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arna Vision

President's Message

Delma Armstrong, BSN, RN, CRN

I never wanted to be a radiology nurse. I was never the child who said, "I want to be a nurse when I grow up." It never occurred to me. I thought I might be a seamstress or a fashion designer (my good friends who know my love of Birkenstocks, jeans, and oversized T-shirts are laughing at that!), or maybe a cook or baker of fine confections (having perfected the making of cream puffs when I was 10 years old).

I graduated high school not having the faintest clue what I wanted to do in college. So I set off to start a general curriculum and get the basic prerequisite courses done. After two years in college, I got a letter from the Dean. It said, "Dear Miss Armstrong, You will soon have enough hours to graduate from Louisiana State University, but you have taken no junior or senior courses."

I was in a quandary. What to do! I got out my college's listing of course requirements and placed it next to a copy of my transcript. I went through each major, checking the course requirements against my transcript to see how long it would take me to complete a degree in dozens of major courses of study. When I got to the nursing undergraduate degree, I was surprised to see that in my first two years in college, I had met all the prerequisite criteria for entering the nursing program. So I began to research careers in nursing.

This was the early 1970s, and there was a nursing shortage then, too. Getting a job was not going to be a problem (not like my threadbare science and English instructors at the University). As I talked to nurses and others in allied health fields, I realized how portable nursing is. It can take you around the world if you want to go. I saw that nurses are not necessarily locked in to one specialty but have the option of moving around if they so desire. I found this very appealing (for obvious reasons, Mr. Dean of LSU).

I chose a nursing school an hour from my hometown where I could finish with my Bachelor of Science in Nursing in another three years. After spending two years in college, I was going to have to spend another 28 months to graduate from a certificate program, so I decided to go for the BSN degree.

My nursing school was a real blessing. I got a great hands-on education – much more clinical than most of my BSN counterparts who went to other schools. I spent three eight-hour days a week caring for patients at local hospitals, nursing homes, or public health agencies. I had two days of lectures. I learned practical, sage advice from seasoned nurses who were my instructors (such as "when in doubt, shout!" and "don't drop the potato" – a cajunism that roughly translates into "don't give up the ship").

I made friends with whom I still keep in touch. My first job was a float position where every day I reported to the nursing supervisor at work and got my assignment. I would go to whichever unit I was assigned to for that shift. I worked every imaginable service. I discovered then that there were cancer patients on every service and that I was really intrigued by the complexity of their care and the struggles for quality-of-life issues. Today I can say that almost every patient was a frequent flyer in the radiology department, too, getting critical tests needed for working through a differential diagnosis.

When I moved to North Carolina the next year, I jumped at the chance to work on a cancer clinical research unit at a major university medical center (Duke). I learned so much doing primary nursing with patients who had a variety of cancers and were undergoing treatment through

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Editorial

Susan Simpson, MSN, RN
Editor

I suppose every so often every one of us has asked ourselves "why?" Why did I become a nurse? Why, oh why, oh why? After much head shaking, I end up smiling and realizing that when it comes right down to it the real reason I become a nurse I am still proud to say is to provide care and comfort to a fellow human being. It has now been 20 years since I became a nurse and that is still what I want to do and want to be. I still want patients to feel safe, comfortable, and cared for. Now I have to ask myself do they? What is the feeling from the other side of the bed? Do I sound like a broken record when I am explaining the sensations they may feel from the contrast? Did I take that extra moment to just sit with them and hold their hand? Did I listen? Was I chatting about American Idol with other staff members over the patients while getting them prepped? Did they feel left out or ignored? Did they feel informed? Did they feel safe? Did they feel comfort? Did they feel cared for? In an attempt to answer some of these questions *Vision* has decided to ask patients about their radiological experiences. You know the old saying about going to the horse's mouth and all. Well here we are off to the races to talk with a few horses. I am really excited about this feature, and it is with pride and great anticipation I introduce you to "The Other Side of the Bed," a regular feature of *Vision* that looks at us through the eyes of patients. I am sure we will learn a lot about the patients, our practice, and ourselves.



