and respect all the Prophets (Adam, Noah, Abraham, Ishmael, Isaac, Moses, John the Baptist, and Jesus, who came before the Prophet Mohamed). Muslims believe in the Torah and the Bible. They go once during their lifetime to Mecca, a city in Saudi Arabia, to complete a pilgrimage called the 'Hajj.' This is where Kabah is located, the first place of worship built by the Prophet Abraham and his son, Ishmael, more than 4,000 years ago. Islam prescribes that Muslims face in the direction of the Kabah when they pray, which symbolizes unity as one community worshipping One God.

Question: I was surprised when one of my patients told me he was Muslim, because he didn't look Muslim to me.

Answer: Not all Muslims look alike. Islam is the second largest religion in the world as well as in America. There are

more than 1.2 billion Muslims in the world and more than 8 million in America. Only 18% of Muslims live in the Arab world; 20% in Sub-Saharan Africa. Indonesia has the world's largest Muslim population. People from India, Pakistan, Bangladesh, China, Russia, Europe, and North and South America are Muslim.

Question: I know that Ramadan is a time of fasting and prayer for Muslims. What is the meaning behind this practice?

Answer: Ramadan is the ninth month of the Muslim calendar. Every year in the month of Ramadan, all able Muslims fast from dawn until sundown, abstaining from food, drink, earthly pleasures and evil intentions. Though fasting is beneficial for health reasons, during Ramadan, it is mainly a means of self-purification and self-restraint. Fasting teaches love, sincerity, and devotion. It develops patience, unselfishness, social conscience and the will to endure hardship. During Ramadan, Muslims focus on their purpose in life by constantly being aware of the presence of God. Muslims, Christians, and Jews have much in common. All worship one God, Creator of the Universe. All pledge themselves to

prayer, peace, justice, harmony, cooperation, compassion, charity, family responsibility, and tolerance toward people of other faiths and traditions.

Question: A patient told me he chose MGH because we have a Muslim

prayer room. Is that true? If so, where is it?

Answer: The Masjid, or Muslim prayer room, is located in Founders 109. It is a room where Muslim patients and staff can go to pray. The schedule of prayer times is available in the Masjid.

Piecing together the puzzle of domestic violence: Are you the missing piece?

**Thursday, October 7, 2004
11:00am-3:00pm
Under the Bulfinch Tent**

Remarks by MGH president, Peter L. Slavin, MD, at 12:00pm

For more information contact Corinne Castro, Domestic Violence Events Committee representative, at 726-8182

POPPS Fair 2004

Police & Security, Outside Services, and Photography are proud to announce their annual Crime Prevention and Safety Fair

**Thursday, October 14, 2004
11:00am-3:00pm
on the Bulfinch patio**

The focus of this year's event will be "Protecting You In this Changing World." Representatives will be on hand to showcase the many programs and services available to the MGH community

The MGH Photography Department will present demonstrations on location photography, framing, and poster printing and will display entries from the 7th Annual Photo Contest

Staff from the MGH Safety Department, Employee Assistance Program, HAVEN, and MassGeneral Hospital for Children are participating in the fair.

Come enjoy food, fun, free raffles, and educational information from the department of Police & Security, Outside Services, and Photography

Confronting disparities through culturally competent care

—by Claribell Amaya, RN; Megan Brown; Kathleen M. Myers, RN; and Ivonny Niles RN

Quality health care and diversity intersect at the bedside every day. Diversity among caregivers and attention to culturally competent care are essential if quality care is to be delivered to every patient. The PCS Diversity Committee has focused its efforts on eliminating disparities in health care and increasing the diversity of our nursing workforce since its inception in 1997.

“Improving the health status of the population by providing national leadership in the development, distribution, and retention of a diverse, culturally competent

health workforce that provides the highest quality of care for all,” is the mission statement of the Department of Health and Human Services’ Health Resources and Services Administration in the Bureau of Health Professions. Their mission mirrors the philosophy, beliefs, and passions of the PCS Diversity Committee.

The face of America is changing. By 2050, one in three Americans will describe themselves as non-white. Today, Boston, our practice domain, is described as a ‘minority majority’ city. Boston has the fifth largest percentage (25.8%) of foreign-born residents

among 23 major metropolitan cities (after Miami, Los Angeles, New York, and Oakland). Nearly half of Boston’s immigrants entered the United States in the last decade.

A 1996 survey of registered nurses released by the US Department of Health and Human Services showed that nearly 90% of the total nursing population is white compared to 72% of the total US population (who describe themselves as white). This lack of diversity is becoming an increasingly challenging problem for the nursing profession. Ideally, the healthcare workforce mirrors the cultural diversity of its

patient population. Does that mean we need to be a certain cultural or ethnic background to care for patients? Absolutely not.

We asked a number of staff nurses their thoughts on the subject. They told us that they learn by listening to their colleagues. As we share experiences, we become more aware of how our practice can be positively impacted by increased sensitivity to the cultural needs and beliefs of our patients. Sharing knowledge and experience allows us to care effectively for patients from a wide range of cultures and traditions. In reality, we’re all multi-cultural; some of us may have been born in the United States, others weren’t.

