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The Spirit of St. Luke's, Spring 1996

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The Spirit of St. Luke's

The Emergency Department

—where saving lives is a daily event

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Dr. Lloyd Olsen describes the pain he felt in his lower back when he woke up on a crisp Saturday morning last November as "excruciating." He had been feeling some back pain for several weeks. He was X-rayed and treated with conservative chiropractic care. He had also consulted an orthopedic surgeon who had not found anything wrong with his back, so he had not been too concerned until this particular Saturday morning when the pain was so much worse.

A 68-year-old chiropractor from Hales Corners, Dr. Olsen believed he needed something for the pain, such as the epidural block he had received earlier in the week. So when the pain got worse he called the emergency room where he had previously received the epidural and was told that no anesthesiologists were available until Monday. (He later learned that the person giving him this information had been misinformed.) While he admits to being irritated at being put off when he was in so much pain, in retrospect this may have been the best thing that could have happened. If he had received another epidural block to deaden the pain, he might not have sought the help he so desperately needed. As it was, it was almost too late when he finally made it to St. Luke's Medical Center's emergency department on Sunday morning.

Hoping to wait until Monday when his orthopedic surgeon had scheduled a variety of diagnostic tests, Dr. Olsen suffered with the pain throughout the day Saturday, thinking it would eventually subside. Sunday morning, however, the pain in his back was worse and it was radiating to his abdomen. In addition, his legs were tingling and he felt faint. Now he knew something was wrong. He recalls saying to his wife, "Call 911. I need to go to St. Luke's."

St. Luke's Medical Center was an obvious choice because both Dr. Olsen and his wife had been cared for there so well in the past. In 1992, his wife, Doreen, was treated in the St. Luke's emergency department for a suspected heart attack. Many years earlier in 1979, Dr. Olsen underwent bypass surgery at St. Luke's after suffering a heart attack. Though he had not had any heart problems since that date, he had been examined for emphysema by the St. Luke's pulmonary staff.

On that fateful Sunday morning, an ambulance arrived within minutes of the 911 call and rushed him to St. Luke's. He remembers saying to the paramedics, "There's no need to turn on your lights and siren. I'm sure it's nothing urgent." Dr. Olsen acknowledges now that he couldn't have been more mistaken. He was in and out of consciousness when he arrived at St. Luke's, but he opened his eyes long enough to know he was in good hands. The emergency department physician handling his

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"I knew something was very wrong. Dr. Olsen was experiencing much more than ordinary back pain. I thought it could be his gall bladder or kidney stones. This was a tough case and it took a real team effort to determine what was happening."

—Dr. Dennis Anderson
“Dr. Olsen’s condition was life-threatening and our only hope of saving him was to perform immediate surgery to repair the ruptured aneurysm.”

—Dr. Dennis Anderson

The case was Dr. Dennis Anderson, the same doctor who had taken such good care of his wife several years before.

Dr. Anderson recalls his case clearly. He says, “I knew something was very wrong. Dr. Olsen was experiencing much more than ordinary back pain. I thought it could be his gall bladder or kidney stones. This was a tough case and it took a real team effort to determine what was happening. The radiologist picked up a subtle abnormality on an X-ray that caused us to look further. One important clue I noted in Dr. Olsen’s medical history was that his father had died of an abdominal aneurysm, along with his father’s brother.”

After further consultation with the radiologist, Dr. Anderson ordered a CAT-scan, which led to a frightening diagnosis. Like his father, Dr. Olsen had a dissecting abdominal aneurysm. This very critical situation involved a rupture in the aorta, which was bleeding into his abdomen. Dr. Anderson said, “Dr. Olsen’s condition was life-threatening and our only hope of saving him was to perform immediate surgery to repair the ruptured aneurysm.”

Miraculously, good luck continued to be on Dr. Olsen’s side. The cardiovascular surgeon readily available at St. Luke’s that Sunday morning was Dr. James Auer, the same surgeon who had successfully performed his bypass surgery many years before. Less than two hours after arriving at St. Luke’s, Dr. Olsen was in surgery. Later, Dr. Auer would tell him that he probably wouldn’t be alive today if he had been diagnosed one-half hour later.

The miracle is that Dr. Olsen did make it—and he made it without any of the dire complications that were anticipated, such as being permanently on a ventilator or suffering kidney failure, which would have meant ongoing dialysis. He was out of the hospital in eight days and is now back working part-time. He’s enjoying his family, which includes three children and eight grandchildren, and is looking forward to taking an active part in all his favorite activities—golf, fishing, hunting, trapshooting, and amateur radio.

