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Yale Nurse

Yale School of Nursing

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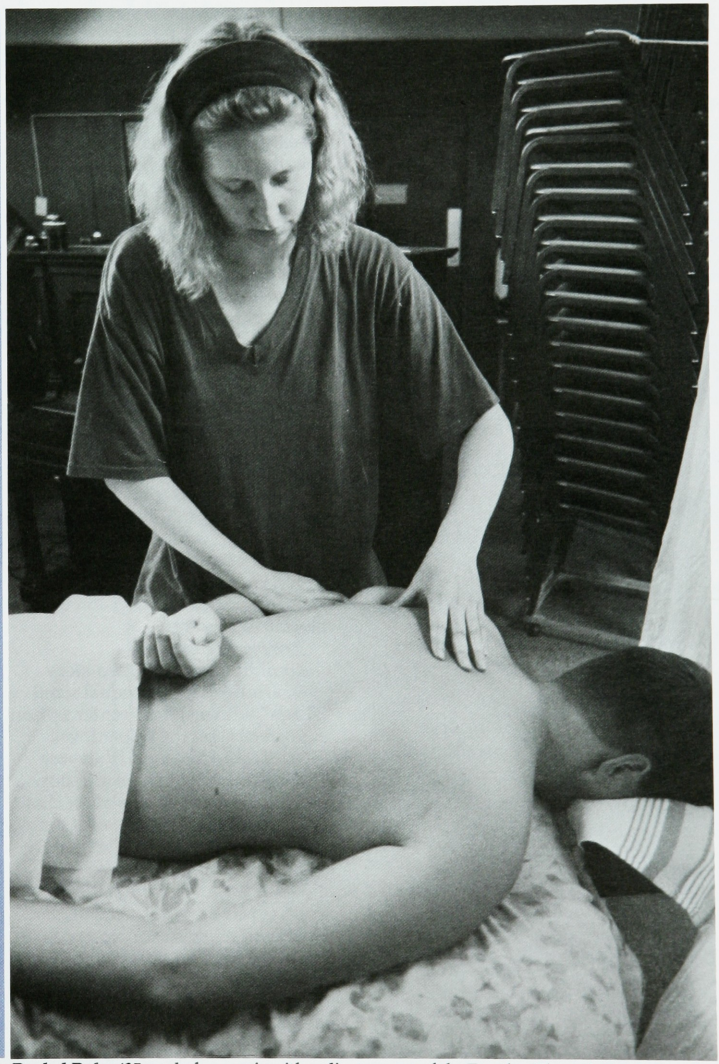
Yale School of Nursing Newsletter *April 1995*

A First Glimpse Inside the New YSN Building

YSN Students Share Experiences



***Rachel Ruby '95** works her magic with a client as part of the Together Through Touch Program.*

From the Dean

In this issue of *Yale Nurse* we are thrilled to bring you a first glimpse inside the new YSN building, located at 100 Church Street South. We are scheduled to be fully moved in and operational by August 1, 1995. The opposite page contains sketches of the overall building plan and the following pages include specific floor plans for YSN.

First, a bit of geography to get you oriented. Church Street South can be reached by a short walk down the Cedar Street Extension, heading toward Columbus Avenue. It is approximately a block and a half from the Hope Building (where we hold many Alumnae/i Weekend events) and it is less than a comfortable 10 minute walk from Yale-New Haven Hospital. The building is already on both the Yale and the Medical Center shuttle routes and we will have ample on-site parking (probably sufficient to park our faculty, staff, and a good portion of our students). Access to the property is gate controlled for those in vehicles and key-card controlled for those on foot. There is a 24 hour security force on site as well as the latest security technology which allows for visitors to be easily screened and admitted. There is a lovely park which was created by the developers and which holds great possibility for future YSN outdoor functions! It is our hope that we will become a welcome presence in our new neighborhood.

Church Street South is a very large building, approximately 200,000 square feet. As you look at the sketches on the opposite page, imagine that Cedar Street runs across the top of the page, Columbus Avenue runs along the left side, Church Street runs along the bottom, and Prince Street runs along the right side. The YSN space is fronted by Columbus Avenue and Church Street. YSN will occupy just under 40,000 usable square feet. This represents a considerable increase in total square footage and will allow us to increase teaching space as well as provide every fulltime faculty member with a private office (a critical enhancement to our teaching and research missions). The other major tenants in the building are the Yale School of Medicine and Yale-New Haven Hospital, an important consideration in our decision to relocate to this site.

The building is a large two-story cube, arranged in four equal sized "quads" with a shared center atrium and cafeteria on the upper level. YSN will occupy Quad IV (lower left corner) both upstairs and down. We will also occupy a small portion of Quad I on the lower level. Our space is highlighted in white on the overall building plan on the opposite page. We have designed a skylit, center staircase in our Quad which will allow inside up and down access to both levels. In addition, we will put signage on the outside of our Quad identifying it as the Yale School of Nursing. Our space is entirely self-contained (through the use of a card access system), with separate entrances; yet we share common area space (atrium, cafeteria, security, restrooms, elevators) with the other Medical Center tenants. We think we've achieved the best of both worlds - a separate identity but the capacity to share costs and space with our Medical Center colleagues.

The following pages contain larger sketches of the YSN floor plans, upper and lower (corridors are highlighted in white). The upper level will house all of our administrative and faculty offices as well as conference rooms (we have four of them in the new building). The lower level will house all of our teaching space. We are very excited about the improvements to our teaching space! We have merged our reference and audiovisual collections into one space, which includes state-of- the-art AV listening/viewing carrels, study carrels, computer search areas, stacks, and improved reading areas. We have created a computer lab which will hold 30 computers and have enhanced teaching space. There will be a large lecture hall with the capacity to hold 225 people, which we can break down into three self-contained rooms - two classrooms of 50 each and one lecture hall of 125. The physical assessment space has been enlarged and has a self-contained classroom as well as a simulated intensive care unit. Walter Zawalich's science lab is simply splendid! In addition to all of that, we will have six seminar rooms which will hold about 22 people, four classrooms ranging in size from 24 up to 45, designated study carrels for our doctoral students, and nine research offices to be assigned to staff on funded projects. All of our space, upstairs and down, will be wired for the latest communication technology including voice, data, visual and audio. We will have the capacity for satellite hook-up, closed circuit TV, E-Mail, and the latest in computer technology. Every classroom will have screens, monitors, and VCRs permanently mounted in the room. The student lounge area (henceforth

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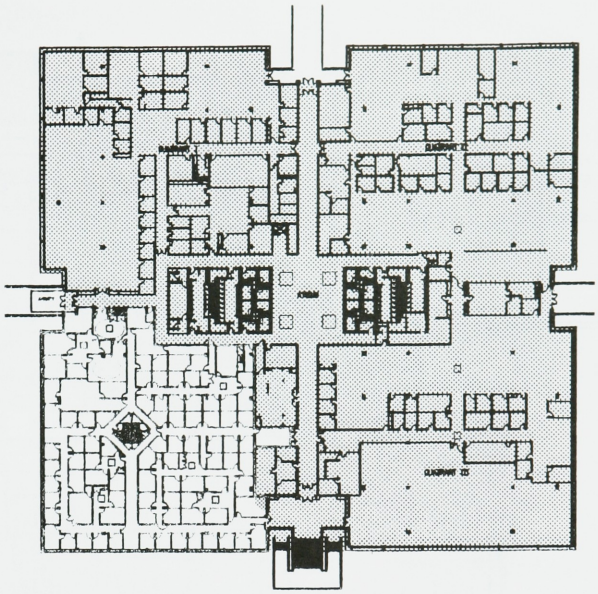
known as the Student Commons) will be the centerpiece of the lower level. There will actually be two areas, one for comfortable sitting/conversation and one with tables and chairs for eating, and it will open out onto a small landscaped patio area just off the lower left corner of the sketch. There will even be room again for our beloved Steinway piano! The mailroom will also be located on the lower level in order to create a common gathering place for faculty, staff, and students.

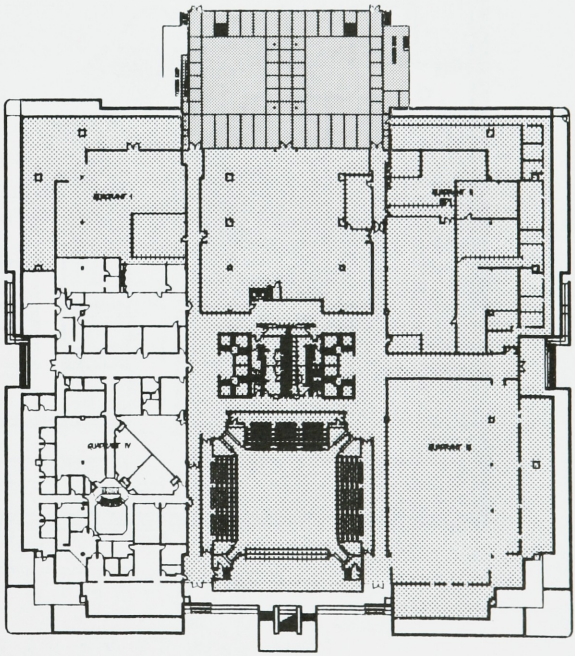
These sketches are really just a "tease." I will be going "on the road" over the course of the next year in order to bring you more detailed news of our new quarters and our new and continuing programs. And, of course, we will do a major presentation on the building at this year's Alumnae/i Weekend. I hope to see as many of you as possible either in New Haven or wherever I travel in the next several months.

There will be an opportunity for those of you who are interested to contribute to our Building Fund. There will be naming opportunities for seminar rooms, the lecture hall, conference rooms, and the like. Now that the project has gone out to construction bid, we will have time to develop a Campaign plan for the building. I am very sure that many of you will be moved to support this project once you've had the opportunity to see more detailed plans and share in the enthusiasm of the faculty, staff, and students.

What excites me most about our new building is the opportunity it offers to recreate the sense of community which has long characterized YSN. We will finally be together again in lovely, coherent space. I cannot tell you how wonderful it will be for all of us to be able to do our work unencumbered by the artificial barriers of bricks and mortar. There are so many other more important challenges ahead and we are eager to meet them!



