

Caring

November 3, 2005

HEADLINES

Inside:

Special Issue

Celebrating Diversity	1
Jeanette Ives Erickson	2
● Re-Connecting with our Diversity Agenda	
Deborah Washington	3
● GLBT; Another Aspect of Diversity	
Foreign-Born Nurse Group	4
Music Therapy	5
Ramadan	6
Clinical Narrative	8
● Sandra Pugsley, RN; Janice Erlandson, RN; and Carly Jean Francois, RN	
Culturally Competent Care ..	10
'May I Help You?'	11
Community Giving	13
Professional Achievements ..	14
Educational Offerings	15
Italian-American Heritage Day	16

Celebrating diversity: *from Rwanda to MGH and beyond*



Staff nurses, Sandra Pugsley, RN (left), and Janice Erlandson, RN, with young Rwandan patient (see story on page 8).

Reconnecting with our diversity agenda

When we first identified diversity as a priority for Patient Care Services, we made great strides in raising awareness, educating the workforce, focusing on culturally competent care, and creating an environment that is welcoming to all. As our patients, our community, and our world changes, we need to step back, re-evaluate our work, and create new strategies for the future. I want to work with everyone in Patient Care Services to be actively engaged in our diversity agenda.

The PCS Executive Committee recently held a retreat to revisit our strategic priorities and come to a consensus

about what issues are most important to us in these busy times. We spent a lot of time brainstorming about ways to improve communication, ways to improve patient and staff-satisfaction, and ways to re-connect with our diversity agenda.

We had an opportunity to hear from our director of PCS Diversity, Deborah Washington, who reminded us that there are still great disparities in the quality of health care received by minorities. "No one *thinks* they're treating patients differently based on race or ethnicity," she said, "but national studies show that disparities exist. So somewhere, something is wrong."

I think part of the issue may be that staff feel knowledgeable about different cultures and traditions, so they assume they're delivering culturally competent care. But we can't forget that culture is just one aspect of patient-centered care. We can't let what we broadly know about various cultures be the sole factor driving the care we provide to individual patients. Not all Catholics share the same interpretation of the Bible. Not all Muslims practice Islam the exact same way. Not all Chinese patients oppose organ donation and transplants.

It's good to have information about different cultures and traditions, but we can't let that knowledge take the place of getting to know each patient as an individual. There is no 'recipe' for culturally competent care; it emerges from the relationships we form with our patients and the understanding we develop about their individual needs.

In her remarks at the retreat, Deb cautioned us not to let our diversity program become 'window dressing.' Our commitment to diversity has



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

to live and breathe in each of us. If asked, how would you answer the question, "What is your personal involvement in our diversity effort?"

It's wonderful that we worked so hard and made such progress all those years ago, but we can't make the mistake of thinking that all the hard work is behind us. Diversity is an ongoing, day-to-day, moment-to-moment challenge that deserves our personal and professional best.

I thank you all for the extraordinary work you do every day. And I ask you to join me in re-committing to a strong diversity agenda where each of us has an important role to play. I ask you to accept the responsibility of treating all patients individually, equitably, and respectfully. I ask you to consciously think about what it means to be culturally sensitive, to

provide patient-centered care, to understand the unique experiences of each patient.

And if someone walks up to you and asks, "What is your personal involvement in our diversity effort? What are *you* doing to ensure that patients at MGH receive the same high-quality care regardless of age, race, gender, religion, socio-economic status, ability, or sexual orientation?" what will you say?

Thank-you for giving this important issue the attention it deserves.

Update

I'm pleased to announce that Fareeda Mahmoud has joined the Psychiatric Nursing Consultation Service.

Chelby Cierpial, RN, has accepted the position of clinical nurse specialist on the Cardiac Access unit.

Important Infection Control update

The MGH *Infection Control Manual* has been revised and updated. The 2005 manual includes new and updated policies.

Please discard the contents of your old infection control binder and replace it with the new, updated, 2005 information.

Infection Control Manuals should be maintained in clinical and research areas.

A limited number of yellow binders is available for areas that don't currently have an Infection Control Manual.

For more information or assistance, please contact the Infection Control Unit at 6-2036.

Gay, lesbian, bisexual, and transgender issues: another aspect of diversity

—by Deborah Washington, RN, director, PCS Diversity

Earlier this year, Patient Care Services presented the second in a series of educational offerings on the care of gay, lesbian, bisexual, and transgendered patients. The day-long session, entitled, “Gay and Lesbian Issues: Providing Care with Skill and Sensitivity,” was a rich source of information for professional practice and personal growth. Presenters included Thomas Lewis from the GLBT Health Access Project; Peter Bane from Beacon Hospice; Katrina Scott from the MGH Chaplaincy; Jon Schum from Dignity Boston; and Lisa Krinsky and Ed Ford from the GLBT Aging Project. The day provided an array of facts and perspectives on general care concerns of GLBT pa-

tients, end-of-life care, confidentiality, spirituality, and care of gay elders.

Diversity is a broad topic. It’s easy to forget that it includes more than just race and ethnicity. One aspect of diversity that requires more active learning on our part is sexual orientation. Our patients who are gay, lesbian, bisexual, and transgendered have a right to expect the same respectful and welcoming healthcare environment as any other patient.

‘Political correctness’ has helped us in some situations to avoid using language and actions that de-value or stigmatize. However, if those actions aren’t supported by actual principles and values, they will be seen as awkward and insincere. Embarrassment, uncer-

tainty, or feeling ill-at-ease caring for gay, lesbian, bisexual, or transgendered individuals allows that person’s sexual orientation to overshadow a fuller understanding of his or her life and needs. Sexual identity should not be allowed to eclipse other important health information. Individual values and beliefs, concerns about a particular disease, personal support networks, and hope for recovery are essential to every health assessment and admission interview. We must be mindful that these aspects of GLBT life carry equal significance. Once the

statement, “I am gay,” or “I am lesbian,” is spoken, it shouldn’t relegate everything else to a vague afterthought or less-important factor of that person’s life. This is an important distinction when trying to develop an open and meaningful connection between a clinician and a GLBT patient.

