IN THIS ISSUE:
A ‘Cool’ Treatment Helps Save Bill Mason’s Life
It was a bittersweet decision. After more than 16 years as president and chief executive officer of St. Joseph’s Hospital Health Center, I publicly announced in June that I will step down at the end of this year. This change in my professional life actually began several years ago, as our Board of Trustees and I began discussing leadership development and succession planning, which are vital to the long-term success of any organization. The timing of my decision was reached in a very deliberate and logical way to ensure the future success of St. Joseph’s and its network of services. Rest assured, St. Joseph’s is well-positioned for the future—financially, programmatically and with our “bricks and mortar.” One of the personal highlights of my time as president was the development of our most recent facility master plan and its implementation. We’ve already completed the renovation of our hospital lobby and construction of the on-campus Medical Office Centre, parking garage and sky bridge. These greatly enhance the campus for our patients, their families and our physicians. Construction is progressing steadily on St. Joseph’s much-needed emergency department expansion, which will include psychiatric emergency services, a chest pain observation unit, new data center and kitchen. Keeping true to our core value of stewardship, our construction is environmentally friendly and we will, in fact, seek LEED silver certification. This phase, expected to be completed in the fall of 2011, will be followed by the patient tower, featuring private patient rooms and a state-of-the-art operating suite. This expansion should be finished in the fall of 2013.

No doubt, inpatient hospital care will always be needed, but I am pleased at how St. Joseph’s network of services has grown to meet the needs of our patients and our community. Our network includes services such as ambulatory surgery centers, satellite dialysis facilities and Franciscan Services, which assists St. Joseph’s in providing ancillary health care services, such as respiratory care and home medical equipment. Franciscan works hand in glove with our Certified Home Health Care Agency to ensure continuity of care for our patients. In addition, our College of Nursing is an asset that provides future nurses not only with an excellent education, but introduction into St. Joseph’s culture of caring as well.

Although we operate within a continually changing landscape of state and federal reimbursement for the care we provide and as we anticipate the changes that will occur as part of health care reform, St. Joseph’s is in a strong position financially. We consistently operate in the “black” and are able to reinvest our operating margin in our staff, equipment and facilities.

As we discussed succession planning, the St. Joseph’s Board of Trustees realized that it would take a number of years to prepare a successor, and a formal process was put in place. I am pleased to report that the Board of Trustees unanimously recommended to the Sisters of St. Francis, and the Sisters unanimously agreed, that Kathryn Howe Ruscitto be appointed my replacement as president and chief executive officer of St. Joseph’s Hospital Health Center as of Jan. 1, 2011. I am confident that the transition will be seamless. This is an exciting time in the life of St. Joseph’s, specifically, and health care, in general. I’m pleased that I will continue to stay connected to the organization in an advisory role to the new president and various corporate boards. I must also note that, during my presidency, it was my privilege to be a part of the re-articulation of St. Joseph’s mission statement, a process that asked for the input of more than a thousand employees, physicians, members of our Council of Advisors, Board of Trustees and the Sisters of St. Francis. Our mission statement articulates the beliefs that guide all we do:

“We are passionate healers dedicated to honoring the Sacred in our sisters and brothers.”

It is my desire that St. Joseph’s Hospital Health Center continue its culture of caring—caring for our patients, families, fellow employees and physicians, our community and our environment. I expect that we will continue to evolve and develop, adopting new technologies and implementing new services as opportunities present themselves. Our network is in great shape due to the hard work and dedication of each and every person associated with St. Joseph’s. They are compassionate individuals who truly care about our patients and their families. I have been privileged to work with every one of them.

I thank all of you for your unending support of St. Joseph’s Hospital Health Center. Let us always be mindful of the culture of caring and mission of service upon which the Sisters of St. Francis founded St. Joseph’s more than 140 years ago.

Sincerely,

Theodore M. Pasinski
President
Our Mission
We are passionate healers dedicated to honoring the Sacred in our sisters and brothers.

Our Vision
To be world-renowned for passionate patient care and outstanding clinical outcomes.

Our Core Values
In the spirit of good Stewardship, we heal by practicing Compassion through our kindness, concern and genuine caring; Reverence in honoring the dignity of the human spirit; Excellence by expecting the best of ourselves and others; Integrity by being and speaking the truth.
Blessed Mother Marianne Sculpture Dedicated

A statue of Blessed Mother Marianne Cope was unveiled at an event on May 6 marking the 141st anniversary of the founding of St. Joseph’s Hospital. Located in the hospital’s lobby, the sculpture was created by local artist Ron DeRutte. The primary founder of St. Joseph’s, Mother Marianne left Syracuse in 1883 to minister to leprosy patients in Hawaii. Mother Marianne has been beatified by the Roman Catholic Church—a step in the process of being declared a saint. Speaking at the unveiling is Anthony Oliva, MD. The statue of Mother Marianne appears at left.

Richard Waldman, MD, Becomes 61st President of ACOG

Richard Waldman, MD, has been sworn in as the 61st president of The American Congress of Obstetricians and Gynecologists (ACOG), based in Washington, DC. Dr. Waldman is chair of the Ob-Gyn Department at St. Joseph’s. He is also president of Associates for Women’s Medicine and clinical associate professor of ob-gyn at Upstate Medical Center.

Dr. Waldman has been an active ACOG Fellow since 1981. He has served as a member of the ACOG Executive Board and chaired the Council of District Chairs. He has held a number of regional leadership positions and has been a member of numerous ACOG committees and task forces. Dr. Waldman is a recipient of ACOG’s Outstanding District Service Award and Outstanding Section Service Award.

In addition, Dr. Waldman is a past president of the Central New York Obstetrics and Gynecology Society and a former consultant to the International Childbirth Education Association. He has been active in advocating for improvements in women’s health for many years and established the first hospital-based midwifery practice in Central New York. Dr. Waldman has served on several New York state task forces working with the Commissioner of Health and the Superintendent of Insurance.

Dr. Waldman received his medical degree from the New Jersey College of Medicine & Dentistry and completed his residency at SUNY Upstate Medical University.
St. Joseph’s Aids Earthquake Victims

Just weeks after a 7.0 magnitude earthquake devastated Haiti on Jan. 12, St. Joseph’s physicians Robert Dracker, MD, a pediatrician, and Michael Fitzgerald, MD, a gastroenterologist, joined other medical providers from St. Joseph’s and across the globe to aid the disaster-stricken country.

The situation was dire and the two worked at least 12 hours a day the entire week they were there, providing medical support to earthquake victims flown in by helicopter. The town of Milot’s Hôpital Sacré Coeur is a private, 73-bed hospital located 70 miles north of Port-au-Prince, the earthquake’s epicenter.

Michael Fitzgerald, MD, previously had traveled to Haiti to provide medical care; however, he and his wife, Margaret, a registered nurse, were taken aback by the injuries sustained by victims of the Jan. 12 earthquake that claimed an estimated 200,000 lives.

“Anybody who took an interest in them with the intent to help them was greatly appreciated.”

“The hospital census was about 450 patients,” says Dr. Fitzgerald, who journeys annually to serve the Haitian sick. Dr. Fitzgerald is a member of the Order of Malta, a Catholic organization dedicated to helping the sick and the poor. Hôpital Sacré Coeur, run by CRUDEM Foundation, or Center for the Rural Development of Milot, is a branch of the Order of Malta.

Outside the main campus, sundry buildings and six Army tents were used to house patients. Both doctors described the site as resembling scenes from the hit television series M*A*S*H.

The doctors brought with them pharmaceutical donations comprised of tetanus vaccinations, and a medicine used for treating the disease, as well as thousands of vitamins and iron supplements for malnourished children.

Dr. Dracker found the milling masses, the pungent odors, the tropical heat and extreme poverty overwhelming.

“To them, it wasn’t so bad because they were used to it,” Dr. Dracker says.

Despite their grim circumstances, the natives, whom Dr. Fitzgerald describes as proud people, pitched in as best they could. Women shared their scarce food stores to feed hungry children and the men in town filled in potholes on the roads, so victims wouldn’t bounce during the ride in from the landing strip to the hospital.

“It was a population of people who really appreciated anything anybody did for them,” Dr. Dracker says. “Anybody who took interest in them with the intent to help them was greatly appreciated.”

While in Haiti, Robert Dracker, MD, diagnosed a 16-year-old girl with leukemia and arranged for her to be treated in the Dominican Republic.

The experience left an indelible impression on both Dr. Dracker and Dr. Fitzgerald. Dr. Fitzgerald intends to continue his work at the same hospital during his annual visit next February. Dr. Dracker is also planning to engage in future missions abroad.

“Personally, it was very rewarding and will always be memorable,” Dr. Dracker says, “despite language and cultural barriers.”

