Yale Nurse

Yale School of Nursing

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YSN COMMUNITY WELCOMES 7TH DEAN

AUGUST 1985
Yale University School of Nursing
ALUMNAE/I ASSOCIATION
Newsletter

Published three times a year
by the YUSNA

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August 1985

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Cover picture by T. Charles Erickson
Taken during reception following announcement by
President Giamatti of appointment of Judith
Krauss as Dean.
Florence Schorske Wald Judith Krauss, A.
Bartlett Giamatti, Donna Diers

Other photos by M. Colwell, R. Knollmueller,
K. Hale.

From The Editor - Margaret Flinter

About this issue...
Two annual cornerstones of the YSN year dominate
this issue: commencement and alumnai/i college.
There is much to convey to those of you who did
not have the opportunity to attend these events.
We'd like to share the recognition of outstanding
achievement by both student and faculty with
the Veckerei! and Goodrich awards, and the
elegance with which Dean Krauss sent the new
grads on their way. The intensity of alumnae/i
college, with its theme of "Technology and
Humanism" is recreated for you with reprints of
the formal addresses of John D. Thompson, RN,
MPH and Dr. Patricia Benner. Read the citations
of the five women chosen to receive the Dis-
tinguished Alumnae/i Awards and be inspired by
how much Yale Nurses have accomplished and given
to our society, from setting up food banks
nationally to promoting breastfeeding inter-
nationally to doing precedent setting health
policy research.

There is more. Sally Solomon '80, is a
former Robert Wood Johnson scholar, a pediatric
nurse practitioner, and now Director of Public
Policy for the National League for Nursing. In
this issue, she inaugurates a regular column
from Washington, DC dealing with political,
legislative, and organizing issues for nursing.

Since you responded enthusiastically to our
"letters from alums" feature in the Spring issue
of Yale Nurse, we bring you four more reflective
letters from Yale Nurses at very different places
in their lives and work. The contrasts are
striking. Enjoy.

From The Dean − Judith Krauss

At this writing I have just returned from
a HCFA-sponsored invitational conference on
psychiatric DRGs. For two days I listened to
the best science has to offer in the refinement
of the technology of DRGs for the prediction of
cost associated with psychiatric diagnosis and
inpatient stays. The news wasn't very good.
It turns out, to no one's surprise, that psychi-
atria diagnosis is not a very good predictor
of resource utilization or associated costs.

I was reminded of our recent Alumnae College
where we examined technology and care−keeping
both in context and, thus, in perspective. There
were very few researchers at the HCFA table who
understood the importance of examining even such
"cut and dry" phenomena like cost and resource
utilization in context. Those who did were
nurses. They will undoubtedly make the more
promising contributions to the development of a
prospective payment system in psychiatry. I was
immeasurably proud to be identified with nursing
in that room. I was also pleased to see nurse
researchers at the table with researchers from
other fields. Their credibility grew from the
quality of their research and the thoughtful,
caring, brilliance of their thinking. The
realization that they were nurses followed rather
than preceded their contributions to the con-
ference.

I think we have entered an era in health
care where the voice that will increasingly
be heard is the voice of nursing−not because
its the loudest but because it is clear, com-
passionate and contextual in a world that is
too easily dehumanized by technology.

If you attended Alumnae College, I hope you
will rediscover the richness that is Nursing
in these pages. If you didn't attend, you are
in for a rare treat!
After two rainy years in a row, Commence-
ment day dawned bright and clear and sunny,
with a gentle breeze ruffling the last of the
azaleas and the first of the rhododendrons.
Dean Judith Krauss and Helen Varney Burst,
as faculty marshall led the graduates onto the
Old Campus -- and a long parade it was: for
the Certificate in Nursing, 25 and for the
Master of Science in Nursing, 70.

The visibility of women this year was
particularly striking. The Procession Marshall,
who leads everyone in was Joni Barnett of the
Government Affairs Office; Sharyn Wilson,
Associate Secretary of the University helped
put the hoods on the honorary degree candi-
dates; our own Ann Slavinsky marched with
Berkeley College as Acting Master; four of the
recipients of honorary degrees were women.

It has become a tradition at the Old
Campus ceremony for graduates from the various
schools to add some symbolic tokens to their
academic attire, or otherwise to show off their
new trades. The Yale College graduates have
balloons which they release as their degrees
are conferred, to the sound of champagne corks
popping. The Divinity School graduates had
pipe-cleaner halos attached to their caps;
the forestry graduates have branches or
flowers on theirs; sometimes the Organization
and Management students unfurl the Wall Street
Journal; this year two graduates in environ-
mental studies had improbably plastic flamin-
goes on their heads, which caused President
Giamatti some humor as he wryly admitted them
to their degrees "with all its rights and re-
sponsibilities." Our YSN graduates had affixed
red crosses to their caps.

Back at the School, the graduates, faculty
and families assembled under our traditional
tent over the parking lot (which is much more
elegant than it sounds) to hear Dean Krauss' remarks (see page 4). Betty Ang served as
Banner Bearer, and Christina Santoni and Rhea
Sanford were class marshalls for MSN's and
Certificate students respectively.

David Steffen receives degree from the Dean.

Kristin Hale presented the class gift -
a live weeping cherry tree which already graces
the northwest side of the YSN property.
Shelley Jerige presented the Annie W. Goodrich
Award for Excellence in Teaching to Dorothy
Sexton, Associate Professor and Chair of the
Medical/Surgical Nursing Program.

"On this day of marching in gown and mortar board
It's now the time to present the Annie Goodrich
award.

Given to a teacher upon our graduation,
The award is for excellence in nursing educa-
tion.

With so talented a faculty you needn't ask
if deciding on one was a difficult task.

Upon reflecting however on all we have learned
in Med-Surge,
One particular professor did finally emerge.
Renowned about campus for her mental agility,
She is certainly possessed of superior teaching
ability.
Demanding, she did never from her high standard’s part, And her published work is truly science at art. She is devoted, pragmatic, consistent and kind With a memory which absolutely boggles the mind. Never unavailable you could always find her Even when trying to find a bookbinder.
A student, no matter how vexed on subject complex, Was welcomed for talks only later to find relevant articles stashed in their box. She was tough but fair and did never berate, Even while monitoring our parterned debate. Helping to nurture our nursing careers It is sure that in Role Development she has very few peers.
The time has come to express deep appreciation On this day of great celebration. Who will ’85's honor rest on? Why the Chairperson of Med-Surge our own Dorothy Sexton!

And Connie Bové was awarded the Andrew A. Veckerelli Prize, which is given to a graduating student chosen by a faculty committee whose clinical and scholarly work has achieved a level of excellence through which it has inspired others.

Concetta Jean Bové

"It has been said that she represents the best qualities of a health professional -- good clinical skills and ability, social awareness and concern, and an ability to maneuver the sometimes complicated health care system and public policy arena. As a first year student, she tackled the problem of infant mortality in New Haven as part of her clinical experience. In so doing, she found there were limited data and very fragmented health services for this high-risk population. These efforts led to her participation on the New Haven Poverty Commission where she supplied important data for the final report of the Commission about infant mortality in the city, highlighting the particular risks in two census tracks. Her major contribution to the Commission was recognized by the Division of Community Health Nursing, State Health Department. Recognition, though, was not her goal. She became a member of a Health Systems Agency committee to further address the problems of infant mortality and to stimulate concern and planning for improved services to this population. She prepared a current maternal-child health services directory for New Haven where none had existed for several years. This directory was given to providers in the public sector. She proposed a tracking system within and among providers who are involved in infant care.

During her second year in the program her contributions once again far exceeded clinical and academic requirements. She initiated an intravenous therapy program for an area home health agency. She didn't just develop the idea, she developed the policies, procedures, and provided the training for selected staff nurses. She also engaged in an independent study that established an evaluation schema for a free-standing urgent-care center in Fairfield County. Not only did she help the center to develop standards of care, she also helped administration and staff to attend to the very real concerns about quality of care and how it should be measured. She gathered important data that will be added to the literature about this new phenomenon in the health care system. Her work exceeds all standards of excellence. More importantly, it is embedded in a concern for the health of the public. Her influence extends to her classmates, the faculty, public policy makers, nurses and other providers in the community, and, ultimately, to consumers themselves."

Our usual sumptuous reception followed, with graduates saying goodbye to each other and to the faculty, last-minute thesis signing, and congratulations all around to the class of 1985!

Remarks by Dean Judith Krauss

It is traditional that the commencement exercises begin with a few brief words from the Dean. Each time I turned my attention to putting those words to paper, I was confronted with the horns of a dilemma. Am I to have the last word at the end of your two or three years with us? Or, am I to have the first word at the inaugural of your professional career?
To solve the dilemma, I turned to the literature. I did this, of course, because I couldn't pass up one last opportunity to provide a scholarly role model. Although all of you are beyond impressing, I at least wanted to impress your parents, spouses, children, friends, lovers, and significant others with the scholarly substance of the place, if not the Dean.
So, I consulted Miss Manners' Guide to Rearing Perfect Children on the matter of proper pomp and circumstance. Miss Manners has this to say about graduations.

"The graduates are welcome to enjoy the festivities, and many do, but it is the invited guests for whom these occasions are really held, and it behooves the graduates to go along to humor them. This not only means attending graduation if one was reluctant to do so, but treating it seriously. And, the true pleasure of letting loose with the whoop afterwards is its contrast to the stuffiness of the ceremonial part."

Miss Manners says that after the recessional march (where, unlike the processional, walking is allowed and those who have babies may carry them) the graduates must pose patiently for the cameras of all of their relatives, friends, and the Yale Nurse.

Miss Manners clearly didn't solve or even address the dilemma of whether this is an ending or a beginning. She does add a dose of levity to what is an otherwise weighty time in your lives.

The graduate professional school experience fits John Nesbit's notion of living in the time of the parentheses -- the time between eras. Graduate school allows you to temporarily bracket off the present from both the past and the future -- which probably explains why you feel neither here nor there throughout most of the experience! Nesbit, in his nationwide best seller, Megatrends, suggests that although the time of the parentheses is uncertain, it is a great and yeasty time, filled with opportunity. It is a time when one learns to make uncertainty a friend. By so doing, one can achieve so much more than mere stability. In the time of the parentheses one can have extraordinary leverage and influence -- individually, professionally and institutionally -- if we can only get a clear sense, a clear conception, a clear vision of the road ahead.

Each of you has engaged in a process of discovery (because that's what graduate education is about) that has obscured or enhanced your vision of the road ahead for nursing. The discovery extends well beyond the classroom walls and is embedded in the very fabric of this place. Some of you have discovered that the more technology we put in our hospitals, the less people want to be born there or to die there and the more they need our touch, our care, our nursing. Some of you discovered that rewards come from empowering others, not climbing over them. Still others discovered the meaning of boundaries, personal and professional, individual and group, when you formed or crossed picket lines and endured the resultant rips and tears in relationships that mattered. Some of you discovered the exhilaration of risk-taking while others discovered that not-to-risk was to risk it all. Some of you discovered a sense of humor and thereby a sense of proportion. And, all of you learned that words are timeless and that they need to be uttered and written with a sense of their timelessness. You have discovered the strength and serenity necessary to sit with the dying patient, the observing sense of self necessary to be with the psychotic patient, the sense of mastery and mystery involved in the birthing process, a sense of the whole and component parts which is the community, a sense of evolving self which is the child and the developing adult, and a sense of inquiry which is both clinical judgment and clinical research.

It is time, then, to remove the parentheses from your lives. It is time for us to return you, as it were, to the world. To family and friends, I must tell you that we are not returning the goods in the same condition in which we received them. Some are fatter, some are balder, some are bolder, and none of them have a nickel in their pockets. They no longer belong to you, if they ever did, any more than they belonged to us. They've changed in significant ways -- ways that I could not possibly characterize to you. They have developed lasting relationships that provide connections back to this place long after they have left it. They have developed enduring beliefs about the practice of nursing and the rights of all people to have access to quality health care. You and they will have to engage in your own process of discovery in order to know each other again. For my part, I thank you for loaning them to us. They are the embodiment and the actualization of the mission of the Yale School of Nursing and they cause us, the faculty, to engage anew in the process of discovery each year.

What does this process of discovery have to do with nursing anyway? It has everything to do with it. In the process of discovering whatever you have discovered while here, you have discovered yourself and that is good for nursing. Nursing is not a selfless profession. To nurse is to know one's self as fully as possible and to use one's personal presence in the context of intimacy to come to know others who are in need of care.

In Virginia Henderson's words:

"[The Nurse] is temporarily the consciousness of the unconscious, the love of life of the suicidal, the leg of the amputee, the eyes of the newly blind, the means of locomotive for the infant, knowledge and confidence for the young mother, the voice for those too weak or withdrawn to speak."