UPPER FLOOR PLAN

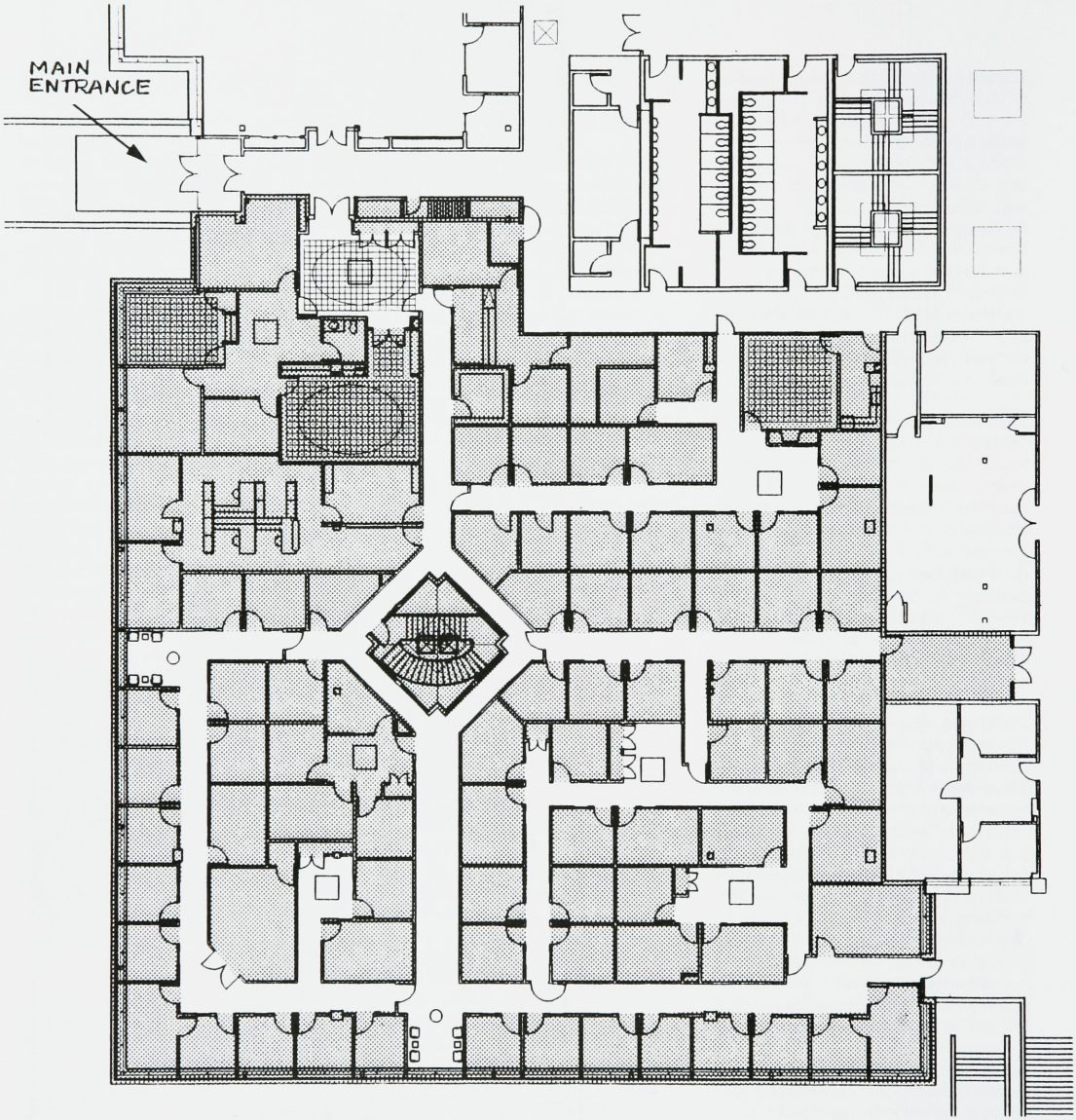


LOWER FLOOR PLAN

YALE SCHOOL OF NURSING – OVERALL BUILDING PLAN

31 MARCH 1995

GREGG & WIES ARCHITECTS



YALE SCHOOL OF NURSING – UPPER LEVEL FLOOR PLAN

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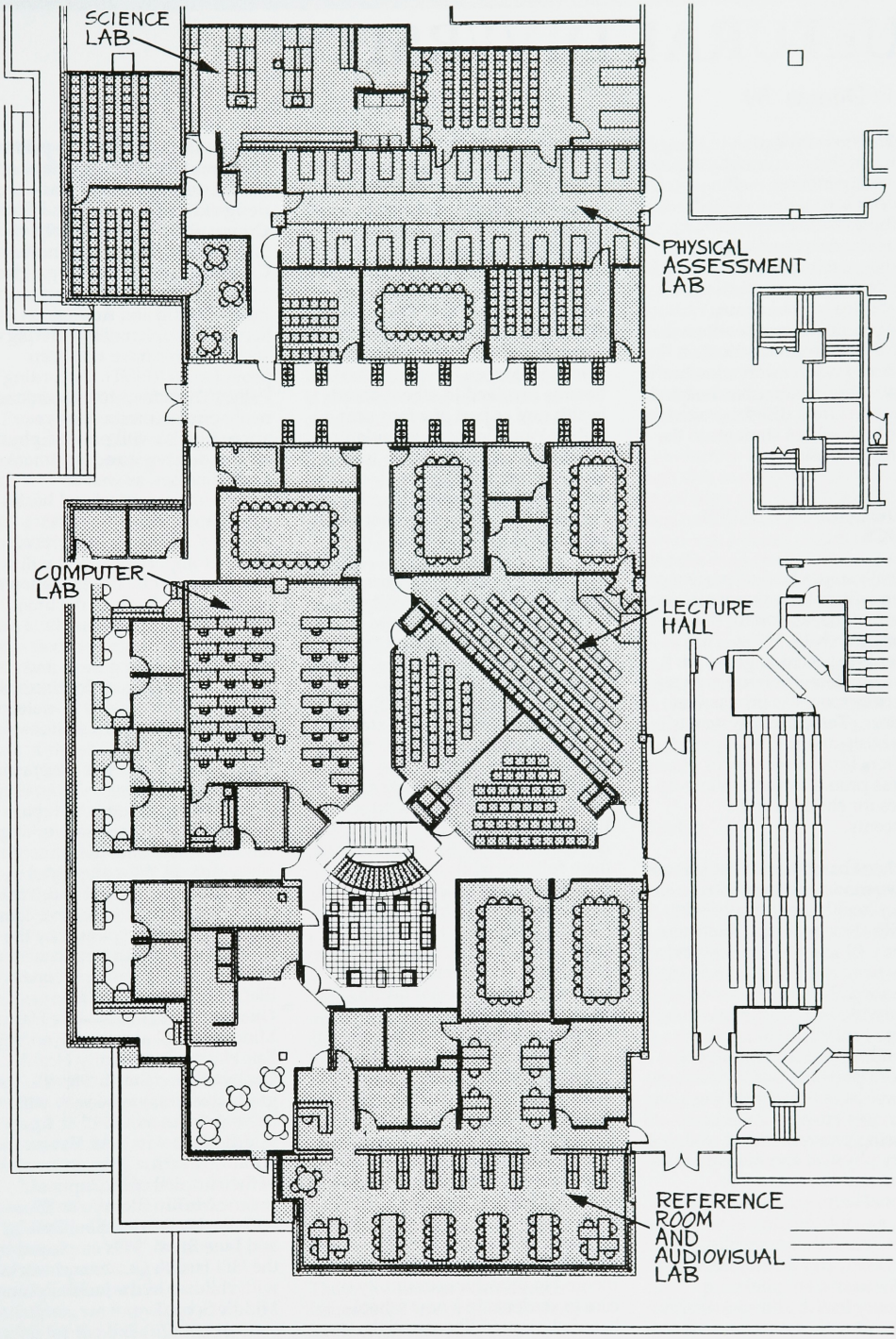


YALE SCHOOL OF NURSING – LOWER LEVEL FLOOR PLAN

31 MARCH 1995

GREGG & WIES ARCHITECTS

CULTURAL DIVERSITY

Linda Demas '89

The *Yale Nurse* invitation to share your examples of culturally diverse practice experiences within American society has yielded contributions that demonstrate, once again, the commitment, challenge, excitement, and reward of the Yale nurse. In this issue we offer articles by, and about, Yale alums practicing in school-based health clinics in Connecticut, in Fort Defiance Navaho reservation health care sites, and in an urban hospital setting recruiting disadvantaged public high school students to the nursing profession.

SCHOOL-BASED HEALTH CLINICS

Nationally, more than 60 percent of women with children under the age of 18 are in the labor force (*Hartford Courant*, March 19, 1995). That number is expected to grow. In urban areas families frequently use emergency rooms as primary care providers. The current system of care is crisis-oriented in approach and offers little in the way of wellness promotion and follow-up services for children and adolescents.

The school-based health clinic is one effective model that provides primary health care to those who live with these realities. There are currently 40 school-based clinics in Connecticut, and more than 600 in the country. They work because they provide our youth convenient access to health care in familiar surroundings with continuity of care from professionals with whom they have established relationships. The services are comprehensive, addressing prevention and wellness, primary physical and mental health services, and have access to additional services if needed. The centers are not insular, but maintain connections with the established school health and nursing services, area physicians, hospitals, community health and social service agencies, parent groups, and other programs and organizations. There are multiple opportunities for the master's prepared nurse to exercise his/her roles as clinician, educator, administrator, advocate, program and policy shaper, and researcher.

The Yale community has been active in school-based clinics for more than 12 years. In the New Haven area Walter R. Anyan, MD, Professor of Pediatrics at Yale School of Medicine and Chief of Adolescent Medicine at Yale-New Haven Hospital (YNHH), became involved in school-based health care as part of a four year Robert Wood Johnson Foundation grant to enhance physician training in adolescent medicine and to join forces with community-based health centers to provide adolescent health services.

New Haven's first school-based clinic opened in 1982 in Wilbur Cross High School under the direction of Dr. Anyan and the Fair Haven Community Health Center. Called The Body Shop, this clinic became a national model. Today the Body Shop continues to be staffed by the Fair Haven Center, including a pediatrician and four YSN graduates: **Elizabeth Magenheimer '76,** FNP; **Kate Mitcheom '81,** CNM; **Kerry Mudano '91,** PNP; and **Almarie Walczak '91,** FNP. Kerry is there fulltime while the others combine an hour or so a week with their other responsibilities at the Fair Haven Center. Health care is often coupled with education at the Body Shop. The clinic also offers HIV, nutritional, mental health, drug, and alcohol counseling; and employs a social worker and several substance abuse counselors. Kerri Mudano explains, "There are just so many issues that these kids bring to school, it's hard to imagine them sitting in class with all this baggage. I think the Body Shop is a place where they can refuel and get down to the business of learning."

In March of 1994 health care, community service, and education merged to introduce continuity of care to students in a new school-based clinic at Hillhouse High School . Most of these teenagers have not accessed traditional health care settings and have no primary care provider. The new clinic at Hillhouse High School was designed by Dr. Anyan and **Polly Cromwell '87,** with the help of June Holmes, manager of the local AIDS Care Program. Funded by a grant from the Connecticut Department of Public Health and Addiction Services, supplemental funding and some services have also been provided by YNHH. According to Polly, "The school-based clinic will really offer a comprehensive approach. We will provide physical exams, diagnosis and treatment of acute illnesses, as well as psychosocial support and health education. We will involve students' families in the process. Another important aspect will be the emphasis on HIV education and prevention." Some of the unique aspects of the Hillhouse clinic are extended hours, after school activities, support groups and family meetings, and continuous care through the YNHH Adolescent Clinic during school vacations.

Denise Orado Wagner '92 practices as a nurse practitioner in the Clinic at Hillhouse. A number of other YSN alumnae/i are also working in school-based clinics in Connecticut. **Elyse Borsuk '90** is employed by the Hospital of St. Raphael and works at the Branford Middle School. **Lynn Donahue '87** is employed by the New Haven Health Department and works at the Katherine Brennan Elementary School. **Elaine Gustafson '86** is at the Fair Haven Middle School and employed by the Fair Haven Community Health Center. **Susan Smith '95** will graduate in May when she will begin practice as a PNP at Troup Middle School in New Haven. Susan will officially be an employee of the Hospital of St. Raphael. **Jeanne Mullin Steinmetz '87** is with the Danbury School System and **Jane Stern '93** is employed by the Hill Health Center and works with children at the Jackie Robinson Middle School.