The relationship between a patient and his or her healthcare professional is not a social one. It shouldn’t be compromised by social judgments and biases. Nor should limitations of care result from those biases.

I’ll always remember one participant in a discussion on diversity who, when asked to divulge his/her sexual orientation, said, “Yes, I have a sexual orientation.” It’s pretty simple. We all have a sexual orientation. Our sexual orientation is part of our biological and psychological identity. That information is relevant to healthcare professionals in order to be able to make an informed assessment and appropriately provide for the needs of each patient.

It’s up to us as clinicians to create an environment that is safe and respectful. Signs clearly indicating that GLBT patients are welcomed should be in plain view. Patient-education materials, marketing materials, policies and procedures that embrace the full spectrum of interpersonal re-
continued on page 7



Deborah Washington



Vincent Licenziato



Thomas Lewis



Lisa Krinsky

Foreign-Born Nurse Group: supporting nurses educated in other countries

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

On September 27, 2005, the Foreign-Born Nurse Group presented, “The Nursing Licensure Process in Massachusetts for Foreign-Born Nurses,” sponsored by The Boston Private

Industry Council and hosted by the PCS Diversity Steering Committee and the Foreign-Born Nurse Group. The session provided a summary of the Foreign-Born Nurse Program, which is designed to support foreign-

educated nurses with updated information about available resources.

Claribell Amaya,

RN, Ivonny Niles, RN, and I presented, “Clinical and Mentoring Support for Foreign-Born Nurses 2003 and Beyond.” The presentation explained our mission to assist in supporting and mentoring foreign-born nurses as they enter the workforce.

The Foreign-Born Nurse Group was formed a few years ago to give nurses born and educated in other countries a voice and a support network. MGH had committed to

increasing diversity in the institution at all levels. To help meet that goal, we created a group that would focus exclusively on supporting foreign-born nurses. We found that few foreign-born nurses were licensed in the United States; others were working in nursing support positions while studying for their license; and still others had no idea how to begin the process. We wanted foreign-born nurses to know that they were welcome and valued at MGH. As a group, we are committed to helping foreign-born nurses achieve their career goals and find the best work environment for their individual goals

and aspirations.

As of April, 2005, there are 2,575 nurses in Patient Care Services. 92% describe themselves as white; 8% describe themselves as Asian, American Indian, African American, or Hispanic. Currently, 37 nurses at MGH and 7 PCAs (or CCTs) identify themselves as foreign-educated nurses.

Representatives from a number of hospitals attended the workshop to learn more about how to assist foreign-born nurses in the licensure process. A highlight of the day was Claribell Amaya’s account of her experience as a nurse coming to the United States from Honduras. Following are excerpts from her remarks:

My name is Claribell Amaya, and I am originally from Honduras, in Central America. My journey started when I decided to move to the United States as a single mother with two children (ages 14 and 4). I was a registered nurse in another country, but without a US license. And with the language barrier, it was very difficult to continue on this path. Thanks to a wonderful family and the values they adhere to, doors were opened to my family and me.

I started working as a housekeeper and signed up for ESL classes at the Salvation Army. It wasn’t easy adjusting to a new culture, new language,

continued on page 7



Kathleen Myers, RN (left), and members of the Foreign-Born Nurse Group (right) at recent seminar to support foreign-born nurses



(Photos by Michelle Rose)

Music: the universal language

—by Lorrie Kubicek, music therapist

In 1835, Henry Wordsworth Longfellow wrote, “Music is the universal language of mankind...” Music can reach people of all ages, cultures, and cognitive abilities. Music therapy is a healthcare profession that utilizes the unique qualities of music to establish connections; address physical, emotional, cognitive, and social needs; and improve quality of life. In my work as a music therapist at the MassGeneral Hospital for Children, I’ve been privileged to see how music transcends many of the barriers that separate us from one another.

My experience with ‘Charlie’ and ‘Matt’ is

one example. Matt and I spent about an hour together, making music and recording it onto a CD. At the end of our session, Matt noticed Charlie sitting on the sidelines. “Let’s see if Charlie wants to make some music with us,” he said. For the next 15 minutes the three of us sat together and created a song. The boys exchanged rhythms and themes, following each other’s dynamics and tempo shifts, all the while laughing and singing. That kind of exchange happens all the time in music therapy sessions. But there was something remarkable about this particular session. Charlie was a one-year old baby, not yet walking or

talking, and Matt was an extremely articulate six-year-old. The clinical music they created in this session gave these two boys a foundation on which to create a relationship. With no words, Matt and Charlie understood what the other was doing because each of them knew and lived in music.

Down the hall, a 13-year-old girl is a recent immigrant from South America. Neither she nor her mother speak English, yet within a minute, three instruments are placed before her, choices are made, and music begins. In five minutes, everyone in the room is singing. And by the end of the session, we’ve

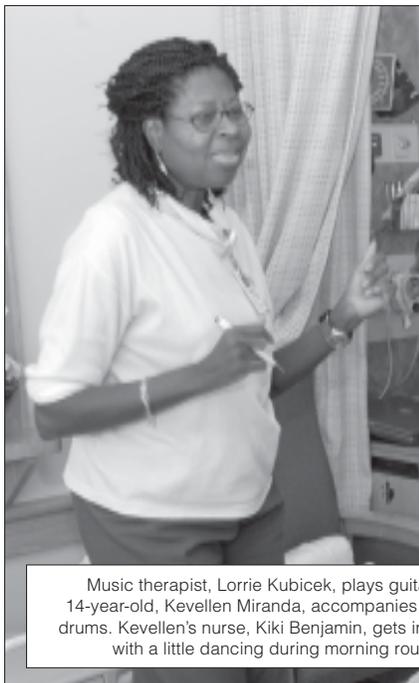
written three new songs and learned to say hello, good-bye, drum, guitar, thank-you, music and friend in another language. In this case, music not only set the stage for establishing a relationship between therapist and patient, it helped this child find familiarity and comfort in the unknown.