The Other Side of the Bed

On February 17, 2003, my life changed. I'd had a short, but profound, episode of dizziness that concerned me enough to make an appointment with my doctor. I'm a registered nurse with 30+ years of critical care experience. I knew which tests I wanted done, and, fortunately, my doctor complied. In the back of my mind, I was concerned about a brain tumor, as my mother had died of a glioblastoma multiforme several years before.

I had my CAT scan with contrast on February 17. Thankfully, I knew the technician. From years of working with critical patients and attending to them while they were having CTs done, I was familiar with what to expect. The contrast was injected, and I realized that he was taking very small cuts. I knew he had found something. While taking out my IV, we were both oddly nervous. I didn't want to take advantage of our friendship, but I asked him outright if he had found something. He held my hand and said, "I'll be right back." Within moments the radiologist came in to see me, sat down beside me, and told me I had a brain aneurysm. He was so kind, but I felt as though I was being catapulted into a deep ocean without a life preserver. The radiologist was kind enough to call not only my primary physician but also the neurosurgeon.

Shortly thereafter I was scheduled for an MRI/MRA. I'm not a big fan of that test! With frequent calls to me over the intercom to check how I was doing, the tech was wonderful and kept me smiling with comical little comments. To lay so perfectly still with my head encased in a quasi football helmet for over 2 hours certainly tested the limits of my patience. Engaging in short, frequent conversations helped the time *appear* to pass more quickly.

My MRI/MRA was reviewed by the neurosurgeon and interventional neuroradiologist at the University of Miami where I had been referred, and it was determined that I would have a routine cerebral angiogram. May 13, I was prepped and ready at 8:00 a.m. for my procedure, but it was delayed by six hours because a 17-year-old boy having an AVM repaired was having complications. A mix of emotions flooded me—I was relieved to be delayed, my heart went out to this young man with such a life-threatening problem, and I was anxious to get my test over with. Finally, at 3:00 p.m., I joined the nurses in the radiology suite and the test was underway. The most comforting aspect was the nurse who stayed at my side and gently talked to me while getting things ready. Her attitude was so calm and friendly, and she never hesitated to touch my arm, squeeze my hand, or give me words of encouragement and comfort, all the while doing her assigned tasks. The staff found out I was a nurse from one of the radiologists, but

the care did not change. I was never in pain but was unnerved by the flashes of light in my eyes and the uncomfortable heat that radiated all the way down my spine during the injection of the contrast. I wish they had told me what was going to happen, as I initially thought something happened to the aneurysm! The final diagnosis: large aneurysm of the paraclinoid region of the left internal carotid artery.



My pre-surgical consultation was June 2. After much discussion with my most incredible and kind neurosurgeon, I opted to have clipping done and scheduled it for June 13. Unfortunately my near 7-hour surgery failed because the aneurysm was very close to the ophthalmic artery, and to proceed with the clipping would have resulted in stroke and/or loss of vision in my left eye. My family was devastated that I would have to endure yet another surgery. They had to wait nearly 2 days before I could understand what they were telling me. Oddly enough, I knew that my neurosurgeon had tried his very best and had kept the promise he made to me that if he saw anything that would cause me harm, he would stop the surgery. He promised to keep me safe, and he did.

Before I was discharged from the hospital, I was scheduled to have endovascular coiling done July 3. I was blessed yet again to have a kind and gentle physician directing the coiling surgery, done under general anesthesia. I was back in the hands of the caring nurses in the neuroradiology suite. They remembered me and assured me they would be taking wonderful care of me during the surgery, which lasted nearly 6 hours. The nurse was exceptional with my family, who were all emotionally and physically drained from going through yet

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5 Minutes with Kate Little

Recently, Vision had the opportunity to participate in a "virtual interview" with Kate Little, RN, Immediate Past President.