YSN alums have clearly been instrumental in the success of

school-based clinics, as they continue to provide care to young people who might otherwise get lost in the health care system. If there are any other graduates who are also currently providing care in a school-based clinic, please let us know so that students and others might network or just plain share their experiences!

Susan Lamar '88 *and* **Debbie Price '90,** *Family Nurse Practitioners, demonstrate how challenge, need, and opportunity frequently go hand in hand.*

FORT DEFIANCE, ARIZONA, JANUARY, 1995

Sue:

When I decided to move from Boston to the northeastern corner of Arizona, to a place called Fort Defiance, my friends back east got out their maps to try to locate my destination. Fort Defiance is the site of one of the six Indian Health Service (IHS) hospitals situated on or near the Navajo Reservation. The reservation, which covers an area the size of the state of West Virginia, straddles the four corners region of Arizona, New Mexico, Utah, and Colorado. I was heading for the beautiful southwest and to become one of four nurse practitioners at a small rural hospital where NPs work in all the clinics (adult, urgent care, peds, OB, well child), the ER, and run community based health programs.

I was fortunate enough to know one other person who was already working at Fort Defiance. Debbie Price and I had been classmates in our non-nurse program at YSN. She and I first became involved with the Indian Health Service, a branch of the US Public Health Service, while still students at YSN. Because of our interests in providing care to culturally different and rural populations, we found ourselves working for the IHS fulltime as family nurse practitioners at the Fort Defiance Indian Hospital.

Despite its small size (43 beds), the Fort Defiance Hospital is a busy place. The Navajo Reservation is broken into several regions that are each served by a particular hospital. Our hospital serves approximately 35,000 people and we have an estimated 80,000-100,000 outpatient visits a year. People often have to travel long distances over dirt roads to get to the hospital. Many patients hitchhike to their appointments. It is not uncommon for people to drive over an hour to get to the clinic even in emergencies. Most people do not have phones, many do not have running water or electricity, and often homes are heated by wood, coal, or propane. When the weather turns inclement - it snows a lot in this part of the country where the elevation is above 6,000 feet and the temperatures go to zero frequently in the winter - the road conditions worsen and the distances between homes, relatives with phone or cars, and the hospital appear greater.

People on the Navajo Reservation are by most standards considered poor. Many people receive some type of federal assistance. People work for the federal government or the tribal government, or for the few industries that are on the reservation. Many people do crafts out of their homes and rely on subsistence farming to augment their resources.

Other social and cultural factors that impact the health care provided for and received by the Navajo people include the dearth of Navajo physicians/providers; the language barrier present, especially with older patients; the high incidence of alcohol abuse, domestic violence, and teen pregnancy; and the cultural differences between traditional Navajo medicine and western medicine which can lead to differences in understanding about medical problems and solutions. The major primary care health issues faced in our clinic include adult onset diabetes, obesity, teen pregnancy, alcohol abuse, accidents, STDs, infectious diarrhea (shigella, Hepatitis A), and other disease processes whose sequelae are made more significant because people in isolated areas tend to seek care later for problems. Because living conditions, attitude towards health care and providers, and distances from the clinic/hospital all contribute to the kind of care people receive, the nurse practitioners at Fort Defiance recognized the importance of developing ways to meet the community needs outside of the hospital.

Community-based clinics that target high-risk members of the population provide a bridge to the community at large. Because community-based clinics would take the nurse practitioners away from their hospital responsibilities, scheduling and staffing issues needed to be addressed. Support from the hospital administration and the medical staff was crucial in making these programs a reality. *Debbie Price was the first nurse practitioner at Fort Defiance to initiate a community-based clinic at a local high school.*

Debbie:

Moving health care into the community has been an ongoing challenge for the nurse practitioners here in Fort Defiance. As active members of a medical staff dedicated to staffing an aging hospital with limited staff and even more limited space, we initially justified our community outreach as a way to alleviate overcrowding in our clinics. However, as our projects have grown and developed they are increasingly valued for their role in health promotion and disease prevention.

Navajo, New Mexico, located 14 miles but a world away from the hospital, is a town built in the 1960's to accommodate a saw mill which closed permanently in 1994. By nearly every measure it is a high-risk community: high unemployment, high teen pregnancy, high school drop-out

rate, high rates of alcohol abuse, domestic violence and injury. The public school is part of a large, mostly rural and generally poor school district. Each school nurse employed by the school district covers approximately five different schools. Navajo Pine High School sees its school nurse approximately once every other week.

Thus, is was not difficult to see the need for a school-based clinic, and the medical staff and administration at the hospital were very supportive of my initiating this project. Convincing the conservative school board was the greater challenge! The school-based clinic has been up and running for four years now with great acceptance by the school community, including the school board. I spend one half day each week there, seeing students one on one for a variety of health needs, including pregnancy, but more importantly, networking with the counselor, teachers, principals, students, and parents. I have even been known to rappel down volcanic cliffs in the name of adolescent health promotion/disease prevention!

My other community-based project is providing care to 100 special needs children and adults at St. Michaels Association for Special Education. The special needs run the gamut from multiply handicapped to Fetal Alcohol Syndrome to Down's Syndrome. Many of the teachers and nurses are Anglo volunteers with Mercy Corps, a Catholic Relief Agency that sends staff here for 12 month assignments. Most of the other staff members are Navajo. Much of my work at St. Michaels is with staff and families, struggling to provide holistic care to children whose medical needs can be overwhelming. I've learned to search for, and find, the "normal" child watching me from her wheelchair or seizing at her desk or signing yes with the blink of an eye.

Sue:

The various school-based clinics/programs were well established when I began to explore opportunities for a community clinic. A colleague suggested that I develop a program to provide care for the inmates at the local tribal jail. The JAIL - I had not given much thought to correctional health as a field where I would work. Nonetheless, the approximately 50 inmates at the tribal jail in Window Rock, eight miles away, were a high-risk population in need of care. Incarcerated for mostly alcohol related offenses (possession and consumption of alcohol is illegal on the Navajo Reservation) such as DUI, assault, resisting arrest, etc., the Jail Health Program was designed to provide health screening and management of the inmates' chronic and episodic health problems by the nurse practitioner. In addition, a comprehensive counselling program that utilizes conventional and traditional approaches, including a sweat counselling program that utilizes conventional and traditional approaches, including a sweat lodge, is being developed for the inmates. I visit the jail one half day a week and initiate referrals to the hospital when appropriate.

In addition to clinically oriented community programs, Debbie and I are both volunteers in a wilderness therapy program for high-risk adolescents that is run collaboratively by the hospital and the local high schools. The program, entitled Nat'aani Trails after the Navajo word for leader, revolves around hiking, rafting, rock climbing, and camping trips with Navajo teens. Leadership, responsibility and appropriate risk taking are concepts explored through each endeavor.

The Indian Health Service is a challenging place for nurse practitioners to work, but it is also a place of opportunity. We at Fort Defiance have each chosen different ways to fill our advanced practice niche. Community-based clinics are one aspect of our multi-faceted role here. The other two nurse practitioners at Fort Defiance have chosen to fill different roles: one has become a nurse colposcopist and the other is the hospital's Chief of Staff. Wherever we nurse practitioners find ourselves, the hospital or the community, we will continue to provide primary care to the Navajo people.

The following article by **Eileen Callahan Hodgman '68** *is her summary of an extensive front page feature in the November 1994* Bay State Nurse News.

CHOOSE NURSING!© A Recruitment, Training, and Career Education Program for Disadvantaged Boston Public High School Students

The Issue: With people of color representing less than nine percent of the employed registered nurse population, increasing the diversity of the nursing workforce becomes a moral as well as a societal and practical obligation. Although recruitment into the profession can and should be aimed at various age groups, the most promising pool remains the traditional one: secondary school students poised to make a career choice. Negative perceptions of nursing as a career are held by some proportion of all high school students, including students of color. Notwithstanding the need to change such perceptions, the greater, more immediate need is to capitalize on the positive perceptions that already exist. This demonstration project confirms that there is an ample number of high school sophomores of color who want to become nurses. Even at this young age, they understand the nature of nursing and are eager to care for others. Moreover, they are willing to invest in professionalism through collegiate nursing education. We, in turn, need to invest heavily in them, through comprehensive programs

that integrate experiential career education, intensive mentorship, academic supports, and community-building during the critical final two years of high school.

The Intervention: Choose Nursing!© identifies Boston Public High School students from racial/ethnic minority backgrounds as well as non-minority students from low income households who have an expressed interest in nursing. Each year the program recruits and selects a minimum of fifteen students completing the tenth grade, and enrolls them in a two-year program of career-oriented preliminary education that supports their motivation and capacity to apply to college-based nursing education programs. The project:

- offers students over 1000 hours of hands-on experience, supervision, and one on one learning with clinical nurse mentors and patients,
- provides diagnostic academic testing, planning, and remedial/supplemental after-school academics,
- tests and refines a competency-based clinical curriculum developed and taught by Beth Israel Hospital clinical nurses,
- pays "earn and learn" stipends for time spent in clinical and academic work,
- evaluates students at critical points to assess progress in the program and development of work and life skills,
- incorporates college-based workshops, a personal discovery writing course, and SAT preparation to help students prepare for college application, admission, and financial aid,
- is designed for dissemination and replication by local hospitals and others in urban areas.

Diana Gist BSN, RN, Choose Nursing©! Clinical Practicum Coordinator, reviews the operation of patient beds with Sean Hinton, a junior student.

The Outcomes: Since 1991, 196 Boston Public High School sophomores have completed an extensive application to compete for 15-18 Choose Nursing!© program slots each year. Although the racial/ethnic mix of both applicants and enrollees varies from year to year, of the 61 enrollees to date, 61 percent have been Black non-Hispanic; 18 percent have been Hispanic; 16 percent have been Asian; and five percent have been white low-income students. Two cohorts (1991 and 1992) have completed the program. All of these 18 students were accepted to four-year colleges with a declared nursing major, and the 1991 cohort has completed the critical freshman year with an 80 percent retention rate. Fifty percent of program graduates to date are employed by Beth Israel Hospital's Department of Nursing in part-time positions while they attend local colleges. In various forums, the majority of students claim that their greatest life achievement has been acceptance into or continuation in Choose Nursing!©. We attribute this to constructing a focused and competitive application process; holding students to high performance standards, and keeping the program strongly relationship-based. Program graduates are currently enrolled at six colleges: Simmons College, Salem State College, The University of Pennsylvania, Curry College, Boston College, and New York University. They enter college with strong motivation to succeed, based on a clear idea of the role of the professional nurse, a sense of competency and confidence in their own caring skills, and professional role models with whom they have already identified.

For more information about this creative program contact Eileen Hodgman directly at Beth Israel Hospital, 132 Brookline Avenue, Room BL-312, Boston, MA 02215, (617) 735-3949.

The student-mentor relationship develops very quickly. Junior student Sylvia Burns and Heather Bryant, BSN, RN, have known each other for only six weeks.

We end this issue's feature with a more traditional illustration, equally affirming, of the Yale nurse "in the field." **Justine Glassman '51** *enthusiastically (and effectively) encouraged classmate* **Joy Livingston Dodson '51** *to share her work with* Yale Nurse. *It is titled,*

"SIX MONTHS IN SOMALIA."