‘Valerie’ is a teenage girl with severe, profound developmental delays. She has no verbal language, is confined to a wheelchair, and often needs to be hospitalized for upper respiratory infections. My job as a music therapist is to take what Valerie *can* do and support and develop those abilities with music. Valerie’s breath becomes the rhythm. In the spaces of the music, she begins to vocalize, soft sounds at first, then, as she hears herself reflected in the song, they get louder and

more purposeful. Her body begins to move. A tambourine is placed by her pillow and at the foot of her bed. The spastic movement of her arms and legs is encouraged and given meaning by the music created as she makes contact with the instruments. She hears and feels herself in the music. In this session, every movement, every breath, every vocalization communicates pieces of who she is.

In 1835, Longfellow wrote about the universality of music. Every week, at MassGeneral Hospital for Children, patients and families prove him right.

Lorrie Kubicek provides music therapy to adult and pediatric cancer patients through the MGH Cancer Center HOPES Program. For more information, call 617-72-HOPES (or 617-724-6737).



Music therapist, Lorrie Kubicek, plays guitar while 14-year-old, Kevelen Miranda, accompanies her on the drums. Kevelen’s nurse, Kiki Benjamin, gets in on the fun with a little dancing during morning rounds.

Ramadan: a celebration, an education

—by Firdosh Pathan, RPh, member of the PCS Diversity Committee

In the spirit of unity and community-building, the PCS Diversity Steering Committee, together with the MGH Chaplaincy and Muslim employ-

ees, organized an Iftar (breaking of fast during the Holy month of Ramadan) on October 12, 2005. For the past five years the MGH community has joined Muslim

patients, family, staff, and friends to celebrate Ramadan.

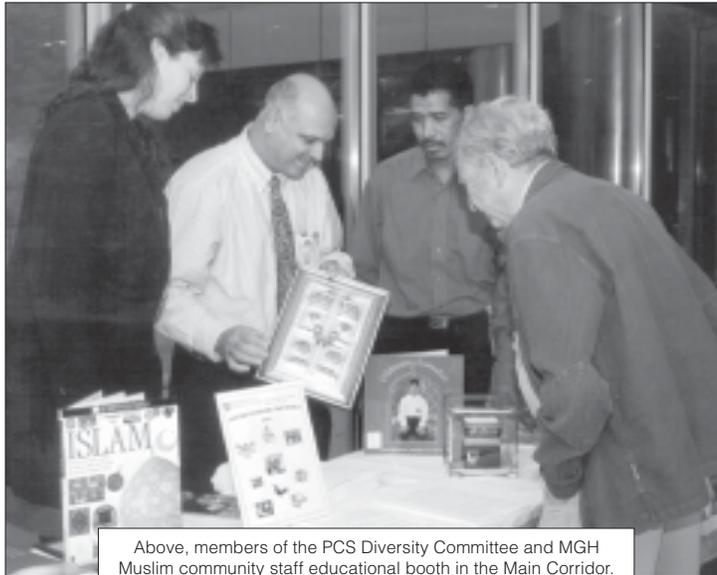
Ramadan is a special month for more than 1.2 billion Muslims around the world. It's a time for

inner reflection and devotion to God. Ramadan is the ninth month of the Islamic lunar calendar, which began this year at sundown on October 3rd. During Ramadan, healthy Muslim adults and many children fast from dawn until sunset for 29 or 30 days. They do not eat or drink during daylight hours, and smoking and

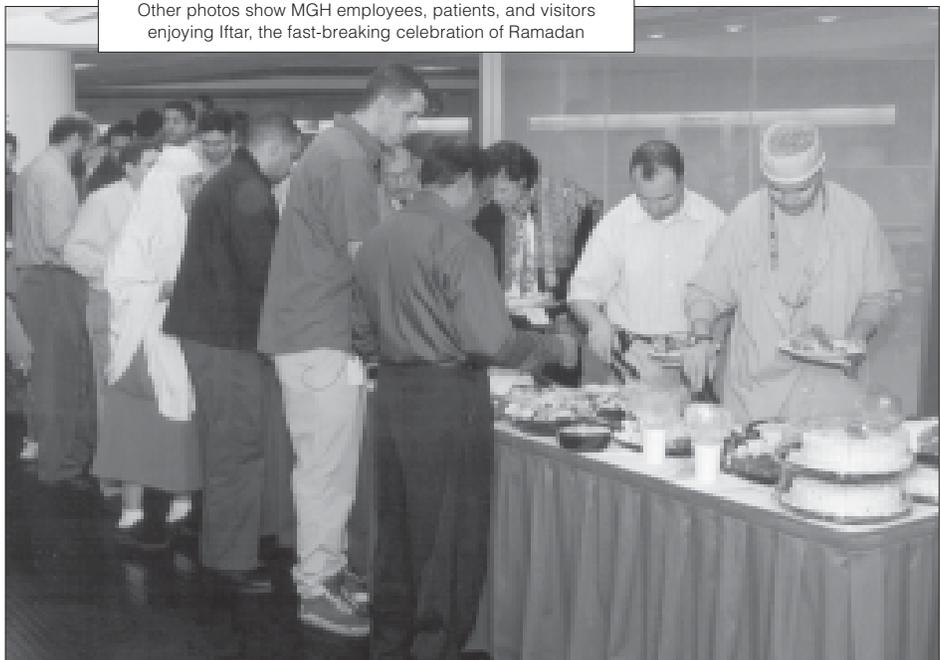
sexual relations are forbidden. At the end of each day the fast is broken with prayer and a meal called the Iftar. During Ramadan, Muslims perform good deeds such as offering more prayers, giving more to charity, giving up bad habits, improving family relations, visiting each other, and helping the poor and

sick. Ramadan is a 'training month' for Muslims to become better Muslims. The elderly and expectant mothers may abstain from performing rituals. In recognition of the Holy month, the elderly may observe the holiday by feeding a person in need every day for a month. Expectant mothers may choose to observe the fasting tradition at another time of the year.

continued on next page



Above, members of the PCS Diversity Committee and MGH Muslim community staff educational booth in the Main Corridor. Other photos show MGH employees, patients, and visitors enjoying Iftar, the fast-breaking celebration of Ramadan



(Photos by Abram Bekker)

Celebrating Ramadan

continued from previous page

The purpose of Ramadan and the fasting tradition is to help Muslims acquire self-control, discipline, generosity, and God-consciousness by eliminating impurities from the body. Because Ramadan is a lunar month, it begins approximately eleven days earlier every year.