Vision: How do you view your role as a radiology nurse and where do you see the nursing profession going in the future?

Kate: My role as a radiology nurse is to work with other team members to provide care to patients. The nursing profession will evolve as the healthcare system in this country changes.

Vision: Where do you see the radiology nursing specialty in going in the future?

Kate: As technology changes, it drives the way that we do business/deliver patient care. I see that there will always be a need for nurses in radiology.

Vision: How do you think individual ARNA members make a positive influence on practice?

Kate: Individuals within our "community" positively influence nursing practice within the specialty by sharing information with each other.

Vision: How did you become involved with ARNA?

Kate: I became involved with ARNA after I attended my first meeting of the Carolinas Chapter in 1993. I was encouraged along the way by my colleagues at the University of North Carolina.

Vision: What journey did you take that led you to becoming a member of the Board of a national nursing organization?

Kate: I became involved in the local chapter first then volunteered as a member on a number of national committees. I then agreed to chair ARNA's Membership Committee.



National "PAD Coalition" Formed

Editor's Note: Kathleen Gross, MSN, RN, BC, CRN, attended the PAD Coalition meeting at the National Institutes of Health on June 17, 2004.

The Vascular Disease Foundation has created a coalition in partnership with 14 other major national public health organizations and professional vascular societies. At its inaugural meeting, the Coalition identified as a top priority the need for a unified, long-term national public awareness campaign about peripheral arterial disease (PAD). Another priority area is to coordinate clinician's educational efforts. These activities will be designed to improve the clinical outcomes of individuals with PAD.

This meeting brought together vascular healthcare professionals from around the country to create the structure of the Coalition. This structure was first conceived at a strategic planning meeting held in January 2003, at which initial consensus was reached and the rationale underlying the goals of such a national PAD awareness campaign was solidified. The PAD Coalition is co-chaired by Alan T. Hirsch, MD, past-president of the Vascular Disease Foundation, and Marge Lovell, RN, CCRC, CVN, a current officer of the Foundation and past president of the Society for Vascular Nursing (SVN).

In addition to the Vascular Disease Foundation, participating organizations included the American Association for Cardiovascular and Pulmonary Rehabilitation; American College of Cardiology; American College of Physicians; American Diabetes Association; American Heart Association; American Podiatric Medical Association; **American Radiological Nurses Association**; Peripheral Vascular Surgery Society; Society for Clinical Vascular Surgery; Society of Interventional Radiology; Society for Vascular Medicine and Biology; Society for Vascular Nursing; Society for Vascular Surgery; and the Society of Vascular Ultrasound.

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ARNA Mission Statement

The mission of the American Radiological Nurses Association is to provide, promote, maintain continuity of and continuously improve patient care through service to members.

ARNA's 2003 JCAHO National Patient Safety Goals Survey

Paulette Snoby, MPA, BSN, RN, CCRN

As an ARNA Board member, I am the liaison to Radiological Society of North America's (RSNA) Associated Sciences Consortium. This year ARNA's topic for the refresher course is "The 2003 JCAHO National Patient Safety Goals-The Effect on Radiology Clinical Practice One Year Later."

In order to obtain a representative sample of the actual influence that the Joint Commission on Accreditation of Healthcare Organization's (JCAHO) 2003 National Patient Safety Goals (NPSG) had on radiology practices, a survey was distributed during the joint annual meeting of ARNA and the Association of Vascular and Interventional Radiographers (AVIR). This meeting was held at the Society of Interventional Radiology (SIR) Scientific Meeting in Phoenix, AZ, March 2004. This provided the opportunity to solicit responses from radiology nurses and radiological technologists.