No sooner had the small, 12 passenger plane bumped to a stop at the end of the dusty airstrip in Luuq, Somalia than I got my first lesson in what it means to live in a country without a government. I saw no buildings, no customs officials, and no immigration officials to stamp our arrival in our passports. The absence of any government also means no postal service or telephone system, no laws, courts or police, no electricity or water system, no banks or reliable currency, and no schools or health care system.

When I volunteered to go to Somalia with Church World Service (CWS) in March, 1993, I was to be part of a medical team. However, sane people were not jumping at the chance to go to Somalia in early 1993, so it turned out that I *was* the team. By the time I arrived in the small town of Luuq in August, the Somali people were receiving enough food, so the hunger crisis was over. But the daunting task of rebuilding the whole infrastructure of the country had only begun.

Earlier the CWS project coordinator, working with the local Somali Relief and Development Agency, identified four villages that had had no health services for a number of years and were seeking help. So, my job was to build a clinic in each of these four villages and retrain the Community Health Workers to work in them. Four very dedicated Somali men worked with me as administrators, translators, and liaisons with the village people.

Since CWS works only in cooperation with the local people

and with their participation in the work of each project, our first step was to visit each village and work out an agreement with the villagers concerning the clinic location and the community participation in its construction. The nearest village is only 21 miles from Luuq, but because the "road" is a sometimes vague track of sand, sharp rocks and occasional land mines, it took us two hours to get there, jolting along in an old Land Rover, using first and second gear most of the way.

Our first meeting with the chief, elders, Community Health Workers, and, at our insistence, several women, took place in a hut with walls of sticks and a grass roof. We sat on grass mats covering the dirt floor as we discussed plans. We agreed that the clinic building would be rectangular with four rooms and a veranda across the front, a concrete floor, walls of sticks tied together in their traditional style and a corrugated iron roof. CWS agreed to furnish the cement, corrugated roofing, lumber, tools, and to pay for skilled workers. The village contribution would be sand and water for the concrete, sticks for the walls and workers to assist. We also agreed to immunize the children and retrain the Community Health Workers who had been unable to work for several years since they got no medical supplies, supervision, or salaries during the civil war.

On our second visit to each village we gave immunizations, obtained through UNICEF in Nairobi, Kenya for DPT, polio, measles, and BCG for tuberculosis. Many children as old as eight and nine years had never received any immunizations. Mothers told us of children they had lost to measles and polio. In all, we gave 743 immunizations to 219 children and could have done a hundred more children if we had known the true population of the villages. After this first round of inoculations, I gave a review class to four women CHWs so that they could return to the villages each month to continue the program. In January, 1994, I held a five day retraining course for eight CHWs, a woman and a man for each village. Topics included sanitation and hygiene in the villages, teaching the villagers good personal health and hygiene practices, record keeping and reporting, symptoms and treatment of simple problems such as worms, skin diseases, diarrhea, malaria, headaches and stomach aches, recognition of conditions requiring a physician's attention, and first aid. I was impressed with the knowledge these CHWs had and by how eager they were to learn more.

Tuberculosis is rampant in this area, and malaria is another major problem, made worse by the fact that an increasing number of patients have strains that are resistant to the available medications. AIDS is rarely seen in this part of Somalia, probably because of the strict Moslem rules limiting intercourse to married people, the severe punishment for infractions, and the ease with which people's behavior can be observed in the small population.

Although in Luuq squat toilets are used by most people, the villages have no toilet facilities. People simply walk out into the nearby scrubby semi-desert to urinate and defecate. Of course, many children do not make it far from their own huts, so worms and diarrhea are impossible to control no matter how much medicine is available.

Village water comes from wells, some as far as half a mile away. Most of the wells are in disrepair or were deliberately contaminated during the civil war. Since the water is usually carried in small buckets or tea kettles by women and children to their huts, it is virtually impossible to maintain the hygienic standards of clean drinking water, clean bodies, clean eating utensils, clean clothes and clean water for cooking that we in the US take for granted. Church World Service, recognizing that these conditions exacerbate health problems, brought in a technician to help the people clean and repair the wells and build squat toilets.

By the latter part of January, 1994 when I left Somalia, the first clinic building was almost completed, and the CHWs had returned to their villages with medical supplies and equipment and with renewed confidence that they could help their people.

This narrative in no way reflects the all pervasive stress and anxiety that I and the 12 to 18 other ex-patriot UN and relief workers felt every minute we were in Somalia. Although we were 250 miles west of Mogadishu where the fighting was centered, we felt the daily anxiety of living in a foreign place where we were looked on as infidels, barely tolerated by many people. We were unarmed; however, the local people were well armed. Many of the semi-automatic weapons we saw being brandished around by a quasi-police force of teenagers appointed by a fundamentalist Moslem group had been furnished to the Somalis by the US and the USSR during the cold war period.

Almost weekly an incident occurred to remind us of how vulnerable we were: hijacking a relief worker's truck at gunpoint and throwing him out of his vehicle onto the dirt road, threatening a British woman relief worker and stoning her with rocks and sticks, throwing a hand grenade at a new building, and many more. The most frightening incident occurred when an American relief worker and his Somali colleagues travelling on the same road we took out to our villages hit one of the land mines. The American had one lower leg blown apart and most of the other foot; one Somali lost a foot and another a hand. They were evacuated to Nairobi. After helping to care for them until the medivac planes arrived, I went back to my tent and counted in my diary that I had been out that road eight times and back eight times, 16 times it could have happened to me!

Launching Your Career

In an effort to establish closer ties with currently enrolled students the YUSNAA Board organized a workshop on career planning, "Launching Your Career." Held at the end of January, the all day workshop offered graduating students the opportunity to obtain practical information in seeking employment after graduation. Board members and other volunteer alums participated after brainstorming about what might be helpful to new graduates in seeking the first job, something with which this group certainly had experience. In the morning session Mary M. Drew, President of Drew Professional Recruiters, Inc. and experienced "head hunter," presented general issues and mechanics of job hunting and resume/curriculum vitae writing. Mary's presentation was followed by Linda Degutis '82 who offered specific suggestions and strategies for the interviewing process. Dorothy Sexton, Professor in the Medical-Surgical Nursing Program, spent an enormous amount of time and effort in collecting a packet of articles and handouts that was distributed to all who attended. It is hoped that the packet will prove valuable in the job hunting process. Lunch was also served!

Although this was a "first time" effort by the Board, evaluations of the program reflected very positive feedback and it is the expectation that the Board will continue to offer the program in years to come. The one goal we did not have time to meet was that of "hands on" critiquing of resumes and CV's and some mock interviewing with alums acting as interviewers in particular specialty areas. Unfortunately we simply ran out of time! Perhaps next time we will offer a second session for practice with the more interactive components of the job seeking process.

1994-95 Board members (L to R) Linda Degutis '82, Kristin Oberg '92, and Anne Aquila '89 were the Workshop organizers.

Mary M. Drew, President of Drew Professional Recruiters

L to R: Kim Lee, Ray Lenox, Jill Obata, Tara Mahon, Tracy Creaser, and Liana Corliss, all members of the Class of 1995

Student News

Kimberly Lacey '97, a first year part-time student in the Medical-Surgical Nursing Program, Cardiovascular Specialty, and Clinical Coordinator in the Vascular Surgery Center at Yale-New Haven Hospital, is primary author of the article, "Outcomes After Major Vascular Surgery: The Patients' Perspective," which was published in the *Journal of Vascular Surgery,* March, 1995. The co-authors are George H. Meier, MD; Harlan Kromholz, MD; and Richard J. Gusberg, MD.

CT Advanced Practice Nurses In Psychogeriatrics Organize

Under the leadership of Monteen Lucas, Psychogeriatric Nursing Coordinator at YSN, graduates of the Adult Psychiatric-Mental Health Nursing Program (Psychogeriatric Concentration) have joined with their colleagues throughout the state to form the Connecticut Advanced Practice Nurses in Geropsychiatry Group. The purpose is to provide a forum to discuss the issues germane to the practice/subspecialty of geropsychiatric nursing. The goal is to formulate standards and define scope of practice for the subspecialty in the state of Connecticut, in collaboration with leaders in the field at the national level.

At this time, the group consists of 23 master's and/or doctorally prepared members who work in diverse settings, i.e. inpatient geropsychiatric units, clinics, academia, home health, and private practice. If anyone wishes to learn more about the group, call either Monteen Lucas at (203) 737-2360 at YSN, **Vicky Bourque '93** at (203) 657-3056 in the Hartford area, or **Judy Chessin '93** at (203) 367-9446 in the New Haven area.

Faculty Notes

Wendy Holmes, Assistant Professor of Nursing at YSN and Clinical Nurse Specialist in the Bone Marrow Transplant Unit at Yale-New Haven Hospital, and **Elin Stangroom '95,** currently enrolled in the PCNS master's program at YSN, have had the abstract, "Caring for the Special Needs Child Undergoing a Bone Marrow Transplantation," accepted for presentation at a multidisciplinary Bone Marrow Transplant conference in Dallas, Texas in March, 1995.

Gail Melkus, MS, EdD, Program Director, Adult Nurse Practitioner Program, is the 1995 Chairman of the National Certifying Board for Diabetes Educators.

Dr. Tomek Smiatacz from the AIDS Clinic at the Academy of Medicine in Gdansk, Poland is visiting Yale and working with **Ann Williams '81** and others until the end of April. Dr. Smiatacz's area of expertise is infectious diseases, particularly HIV and opportunistic infection in drug users. He is observing treatments and approaches to patients who are followed in the Nathan Smith Clinic at Yale-New Haven Hospital. His visit is funded by the American Foundation for AIDS Research.

Tomek Smiatacz

Virginia Henderson Awarded Honorary Membership In AACN

In October, 1994 at the Global Connections World Congress on Critical Care Nursing the American Association of Critical-Care Nurses (AACN) awarded honorary membership to Virginia Henderson. In her presentation remarks, Nancy Curtis Molter, RN, MN, CCRN, AACN Immediate Past president, stated, "At 96 years of age, Virginia Henderson's life work symbolizes the finest in caring, teaching, writing, and research in nursing.

Miss Henderson has dedicated her life to uncovering the nature of nursing, acknowledging the global interdependence of nurses half a century ahead of her peers....[She] has defined nursing in a way that applies to all dimensions of our profession. This timeless definition goes beyond the boundaries of acuity and life itself." We congratulate Virginia on yet another special honor !