History shows longstanding disparities in the quality of health care provided to people of color and other diverse backgrounds. This makes the need for cultural diversity among caregivers even more urgent. As clinicians we want to uncover and dismantle the processes that contribute to disparities in care. Access to quality care (or the lack thereof) continues to be the most important predictor of outcomes for people of diverse racial and ethnic groups. As an institution that trains future caregivers, we have a responsibility to educate ourselves and others about the customs, traditions, beliefs and health practices of those we serve.

The commitment of the Diversity Committee remains strong to create “a practice environment with no barriers that reflects a culturally competent workforce supportive of the patient-focused values of the institution.” If we look at our nursing employment data over the last seven years, we see it’s beginning to reflect our commitment to increasing the diversity of our workforce:

- In December of 1997, of 1,782 nurses, 5.5% were non-Caucasian
- In December of 2002, of 2,624 nurses, 6.2% were non-Caucasian
- In December of 2003, of 3,085 nurses, 7.0% were non-Caucasian

Clearly there is an upward trend, and there are a number of ways we can help sustain that forward momentum. We can continue to support foreign-born and minority nurses. We can continue to support programs such as the Nursing Career Ladder Initiative and on-site BSN and MSN programs. And we can continue to hire, mentor, and support staff, managers and clinical specialists from diverse backgrounds.

An article in the Diversity issue of *Caring Headlines* in 2001 ended with the words: “As an institution, our work and dedication (to diversity) are beginning to show. The next time you walk down the main corridor, look around... let me know what you think.” We think things *are* changing. What do you think?



Standing: Claribell Amaya, RN (left); Ivonny Niles RN; and seated: Megan Brown (left); and Kathy Myers, RN

Overcoming challenges in caring for non-English speaking patients

—by Tamara K. Edelman, NP



Tamara K. Edelman, NP,
nurse practitioner

Think back to a time when words like pleurocentesis, ECHO cardiogram, and metastasis sounded foreign to us. As providers we sometimes forget how and when ‘medical language’ became our primary language.

Trying to process and understand information at a time when emotions are running high and senses are low is difficult enough for people who speak English fluently. Imagine being a patient who speaks no English or whose primary language is not English. As clinicians we provide care to a culturally diverse patient population and we must be competent in every interaction to provide the best pos-

sible care to every single patient.

In the past, I’ve had many interactions with non-English-speaking patients where I was unable to communicate verbally. I was frustrated with myself because I was unable to have a complete interaction with the patient. I can only imagine how my patients must have felt as fear ran through their minds and I couldn’t console or explain the care I was proposing.

As providers we are very busy and getting busier every day. Just as physical therapists, occupational therapists, and social workers are essential members of the healthcare team, interpreters are vital members of the team for non-Eng-

lish-speaking patients. The obvious benefit of using an interpreter is clear, concise communication between provider and patient. Some clinicians might be wary of using an interpreter for fear that the message could be ‘mis-interpreted,’ and wrongly influence communication. You should know that medical interpreters work within a strict set of standards, one of which is called judicious clarification. This means that interpreters aid the communication process; but it is not within their scope to explain a procedure or medical condition or convey their own biases.

Many patients hold interpreters in high regard, because they’re from the same or a similar cultural background. Interpreters can function as cultural mediators—not by offering opinions, but by providing a more effective means of understanding and communicating by applying specific cultural ideals and customs to an interaction.

To ensure an effective patient-provider interaction with the help of an interpreter, providers should set up a pre-interview meeting with the interpreter. This enables the provider and the interpreter to review perti-

nent portions of the patient’s medical history. During the interaction with the patient, providers should speak directly to the patient (not the interpreter) and use non-verbal as well as verbal cues to communicate. This enables the provider to ‘read’ the patient’s facial expressions and non-verbal cues.

The same challenges that impact the care of non-English-speaking patients in the hospital setting affect ambulatory and home-care patients as well. I once received a call from a private nurse who was caring for a Chinese-speaking patient (who was under my care) in his home. The patient had undergone an extensive surgical procedure and needed to be evaluated on a continuing basis. The nurse was unable to communicate with him, which made caring for him effectively nearly impossible. This is a perfect example of a situation where an interpreter’s services in a home-care setting would

have been invaluable. Being aware of these challenges can help lead to viable solutions and improved care for all patients.

Non-English-speaking patients, like English-speaking patients, can usually repeat back only 30% of verbal instructions or information during a visit. So it’s important that verbal information be short and concise. It may take more than one attempt for a patient to fully comprehend something. Be patient, confident, and inventive with your communication. If possible, provide written information in the patient’s primary language, use pictures, and include the patient’s family in the plan for care at home.

It’s important to remember as we strive to excel as caregivers, that the most effective form of communication is still a smile and the touch of a hand. And that’s the same in every language... even medical.

Domestic Violence Support Group

The Employee Assistance Program is offering a 10-week support group for female employees who have been affected by domestic violence in a past or current relationship.