Along with Michael Fitzgerald, MD, and Robert Dracker, MD, St. Joseph’s pediatrician Jim Crincione, MD, traveled to Haiti in February to care for the injured after a devastating earthquake rocked the country in January. Two nurses from St. Joseph’s North Surgery Center—Vonn Lee, RN, (photographed) and Leslie Tansey, RN—followed in March. Many others—including St. Joseph’s Executive Vice President Kathryn Ruscitto, who chaired the response efforts of the National Committee for the Order of Malta Federal Association USA; Joe Bick, RN, St. Joseph’s emergency management manager; St. Joseph’s Medical Executive Committee; Franciscan Management Services Inc.; Welch Allyn Inc.; Dalpos Architects & Integrators; Wegmans; Kinney Drugs and the Marcellus community—joined forces with St. Joseph’s to support the relief effort.
Getting the Elephant Off Your Chest Might Be Easier With Robotic Surgery

No one wants an elephant sitting on their chest, but if it takes painful surgery to get the pachyderm off, anyone might have second thoughts. Fortunately, there is another option.

When Daryl Shultz learned that she could get rid of the elephant (and the hiatal hernia that was causing the pain) without going through painful, slow healing open surgery, she signed up for the procedure immediately with St. Joseph’s Hospital Health Center general surgeon Balasubramaniam Sivakumar, MD, known among his patients and colleagues as Dr. Kumar.

Dr. Kumar has performed hundreds of hiatal hernia repairs, first with the traditional open procedure, then with less invasive laparoscopic surgery, and finally with the minimally invasive da Vinci® surgical robot at St. Joseph’s. In Shultz’s case, however, Dr. Kumar would be using St. Joseph’s most advanced robot yet. And Shultz would be the first patient for the new robot. The robotic approach shortens the hospital stay to a day instead of three or four days, speeds healing, and reduces the possibility of infection.

Shultz, who is an executive administrative assistant for Excellus BlueCross BlueShield, had suffered with increasing pain for seven years, treating it with antacids. “In March,” Shultz says, “all of a sudden there was a pain like an elephant sitting on my chest that wasn’t going away. It was diagnosed as a hiatal hernia by a gastroenterologist who recommended surgery rather than continued medical treatment. A coworker recommended Dr. Kumar.”

A hiatal hernia is caused by an enlarged hiatus, a small hole in the diaphragm, the muscle that separates the abdominal cavity from the chest. In a hiatal hernia, the enlarged hole in the diaphragm allows the stomach to force its way up into the chest cavity. The stomach’s upward movement weakens a valve in the lower esophagus (the tube that carries food to the stomach) letting highly corrosive stomach acid flow up into the esophagus. The result is intense pain commonly known as “heartburn.”

The new da Vinci robot that Dr. Kumar used is two generations beyond the robot he and other St. Joseph’s surgeons have used since 2005. Unlike the first version, the new robot provides the surgeon with high-definition video of the surgical site—the same degree of vision available on large screen televisions. The new robot also gives Dr. Kumar and other surgeons a longer reach and a far greater range of motion. “Not only is there a great range of motion,” Dr. Kumar says, “but it allows us to scale the motion...”

Balasubramaniam Sivakumar, MD, (Dr. Kumar) assembles the da Vinci robot’s high-resolution camera before Daryl Shultz’s surgery to repair a hiatal hernia.
...down so we can make extremely precise movements. It also has a degree of retroflexion that lets us move forward and backward. The high-definition optics give us far better visualization than the earlier models, too."

Those optics are needed as Dr. Kumar frees the upper part of Daryl Shultz's stomach and pulls it back down into the abdomen. He then wraps the flexible upper part of the stomach about three-quarters of the way around the esophagus and delicately stitches the two together. The stomach's muscles will prevent stomach acids from flowing backward into the esophagus.

Throughout the surgery, which began at 8:08 a.m., Dr. Kumar was seated at the robot's console about 15 feet away from his patient. Grouped around Shultz's bedside, however, were surgeon David Wormuth, MD; anesthesiologist Mihael Puc, MD; physician assistant Yana Popilevskaya, PA; surgical technologist Ginette Soule, ST; and circulating nurse Deborah Larabee, RN. The team surrounding Shultz, besides minding her anesthesia, also monitored her vitals signs and was charged with opening five small incisions through which the miniaturized videocamera and the robot's movable arms and tools pass.

At the console, Dr. Kumar's thumb and first two fingers of each hand were inserted into precision controls. The robot's instruments within Shultz's abdomen replicated every movement Dr. Kumar made at the console. There was one difference: If needed, the tools could be made to move in ways the human wrist cannot. The tools, one of which delicately cuts through tissue using a heat-generating ultrasonic knife that also immediately stops the flow of blood, appear to have learned the surgeon's skill.

As soon as Dr. Kumar pronounces the surgery finished, Dr. Wormuth stitched closed the dime- and quarter-sized openings in Shultz's abdomen. The time was 9:22 a.m.

Daryl Shultz was up and walking around the afternoon of her surgery. She enjoyed a liquid supper and spent the night in the hospital before being released the following day.

"Everything healed up beautifully," Shultz says the day she returned to work. "It was an easy recovery. I'm a chicken when it comes to things like this, but after Dr. Kumar explained it to me, I had no qualms about it. I figured with a robot there would be fewer fingers in there and the fewer fingers, the better!"
Quick Action—and Therapeutic Hypothermia—Save Bill Mason’s Life

When Bill Mason’s heart started quivering wildly and he collapsed in cardiac arrest last March, his chances of survival were less than 1 in 10. Even if his heart did return to its normal rhythm, doctors say, the chances of escaping without permanent brain damage were not much better.

Thanks to the efforts of Joseph’s Hospital Health Center’s critical care physicians and nurses, paramedics from the Syracuse Fire Department, ambulance personnel, a few of Mason’s friends, and some serendipity, as well, Mason survived and is recovering.

It is generally agreed, however, that unless St. Joseph’s critical care staff had been ready to use a relatively new procedure called therapeutic hypothermia, Mason probably would have died. Instead, he became something of a medical pioneer by being the first St. Joseph’s patient to undergo the process.

Mason and his wife, Pam, never saw this scenario developing. At the age of 44 (he’s 45 now), Mason thought he was in good health. He is a long-time member of the Syracuse Track Club, runs every other day, has completed half a dozen marathons, and has finished 20 editions of the Boilermaker Run in Utica. He also works out in the Utica Fire Department gym where he’s a station captain. So at 6’1” and 185 pounds, Mason is far from being a “couch potato,” but it was during one of the Syracuse Track Club’s regular evening runs that Mason’s saga began.

“I don’t know how I can help you,” an apologetic Mason says. “I don’t remember anything of the three-week span from a week before this happened to the week after I left the hospital. My wife even had to remind me that she was 10 weeks pregnant.”

Russ Abraham, a childhood friend of Mason’s and fellow runner, tells the tale that Mason cannot. Abraham, 51, a runner with more than 30 marathons under his belt, was about 200 yards ahead of Mason the evening of March 11 when he heard someone yelling that his friend was in trouble.

“He went down to his knee first, then tried to stand and lost consciousness,” Abraham recalls. “We thought about giving him CPR, but he was still breathing, although the breaths were short and deep.”

There was no telephone at the Syracuse park in which they were running, so someone hailed the driver of a car and borrowed a cell phone to call 911. Abraham remembers checking his watch in case those at the hospital wanted to know when this happened.

“The Syracuse Fire Department paramedics arrived in eight minutes and used a mechanical ventilator to assist his breathing,” Abraham continues, “and the ambulance crew arrived 10 minutes later and used an external defibrillator. It stopped the ventricular fibrillation.”

The ambulance arrived at St. Joseph’s emergency department (ED) 21 minutes after Mason had collapsed. The mantra recited throughout St. Joseph’s ED in cardiac cases is simple: “Time is muscle.” With every passing minute without an adequate oxygen supply, heart tissue is damaged. In cases like Mason’s, however, the same is also true of brain tissue. Even with Mason’s heart rhythm restored, he remained unconscious. That’s the paradox in cases like these, according to Doug Fetterman, MD, a critical care anesthesiologist at St. Joseph’s medical intensive care unit (MICU) where Mason was transferred after his initial treatment in the ED.

“With patients like Bill Mason who reach the hospital alive, it’s probably not their heart that is going to kill them,” Dr. Fetterman says. “If they make it to the intensive care unit alive, it probably means they have reestablished their normal heart rhythm and blood pressure. The problem ends up being the brain. If you can’t save the brain, then you’re essentially left with a body with normal vital signs, but no functionality.”

Without oxygen, the brain at normal body temperature begins to deteriorate in a chain reaction—like a line of tumbling dominoes. Therapeutic hypothermia—or lowering of the body’s temperature—reduces the brain’s need for oxygen and other nutrients and slows down brain damage from swelling. The dominoes are still falling, but in slow motion.

Robert Constantine, MD, another St. Joseph’s critical care anesthesiologist, and Amy Pine, PA, were on duty in the MICU that night when Mason was transferred, and, in consultation with others in the unit, made the decision to start Mason on therapeutic hypothermia. Not everyone, Dr. Constantine says, qualifies. If the patient has survived a confirmed cardiac arrest, but has regained a regular heartbeat and has a sustainable blood pressure, they’ve met the first criteria for qualification. But, they also must have incurred some neurological injury as demonstrated by a failure to respond to oral commands, pain stimuli, or making purposeful movements like reaching to pull out a breathing tube.