Dr. Anderson says, “Dr. Olsen’s case shows how at St. Luke’s we can tap into all the resources of the emergency department and the hospital to diagnose and treat a critical medical problem quickly and effectively. It was a real team effort. We could not have solved this problem without superb X-ray back-up, the prompt response of a cardiovascular surgeon, and expert nursing support throughout the entire process. This is one of those fascinating cases with a wonderful ending. It’s the kind of case that reinforces my decision to work in emergency medicine.”

Dr. Olsen says, “I wouldn’t have made it without good doctors, good nurses, good care, and God. These are the big things. Whenever anyone looked at my chart while I was in the hospital, they would say something like ‘Boy, are you lucky!’ I am lucky. But I also went to the right place just in the nick of time.”
Michael Sadowski’s case was equally formidable. While Michael, who is 47 years old, has lived with polycystic kidney disease for a number of years, he felt he was finally on the road to leading a normal, healthy life. In January of this year, he had a kidney transplant, and his recovery was going well. He was scheduled to return to his job as an international sales engineer at the Ladhish Company within a week. Then Michael encountered an unexpected hurdle.

As part of an effort to regain his strength after the transplant, he was walking every morning at a mall near his home. He recalls, “Normally, I would walk around the mall five or six times, but on this particular day I just didn’t feel right. I walked around twice and then decided not to push it.” Michael picked up his 25-year-old son, Dan, from a class and went home to take a short nap before lunch. It wasn’t long, however, before he told his son that he was feeling extreme pressure in his chest. His son called 911 and Michael was rushed to St. Luke’s via ambulance.

The situation became even more dramatic because Debra Sadowski, Michael’s wife, is the supervisor of emergency nursing in St. Luke’s emergency department. She was working when her son called to say that his father was on the way in an ambulance. She says, “Waiting for Michael to arrive seemed to take forever. We had no idea what condition he would be in.”

While Debra and her staff deal with medical emergencies every day, seeing her own husband as the patient in crisis was a new experience. Debra says, “As hard as this experience was, I knew that whatever was wrong, Michael was in the right place and would receive the best care possible, just as all our patients do. Having that confidence made a big difference to me.”

Dr. John Tucker, the emergency physician who examined Michael, says, “Michael was obviously in acute distress. We immediately tried to stabilize him and find out what was causing the problem. An EKG indicated we were dealing with a heart attack resulting from a blood clot that was blocking the flow of blood to his heart. It was definitely a life and death situation. We were able to get a cardiologist, Dr. Frank Cummins, involved immediately who took him to the catheterization lab. An angioplasty procedure was used to insert a stent (small tube) so the blood could flow through the blocked area.”

“As hard as this experience was, I knew that whatever was wrong, Michael was in the right place and would receive the best care possible, just as all our patients do. Having that confidence made a big difference to me.”

—Debra Sadowski, R.N.,
ED supervisor

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Paramedics work closely with the emergency department team.
“An EKG indicated we were dealing with a heart attack resulting from a blood clot that was blocking the flow of blood to his heart. It was definitely a life and death situation.”

—Dr. John Tucker

Michael Sadowski (left) meets with Dr. John Tucker, the emergency physician who handled Michael’s heart attack.

Michael recalls, “I started to feel better right away.”

Dr. Tucker emphasizes, “Because St. Luke’s is a major cardiac center we have a range of very sophisticated options available so we can deal effectively and promptly with heart attacks and other cardiac problems. This was definitely an asset to Michael. The handling of Michael’s case represents a classic team effort with everyone working together. The emergency department staff picked up the ball and didn’t let it drop until he was out of danger. It was quite a moving scene and we were all very concerned about Michael.”

While Michael says he has always been impressed with the St. Luke’s emergency department and his wife’s colleagues, he admits to gaining a new appreciation for their skills and effectiveness as a result of his experience. He says, “I knew I was in good hands with Dr. Tucker, Dr. Cummins, and the emergency department staff. Without their quick intervention I doubt if I would be here today.”

Despite his recent medical challenges, Michael feels well and is back enjoying his family and his work. He and Debra have three adult children, including one daughter who works at St. Luke’s in radiology. In addition to appreciating the way St. Luke’s handled his challenging emergency, Michael also praises the quick thinking of his son in calling 911 right away.

As dramatic as these cases were to the individual patients and families involved, they are not unusual. The St. Luke’s emergency department is in the daily business of saving lives. Dr. Anderson emphasizes, “Diagnosing and treating medical emergencies like these takes a coordinated team effort. The St. Luke’s emergency staff is trained and prepared to handle these situations. Anyone who comes to the St. Luke’s emergency department is going to get the utmost in skilled care. We pride ourselves on pulling together to solve problems and on having the highest expectations for our patients.”