The risk of losing one's self in the act of nursing is significantly mediated by the sense of knowing one's self in the act of nursing.

To nurse, then, is to simultaneously know oneself and lose oneself in the care of another human being. Your time here has been one of both knowing and losing yourself many times over. As to whether you are ending an era or beginning one, I give to you the thought of Kahlil Gibran:

"My house says to me, 'Do not leave me, for here dwells your past.'"
And the road says to me, 'Come and follow me, for I am your future.'
And I say to both my house and the road,
'I have no past, nor have I a future.
If I stay here, there is a going in my staying;
And, if I go there is a staying in my going.'
And so ... I say to you, Goodbye, valued students and Welcome, treasured colleagues.

ALUMNAE/I WEEKEND

Thursday night arrivals kick-off the reunion weekend with an Old Campus Picnic. Following this was an informal program, "Yale Nurses in Asia," with Deborah Mayer '85 (Japan), Ed Branson '80 (Nepal) and Kay Flynn (China) sharing their experiences.

Members of 1940: Marion Fasanella, Marge Allen, Genevieve Fraga, George Fraga, Aileen Harms, Wilbert Allen.

Alumnae/i College

Keynote Speaker, John D. Thompson, Professor of Public Health and Nursing Administration (and Honorary YSN alumnus) was honored in April at the Association of University Programs in Hospital Administration annual meeting in Washington, D.C. The Association recognized him for his contributions to hospital planning and design and to the research that led to Diagnosis Related Groups (DRG's).

"Technology and Economics: A Revolution in Payment"

The titles of programs on this alumnae/i weekend are instructive. At the School of Public Health, the program is about "Doctors and Hospital Administrators -- Partners or Competitors". Today, Dr. Arnold Relman, Editor of the New England Journal of Medicine is going to speak about "The Commercialization of the American Health Care System" at the Medical School's program. Your title has much more class, and I must say, focuses on the real problem, which is technology and humanism. Because those are the issues that the other programs are symptomatic of and I hope I will be able to get this across today.

When I began examining aspects of the conflict between technology and humanism, I became convinced that the problem of high technology itself, while an important one, was not the only one that nurses were concerned about. There were at least two others, which along with high technology were perceived to contribute to depersonalization in the provision of health services. First, the increase in the number of for-profit hospitals. Second, and I hate to say this, today's accent on competition which crosses all lines in the health care delivery sector with its consequent accent on productivity which is embodied in the DRG payment scheme.

As I examined these three areas more carefully I became convinced that what nurses are facing at this time is a rather complex "shell game". Now for those who don't know what a shell game is, I'll try to explain it. It embodies three shells and a pea. And the operator very carefully jiggles the shell and he bets you if you can pick the shell under which the pea lies. Now he does this so deftly you think you know where he put it. But you never take that one. The peculiar thing about this is that he's paying you five to one if you guess and everybody knows the odds ought to be three to
to one. The answer is that a lot of times, there's no pea under any shell. He's palmed it.

So a great deal of what we're talking about is really a shell game.

When you look at the full problem of technology, for profits and technicians, there is the pea of depersonalization under all three shells. Often enough, however, when you pick up the shell, there's nothing there, it looks like everything is fine. That's what's so bad about the shell game, it sucks you in and become a part of it. I hope that we can change that a little bit and try to fashion a strategy that nursing as a profession should use in dealings with the game.

Let us first examine the area of high technology, remembering that the major criticism of high technology is that by increasing costs and substituting technical expertise for personal care, it distorts our humanistic priorities. There isn't a day that goes by that somebody isn't talking about a new NMR or a new type of CAT-scanner or some new instrument that seems to be contributing enormously to the cost of health care. Each one of these machines, it is said, has to have its own set of acolytes -- at least three -- to operate 24 hours a day, so it is not only the cost of machinery but the cost of personnel.

When the reasons for the increase in expenditures for health care, which have climbed remarkably as a percent of gross national product (now accounting for 10.8%) are examined, the actual inflationary push by technological innovation can be determined. One would anticipate, according to the propaganda -- the spiel of the shell game operator -- that it would be enormous. It is estimated that changes in technology accounted for only 13.4% of the increase in public expenditures for health care from 1965 to 81. To give you another benchmark, general inflation contributed another 55.7%, the aging population 4.7%, reimbursement policies of the federal government alone -- the old retrospective reimbursement policy -- accounted for a 15.8% increase. So you can see that in actual increases in expenditures, technology did not account for all that great an increase.

The problem is that once you get comfortable with that, we lift up the technology shell and, by George, there is a pea under it, particularly when it comes to one single program, and that is End Stage Renal Dialysis. A law was passed -- 92-603 -- on October 30, 1972, which made any individual requiring end stage renal dialysis an automatic recipient of Social Security and Medicare along with their dependents. A rather substantial increase in the cost of this one technological innovation followed. In July 1973 at the beginning of this program, there were 11,000 beneficiaries of this service. By 1979, the average yearly enrollment was 56,000 and estimates are of 90,000 by 1995.

What also happened here was a marked shift in the kind of patients treated -- an increase in older patients. Persons over 65 amounted to only 5% of the annual enrollment in '74; by '78 they had increased to 19% and are still climbing. In actual numbers, they increase from 1,000 to 9,000 from 1974 to 1978. The annual bill for E.S.R.D. in 1974, the first real year under Social Security was 283 million. By 1979 this had risen to 1.2 billion and it now exceeds 4% of total Medicare expenses. One program -- one technological program.

This is really more or less the secret of high tech. One, it affects relatively few patients; two, it is very expensive per patient, and three, it is humanistically blind. That is, it does not distinguish in any way who would be better off with it and who would not, but even more importantly, it cannot make the distinction whether these billions of dollars should be spent in an area that would achieve more social 'good'. For example, what would happen if this money were spent on maternal and child health? High tech cannot make these decisions.

It is this, then, the fact of a moral blindness and a consequent distortion of our social priorities that disturbs most of us about high technology.

The same kind of unease is felt when viewing proprietary or for-profit hospitals. These institutions have received a great deal of publicity over the past few years and again, like the pitch of the shell game operator, it could stand a little examination. For example, over the past five years, American hospital chains have purchased some 140 hospitals. Now that is a little alarming until one finds that about 60% of these were previously investor owned; 20% were government hospitals and just under 20% were voluntary not-for-profit hospitals. So the legend that they are "taking over the world" is not quite true. They have increased as a percent of total US hospitals from 1979 to 1984 from 17% to 22%. Not a very great increase. This is not to say that when you lift the shell there will never be a pea because their future strategy which is to build so-called "vertical systems" -- is more dangerous than their past strategy. They are going into home care programs, in competition with VNA's. They are going into Health Maintenance Organizations, Preferred Provider Organizations, and they've always been in nursing homes.

The rather frightening thing about this is that private hospitals owe much of their current prosperity to Medicare. As we will discuss in the next part of this, Medicare spending has increased. It rose from 1 billion in 1966, the first year it was in operation to 66 billion in 1984. Medicare provides about one-third of the revenue of the average hospital, but about half of the revenue of the for-profit chains.

Now, the for-profit hospital chains are a bit concerned about the new reimbursement program. Humana, for example, has reduced its
capital spending; National Medical Enterprises forecasts that its bed occupancy will drop 5% this year to 55%, and the average length of stay has declined in Hospital Corporation of America's hospitals each of the last two years.

What concerns us so much about this -- the pea of our discontent here -- is the fear that these hospitals who will often openly discriminate and select only "profitable" patients for admission will now begin to select profitable DRG's among one class of patients -- Medicare -- throwing additional burdens on voluntary hospitals, city hospitals and visiting nurse associations.

So it seems that a lot of blame is being put on DRG's.

The first thing we have to do is separate out the DRG concept of classifying patients by the resources they use in order to help manage and operate the hospital more effectively and the application of DRT's into payment. Donna and I gave some papers earlier this week at the National League for Nursing and this was the critical message we tried to get across to them. Actually, DRG's, as we hope to demonstrate, may provide opportunities to nurses, that we never had before, if we seize the task.

The problem with DRG's is that they are indeed working. DRG's went into effect in Connecticut on October 1, 1984 and when you compare fiscal '84 with '83, the 35 hospitals in Connecticut (and Connecticut has always had a very parsimonious health care delivery system; we have fewer beds per thousand than most states, fewer admissions and fewer days to start off with) 152,850 fewer patient days were given last year. Those are strictly limited to adult med/surg patients. That was a decrease of almost 6%. At the same time there were fewer admissions, but that decrease was very small in Connecticut compared to the rest of the country -- it was only a decrease of .75% in admissions. The average length of stay in hospitals in Connecticut dropped from 8.50 days for the first quarter of fiscal '83 to 7.73 days, second quarter of fiscal '85, a decrease of .77 days. That's a very large decrease. DRG's are indeed changing the behavior of physicians. They're changing the way patients are being treated.

Nurses are very concerned about this. They are concerned that we are pushing patients out of the hospital before they ought to go and they are concerned, as I am concerned, that we may be repeating what I consider to be the greatest social sin our civilization has committed in the last 10 years. And that is emptying out the psychiatric patients from the long-term hospitals into the community without a support system. That was a social sin. There was nothing humanistic about it. The only thing that makes it bearable, at least in Connecticut, is that the greatest thing that helped these patients was the "bottle bill". If you travel throughout New Haven, you see these patients, some with a shopping cart, full of bottles and cans, going to some supermarket to trade it in so they can support themselves.

Now we cannot let that happen again.

What I want to do now is to examine two major criticisms of DRG's -- the system itself and the payment system. The first is whether DRG's are a measure of severity of illness and the second is how do DRG's measure the different kinds of nursing resources consumed by different patients. These two questions are somewhat related.

The issue of severity will be addressed first. There are those who claim that there are wide differences in severity of illness in patients within a single DRG. Further, it is said that the information used by DRG's is not sufficiently sensitive to measure that difference. Therefore, a whole different system of examining patient charts must be undertaken.

There are problems with the literature on this subject. One is the measure taken of patient severity of illness without defining it precisely becomes a pretty subjective exercise. Two, to measure severity of illness without associating severity of illness with DRG's, that is to measure nursing intensity seems to be missing a very important component of severity, however defined. And three, the techniques used are not replicable. The findings of the main workers in this field cannot be repeated because many of the judgments are subjective, estimates, followed by an overall integrating subjective estimate, blending in seven subjective estimates. Recent articles have appeared focusing on the inability of other independent researchers to replicate these findings and the need for precision in the definition of severity of illness whether the person making the judgment was the patient, a hospital administrator, a physician or a nurse.

The second criticism of DRG's is far more valid. In essence, this objection states that the component of patient care known and billed as "room and board" or in some circles as "routine services" is not allocated to the DRG according to the utilization of resources by individual patients. This class of resources, which include nursing care, is buried in a variety of unrelated expenditures and accounts for 46% of the cost expended in treating the average Medicare patient. The different nursing resources used in treating different DRG's are not, then, allocated correctly. It is only the 10% which is the estimate of how much it costs to provide intensive care that reflects a close approximation of the use of nursing care by patients.

Now this is an old problem, due to the fact that in most hospitals, patients are not charged for, nor are records kept, of the kinds and types of nursing care they receive on the routine inpatient floor. As a consequence, nursing costs are blended in to a variety of unrelated costs and promptly mislabeled. We try to describe this as "mops and bils and cleaning wax and spinach greens and canes." Because included in "routine services" are laundry, linen, business office expense on accounts receivable, housekeeping costs and uncharged medical supplies. These are not the only costs, but these are,
along with nursing, the major categories of "routine costs". That's what I mean by mislabeling.

The DRG system allocates its expenses to each patient by the number of days of stay. The amount allocated per day is the same for a patient with a lens extraction or hospitalization for the implantation of a heart device. There's no way of identifying or even defining the cost of nursing care.

The burying of these costs in the hospital's cost accounting system was a historical accident, starting about 1930 when the first real cost accounting studies were done. Oddly enough, one of the first was for nursing but the purpose was not to determine, in those days the different hours of nursing for different kinds of patients, although to some extent this was done, but to separate educational costs from nursing service of student nurses. That was the major problem in those days. Now, this model was given life later on when hospitals began to cost out room and board, or "day rates" in order to give a price to Blue Cross to sell their service contracts.

Now, we're not here to decry or make over past mistakes other than to repeat that the present problems are part of the previous solution. We are looking for new solutions. It looks as though the day is coming when nursing research and nursing studies carried out in two different areas will make us able to make the DRG more accurately reflect the cost of caring for each patient.

Nursing costs can be properly allocated by, (1) defining nursing costs in some meaningful way and (2) relating nursing costs to DRG's and much broader issues such as treatment choices, making it possible to carry out effectiveness studies on patient care by specific DRG's in various settings, with various kinds of nurse staffing patterns.