Methodology

The survey consisted of three demographic queries: Work at what type of facility? Work in what geographical area of the USA? and Are you a professional RN or RT? There were five survey questions that requested information pertinent to the descriptive study. The first question determined the primary inquiry, "Are you aware of JCAHO's 2003 National Patient Safety Goals?" If the response was *no*, then there was no further need for the participant to complete the remaining four questions. The second question "How has your department been affected by these goals?" presented twenty-six possible outcomes to choose. There was no limit on the number of responses the participant selected. The last three questions dealt with the perceptions the NPSG had on the radiology nurse's (RN), radiologist's, and radiological technologist's (RT) roles.

Question 3 explored the radiology nurse's role, question 4 the radiologist's role, and question 5 the RT's role.

Summary

The 2003 JCAHO National Patient Safety Goals have resulted in a multiple effects on radiology departments, the majority of which were positive. The positive outcomes were "prevention of medical errors, prevention of near misses in patient identification and wrong site, improve patient care, and improved documentation."

There were a few negative outcomes of "increased paper work and increase in clerical functions." Surprisingly, only a few responded that there was an increased cost for the radiologists or increase in personnel budgeted for the radiology departments.

The RNs and RTs agreed that their roles were changed which required increased QI and monitoring functions, clerical duties, and documentation. Both groups agreed that the radiologists' roles experienced the same three effects. Additionally, the radiologists became advocates for aseptic techniques, patient advocates, educators of patients and their families, and clinicians who made rounds on patients.

The purpose of the 2003 JCAHO National Patient Safety Goals was to reduce medical errors. In view of this survey, there has been a positive impact on radiology departments and the professional roles of the radiology RNs, RTs, and radiologists across the country.

5 Minutes with Rhonda Caridi

Recently, *Vision* had the opportunity to participate in a "virtual interview" with Rhonda Caridi, RN, CRN, Board member.

Vision: How do you view your role as a radiology nurse and where do you see the nursing profession going in the future?

Rhonda: Foremost, I see myself as an educator. Being in radiology for the last 14 years, I still find that I'm not only an educator to patients (explaining their procedures, post-care, and so on) but also to technologists, radiologists, and directors. Even though I have been in the radiology field for quite some time now, I am amazed that I can still enlighten my coworkers with my experience and the nursing perspective.

My favorite role is that of patient advocate. No matter how wonderful the radiologists and associates are, their job is to focus on the procedure at hand. I believe that radiology nurses are the crux of the personal touch that patients need and deserve from arrival to discharge.

I see the nursing profession in radiology escalating to realms we never dreamt of from practitioners working intimately with the radiologists to researchers and administrators. The possibilities are endless.

Vision: Where do you see the radiology nursing specialty going in the future?

Rhonda: In my opinion, the role of the specialty will grow. As the field of radiology evolves, so will the horizons for radiology nurses.

Vision: How do you think individual ARNA members have a positive influence on practice?



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Certification Notice

The Radiologic Nursing Certification Board held a conference call to review the practice requirement to be eligible for certification. The current requirement is 4,000 hours within the previous two years. Following discussion, the Board determined that the requirement should be set at 2,000 hours of practice in radiology nursing within the previous 3 years.

Call for Manuscripts

The *Journal of Radiology Nursing (JRN)* is looking for manuscripts on the following topics:

- ❖ Nursing Leadership
- ❖ New Procedures
- ❖ Research Studies
- ❖ JCAHO Requirements
- ❖ HIPPA
- ❖ Orientation and Competency for Radiology Nursing
- ❖ Patient Satisfaction
- ❖ Moderate Sedation
- ❖ Radiation Safety
- ❖ Magnetic Resonance Imaging
- ❖ Management of Lines
- ❖ Drug Eluting Stents
- ❖ Multidisciplinary Approach to Team Building in Interventional Radiology
- ❖ PI Efforts
- ❖ Infection Control Policies
- ❖ Budget and Financial Strategies
- ❖ Patient Safety Issues
- ❖ Role of the PA and ARNP in Interventional Radiology
- ❖ Patient Teaching Techniques in Interventional Radiology

For assistance in developing an idea or writing a manuscript, contact the Editor, Marie Korenstein, MHS, RN, CRN, at 7794 Grow Drive, Pensacola, FL 32514, (866) 486-ARNA (2762), fax (850) 484-8762, or e-mail mariek@bhssf.org We're eager to hear from you!