Sigma Theta Tau Inducts New Members

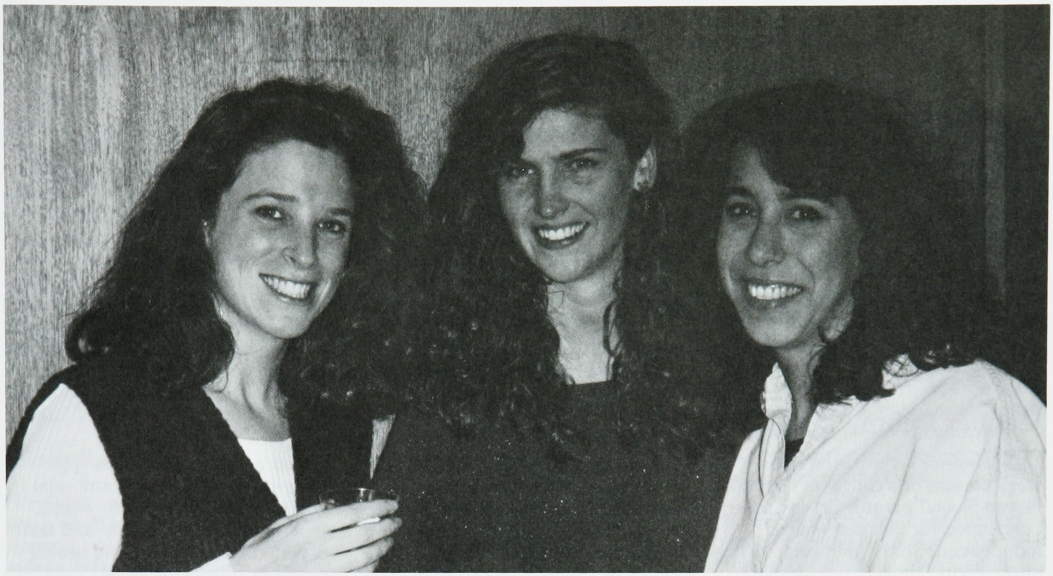
On March 28, 1995 Delta Mu Chapter of Sigma Theta Tau inducted 18 new members at a dinner meeting held at 500 Blake Street in New Haven. Shirley Samy '96 transferred her membership from another chapter. New YS inductees are Lea Ayers, Leslie Blatt, Crystal Chi, Patrick Cunningham, Cindy Czaplinski, Patricia Hertz, Kimberly Lee, Raymond Lenox, Mariette McCourt, Rosalind Melnicoff, Susan Miller, Melanie Morris, Karin Nystrom, Jill Obata, Rachel Ruby, Irene Stukshis, Eileen Whyte, and Kathleen Wilson. Congratulations to all!

Photos of the Holiday Party Bring Back Happy Memories

Santa charms Madeline Barr, daughter of ***Emily Barr '97.***

Entertainment was provided by The Hopkins Quartet. Gwendolyn Forrest, daughter of ***Catherine Forrest '71,*** *is on the far left.*

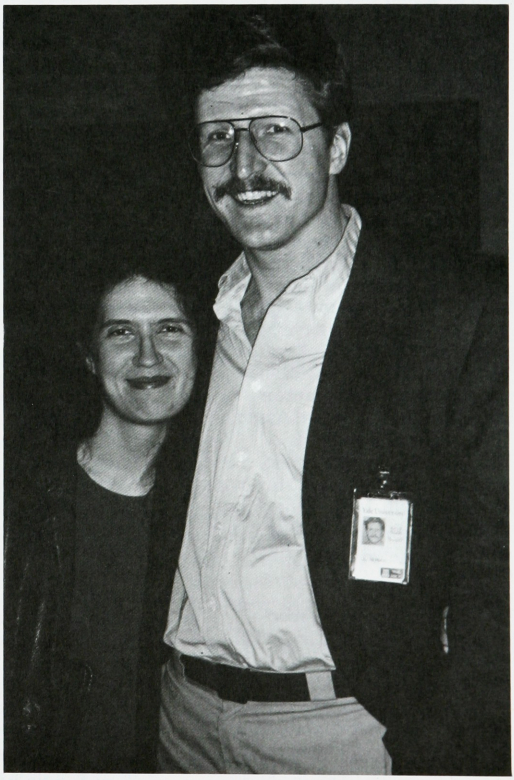
Fran Gwinnell '96, *third from left, with (L to R) friends Alexandra Gwiazda, Peter Gwiazda, YSN faculty member Jane Dixon, and daughter Heather Gwinnell*



Classmates through thick and thin (L to R) ***Lani Wishnie '95, Eileen Whyte '95,*** *and* ***Jayme Radding '95***

Everyone loves buffalo wings, including (L to R) Eddie and Andrew Peccerillo, sons of ***Sandy Peccerillo '96!***

Peter Reilly '97 *(L) and Marv Johnson, spouse of* ***Kelly Riordan '97***



Jim Schwendinger '96 *(R) and spouse Lisa Grohskopf*

YSN Students Share Experiences

Not only are YSN graduates engaged in diverse practice roles as has been shown in the last several issues of *Yale Nurse,* but currently enrolled students are also involved in a wide range of volunteer, clinical, and research endeavors that bear witness to the remarkable calibre of the YSN student body. The following articles, written by current students, are representative of this diversity.

Contemplations of a Graduate Sexual Assault Counselor

Jennifer Dehm FitzGibbons '96

This semester I completed a six-week counselor's course at the New Haven Sexual Assault Crisis Center. I registered for the course as an Independent Study to develop my interviewing skills in preparation for thesis data collection and to gain more practical knowledge in the area of sexual assault. My master's thesis research intends to study the utilization and perspectives of gynecologic care by survivors of childhood sexual abuse.

The content of the counselor's course was on the periphery of my research topic — unfortunately the focus of my thesis is hardly addressed at all in the literature — but I was hoping to increase my knowledge of this topic, make some contacts, develop my interactive skills, and increase my sensitivity for individuals who have been sexually traumatized. I was not certain of my ability or desire to actually become a volunteer counselor for the Sexual Assault Crisis Center. Besides, I rationalized, I have a hectic schedule and I am not a survivor of sexual assault. How could I, as a counselor, understand their issues and appropriately assist them during their crises?

I admit my attitude seemed a bit reserved and self-centered. Perhaps I just needed a little more motivation and confidence in my abilities. But after a few classes, I started to learn more about my classmates. Almost all of them were victims of sexual assault. Some were violently raped as teenagers, some were molested repeatedly by their fathers. In hearing their stories, a realization came to me like a slap: could I really handle the ugly, traumatic experiences that would be shared with me as a counselor? Was it my busy schedule that was problematic, or the close involvement with a brutally violated and victimized population? It was fine to sit in a conference room, listen intently to the material presented about sexual assault, practice a few role-plays, and go home. It is quite another situation to actually counsel a woman desperately calling for help because she has just been gang-raped. This realization became one of the valuable learning experiences I acquired from this course: survivors of sexual assault are burdened with experiences that are too heinous to tell, and very few people desire to hear them.

I suppose it is irrelevant to the outcome of my independent study whether I become a counselor or not. My main goals were accomplished: I spent forty hours learning about the community resources for sexual assault, the legal recourse available to victims, the effect of sexual abuse on victims, how evidence against perpetrators is collected and analyzed, how to empower survivors to face their anger and guilt and initiate their own healing. I practiced role-playing scenarios with classmates to become accustomed to issues that may arise while answering the Center's hotline or while discussing painful issues with survivors. I talked with my classmates who were survivors of incest and rape about my study, inquiring about their own health behavior and their experiences with receiving health care (my suspicions were supported, by the way). My sensitivity and awareness of cultural and sexual differences were increased. But frankly, I became close, but not too close, to the consequences of sexual assault.

Until one is actually victimized, it is impossible to truly comprehend its tremendous scope of influence. I became friendly with a young woman in the class named Michelle (the name has been changed to protect her privacy). She is 22 years old and lives with her parents in Hamden. She graduated from Boston University last spring and is applying to graduate psychology programs. I offered her rides after class because I heard she was taking the bus home every night at ten o'clock by herself. She didn't live too far away from me, and I felt compelled to provide her with a safer way of getting home at that hour. She gratefully accepted my offers and we got to know each other during our rides together after class.

Michelle started having a difficult time coping with the subject matter of some of the classes. During the presentation on "Suicide and Depression" she told me during the break that she was going home early, because she didn't feel well. I didn't want her to take the bus, especially if she was sick, so I

insisted I'd take her home. On the way, she admitted she was not sick, but was recalling her own suicide attempt. It was painful to be reminded of it and she had to remove herself from the environment. But she didn't want me to take her home; she wanted to be dropped off at a friend's house because her brother was home. "Your brother is preventing you from going home when you're upset like this? You don't want to go home?" I asked.

Then it all came out.

Her older brother molested her for years when she was a child. He stopped when he went away to college, but refuses to acknowledge anything every happened. Her mother knows the abuse occurred, yet wants Michelle to work toward having "a close relationship" with him because "he's family." No one in her family has ever confronted her brother, and worst of all, no one recognizes the abuse she experienced and the effect it continues to have on her. The abuse happened in the past, she just needs to forget about it. " It was no big deal," her mother says.

NO BIG DEAL??? I almost swerved off the road! My heart was in my throat! This intelligent, beautiful young woman can't get out of the nightmare she's living. She gathered the strength to expose her abuser, attempted suicide no less, and no one in her family seems to care. "Get over it. You're the one with the problem," they said. Yet she continues to manage on her own, maintain her sanity, and give the impression that all in her family is perfectly normal.

Michelle helped me to realize something else about survivors of sexual assault. Not only do they need to tell their story, they need to be believed. It amazes me how two things so simple, are so difficult to achieve. Claims of False-Memory Syndrome and the recently passed Pennsylvania law requiring victims of sexual assault to actually prove that they said "no" to their attackers aren't helping. There is a long way to go.

Needless to say, I now feel a tremendous responsibility to become a counselor for the Sexual Assault Crisis Center. I have learned from my classmates that finding the strength to confront the realities of sexual assault is a difficult, but important task. The fact that I am not a survivor perhaps gives me a stronger base to bear the weight of the stories I will hear. It makes me grateful for the childhood I experienced, the parenting I received, and the people that love and support me. It makes me want the same for others not as fortunate, who are faced with violations of trust and emotional development because of sexual trauma.

Since beginning my thesis project and taking the counselor's course at the Sexual Assault Crisis Center, I have talked with so many acquaintances who, upon learning of my interest in this area, have disclosed their own histories of abuse to me. I can see the pain in their faces when they share this fact, but then the relief that someone else has listened and believed.

I start manning the hotline next week.....

NP Resolves To Continue Work With Underserved After Placement At Homeless Shelter

Susan Moscou '95

I am a family nurse practitioner student at YSN and will graduate in May, 1995. During my summer (1994) break, I was selected to participate in the National Health Service Corps's Health Promotion/Disease Prevention Project (HPDP). My eight-week placement took place at two different sites in New York City. I spent four days a week at CHCANYS and one day a week with the Montefiore Homeless Team providing care at a homeless shelter for families in the South Bronx.

CHCANYS

CHCANYS is an organization comprised of community and migrant health centers (C/MHCs) in New York State. CHCANYS performs several functions for its members, but its major objective is to ensure that C/MHCs are recognized for their role in providing primary care services to medically underserved communities. My HPDP assignments at CHCANYS were the Clinical Support and Clinical Measures Evaluation Projects. The Bureau of Primary Health Services (BPHS) developed and funded these projects to improve clinical procedures and outcomes within federally funded C/MHCs.

The Clinical Support Project was completed early in my eight-week

placement, as it required a simple analysis of questionnaires to determine if C/MHCs would attend mini-residencies and workshops on PAP and sigmoidoscopy procedures, faculty development and recruitment workshops, and an AIDS workshop. The Clinical Measures Evaluation Project entailed developing and/or recommending clinical tools which would enable the documentation and utilization of clinical life cycle indices developed by the BPHS. The BPHS has established clinical measurement indices for the following life cycles: perinatal, pediatrics, adolescent, adult, and geriatrics.