Let's start with the first area of inquiry, the isolation of nursing costs altogether. A great deal of work is being reported in this area, stimulated by Walker's article in NURSING IN THE 1980's. At least five other articles trying to isolate and identify nursing costs have come out. In an early article from our group at Yale, we addressed pulling nursing costs out from the room and board altogether, identifying it as a separate cost center and call all other routine costs "hotel expenses". There now seems to be emerging an accepted definition of nursing costs, defined as the direct costs of nursing care to patients in inpatient units plus that part of nursing administration that is assignable to this direct patient care activity. Nursing as a cost center is not only a result of DRG's but comes from a concept of charging for routine nursing care and transforming the cost center labeled "nursing care" from simply a cost center to a revenue center as well. Many of you may know that St. Raphael's Hospital is actually experimenting with this in New Haven today.

Now such a definition, of course, includes nursing salaries in operating rooms, outpatient departments etc.

The other part of the direct nursing care costs which are specifically identified and for which charges are made in almost every hospital is that care given in special care units. As I said before, this comprises about 10% of the cost of treating patients, so it is no insignificant item. There are indications that care in these units is growing rather than decreasing like all hospital days, as a percent of all hospital costs. These expenditures can be identified, captured, isolated by DRG and therefore entered into budget projections. Comparisons across hospitals on this particular type of nursing care can be done.

The isolation and identification of routine nursing is a little bit more difficult but it can be done by costing out the patient classification systems now in use for staffing. There was a recent piece of research by Sovie from the University of Rochester/Strong Memorial Hospital that demonstrates the possibility of this approach and defines nursing intensity as the percent of time the patient spent in four different levels of nursing intensity during a single hospital stay.

So we are beginning, then, to demonstrate the relationship between DRG and nursing intensity and it will change some of the cost weights for DRG's based on a nursing intensity factor. More important, perhaps, is the relationship of some of these findings to answer some of the hidden questions in nursing. There is no doubt that as this research continues, that nursing should begin to ask the same kinds of embarrassing questions that are now being explored using the rest of the DRG costing algorithm. For example, individuals are beginning to focus in on medical teaching costs -- how much are they? How much should they be? Should the patient carry these costs? It's a matter of public debate now and it is only possible through the DRG costing algorithm. Others are beginning to question research costs which also may be buried in the patient's bill. The whole practice of cost shifting across departments is also being questioned, again because of the DRG costing algorithm. We expect the same thing in nursing service.

The first issue is, as has been mentioned above, is the separate charging for routine nursing -- should we do it, and how much is it going to be and what will it mean in shifting relationships between the Director of Nursing and the Administrator of the hospital. She now has control of a rather sizeable revenue. And again, more importantly as far as the topic today is concerned, at the DRG level whether it is more cost effective and humane to employ different mixes of nursing staff in different treatment settings.

If we take a look at the kinds of patients, particularly Medicare patients admitted to our hospitals, and we just try to rank all the DRG's
by the most expensive -- those that have the highest volume times the highest cost, we find the following kinds of diagnoses: heart failure and shock; CVA, atherosclerosis, COPD, AMI (anterior myocardial infarction), simple pneumonia, esophagitis, major joint procedures, lens procedures (operations for cataracts) and diabetes.

Now I maintain that for all of these top diagnoses, and they account for a lot of money, only two of them are really treated with high tech these days -- AMI and major joint. All the rest of the patients are in because they need nursing care. That's why they're in the hospital. Again, these are chronic conditions and the real problems are readmissions. And readmissions in these diagnoses is due to a failure of the support system outside the hospital and that also is the business of nursing.

So when they give you all the guff about high tech, just be sure that somebody's going to take that high tech and scrape off the money and leave the patients with their problems, to nurses.

Now what should we do about it, what should nurses' posture be? The first thing is, please do not be taken in by the pitchman. You people should know enough about the system so that when he starts juggling the shells, you be sure you don't listen to him, you watch the game.

The second thing is, you have to seize the space between high technology and the patient; that's your space. Nobody else has that space. You have to supervise the transition between the institution and programs the patient is going to have to travel. You have to supply the support to the patient and his family. Nobody else is going to do it. Nobody else is going to do good discharge planning, to really explain to the patient what the implications of some of these new technological procedures are but nurses. That's your space; grab it.

Now, the third thing is, this I want you to watch the way the wind blows through the money tree. And you have to be able to get nurses' share of that money. What we're talking about is not that I want to make money-grubbers out of you. We're talking about control of a professional role definition, we're talking about the control of money that is due the profession, that the profession earns, and we're talking about responsibility for a much broader spectrum of care because you can get the money to do it now, more than it has ever been possible before. So please, watch the way the wind blows through the money tree.

Now, you also have another role and this is, that if indeed we're in a shall game, and we are, you keep the game honest. Be sure that the pea is under the shell. Again, because of your particular knowledge and your interest and concern about the patient, you are the only ones who can keep score, who can keep track of what's going on as far as the patient is concerned, as far as the humanism of patient care is concerned.

Now that's a pretty big agenda for nurses, but the problem is I don't see anyone else even interested in that agenda. And if you people don't take over, then everybody else is going to be talking about "partners or competitors" or the "commercialization of the care system" and shedding a few tears on the way to the bank, and you people are going to be catching all that's left.

These are my words of advice to you about humanism and technology.

Audience Participation

J. Krauss: Talk to us about humanism and technology, DRG's and psychiatric care and nursing!

JDT: As Judy knows very well, psychiatric DRG's are not used as a payment source for those patients treated in specially defined psychiatric units in general hospitals. The psychiatrists didn't like them. They mounted a rather successful publicity campaign during the hearings of the prepayment bill and therefore got themselves excused. Also excused, by the way, are children's hospitals but then that's not much -- how many children are treated under Medicare anyway? So the federal government didn't give away a hell of a lot when they gave that away.

Psychiatry -- there are two problems. One is that the sample that we used to fashion DRG's did not differentiate between hospitals that had formal psychiatric units and hospitals that didn't. And it contained no data on free-standing psychiatric hospitals of any kind.

The second thing was that when we looked at the data, the variance was just enormous. You couldn't explain as much of the variance in the use of resources in psychiatric patients as you could in somatic patients where we could explain a great deal. We then made up our minds that the problem was that the data that we worked with -- patients' diagnoses, age, presence or absence of complications, secondary diagnoses and comorbidities -- in psychiatric patients was not sufficient. What we needed was the place where the psychiatrist was trained.

In other words, was this psychiatrist -- a rocker, or a shocker, or a druggie or a talker? Because each one of these different kinds of therapeutic philosophies greatly affects the length of stay far more than what the patient's diagnosis was. So unless that was on the UHDDS, and it's not, we really could not make any selection. HCFA is supposed to make up its mind this year what it's going to do about this. There are rumors they're just going to tell the psychiatrists, "shape up, kid, we're laying this on the rest of the medical profession, we're going to lay it on you." We don't really know.
Audience: I'm concerned that there's the same kind of problem in home care, that the DRG's don't explain enough to the variance. For those of us planning research in home care, I'm wondering if you feel it's better to forget those medical diagnoses and start back measuring nursing intensity.

JDT: I think that to apply DRG's to home care would be a serious mistake and a tragedy even. In the first place, they weren't designed to measure that. In the second place, we have worked with so-called RUG's, Resource Utilization Groups for long term care patients that are probably much more applicable to home care than are DRG's. Now, RUG's do not make the assumption that there's a definite length of stay; it pays by day with different payment per day. More important, it takes into account the patient's activities of daily living (ADL) as the important indicator here, not what the diagnosis was or is. It isn't that we're not interested in this. We wanted to do a piece of work with Peg Cushman and the people in Waterbury/Hartford in order to find out what does go on here. Two nurses at YSN did a preliminary study on what are the factors that seem to predict at least the number of visits. But it's going to be tough. I sincerely hope that nursing researchers will get on with it and forget DRG's. Go down to the real problem, which is degree of dependence/independence and the support system -- that's what's critical.

Audience: Would you comment on the current economic climate and primary care centers associated with hospitals and the use of nurses as primary care providers?

JDT: Well, the only way you can "win" under the DRG system is to keep the patient out of the hospital, as long as you can, and do as much work before you get to the hospital as you can, so you can keep the price down and therefore make the DRG numbers and make money on DRG's. If they can do a lot of preliminary stuff before the patient comes to the hospital, not only care, but testing and all the rest, they get a patient admitted, the patient's out pretty quick and home. But that means that the HMO has to have a pretty fair idea that it is going into the visiting nurse business, particularly for followup. Some have and some haven't.

When they begin to contract, we can anticipate that more and more nurse practitioners are going to be used. In the first place, they're the only ones who can deal with these problems, and secondly, to be crass, they're cheaper than doctors. It seems to me that there is that possible approach. Even though most nurses are indeed hired by hospitals, there's nothing in the profession that ties her to hospitals. She has a lot more options than she realizes. And it's opening up these options that I think is important.

Audience: How does keeping the patients away from hospitals affect the nursing profession? Because if there are so many fewer patients, you don't need so many nurses.

JDT: The fastest increasing part of the hospital business is intensive care. Intensive care is one area, whether you like it or not, that eats nurses. It's RN's, it doesn't need LPN's or aides. It uses a LOT of them. So as patients are sicker, we would anticipate more nurses being hired.

We would also hope, and many of us feel, that we can pretty well demonstrate, once we get some nursing intensity figures that, for example an RN staff is probably more effective -- I didn't say efficient, I said effective -- than a mixed staff in processing patients through the system. So we will see, we hope anyway, more of a shift onto more RN staff. We also feel that primary nursing is the only way you can handle it. If indeed you are going to escort a patient through this system and do discharge planning and enter him into the system, you have to have responsibility for that patient from the time he goes in to the time he leaves. And you have to hand him over, perhaps, to a home care nurse. (That's at least my definition of primary nursing -- I'm not going to get into definitions because I'm not an expert, but that's how I view it). And then we're going to see more of these other roles. We're going to see more nurses used in HMO's. I hope we see a much stronger and more vibrant home care system. And then there's the whole area we have just explored but haven't done anything about -- and that is the role of the nurse practitioner in the nursing home. We did some exploration some time ago, looking at the problems in nursing homes. The problem in nursing homes is not nursing care. The problem was the medical care. Now, there have been several experiments, out in the midwest primarily, where they have put nurse practitioners in nursing homes and they found out that she can handle about 99.9% of the problems and do it much better, and work much closer with nurses to move patients from a passive mode to an active mode. Now, we haven't even explored that -- that's a whole new market out there. But nursing has got to free itself from its entrapment in hospitals.

Audience: I'm involved in collective bargaining and most of the time we've done that through hospitals, which have a lot of nurses. And most of the time we've been able to bring nurses up to a decent wage. I'm looking at the dangers inherent in going into agencies that are much smaller -- nursing homes. Nurses get paid much less at nursing homes than when they work in hospitals. They're going to have to fight to get a decent salary even as nurse practitioners in home health care.

JDT: That's probably true. But let me ask you a question. Wouldn't you be in a more powerful bargaining position if nursing was a revenue
center as well as a cost center? I'm talking about a real revenue center, where you make charges and then you're just like the radiologists. The guy says, "what do you mean, you're not going to approve my budget, look how much money I made for you. Come on."

Audience: You mean, I need to put a charge to that? Every treatment I make, I need to put a charge to?

JDT: Well there are several ways of doing it. That's one way. You can arrive at your own staffing algorithm -- GRASP, San Joaquin, Medicus -- they're all the same, by the way. And you say, as Sovie did, "okay, you spent four days in the intensive care category (not the intensive care unit, these are floor care categories), and three days in intermediate care, and I have a price for each one of those." I don't have to make out a bill for every time I take someone a cup of water. But she charges and gets it."

Panelists responding to John Thompson's address represented specialty areas within nursing: L-R, Linda Norton '80 (Med/Surg), Ruth Knolmueller (Community Health), Kathy Reilly Powderly '75, Helen Burst '63 (Maternal-Newborn-Nurse Midwifery), Jill Strawn '77 (Psych-Mental Health). David Whitehorn '85 at podium, discussed his thesis research "Attributes of Clinical Nurse specialists Towards Computers in Nursing Practice."

Special Address by Patricia Benner, Ph.D.

Introduction by Shelley Jerige '85

It is my great pleasure to introduce Dr. Patricia Benner, Associate Professor, Department of Physiological Nursing, University of California, at San Francisco. After completing her Master of Science in Medical Surgical Nursing at the University of California, San Francisco, she went on to study with Richard Lazarus and received her Ph.D. from the University of California at Berkeley, School of Education. Dr. Benner has traveled, lectured and written widely on many subjects as stress and coping, as well as power and excellence in clinical nursing practice. I was first introduced to Patricia Benner's work by Kay Flynn who drew many students' attention to her 1982 article in AJN entitled "From Novice to Expert". Later that same year I reread that article many times to anchor myself as I experienced being a novice student in the Cardio-Thoracic Intensive Care Unit, my first ICU experience--hereafter named the "semester of the sweating palms".

