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SPECIAL REPORT

PAULINIAN NURSES RECOGNIZED WORLDWIDE

The prestigious *Wall Street Journal* recently featured in its Health and Wellness Section the story of six Filipina nurses who are alumnae of St. Paul Manila.

Following are excerpts of the long feature:

As a girl in Manila in the late '60s, Teresa Santos set her heart on becoming a nurse because she was dazzled by the starched white uniforms and jaunty caps nursing students wore. "One of these days," she promised herself, "I will be in that group." She trained in her native Philippines and in 1979, was hired by Cedars-Sinai in Los Angeles.

Five classmates from the same nursing college in the Philippines joined her at Cedars-Sinai: Connie Arostegui, Patricia "Peachy" Hain, Joyette Jagolino, Nora Levid and Gertrudes Tan. Over the past 40 years, the six women have been not just friends and colleagues but family. What carried them through personal and professional crises in their adopted country and back home were the extraordinary bonds they formed with one another through their work.

The women recently gathered in Los Angeles at Cedars-Sinai, where five of them still work. Clockwise from bottom right: Nora Levid, Connie Arostegui (in beige), Teresa Santos, Joyette Jagolino, Gertrudes Tan and Peachy Hain. PHOTO: DAVID WALTER BANKS FOR THE WALL STREET JOURNAL

Together, they weathered the dramatic changes that have swept health care. Joyette, now an associate director of the Comprehensive Transplant Center at Cedars-Sinai, has worked in transplant units and seen the development of anti-rejection drugs which improved survival. Others labored in ICUs and witnessed the introduction of life-saving technologies.

But the women also saw medicine lose a measure of the human touch, they say, as more machines moved into the field. Hospitals trimmed costs and focused on efficiency. Patients went home sooner and their shorter stays left nurses little time to bond with them. As superbugs developed, the nurses worried that hospitals had become more risky.

At a time when doctors and nurses are leaving the profession and feeling burned out by the demands of electronic record-keeping and treating too many patients, the women say they remain passionate about their work. "The fundamentals of nursing haven't changed," Joyette said. "We care as we did 40 years ago."

When they began their careers, there was a nursing shortage in America. Hospitals were turning to the Philippines for recruits because of the country's rigorous nursing programs. In turn, the new hires looked to escape political and economic turmoil at home through work in America.

1970s

St. Paul College of Nursing in Manila was an all-girls' private Catholic institution when five of the six women joined it as second-year transfer students in 1972. Classes included anatomy, chemistry, microbiology and public health.

The school, which later became co-ed, was run by nuns, and faith infused the training. Student nurses, who wore crisp uniforms and white stockings, received their first nursing caps with a special mass. Senior students worked the night shift at local hospitals but were expected to be in class the next morning. At St. Paul College of Nursing in Manila, the nursing students' capping ceremony in 1973 was followed by Mass in the school's chapel. **PHOTO: ST. PAUL COLLEGE OF NURSING**

After the six graduated in 1976, they asked a U.S. hospital recruiter to be hired as a group. There was no point staying in the Philippines, where a nurse's salary "wouldn't buy you a pair of shoes," Peachy said. Filipino nurses were in high demand in America and the women were placed with a Missouri institution then known as the Kansas City College of Osteopathic Medicine.

Adjusting to their new country wasn't easy. Kansas City was a sleepy contrast with crackling Manila and the women, who were living in a converted floor of the hospital, were homesick.

In late 1978, Gertrudes, who had recently married, went to Los Angeles and landed a job at Cedars-Sinai. Peachy and Joyette followed in 1979 and Peachy asked Cedars-Sinai to hire the rest. "There was such a shortage that hospitals were willing to promise the sun, moon and stars," she said. The five began working at Cedars-Sinai, making between $7 and $8 an hour; Connie joined them in 1980.

1980s

Early in the decade, each woman found her professional niche, from pediatrics to intensive care. Except for Peachy, they also were getting married and some were starting families. They became godmothers to each other's children.

Practices and mores at the hospital were different then. Smoking was allowed in the wards and "everybody smoked," Peachy said. When physicians approached the nurses' station, at times, "they expected us to stand and give them our seat," Peachy said. If doctors were unhappy, "some would yell at us." During rounds, Nora had to walk behind doctors, carrying patients' charts.