C/MHCs use several clinical tools such as health maintenance flow sheets, medication records, immunization records, and problem lists to ensure that health care providers satisfy clinical protocols. However, many C/MHCs indicated a need for a data collection system that would assist them in chart audits and provide feedback about specific life cycle performance indicators.

As part of my project or responsibility, I contacted the pilot regions that had received funding last year from the BPHS to discuss their clinical measures reporting systems. These regions developed data collection tools that standardized chart audits and enabled uniform reporting of data to Public Health Service regional offices. Region III developed a clinical health information program (CHiP), a computer database application. CHiP is a mechanized chart audit reporting system based on the measurable clinical life cycles. CHiP enables C/MHCs to enter clinical measurement data into a computer, thus creating a database that would allow C/MHCs to evaluate their patient care.

Because my internship would end before this project would come to fruition, I recommended that CHCANYS collaborate with Region III and initiate a trial CHiP at several C/MHCs. Standardizing the clinical measurement reporting enables uniform data collection within C/MHCs and facilitates:

1) analysis of life cycle performance indicators

2) identification of clinical area strengths/weaknesses

3) determination of positive/negative trends in health care delivery system

4) establishment of objective feedback about clinical indices.

Susan Moscou '95

Working with the Montefiore Homeless Team

Montefiore Hospital provides ambulatory care services to several homeless shelters and soup kitchens in the Bronx. One day a week throughout my HPDP placement, I worked at the Jackson Shelter for homeless families. The Montefiore Homeless team consists of a medical director, family nurse practitioner, health educator, and medical assistant. The team provided primary care to adult and pediatric populations. My clinical activities included history taking, physical examinations, women's health care, patient counseling, and medical charting.

One of my learning experiences was to learn to look for horses, not zebras. However, nervousness about missing a crucial diagnosis and just plain lack of confidence plays a large role in overlooking the obvious, which I am sure all nurse practitioner students have experienced. One day a mother brought in her nine-month old daughter who had developed a "rash" yesterday which appeared worse today. The child had two erythematous wheals on her face and three more on her trunk. After taking a careful, long, and involved history, I went to consult with my preceptor. I was so focused on getting the description correct — superficial areas of local swelling, erythematous base, no crusting, no oozing, non-tender, etc. — that when my preceptor asked if I had questioned the mom about open windows in the baby's room, had the child been outside recently, or had she been recently bitten by mosquitos or insects, I drew a blank. As it turned out, these were mosquito bites and obviously the redness and localized edema were normal reactions.

For my HPDP community project, I developed a portable patient medication record which would serve as an educational tool for the provider and patient. Patient education has been an extremely important aspect of the nurse practitioner role. Additionally, this portable record should reduce misunderstandings as the patient and clinician have an opportunity to discuss and review prescribed medication. Moreover by creating the medication record for the patient, the health care environment becomes dynamic as the patient has an opportunity to become an interactive participant by actively receiving information rather than passively listening to the clinician detail her or his medications.

Serving the Underserved

I entered nursing school after receiving a Master's in Public Health (MPH) in policy and

management. Half-way through the MPH, I decided I needed clinical skills, since I believed that good administrators should understand the health care delivery system. Additionally, I felt that public health and nursing would be an optimal fit as well as a splendid melding of my administrative skills and previous work experiences. Moreover, participating within the health care system would enable me to develop the kind of health care I desire for myself and for patients.

After graduation, I will seek employment in a community health center in a medically underserved area. As a National Health Service Scholarship recipient, I owe the government three years of service. Medically underserved communities are found in both urban and rural settings. As a "die hard" New Yorker, I hope my placement will be the South Bronx or Harlem, but I am also open to the possibility of practicing in a rural area.

Being a HPDP summer intern was exciting since both placements were interesting and each offered opportunities to learn and reinforce existing skills. Moreover, CHCANYS and the Montefiore Homeless Team strengthened my desire to work in medically underserved communities. Developing and carrying out the HPDP projects allowed me the opportunity to thoughtfully consider the needs of the community and how clinicians need to work with the community to develop and implement principles of community oriented primary care.

Together Through Touch

Melanie Morris '95 and Rachel Ruby '96

Melanie's Experience

Rachel and I began volunteering for Together Through Touch in the fall of 1993. Together Through Touch was started five years ago by three local massage practitioners. Its purpose is to provide therapeutic massage to people who are HIV-positive or have AIDS. It meets the third Saturday of each month at the United Church Parish House. Since 1991 Together Through Touch has been affiliated with and received funding from AIDS Project New Haven. This has enabled it to expand so that now there are enough volunteers and administrative support to offer massages to people who are homebound or in the hospital.

When I began volunteering, I gave massage at several of the monthly sessions at the church. I did not have professional training in massage, which was not required to be a volunteer. I had taken workshops over the years in Swedish massage, shiatsu and reflexology, and had practiced my skills occasionally with friends, enough to know that massage is a powerful mode of healing and communication. Volunteering with Together Through Touch seemed like a good opportunity to provide a valuable service and to improve my massage skills.

During the time I attended the church massage sessions, an on-call program was instituted to provide massage to people who were homebound or hospitalized and unable to come to the church. I expressed interest in providing massage on a monthly basis to someone who was homebound. I wanted to establish an ongoing therapeutic relationship, rather than to go to the church each month and massage whoever showed up, or do one-time massage to someone at home or in the hospital. I was assigned to a couple who were both homebound with AIDS.

In the six months that I have visited Mr. and Mrs. G. in their home, I have learned a lot from them about the effects of AIDS on their lives. Mrs. G. has refused to be massaged, but she is present when I massage Mr. G. who has an arthritic condition. There is ample opportunity for conversation with both of them before, during, and after the massage. It has been a rewarding experience for me, and has cleared up many of my misconceptions about the virus and the disease. I leave after each session feeling more energized than when I arrived, and Mr. G.'s appreciation gives me a deep sense of satisfaction. I feel fortunate to have had the opportunity to get to know this couple and to become more confident and skilled in massage. I plan to pursue more training in massage in the future and to incorporate it into my nursing practice.

Rachel's Experience

Unlike Melanie, I have chosen to work at the monthly massage sessions. The afternoon begins at 12:45 p.m. when I arrive to help set up in the community room of the church. The massage tables are arranged in stalls created by wooden dividers with shower curtains strung across the front. In the lounge, tea and snacks are laid out for those people waiting for a massage. When the volunteers have finished the set-up we stand in a circle, holding hands for a moment of meditation.

Between massages I join the social

group in the waiting room. By listening to people describe the individual coping skills that they have developed to deal with their illness, it has become clear to me that each individual deals with the disease in a unique way, whether by personifying the virus and greeting it each morning, or by mentally boxing it in to prevent it from overwhelming one's life. While clients may have supportive friends and family, and may belong to support groups of other HIV-positive people, they are essentially alone with their illness. Even the most upbeat and social clients have this underlying river of loneliness.

I usually massage two to three people in an afternoon. A massage session begins with a verbal assessment to determine areas needing special attention and tender areas of the body to avoid. The needs of a client will vary from visit to visit. A session may involve mostly talking and perhaps a very light massage, or a touch session may involve simply holding someone's hand. Visual and tactile assessment allow the massage practitioner to further assess sensitive areas and to identify skin conditions that should be avoided in the massage. Many of the specific learned techniques of massage are geared towards a healthy body. A person with AIDS may be experiencing failure of particular organs or ill health and a strong massage may cause a release of toxins into the system that can cause the client discomfort. Throughout the massage an unspoken dialogue occurs and the practitioner must stay aware and open toward the client to recognize the constantly changing needs and to provide compassion and support as well as physical relief from pain. Perhaps the most important lesson I've learned is that I am not going to "fix" anyone's problems by being there, but I can help simply by listening and through massaging.

Giving a massage has a very calming effect on me, also. It is a way of responding as a compassionate listener without having to form awkward sentences. There is also the health component of massage, the relaxation of the muscles and the sharing of energy through touch. When I massage, I'm reminded of Lewis Thomas and his assertion that each new medical technology, beginning with the stethoscope, has had the negative consequence of putting distance between provider and patient. Touch is a nearly lost element of medical care that I hope to include in my own practice as a nurse practitioner.

A Study Of Brazilian Bisexual Men As A Bridge For HIV Infection To Low-risk Partners

Josefina Pereira-Marquez '95

I went to Brazil in the summer of 1994 and spent over three months in Belo Horizonte (the fourth largest city in Brazil) in the state of Minas Gerais. I was awarded the Wilbur G. Downs Fellowship from Yale School of Medicine to conduct data collection from the sample which I am using to write my master's thesis. Before I traveled to Brazil I was aware of the Brazilian sexual culture which influenced the way that I approached the population I interviewed (150 Brazilian homosexual/bisexual males) in order to study their sexual practices.

I was interested in developing this project in Brazil because Brazil is now the country with the third highest number of reported AIDS cases, and recently heterosexual infection with HIV in Brazil has been associated with bisexuality in men. The extensive prevalence of bisexuality among Brazilian men is intricately associated with the sexual culture in Brazil. Therefore, understanding the epidemiology of HIV/AIDS, as well as designing control efforts, requires an appreciation of the influence of cultural sexuality in Brazil.

The transmission pattern in Brazil is mainly by sexual contact. Until 1993, 60% of the cases were related to this mode of transmission. The beginning of the AIDS epidemic in Brazil was associated with sexual practices among men who have sex with men. Today, this pattern has shifted to the heterosexual population, increasing alarmingly among women.

Few studies have been done of sexual practices among Brazilian males regarding the spread of HIV infection. Knowing their sexual practices and the underlying causative factors will help significantly in developing prevention strategies for homosexual and bisexual males in Brazil. Consequently, prevention programs for homosexual/bisexual males will help slow progression of HIV infection among both homosexual/bisexual males and heterosexual populations. The interrelationship of heterosexual populations with homosexual/bisexual males through males who consider

Josefina Pereira-Marquez (third from R) with colleagues at a World Health Organization sponsored HIV vaccine trial conference in Brazil

themselves "heterosexuals," but who engage in sexual relationships with both men and women, increases the risk of HIV transmission to heterosexual men and women.

Social, cultural, and sexual factors have a tremendous influence on sexual attitudes and practices. Sexual identity is often ambiguous in Brazil due to the way in which Brazilians construct their own sexuality. Many Brazilian males make a distinction between their sexual practices, dividing them into "active" and "passive" roles. Thus, for a male to be considered "a man" he should play the dominating (active) part in his sexual relationships, whether his sexual partners are men and/or women. Under these peculiar categories a male will not lose his "masculinity" when having sex with another male if taking the active role.

Consequently, a man can have sex with both men and women without losing his heterosexual identity. This way of constructing sexual culture has had, since the epidemic was initiated, a tremendous impact on the spread of AIDS in Brazil.

In general, Brazilian homosexual/bisexual males do not look for information and prevention about HIV/AIDS. And they are only reached by the medical system and by support groups when their HIV status changes and they become sick. On the other hand, their low-risk partners, and especially women, are at risk of HIV infection due to high-risk behavior among homosexual/bisexual males. The balance of power in most opposite-sex relationships strongly favors the man, such that Brazilian women lack enough position to insist on preventive measures in their sexual relationships. Lack of awareness in low risk women of being at high risk and their lack of power to intervene in the situation support the need for further research into the sexual behavior of bisexual males in Brazil.