Some time later, Connie Donovan of the Med/Surg Faculty at YSN lent me a copy of Dr. Benner's book From Novice to Expert: Excellence and Power in Clinical Nursing Practice. There is something wonderful and very different about this book. The language is rich in specific involvement, the color and texture of a novice nurse's mistakes and descriptions of supreme nursing skill. It tells us about involved, committed human relationships between real nurses and real patients. You can really make the journey from Novice to Expert with this guide. Please welcome Dr. Patricia Benner.

Preserving Caring In An Era Of Cost-Containment, Marketing and High Technology

Expert caring makes the difference between life and death, short hospital stays versus long ones, creates moments of closeness, communication and dignity at death instead of isolation and dehumanization; it unites mothers, babies and fathers in celebration at birth, affords comfort and pain relief measures that are not limited to pharmaceutical potions, makes an uncharted illness or disfigurement interpretable and approachable, mobilizes hope, provides an early warning of patient change even before measurement in vital signs is possible, assists the diagnostic and monitoring functions mandated by highly technical and risky therapeutic interventions, and offers innumerable other kinds of empowerment made possible by knowledge combined with caring.

In an era of cost containment, marketing, and high technology, caring is more than ever overlooked and unrewarded. This is a dangerously blind position because without care a highly technical health care system cannot function. Without care the number of catastrophes can outnumber the cures. I have been studying the practice of expert nurses for the past six years and they have taught me a lot about the primacy and power of caring.

I believe that a new relationship between health care providers and patients or consumers has been ushered in. I cannot locate the exact turning point, but a clue might be that the Hospital Literature Index did not include the subject heading "Marketing of Health Services" until 1979, and "Economic Competition" did not enter until 1982 (Levey and Hesse, 1985). My thesis is that DRG's are not just a way of containing badly escalated costs but a significant
way of understanding human beings, health and illness, care and recovery. The three cultural forces that best reflect this changed relationship and self understanding are 1) Utilitarian Individualism, 2) the ethos of technology, and 3) the marketing of health care services. These three cultural forces are not new on the scene, but are now more pervasive than was ever the case in the sixties, and early 70's. I want to make a case for the primacy and power of caring in any cure, or recovery from illness, and to conclude by identifying ways we might act to conserve and preserve caring in the current commercial climate of health care.

Utilitarian Individualism

"Utilitarian Individualism views society as arising from a contract that individuals enter into only in order to advance their self-interest" (Bellah et al., 1985.). The notion is based upon both Hobbesian and Lockeian ideas and was made explicit for American culture by Benjamin Franklin. Utilitarian individualism is basically an economic view of people and is expressed in the language of cost/benefit analyses, that is, rational calculations derived from a scientific understanding of meaning that focuses on the designative and denotive functions of language (Taylor, 1982). In other words, meaning is constrained to what objects language can point to or represent. Language is seen to have only propositional content; the expressive and constitutive roles of meaning are overlooked. In this paper I am using Heidegger’s notion of understanding that goes beyond designative and denotive theories of meaning, and encompasses the person’s understanding of their own possibilities, what it means to be the kind of human being that they are. This view of the person contrasts with the self of Utilitarian Individualism which proposes the notion of the self of possession (Sandel, 1982). The self of possession freely chooses its own meaning, and even views friendships as being based upon attributes that match one’s own affinities, desires, or needs. The self of possession overlooks friendship as a way of knowing oneself (the constitutive role of friendship). In the constitutive view, membership in a community or a friendship cannot be fully captured by listing all the reasons for liking one’s friends or choosing to belong to a community if the friendship or community are self-defining. In the constitutive view, relationships are not contracts between autonomous individuals but are memberships based upon shared meanings and goals.

By contrast, in Utilitarian Individualism, the self is the center of all meaning-giving activity, and the individual is radically free to give any meaning to any event at any time. The common background meanings, skills, and practices that one is constituted by from conception on, are overlooked. From the perspective of Utilitarian Individualism, life is a contract and you get what you earn. Generosity, blessing, and altruism can only be interpreted as enlightened self-interest. Caring for others or being in the position of requiring care becomes an embarrassment, something that one wants to cover up. However, this extremely individualistic picture overlooks that health maintenance and illness require care and community. A few definitions are in order here. Health is the personal experience of relative well-being. What is perceived as "healthy" by a person with a history of chronic illness or disability is different from the perception of "health" by a young athlete. Likewise, illness is the human experience of sickness, the experience of relative loss of well-being. Illness includes the perception of pain, suffering, the fear of loss and the sense of interruption that comes when illness strikes. In contrast to health and illness, disease is the manifestation of abnormalities in the function and structure(s) of cells, tissue, and organ system (Kleinman, Eisenberg, and Good, 1978). Illness and disease do not stand in a one-to-one relation. Illness may occur in the absence of discernible disease, and the course of a disease can be quite distinct from the illness experience trajectory of the accompanying illness.

Contemporary medical practice no longer matches lay expectations (Kleinman, Eisenberg, & Good, 1978). Modern physicians diagnose and treat diseases, whereas patients suffer illness and want more health promotion and illness prevention. Health and illness are shaped by cultural practices and interpretations. These meanings are embedded in a web of cultural, historical and social networks. Therefore, the individual is not radically free to choose just any meaning of their health and illness experience (Taylor, 1979). For example, though the pain of childbirth and the passing of kidney stones might be comparable from a purely physiological and structural perspective, the coping strategies, meaning and valuations available to the same woman having a baby, and who at another time has the misfortune of passing a kidney stone, are entirely different because the
meanings and valuations of the two events are so different. Likewise, the person suffering from treatable severe burns has an experience and valuation of pain quite different from the person with terminal cancer. These extreme examples point out the extent to which cultural meanings shape the health and illness experience and influence the course of the disease.

We know from psychosocial epidemiological research that social support, stressful life events and personal appraisals contribute to the etiology and alter the course of disease. A strictly microbial view of disease will no longer suffice (Cassel, 1976). Nor is the traditional Cartesian split between mind and body adequate for understanding health, illness, and disease (Cassel, 1982). Likewise, old distinctions between the functions of caring, curing and healing are no longer adequate. Caring is often frankly curative because it facilitates healing. And many attempts to cure will fail if the patient's fears are not alleviated by reliable caring.

A major criticism of Diagnostic Related Groups as a means of cost containment, and of marketing and bottom line health care management is that only theisode side of loss of health is noticed. As Stern and Epstein (1985) point out in the New England Journal of Medicine:

"The current classification system does not consider the severity of illness, socioeconomic characteristics of the patient, or other factors that may affect the cost of providing care to a patient with a given diagnosis" (p. 622).

In my work in practical knowledge I collect examples of new clinical knowledge that is developed as a result of new technology or new practices. Recently, an emphasis is being placed on who can or cannot make it in a hotel room near the hospital by themselves during chemotherapy. One example was an older man who was having fainting spells during his initial treatments in the hospital. The nurse was adamant that the patient was not well enough to be discharged alone to a local motel. She persisted in the face of physician disagreement with her assessment and family resistance in taking the somewhat estranged father into the daughter's home where he would not be alone. The nurse's intervention had lifesaving consequences because the patient was found unconscious in the bathroom of the daughter's home early the second morning after discharge and was rushed to the hospital where he recovered. The nurse's judgment was credited with saving this patient's life. This illustrates the primacy and power of caring in cure and recovery because this nurse had to care in order to notice this patient's responses and behavior closely enough to recognize the danger inherent in releasing him alone. She also had to recognize the breakdown of care in the family and make a strong case for the patient's need for observation and care. And finally she has to care to take a stand and not be dissuaded easily by family or doctors.

The Ethos of Technology

Here I turn to Heidegger's notion of technology as a means of self understanding (Palmer 1969, Heidegger, 1962). A technological view is both extremely subjective and objective. The world as coherent and meaningful is passed over and objects are identified as represented by subjects whose goal is to manage and control the objects as raw material to be manipulated, managed, and used to the fullest. Indeed the self becomes raw material to be managed, developed, and controlled. Palmer describes Heidegger's view this way:

"Thought becomes technological, shaped to the requirements of concepts and ideas that will give control over objects and experience. Thinking is not longer a matter of open responsiveness to the world but of restless efforts to master it; it does not conserve and act as guardian of the riches of the earth, but exhausts the world in trying to restructure it to man's purposes." (p. 147)

I think that without an advanced self-understanding based in technology that DRG's as a cost-containment system would not have been plausible. Patients become objectified into disease categories; their illness, what it means to be ill and recover in their world is overlooked. One can be cured at the tissue level without recovering from the impact of the illness. Within the ethos of instrumentalism or technological thinking, the patient becomes raw material or an object to be manipulated and controlled or managed. The wisdom of the patient, the wisdom of the body, and the role of the family and community in bringing about restoration and full recovery are overlooked.

From the patient's perspective, a technological understanding of the body may render health and wholeness inaccessible, as one is barraged daily by the latest discoveries of the vulnerabilities of one's bodily parts, and the concomitant dangers of a modern industrial age. Indeed the loss of the sense of the body as a unified system of capacities meaningfully related to the world is substituted for an atomistic, elemental notion of the body as machine comprised of many bits and pieces that can be substituted, altered or strengthened (see Merleau-Ponty, 1962). Utilitarian individualism and a technological self-understanding are both essentially economic views of human beings and lead easily into commercial view of health and disease.

The Marketing of Health Care Services

I have tried to recover for myself what it was like before health care services were marketed, when a sense of shame was connected to openly benefiting from someone else's suffering. Hospitals were to serve the sick and suffering, to provide comfort and care. It was at least publicly reprehensible and greedy for hospitals to develop fortunes on the misfortunes of others.
Charity and mercy were considered essential to the helping professions. The health professional was to care. Now we all recognize that this earlier view was largely an institutional fiction because hospitals did profit, and with an open invitation to spend whatever was necessary to care for the sick, they proliferated services to individuals already served rather than increasing their services to the underserved. However voluntary not for profit hospitals depended on community fund raising and allocated portions of their services as charity.

The old view of a healing community that cared for the ill, bounded in the Judeo-Christian tradition, had overtones of paternalism, and did not match the view of the self as an autonomous agent who freely entered into egalitarian contracts that could be paid for or understood in terms of some form of benefit or exchange. We switched from the notion of health care providers as healers and servants to health care providers as partners in a contract where the health care providers deliver goods and services that we freely elect.

I must admit, I am more comfortable with this contractual picture. I have a great ambivalence for modern technological medicine, and I know that I want to be free to pick and choose what services I will or will not partake of. But I am troubled with the reality that should I require intensive care due to a gravely serious accident or illness, that in reality, my powers to monitor and choose my health care would be compromised and I would in fact have to depend on the charity and mercy of those taking care of me. I will be a patient instead of a client freely contracting for services Notice in this circumstance I am not even willing to talk about justice, or my rights as a patient, because rights and justice are remedial in a context of generosity and the ethics of care and responsibility (Sandel, 1982). For example, in a family where mutual concern and a spirit of generosity abounds, the issues of justice and rights seldom come up because members receive far more than their rights and forgiveness supercedes justice. I am clear, I do not merely want rights or justice, I want mercy and generosity. I think that the autonomy of the critically ill patient is limited on a number of levels. They dare not be troubled with too many trivial choices when they have to weigh, under stressful conditions life and death decisions about their treatment and their ability to contribute to their recovery. In the ambulatory care environment, I think the patient should even provide input on the preferred color of bandaid but in an intensive care unit the trivial decisions should be judiciously withheld and astutely restored in the context of care and understanding of the meaning of daily activities and treatments. I do not think that this view is paternalistic; it does depend on mutuality and trust and draws on the ethics of care and responsibility (Sandel, 1982; Gilligan, 1982).

Our language shapes our self-understanding, so I cannot take a marketing approach to health care lightly. It will change the context of care and cure, and will shape our self-understanding and, as was noted in a recent article in the New England Journal of Medicine, in bottom-line health care

"...patients become 'customers,' and physicians become members of the hospital 'sales force.' Emulating the business sector's preoccupation with short-term financial returns, some managers appear to have discarded 'sick' or 'injured' patients from their lexicons, categorizing them instead as 'doctor know best consumers,' 'repeat consumers,' 'convenience consumers,' or 'image consumers.'"

It is only a short distance from viewing the patient as a consumer of goods and services to the development of superfluous treatments and services, and finally in the worst of all deterioration, to view the patient as a mark in a con game.

In sum, Utilitarian Individualism, a technological self-understanding and a marketing relationship between health care providers and consumers are threats to an ethic and relation of care and responsibility. These three cultural forces overlook the primacy and power of care in cure.