At the end of the holy month, Muslims celebrate Eid-ul-Fitr, the festival of fast-breaking,

which will take place this year on November 4th or 5th (to be determined by the sighting of the moon). Muslims celebrate Eid-ul-Fitr by visiting each other and performing more charitable deeds. It is also a time of gift-giving for the children.

Muslims follow the Islamic religion, the religion revealed to the Prophet Muhammad, peace be upon him (pbuh). Muslims believe that

Muhammad (pbuh) was the last messenger. Islam began as a way to reinforce the religion of God (Allah, in the Arabic language) that was revealed through prophets and messengers (Adam, Nooh (Noah), Ibrahim (Abraham), Yakoub (Jacob), Youssef (Joseph), Iss-haq (Isaac), Moussa (Moses), Haroon (Aaron), Yahia (John the Baptist), Issa (Jesus) and Muhammad, peace be upon them all.

Muslims generally celebrate Ramadan with family members, but many patients and staff are far from their families during this time. The Eid-ul-Fitr celebration, open to all patients, fam-

ilies, and staff, was an opportunity for Muslims to feel part of a larger community, to break fast with other Muslims and friends. Muslim patients, families, and staff were thrilled to have this chance to share Iftar with the MGH community.

During Ramadan, group prayers will take place in the Muslim prayer room in Founders 109. For more information about prayer times, or to learn more about Ramadan, send e-mail to: teid@partners.org, or fpathan@partners.org.

GLBT Issues

continued from page 3

relationships are ways we can show our commitment to equity in health care. Friends, families, and partners of GLBT patients should experience a gay-friendly environment when they come through our doors.

Ensuring a positive and welcoming experience for GLBT patients can be achieved through raised awareness and a willing, knowledgeable staff. New information, understanding gained through dialogue, and educational sessions help set the stage for more open clinical encounters that benefit patients and healthcare professionals alike.

The biggest stumbling block in caring for GLBT patients is a lack of self-confidence in asking relevant questions and documenting an-

swers. Fear of offending often makes clinicians hesitate to ask for information necessary to manage good health, sexuality, self-concept, stress, relationships, physical and emotional safety, and reproductive health. Clinical competence requires that every health professional be capable of demonstrating the skill and knowledge necessary to meet the care needs of all patients, including GLBT patients.

Providing culturally competent care to the GLBT community requires our full attention and an understanding of the specific issues and unique concerns they face. Professional integrity and fairness compel us to develop our knowledge and clinical practice to reflect the best we have to offer to patients who are gay, lesbian, bisexual or transgendered.

Foreign-Born Nurse Group

continued from page 4

food, etc., but it wasn't impossible. My goal was to become a bilingual nurse in the United States and make a difference within the Spanish population. It's frustrating to be sick and unable to speak the language, not knowing if you are receiving the right treatment.

While visiting my parents in the states, my daughter came down with food poisoning and had to be admitted to the hospital. She spoke English, so staff was able to communicate with her, but my experience was very different. There was no Spanish interpreter available, so staff excluded me. I felt ignored,

hurt, and disappointed. This experience only made me want to reach my goal faster.

The process of becoming a registered nurse in the United States when you are from another country is overwhelming, but not impossible. I worked as a CNA, while taking ESL classes and earning my requirements to apply for a nursing license. Finally, I was ready to apply. I remember how draining it was on so many levels: emotional, financial, physical, and family.

The day finally arrived when I received my nursing license in the mail. I was so happy. I came to MGH as a PCA,

then my nurse manager hired me as a nurse. I wanted to support and encourage others who came from different backgrounds and cultures. I joined the PCS Diversity Committee and soon became part of a group called the Foreign-Born Nurse Group.

It is still very fresh in my memory—the first day I started working as a nurse. I'm very grateful and proud of what I accomplished. It was worth it.

If you are a Latino nurse who needs help becoming licensed in the United States, please don't hesitate to do it. The Foreign-Born Nurse Group can help.

For more information about the Foreign-Born Nurse Group, Call Kathleen Myers at 6-5319.

An extraordinary team cares for an extraordinary young girl

Sandra Pugsley, Janice Erlandson, and Carly Jean-Francois are clinicians in the PCS Clinical Recognition Program

My name is Sandra Pugsley, and I am writing this narrative on behalf of myself and my colleague, Janice Erlandson. Throughout the years working on the Adolescent Pediatric Unit at MassGeneral Hospital for Children, I've had the privilege of meeting many amazing young people. Children with cancer diagnoses always inspire me with their resilience, courage, and strength. Claudine is one of those children who's taught me more life lessons than you would have thought possible of any 14-year-old girl.

Claudine came to MGH from Rwanda. Her trip was made possible after meeting a health-care provider from the Partner's network while living in a Rwandan orphanage. Claudine had been through many health-related challenges and ordeals, and it was felt that she might be able to find treatment in the United States that wasn't available in her country.

Claudine's life had been difficult from the beginning. Her father was killed during a civil uprising eight years ago; several of her siblings were taken from their home and are missing to this day. Claudine, a bro-

ther and sister, and her mother were brought to a refugee camp where her mother died of malaria a week after arriving at the camp. Claudine was six years old.