The group is free and confidential

**The first meeting will be held
Thursday, October 14, 2004
4:30–6:00pm**

For more information, contact Donna at the EAP: 726-6976 or 1-866-724-4EAP

MGH employees welcome 'New Bostonians' in special multi-cultural event

—by June McMorrow, RN; and Elizabeth A. Nolan, MALD

In an effort to address healthcare disparities among local linguistic minorities, the Patient Care Services Diversity Committee joined forces with Interpreters Services, Human Resources, the Partners International Program, and the Mayor's Office of New Bostonians to conduct

free blood-pressure screenings and distribute 'basic medical ID cards' during Boston's fifth annual New Bostonians Community Day Celebration. The event took place September 22, 2004, at City Hall Plaza.

Approximately 150 refugees and immigrants visited the booth, where they were greeted by nurses and

bi-lingual volunteers, who helped them fill out wallet-sized cards containing important health information such as their name, native language, blood pressure, known allergies, and emergency contact information.

In addition to laminated medical cards, the team distributed multi-lingual information on asthma,

diabetes, and high blood pressure.

June McMorrow, RN, who volunteered to staff the booth for the second year in a row, says, "Participating in this event gives me an opportunity to share my enthusiasm for nursing by interacting with people from many different groups within the city."

Nearly 4,000 people attended the 2004 New Bostonians Community Day celebration. Visitors to the MGH booth hailed from Bosnia, Burma, Brazil, China, Cape Verde, Colom-

bia, the Dominican Republic, Greece, Haiti, Kenya, Panama, Peru, Puerto Rico, Somalia and Vietnam.

According to the latest census, 25.8% of Boston's residents are foreign-born, and more than 140 languages are spoken in our city. Twenty percent of Boston's schoolchildren speak a language other than English at home, the most prevalent being Spanish, Haitian Kreyol, Mandarin, Portuguese, Cape Verdean Kriol, Vietnamese and French.



Above and on opposite page, members of the PCS Diversity Committee and hospital volunteers participate in this year's New Bostonians Community Day event at City Hall Plaza, providing free blood-pressure screenings and medical ID cards to refugees and immigrants new to the Boston area.

[Continued on Next Page](#)

Locally, more immigrants work in the health and social-services field than in any other sector. Because access to employment opportunities was identified as a key need among newcomers, this year, MGH added bi-lingual employment information to the materials they distributed at the event.

Commenting on the value of Boston's multiculturalism, director of PCS Diversity, Deb Washington, RN, said, "Every time a new patient or staff member walks through our doors, MGH is re-born. If you look back at our history, our strength and innovation have always been derived from diversity—diversity

of people, diversity of ideas, diversity of experiences."

New Bostonians Community Day was established in 1999 as the city's most visible celebration of immigrants and multiculturalism. Coordinated by a public/private coalition representing various city departments and community organizations, New

Bostonians Community Day helps facilitate the integration of newcomers into our society by explaining how city government works and by highlighting many available social services.

Activities include free immigration clinics, performances by musicians and dancers, multi-lingual tours of City Hall, and an

information fair consisting of resource tables on topics such as health, housing, employment, civil rights, youth activities and educational opportunities.

For more information about the New Bostonians Community Day event, contact Beth Nolan of the MGH International Program, at 726-4284



Healing through patience and understanding

My name is Immacula Benjamin. I am the resource nurse on the Ellison 18 Adolescent Pediatric Unit. I have worked at MGH for 27 years, and the patient I'm going to tell you about has challenged all my skills, energies, compassion, and creativity.

'Angelica' is a 14-year-old Haitian girl whom I first met a few months ago when she was admitted to our unit with encephalitis. I became her primary nurse. I knew when I saw her and learned her history that she was going to need someone to look out for her, to protect her, to go the extra mile in getting her what she needed. I entered the relationship with my eyes wide open as I have cared for 'difficult' patients before.

Angelica was in DSS custody due to allegations of abuse in her aunt's home where she lived. Angelica had come to America from Haiti with her aunt a few years before. She left not only her mother, but also her country and the native culture she was so accustomed to, which included the frequent practice of her religion. Her sister also lives here with her aunt. Angelica's aunt continues to be involved with her, and DSS has appointed a guardian who is attentive to An-

gelica's needs. Her sister acts as a link between Angelica and her mother in Haiti.

Angelica's medical course has been very rocky, requiring the best skills of many of our services. As her primary nurse it has been up to me to coordinate these services, provide direct care, and keep Angelica safe from herself. Along with a host of medical complications some requiring a stay in the Pediatric Intensive Care Unit, Angelica's behavior has been one of the most difficult challenges in her care. She has extreme obsessive-compulsive behaviors, aggressive tendencies, and a desire to flee at any opportunity.

My primary concern upon assessing Angelica was her safety. At times, her behavior required her to have sitters and/or soft restraints. At one point she was moved to a Vail Bed (a bed totally enclosed with a zipper so she could move freely but not flee).

One of my first challenges was to educate staff about why the bed was necessary and how it worked. One day, an energetic medical student went into Angelica's room to do an exam and as soon as he opened the zipper she was out of bed and down the hall. This brought everyone to the hallway to help. I

know there's something to be said for exercise, but I cringed when I thought about how frightened she must have been as we tried to 'catch' her and get her back to bed.