Caring as I am using the term reflects interpersonal concern and liking so that the other person's plight and fate matters to the one who cares. Caring is possible only from an involved stance on this definition. Caring behaviors void of involvement may exist and may even be effective as ministrations; however, caring as I am using the term here implies emotional and motivational components such that the person is engaged in the situation and is not detached or uninvolved (See Dreyfus and Dreyfus, in Press). Caring sets up the condition for salience so that significant details are noticed. I have some evidence that there might be effective and ineffective kinds of involvement. Nurses have described instances where their own self preoccupation interfered with meeting patients' needs and instances where their involvement led to over-identification so that the "otherness" or patient's perspective was missed. I do not have sufficient data to talk about ineffective involvement. I think that we have tended to see the problem with involvement and have erroneously concluded that detachment and distance were the only safe antidotes to the "hazards" of involvement. In my research, I have concentrated on instances where nurses felt that they made a difference in the patient's outcome and where their involvement was a necessary enabling force in the situation. Nurses were also asked to describe situations where things did not go well, where there was breakdown or unfavorable outcomes; however, these incidents did not yield clear instances where involvement contributed to the breakdown or unfavorable outcome. ↓
must await future research to spell out characteristics of ineffective or harmful involvement.

Caring, as I am using the term, reflects interpersonal concern and liking so that the other person's plight and fate matters to the one who cares. Caring is possible only from an involved stance on this definition. Caring by its nature does not seek to control or master but to facilitate and uncover the possibilities inherent in the situation and the person. Caring provides empowerment (Benner, 1984). Empowerment strategies offer an alternative to depersonalization and powerlessness in the practices of Utilitarian Individualism and in the drive for technological manipulation and control. However, the values and practices of Utilitarian Individualism and a Technological Self-understanding cause a devaluation and misunderstanding of caring.

I think we as nurses have to rediscover the primacy and power of caring in restoring people to full recovery from both illness and disease and in promoting health. On every side we have to protect the language of care from trivialization and sentimentality; that is why I have preferred to stick to concrete examples of caring. Caring does not have to rob one of his/her sense of mastery; it can reawaken an understanding of the expressive and constitutive role of meaning in recovery. In the midst of all the competition and exploitation of illness and disease in today's bottom-line health care, I can imagine that if a hospital that would proclaim even more rigorous tenets of care, and take the risk of developing their care based upon real health care needs rather than gamesmanship, they would more than survive in the current economic health care scramble. I think that the window of opportunity might be here in Prospective Payment of health care for nurses to offer health promotion and the teaching of self care for a range of illnesses, and to offer support services for those who are caring for their family in the home. I worry about the inequities of the DRG system, and a free market driven health care system; I also worry about the loss of the language and practices of care, and I am concerned about the changed relationship between health care providers and clients now that health care is primarily a business. As Robert Bellah points out,

"Social ecology is damaged not only by war, genocide, and political repression. It is also damaged by the destruction of the subtle ties that bind human beings to one another, leaving them frightened and alone. It has been evident for some time that unless we begin to repair the damage to our social ecology, we will destroy ourselves long before natural ecological disaster has time to be realized." (p. 284)

The problem we face in preserving care in this era is compounded by the fact that expert care has an inherent hiddenness that is further masked by excessive rationalization and instrumentalism.

I have been intrigued with nurses' responses to stories of expertise. When I look at the common denominator in all stories of making a difference, there is an emphasis on the caring relationship between patient and nurse. Some of my most discouraging moments came early in this work. Even though I described actual patient care situations with less than perfect physician responses and poor staffing, nurses were skeptical and would say: "Well that is not possible in my setting." When I talked about helping relationships using some psychiatric nursing examples, but primarily examples from medical-surgical units, nurses would attend only to the psychiatric examples, saying that psychiatric settings expect nurses to attend to their helping relationship. At first I was very distressed at this kind of disowning and denying of our excellent caring. I thought that this response was a result of nurses' self-deprecation and lack of self-esteem so that it just didn't occur to nurses to take credit. And I still think that nurses' socialization as women contributes to disowning their good accomplishments. We have been taught not to brag. We have been taught that we should be seen and not heard, and we took it too seriously. But that is not the whole story. I want to illustrate how expert caring is disowned and hidden in the context of Utilitarian Individualism, Technology, and Commercialization.

Focusing on the predictable, and what can be guaranteed.

Some of the most important outcomes of clinical nursing expertise cannot be guaranteed or legislated. It cannot be put into standards of patient care language. And you cannot promise to deliver it yourself, much less demand such feats from other nurses. This aspect of expert caring violates a contractual notion of exchange of goods and services. For example, I have many stories where nurses made a difference by mobilizing a patient's hope. A nurse in Nova Scotia told a story of weaning a patient from a respirator. The patient had had his third coronary artery bypass and everyone including the patient was afraid it was going to be extremely difficult to get him off the respirator. This nurse, who was very experienced in weaning patients from respirators, talked with him early in the day and recognized his fear. She said to him with confidence, "Today, you are I am going to get you off the respirator." The day was spent in helping him get into a chair, get comfortable, get confident, feel encouraged. The nurse gave the patient a sense of control, but also a sense that she knew what she was doing and that he was in reliable hands. (It is almost impossible to fake this.) By the end of the day he was off the respirator and his blood gasses were O.K. Now we all can imagine different scenarios:
what if this nurse had been inexperienced, or not able to tune into the patient's style, or even too tired or too disinterested to care whether or not the patient got off the respirator that day? Had he gone to the next day he might have been more anxious, more discouraged, and he would have been at more risk for lung infection. Getting him off the respirator early was more than likely a crucial factor in his recovery. Certainly the patient believed that getting off the respirator early was crucial to his recovery. At the end of the day, he had tears in his eyes, and the nurse said to me privately, "He reached over and gave me a kiss." Now how can you write such an example up in a standard care plan, or as a regular expectation? How could you even personally promise to be able to do that well again? The nurse can learn from this success that it is possible even for patients with difficult histories to get off the respirator if you work carefully with them, give them a sense of confidence, and do not tire them out. Certainly this nurse added one more perspective to her expertise that day. And she can give hints to others less experienced than her and talk knowingly about this situation with nurses who are as expert as she is. But there are crucial situational aspects to this story that though transmissible cannot be mandated nor made predictable or standard.

I have many stories of where nurses made all the difference by mobilizing a patient's hope. And I feared that somewhere someone might write a care plan, "Mobilize hope ten minutes a day A.M. and P.M." Please don't misunderstand me, I know first hand that we have to systematize our care, we have to coordinate and communicate with many other caregivers as clearly as possible, and we have to identify and talk about standards. We would have chaos if we did not do this. I just want to point out that we never capture the whole picture in our standards and systems because whenever we come up with a standard that we can predictably and reliably promise, even though it is a high standard, we necessarily leave out those highly relational, highly perceptive recognitional abilities that daily make the crucial difference in patient recovery.

We know that these virtuoso performances require a reasonable environment, ability to work the system, personal energy, and a unique blending of our clinical knowledge, our connection with the patient and the patient's particular situation, and such patient outcomes only occur in the context of care. That is why we develop ad hoc wisdom about which nurse connects best with which kinds of patients and which ones do not. That ad hoc wisdom can never show up in a job description and yet we cannot do our jobs well when we do not know patients and nurses well enough to take this kind of matching nursing expertise with patients.

The point is that by focusing on the predictable, and talking only about what you can always deliver, (the contract and marketing approach) we curtail and are somewhat embarrassed to talk about our really excellent performance, not only because we do not want to brag, but because in a marketing era we know that we cannot be held accountable to always deliver that level of performance, nor can we expect our colleagues to be able to replicate what we have done.

Elizabeth was recognized as an excellent clinician by all her peers. She give what they called a "forward looking report." When Elizabeth gave a report you did not get just the history of the last 12 hours, you got a preview of what you could expect the next four hours. She did incredible interventions with her patients. She frequently recognized patient changes before it was obvious by overt signs or noticeable to anyone else. But the administrative nurse explained that Elizabeth was not really a good candidate for advancement on the clinical ladder because she could not easily pass along her wisdom, and the ability to teach and be a role model was clearly a criterion of advancement; also her standards were too high and others could not easily model their practice on hers. Those of you who are nurse managers will easily recognize this as a tyranny of the lowest common denominator. This example illustrates worshiping standards we can replicate, and the mistaken view of them as the ceiling instead of the floor.

Expertise accomplishes feats that look impossible BEFORE AND AFTER they are performed. This is because expertise or virtuoso performances come from an involved stance that calls upon past whole concrete situations, relies on fringe consciousness, and the ability to perceive often only on a feeling level similarities and differences between past situations. Nurses become expert at reading patients' faces, they develop a web of expectations, and timetables that make them notice when these expectations are not met. Stuart Dreyfus calls this "understanding without a rationale." (Dreyfus and Dreyfus, In Press)

This is what I call "guided intuition," because I don't want people to misunderstand and think I am talking about blind or magical intuition. The intuitive grasp is based on concrete past experience and is not available to the novice. But even though nurses become confident in their ability to provide an early warning, this kind of performance in concrete situations, has a magical, nonreplicable feel to it. For example, a nurse insisted that a private physician comes in at three o'clock in the morning even though the documentable signs were limited to a small bruise in the patient's groin and a dip in blood pressure of only 2 mm of mercury. This nurse called the physician in because the patient did not look right, and was anxious. The patient's face looked extremely distressed, and as the nurse said, "I had a funny feeling about her."
By the time the physician arrived the nurse had started fluids and ordered blood work because the patient was putting out copious amounts of burgundy stools. It turned out that she was bleeding because of a Vitamin K deficiency due to prolonged antibiotic therapy after GI surgery (Benner, 1984). As Polanyi (1985) says: "Good clinicians always know more than they can tell." And because we cannot make the knowledge embedded in expertise completely explicit, because it depends on subtle recognition skills and requires concrete situations to call it forth, we distrust it ourselves. There is a wise touch of humility in expert performance because the expert understands that no grasp of the situation is infallible, and stays alert for evidence that would disconfirm her or his expectations. Clinical situations always contain indeterminacy and ambiguity. They are open situations. Many of our analytical strategies to clarify and to rationalize clinical situations actually cover over their essential ambiguity and openness. In covering over the ambiguity and openness we also cover up possibility inherent there.

Some of the most elegant helping is private and is violated somehow when discussed publicly. Nurses are hesitant to talk about what they offer in the context of helping people in some of the most extreme, exalted and ignoble situations in their lives. One nurse talked about how her relationship with a cancer patient changed after they both got stuck in the shower when the nurse arrived just in time to prevent a fall. It's not a very transferable or translatable story, yet the ability to maintain someone's dignity, express genuine interest, and not be embarrassed by a less than "professional contact" is the hallmark of nursing expertise. This patient had been extremely depressed and noncommunicative with her family, other nurses, and her physicians. After this encounter, handled with expert care, the patient talked with this nurse and broke her silence to others as well. The earlier reference I made to the patient kissing the nurse at the end of the day when he was off the respirator, is not translatable or transferable, and the nurse did not tell this part of the story publicly, even though the tears and the kiss were evidence of the difference she had made, because it was private, and could be misunderstood. Nothing is gained by my talking about it publicly, because it is private. We cannot always convey in words the difference our caring makes to someone who is dying or suffering or learning to be a new parent. Expert caring remains hidden often because it is private and too unique and too significant to risk having it misunderstood by talking about it publicly, or too much a breach of our professional and personal relationship with the patient to make it public. These wordless places are undervalued and can be destroyed by instrumentalism. They cannot be marketed. The question is: How can we preserve them without packaging and marketing them?

Conclusion: I believe that we have to learn to talk about what we do in more understandable terms to ourselves and to others. I think the first step is to recognize that expert caring requires a different kind of descriptive language because it entails a different approach and different outcomes than can be captured by analytical and systems language. The nursing process description is too narrow and too linear to capture the expertise that may be demonstrated in assessment alone, or intervention alone. If you constrain yourself and limit your descriptions to your patient care to A DISEASE CATEGORY OR TO WHAT YOU CAN COST OUT AND MARKET, THEN YOU WILL NECESSARILY OVERLOOK THE PRIMACY AND POWER OF CARING. I think that you have to resort to exemplars to describe the highly relational and contextual skilled performances of nurses. I think that we need to talk to each other about what we are learning from our clinical practice. No other health care group spends as many hours in direct contact and observation with patients as nurses; we need to learn new ways to talk about what we do and what we are learning. We need to find ways of crediting and validating our knowledge among ourselves and to others. I think this kind of talking about what we are learning from our patients will increase our expertise, and help to make visible to ourselves and others the contribution of care to cure.