In 1985 the hospital banned smoking. Other changes followed as the feminist movement of the '70s took hold and nurses demanded fair treatment. Over time, white uniforms gave way to scrubs, which were seen as more egalitarian.

1990s

By the early- to mid-1990s, there was upheaval in the workplace that the women once considered their immutable home in America. Like hospitals across the country, Cedars-Sinai was squeezed by managed care, and patient rolls plunged. Peachy remembers that hospital rooms were turned into offices. There were layoffs and hundreds of positions were eliminated, according to reports at the time. But the women hung together and all six held on to their jobs.

During the late 1990s, Peachy helped start an effort to improve doctor-nurse relations, and persuade physicians that nurses "weren't only there to take orders" and instead were "integral parts of the care team."

2000s

The women's parents, many still in the Philippines, had grown old. In 2001, Connie learned that her mother was desperately ill and longed to be by her side. But she arrived in Manila to find her mom in the hospital, near the end. After her death, Connie was despondent and leaned on her husband and the group to get through her grief, she says. A couple of years later, at 53, Connie suffered a major stroke and became a patient at Cedars-Sinai. She learned to speak and walk again but no longer was able to work. She took early retirement from the hospital.

By then, Cedars-Sinai was past its 1990s retrenchment and in expansion mode. The hospital's transplant program was flourishing and it performed record numbers of heart transplants. Hollywood donors such as Steven Spielberg helped fund a pediatric research center, while Barbra Streisand both contributed to and raised millions of dollars for a women's heart center.

In 2009, the women toasted their 30th anniversary at Cedars-Sinai during the hospital's annual dinner honoring long-time employees. From left, Gertrudes Tan, Peachy Hain, Nora Levid, Joyette Jagolino, Connie Arostegui and Teresa Santos.

PHOTO: JOYETTE JAGOLINO ARCHIVES

The women achieved the American Dream through their work at Cedars-Sinai, each setting down roots and buying a home in the U.S. Even Kansas City, Mo., where they felt homesick as fledgling nurses, has become more lively. A spokeswoman for Kansas City University of Medicine and Biosciences, which operated the hospital where the women worked in the 1970s, said the city has undergone a renaissance in recent years. "I wish that they could come back and see how it is now," she said. "Kansas City is a great place."

Gertrudes said the women should buy a condo where they can live and care for each other when they are elderly. Her friends are considering it. Teresa loves the idea, saying such a setup would be "like the Golden Girls."

The Philippines: An Incubator for Nurses

There are several hundred nursing colleges in the Philippines. The country has emerged as "the largest single source of foreign nurses to the United States," according to a study by Patricia Cortés, an associate professor at Boston University and Jessica Pan, an associate professor at the National University of Singapore. Their research, published in the Journal of Human Resources in 2015, found that foreign nurses "in particular Filipinos, tend to work in more demanding settings, and maintain less desirable schedules."

Note: Sources: Census Bureau data via Patrica Cortés, Boston University

Their drive and work ethic help them earn more money, Dr. Cortés said, but they are also simply "very good" at what they do. The intensive four- and five-year nursing programs in the Philippines can produce nurses who are better educated than some of their American counterparts, Dr. Cortés said. They take on tough assignments, working in hospitals—rather than doctor's offices—and can often be found in the ICU, "where you want the most skilled nurses." They tend to be recruited by the larger, better hospitals and often take on undesirable shifts, such as nights.

"The very best of Filipino women decided to go into nursing," Dr. Cortés says. "They would have been doctors" if they had been able to pursue medical careers in the Philippines. Instead, she noted, they went into nursing, knowing they would be able to find work abroad, ideally in America, and earn substantially more than they would have at home as physicians or lawyers.

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Another US-based Paulinian nurse, Teresa Ignacio-Gonzalvo, RN, BSN, MPA, CPHQ, ACM-RN, is a Clinical Advisor in the Athulya Assisted Living in India. Recently the newsletter of the facility featured this article by her.