How to coordinate the efforts of all the services became my next challenge and highest priority. I felt if I could get everyone in the same room, I could provide a clear understanding of Angelica's special needs. I called a team meeting and invited all members of her care team (Speech-Language Pathology, Occupational Therapy, Physical Therapy, Dietary, Child Life, Chaplaincy, Psychology, DSS, her physician and others). It was very heartwarming to see the turn-out. I could see how much they all cared and wanted the best for Angelica. Everyone was willing to listen and learn and work together.

All services reported on their interactions with Angelica, and the common thread from everyone was this young girl's spiritual connection and her love of the religious rituals from her homeland (Haiti). We were fortunate to have a chaplain present from Haiti who was able to converse and pray with Angelica in her own language. Prayer helped to calm her like nothing else had. My job as primary nurse at this meet-



Immacula "Ki-Ki" Benjamin, RN, staff nurse, Ellison 18

ing was to connect the dots and see how we could use Angelica's culture and religion to help her heal and make her time with us less traumatic.

In the following weeks we worked on a plan in which prayer was a big part of her daily routine and therapy. Chaplains weren't the only ones to pray with her, but they became the most visible and important part of her care plan and team.

Angelica's mother sent her a dress from Haiti, with instructions for us on when to put it on her (a particular time and date). The dress came with a prayer card, which was to go under her pillow. I made sure this was done, and it was amazing the effect it had on Angelica. She became so calm and cooperative with prayer.

Every department individualized the care they provided for Angelica, celebrating her diversity to help her heal. Nutrition & Food Services made special meals

for her. OT and PT worked with child life specialists to incorporate their therapies into special activities and times for her. Nurses took the time to learn her special daily needs, and that, in itself, made her care easier.

Angelica remains at MGH as we look for the proper discharge plan for her, one that can keep her close to her family in America and support her ethnic diversity and religious practices. We don't know how Angelica will progress medically, only time can answer that.

What Angelica has taught me is invaluable: patience, that nothing happens quickly; faith in a supreme being and the healing peace that belief can bring; and the importance of primary nursing. Nurses make a difference. I know I've made a difference in Angelica's life. Pediatric nurses are there to pull all the wonderful people together to provide the best care possible for our young patients.

Caring for children with multiple medical issues

—by Carly Jean-Francois, RN, staff nurse, Ellison 18

The Diversity issue of *Caring Headlines* may not seem like a place where you'd read about children with multiple medical issues. But children who suffer from a variety of physical and developmental challenges are often regarded as 'different' or 'outside the norm.' Perhaps physician, Jeffrey Bosco, from the University of Miami phrased it best when he said, "There is something about their body that makes them different from most other people. Maybe their eyes don't see or their ears don't hear. Maybe their legs don't move through space or their brain doesn't get through a book. After that, it's all the same. These children share some of the same struggles, longings, fears, joys and pains as anyone else." When considered through this quote and the stories of the families we see, these children and their families face many of the same issues as people of color and people from diverse ethnic backgrounds.

We live in a world where we label people who are different from us. Terms such as handicapped, mentally different, slow, developmentally delayed, special, and physically-challenged are used to describe these

individuals. Sometimes, in an effort to improve their prognoses, children are placed in homogenous groups where their diverse cultures become lost. The holistic and advocacy needs of these children and families are great, and the need for individualized services is steadily rising. This is an opportunity for nursing to intervene and make a significant difference.

Recent surveys conducted by the Center for Disease Control and Prevention reported that approximately 13% of all children have special healthcare needs reflecting a wide range of severity. Findings from this study revealed that these children have an ongoing need for health services, yet 21% of respondents reported difficulty in securing referrals for those specialized health services. Parents become frustrated that there are centers and clinics devoted to their child's limitations, but few that look at the needs of the child and family as a whole or that focus on their abilities rather than their disabilities.

Every day as medical professionals we share in the experience of families receiving news of a 'not-so-perfect baby.' We share health information that profoundly affects the lives of an entire

family, yet for many of us it's just our job and we move on. Mrs. Wood, a member of the Mass-General Hospital for Children Family Advisory Council shared some of her thoughts regarding her child, Nancy, and their family's journey in the healthcare system. When the Woods learned that Nancy was born with a chronic medical condition, they were devastated. They felt angry, afraid, helpless, and vulnerable. They didn't know if they were capable of caring for Nancy at home. They never doubted their love for Nancy but feared making the wrong decisions about her care. The Woods wanted a pediatrician whom they could partner with, who would value Nancy's life and see her potential as they did. They wanted someone who would listen to their hopes for Nancy and treat her symptoms not her diagnosis.

The Woods connected with MassGeneral Hospital for Children's Dr. Robert Wharton. Says Mrs. Wood, "He was the first doctor we met who was brave enough to give us hope for the future." Recent research suggests that when parents are given a realistic image of their child's disability and when they receive ade-

quate information and practical advice on how to care for their child in everyday life, it can have a positive effect on the functioning of the family as a whole. The Woods are a perfect example of this.