(Five Minutes with Rhonda Caridi, continued from page 4)

Rhonda: No matter how novice a radiology nurse may be, the diverse experiences he/she brings to the field shows radiology nurses' professionalism and knowledge base. Being an ARNA member enhances this by having the organization support that member, as well as providing networking opportunities and peer assistance when necessary. The educational opportunities via meetings, our journal, and so on keep ARNA members at the forefront of their specialty and empower them with the tools they need to perform to the best of their ability on a daily basis.

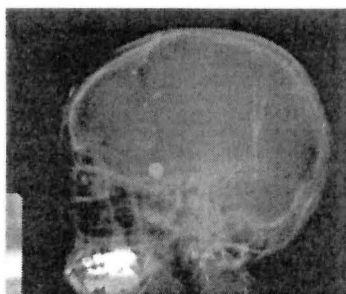
Vision: How did you become involved with ARNA?

Rhonda: My first radiology position began 14 years ago. I was totally intimidated, as I was the first radiology nurse the department had ever hired. Fortunately, my boss told me a requirement was to join ARNA. I was thrilled to know I wasn't alone and had resources to assist in developing guidelines, policies, and procedures.

Vision: What journey did you take that led you to becoming a Board member of a national nursing organization?

I believe that ARNA is a worthwhile organization to invest my time and energy into, especially since the organization helped support me in growing in my specialty. Therefore, I offered my assistance to the organization in any capacity. I served on committees and eventually developed the confidence to run for a Board position. Even though I ran several times and didn't succeed, several board members were always there to support me and convince me to try again. I'm so happy I didn't give up. Along the way, I learned so much about how the organization functions. Being a Board member is an enormous responsibility, but it is so fulfilling to be able to attempt to give back to the organization. Not only do I endeavor to use my experience to guide the organization, I am ever learning from my fellow Board members and membership. Last but not least, I have been given the opportunity to make life-long friends.

(The Other Side of the Bed, continued from page 2)



another surgery with me. The coiling was successful and I was discharged home in 24 hours.

My follow-up angiogram was done February 7, 2004. The same nurses were present, very happy to see me in good health and doing so well. The most unpleasant aspect of this angiogram for me was the lying flat for 4 hours after the

test. They had used the arterial plug after the first angiogram, but I'd had an allergic reaction to the Clindamycin, so they couldn't use the plug again.

Considering I had undergone two major surgeries in 2 weeks, I was grateful

MRI Experience

Last night, I offered up my body... in the name of science. I have a friend who works at NIH, and he alerted me to the fact that they needed healthy people to come in and get their brains scanned twice—once on the current MRI machine and once on the new MRI machine—so they can calibrate it or something. My incentives: \$80 and a picture of my brain! Shoot, I'd do it for either one. Possibly for free.

So I leave work around 6:30 p.m. and head to NIH. The woman suggested I try and get there around 7:00 p.m. for my 7:30 p.m. appointment. Okay I think to myself, I come here once a week, no problem, right? She mentioned something about valet parking, but I don't know what's up with that. So I arrive on campus with 5 minutes to spare and start trying to figure out where to park. Okay! Wow. The clinic is the building the size of, well, a huge hospital in the middle of everything, but in the dark and shadows, and maze-like road network, it's all very confusing. Plus there's construction. So I'm trying to follow the signage. I can't decide if I'm an outpatient or a visitor/guest, so I settle on the latter for safety's sake and keep going in circles. I encounter not one but two loading dock dead ends, and I've still got no idea. Finally, in irritation I just pick a small parking lot, the hours of which are 9:00 a.m.-7:00 p.m. It's like 7:05 p.m. There's a booth, a gate, and a ticket machine. I sort of pause ... does 9:00 a.m.-7:00 p.m. mean I can't park there now? Or that it's free now? Hmmm. I look at the ticket machine. I look at the gate and look at the booth. No one is in there. The gate is up, so I take this as my cue to mean "free parking" and pull in; there are maybe three other cars in there. Okay, fine!