Within the context of a technological approach, knowledge is reduced to what can be broken down into elements and procedures. Teaching in this case becomes the transmission of factual information or theoretical systems, and expert human understanding and skilled knowledge is overlooked or discounted. Teaching of advanced and expert clinical knowledge cannot be reduced to technical-procedural information, but salience, pattern recognition and qualitative distinctions can be taught by demonstration, simulation of meaningful patterns and configurations and advanced case studies. (Benner, 1984) (Dreyfus and Dreyfus, in press). To discount this kind of contextual clinical expertise is a technological cultural blindness, an ethnocentrism which can have grave consequences.

I think that nursing and caring are cultural embarrassments. Autonomous individuals in full possession of their powers do not want to think about being less than self-reliant. The most we can admit to in this culture is that we want our loved ones to be well cared for, but we most admire relatives who are self-reliant and able to care for themselves. As nurses we daily make observations, decisions, and interventions that make the difference between life and death. And in order to improve our status--to correct the professional and societal recognition lag, and market our-
selves to ourselves – we present ourselves as cool, rational, autonomous, decision makers who adjust, titrate, monitor, treat and evaluate our performance. We cover over for ourselves and for the culture the attentiveness and caring required to coach someone through a serious illness or to assist in health promotion. As Fagin and Diers (1983) point out:

"Nursing is a metaphor for intimacy. Nurses are involved in the most private aspects of people's lives, and they cannot hide behind technology or a veil of omniscience as other practitioners or technicians in hospitals may do. Nurses do for others publicly what healthy persons do for themselves behind closed doors. Nurses, as trusted peers, are there to hear secrets, especially the ones born of vulnerability. Nurses are treasured when these interchanges are successful, but most often people do not wish to remember their vulnerability or loss of control, and nurses are indelibly identified with those terribly personal times." (p. 116)

Treatment without care is possible but recovery from illness and cure of disease will continue to rely on a context of care. The question is whether our instrumental scientific language that is limited to designative and denotive meanings will blunt our talent and sensitivity to the expressive and constitutive functions of meaning that seem essential to recovery. The extreme rationalism and instrumentalism evident in marketing strategies, cost containment strategies and high technology that focus solely on disease are actually feasible only on a background of care.

The dilemma we face is that the language and practices of high-tech, bottom-line health care and our own cultural tradition of Utilitarian individualism threaten to undermine and erode the very caring practices that make the system work. As Delores Little put it succinctly, "Now more than ever Mrs. Reynolds needs a nurse." I do not think that it is possible or even desirable to retreat from the pursuit of high-tech medicine even though we all need to be protected from it at times. We do need to intensify our study of the relationship between illness and disease. And we have to recover and communicate our understanding of the primacy and power of caring in cure. This is an extremely difficult task because the very language and tactics of bottom-line health care and marketing (packaging and selling our product, efficiency, and image management) are antithetical to the highly contextual and relational nature of caring, which requires that we not treat people as products, and that we do not manipulate them for business or institutional interests. Generosity, charity, and mercy, may even be good for business, but once you make them instrumental you change their nature. I think to recover and preserve the language and practices of caring we have to counter the language and practices of pure instrumentalism. If we had a better understandings of the relationship between illness and disease, and between caring and curing, then our primary cost containment strategies would look very different. For cost containment and effectiveness, I think high-tech medicine needs to be augmented by nurse practitioners and expert nurse clinicians who coordinate and provide health and illness management and who provide the kind of care that attends to what the illness interrupts and symbolizes, who coordinate and attend to all the dangers and incompatibilities, overlap, complications, toxicities, idiosyncratic untoward reactions, and lack of safe adherence to high-tech cures (See Brykczynski, 1985).

In the press for objectification and standardization, we have to remind ourselves that what we can capture in clearly stated goals and objectives, what we can readily promise and predict, are not the ceiling to our performance–they are the floor. We need the floor but we also need the ceiling. If I should ever become your patient, I do not want to be limited to my rights as a patient. I will not even be satisfied with justice. Please, when I am sick I would like generosity and mercy. I want excellent caring.

REFERENCES


Requests for Transcripts

Mail request with $2 for each copy to:
Office of Student Affairs
Yale School of Nursing
855 Howard Avenue, P.O. Box 3333
New Haven, Connecticut 06510

Following is the toast offered by former deans, Florence Wald and Donna Diers, to Dean Judy Krauss at the Alumnae/i banquet on Friday evening:

For Judy

We are the ghosts of deanery past

Offering some toasts to the future that's vast.

Here's to the kid not so new on the block

When she takes the mike they're in for a shock.

Here's to the horns of perennial dilemmas

When faculty roar and the rafters tremor.

Here's to the buck that stops on your desk

Here's to a weekend of 4th stage REM rest.

Here's to the husband who hears all your woes

Between women calling to say that they show.

Here's to the 4 AM nightmares that wake

As last drafts of budget revisions you make.

Here's to the carpet red and threadbare

From Goodrich's portrait to your very own chair.

Dean number seven we salute you and hail

All friends -- now join us: God, country and Yale!

Social hour before Friday's Banquet was held outside in courtyard of School of Organization and Management.

Libet Streiff '85 (left) stands by her Research Poster Display. Sigma Theta Tau sponsored displays of several research projects during midday Friday.
DISTINGUISHED ALUMNA AWARDS

Virginia M. Brown, Class of 1950

"Your voice has been the voice of the scholar, researcher, teacher, and administrator during three and one-half decades of contribution to the public health field. You organized, administered, and taught the system of care under which humane and intelligent health care could be delivered.

At the time of your investigations into the quality of home care programs and second surgical opinions, yours was a lone voice in the wilderness, but the results of your studies led to changes in the health care system that we in practice now take for granted. Ever the nurse, in your study of long-term hospital stays you insisted that amidst the strick statistical reporting and analyses there be room for a chapter on the actual stories of the patients so that 'what actually happens to people will not be buried in statistics.'

Your insistence upon excellence and your appetite for daily rigorous productivity is legendary, leading one colleague to paraphrase Thornton Wilder and say that 'your genius is such that had you not been possessed of it, you would have had to invent it.'"

Betty Ann Kosters Countryman, Class of 1944

"Yale and Harvard can both claim her -- a woman whose roles as mother, organizer, leader, initiator, educator and writer have been truly remarkable. From Indiana to El Salvador, she has worked tirelessly for over 25 years to document and promote the positive effects of breastfeeding. She chose the La Leche league as the vehicle of promotion for improved nutrition, maternal-infant bonding, parenting, and alternative forms of childbirth for mothers and families in 54 countries. Co-founder of the League in Indiana and midwife of the La Leche Center in El Salvador, she was claimed by the League itself as the first non-founder Chairman in 1983. Teacher of maternal and child health, lecturer and writer, international consultant, mother and grandmother -- you evaluate them all."

Evelyn Hamil Shopp, Class of 1947W

"Our West Coast sister has never allowed geography to place artificial limits on her vision or influence. Indeed, her influence has spanned local, regional, state, national, and international boundaries. She has made full and wide use of organized nursing and related health forums to thrust her profession into a place of leadership in the health care system. Committed to the Yale School of Nursing tradition of practice, teaching, and research, her career bears evidence and fruit of her dedication to education and service and to the active promotion of research. Author, speaker, director of nursing, board member, presidor over national organiza-
tions, she brought nursing service and nursing education alive wherever she traveled -- West Coast, East Coast, the South Pacific, Europe or Russia. Ever the loyal alumna, she always finds time for her YSN classmates and is the glue that holds them together.

Patricia M. Walsh, Class of 1935

"New Haven claimed her briefly after her Yale graduation. But, it was on to New York for a degree in Public Health and then to Ann Arbor where she left her mark on public health nursing and the profession at large. She was attracted to presidencies of the Michigan League for Nursing and the Michigan Public Health Nursing Association -- and they to her. Already claimed by Michigan as 'Nurse of the Year', she was the first nurse to be named Acting Director of the County Health Department and later became its Assistant Director. Upon her retirement, the Board of Commissioners declared a day in her honor."

Reunion Classes

Eight members of the class of 1935 gathered for their 50th reunion! They were a valuable and inspiring delegation!

Laura Rounds Bloom  Raidie Poole Merdinger
E. Jean Hill  Patricia Walsh
Virginia Harte Hulbert  Eleanor Stonington White
Elizabeth Cohane Hurley  Mildred Bushnell Yale

The class of 1940 had 13 members attending their 45th reunion. A more energetic and enthusiastic group would be hard to find. At their class dinner on Saturday evening at Marion Fasanella's home, a "retrospective" was read - a collage of members' recollections and impressions, a copy of which they sent to the dean. (See some quotes on page 27).

The classes of '45 and '45W each had three members in attendance. 1950 celebrated with 10 members over the course of the weekend. Seven people from 1955 returned, and the class of 1960 "took the prize" for having the largest number of grads attending some part of this alumna/i weekend with more than 16 people.

The interest and enthusiasm in being with YSN friends, at YSN, and attending the planned program was heartwarming! There's nothing like a return trip to YSN to "get a lift" -- some day you should try it -- you'd like it!

Donna Diers stands beside the portrait which was unveiled during the reception on Saturday afternoon. Claudia Post Schaffer of Cheshire, Connecticut, was commissioned by the Alumnae/i Association Board to paint this portrait which will be hung in the School with the other former deans' pictures.

From The Archives: A Query

In a 1939 issue of the American Journal of Nursing Eleanor Herrmann, Associate Professor, has found a mention of the YUSNAA in the report of the annual meeting of the Connecticut State Nurses' Association. At the banquet the Alumnae Association of the Yale School of Nursing received the state membership trophy, an electrified Florence Nightingale lamp, for making a gain in membership of 27.7%. Eleanor, who teaches Topics in Nursing History, asks whether anyone remembers this lamp or has any idea of its whereabouts today. (It may help us to keep a sense of perspective by noting that even in 1939 the "meeting was largely given over to discussion of the nurse practice act...which has not yet been reported out of committee.")

When you come upon nursing treasures tucked away in your attic, bookshelves, or scrapbooks, please remember that these may be of value for our Archives.
Sherry Shamansky '69, Chairperson of Community Health Program at YSN has been appointed Vice President for Operations at the National Center for Education and Research in Home Care of the Visiting Nurse Service of New York as of January 1, 1986. It is planned that the VNS will become a live learning laboratory for all in the country interested in Home Care. This Center will house a national library for Home Care. Offices will be on the fourth floor of the Empire State Building.

YALE NURSES

In Their Own Words

Patricia Ryan '81 is a PNP in the Kentucky River District Health Office in Hazard, KY.

As I write this letter the redbud and wild dogwood are finally beginning to brighten the hillsides after a long and unusually snowy winter in the Appalachians of Kentucky. I came to Kentucky very naive about rural life and with all sorts of romantic visions of quilts, log cabins and fiddle music. Instead of these, I discovered a unique region of the country which has offered overwhelming challenges to me as a PNP. It is an area with a complex history and a host of social, economic, political and health problems that have challenged many before me, that challenge me daily and that will surely challenge those that follow me here.

For the past three and a half years, my husband Tom and I (and now our toddler Matthew) have lived in the city of Hazard (population 5,000), which is located in the "heart of the coal fields" about two and a half hours from Lexington. This total isolation from a city has been a real adjustment for us. Tom works as the Assistant Administrator of a Community Hospital which is part of a system of ten non-profit hospitals in Appalachia. I work as a Public Health Nurse Practitioner for the Kentucky River District Health Department which includes seven counties along the Kentucky River. Unlike most health departments in the North, Kentucky's health departments offer a wide range of direct health care services to primarily indigent populations.

As one of only two nurse practitioners employed by the District Health Department, I have had plenty of clinical experience here, mostly in pediatrics and family planning.

Several mornings a week I load my toys and my tools into "The Buggy" (a four-wheel drive vehicle) and head for a different county health department to conduct well child clinics. The children are often beautiful and reflect their Celtic and Anglo heritages, with befreckled red heads and blue-eyed towheads in abundance. In addition to the usual pediatric conditions, there are many problems that arise from the extreme poverty, widespread illiteracy and often unhealthy physical environment of the mountains. Reactive airway disease and allergies are very common and partially attributable to the poor quality of air in the coal fields. (Adults occasionally develop black lung disease without even working in the mines). Nutritional deficiencies are prevalent although WIC programs have helped improve childhood nutrition tremendously. Since drinking water is sometimes contaminated by sewage, runoff from mine sites or large quantities of sulphur, Pepsi is consumed in astounding quantities even by children as young as two and three months old, with the obvious dental results. Several counties have had widespread Hepatitis A outbreaks and symptomatic giardia infections are not uncommon.

New mothers that I see are often adolescents who may or may not be married but who depend very heavily on extended family members for help with their children. Because of the involvement of older family members, folk medicine continues to play a role in family health care, although most families do seek medical care for very serious illness. Thrush, better known as "the thrash" may be cured by having the seventh son of a seventh son blow into the child's mouth; teething pain may be lessened by wearing a amulet of a rattlesnake's rattle and wheezing is controlled by drinking rendered ground hog grease.