That’s the situation Mason was in the night of March 11 when the MICU team began rapidly lowering his body temperature. The process began by feeding about two quarts of 39 degrees F sterile saltwater through intravenous tubes. At the same time, ice bags were nestled in Mason’s armpits and groin. Double layered plastic blankets with chilled water running through them were applied to Mason’s body. Within six or eight hours, the critical care team had lowered Mason’s body temperature to 91 degrees F—in medical terms, far below the normal temperature of 98.6 degrees F. Mason would remain at the lowered temperature for about 36 hours, enough time, it was hoped, to halt any additional brain injury.

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on the way to 91 degrees F, the team monitored Mason closely. He was given additional sedatives, and the team was prepared to administer paralytic drugs if he started shivering—the body’s natural method of generating its own heat to keep us warm. Shivering, however, slows down the cooling process and also creates a high demand for oxygen, just the opposite of what Dr. Constantine and his MICU crew were trying to accomplish.

In most cases, patients are kept at the lowered temperature for 24 hours. Mason, however, had started the cooling process around 8 p.m. on a Thursday. Both Dr. Constantine and Dr. Fetterman wanted the cooling process to end on Saturday morning, as Dr. Fetterman says, “all hands were on deck.”

“Rewarming the patient is the most medically challenging part,” Dr. Fetterman says, “because you are going to start seeing things that you didn’t see while they were cooled and sedated. Metabolic demand will go up. You’ll find out if they had any lung injury. A patient’s blood pressure drops during the warming process. Bleeding may be a problem, and there’s a chance of increased seizures as we lighten up the sedation.”

Mason’s return to his normal body temperature on Saturday was uneventful. But he was still under sedation and unresponsive, although Pam Mason noticed involuntary eye movements and head movements.

Now, months after Mason’s cardiac arrest, recalling times, dates and milestones in sequence is difficult for Pam Mason and Russ Abraham. Abraham recalls the afternoon, Sunday, he believes, when Mason smiled at him, pointed and made fun of the temporary hospital photo ID Abraham was wearing. Pam Mason says her husband began joking with his nurses not long after he “woke up.”

After Mason regained consciousness and his brain appeared to be virtually unaffected, St. Joseph physicians still had to determine the cause of his original cardiac arrest. On Wednesday, a week after he entered the hospital unconscious and near death, he was well enough to visit the hospital’s cardiac catheterization lab where interventional cardiologists performed an angiogram that showed a 90 percent blockage in an important coronary artery. That blockage, Dr. Constantine says, is probably what triggered Mason’s cardiac arrest. While Mason was still in the “cath lab,” cardiologists went ahead and performed a balloon angioplasty to open the blockage and inserted a stent to keep the artery from renarrowing.

Nine days after Mason was admitted, he was released from St. Joseph’s.

“I still couldn’t remember much, but I was talking and able to walk around,” Mason says. “I’m in cardiac rehab now, and will return to work soon.”

For someone who has run marathons, working out on a treadmill is less than exciting. Mason says he has occasionally allowed his heart rate to climb higher than allowed and was gently scolded for it. He slows down and counts his blessings.

“I’ve been told that my good outcome could partly be attributed to luck and timing,” Mason says. “The fact that I was running with a group instead of alone was important. The fact that I exercised regularly also helped. I’m also fortunate it happened where it did, so it didn’t take too long to get to St. Joseph’s.”

It also mattered, Dr. Fetterman says, that St. Joseph’s had recognized the potential of therapeutic hypothermia and made the effort to add it to the treatments available for those who suffer cardiac arrest like Bill Mason.

“The thing that makes this exciting as a therapy is that it’s one of those examples in life where it’s a very simple principle,” Dr. Fetterman continues, “and yet you see such a dramatic difference in outcome.

“Ninety to 95 percent of people with cardiac arrest don’t even make it to the hospital. We can’t say that therapeutic hypothermia is a panacea and not everyone is going to be cured, but it triples the likelihood of a meaningful neurological outcome from only 10 percent to approximately 30 percent. I can’t think of many other therapies that triple your chances of a meaningful recovery.”

Months after Bill Mason’s heart stopped while running in a Syracuse park last winter, he and his childhood friend Russ Abraham (right) lead the pack during a recent run.
St. Joseph’s Celebrates 50 Years of Providing Critical Care

Patricia O’Neil Donnelly, RN, had never seen the inside of an intensive care unit (ICU) on May 21, 1960, but a day later she was running one. It was the first for St. Joseph’s Hospital and also the first in Central New York, but it was more a concept than a physical reality.

Donnelly’s domain consisted of eight beds, four on each side of a hall, on a general surgical unit. The only difference was the higher nurse-to-patient ratio.

It was, Donnelly says on the 50th anniversary of the founding of St. Joseph’s first ICU, a simple idea: “this was a new concept—if we concentrated on a smaller number of what we deemed to be critically ill patients in a smaller work area, we thought they would benefit from closer nursing observation and care.”

“We believed these very sick patients would benefit from very close observation because we would be able to pick up early signs and symptoms of impending problems and that we, the doctors and nurses, could stabilize them before things got worse.”

Donnelly waited a day for the ICU’s first patient, a woman who had undergone abdominal surgery that, at the time, was considered to be major. Today, that same surgery, she said, is considered very routine. Unlike today’s intensive care units in which nurses and physicians are aided by technology that probably hadn’t been imagined five decades ago, that first ICU in 1960 relied on whatever technology all the other floors had.

“There were no cardiac monitors, no pacemakers, no respirators, no cardiopulmonary resuscitation,” Donnelly recalls. “When the ‘crash cart’ was developed to resuscitate patients in cardiac arrest, there was only one and it was in a big Craftsman® toolbox from Sears kept in the emergency department. If we had an emergency we had to call for it.”

The ICU was lent an electrocardiograph (EKG) device that also doubled as a crude pacemaker to maintain a patient’s steady heart rhythm. In nursing school at the time, students were taught about heart irregularities, but did not read the squiggly-lined EKG tracings. The tiny screen showed them three-seconds-worth of the heart’s rhythm on a screen smaller than a playing card. But, as Donnelly remembers, “We didn’t have a clue what we were looking at.”

“Besides the lack of technology, there was no education on critical care, either,” Donnelly recalls. “It was on-the-job training. We were dinosaurs compared to now, but we still gave good nursing care.”

Another nurse in that first ICU praised the education both she and Donnelly received from St. Joseph’s College of Nursing (School of Nursing at that time). Stella Sroka, RN, who was handpicked by Donnelly to help staff the ICU, said the nursing school prepared them as well as it could, given what was known about intensive care units at the time.

“We were the only nurses who were allowed to call doctors at home,” Sroka says, “because the doctors knew that an ICU nurse would not call unless there was something significant that needed attention.”

Physicians also were learning about the ICU concept back in the ‘60s and were developing a new kind of relationship with ICU nurses, according to Donnelly and Sroka. It was, Donnelly says, almost a codependent relationship as doctors learned about this new way of working at the same time the nurses were. There was, Sroka says, a great deal of respect built between nurses who spent their entire day in the ICU and doctors who also were spending more and more time there.

“We were the only nurses who were allowed to call doctors at home,” Sroka says, “because the doctors knew that an ICU nurse would not call unless there was something significant that needed attention.”

As St. Joseph’s administration was planning a new ICU set for opening in 1966, planners called on the expertise of both ICU doctors and nurses to help design the very first unit that was built specifically to be an ICU. The new ICU included 12 beds in an open unit, plus a kidney transplant room, a kidney dialysis room and a four-room burn unit. In 1974, the second ICU
was split into two units, a 12-bed surgical intensive care unit (SICU) and an eight-bed coronary care unit (CCU).

In 1976, a coronary surgery team from the Cleveland Clinic converted the four-bed burn unit into an open-heart unit housed within the 12-bed SICU.

Esther Santos, RN, who started working in the ICU in 1973 and continued until 2006, had a front row seat as ICU technologies advanced along a curve that has grown steeper and steeper.

“The environment in St. Joseph’s ICUs is never static,” Santos says. “There is no end to the learning.

“While we are taking care of patients in an increasingly high-tech environment, there is one thing at St. Joseph’s that has never changed. We know that the technology only complements the care our patients and their families receive. We aren’t taking care of machines, we take care of patients.”

Just as the ICUs have grown in size and scope, and the technologies to help care for the sickest patients have blossomed, Esther Santos, Patricia Donnelly and Stella Sroka have also witnessed a dramatic change in the way ICUs are operated with the advent of a new medical specialty, the intensivist.

Intensivists are doctors who, besides their primary specialties, have advanced training and certification in critical care medicine—the level of care offered in St. Joseph’s intensive care units and often aimed at patients whose problems involve multiple organ systems. They are often pulmonologists, anesthesiologists or surgeons who regularly spend all or much of their time at the hospital.

Marveling at 50 years of advancement in critical care, Esther Santos, RN, (left), Patricia O’Neil Donnelly, RN, (center) and Stella Sroka, RN, (right), tour a patient room in St. Joseph’s current intensive care unit.

Brian Chanatry, MD, is a good example. Dr. Chanatry came to St. Joseph’s as an anesthesia resident in 1985 and stayed on as part of the anesthesia staff. In 1992, he took a year off to earn his fellowship and certification in critical care and has filled a joint role since then.