So now I have to find my way back to the clinic. However, it's one of those buildings that has a lot of wings, and there are also dozens of *other* buildings all around it, so from ground level in the dark, it's slightly impossible to figure out which one you want. I head off in the direction I believe to be right and eventually find a sign with an arrow which leads me to a locked door. In bewilderment I accost a hurrying man in a lab coat, and he points me to the main entrance. Whew!

In the lobby, there is a sign-in and security check. The woman asks me what floor I'll be going to. I have no idea! I don't have my contact's phone number either and don't remember her last name. Hmm. She sighs and signs me in. The man at the security table asks where I'm going. I'm like "I don't know! I need an MRI." so he gives me directions for how to get to the other corner of the building some 1/4 mile away.

When I arrive in radiology, I finally find someone who appears to work

for the 4 months I had taken off from work. I was able to regain my strength and mental clarity without being rushed to do so. October 6, 2003, I returned to the emergency department full time. I certainly have a new appreciation for patients who are in my care.

One never knows when a simple test will reveal something horrible. I found unlimited caring and kindness during my ordeal, and I will be forever grateful to have had those particular people in my life when I needed them most.

Chris Campbell, RN
Port St. Lucie, FL

there. I announce, I'm here for an MRI. She looks puzzled and checks the schedule and my name, repeatedly. Nope. Not on the schedule. I plaintively offer up the name of the woman I talked to; there is no one in this department by that name. The woman suggests that I want to go down to level B1. I'm like "so, there's another different MRI place?" Yes. Yes, there is.

Right then, I try to find the elevator, but I'm abysmally lost by this point. I've taken so many turns. A kindly man takes pity on me and gets me to the elevator. Down to B1, I wander past laundry rooms, with the pervasive smell of hospital cafeteria (they always smell like fake mashed potatoes to me) lingering in the air. Finally I find my woman. She announces that first I need to check in at admissions, so we troop back upstairs. They make a file for me, and I get a packet of information. Then back down.

Finally, we are getting somewhere! We do a height-weight check (I'm taller than usual and, as suspected, weigh less. Interesting.) And then I have to take out my jewelry. *That* was a process! It felt very, very weird not having the nose ring and tongue rings. I found it difficult to talk properly; having full range of motion just seems like too much to me now.

At last I'm free of metal and credit cards, and we enter the room with the glorious huge machine with "GE" proudly emblazoned on it. They take three vitamin E capsules and tape them inside my ears and to the left side of my face. I'm told these provide reference markers. Then, I lie back and get comfy, and she pads my head inside this basket so it can't loll about very much. When I'm all positioned, with a smooth whirr of precision machinery, I slide backwards into the depths of the tube. I feel a strange tugging at my pants, and realize that the snap or zipper is being pulled up toward me by the magnetic field. Heh.

Now, they haven't told me what to expect at all, in terms of length of time. The technician did say that the machine makes a noise "like a jackhammer" and that when it's making this jackhammer noise I should lie as still as possible.

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(President, continued from page 1)

research protocols. From this job, I went on to work in a rural hospital in a variety of oncology roles—unit nurse (the one who always volunteered to go down to x-ray to sedate a patient or monitor during a cerebral angiogram), nurse clinician, teacher of chemo courses and symptom management to nurses, coordinator of a grassroots hospice team, educator and mentor of community college students, preceptor of new nurse graduates, hospice volunteer, home health nurse, and, last but not least, during my summer vacations being a camp nurse for children with diabetes.