Claudine was placed in an orphanage with her remaining siblings, where despite the odds, she thrived for six years. At 12, Claudine developed intractable leg pain. After multiple hospitalizations in Rwanda, Claudine was diagnosed with osteogenic sarcoma (OSA). In Rwanda, the only treatment for OSA is amputation. Claudine's left leg was amputated above the knee.

Studies show that children with osteogenic sarcoma treated with amputation and no chemotherapy have only a 20% survival rate. Since coming to MassGeneral Hospital for Children, Claudine's care has included chemotherapy, the introduction of a prosthetic leg, and rehabilitation.

I first met Claudine when she was admitted to our unit; at that time her healthcare needs seemed insurmountable. Claudine was here without any family, she spoke no English, and had no place in America to live. To say that her support system was minimal is an understatement. But what

she lacked in resources, she more than made up for in hope and tenacity. And she had a smile that could light up a room.

Claudine had come to the United States with an American missionary named Martha. In Rwanda, Martha had taught English, so she acted as an interpreter for us until a medical interpreter familiar with Claudine's dialect could be found. Martha planned to stay with Claudine for two weeks and then return to Rwanda. Martha worked with Claudine, her nurses, and speech therapist to help establish a communication system. The speech therapist provided a communication board that had pictures and symbols that Claudine could point to. Martha translated a number of English words and phrases into Kinyarwanda for us. She spelled them phonetically so they would be easier for us to pronounce. These interventions were very helpful, but like everything else Claudine did, she learned to speak and understand English in a very short time. Her English was much better than my Kinyarwanda, so I tended to use a lot of non-verbal gestures to let her know how much I cared for her and hoped she felt safe.



Sandra Pugsley, RN (left), and Janice Erlandson, RN staff nurses, Ellison 18 Pediatric Unit

As Claudine became more familiar with her new environment, she opened up more and more and began to share her story. I felt such compassion and respect for what she'd been through. I was happy she was getting this opportunity for a longer, better life.

Before Claudine could begin chemotherapy, she had to have a thoracotomy to remove some metastasis from her lungs. Her surgical experience was not easy; she experienced a lot of pain post-operatively with the placement of a chest tube. My most meaningful nursing intervention during that time was my presence. I scheduled time to just 'be' with Claudine. I knew she needed to feel compassion and caring. Even if I couldn't communicate with her verbally, I could hold her hand and let her know I was there for her.

Everyone on the team was drawn to Claudine and her beautiful smile. She looked at life, new things, and America with

a sense of wonder. Everyone on the team, from child life specialists to unit service associates, to dietitians and doctors, went out of their way to make Claudine feel welcome and safe. I really believe it was that team approach that enabled Claudine to overcome so many of the issues that at first seemed insurmountable.

With maturity and intellect beyond her years, Claudine took an active role in her care, asking many questions about her treatment and the care plan. Claudine's care was provided by a core group of clinicians so she could easily identify her caregivers and develop a sense of trust.

When a medical interpreter was found, she was called frequently to explain new procedures or treatments, to be sure Claudine understood everything that was being said and done. Child life specialists scheduled time with her every day. They showed her how to

continued on page 12

When I was in Rwanda, I was very sick. When I went in the hospital from Rwanda, they couldn't find the medicine to make me feel better.

They brought me to Boston to the Mass General Hospital. In that hospital, there were two nurses named Sandy and Janice. They have taken care of me since the first time I went into the hospital.

And there was a doctor named Dr. Ebb. He takes care of me every day, and the first time I was in the hospital he was there, too.

And every day when I go into the hospital, they are always there to take care of me.

When I am in the hospital, they never forget me.

Sandy, Janice, and Dr. Ebb are always thinking of me. Even when it was my birthday, they brought me a cake. That was a good thing for me.

I will always remember them.

The End.



**14-year-old,
Claudine Humure**

Story-telling, a powerful teaching tool for culturally competent care

—by Brenda Miller, RN, nurse manager, Pediatric Intensive Care Unit

The age of technology brings with it a feeling that the world is shrinking. It's easy to see that our work as healthcare professionals is changing. The number of staff who volunteer to provide humanitarian aid in underserved areas is growing; many healthcare providers at MGH spend a significant amount of time caring for patient in other countries. As this trend continues, the need for culturally competent care becomes even more important.

American-born nurse, Kelly Nelson, RN, and

her husband, ordained minister, Robert Nelson, work in the Dominican Republic providing health care in a number of mobile clinics they've established under very primitive conditions.

In August, the Nelsons came to MGH to present at a forum co-sponsored by the Foreign-Born Nurse Group, the Chaplaincy, and myself. They talked about an environment where surgery is routinely cancelled due to a lack of sterile gloves; there are critical shortages of medications; and people die from parasitic dis-

eases. In their clinics, there's no such thing as 'trash' because everything is recycled or put to

some use. Despite the lack of resources the Nelsons are optimistic about their work and are making significant changes in the Dominican.

The Nelson's model brings medical care to natives in their villages and schools. It works because there is a mutual

acceptance and sharing of cultures (American, Dominican, and Haitian). The model seeks to educate and empower indigenous leaders by setting an example of a strong work ethic, effective self-governance, and valuing education. The Nelsons believe that if they can

continued on next page



Above: In an effort to improve the quality of life for residents of the Dominican Republic, Kelly Nelson, RN, of Island Impact Ministries administers primary care in schools in the Dominican Republic.

At left: With other volunteers, Brenda Miller, RN, nurse manager of the Pediatric Intensive Care Unit and Pediatric Ambulatory Care, saw more than 300 patients in villages and schools. In this village 100% of the patients seen required treatment.



(Photos provided by staff)

'May I help you' cards now available in different languages

Sometimes, even veteran employees have difficulty finding their way through the corridors of MGH. Imagine the challenge for a newcomer who's unfamiliar with the layout and doesn't speak or read English. Navigating the buildings of MGH under those circumstances can be daunting.

Interpreter Services receives more than 800 calls a week; approximately half of them are simple requests for basic information such as directions to and from appointments.