Dr. Anderson and Dr. Tucker are among twenty board-certified emergency medicine physicians who work on rotating shifts in the emergency department. During peak hours, three physicians and about ten nurses are on duty. Both
"Anyone who comes to the St. Luke's emergency department is going to get the utmost in skilled care. We pride ourselves on pulling together to solve problems and on having the highest expectations for our patients."

—Dr. Dennis Anderson

Doctors say they chose to practice emergency medicine for similar reasons, including the diversity of patients, the challenge of fast-paced decision-making, and the acuteness of the situations they face.

Dr. Tucker, who has worked in the St. Luke's emergency department for ten years, says, "I like the fast pace of emergency medicine and the opportunities it presents to have an immediate impact on patients, but there are special challenges in emergency medicine, including having to make quick decisions without as much information as we'd like, and dealing with patients who are frequently under great stress."

Dr. Anderson, who has been at St. Luke's for 12 years, agrees. He adds, "Emergency medicine is exciting and challenges me mentally and physically. I enjoy the wide diversity of patients, and while I may work long days, I appreciate the flexibility of its hours. The greatest reward in emergency medicine is having good outcomes and satisfied patients."

While both Lloyd Olsen and Michael Sadowski are obviously satisfied patients, it is important to remember that they are only two out of an average of 150 patients treated each day in St. Luke's emergency department. While not all these patients are facing life-threatening crises, the great majority are equally pleased with the responsiveness of the staff and the care they receive. The staff prides itself on treating each patient with the same high level of compassion and skill Lloyd Olsen and Michael Sadowski experienced, whatever their problems may be.

Dr. Tucker emphasizes, "At St. Luke's, we believe the patient defines the emergency. If the patient feels a problem deserves attention, then we pay attention."

"At St. Luke's, we believe the patient defines the emergency. If the patient feels a problem deserves attention, then we pay attention."

—Dr. John Tucker

In St. Luke's emergency department, saving lives is a team effort.

Calling "911" was an important step in saving the lives of both Lloyd Olsen and Michael Sadowski.
Above and beyond the call of duty . . . 

Emergency nursing: what it takes

What does it take to be an emergency nurse? Why do some individuals voluntarily subject themselves to the intensity, the stress, the long hours, the unpredictability, the emotion, the heartbeat, the inevitable fatigue, and the daily demand for widespread expertise in all areas of medicine? We recently had a candid discussion with several St. Luke’s Medical Center emergency nurses about why they do what they do. The following questions and answers are highlights from this discussion.

The Spirit: Why did you choose to be an emergency nurse?

Kristine: I like the variety, the fast pace. You never get bored because you’re so busy. You have the opportunity to do critical care in a variety of different areas.

Bob: I also work on one of the hospital floors so I can see the difference between emergency nursing and floor nursing. You really need to be a jack-of-all-trades to be an emergency nurse. You have to have an understanding of oncology, cardiology, orthopedics, pediatrics, geriatrics, and all kinds of other specialties. There’s a learning curve to becoming an ED nurse. I think it takes two to three years until you’re really comfortable.

“You really need to be a jack-of-all-trades to be an emergency nurse. You have to have an understanding of oncology, cardiology, orthopedics, pediatrics, geriatrics, and all kinds of other specialties.”

—Bob Ottoson, R.N., emergency nurse
"We also have ongoing team-building sessions that help us learn how to communicate our needs and work as a team, particularly in stressful situations."

—Kristine Zagrodnik, R.N., emergency nurse

Carol: I like the opportunity for quick decision-making and dealing with a variety of acute cases. The independence of emergency nursing is also appealing to me.

Debra: I probably chose emergency nursing because of the ongoing challenge of continued priority setting and decision-making. I like responding as the needs of patients change.

Jeanne: Patients are the priority. Every day is different and I really enjoy the interaction with patients.

The Spirit: Do you have to be certified to be an emergency nurse?

Bob: Everyone is Advanced Cardiac Life Support-certified which involves knowing the protocol for treating a patient in cardiac arrest. Many of our nurses have also gone through the training process to become Certified Emergency Nurses.

The Spirit: What are the special challenges you face as an emergency nurse?

Carol: I believe the biggest challenge I face is time management and keeping everyone happy. When you have 60 people who want to be seen right now and believe their illness or problem should be the top priority, it’s a challenge to help them understand that we’re doing the best we can and that they are important to us. We take cases in order of urgency, so the people who are not in life-threatening situations need to understand that they may have to wait.