Effective communication with our elderly population-critical success factors

Our healthcare community continues to be faced with ongoing challenges on our communication techniques with our growing geriatric population. Poor communication with this vulnerable population can undermine our efforts to provide person-centered care. In general, the communication process is highly complex and may be further complicated by age, illness, sensory loss, decline in memory and slower processing of information. At an important time when the elderly needs have increased the urgency to communicate with the members of their healthcare team, physical and physiologic factors make this a challenge. Unclear and confusing communication can cause the interactions to have more negative consequences. Respect is a critical factor when communicating with the elderly population. Condescending attitudes and behaviors to include lack of patience are not acceptable at all. Communicating with the senior members of our community require patience, kindness, understanding, resilience, highlighted with care and compassion.

Techniques for improving communication strategies

1. Sit face to face and maintain eye contact. Some of our elderly patients have hearing and vision loss. Reading lips may be critical for them to understand the information we are conveying. Patient and family compliance to treatment regimens increases when done face to face. Maintaining eye contact is one of the most effective form of nonverbal communication.

2. Avoid distractions. Giving our elderly patients undivided attention for at least the first 60 seconds, reducing the amount of visual and auditory distractions will allow for a more effective interaction and lasting comprehension.

3. Allow extra time for conversation. Due to the elderly patients' increased need for details and poor communication techniques, lack of focus and illness, we need to factor in additional time, not to rush through the discussion. This will allow for a more productive question and answer visit.

4. Listen attentively with no interruptions. Be totally mindful. Good communication is based on active listening. Be conscious of what our patients are saying. Many problems and conflicts may be reduced or eliminated just by sincerely taking the time to what our patients are telling us. Mindfulness is paying attention on purpose, in the present moment, fully and without judgment. 2

5. Speak slowly, loudly and clearly. Do not shout. The elderly person processes information at a much slower rate that the younger generation. Take your time as you impart information to assist the patient with understanding and committing to memory.

6. Use short, simple words and sentences. Do not use clinical jargon or technical terms. Speak in a manner is easily understood, using familiar terminology. Stick to one topic at a time. Information overload can confuse patients.

7. Write down the instructions. Use pictures and any visual aids possible. Use an outline format and an easy to follow flow, when putting information in paper. A summary with detailed instructions will be beneficial for the patient to review when they are in a less stressful environment. A list with a checkbox may be ideal for them to understand and check off when completed.

8. Summarize the key points and have the patient repeat back the information. This will help the team assess the patient's level of understanding, whether it is for taking medications, diet or mobility. Repetition and rephrasing are also effective techniques. Having a family member present during this interaction, will help ensure that the instructions are understood.

9. Give our elderly patients ample opportunity to express themselves and ask questions. Once the care team has explained the plan of care, new medications and treatment changes, giving our patients time to clarify the information given and ask relevant questions will help allay any anxieties that they may still have.

10. If the elderly patient is going back home or being transitioned to another level of care, saying goodbye will allow you to impart a compassionate and caring feeling. Following up with a telephone call after 24 hours to see how they are doing is an excellent communication strategy, improving relationships and providing an outstanding customer experience.

Communicating when dementia is a factor

When Alzheimer's or another form of Dementia is a factor, we need to remember that our patients who have these conditions live in a very different world that we do. To a certain extent, their illnesses have disrupted their brain circuits to the point that they must cope with the world that may not make sense anymore. This may manifest itself as confusion, anger or combativeness.

1. Do not argue with our patients. The important premise to keep in mind is, to not argue or try to correct our patients. We cannot convince our patients that our reality is the true reality. When they say something, they believe to be true, it is their reality. Trying to correct them adds to the confusion and frustration.

2. Validation. Accept whatever behavior our patient has and try to become a part of it.

3. Tell them what you are going to do before you do it. This is more important especially if you are going to touch them. It is important for them to know what is coming first so they don't think that you are harming them.

4. Be careful of the words we use. Many a time, the words we use can influence the feelings of the patients with whom we are communicating with. The bottom line is to communicate in simple, succinct terms, with respect and compassion. We are caregivers and our roles are to be aware of the plan of care, effectively communicate the goals to the multidisciplinary team caring for our patients so we all are on the same page.

CONDOLENCES

The Paulinian Family condoles with the families of two young alumnae:

Charmaign Rocafort (BS Tourism 2017) and

Angela Asis-Supremido (AB Mass Comm 2005)