In an effort to more

fully meet the needs of non-English-speaking patients, family members, and visitors, The PCS Diversity Committee applied for, and received, a grant from the MGH Making a Difference Program to expand on the existing 'May I help you' initiative. The committee produced easy-to-read cards that say, 'Welcome' in 19 different languages. Any MGH employee who has the language skills to offer basic information or assistance (not including medical interpreting) in another language can request a card. The hope is that non-English-speaking visitors will see the cards and



feel comfortable asking for help.

For more information, or to receive a card, call Judy Newell at 4-5820; Beth Nolan at 6-4248; or Donna Perry at 4-0430.

Culturally Competent Care

continued from previous page

keep children in school, the quality of health care will eventually improve.

Clinics are held once a month in schools where children receive primary care for free. Other mobile clinics are held on sugar cane farms and in other locations accessible to the locals.

The Nelsons have found that using storytelling as a teaching tool makes cultural lessons easier to understand and apply. Kelly shared a story about a young Hai-

tian woman whose son had died. When she delivered her second son, she dressed him as a girl to fool the evil spirits so they wouldn't take him, too.

That story reminded me of a situation in the Pediatric Intensive Care Unit several years ago. In our ignorance of Haitian customs, we had counseled a Haitian woman not to dress her son as a girl anymore. It wasn't our usual practice to think of evil spirits as a cause for behavior we perceived as

'odd.' In retrospect, we would have handled that situation much differently had we understood more about the Haitian belief system.

Our ability to practice culturally competent care depends on our ability to see possibilities outside our own way of thinking. As the world gets smaller and our work expands into areas we never thought we'd be, we need to pause and listen to the stories. We can learn to give culturally competent care but only if we stop long enough to ask the questions and listen to the stories.

The Employee Assistance Program Work-Life Seminars

presents

"Working and Breastfeeding"

Presented by

Germaine Lamberge, RN, IBCLC
lactation consultant

Presentation will provide expectant mothers and nursing parents the basics on how to use breast pumps and how to maintain a milk supply while working. Identifying and resolving potential problems will be discussed.

Tuesday, November 8, 2005

12:00-1:00pm

VBK401

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

Clinical Narrative

continued from page 8

e-mail the orphanage in Rwanda and taught her other computer skills.

Now, Claudine leaves and is re-admitted to MGH every few weeks for on-going treatment. Child life specialists always have a welcome sign waiting for her when she returns, as well as a few special DVDs, and her favorite stuffed animal.

Claudine has a gentle soul that reaches out and touches people when they meet her. Claudine was introduced to a wonderful family that has welcomed her into their home and given her a place to stay when she's not in the hospital. With this new support system in place, Claudine has begun to blossom and enjoy American culture.

I notice such a change in Claudine when she returns for her treatments.

Her 'American mom' has taught her enough English to carry on a conversation. She is so excited by new discoveries, like French fries, pizza, and salt!

Claudine's American mom has been encouraging her to write the story of her life. Claudine has started writing, and as she has become more secure with us, she has shared her stories, which is a true privilege. I continue to be in awe of this young girl who has survived and prospered and continues to be so happy and optimistic.

I look forward to Claudine's visits and the opportunity to care for her during her treatments. I'm honored to be part of the extraordinary team that is supporting this extraordinary girl through this extraordinary experience.

Submitted by Carly Jean-Francois, RN, Claudine's night nurse

As a nurse at MGH for eight years, I've had the opportunity to work with and care for people from all over the world with different backgrounds and experiences. Many patients have touched my life with their struggles and their strength, but none has impacted me as strongly as my dear young friend, Claudine.

Before meeting Claudine, I had been informed of her family history and prior medical treatment. I was sure that when I met her I'd see a small, weak, child, overwhelmed by the hard life she had led. But when I met her, I was amazed to see a strong, young girl with a smile that captured my heart.

I recall one night when Claudine wasn't feeling very well, but she was trying to be strong. I sat with her, and we talked about some movies and television shows she liked. We chose a couple of movies and stayed up late watching them, talking, and laughing. That night was memorable for me because I remembered how shy Claudine was when she first came to MGH and how little English she spoke. To see her laughing and talking so clearly and openly (in English) brought a smile to my face and to my heart.

I believe the level of care and the love and support Claudine received from her MGH caregivers is what made the biggest difference in her



Carly Jean-Francois, RN
staff nurse, Ellison 18 Pediatric Unit

recovery. Showing her how special she was and how much we cared about her as a person made her feel comfortable and enabled her to progress more rapidly in her treatments.

A few weeks ago she let me watch her sing and play the guitar during one of her music therapy sessions. I don't think she would have let me do that when she first arrived.

It's not often that you come across a patient as special as Claudine. She showed me how to look at my family, my friends, and my life, and truly appreciate the gifts I've been blessed with. Claudine taught me the true meaning of the phrase, "The best things come in small packages." Caring for the beautiful, strong, little package named Claudine has been one of the most rewarding experiences in my life.

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

Claudine's arrival brought staff face-to-face with events many of us only hear about on the news. Sandra, Janice, and Carly describe a young girl traumatized by war, but able to feel hope and trust in an unfamiliar country half-way around the world from where she calls home. These three nurses and their colleagues bridged the language and culture gap with interventions like the communication board and limiting her care to a core group of clinicians to allay her fears and help build trust. But the most powerful intervention was just being there for her—spending time, laughing, sharing stories, watching movies. These are the things that are important to a 14-year-old girl; these were the things that meant so much to Claudine as she recovered from an experience no 14-year-old should have to endure.

Thank-you Sandra, Janice, and Carly.

PCS News and Information website

Patient Care Services has developed a News & Information website.

The site includes links to articles in the news about PCS staff and programs; annual reports; video clips; photographs; information about upcoming events and educational offerings; and a link to current and back issues of *Caring Headlines*.

Visit the PCS News & Information website at:
http://pcs.mgh.harvard.edu/News/News_Index.asp.