“Traditionally in anesthesiology, once you have completed your surgical case, then you are finished with the patient and care is transferred to someone else,” Dr. Chanatry says. “I wanted the opportunity to get involved with critically ill patients because it’s an important role and we are well suited because of our training.

Many of the techniques for resuscitation and the ongoing monitoring and treatment of people who are unstable from a hemodynamic (blood pressure) or respiratory standpoint are the techniques we use in the operating room just as a matter of course. So handling airways, placing breathing tubes, ventilating the lungs...
with mechanical ventilators, using continuous-drip medications to manage blood pressure and cardiac rhythms translate to the ICU just as well."

Currently there are four intensivists responsible for the delivery of critical care to St. Joseph’s ICU patients, and the newest is Herbert Lehman, MD, a surgeon and surgical intensivist who joined St. Joseph’s staff last year to concentrate solely on delivery of critical care. Dr. Lehman says St. Joseph’s newest ICUs, built in 1988, have kept ahead of the times. They were so well designed originally that they function as if they were brand new. Both the surgical ICU with 21 beds, and the medical ICU with 15 beds are circular in design with the nurses’ station in the center. Built with glass doors for full visibility from the nurses’ station, the rooms’ windows supply outside light like the ICUs being designed today. New intensive care units are anticipated in about three years as part of St. Joseph’s expansion, along with a patient tower and new surgical suite.

The physical aspects of critical care—new machines and electronics—have been updated regularly. Dr. Lehman, his fellow physicians, physician assistants and critical care nurses who already staff the ICUs continually polish the methods and protocols by which the ICUs are operated. Critical care, he said, is evolving in new directions.

"The classic model of intensive care medicine involved the patient’s doctor calling in specialists to consult and make recommendations with the patient’s doctor who then prescribed treatment," Dr. Lehman says. "In more and more ICUs, the intensivist is becoming the hub through whom everything goes, so that the recommendations of specialists are centralized and coordinated."

The importance of this coordination, Dr. Lehman comments, is that specialists may be focused on taking care of a patient who has a single organ failing, while the reason many patients are admitted to the ICU is because more than one organ system is compromised. An example might be a patient at any hospital who underwent surgery and later experienced severe bleeding, breathing problems and an infection all at the same time. He or she would be at high risk and become a candidate for the ICU, where treatment might be totally coordinated by an intensivist.

"The common thread for all of us who do critical care is that we are trained to manage the entire patient with all of their issues," Dr. Lehman stresses. "We must focus on the patient as an individual, not on segments of the patient depending on what our specialty is."

Along with the intensivists, several specialists, nurse practitioners, physician assistants and nurses visit each patient several times a day. You’d think it might be chaotic, but, as Dr. Lehman says: "Debate is healthy."

"An ICU is a place where mistakes are costly," Dr. Lehman continues. "You want debate, discord. You want people to be encouraged to question, and it doesn’t matter what your title is. Everyone should be encouraged to say, ‘But what about this?… Did you take this into account?… Did you really mean to say that?’"

"We don’t want the ship hitting the rocks because someone is afraid to say turn left, not right, so we encourage this to be an open exchange of information."

People, Dr. Lehman says, are the most important element in good critical care, but he doesn’t underestimate the value of technology. Taking advantage of large volumes of data from thousands of patients allows physicians to look at trends to see what has happened and what may be happening with the individual patient in a St. Joseph’s ICU. A part of the "art" of critical care is using data to understand whether a patient is improving, or whether something is going wrong. If you pick up these clues and anticipate what might be going wrong before it happens, you’ve just saved a life."
WE THINK FLORENCE NIGHTINGALE WOULD APPROVE

Profiles in Nursing at a Magnet Hospital

To the tens of thousands of patients who are treated annually in St. Joseph’s Hospital Health Center as well as its various programs and satellite facilities, nurses are the institution’s most visible face.

There are nearly 2,000 of them serving at patients’ bedside or shoulder-to-shoulder with surgeons in operating rooms. They coach dialysis patients through lengthy treatments or calm disoriented wanderers pounding on an emergency psychiatric center’s door. Some help expectant mothers and anxious fathers deliver new life on snowy mornings. Others, equally dedicated, calm grieving families as a loved one quietly passes. Some do research, while others teach. They are a much more diverse and educated population than the women in white dresses and pointed caps portrayed in mid-20th century films. Their jobs are far more difficult and demanding, as well. Yet, they do it willingly.

Nurses are, regardless of their role or title, among the compassionate healers spoken of in St. Joseph’s mission. August marks the 100th anniversary of the death of the mother of modern nursing, Florence Nightingale, and it seems to offer an appropriate opportunity to look at the breadth of nursing through the eyes of a tiny sample of those practicing their profession at St. Joseph’s.

AnneMarie Czyz, RN, vice president for clinical services and chief nursing officer, has the clearest view of St. Joseph’s kaleidoscopic population of women and men who are proud to call themselves by the simple title of nurse. Czyz is fortunate, she says, in that all hospital staff members understand and appreciate the vital importance of nurses and nursing to St. Joseph’s patients, so she doesn’t have to spend her time explaining how critical nurses are to excellent patient care.

“Non-nursing colleagues at St. Joseph’s understand that supporting the nurses means supporting the patients, as well,” Czyz says. “If there is something they can do to meet a nurse’s need, then they know they are meeting a patient’s need. That is remarkable. The respect that St. Joseph’s people have for our nurses is palpable.”

That support may also be the reason that St. Joseph’s vacancy rate for nurses is so low when compared to others within the “industry.” Nationally, the vacancy rate “best practice” is 18 percent. At St. Joseph’s the rate is less than 6 percent. St. Joseph’s has one of the highest retention rates in the state and nation. Part of the reason that nurses want to come to St. Joseph’s and then stay is a successful orientation process that thoroughly acquaints them with their role and expectations at St. Joseph’s and connects them with an experienced nurse in their department willing to act as a mentor, showing them “the ropes” and answering questions as they develop.

Once they have found their footing, they also find that there is much more available to them as nurses than they might have known. There are entry-level programs for nurse assistants. There are licensed practical nurses and registered nurses. There are more than 20 nursing specialties—everything with the exception of acute trauma and inpatient pediatrics.

“We have nurses at all levels and leadership here,” Czyz says, “and that is a sign of the value of our nurses in direct care settings as well as educational and administrative levels. There are nurse coordinators, managers and directors, if they want to advance beyond the scope of care at the bedside.

“The nursing offered to patients at St. Joseph’s already has earned the most coveted recognition available in the United States—Magnet designation from the American Nurses Credentialing Center. Magnet designation confirms that St. Joseph’s has earned and sustained excellence in nursing care for its patients. There are only 17 hospitals in New York to have earned the Magnet designation, and St. Joseph’s is the only one in Central New York.

“Magnet designation is difficult to achieve and sustain,” Czyz says, “and we should remember that the Magnet criteria standards are raised higher each year. The fact that St. Joseph’s has been recognized again says a lot about the abilities and commitment of every St. Joseph’s nurse and the nurses’ role as compassionate healer. The profiles here are but a few among so many.”

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BOB FISHER, LPN

‘I Like the Intensity It Can Bring and the Skills It Requires.’

Variety and never quite knowing what he’ll find when he gets there are both challenges and joys for Bob Fisher, LPN, a home health care nurse for St. Joseph’s Certified Home Health Care Agency.

His patients have ranged in age from 16 to 104. They may be new mothers or those nearing the end of life. Some live in a tiny apartment, others in opulent surroundings. Fisher may do little more than check on a bandage, but he has been called on to stop serious bleeding or intervene when a patient with diabetes is weak and shaking because of low blood sugar.

“There are so many things I like about what I do,” Fisher says. “Part of it is being able to help people who need help. Part of it is the intensity it can bring and the skills it requires. I never stop learning.”

Fisher, who has been a St. Joseph’s home health care nurse for six years, also never stops teaching. He estimates that at least 75 percent of his work with home care patients involves teaching them what they need to know to improve their condition and keep them at home instead of back in a hospital. Following on the heels of St. Joseph’s hospital-based diabetes educators, he reminds patients with diabetes about what high or low blood sugar feels like and what they must do in terms of insulin usage or proper diet to keep their blood sugar at required levels. For patients recovering from surgery with wounds to dress, he teaches them not only how to avoid infection, but also how to recognize signs of infection like fever, redness, heat and swelling.

“Teaching is probably the most important thing we do. If our patients and their families know what to look for,” Fisher says, “they can inform us early. That way we can address the problem with the goal of keeping the patient out of the hospital.

“I have patients that I’ve known for four or five years.” Fisher continues. “You get to know them very well and build up a special rapport and trust. I’ve known one patient long enough that he asks me every year how my deer-hunting season went, or whether or not my golf game is improving.”

Even with those rare long-term patients, Fisher’s clear goal is to see his patients through to recovery without the need to be readmitted to St. Joseph’s or any of the other area hospitals that his agency serves. Something appears to be working because of all the home health care agencies in the United States, St. Joseph’s Home Health Care Agency has a lower hospital readmission rate than 95 percent of them. In addition, St. Joseph’s Home Care has been cited as one of the top 500 home care providers in the United States, according to the 2009 HomeCare Elite Top 500 List from Outcome Concepts Systems (OCS). St. Joseph’s Home Care was one of only 15 home care agencies in New York state—and the only one in Onondaga County—to receive this designation.