The partnership that formed from their first conversations with Dr. Wharton has taught the Woods and parents like them the importance of valuing all children as individuals. When it came to Nancy's care and well-being, Dr. Wharton was more than her pediatrician. His knowledge and expertise about Nancy's condition allowed the Woods to become better caregivers, teachers, therapists, advocates, nurses, and most of all, parents. He made home visits and took a genuine interest in Nancy's triumphs. Mrs. Wood acknowledges the gift they have in Dr. Wharton, as it's not always easy to find medical professionals willing and able to take on a child and family with special needs. It

can be frustrating for both medical professionals and families, and devastating for a family, when their child is 'refused' by a healthcare professional. Unfortunately, our healthcare system doesn't always support or reimburse the kind of care these children and families need. Physicians sometimes feel that their practice can't handle the increased workload and the system doesn't allow reimbursement for the extra time necessary to provide coordination of care. However, parents can be our greatest ally if they are valued for the expertise they provide as their child's primary caregiver. Nurses and nurse practitioners can use their role as advocate and coordinators of care to work with families to develop and support a plan of care that is family-centered, coordinated within the community, supportive of the child's strengths, and proactive in helping the child at

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Carly Jean-Francois, RN,
Staff nurse, Ellison 18

Food for thought *tapping into the cultural richness of Nutrition & Food Services*

—by Mary Cunningham, and Judy Newell, RN

Every member of the health team has a unique life experience that adds special meaning and perspective to his/her work. In the department of Nutrition & Food Services, more than 140 cultures are represented, bringing a multi-ethnic array of beliefs, customs, and traditions to MGH. Among the many wonderful differences derived from diverse cultures is our relationship to, our preparation of, and our appreciation for, food!

Recently, a group of nutrition service coordinators and dietitians from Nutrition & Food Services came together to share some of their

thoughts on the meaning and significance of food in their native countries (India, Jamaica, Monserrat, Morocco, Puerto Rico, Barbados, and the United States). How do members of this diverse department feel about food as they plan and coordinate the delivery of more than 2,500 meals to our patients every day?

One observation that came out in the course of the discussion was how the abundance or scarcity of food in one's homeland can influence the value that is placed on food in this country. The importance of choice was another factor in how people perceived food—in most

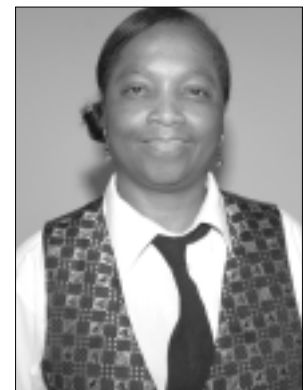
areas of the United States, there's a wide variety of foods to choose from. In other countries, choice can be non-existent. In some cultures food is a sign of acceptance, hospitality or good cheer. When not eaten, it may be interpreted as a sign of waste, carelessness or insult.

As we listen to these comments, recollections, and observations about the significance of food in various cultures, we are moved to think about the importance of food in the lives and care of our patients who come to us from all over the world. What is their relationship with food...?



Tiash Sinha

"We are so concerned that our patients receive proper nutrition, that we often order more for them than they can eat. In many cultures, this is seen as wasteful. It is upsetting to some people."



Maudline Tuitt

"I work at Coffee Central, and I see how food 'connects' people every day. After I take someone's order a few times, I always remember what they like. When I see them again, I know what to get for them."



Sarah Estabrook, RD
assistant manager, Patient Food Services

"I come from a wonderful New England background of baked beans and brown bread. I really enjoy interacting with the diverse population at MGH and having the opportunity to create different foods for our patients from all over the world."



Simone Prescod

"My mother lives in this country now. When she spends holidays with friends, she doesn't eat anything because she knows that relatives back home have no food. When I see all the food that goes to waste, it hurts my heart; I know so many people who have so little."



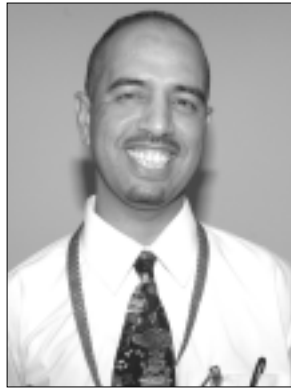
Francisca Nogbou

"My job is to mix up food in a blender for patients who have special diets. Sitting in my work area all day, it's easy to forget why I'm doing what I'm doing. But when I go up to the units and see all the patients, I am reminded why my work is so important. When I stop seeing a certain recipe, I always wonder if that patient has been discharged."



Chhaya Sithowath

"I learned to cook in the army in my country. Things were a little different there. If you didn't do something right, you could get shot! I worked very hard to learn how to cook, and I'm proud of the work that I do."



Mustapha El Fakir

"In my country, freshness is everything. No one uses freezers. Ingredients go straight from the garden to the table. In this country, food can sit in a freezer for months at a time."



Miriam McLean

"I come from the beautiful isle of Jamaica where everything is wonderful, and food is a big part of our culture. It is amazing the effect your physical surroundings can have on your mood and spirit."



Nancy Medina

"I remember thinking that American food was so bland. In my country, we have so many distinctive spices. We use spice on everything!"