When I decided to move out of the country and back to Chapel Hill, my son was five years old and just diagnosed with diabetes. I moved to the area knowing he would get good medical care. But I had no job (just a lot of experience!). When I went to apply at the University of North Carolina (UNC), I saw a position listed for radiology nurse. The applicant needed to be a seasoned nurse (that would be me). The position offered regular hours during the day, during the week (wow – just what I needed). I put the radiology nurse position down as one I was interested in. Then I called Sue Forloines-Lynn, the only nurse at UNC I knew (she is now the nurse practitioner in the Vascular and Interventional Radiology Department). Lucky for me, the radiology nurse manager was a friend of hers. JoAnn Belanger hired me, and I showed up for a job I would grow to love. Actually, the first day I showed up, I got lost and was about thirty minutes late looking for the radiology department (how embarrassing). Ever since then, I stop and help patients and visitors find their way through our rabbit warren of a hospital.

For the next 10 years, I went in to work every day knowing only where to report (CT, Ultrasound, MRI, Nuclear Medicine, Interventional, or Diagnostic Radiology). I tried to meet each challenge thoughtfully and with good humor. I found that as the only nurse in a department, my interactions with the staff there reflected on all my nurse colleagues. I spent a lot of time building bridges with the technologists and radiologists, other physicians, and unit nurses.

When a position was created in the mammography department (in large part because of new federal regulations on mammogram reporting and notification of patients), I applied (begged) to work there. I figured it would be a good fusion of my years of oncology and radiology. I enjoyed being part of an interconnected team caring for women in crisis. I learned how the surgeons and medical oncologists approach different breast cancer scenarios and develop individualized treatment plans for patients. I saw many patients over and over again during my years in mammography. I was the primary radiology nurse. It was very gratifying.

At this point in my career I can say that I have reached a happy fusion of my two nursing loves – radiology nursing and oncology nursing. I get to counsel patients about their mammograms and about staging studies and teach them about diagnostic and therapeutic procedures they have to undergo. I also spend a lot of time doing chemotherapy teaching, symptom management, and supportive counseling.

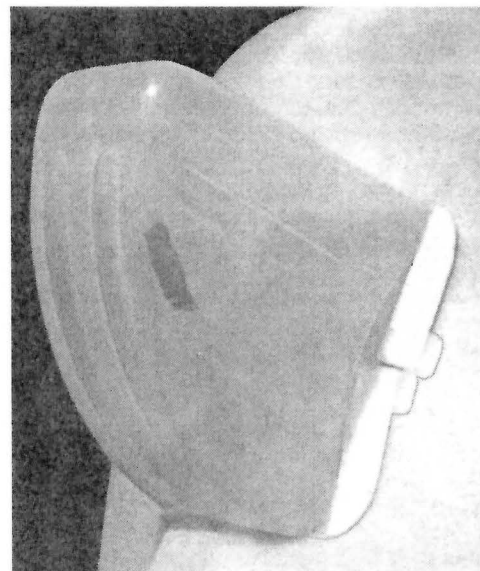
I get very excited at our annual meetings when I see the trend of care in

interventional radiology moving toward more minimally therapeutic interventions for conditions such as liver metastases, thought to be untreatable in the past. Oncology and radiology continue their “bread and butter” relationship. They each depend on the other for creative solutions to age-old problems. And as the baby boomers age and begin to develop cancers, the relationship between radiology and oncology can only become stronger. It is all very exciting. The promising new interventions and novel therapeutics are fascinating.

This trend emphasizes for me that radiology nurses are all valuable cogs in an important wheel of the healthcare delivery system. Our value increases daily. We are the caregivers the patient rely on to see them as whole people. We interface with the patient and family, the staff in radiology, and the primary care physicians. We are the advocates when patients are sedated or confused. We are the soft voices, the easy laughter, the warm touch, and the bulldog through our complicated medical systems for them.

Or as Freddie Mercury puts it, “We are the champions, my friend, and we’ll keep on fighting till the end.”

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