At any one time, St. Joseph’s Home Health Care may have a total of 700 patients in both Onondaga and Cortland counties. Home care nurses like Fisher are on call seven days a week around the clock. Fisher works some weekends and his schedule also includes a couple of 12-hour days a week. On a 12-hour day he...
may visit 10 or more patients, each time not knowing exactly what he's going to encounter. “We often don’t know what kind of situation we’re walking into,” Fisher stresses. “You need to function independently. We do work as a team, however, and if an extra set of hands is needed, other nurses or other specialists can become involved in moments.”

That autonomy, the ability to work alone and assess quickly not only a patient’s condition, but also his or her environment and regular support network, keeps Fisher’s work interesting. regardless of what he encounters on each visit, the patient’s immediate well-being is in his hands.

“The fact is, we’re a dedicated group of individuals who are passionate about our patients’ care,” Fisher says.

AMelia WILLiAMS, RN
‘Teamwork Makes the Dream Work.’

Kamia Williams, RN, credits her mother for nudging her into a nursing career, and her fellow nurses for the camaraderie that makes long days so pleasant. It is, however, the patients that keep her coming back day after day.

As a nurse in St. Joseph’s Hospital Health Center’s busy 24-hour cardiac catheterization lab, those patients are sometimes critically ill, frightened, and looking for someone to take their mind off what they’re going through. Williams’ job is to assist the hospital’s interventional cardiologists as they search for, locate, and then clear blockages in the arteries that supply blood and oxygen to their patients’ hearts. But doing that job doesn’t keep her from easing patients’ jitters by asking about their favorite restaurants, or the outcome of the latest basketball game.

Williams joined St. Joseph’s in 2003 after becoming a registered nurse at St. Joseph’s Hospital Health Center’s College of Nursing. She went straight from school to St. Joseph’s surgical intensive care unit (SICU), working with some of the hospital’s sickest patients.

“I really liked it,” Williams says. “It was, as the name implies, very intense work. The longer I stayed, the more responsibility I earned. But working in the SICU I was working with everything after the fact—at the end of everything. I was interested in seeing where it all started, so I applied for an opening in the cath lab and got it four years ago.”

Her nursing career may have started many years before her latest move. Williams says her mother was the one who kept repeating that she’d make a good nurse, remembering the times her daughter would come home from school using “big” words like “vertebrae” instead of just plain old “back.” She studied information technology—computers—and did well, but admitted to herself that she couldn’t imagine spending her days sitting in front of a computer screen.

“I went with the calling I had—it definitely is a calling—and completed two years at St. Joseph’s College of Nursing. I knew all along that I was in the right place. This was exactly where I should be.”

With four years of experience, Williams is comfortable with any role in the cath lab, from circulating nurse, to scrub nurse, to monitor tech. In her first role as a circulating nurse, she made sure that any equipment or medication the next patient would need was at hand for the scrub nurse or cardiologist. If the doctor called for a JR-4 catheter with a right coronary artery configuration, she made sure it would be within reach.

Her next role was as a scrub nurse, the assistant who helps the cardiologist ready the catheters for insertion and removal.

“Being the scrub nurse standing by the doctor’s side is something you never learned in nursing school,” Williams says. “You learn each doctor’s preferences (we have one doctor who likes to wear a camouflage-colored lead vest during fluoroscopies) and how they like to do things, so you can make sure the room and the procedures flow smoothly.

“The best parts of the cath lab are the people I work with. We’re a small group. The work we do is very specialized and we work well together. Our motto is ‘Teamwork makes the dream work,’ and the dream is to make sure our patients are safe, make sure we all get along, and make sure the cath lab runs smoothly.”

The cath lab is not always as calm as it seems. Williams says, especially when the staff is dealing with patients whose blockages are so severe that they need to be taken for open-heart surgery.

“That,” says Williams, “really gets your adrenaline pumping. There’s so much to do in such a short time to get that person to surgery. We stay with our patients. continued on page 16
We don’t leave until the surgery staff literally has them on the operating table. Everyone covers each other’s back, and if you need extra help in an emergency, they are there in a heartbeat.”

For the most part, patients in the cath lab can be helped right there without the need for open-heart surgery. But that doesn’t mean it’s easy for them. Williams says patients often tell her the environment is intimidating.

“We really do our best to make sure our patients stay calm and relaxed,” Williams continues. “Some are worried because it’s their heart. The fact is, we can relay very good news to them, or very bad news. A lot of the time, we try to include them in our conversation and let them know what we’re doing and what they can expect. I’ve learned that just talking to them and explaining what’s going to happen helps to ease their tension.”

Perhaps Williams is so good at what she does because she has a little family history at St. Joseph’s. Her sister has a nursing degree from St. Joseph’s College of Nursing, and, she says, quietly, her own father had been through the cath lab. He had ignored his chest pain for two weeks until it became so strong he couldn’t walk and finally came to the hospital. He ended up going through the cath lab and on to open-heart surgery. That’s one reason why her work extends outside the hospital’s walls as she tells anyone who will listen about the need to pay attention to chest pain.

“We really want the general public to know that chest pain is no joke,” Williams stresses. “Time really is muscle, so if a person is having chest pain or anyone they are with is having chest pain, don’t even think about it—call 911.”

When they do, they can feel confident that someone like Kamia Williams will be there to help them.
Diabetes: What You Don’t Know Can Hurt You

Do you know that nearly 24 million people in the United States have diabetes, and that an additional 57 million (one in five people) have pre-diabetes that puts them at high risk for developing the disease?

Diabetes is diagnosed when a fasting blood sugar (glucose) level is 126 or greater. Pre-diabetes is diagnosed when a fasting blood glucose level is between 100 and 125. Diabetes is called the “silent killer” because nearly one fourth of those with the disease do not know they have it.

Diabetes may lead to heart and kidney disease, stroke, loss of vision and amputation. Risk factors include being overweight, underactive or more than 45 years of age. African-Americans, Hispanics/Latinos, Native Americans, Asian Americans and Pacific Islanders are also at increased risk.

The development of Type 2 diabetes may be prevented or delayed with weight loss, proper nutrition and regular physical activity, according to the American Diabetes Association.

However, for those diagnosed with Type 2 diabetes, current studies show that complications may be significantly decreased or delayed with good management of the disease.

Take Charge of Your Diabetes, a St. Joseph’s outpatient diabetes education program, aims to teach those with diabetes how to manage their disease effectively. A team of registered nurses and registered dietitians—who are also certified diabetes educators—teaches what good diabetes control is and how to attain it. The program lasts approximately five weeks. The first two sessions are private and take about one hour each. At one session, a registered nurse evaluates patients’ needs and takes about one hour each. At one session, a registered nurse evaluates patients’ needs and teaches such necessary skills as how and when to test blood sugar. Participants learn what the results mean and how to begin to control them. In another session, a registered dietitian assesses diet and identifies changes that will help control diabetes and increase overall health.

The next part of the program consists of three group classes that provide education, practice, discussion and support.

Eight weeks after the last meeting, participants return for a follow-up visit. Progress toward a diabetes goal is discussed, and diabetes management is fine-tuned. Lab work at the start and end of the program provides objective feedback.

Group and private sessions are held at St. Joseph’s Healthcare Network Building on the North Medical Center complex in Liverpool.

St. Joseph’s program is recognized by the American Diabetes Association as a quality self-management education program. A referral from a physician, nurse practitioner or physician assistant is required. The program is covered by most insurance plans, including Medicare and Medicaid in New York state.

For more information about St. Joseph’s Take Charge of Your Diabetes Program, call 315-458-7171.

“Some new patients are too ill, too tired or too stressed to learn everything and need to be followed up on by our home care nurses. They are the safety nets in these transitions.”

Those with Type 2 diabetes may not need insulin to start with but take daily medication. Others may take a combination of both, or insulin by itself. With a specialization in diabetes, Fitzgerald must be prepared to teach everything as well as keep herself abreast of new, more effective insulins, new delivery systems and new meters that make it easier to check blood sugar level.

When Fitzgerald took the job of patient educator, diabetes was only part of her responsibility. Over time she grew more interested in the challenges that her patients with diabetes presented. To become a certified diabetes educator, it took 2,000 hours of clinical practice hours working with patients with diabetes, plus home study and an examination. Recertification every five years demands additional coursework. Fitzgerald’s work also includes maintaining a website, serving on patient committees, and teaching other nurses about diabetes care. But at least 70 percent of her time is devoted to patients with much to learn.

“If I have to review a book, or something, I can always do that at night, or tomorrow, or the day after,” she says. “But if someone has to learn to take insulin—that’s right now.”

It has, Fitzgerald says, been worth the effort.

“I learn a lot from patients about life,” Fitzgerald admits. “Patients teach me about their willingness to keep trying when they’re not feeling well. I learn about courage as I watch them keep working against a chronic disease. They get tired of sticking their fingers four times a day to watch for low or high blood sugar. They get tired of eating a certain way. But I see their resolve as they say, ’I’ll try.’”