For information about the PCS News & Information website, contact Georgia Peirce at 4-9865

MGH community embraces Somali Bantu refugees

—by Kathleen Healey, CPNP, Chelsea HealthCare Center

Last year, the Chelsea Health-Care Center Refugee Health Assessment Program received more than 50 families from refugee camps in Kenya. These families were members of the Bantu tribe of Somalia and had been living in refugee camps for many years after being driven from their homes by war.

Our Somali Bantu visitors had lived nomadic lives, never exposed to modern conveniences like electricity, refrigerators, and telephones. The families were large, many with four or more children. When they arrived in Chelsea in late fall, they were ill-prepared for the winter that was fast approaching.

In October, HAVEN staff coordinated a shoe and boot drive to collect warm footwear for the children. We measured their feet, allowing room for socks. Staff purchased sneakers, boots, and socks, and received donations from local shoe stores. We were able to provide winter footwear for all the children and most of the adults.

Our next concern was outerwear. We had collected and distributed warm coats to those in need in the past, but this sudden influx of Bantu families was daunting. More than 175 children and adults needed cold-weather clothing... and fast! We approached the Patient Care Ser-

vices Diversity Committee to assist in providing coats and warm clothing for our newest patients who would soon be citizens. Diversity Committee member, Beverley Cunningham, put out a call for help, and the response of the MGH community was overwhelming.

In November, and again in December, truckloads of donations arrived—and it was more than just clothing. Many units adopted Somali families as part of the Diversity Committee's holiday gift-giving event. Gifts were distributed on a snowy Saturday in December. Families snuggled into new coats and hats and were very thankful for the generosity of all who had participated. This is just one example of the commitment, community spirit, and tradition of giving that drives the MGH family.



Members of the PCS Diversity Committee and others in the MGH community at last year's annual gift-giving event

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Submission of Articles

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

Next Publication Date:

November 17, 2005



Carroll elected to European Society of Cardiology

Diane L. Carroll, RN, clinical nurse specialist, Coronary Care, has been elected to the European Society of Cardiology as a nurse fellow (NFESC).

Levin presents

Barbara J. Levin, RN, staff nurse, Orthopaedics, presented, "Fractured Foundations," to the Massachusetts Nurses Association, in Canton, in September.

Jampel presents

Ann Jampel, PT, physical therapist, presented, "Education Strategic Planning Group for the Year 2020," at the American Physical Therapy Association Department of Education in Washington, DC, August 21-22, 2005.

PCS staff recognized by QuadraMed

Christina M. Graf, RN; Sally Millar, RN; Charlene Feilteau, RN; Paul Lindquist; Janet Madigan, RN; and Nancy McCarthy, RN, received the Richard C. Jelinek Vision Award in recognition of outstanding innovative use of information systems in the field of Nursing at the annual QuadraMed Users Group meeting in September.

Rowell receives award for excellence

Pat Rowell, director of MGH Volunteer Services, received the 2005 American Society of Directors of Volunteer Services (ASDVS) Award for Excellence at the ASDVS Annual Meeting in Minneapolis. The award recognizes individuals who have demonstrated exemplary service and contributions to the society and the profession of healthcare volunteer management. Rowell was selected for her strong leadership serving as ASDVS president, traveling the world educating others about volunteerism, and her work on committees at the local, state, and national levels, including the Points of Light Foundation and America's Promise with former Secretary of State, Colin Powell.

Lucas publishes

Michele R. Lucas, LICSW, social worker, published, "Hyper-Vigilance: a Contributory Factor in Cancer Fatigue," in the September/October 2005 issue of *Coping with Cancer*.

Carroll and Rankin publish

Diane L. Carroll, RN, clinical nurse specialist, and Sally H. Rankin, RN, published, "The Testing of Nursing Interventions in Older Unpartnered Adults After Myocardial Infarction," in the September, 2005, issue of *European Journal of Cardiovascular Nursing*.

Samatis presents

Kristen Samatis, CHES, health educator in the Blum Patient & Family Learning Center, presented, "State of the Art Computer and Website Technology in a Consumer Health Library Setting," at the Health Care Education Association, in St. Louis, September, 2005.

Carroll, Hamilton publish

Diane L. Carroll, RN, and Glenys A. Hamilton, RN, published, "Response to P. Draper (2005) Commentary on Hamilton, G et. Al. (2004)" in the September, 2005, issue of the *Journal of Clinical Nursing*.

Bolton, Mannix, McManus present

Rachel Bolton, RN, staff nurse; Catherine Mannix, RN, nurse manager; and Patricia McManus, RN, staff nurse, in Radiation Oncology, presented, "Beam Me Up: Proton vs. Photon Radiation," at the Association of Pediatric Oncology Nurses, in Portland, Oregon, in September.

Amaya, Myers, and Niles present

Staff nurse, Claribell Amaya, RN; nurse manager, Kathleen Myers, RN; and staff nurse, Ivonny Niles, RN, presented, "Clinical and Mentoring Support for the Foreign Born Nurse: 2003 and Beyond," at Strategies to Address the Nursing Shortage sponsored by the PCS Diversity Committee.

Michel appointed chair of the faculty

Theresa Michel, PT, physical therapist, was appointed chair of the faculty at the MGH Institute of Health Professions from September, 2005, to August, 2006.

Peterson appointed to Health Policy Committee

Gayle Peterson, RN, staff nurse, General Medicine, has been appointed to the Health Policy Committee of the Massachusetts Association of Registered Nurses.

Squadrito receives Emerging Leader Award

Alison Squadrito, PT, physical therapist, received the "Emerging Leader Award" from the American Physical Therapy Association Section on Geriatrics, in Alexandria, Virginia, in August.

Ives Erickson appointed to Editorial Advisory Board

Jeanette Ives Erickson, RN, senior vice president for Patient Care Services and chief nurse has been appointed to the Editorial Advisory Board of *Nursing 2005* beginning September, 2005.

Millar presents

Sally Millar, RN, director, Office of Patient Advocacy and Patient Care Information Systems, presented, "Information Systems: Planning, Purchasing, Implementing," and "Development of a Patient Advocacy Program," at the American Association of Critical-Care Nurses National Teaching Institute, in New Orleans.