Ghislaine Laurore

"When I first came to this country, it took me a while to get used to the food—everything looks and tastes so different here. I really missed the familiar foods of home. I'm starting to get used to American food. A little bit."



Gertrude Dominique

"Here at MGH, our patients are given a choice as to what they want to eat. In the hospital back home, there is no choice. Patients get whatever is available. Sometimes chicken broth is all there is."

The Patient Education Committee presents:

Healthy Behaviors: Coaching your Patient to Success

Featuring keynote speaker, James Prochaska, PhD, author of *Changing for Good* and *The Transtheoretical Approach*

Professionals in the fields of addiction, decision-making, weight-control, smoking-cessation, and exercise will report on their experiences

Come learn how people make decisions to change

**November 5, 2004
8:00am-4:30pm
O'Keefe Auditorium**

7.5 Contact Hours
Pre-registration is required. For more information, call the Center for Clinical & Professional Development at 726-3111

Case Management Week

Case Managers, the passion for caring, the power of collaboration, the promise of hope

Visit the Case Management information booth

**October 12 and 14, 2004
8:00am-4:00pm
Main Corridor**

Attend educational session on, "Alternative Therapies" that will combine information about complementary and alternative therapies

**November 2, 2004
2:00-3:00pm
O'Keefe Auditorium**

(CEUs and CCMs TBA)

The annual Case Management Variety/Change Show

**October 14, 2004
3:00pm
Meltzer Auditorium, MEEI
3rd floor**

All are welcome
For more information, contact Anna Carson at 6-8184, or Melissa Robinson at 4-7474

A visit to Morocco: the journey of a lifetime

—by Beverley Cunningham

*M*y odyssey began when Touria, a friend at MGH, invited me to go home to Morocco with her. I was both thrilled and apprehensive about this opportunity to visit a country whose name evoked a sense of mystery and intrigue.

Morocco is in North Africa where the language and culture are very different. Not knowing much about the area, I have to admit, I wondered about safety, the political climate of the country, how women were treated, and a number of other fleeting concerns. But I soon realized that what I feared was the unknown. I reminded myself that I trusted my friend and knew she'd never put me in harm's way. I accepted Touria's invitation, then went out and bought a travel guide to educate myself and prepare for my journey.

Any doubts about my safety were quickly dispelled as I landed at Mohammed V Airport. Touria's family greeted me warmly, and I felt safe and well cared for during my entire visit.

Great excitement surrounded our arrival. Sisters, brothers, mothers, cousins, aunts, uncles, nieces and nephews had made the three-hour trip to Casablanca to meet Touria and her husband

who were returning to Morocco for the first time in two years. Tears of joy were shed as they were reunited with their two-year-old son (who lives in Morocco because of the expense of child care in America). Family members greeted me using whatever French or English they knew to make me feel welcome. We piled into four cars and a small truck along with six, 70-pound suitcases brimming with gifts from America.

Touria's family has lived in the same neighborhood for many years. Recently they moved into a new house, built with money earned working many over-time hours in America. Touria's family lives upstairs; her husband's family lives on the first floor. The doors to both apartments are always open and family members drift comfortably between the two homes. Because of our visit, relatives came from far and near. When I woke up each morning, I never knew how many relatives would be there. The lilt of female voices chattering, all wanting to talk to their long-absent relatives could be heard throughout the home. I didn't understand a word of Arabic, but the happiness in that chorus of voices told me that there was a lot of joy and love present.

Meal time was a wonderful, community event. All the women seemed to have a part in preparing and serving the food. Each meal began with rituals acknowledging the respect and values that bonded this large, extended family. Tea, the traditional Moroccan drink was a staple at each meal. One of the women would bring a tray with glasses and a tea pot. The tea was poured in a formal ritual with the pot held high over the glass, the sweet liquid cascading down from the spout. Before eating, someone would bring around a kettle of water and a bowl for us to wash our hands. A large platter of food was placed in the middle of the table; everyone helped themselves, using pieces of bread to scoop up savory meats and fresh vegetables. The food was so flavorful, subtly infused with wonderful spices like cinnamon, paprika, cardamom and saffron. There was always plenty to eat no matter how many people came to the table. Laughter and camaraderie were ever present, and I always felt part of the group. We quickly learned to communicate with a few words, gestures and facial expressions.

Communication was a great source of entertainment between the



Touria Ghouache (left) and Beverley Cunningham

children and me. They were very curious about me and often tried to engage me in some way. We would play word games to try to learn each other's language. 'Thank-you' was the one word everyone seemed to understand. Yassim, Touria's 12-year-old nephew made a special effort to tell me, "I hope to travel in America." I was honored that he made such an effort to find words to speak with me in English—that memory is my favorite souvenir of Morocco.

Children ranged in age from two to 20. They were polite and friendly. They seemed to be happy and secure in their extended family. There was some rivalry among the younger children but everyone looked after one another. Coming from a home where my four-year-old grandson has more toys than he knows what to do with, I was very impressed at how few toys it took to entertain these children. They were so creative at making up games with

simple things like paper airplanes and make-shift jump ropes.