KIM MURRAY, RN, MS, CNOR

‘I’m Surrounded by the Best People.’

Given the ways she fills her 12-hour work days, it wouldn’t be at all surprising to find out that Kim Murray, RN, MS, CNOR, also is a master juggler, amateur gourmet cook, avid hiker and mother. Actually, all but one of those are true. And while she’s not a juggler in the traditional sense, she very well could be if you include the mental and sometimes physical juggling of operating rooms and schedules—hers and others—to keep surgeons, anesthesiologists, nurses, patients and their families safe, well looked after and happy.

Kim Murray is St. Joseph’s Hospital Health Center’s director of surgical services. She also is the hospital’s co-director of its orthopedics service line. And even with all this on her plate, you’re just as likely to find her attending to the individual needs of her staff or taking...
the time to reassure a family in the surgical waiting room that the operation is taking longer than expected, but everything is OK. Not to worry.

All those degrees after her name, RN, MS, CNOR, tell the story of her nursing career at St. Joseph’s over the last 25 years. Her tenure at St. Joseph’s began as a registered nurse on one of the surgical units. She later earned a master’s degree as a clinical nurse specialist. The CNOR stands for certified nurse—operating room. Each degree demonstrates Murray’s drive to learn everything she can about the ins and outs of how St. Joseph’s provides surgical care to more than 16,000 patients a year. In her role now, she has complete administrative oversight of the clinical, financial, quality and operating performance of the hospital’s 12 operating rooms, recovery rooms, two off-site surgery centers, cardiac perfusion (heart/lung machines), and pre-admission testing.

“It sounds like a lot,” Murray says, “but the secret is that I’ve got a great team. I’m surrounded by the best people.”

A majority of the time you’ll find Murray dressed in light green scrubs, a surgical head cover, booties and a surgical mask like everyone else in the operating rooms. She’s there to make sure all is going smoothly for surgeons, anesthesiologists, surgical nurses and patients.

“My primary role is to do whatever needs to be done to support the surgical staff,” Murray says. “We make it happen.”

That role—doing whatever needs to be done—covers a lot of territory, including keeping track of the “census” of the hospital. If all the operating rooms are full, what needs to be juggled so that no procedures are cancelled? The operating rooms may be able to handle the workload, but are there enough post-operative rooms once the surgery is finished? Can the patient be kept in the PACU (post anesthesia care unit) a little longer until another bed is free? What adjustments have to be made to keep an operating room open and staffed, so a patient’s surgery doesn’t have to be postponed? And if that wasn’t enough, Murray also is co-director of the orthopedic service line at St. Joseph’s and has helped lead the efforts that have made the hospital’s reputation for orthopedic surgery among the best in New York and the nation.

“There never seems to be enough time to get everything done,” Murray says. “There’s constant re-prioritization and the need to be flexible, not rigid. But we have to keep in mind that this is a patient-centered organization and the human side of things always wins out over the administrative side of things.”

Responding to these situations often requires as much diplomacy as it does logistical skill and planning.

Surgery at St. Joseph’s is not a 9 to 5 job. Surgeries begin as early as 7 a.m. and continue into the evening in all 12 operating rooms. In addition, three rooms are open until 11:30 at night, and they have become busier, presenting Murray with a ticklish problem that requires some of those juggling skills.

“As the evening shift became busier, it became more challenging to get the operating room staff fed before the cafeteria closed,” Murray recalls. “I worked with nutritional services to develop a process that would let us deliver meals to the operating room staff—when they are unable to break away from the OR—without extending hours for nutritional services staff.

“It’s a simple fact,” Murray says. “If you take care of the staff and the physicians, then they will be able to take care of their patients. That’s what makes this job so worthwhile—being able to see that we are making a positive difference for patients, the hospital staff and physicians.”

Because of her ability to fill so many of nursing’s various roles, so well, Murray was honored as the first recipient of the hospital’s Nursing Leadership Award this past May. Typically, she credited others.

“Peer recognition takes on a very special importance because it suggests an appreciation of the many challenges, as well as successes, that we mutually face on a daily basis,” Murray says. “I am blessed to be able to work with these wonderful people who recognize the critical importance of their roles in providing exceptional patient care.”

Continued from page 17
Orthopedic Research Gains a Foothold at St. Joseph’s

There are several operating rooms at St. Joseph’s Hospital Health Center that have a benefit that relatively few in the country have—ultraviolet (UV) lighting that appears to help prevent infection after joint replacement surgery.

There is anecdotal reporting that says UV lighting does help prevent infection, but two orthopedic surgeons at St. Joseph’s, Brett Greenky, MD, and Seth Greenky, MD, are spending $250,000 of their practice’s own money to prove it. And, regardless of what answers their multi-year research yields, they’ll let their fellow orthopedic surgeons across the country know—one way or the other.

“Our focus is on clinically based research that helps us improve what is already a highly successful joint replacement program.”

—BRETT GREENKY, MD

The study represents a modest example of ways in which research by physicians and others at St. Joseph’s could help advance knowledge of what works—and what doesn’t—in medical practice. The potential cost savings that valid, reliable studies like these might produce are significant.

As Brett Greenky, MD, puts it, the UV lighting study is a very modest effort to prove that a technology, if applied on a larger scale, could spare some recipients of hip or knee replacements from devastating infections while also saving millions of dollars in unnecessary health care costs.

As Dr. Greenky points out, hip replacement surgery has become the most reliable operation in the world with knee replacement right behind it. Statistics generated by clinical outcome studies show a 99 percent or higher success rate, and there is a 95 percent likelihood the joints will last trouble free for 10 years. The 20-year “survival” rate for the artificial joint is 90 percent or better. But watch out if infection attacks the surgical site. Dr. Greenky says the results are devastating. The patient would be very sick. There would be a need for repeat operations, lost time from work, prolonged antibiotic use, and the second replacement might not work as well. The financial cost also would be high—an estimated five times the cost of the original surgery.

“We certainly don’t perceive that we are going to surpass the Mayo Clinic or the Cleveland Clinic with our research,” Dr. Greenky says. “This research is focused on evidence-based medicine and improving the experience of our patients. Our focus is on clinically based research that helps us improve what is already a highly successful joint replacement program. And, we can share these important results with other surgical centers like St. Joseph’s.”

The potential, Dr. Greenky says, is to reduce the relatively high infection rate found in other hospitals around the country. Hip and knee replacement surgeries enjoy their nearly “slam-dunk” reputations because of efforts over the last 20 years to reduce the infection rate. Patients are now started on antibiotics before surgery. Operating rooms used for joint replacement have a higher degree of sterility supervision than other operating rooms. The environmental controls—the way the filtered air in the room is distributed—continued on page 20
also help lower infection rates. Some hospitals like St. Joseph’s encase doctors and nurses in lightweight body suits and helmets to further reduce the spread of bacteria carried on skin and hair cells that are constantly shed by all of us—surgeons and nurses included. The latest advance has been the addition of ultraviolet ambient lighting that kills even more bacteria hitchhiking on dust particles and other surfaces.

“The literature about the germ-killing ability of UV has been around for years,” Dr. Greenky says. “There is evidence that it works, but the data we are gathering will add to the body of evidence, one way or the other.”

The national average for infection in hip and knee replacements is already low, at about 2 percent, Dr. Greenky says. Although, he adds, institutions doing a really good job of infection control should have a rate, like St. Joseph’s, of considerably less than 1 percent. With infection rates already so low, it will take a large (more than 6,000) sample of patients to gain meaningful statistical data about whether or not UV light really works to reduce surgical site infection.

St. Joseph’s and Syracuse Orthopedic Specialists (SOS), Dr. Greenky’s practice group, perform between 1,200 and 1,300 joint replacement procedures each year. The data already exist on 3,068 replacement patients who were operated on in rooms without UV lighting. Data on those whose joints were replaced under UV light (installed on March 30, 2009) is being gathered now, but there will be a lag because a patient cannot be considered “infection free” unless there has been no infection within a year after the surgery. In procedures in which an artificial joint is not implanted, patients are considered “infection free” after only 30 days.

Much of the research project is being funded by SOS, and the costs are primarily to pay the salaries for two full-time and a single half-time employee over the life of the research.

“For years we have refined our process based on the findings of other people’s research,” Kim Murray, RN, MS, CNOR, St. Joseph’s director of surgical services, says. “That’s why this program is so great. This is really the first initiative to do our own primary research, and it’s really a huge commitment mainly due to the labor intensive information gathering, medical record review and data transmission.”

Anything that is considered human research must be approved by St. Joseph’s own investigational review board that is under the watchful eye of the Food and Drug Administration. It’s heavily regulated.

“The ultraviolet light industry is not paying for this research,” Dr. Greenky says with a smile. “The $250,000 is part of our contribution to the community, aimed at doing what we do best for our patients and then making it even better.”

The UV light study is well underway, and there are other research projects under consideration, Dr. Greenky says. Funding of up to $400,000 is being sought now to determine the effectiveness of a combination of common painkillers used in joint replacements that are delivered by an alternate route directly to the surgical site where they are most needed. The use of this device (described by Dr. Greenky as being like a “soaker hose” used in local gardens) is believed to decrease the need for narcotic drugs during recovery, decrease the patient’s perception of pain, and possibly decrease the length of a patient’s hospital stay. The study focuses on optimizing the combination or type of medication delivered directly to the surgical site. The research would be what’s known in medical research circles as a prospective, randomized, double-blinded, placebo-controlled study. That essentially means that no one knows which patients are being treated with which combination of drugs until research coordinators begin the data analysis phase.