Fitzmaurice receives Alumni Achievement Award

Joan B. Fitzmaurice, RN, director of the Office of Quality & Safety, received the Alumni Achievement Award for Health from Boston College Alumni Association on September 29, 2005. Fitzmaurice was recognized for her leadership at a premier international teaching hospital and her role in educating medical practitioners.

Educational Offerings

November 3, 2005

When/Where	Description	Contact Hours
November 16 4:00–5:00pm	More than Just a Journal Club Thier Conference Room	1.2
November 17 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
November 17 1:30–2:30pm	Nursing Grand Rounds “Caring for Victims of Sexual Assault.” O’Keeffe Auditorium	1.2
November 18 8:00am–4:30pm	Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza	8.1
November 18 12:00–1:00pm	Schwartz Center Rounds Walcott Conference Room	---
November 18 TBA	Ethics Program O’Keeffe Auditorium	---
November 23 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
November 28 8:00am–4:30pm	Special Procedures/Diagnostic Tests: What You Need to Know O’Keeffe Auditorium	TBA
December 1 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
December 1 7:00am–12:00pm	CVVH Core Program Yawkey 2220	6.3
December 2 8:00–2:30pm	Pre-ACLS Course O’Keeffe Auditorium \$100. (to register e-mail: ccatt@partners.org)	---
December 2 8:00–2:00pm	Pre-ACLS Course O’Keeffe Auditorium \$100. (to register e-mail: ccatt@partners.org)	---
December 5 8:00am–4:30pm	Coronary Syndrome O’Keeffe Auditorium	TBA
December 6 and 9 8:00am–4:00pm	Oncology Nursing Society Chemotherapy-Biotherapy Course Yawkey 2220	16.8 for completing both days
December 7 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
December 7 8:00–11:45am	Intermediate Arrhythmias Haber Conference Room	3.9
December 7 12:15–4:30pm	Pacing Concepts Haber Conference Room	4.5
December 7 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
December 12 8:00am–4:30pm	Intermediate Respiratory Care Respiratory Care Conference Room, Ellison 401	TBA
December 14 11:00am–12:00pm	Nursing Grand Rounds “Pulmonary Hypertension.” Sweet Conference Room GRB 432	1.2
December 15 8:00am–4:30pm	Workforce Dynamics: Skills for Success Training Department, Charles River Plaza	TBA
December 15 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---

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>.

Italian-American Heritage Day

—by Charlie Ciano, operations coordinator

Resolutions passed by state and federal government officially recognize October as Italian-American Heritage Month and October 25th as Italian-American Heritage Day.

On Tuesday, October 25, 2005, MGH celebrated Italian-American Heritage Day with art, videos, hands-on displays, and informational tables in the Main Corridor. Visitors had an opportunity to meet fellow employees and others of Italian descent and pinpoint their towns of origin on a map of Italy. Recipes from various regions were exchanged.

Italian-American artist, B. Amore, displayed a collection of her artwork depicting the immigration of Italians to America and Italian im-

migrant life. A number of authentic Ellis Island immigration papers were available for viewing.

Americans of Italian decent are susceptible to a number of diseases and disorders. One blood disorder that affects Italian-Americans is thalassemia. The severe form of thalassemia, often called Cooley's anemia, is hereditary. People with moderate forms of thalassemia may occasionally need blood transfusions. People with severe thalassemia may require regular blood transfusions, iron chelation therapy, and bone-marrow transplants. Without treatment, children with severe thalassemia may not live beyond early childhood.

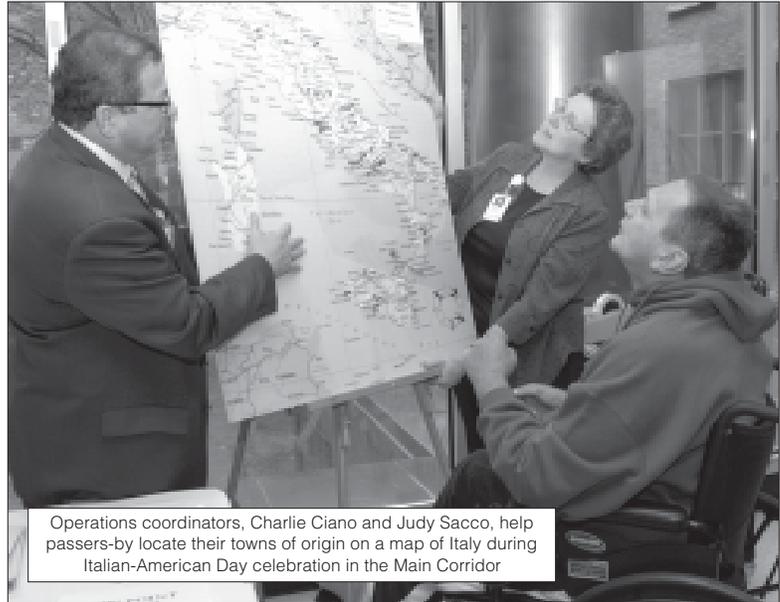
Some important contributions to health care have been made by Ital-

ian-Americans. Frances Cabrini immigrated to America in 1889 and within a few months opened her first of 28 orphanages and eight hospitals. California has pediatric and maternity

wards in every county hospital thanks to Mariana Bertola, MD, recipient of the Nobel Prize in Medicine (1998). Robert Gallo, MD, is credited with co-discovering that the HIV virus causes AIDS. Catherine DeAngelis is the first woman to edit *The Journal of the American Medical Asso-*

ciation (JAMA) in its 116-year history.

Every day Italian-Americans make a contribution to health care at MGH. In all role groups, Italian-Americans proudly share their heritage, talents, and compassion to help bring excellent patient care to our diverse hospital community.



Operations coordinators, Charlie Ciano and Judy Sacco, help passers-by locate their towns of origin on a map of Italy during Italian-American Day celebration in the Main Corridor

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