Family size continues to be large. Strong fundamentalist religions have denied the need for these services until fairly recently, but family planning services are becoming more accepted and popular. A physician and I conduct weekly family planning clinics and see between 30 and 50 women per clinic. Prescription and non-prescription contraceptives are provided with the pill being the most widely requested. A very pleasant feature of my position is the opportunity to know the whole family. I often provide family planning services to the mother after her delivery and continue to follow her in the program while I follow her child for Well Child care. Since unemployment is so high, many fathers are available during clinic hours and sometimes participate in the child's visit. Presently a social worker and I are attempting to organize small discussion groups for parents of like-age children so that common concerns and questions may be shared and some group education provided.

The professional isolation is very difficult
Evelyn Hamil Shopp '47W, was a Distinguished Alumna Award Recipient this year (See page 19).

Your request for a letter regarding my ideas and feelings about the challenges, frustrations, and issues in health care has caused me no end of soul searching. Had you asked me a few years ago, my answer would have been immediate and detailed, but as a retiree quite removed from health care responsibilities, I'm afraid my concerns are more related to those of a consumer, not a provider. I'm worried that serious illness might strike before I have the back-up protection of Medicare. I'm frightened that my Living Will might not be honored, and that "death with dignity" might not be permitted. Although I rejoice at the advances in medical technology, I cringe at the replacement of common sense and of touch by multiple unfeeling machines. I want the sophistication of modern medicine, but I want a heavy overlay of health "caring."

As a senior citizen (how I hate that term) I'm concerned that health professionals, as a group, have little empathy with the geriatric patient, and all too often, little patience. But then, I do understand for I am in the position of being retired yet still responsible for aging parents and with relatives in the 90's on my husband's side. This will undoubtedly become more and more common as the average national age range rises. I feel great ambivalence about the tremendous concentration of financial and human resources, concentrated on the two extremes of the life span, prematurity and old age.

I am greatly concerned about the trend toward for-profit hospitals. Although California has more of these than other areas, they will undoubtedly continue to increase. I am concerned that this may lead to erosion in health "caring."

There are many things that bother me about nursing, even Yale nursing. I am appalled when studies involving a very limited and circumscribed population are perceived as valuable and quoted ad nausam. I'm concerned when the nurses appear to be adopting the God-Image we have so long deplored in physicians. I'm upset when I walk into a clinical setting and see a motley collection of tacky people, some of them supposedly responsible professionals. I'm angry when the primary nurse begins an initial conversation with the use of my first name.

But there is another side: I rejoice at the movement toward charging for nursing services in hospitals; at the wide range of specialists within nursing; at the independence achieved by many practitioners. I am happy that nursing as a profession is steadily gaining recognition; I'm glad the image of the subservient female never present at Yale is fast disappearing.

Would I be a Yale nurse, if I had it to do over? Indeed I would, for we gained far more than skills and knowledges, far more than one could ever put into words. It strengthened my backbone, "salted" my courage, and started me on a fascinating, involved, highly visible and deeply satisfying career. I only hope today's Yale nurse will always feel the pride in our School I have felt over the years.

Receiving a Distinguished Alumna Award for 1985 was an honor I shall cherish forever.

Debra Harrison Sweeney '79, lives and practices in Atlanta, Georgia.

Hello from Atlanta. Life, personally and professionally, here in Atlanta is wonderful, perhaps even more so because of my experiences at Yale. I feel that my being in the South brings some of Yale to another area, thereby spreading knowledge. Atlanta gains by being introduced to, and influenced by, nursing at a national level.

Clinical Nurse Specialist positions here are rare. Like New Haven and Boston, the Atlanta area includes many fine health care and teaching facilities (CDC, Emory University Medical School) and thus a preponderance of highly educated health care professionals. The South is somewhat slower accepting nurse specialists, nurse midwives, etc. Of course, if we were just like "Y'ale", I wouldn't have been asked to write about Nursing in the South.

Here in Atlanta, the people are friendly, the weather is beautiful, jobs are steady, and the Sun Belt is growing. All of these factors make it a wonderful place to live (contrary to the Rand-McNally report). These attributes, plus the fact that my family lives here, drew me back following graduation. I then got married, and as my husband had three years of a Neurosurgery Residency to complete, I remained in Atlanta. Currently I am an instructor at the Georgia Baptist Hospital School of Nursing, which draws heavily on my Master's preparation at YSN. For those of you who would like to visit, please come, and I'll show you our Southern Hospitality.

Even our politicians are hospitable. Max Cleland, former President Jimmy Carter's Chief of the VA, is presently in charge of the State Board of Licensing, and is very helpful to nurses. Our Georgia Nurses' Association is full of energy, and exhibits great interest in the future of
Dear Friends:

Because I have always been a mover, my resume is long and varied. I didn't spend much time in any one place until I came to Baltimore in 1950. I had just returned from 2 years in Japan doing Public Health Nursing when my brother's wife left him with two small children to care for. For two and a half years I was a mother and housewife. Like everyone else who experiences it, I learned that the change from teaching about or working with children on a forty hour week to full time parenting is a broadening and mellowing experience. It makes a great difference in all future contacts with mother's classes and people who work in Day Care.

In 1959 I joined the Baltimore City Health Department. As volunteer supervisor, I was able to find an excellent group of Black volunteers who set up a vision screening program in the public schools. The summer teen-age program was the first program in Baltimore that admitted Black teen-agers. Incidentally one of the graduates of that program was Mary Welcome who was the lawyer who defended the man accused of the child killings in Atlanta. I was also able to help set up Baltimore's first Health Fair where Planned Parenthood made its first public appearance. The Fair was held in an inner city neighborhood park and Planned Parenthood went all out to set a memorable exhibit. The exhibit included balloons which said Planned Parenthood. They were in competition with the March of Dimes which also had balloons, but the Planned Parenthood rubber bands lasted causing quite some protest from a neighborhood church. However, since that day Planned Parenthood has been able to exhibit publicly on all appropriate occasions.

My next venture was into Day Care. In 1960 not much was happening. Day Care was looked on as unnecessary because women should stay home and take care of their children. There was an active Committee on Child Day Care in Baltimore which had insisted that the Health Department should set standards and inspect nurseries because there had been an epidemic of scarlet fever in one of the nurseries. My job was to inspect Day Care centers which, at that time, were sterile in program as well as in environment. We were able to set up a series of workshops which brought a bit of enthusiasm with knowledge to a much maligned group of caretakers. Eventually, with the help of the Maryland Committee for the Day Care of Children, we were able to establish a Division of Child Day Care in the Baltimore City Department of Health. The person hired to direct the new Division had a Master's Degree in Early Childhood Education. She was able to raise standards and provide training for Directors of Day Care Centers and thus dramatically improve the quality of care in Baltimore.

When the Johns Hopkins Hospital received a grant to initiate a Comprehensive Child Care Clinic, I went there as Public Health Nurse to be part of a team which would provide total care to children within the neighborhood surrounding the hospital. The recruiting and training of Health Visitors was a large part of my assignment. This staff was recruited from the neighborhood and were taught to do follow-up visits to help patients carry out doctor's orders and to find out what additional assistance was needed in order to make prescribed treatment effective. The team included a social worker and a nutritionist who were available for consultation -- an ideal situation.

It was while I was at Hopkins that Martin Luther King was assassinated. The hospital was located in the middle of the area most affected by the ensuing 'civil disturbances.' For a week we were under martial law, under constant guard. Following the disorders, I requested permission to set up a workshop for the staff of Comprehensive Child Care and any other members of the Pediatric Staff who wanted to attend. Members of the involved community as well as the Chief of Police were asked to be part of the panel. The Chief of Police declined, but four community residents did come. The room was crowded and the speakers were not awfully polite. This was the first time they had had an opportunity to tell Hopkins of their long standing resentment of being used as guinea pigs, of the appropriation of their land for staff residences and a swimming pool that was closed to the neighborhood. It was a peaceful if disturbing session for all involved. Although the initial reaction of administration was negative, there have been many conferences since then with neighborhood residents while a staff committee has been formed to review questionnaires and projects to be implemented in the neighborhood.

In 1968 I left Hopkins intending to return to nursing after a short period of recuperation. But I got involved in politics. During the '60's I had become involved in the civil rights movement. I was an active participant in the sit-ins which eventually opened Baltimore's restaurants to everyone regardless of race, color, creed or national origin. In fact, I had organized a letter writing campaign to the
department stores after one had bravely opened as an experiment and was waiting to see how it would effect business. Eventually all of the department stores opened after mapping where the letters came from. I helped organize the Maryland Task Force on Welfare Reform, an advocacy coalition made up of professionals and welfare recipients, which was largely responsible for a consistent rise in welfare grants including a 13% raise the year that SS1 came into existence. From 1968 through 1979 I was an unpaid lobbyist for the Maryland Conference of Social Concern constantly working to improve the grant level for recipients of public welfare.

In 1968, the Baltimore City Health Department released a report showing 50,000 children in elementary schools with low hematocrits. A Task Force was formed by the Mayor to study the problem and recommend solutions. When it became evident in June that despite the Governor's promise that all children in Baltimore would be able to have a school lunch by the beginning of the Fall semester, there were no plans for implementions, Susan Tippett and Joan Galkin, both nurses, took on the monumental task of making this happen. The government suggested solution of finding volunteers to prepare 50,000 lunches per day seemed not only impractical but also a way of relieving government of its responsibility for the welfare of the governed. The Governor was approached. He welcomed the interest of the voluntary community but offered no government help. Following a torrent of publicity, a poverty dinner was organized, the proceeds of which would feed the hungry children of Baltimore. Two days before the dinner, the Governor announced that he was putting two million dollars in the budget for a school lunch program. With the $60,000 raised at the Hunger Banquet, the Maryland Food Committee was born. This became a highly effective hunger taskforce of which I remained a Board member and sometimes president until the Maryland Food Bank was founded under their aegis. Among its other noteworthy accomplishments is the fact that it funded the studies done at the Johns Hopkins School of Hygiene and Public Health which led to the establishment of the WIC program. (It has other notable firsts which I'll be glad to make available if space permits).

The Maryland Food Bank really began when, in 1978, a former Board member of the Maryland Food Committee described a Food Bank in Detroit with which she was associated. The Maryland Food Committee immediately saw this as a way of meeting the chronic need for supplementary food which exists among those whose incomes are not sufficient to meet daily needs much less those that arise in times of illness or unforeseen emergency. Foodbanking is based on the fact that in the United States we throw out 137 million tons of food every year. A food bank is equipped to store large quantities of food, perishable or non-perishable, and to distribute it to non-profit agencies that feed the ill, the needy, and/or children. Because the bank makes it possible for industry to distribute its salvage and surplus through a reliable central facility, they are willing and anxious to help. When it started in 1979, the Maryland Food Bank had no food and 37 charter member agencies. Today our 10,000 square foot warehouse distributes seven million pounds of food a year to 450 agencies throughout Maryland and Delaware. We are licensed by the Health Department. The Maryland Food Bank was the first on the East Coast where there are now 28 certified by Second Harvest between Massachusetts and Florida.

Although too much of the product we receive is junk food, we still do receive large quantities of bread, cereals, and fresh fruits and vegetables. During these six years of our existence the focus has had to be on warehouse management. We have, however, been able to do some teaching on nutrition and primarily on how to prepare unfamiliar foods. The greatest cry for assistance from our inner city churches is for help with cooking classes for their young mothers who have never learned to cook. Unfortunately our total budget comes from ten cents per pound our agencies pay as a service charge so that adding new positions takes time.

As I think back on all of this, the thing that comes most sharply to mind is a day at Yale in the Dean's Course. It was toward the end of our Senior year and Miss Barrett asked us, "Who is the most important person in the Yale-New Haven Hospital?" Everybody had an answer, "Miss Grant," "Dr. Harvey", "The Director of the Hospital", etc.

Jean stood at the front of the room and shook her head sadly. Finally she said, "When you first came to Yale, I told you that the Most important person in the Yale-New Haven Hospital was the patient. That hasn't changed a bit."

They are indeed words to remember!

Patricia Walsh, '35, received a Distinguished Alumna Award this year. She currently lives in Ann Arbor, Michigan, and shares her reflections on fifty years in the Public Health Field with us.

My fiftieth reunion encouraged reflection--it seems impossible that this period of time has elapsed and that I've participated actively in its transition.

Fifty years ago, YSN's mission to provide comprehensive professional preparation for entry into nursing practice included a strong emphasis on health promotion and disease prevention. Each graduate was also expected to play an important role as citizens and community members after graduation. These were very heady aims considering the state of the nation in the mid 1930's; then as now, social and economic factors contributed to and con-
trolled the health care system.