“The thing that makes St. Joseph’s orthopedic program so ripe for formalized research is that we have a large number of patients having procedures performed by a small number of providers who are using almost identical procedures,” Dr. Greenky says. “That’s unusual, and it is very much the right base for research studies.”

continued from page 19
Dear Friend of St. Joseph’s,

“True happiness comes from the joy of deeds well done, the zest of creating things new.”

Antoine de Saint-Exupery’s wisdom in this quote rings true, and it strikes me as relevant to what is happening at St. Joseph’s as construction moves forward on Phase II of our facility master plan.

“The zest of creating things new” is indeed creating happiness as we see the future take shape before our eyes. Our facility expansion and the revitalization of Syracuse’s North Side are certainly worthy deeds. These initiatives will improve the quality of life for those we serve, and for those with whom we live and work, as we carry out St. Joseph’s mission.

These deeds we’re undertaking are truly substantial, even historic, which adds to the excitement. In three short years we will look back on the greatest expansion in St. Joseph’s long history, a total investment of more than $220 million, and the largest green health care construction project in Upstate New York. To enable St. Joseph’s mission so that it thrives well into the 21st century is an ambitious aim, as well as an energizing one, as we consider how Phase II will improve the health care we provide and the infrastructure not only of the hospital but of the surrounding neighborhood as well.

You can track the progress of Phase II, and of our capital campaign underway to support the project, Generations of Compassion ● Healing ● Innovation, by visiting a special website: www.generationscampaign.org. We look forward to giving you continual updates on this massive undertaking.

So many people in our community and around the world have been incredibly supportive of Phase II, including the Sisters of St. Francis, our physicians, our employees, retirees, College of Nursing alumni as well as local companies and our business partners. All play a vital role in this major step forward. As our Foundation proceeds with the Generations Campaign, please know that your support is an inspiring and energizing force, a force for good in health care, in our community and in the lives of patients we will serve today and in years to come.

The good work of St. Joseph’s would not be possible without your important commitment to deeds well done, and to creating things new. With our gratitude, we wish you the true happiness that will certainly result.

Sincerely,

Margaret Martin

Vice President

Margaret Martin

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Two Syracuse organizations are in very different service lines, but nonetheless share a similar commitment to service excellence: St. Joseph’s and Sysco. Sysco is the global leader in selling, marketing and distributing food products to restaurants, health care and educational facilities, lodging establishments, and other customers who prepare meals away from home. Its Central New York-based operation is a key supplier to St. Joseph’s, providing the food that plays such an important role in the daily operations of the hospital and in the nutritional health of patients, visitors and staff.

Recently, Sysco provided to St. Joseph’s in another way as well: through support of the Generations Capital Campaign by funding the food service line in the North Patient Tower to be constructed as part of the Phase II facility master plan. In addition, Sysco Syracuse President and CEO Joseph H. (Joe) Wood, made a personal gift to help establish a family waiting area in the new tower.

“T’ve lived and worked in the Syracuse community for 26 years, and in that time T’ve visited a lot of people, including a lot of our employees, at St. Joseph’s,” Wood remarked. “Beyond the strong business connection we have with the hospital, I’m so appreciative of the tremendous compassion St. Joseph’s always demonstrates, the quality of care they provide, and the wonderful work of the Sisters of St. Francis.

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Wood’s remarks come at a poignant time, as after 26 years at Sysco Syracuse he left at the end of June to become president of the company’s Cleveland, Ohio, operations. He was succeeded by Michael Scanlon, previously Sysco Syracuse’s senior vice president.

“Having spent my entire career here and being an Upstate New York native, I truly appreciate what a great business climate this has been for Sysco Syracuse and our employees,” Wood said. “This is a great place to raise a family, the health care and the schools are outstanding, and that’s meant a great deal to our company and to me personally. As Mike takes the helm here, Sysco’s support of the community will certainly continue.”

With approximately 500 local employees and more than $400 million in revenues, Sysco Syracuse has a substantial community presence—a presence that extends beyond its business relationships to volunteer and philanthropic commitments as well. In 2007, the company received the hospital’s St. Joseph the Worker Award in recognition of its support of health care and St. Joseph’s mission.

In May of this year, Sysco was honored by the United Way of Central New York with one of its prestigious Spirit of Caring Awards, given annually to organizations that have initiated outstanding charitable efforts. Sysco was given the Spirit of Caring Gifts-in-Kind Award for its support of the Samaritan Center, a not-for-profit agency that provides meals free of charge to people in need. In addition to donating generously to a number of soup kitchens and food pantries, Sysco and its employees “adopted” the Samaritan Center, preparing and serving food the company donated to hundreds of adults and children that utilize the center’s services each day.

Sysco’s professional expertise and service ethic is also in evidence at St. Joseph’s. According to Jamie Nicolosi, the hospital’s director of nutritional services, Sysco is a significant and effective partner. “They are our primary vendor in nutritional services, Sysco is a significant and effective partner. “They are our primary vendor in nutritional services, and provide the bulk of our food supplies,” Nicolosi said. “I’ve toured their facilities and am very impressed with their quality standards, and the commitment they make to providing the finest products and services to our patients and employees.”

Occasionally the relationship can involve rather unusual services. Nicolosi recounted how Sysco assisted St. Joseph’s when the hospital conducted a

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Sysco Partners with St. Joseph’s

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Vascular Surgeons of CNY Names Hybrid Operating Room

Syed Zaman, MD, is quite understated when describing Vascular Surgeons of CNY’s naming gift of $230,000 for a hybrid operating room in support of the Generations Capital Campaign. One senses he doesn’t think it’s particularly remarkable.

“It is not unwarranted that we would do something like this,” Dr. Zaman said. “We have one of the country’s largest vascular surgery groups here, and St. Joseph’s has been totally supportive of our efforts to build it. As a group, we consider this gift an appropriate gesture of appreciation.”

Dr. Zaman certainly has an appreciation of the group’s beginnings at St. Joseph’s. He joined the hospital in 1976, and is chairman of the Department of Surgery and coordinator of surgical education. In 2009, he was honored with St. Joseph’s inaugural Dr. Pease Award, named in memory of Roger W. Pease, MD, who became the hospital’s first surgeon in 1869. The award recognizes physicians, who are nominated by their peers, for leadership, clinical expertise and social responsibility.

Dr. Zaman credits his partners—Lawrence Semel, MD, Robert Carlin, MD, Mark McGurrin, MD, and James Riley, MD—for a shared dedication to patients that has led to the practice’s success. “We had a disastrous surgery case just last night,” he said. “We had four of our surgeons scrubbed until 9 p.m. and none of them were on call.

“This group will do anything at any time. You don’t get compensated monetarily for these things—you do well for the patient and everyone will do well.”

Vascular Surgeons of CNY has five physicians and is now looking for more. The group handles all aspects of vascular care, including diagnostic, radiological, catheter interventions and surgery, and the group works closely with St. Joseph’s highly regarded staff of cardiac surgeons.

Dr. Zaman’s recognition of this gift is remarkable.

“Life has been very meaningful for me because of my interactions here.”

Similarly, St. Joseph’s and the lives of the people it serves have been enriched thanks to the commitment of Vascular Surgeons of CNY, a gift that truly is, after all, remarkable.

Syed Zaman, MD, and Mark McGurrin, MD.
To walk into a meeting with brothers and orthopedic surgeons Seth and Brett Greenky is to see two driven men in action. Before 7 a.m. on a recent Friday, they had already completed an hour-long orthopedic center design planning meeting, and scrutinized images on a computer screen of a total shoulder replacement surgery performed by Seth the evening before. And they’re just getting warmed up.

Partners in Syracuse Orthopedic Specialists (SOS), Seth and Brett have a vision for their practice that is straightforward and ambitious, and completely aligned with St. Joseph’s mission. “We believe to our very core that we can elevate the quality of orthopedics here to be a national model,” Seth said. “And in St. Joseph’s we have found a progressive hospital that’s committed to the highest quality, and is an outstanding and appreciated partner.”

SOS has expressed that appreciation by “putting our money where our mouth is,” said Seth as he described the group’s gift of $350,000 to St. Joseph’s Generations Capital Campaign which will name a new operating room as the facility master plan proceeds. The Greenkys committed $200,000, and the SOS organization, including St. Joseph’s affiliates Glenn Axelrod, MD, John Parker, MD, Daniel Murphy, MD, and Stephen Robinson, MD, contributed an additional $150,000—not only out of gratitude for their successful relationship with the hospital, but as an investment in the future.

“Thanks to a great deal of effort by St. Joseph’s and our group, quality and efficiency of services have dramatically improved, and will continue to”

BRET GREENKY, MD

That pace is due to a number of factors, and SOS has been instrumental in enabling the higher quality, improved clinical outcomes, and better efficiency that have enhanced the program’s growth. Since its founding in the late 1990s, the group has assembled a team of fellowship-trained orthopedists in a variety of sub-specialties to provide the gamut of orthopedic services. Together with the hospital’s resources and commitment to quality care, the practice has flourished, now handling 45 percent of the joint replacements in Onondaga County, a figure that continues to rise.