Marriage customs were very interesting. The reasons for getting married seemed to vary with the age of the girl. Touria's older sisters' marriages were arranged by their father. They were married in their early teens because their father thought it was best for women to have children while they were young. Touria's oldest sister had her first baby when she was 14. She is now a grandmother at the age of 44. A couple of siblings in their 20s work professionally and have not yet married. They plan to marry in the future because they want children and companionship as they grow older. Touria is the baby of her family. She was 26 when she married. She and her husband chose to marry when he won a lottery that allowed him to come to America with a wife. None of the typically romantic notions that

continued on next page

motivate courtship and marriage in our country influenced their decision to wed. They became a couple because their families had known each other as neighbors. They knew they shared the same values and goals and they respected each other. They are committed to each other and both work very hard to support their son and families who remain in Morocco. The married children of Touria's family continue to maintain strong bonds with their maternal relatives and involve them in the raising of their children.

On my last morning in Morocco I was awakened at 4:00am by the call to prayer that resonates from every minaret of every mosque throughout the country. As I lay quietly waiting for the family to stir, I heard a symphony of sounds: dogs barking, roosters crowing, donkeys braying, cars passing on the street below. The chorus was punctuated by the rhythmic clip-clopping of horses pulling flat-bed carts to market. This pre-dawn serenade was a reminder that this country had not

yet caught up with the fast-paced hustle-bustle of the twenty-first century. I found a kind of comfort in realizing that people can live without fast cars, fast foods, super markets and shopping malls. Perhaps it's the slower pace that allows people to appreciate the value of their traditions and families, and the sense of community that comes from working and living together and sharing limited resources.

At the airport as I prepared for my flight home, I got a sense of how Touria and her husband must have felt when they first arrived in America speaking very little English. I was frightened because I realized there was little I could do to communicate with the people I needed to interact with. For that short amount of time, I felt very vulnerable. I can only imagine feeling that way every day while attempting to find work or caring for a family. I have developed great respect for those who risk feeling alone, isolated, and helpless in order to make a better life for themselves and their families.

I could go on and on about the fascinating things I learned in Morocco. It was an incredibly rich experience despite the fact that few words were exchanged. I discovered that the people of this North African nation love their god and are proud of their history. They love to shop, eat sweets, go to the beach, and have coffee with friends. They love their families and are true to their friends.

I also learned something about myself. I realized that the things I take for granted (air conditioning, owning my own car, being educated in my primary language, receiving health care from knowledgeable and caring clinicians) are rare privileges for others. I found how much can be communicated and understood without words. I found that how a message is communicated can be more important than the words that are spoken. And most importantly, I came to understand that you have to suspend judgment and preconceptions and learn by experiencing. The results are so rewarding.



Touria (front left) with her family in Morocco

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When in doubt, ask...

—by Oswald Mondejar, Human Resources manager and disabilities coordinator

Even under the best of circumstances, visiting a hospital for care can be an intimidating experience. We often put these visits off for as long as possible to avoid the anxiety they inspire. For millions of Americans who have limiting disabilities, a visit to the hospital is even more daunting.

We all have questions when we arrive at a hospital for the first time. How do I get where I need to go? Where do I register? What kind of forms will I need to fill out? How long will I have to wait? How much time will I spend with the clinician? Add a visual, hearing, mobility, or

cognitive impairment to the mix, and fear and anxiety increase exponentially.

Just getting to an appointment can be like tackling an obstacle course. Transportation can be an issue. The physical layout of the building can present a number of challenges. Wheelchair access may not be available in all areas. Signage for blind and visually impaired patients may not exist. Assistance may be needed to fill out forms. What takes a 'normally' functioning person a few seconds could take a person with disabilities much longer; and there is an added level of frustra-

tion that accompanies these barriers.

Recently, the Council on Disabilities Awareness sponsored a panel discussion where individuals with disabilities were invited to talk with MGH employees about how their disabilities affect their day-to-day activities. Much of what was said enlightened audience members and brought a new perspective to the table.

Here are a few of the comments:

"As a blind person I find it difficult to navigate unfamiliar, open spaces (such as lobbies) without support.

I prefer to have registration information sent to me in advance so I can complete it in privacy instead of having someone assist me in a waiting room where others can hear my responses."

"I'm not deaf, but I am hearing-impaired, so I read lips. I can't read lips when people cover their mouths when they speak. In the waiting room when the receptionist calls a



Oswald Mondejar,
Human Resources manager

patient's name from behind a clipboard, I can't tell who she's calling. If no one gets up, I assume it must be me."

"As a wheelchair user I find many obstacles that impede my access to services. Public transportation is one of the worst. To get here today, I had to get off two stops away (because the MGH T-station is not equipped to handle wheelchairs) and propel myself through four city blocks over cobblestones and bricks. I'm glad I was able to get here, but I knew full well that when I got to the doctor's office it would be an ordeal to transfer from my chair to the exam table."

"My anxiety disorder can make it difficult for me to focus, and I'm easily distracted in busy places. So I try to avoid them."

These examples give us some insight into why a person with a disability might delay seeking medical help. Regardless of why an appointment was

made, often the disability becomes the focus in the mind of the clinician, and this can be an unwelcome distraction.