Rochester's Quintessential Nurse Researcher: Dr. Jean Johnson

Nancy W. Bolger

Life on a Kansas farm may nurture special human qualities. Growing up in a rural community whose fate depends on the vicissitudes of weather (Will the rains come soon enough to save the withering wheat?) may lead to a deep understanding of life's underlying seriousness.

Watching neighbors struggle with hard economies and uncertain futures may sensitize a young person to the need for practicality and for paying strict attention to how any given set of actions may have long-range consequences. When rural ways are bred in the bone, a bright young woman may have her instincts sharpened, her hoping skills honed, her determination focused. Those characteristics are frequently mentioned when talk turns to Jean Johnson '65, PhD, FAAN, Associate Director for Oncology Nursing for the University of Rochester Cancer Center, Professor and Clinical Chief of Oncology Nursing at the School of Nursing, and quintessential nurse researcher.

Jean Johnson was born on a farm in Wilsey, Kansas, daughter of a farmer and a schoolteacher, and sister to five brothers (three of whom

became veterinarians). "Jean is one of the stellar people at the Medical Center," says Robert J. Joynt, MD, PhD, University Vice President and Vice Provost for Health Affairs, and former Dean of the School of Medicine and Dentistry — also a Midwesterner.
"She has turned the art of coping with patients' pain and stress into a science," he adds. "And she has developed a corps of nurses who are essential to the outstanding patient care that is one of the hallmarks of our Cancer Center."

During the 14 years since Dr. Johnson arrived in Rochester, recruited from her post as Professor and Director of the Center for Health Research at Wayne State University's College of Nursing in Detroit to serve as Director of Oncology Nursing at the new Cancer Center, she has held many roles: teacher, administrator, mentor, researcher. Her 20-page curriculum vitae lists more than two dozen major honors and awards, including a Distinguished Alumna Award from Yale, the University of Rochester Graduate Teaching Award, and the First Distinguished Researcher Award given by the Oncology Nursing Society. In 1991, she was named an honorary alumnus of the University of Rochester School of Nursing. Her name is listed in seven different compilations of "who's who" in American life, volumes that record the accomplishments of distinguished men and women.

At the national level, Dr. Johnson has played a leadership role in shaping the nation's health care — as a member of the governing council of the Institute of Medicine of the National Academy of Sciences; as a permanent member of two review committees of the National Institutes of Health; and as former chair and longtime member of the American Nurses Association's Council for Nurse Researchers. At the University of Rochester Cancer Center, she has a similar stellar record. "As a member of the Cancer Center Executive Committee, Dr. Johnson has played a critical leadership role in shaping our programs, especially those providing direct patient care," says Richard F. Borch, MD, PhD, Dean's Professor and interim director of the Cancer Center. "As director of the Division of Nursing Oncology, she has developed a nationally recognized research program, out of which has come significant data directly beneficial to people with cancer and their families. Personally, I have found Jean to be incisive, insightful, and inspirational," Dr. Borch says.

Is there a key to Dr. Johnson's success, as teacher, researcher, and administrator? If so, many colleagues say, it's that she has the rare quality of combining clarity of approach — a consistent utilization of the scientific method — with a vision that enables her to see the consequences of decisions. That insistence on the importance of future consequences has made Dr. Johnson an invaluable teacher. She insists that one look at every potential solution to a problem — outside the context of the current situation — and Jean has taught us to see that short-term solutions may stand in the way of future goals.

"Jean's role as a researcher is the central characteristic that defines all her many other roles," says Linda S. Jones, DNSc, RN, Assistant to the Associate Director for Nursing Oncology at the University of Rochester Cancer Center. It is "Dr. Jean Johnson, researcher" that was profiled in an issue of *Rochester Nursing*, and which is reprinted (and edited in part) in this issue of *Yale Nurse*.

Dr. Johnson's research on helping people cope with their experiences with health and illness, and how to reduce the impact illness has on their lives is more than nationally recognized. Her studies are among the most cited in the literature. Her research has been continually funded since 1966, the year she received her first grant. Currently she is project director of a grant from the Center for Nursing Research, NIH, on coping with cancer. "I discovered research in nursing as a graduate student is psychiatric nursing at Yale in 1963," Dr. Johnson says. By the time she applied for graduate studies at YSN, she had spent more than 10 years teaching nursing students, first at a hospital in Sioux City, Iowa; then at hospitals and a small college in Denver; finally at the University of Kansas. "This was at a time when only 10 percent of nurses had baccalaureate degrees," Dr. Johnson recalls. Her own degree was from Kansas State University. She received a second master's degree and her doctorate in social psychology from the University of Wisconsin-Madison. "My research started in the laboratory, moved to diagnostic tests of short duration, such as gastro-endoscopy exams, to cast removal in children, to surgical patients, to cancer patients," she says. No matter what the patient population, Dr. Johnson has been there analyzing, testing, and promoting the best ways to help men, women, and children cope with the complexity of stress in the health care experience.

From Dr. Johnson's research have come very important findings: If patients focus on the emotional impact of an illness, concentrating on how bad the treatment will be, how it will upset their lives, or how painful it will be, their outcomes tend to be compromised and healing does not come easily. Conversely, she has documented (and taught others) that patients do best when they understand their treatment, and when the information they receive from health care providers is presented in clear, structured, concrete terms, and not emotion-laden. One of Dr. Johnson's earliest studies, from the 1960s, can serve as a good example. In that study, she informed a group of patients about a procedure that required the use of a gastric tube. Doctors and nurses involved in the study were not told which patients were informed about the procedure, or what information they were

given. The study revealed that fully informed patients needed fewer tranquilizers and were less restless and tense during the procedure. As a result of Dr. Johnson's research, the content of nursing curricula across the country has changed, as has nursing practice. Nurses now know how important it is to provide patients with descriptions of the impending experience in concrete, objective terms, sometimes called "sensory information." That type of information helps patients to cope with health care experiences. For someone anticipating surgery, for instance, it is now standard practice for nurses to "walk through" the impending experience with the patient in advance, and to explain that the pre-operative medicine will make them drowsy and that sharp, pulling pain will be felt in the incision area. The usual result: less patient distress and increased ability to regain or maintain usual functions.

As the capstone of her research career, Dr. Johnson has taught staff nurses how to use theory and research as a basis for the care they provide patients receiving radiation therapy for cancer. It is expected that patients receiving that care from their nurses will have low emotional upset and the disruption to daily activities will be minimized. The study will be completed in 1995.

As a senior member of the faculty, Dr. Johnson's vision is on the future of the nursing profession. She's looking ahead to a time when nurses have even more professional independence and she's asking what steps need to be taken today to move toward that future. She has a deep commitment to helping people develop professionally, not only those she mentors personally, but all nurses. With an overriding commitment to the profession, she's working to ensure it's safe passage into the future.

Others know well Dr. Johnson's commitment to developing the best possible educational network for nurses. Last year, when the Mayo Clinic was designing a postdoctoral program in nursing, Dr. Johnson was asked to consult. Her outreach continues, as attested by a busy lecturing and teaching schedule. At the Rochester School of Nursing, Dr. Johnson teaches the last of four seminars in the course on nursing research for PhD candidates. Her contributions to the profession, colleagues say, assure her a permanent place in nursing's pantheon. "Jean Johnson's legacy of compassionate cancer care, of far-reaching research, and excellence in education will influence cancer treatment for decades to come," says Cancer Center Director Richard Borch, MD, PhD, and Dean Sheila A. Ryan adds her own note of tribute. "When I was a young nurse, the climate was such that we never told patients anything that might upset them or cause them anxiety — from their diagnosis to the nature of their treatment and procedure expectations. It was most frustrating to see the fear and uncertainty in patients' eyes and to pretend that they just 'shouldn't worry.' Then came Dr. Johnson's research, proving that informed patients have better healing outcomes! Over the past 27 years, throughout continual funding, Jean has left her mark — improving patient care, challenging generations of oncology nursing leaders and mentoring future nursing researchers."

Yale Nurse gratefully acknowledges permission to reprint (and edit for purposes of length) from *Rochester Nursing*, Fall, 1993.

Caring For The Frail Elderly—The Dorothy Adler Geriatric Assessment Center, Yale-New Haven Hospital, New Haven, CT

Dianne Davis '72

The Dorothy Adler Geriatric Assessment Center is an outpatient consultative service that provides a comprehensive assessment of older persons who have medical, psychological, cognitive and/or social problems impeding functioning or threatening independent living. The majority of the patients seen in the Adler Center are either somewhere in the course of a dementing illness such as Alzheimer's disease or have psychiatric problems such as anxiety or depression. We also see cognitively intact persons with functional problems such as frequent falls, movement disorders, and incontinence.

What distinguishes our approach from the standard medical work up of dementia, which might be done by an internist or neurologist, is our focus on the patient/family as the unit of care and the emphasis on functional not just medical

problems. The involvement of family is particularly important for a number of reasons. The demented patient is often unable to give an accurate history and may think that nothing is wrong. Family members are the primary care providers, and if stress on the family is not addressed, the care givers may burn out and the patient may be prematurely institutionalized. The Adler Center uses a multidisciplinary team which includes a geriatric case manager, a physician (geriatrician, geriatric psychiatrist or neurologist), and a geriatric nurse.

Patients are referred to the Adler Center from a number of sources: community physicians, other community providers such as the VNA, Elderly Protective Services, and nursing home personnel. We do not require that patients be referred by professionals, and most of our referrals come from concerned family members.

The evaluation process begins with a telephone intake by one of our nurses. She collects basic information about the patient to decide if the problem is one which is appropriate to be seen in the Adler Center. (We do not become the primary physician for patients or treat acute medical problems.) The nurse decides if the patient should be seen by a geriatrician, neurologist, or psychiatrist. She also orients the family regarding what to expect at the visit, asking them to gather old medical records, fill out a personal history questionnaire, and bring all current medications to the visit.

At the visit, the case manager conducts the mini mental status examination with the patient, and collects data from the family about the history of the current problem, physical activities of daily living (ADL) and instrumental ADL functioning, and problems the family hopes we can help them with. The geriatric nurse does vital signs and assesses mobility, hearing, vision and nutritional status, and documents current medications. The nurse and case manager then present the case to the physician, who has been reviewing old medical records. The physician does a medical assessment of the patient including a neurological and physical or psychiatric examination, while the case manager spends more time with the family getting a sense of the way that the family has responded to the changes in the patient. This is a time when the case managers do a lot of teaching and supportive counseling.

By the end of the evaluation, which usually lasts 1-1/2 hours, a number of things have been accomplished:

1. A differential diagnosis of the problem includes plans for what, if any, further work is needed. We do screening blood work to look for reversible causes of dementia and medical causes of depression and anxiety. If indicated by the history (abrupt rather than gradual onset) or physical examination (focal neurological findings), we order a head CT or MRI to look for evidence of stroke or tumor. There is not a specific blood test or x-ray for Alzheimer's disease, which remains a diagnosis made by excluding other causes of dementia, and having a history of progressive decline in cognition and functioning. The "low tech" approach of talking with patient and family is the most important diagnostic tool.