SOS now has 23 physicians, almost 20 physician assistants and nurse practitioners, eight offices and a surgery center.

“Thanks to a great deal of effort by St. Joseph’s and our group, quality and efficiency of services have dramatically improved, and will continue to,” Brett said. “Better technologies and implants, better surgery, better practices in preoperative techniques, anesthesia, nursing care, and physical therapy have all contributed.” The proof is in the data: just over a decade ago, the average length of stay for a St. Joseph’s orthopedic surgery patient was five to seven days, now it’s less than 2.5 days.

In addition, better implants have enabled orthopedists to confidently recommend joint replacement to younger patients in need of it, as modern technology and materials have led to artificial joints that can last much longer and work more effectively and comfortably. “There are actually two very different populations that need joint replacement,” Brett remarked. “There are very active people, some who stay active into their older years, who have stressed a joint through overuse or injury, and there are sedentary people who suffer joint damage due to lack of exercise, weight gain and the problems that can result from that.”

While the Greenky brothers’ specialty in joint replacement has certainly led to rapid growth and Central New York market leadership for the practice...
Syracuse orthopedic Specialists Commit $350,000 to new operating room

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Summer 2010

St. Joseph's Hospital Health Center

Caring Connection 25

and St. Joseph’s, their colleagues’ specialties have contributed greatly as well. Among these musculoskeletal specialties are hand and elbow surgery, shoulder surgery, spinal care and surgery, sports medicine, and foot and ankle care and surgery, which is provided by the only fellowship-trained foot and ankle surgeon in private practice in Central New York.

The practice serves three hospitals, primarily St. Joseph’s, which honored SOS with its St. Joseph the Worker Award in March of this year for the Greenkys’ and the entire practice’s multifaceted commitment to the orthopedic surgery program at the hospital and for their generous support of the entire institution. The doctors generously share their expertise with orthopedic residents and others through lecturing engagements as well as by mentoring other orthopedic surgeons. Passionate about improving clinical outcomes, the Greenkys have recently become involved in clinical research initiatives to advance patient treatment in musculoskeletal care.

Yet their work is far from complete. Both standout collegiate wrestlers in their undergraduate days at Northwestern University, the brothers maintain the drive and singleness of purpose characteristic of that sport’s devotees. “For us, the ultimate thing is to do a great job,” Brett said. “We’re a dynamic group in a dynamic hospital that wants to set new standards for the future, and we’re really pleased to contribute to the growth at St. Joseph’s.”

A heartfelt gift from Joe and Lynne Romano, whose family has over the last 35 years built a network of successful automobile dealerships in Central New York, will turn on some very important lights at St. Joseph’s Hospital.

The Romanos have pledged $30,000 to the Generations Capital Campaign to be used toward operating room lights in the hybrid room named by Vascular Surgeons of CNY. The donation is in appreciation for help their family received from Syed Zaman, MD.

Several years ago, one of the Romanos’ daughters, who was 28 years old at the time, became ill with a virus and the family had difficulty finding a doctor in Central New York to treat her. They had visited doctors at Sloan-Kettering in New York City to diagnose her condition and advise them on treatment, but needed a local doctor to oversee her care.

Looking for guidance, Joe Romano decided to call Dr. Zaman for help. The two men knew each other because, over the years, the auto dealer had sold the physician several cars.

“This very busy man called me back in 20 minutes and personally referred me to a local neurologist, Dr. Tarakad Ramachandran, who knew of our daughter’s disease and was able to treat her with intravenous antibody injections,” Romano said. “Today, she is healthy and strong.”

Dr. Zaman, Romano noted, is humble about his important role in their daughter’s treatment and recovery. “He made a crucial difference through his caring and responsiveness,” Romano said. “Lynne and I are so pleased to make this contribution that will enhance the operating room he and his partners at Vascular Surgeons are donating.”

As business owners, the Romanos understand the importance of good service. Joe and his brother Mike have a successful group of dealerships and are also active in charitable causes. Their Romano Auto Network organization, which started when Joe opened a Chrysler Plymouth dealership in 1974, has grown to include Toyota, Subaru, Mercedes, Volkswagen, Jeep and Honda dealerships. In keeping with the family tradition, Joe’s son David Romano, his son-in-law Seth Cohen, and Mike’s son Jonathan Romano are also involved in the businesses.

While Joe and Lynne Romano are active members of the Central New York community, it was their deeply personal experience as parents that motivated this gift to St. Joseph’s. So it is quite appropriate that, after a caring physician helped give a ray of hope to their family, the Romanos are extending a gift of light to the hospital.
19th Annual Gala a Roaring Success

F lappers, feather boas, Franklin cars and about 800 “guys and dolls” were seen at The Roaring Twenties, St. Joseph’s 19th annual gala. The event, which netted $304,973, was held June 4 at the Turning Stone Resort & Casino. Proceeds will be used to support St. Joseph’s nationally recognized programs and services.

Two classic Franklin autos, manufactured in Syracuse, were on display from the Northeast Classic Car Museum in Norwich, NY, courtesy of Hancock & Estabrook, LLP. In addition, the Onondaga Historical Association showcased a variety of 1920s artifacts, including vintage clothing, Syracuse China pieces and other popular consumer products from the era.

College Corner

114 Students Graduate

S t. Joseph’s College of Nursing at St. Joseph’s Hospital Health Center held its 110th annual graduation ceremony on May 20 at the John H. Mulroy Civic Center in Syracuse.

The associate degree in applied science with a major in nursing was conferred on 114 students. Seventy-two completed the school’s Weekday Program and 42 completed the Weekend Program. Students participating in St. Joseph’s Dual Degree Partnership with Le Moyne College received their associate’s degree in nursing from St. Joseph’s and will continue their studies at Le Moyne, receiving their bachelor’s degrees in another year.

St. Joseph’s College of Nursing is accredited by the National League for Nursing Accrediting Commission (NLNAC). The college is one of just a handful of nursing colleges in the nation affiliated with a hospital awarded the prestigious Magnet Recognition for Excellence in Nursing by the American Nurses Credentialing Center. For more information, visit the website at www.sjhsyr.org/nursing.

Weekday Program graduate Colleen Field (left) was presented the Esther G. McCarty Memorial Scholarship for Academic Achievement to further her education upon graduation.
Recent Grant Awards
We thank the following foundations and agencies for their support of St. Joseph’s mission and services:

Through the Health Workforce Retraining Initiative, a grant of $60,177 over two years has been awarded by the New York State Department of Health to St. Joseph’s College of Nursing. Funds will allow the college to expand its capacity through use of clinical simulation, which is essentially a very sophisticated human mannequin that can be programmed to mimic illnesses and responses.

Bristol-Myers Squibb Company, Syracuse Operations, has awarded a grant of $5,000 to print a resource directory of mental health services for children and adolescents in Onondaga County. The directory will be used by pediatricians, family physicians and other primary care providers.

In addition, St. Joseph’s LINK program will receive $1,000 from Bristol-Myers Squibb Company, Syracuse Operations, for community picnics to promote family interaction during the summer.

LINK (Leading, Integrating and Networking for Kids) serves school-age children and their families.

St. Joseph’s Maternal Child Health Center promotes childhood literacy through the national Reach Out and Read program. At checkups, pediatricians give each child a new book of their own to take home. Donations from the Ella Fitzgerald Foundation, First Books and Reach Out and Read have kept the center supplied with books.

Don’t Miss Out in 2011
Don’t miss out on all the fun—plus the opportunity to benefit St. Joseph’s Hospital Health Center’s award-winning programs and services. Please make sure you reserve the following dates in 2011:

- St. Joseph’s Foundation’s Gala
  Friday, June 3, 2011
- 19th Annual St. Joseph’s Golf Classic
  Friday, Sept. 9, 2011

It’s Not Too Late To Be Part of the Golf Classic on Sept. 10
St. Joseph’s 18th annual Golf Classic offers a number of ways to support St. Joseph’s Hospital Health Center and benefit patient care. To be held Friday, Sept. 10, at the Turning Stone Resort & Casino, the Golf Classic invites golf participants as well as sponsorship and advertising supporters.

For more information, contact St. Joseph’s Foundation at 315-703-2137.
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If you know someone who would like to receive Caring Connection or be removed from our mailing list, contact the editor c/o St. Joseph's Marketing/Communications Office, 973 James St., Suite 245, Syracuse, NY 13203, or call 315-703-2140.

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All telephone numbers are in area code 315.

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- Digital Mammography – Utilizing the only Dimensions 2-D technology in all of Central New York, along with MammoPad®, we obtain the highest quality images while maximizing patient comfort.

- Uterine Fibroid Embolization – An alternative to hysterectomy, this minimally invasive procedure is used to treat fibroids. We are one of the top 5 programs in the Northeast for UFE.

- Bone Densitometry – As the only facility in the region with the newest, leading-edge DEXA technology, we can detect and treat osteoporosis in its earliest stages.

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