Individuals with disabilities ask that you see us as whole people with different ways of achieving similar objectives. Clearly, the world was not designed to accommodate the vast array of abilities shared by this population; so we adjust and plan ahead in order to participate fully in the everyday aspects of life. It's a responsibility that comes with the territory. When help is needed we're the first to know. If you think a person with a disability may need help, don't hesitate to offer assistance. Ultimately, we just ask that you see us as people.

I recently visited one of our clinics and when the exam was completed the nurse asked, "Can I assist you with buttoning your shirt?" Though I didn't need help, the offer was appreciated.

The best advice is... "When in doubt, ask."

Panelist at the Council on Disabilities forum shares his experiences as a person with disabilities navigating the healthcare system



Educational Offerings

October 7, 2004

When/Where	Description	Contact Hours
October 18 8:00am–4:30pm	A Diabetic Odyssey O’Keeffe Auditorium	TBA
October 20 1:30–2:30pm	USA Educational Series Bigelow 4 Amphitheater	---
October 21 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
October 21 8:00am–4:30pm	Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other Training Department, Charles River Plaza	7.2
October 22 7:30–11:30am and 12:30–4:30pm	Congenital Heart Disease Burr 3 Conference Room	4.5
October 25 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
October 25 and 26 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: Wellman Conference Room. Day 2: VBK601	14.4 for completing both days
October 26 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
October 27 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
October 28 1:30–2:30pm	Nursing Grand Rounds “Focus on Patient Safety.” O’Keeffe Auditorium	1.2
October 29 8:00am–4:30pm	Workforce Dynamics: Skills for Success Training Department, Charles River Plaza	TBA
October 29 12:00–3:30pm	Basic Respiratory Care Ellison 19 Conference Room (1919)	---
November 2 8:00am–12:00pm	BLS Certification—Heartsaver VBK 601	---
November 3, 4, 8, 12, 15, 19 7:30am–4:30pm	Greater Boston ICU Consortium CORE Program Days 1, 2, 3, 6 Wellman Conference Room. Days 4, 5, O’Keeffe Auditorium	44.8 for completing all six days
November 3 4:00–5:30pm	Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements Founders 626	1.8
November 4 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
November 5 8:00am–4:00pm	Healthy Behaviors: Coaching Your Patient to Success O’Keeffe Auditorium	---
November 8, 12 8:00am–5:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
November 8 7:00–11:am and 12:00–4:00pm	Congenital Heart Disease Burr 5 Conference Room	4.5
November 10 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
November 10 1:30–2:30pm	OA/PCA/USA Connections “Personal Safety: Services Offered by Police & Security.” Bigelow 4 Amphitheater	---

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>.

Caring for children with multiple medical issues

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tain his/her fullest potential.

At the MassGeneral Hospital *for* Children, we are ever aware of the needs of this population of children and families. Advances in medical technology and medical research have improved survival rates of children with a wide range of diagnoses. Nursing research demonstrates that with a family-centered approach to care, the child and family can be empowered to navigate the healthcare system and function effectively in the community.

Family-centered care recognizes the central role that parents, siblings, and significant others play in the lives of children. It supports alliances where families and professionals work

collaboratively, each bringing different knowledge and skills to the relationship. It's important to recognize the value of parents as integral members of the care team. It's equally important to help them cope with the stresses of parenting a child with multiple medical challenges. As part of our mission at MassGeneral Hospital *for* Children, we are dedicated to serving the pediatric community and realize that excellence in care is the result of an interdisciplinary effort requiring collaboration from all members of the care team. We advance our understanding of illness through innovative medical research and education, we are empowered by skill and technology, and we are motivat-

ed by a commitment to excellence in pediatric practice that is sincere and compassionate. (Mass General Hospital *for* Children 2002).

Different is beautiful, whether it's a difference in culture, ethnicity, religion, language, or our physical, emotional or mental lives. Differences, however, can be frightening... to medical professionals as well as the general public. Fear of differences is usually fueled by the unknown, the misinterpreted, or the misunderstood. It is the goal of the Diversity Committee to raise awareness and educate all around the issues of diversity. We must include the needs of children and families with chronic medical challenges in that work. We, as a committee, must learn more about this population, just as we would about any other diverse group.

MGH celebrates Pastoral Care Week

Imagining peace

Information tables, refreshments, and Filipino art display

**Wednesday, October 13, 2004
10:30am-2:00pm
Main Corridor**

Charlie King and Karen Brandow, musical storytellers and political satirists

**Wednesday, October 13, 2004
12:00-1:00pm
Main Corridor**

The Blessing Of The Hands

**Thursday, October 14, 2004
6:30-8:00am; 11:30am-1:00pm;
3:00-5:00pm**

The MGH Chapel, Ellison One

All are welcome

The MGH Chaplaincy seeks to meet the spiritual and religious needs of patients, families, and staff of all faith traditions and those of no religious affiliation. If you would like to speak to a chaplain, call the Chaplaincy directly at 617-726-2220 or ask your nurse to relay your request

The Chaplaincy has resumed Episcopal services in the MGH Chapel Tuesdays at 2:30pm

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