2. Care problems are identified. These include needs which are unmet because the patient is no longer able to function independently, e.g. the demented person living alone and losing weight because he cannot shop and cook or forgets to eat; or the person still driving but getting lost; or forgetting to pay bills. They also include the behavioral problems (agitation, paranoia, hallucinations, insomnia, wandering, depression, and anxiety) and physical problems (incontinence, difficulty with ambulation, and dependence in physical ADLs) which make care giving difficult.

3. Family stress and family resources are identified.

4. A plan of care is developed to address the problems identified. We medicate problematic behaviors and teach the family behavioral strategies to deal with them. We line the family up with community resources such as adult day care, Meals on Wheels, and home care agencies for homemaker/companions, home health aids, and physical therapy. We help them to think about and plan for the future, including finding alternative housing, getting legal advice, and looking at nursing homes. We refer the family to other sources of information and support such as the Alzheimer's Association and family support groups. If necessary we help the patient find a primary physician, or write the physician's certificate for probate court conservatorship, or do the paper work for nursing home admission.

What follow-up we do depends on the plan of care. We usually ask the patient to return at least once to review the results of testing and answer further questions, and to determine if the family has been able to follow through on the plan of care. If we have prescribed medications for the patient, the case manager has frequent phone contact with family to assess the response of the patient and to work with the physician to make medication adjustments. The written evaluation is sent to the primary physician. We invite family to contact us at any time in the future to address new issues as they develop. Since dementia is a progressive illness they commonly do call us. Our most important service is listening to families and responding to their concerns.

Reprinted with permission of the Yale-New Haven Hospital *Nursing Update* from Vol. 11, No. 2, Spring 1994 issue.

Class News

Victoria Conn '48

Victoria Sellens Conn '48 was recently honored by the American Psychiatric Nurses' Association (APNA) as Psychiatric Nurse of the Year. Her nursing career has spanned 40 years, first as a nurse on Yale's multi-disciplinary pre-frontal lobotomy research team and extending into the 1980's as a specialist in the nursing management of psychotropic medication. The APNA award was given in recognition of her role as an advocate for persons with serious mental illness and their families. For the past 15 years, as a member of the National Alliance for the Mentally Ill, she has, "broadened the understanding of professionals to the neurobiological bases of mental illness, increased their sensitivity to the needs of family caregivers, and been a change agent to the toughest audience possible, her own peers and colleagues."

Margretta Styles '54, President of the International Council of Nurses and former Dean and Professor Emeritus of Nursing at the University of California, San Francisco, is joining the staff of Tuft and Associates, Inc. as an expert consultant in nursing education, academic administration, professional associations, and consensus-building. Tuft and Associates, Inc. are specialists in executive search, based in Chicago, IL.

Mary Collins Renken '75 and spouse announce the birth of Charlotte Anne, born on January 12, 1995. Due to some confusion on the part of the Alumnae/i Office Mary's address was incorrectly listed in the class directory that was recently mailed to reuning classmates. Her correct address is 1800 S. Sherman Street, Ste. 1, Denver, CO 80210. Her home phone number is (303) 733-5754 and business number is (303) 778-0557. Apologies to Mary for the error!

Jamie I. Richardson '77 was recently elected President of the American Association of Nurse Attorneys (TAANA) for the Texas chapter.

Sheila Conneen '79 has finished her JD degree at the University of Arizona.

Patricia Minard '79 completed requirements for the JD degree at the University of Connecticut Law School. Currently Pat is a member of the nursing staff in the coronary care unit at the West Haven Veterans Administration Medical Center.

Tom Weaver '80 recently relocated to Anchorage, Alaska to teach at the University of Alaska, Anchorage (UAA) with the responsibility for the Adult Medical-Surgical Nursing course. Tom reports that, "Alaska offers the opportunity to live in America's scenic and wildlife photographer's heaven."

Patricia Adams '82 is the Administrative Director of Critical Care at St. Joseph's Hospital in Stamford, CT.

Ann Neureuter Burnham '83 is on the staff of the Visiting Nurses Association in Pittsfield, MA.

Lyn Davis '83 is a staff member of the Visiting Nurses Association in Goshen, CT.

Eileen Sherburne '83 writes that she is a clinical nurse specialist in a children's hospital in Milwaukee, WI. She divides her time with children on a rehabilitation unit and in a pulmonary clinic.

Marguerite Witmer '83 is a clinical nurse specialist in neurology-neurosurgery at Hershey Medical Center, Hershey, PA.

Marjorie Funk '84 and Kate Griffey '93 published in the *American Journal of Cardiology*, Vol.74, p. 1170-1173, an article entitled, "Relation of Gender to the Use of Cardiac Procedures in Acute Myocardial Infarction." **Marge** also co-authored with **Michelle Bolles Vitale '93** an article, "Quality of Life in Younger Persons with an Implantable Cardioverter Defibrillator," published in *Dimensions of Critical Care Nursing*, March, 1995.

Janet Parkosewich '85, was awarded a Certificate of Appreciation in May 1994 by the American Heart Association and the Women's Health Initiative at Yale for outstanding service in advancing the heart program and stimulating public support in the fight against heart and coronary disease. Janet was also recently appointed to the Board of Directors of the Women's Health Initiative at Yale, as well as the Temple Cardiac Rehabilitation Program. Janet also presented at the following conferences: "Translating Clinical Questions into Research Problems," in Meriden, CT sponsored by the West Haven VA Medical Center; "Rehabilitation after a Cardiac Event: Focus on Women," at the Trumbull Marriott, sponsored by the American Heart Association and the Women's Health Initiative at Yale; and "Patient and Family Education: A Model for the Rehabilitation Setting," for the Connecticut Chapter of the Association of Rehabilitation Nurses at the Ramada Inn in Meriden.

Mary Marta '86 has been named Editor of *Journal for Healthcare Quality,* the official publication of the National Association for Healthcare Quality. She invites manuscripts regarding quality, utilization, and risk management from *Yale Nurse* readers. Please submit to: 101 Edgewater Road, Severna Park, MD 21146.

Suzanne Serat '87 and James Greenleaf welcomed their first child, Simone, into the world on August 13, 1994. **Suzanne** was delivered by two other YSN midwives, **Maria Cabri '82** and **Katrina Alef '86.**

Rebekah Kaplan '89 is doing well and continues to enjoy teaching with the UCSF midwifery program and her clinical work with San Francisco General Hospital.

Stacey Young-McCaughan '89 was recently featured in a career profile by the US Army Recruiting Command, Fort Knox, Kentucky.

Zoevonda Sutton '89, currently on sabbatical, spent the past 5-1/2 years working with high risk teens in San Francisco.

Martha Czelusniak '90 gave birth at home to a son, Devrim Mark, on December 11, 1994. Attending midwives were **Susan Moore Daniels '88** and **Carolyn Ansell '87.**

Liz Howard '91 and husband announce the birth of Annelise Catherine Spurgin, born on December 4, 1994, weighing 8 lbs. and 14 oz. Liz is now living and working in Tennessee.

Judy Moriarty '91 and spouse welcomed Rebecca Ann, 7 lbs. and 11 oz, in September, 1994.

Denise Guaglianone '92 and **Antoinette Tyndall '79** co-authored an article, "Comfort Issues in Patients Undergoing Radiofrequency Catheter Ablation," published in *Critical Care Nurse,* February, 1995.

Chris Beard '93 writes that her midwifery practice at the Yakima Valley Farmworkers Clinic in Prosser, WA has been, "rewarding and challenging, frustrating and fun." She is the first and only midwife in the area which has been both a personal and professional challenge. Chris is looking forward to life beyond loan repayment and has her sights set on Oregon!

Jane Dickinson '93 recently accepted the position of Clinical Director at the Clara Barton Diabetes Center in North Oxford, MA. Jane is excited about the move and is glad to be working with her first love, diabetes.

Annette Hatch-Clein '94 is alive and well and enjoying Bangor, ME. She is working as an FNP at Family Practice Residency Program at Eastern Maine Medical Hospital. Any FNP interested in working there starting late spring-early summer, contact Annette.

Kathy Kaspar '94 and spouse Fred Konkel recently moved to Baltimore, Maryland where Fred found a great job and Kathy is "happily unemployed" and expecting a baby sometime in March.

Gerald W. Kowalski '94, was recently named Director of Clinical Informatics, Department of Information Systems, Allegheny General Hospital, Allegheny Health and Education Foundation, Pittsburgh, PA.

IN MEMORIAM

Gayle Isensee '30

Xenia Beliavsky Horn '31
died on January 3, 1995.

Marguerite Luce Young '31
died on December 5, 1994.

Olive L. Blandau '38
died on November 25, 1994.

Marion Inglehart Richardson '39
died on November 19, 1994.

Aileen Harmes '40
died on January 4, 1995.

Dorothy Janet Brodrib Weed '45W
died on September 20, 1994.

Elsie E. Calhoun '46
died on January 25, 1995.

Clorinda Mardus McAteer '46
died on January 21, 1995.

Evelyn H. Piersol '47
died on December 15, 1994.

Elizabeth Smathers '47W
died on November 25, 1994.

Theresa (Betty) Shea Valentine '50
died on March 22, 1995.

CORRECTION

Apologies to Laura R. Bloom, Class of 1935, whose contribution to the 1994 Alumni Fund was listed as In Memoriam. Laura is alive and well and approaching her 60th reunion this year!

Reunion Weekend Program Upadate, June 1-3, 1995

The reunion weekend theme, "Building a Future on Shifting Sands," has taken shape and promises to be a stimulating and provocative program. Elizabeth H. Hadley, JD, MPH, Friday morning's keynote speaker, is a Phi Beta Kappa graduate of Yale College where she majored in history. She earned a law degree from the University of California, Berkeley and an MPH from Yale's Department of Epidemiology and Public Health. Her published master's thesis was on the legal and economic issues surrounding prescriptive authority for nurses. Beth has worked as an assistant attorney general for the State of Connecticut; as both a health policy analyst and a policy coordinator for the US Department of Health and Human Services; and as a Senior Policy Fellow for the American Nurses Association. She is currently a Senior Analyst for the Office of Technology Assessment, an agency of the US Congress. Friday afternoon William McIver, Regional Director, Medical Delivery Systems, Oxford Health Plans, will explain the complexities of the managed care concept and on Saturday our main speaker will be Bruce Carmichael '82, ScD, MSN, MArch, whose topic, "Rivers and Reunions: Crossings, Reflections, and Change," will identify indicators of change in the health care environment and will explore tools for evaluating one's work environment with an eye to promoting strategies for adjusting to the changes. Bruce is currently Director of Project Management at Yale School of Medicine, and serves as Assistant Clinical Professor of Nursing at YSN.

Elizabeth H. Hadley

In addition to the formal program offerings Dean Krauss plans an in-depth State of the School address in which she will elaborate on plans for the new building and discuss the new and exciting programs now being offered at the School. Come join the social festivities also planned and revisit those people and places that made your years at YSN such an important part of your personal and professional growth.

Virginia Henderson Celebrates 96th Birthday on November 30, 1994!

Harris Foss '96 with Virginia

L to R: Former YSN faculty member Eleanor Herrmann with former Deans Donna Diers and Florence Wald celebrated with Virginia.

L to R: YSN students ***Ariel Yellin '96, Bethany Berry '96,*** *and* ***Rebekah Mull-Wilmes '96*** *felt privileged to be a part of the birthday party.*

Yale University School of Nursing
Alumnae/i Association

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