My choice of practice was community health, beginning with my first position as a staff nurse with the New Haven VNA. It was challenging, and I benefited from the administrator's awareness of the need to foster a framework of openness to new ideas and development within the organization and the community. Way back then, I learned to value involving the community and the individual in planning their care, taking care to the community in home care and in group settings, identifying standards of care, determining preparation needed and necessary educational programs, utilizing the skills of a variety of health workers, and maintaining concern for the cost of care. There is a certain gratification in seeing how strongly these values are embraced in 1985! Home care, in particular, is an idea whose time has come. It has a promising future even as it did fifty years ago to a new grad. It must be handled with care, nurtured carefully and constantly, to ensure that gains made will be sustained and advanced.

It was exciting and gratifying to be part of the reunion (although a 50th reunion is anticipated with some uncertainty!) which brought eight members of our class together.

Following the reunion, the June mail brought an interesting socioclinical remembrance of YSN from Margaret Hitchcock Carson assembled by the Class of 1940. A few excerpts from it sketch a vivid image of the preparation of the Yale Nurse in what Marge Carson refers to as the "B.P., B.T." (before penicillin, before thorazine) days:

...Jean Barrett said "You will do the procedures perfectly. That's how I teach them. I never show you short cuts - you'll find those out for yourselves." And we did.

...We made up our own IV's and sat with patients as the IV fluids and transfusion ran in from open flasks covered with a piece of gauge. We sat with those patients, tuning every nerve to possible adverse reactions. And we sat with the dying.

...We did our best to teach what was needed prior to discharge. Because we had a 3 month public health affiliation, we saw the actual conditions with which our patients had to cope on the outside — a humbling, sobering experience. During our obstetrics rotation, we not only worked in the hospital, but went out with a team for home deliveries — and on the first postpartum day home visit, joined the family in toasting the newborn with the everpresent homemade wine!

WASHINGTON "HOT LINE"

Sally Solomon '80, is Director, Public Policy and Research of the National League for Nursing. She was a Robert Wood Johnson Scholar in 1979.

New NP Coalition Launched

A new coalition of organizations representing nurse practitioners has entered the scene, known as the National Alliance of Nurse Practitioners (NANP), the group is designed to provide an umbrella structure for NP's nationwide, in order to promote NP legislation, market NP services and enhance communication regarding NP issues with both the general public and amongst NP groups. The first meeting of the "Alliance" was held in Washington, on June 30th.

The NANP sprang from the National Nurse Practitioner Forum, held in Chicago in May, 1985. That Forum was the culmination of months of discussions regarding the need for a more cohesive strategy to increase legislative triumph for NP's and improve the effectiveness of NP's in the eyes of the public unity amongst NP's has been the major thrust of the group.

The groups that now comprise the NANP Implementation Task Force are: American Academy of NP's, American Nurses' Association Council of Primary Health Care Nurse Practitioners, Association of Faculties of Pediatric Nurse Practitioner/Association Programs, Free Standing Nurse Practitioner Associations, National Association of Nurse Practitioners in Family Planning, National Association of Pediatric Nurse Association and Practitioners, National Organization of Nurse Practitioner Faculties, Nurses of the American Association of the College of Obstetricians and Gynecologists, Nurse Practitioner Organizations Affiliated with State Nurse Association, and other NP's who are unaffiliated with major NSG organizations.

At the June 30th meeting, the Alliance decided to designate rotating chairs for its meetings and to appoint each representative to
one of three task forces: 1) legislation -- focusing on national issues such as nursing education, research and third party reimbursement 2) organization structure, membership and operating guidelines and 3) marketing. The next meeting of the NANP representatives is scheduled for next fall. This will enable them to get the Alliance off the ground and report their progress at the next National NP Forum, tentatively scheduled for Spring, 1986.

There is no doubt that this new coalition, which took many months and painstaking sessions to produce, has the potential to bring a new and needed dynamism to the NP movement -- as long as the theme of unity prevails.

Grants & Gifts

Mellen Graduate Grant

Pamela Stacy Forte '86 and Sarah Waddell '86 have been awarded Louise Mellen Graduate Fellowships in Critical Care Nursing for the '85-'86 academic year. This supplies each student with partial tuition and a stipend during their months of registration in the Med/Surg Program.

USPHS Grant

The School of Nursing has received a three-year grant of $292,460 to enrich the clinical component for student clinical nurse specialists. The advanced training grant from the Division of Nursing, USPHS will support jointly-appointed clinical nurse specialist faculty and curriculum development. A clinical specialist in surgical nursing will be jointly appointed to Y-NHH and a specialist in cancer nursing will have an appointment with the School and the Hospital of St. Raphael.

Bequest

On Alumnae/i Weekend, Judy Krauss announced receiving notice of a bequest to YSN of $49,000 from the estate of Florence Blake, who was Assistant Professor of Nursing in Pediatrics at YSN from 1942 to 1946. This will be an endowed fund to support scholarships for students and research related to hospitalized children.

YSN Alumnae/i Fund, Mary Jane Kennedy, Chairman

As of the middle of June, the Alumnae/i Fund has realized $68,200 from 50% of eligible givers. Alas, this total is only 68% toward our hoped for goal of $100,000! I am encouraged, however, that we are keeping abreast of last year in terms of our participation which has, traditionally, been excellent.

Although our final report will bring us closer to last year's goal of $80,000, the results so far bear careful analysis.

I am pleased to report that we inaugurated a successful student phonathon in late spring at which time over $5,000 in pledges was realized from alumnae/i who had not ever previously given. We are planning a 1986 "Valentine's Day" encore.

Left to right: Sarah Abrams '87, Lorinda Evans '87, Tracy Rosner '87, Deborah Mayer '85.

The Alumni Fund Chairman's Advisory Committee will meet in late July to look at our final statistics, and to plan our strategy for 1985-1986. If you have any ideas or if you simply wish to comment on this report, I'd be delighted to hear from you.

I have many to thank for their support, guidance and assistance: to Dean Krauss for hosting a kick-off cocktail party for the student phonathon, and for the overall support of the Alumnae/i Fund; to the members of the advisory committee who have given freely of their time and their ideas; to the students and alumnae who pledged and gave their time to the phonathons last, but not least, to the class agents. The letter campaign is the bedrock of Alumni Fund activity and no successful fund raising effort would be possible without you.

1986 will be the 60th anniversary of the first class to graduate from YSN! We should all rejoice right now with pioneers Doris Pinkney Allison, Wina Gauya, Priscilla Augur Kublanov, and Catherine Spaulding as they must be recalling those earliest days at YSN with Dean Annie W. Goodrich.

Alumnae/i Weekend and reunions will be June 5, 6, and 7 in 1986. It is not too early to start making your plans for the trip to New Haven. Just as a reminder, here are the classes to assemble next Spring:

1926  1946  1961  1981
1931  1946W  1966
1936  1951  1971
1941  1956  1976
Some of 1950 gathered for dinner on Saturday
across front to back: Mary Colwell, Stevie
Virginia
Betty Orser, Jean Butler, Fran Hindley
Brown, Isabel Field, Mary Bronzah, Fran Hindley

A parting shot on Sunday, three members of 1940
Emeline Armstrong, Eleanor Voorhies, Mary White

The weekend is over:...
Margaret Carson '40, Elizabeth Hanks '40

Emanuel and Radie Poole Merdinger '35
pack up for home
FACULTY NOTES

Helen Varney Burst '63 was one of the 1985 recipients of the Alumni Medallion of the Kansas State University at the Commencement in May.

Donna Diers '64 gave the first Dorothy J. Novello Memorial Lecture at the NLN Convention in San Antonio on June 4th. The theme of her presentation was "Making Space for Health Policy in the Nursing Curriculum". Also, Donna gave the graduation address at the Mass. General Institute for the Health Professions in June. In honor of their first graduating class of nurses (from the program first headed by Roz Elms '63) she wore Elizabeth Bixler Torrey's academic gown and Annie Goodrich's academic hood.

Ruth Knollmueller, Associate Professor. In March gave one day workshops on "Middle Management Squeeze Strategies for Survival" to Community Health Nursing Supervisors in Connecticut.

In April, to staff at Stamford, CT Health Department, "Public Health Nursing History and Future Implications" and presentation on "Something Old, Something New Community Nursing Centers" for consultants and staff of Division of Community Health Nursing and Home Health of the Department of Health Services.

In May, a paper entitled: "Education for Nurses in Home Care" at the first National Nursing Symposium on Home Health Care at University of Michigan.

Ann Slavinsky '67 has been appointed Master of Saybrook College effective July 1, 1985. She is the first School of Nursing faculty member ever to be appointed a Master of a Yale Residential College. She will continue her responsibilities as Chair of the Three-Year Program and selected teaching responsibilities at YSN. Ann was married in June.

Research and three-year program faculty


Elizabeth Selvaggio '79 was married in June to Richard Johnson. Liz is head nurse MU 10 at Yale-New Haven Hospital.

Jane Dixon, Associate Professor, Yale School of Nursing Research Program, has been granted tenure effective July 1, 1985.

Dianne S. Davis '72 - Presentation. Adaptation - "The Psychosocial Response" Advancing Rehabilitation Nursing Practice, CT Chapter Association of Rehabilitation Nurse, Stratford, CT, March 1985.


Joan Dreyfus '82 Presentation paper "Depression in Women on Initial Visits to a Medical Clinic" Sigma Theta Tau Research Conference, Rhode Island, March 1985.

Conducted a Stress Management Workshop for nurses at the Greenwich Hospital, January 1985.


"The Strategic Use of Games with Child Groups" - publication submitted to: Child & Adolescent Psychotherapy.


Lee Swearingen '80 has opened her own private practice in New Haven.

In Memoriam

Sarah Kaufman Featherman '33 died March 9, 1985.
Mary W. Bischoff, MS in 1951, died July 11, 1985.

CLASS NEWS

Barbara Anderson Guptil '42 continues to work two jobs: one full time with the State of Georgia as Standards Surveyor in the Office of Regulatory Services, and half time as Clinical Nurse at Crawford Long Hospital. "Yale certainly girded me for these 26 years of hard work which I love, -- very fulfilling work!"

At the Banquet on Alumnae/i Weekend, a specially inscribed silver tray was presented to Mary Cushman Colwell '50, Assistant to the Dean for Alumnae/i Affairs, and Executive Secretary of our Alumnae/i Association in appreciation for her 15 years of work in behalf of YSN alums! It was extra special because some of her classmates, celebrating their 35th reunion, were present to share in the excitement.

Bunny Forget '78 has been appointed Assistant Clinical Director of Ambulatory Nursing Services at Yale-New Haven Hospital.
Susan Schmitter Hogarty '80 was married this summer to Gerard Hogarty. Susan is Psychiatric Clinical Specialist at Shadyside Hospital in Pittsburgh.
Antonia Labate Ross '80 graduated from Univ. of Pennsylvania School of Medicine and was married in May 1985. She and her husband will be doing three year residencies in Internal Medicine at Rhode Island Hospital in Providence.
Kathy Porterfield Zojdites '80 had her third child, Alexandra, in March.
Denise Canchola-deTournillon '81 is coordinator of Aftercare/Day Treatment at the North Miami Community Mental Health Center, Inc., in Miami, Florida.
Fred Pond '81 was reported in April to be "temporarily in Thailand working with the American Refugee Committee."
Beth Kratochvil Boyarsky '82 had a son, Daniel, born in March.
Luc Pelletier '82 keeps busy on the West Coast. He is Vice President of California Nurses' Association (Region 6), and Vice Chair of California Council of Psychiatry, Psychology, Social Work and Nursing; delivered a paper on "What's Wrong With the Mental Health Delivery System in California: A Nursing Perspective", and has published two articles: "Nurse-Psychotherapist, Whom Do They Treat?" (based on his YSN Thesis) and "Depression Update" co-authored with Ann Cousins. Luc works at the UCLA Neuropsychiatric Institute.
David Collier '83 has been employed at North County Health Services, and in the Fall will start in a Ph.D. program in Sociology at UCSD. He and Terri Clark '79 had a daughter in April.
Lisa Summers '83 is involved with the Nurse-Midwifery Service in Baylor College of Medicine -- teaching and practicing. The 30th Annual ACNM Convention was in Houston in May and 11 of the 14 members of Yale's 1983 Midwives had a mini reunion!
Ros Webster '84 moved to Boston in June to start work at Martha Eliot Health Center in Jamaica Plain.

Madelon O'Rawe Amenta '57 was appointed by Governor Dick Thornburgh of Pennsylvania to be a member of the State Health Facility Hearing Board. She is the first nurse to be appointed to this position.
Ann Hoff '77 is on another "tour of duty" in Central America - expects to be in San Salvador until the end of 1985. She writes: "the battles are close to San Salvador, and the bombing is close to volcano San Vicente, near where we go for some of the clinics. We still have had no trouble in carrying out our work and so far I've managed to stay out of the wrong place at the wrong time."