Kristine: It’s hard sometimes, since people don’t always understand that concept. Their bleeding finger is just as important to them as someone else’s heart attack—and they don’t necessarily know what’s going on with other patients. The general impression is that this is the emergency room so they can come in quickly, get their problem solved, and move on with their lives.

Carol: We should point out that St. Luke’s has a really well-staffed emergency department and generally treats people efficiently and promptly, but when you add the complicating factors of alcohol, drugs, and other personality-changing substances, we’re never going to be quick enough.

Bob: Since I do a lot of weekend work, I tend to see many alcohol-related cases. People are not always in a normal frame of mind, and you have to tailor your nursing care to deal with these circumstances.

Jeanne DuPont, R.N., handles a wide variety of patients each shift.

"I probably chose emergency nursing because of the ongoing challenge of continued priority setting and decision-making. I like responding as the needs of patients change."

—Debra Sadowski, R.N., ED supervisor

Kristine Zagrodnik, R.N. (left), and Linda Ford, R.N., discuss a patient’s condition.
There is a tremendous amount of valuing of each individual patient going on. You are not an earache. You are not a cut finger. You are not acute chest pain. We see you as a person with a problem.

—Rebecca Long, R.N., director, emergency services

Debra: I think that people generally are appreciative of how quickly we respond, especially when they have been to other urban emergency rooms where they may have to wait five or six hours to be seen. Our turnaround time on a national average is very low.

The Spirit: Do you feel people use the emergency room appropriately?

Debra: I think it depends on how you look at it. If the emergency department is their only access to health care, then you can’t say people are misusing it. People make some decisions that I might not make, but I’m not in their situation. I believe an emergency is what a patient defines as an emergency.

Kristine: An appeal of the emergency department is that people have access to many specialty tests that aren’t readily available to them otherwise. For instance, you can have a stress test on the weekend if you come in with chest pain instead of being scheduled three weeks from now at your doctor’s office.

Rebecca: I think one of the things that happens in this department, more than any other place I’ve been, is that there is a tremendous amount of valuing of each individual patient going on, however minor or momentous their problem might seem. You are not an earache. You are not a cut finger. You are not acute chest pain. We see you as a person with a problem. We also need to deal with your mother, your son, and your other family members. Each situation requires a multi-disciplinary approach if we’re really going to be effective.

The Spirit: How do you deal with the emotional strain of difficult situations?

Carol: The stress of this job is recognized by staff and management. Bad things happen that can be emotionally draining. We learn that there is a lot we can do to take care of ourselves. We have an active critical incident debriefing process for our staff members that encourages us to express our feelings and deal with emotional situations. (See the article on page 15 for more details about this debriefing process.)

Jeanne: We deal with a lot of hard situations. Babies die. People have heart attacks and don’t make it. We have bad motor vehicle accidents. We get fire and smoke inhalation victims because of St. Luke’s
hyperbaric chambers. I usually handle these traumatic incidents efficiently at the time and then go home and it really hits me.

**Kristine:** We also have ongoing team-building sessions that help us learn how to communicate our needs and work as a team, particularly in stressful situations. It's the team effort that makes our emergency department successful and that helps us deal with difficult situations.

**Carol:** I can personally say that every critical incident I take care of affects me in some way. It's very helpful to go through the debriefing process and talk to my peers about what happened, but I will also learn something from what happened. I practice a much safer lifestyle since I began working in the emergency department than I did prior to working here. You get a good taste of what real life is all about and see that bad things really do happen to good people. I see people every day who thought it would never happen to them.

**Rebecca:** A perfect example of what Carol means is what happened in our community yesterday. Four people left their office to have a fast food lunch. They hopped into a car and did not fasten their seatbelts. Within minutes they collided with a bus and they all died at the scene. As an emergency department, there was nothing we could do to save them, but we did send our crisis debriefing team out to help the people who had to deal with the accident.

**Debra:** Those kinds of crises can have a cumulative effect and we need to cope with burnout. I think there is a high level of awareness by management and administration to make sure we are taking care of ourselves. If we don't take care of ourselves, we won't be effective with our patients.

**Carol:** I was just at a statewide Emergency Nurse Association meeting. The topic came up about dealing with the emotional impact of critical incidents. No one I talked to worked in an emergency department that offers the kind of support we have at St. Luke's. They were all amazed and impressed with our debriefing approach.

**Rebecca:** We have very caring nurses in this department. They're in touch with their own feelings, which tends to make them more empathetic. That's what being an emergency nurse is all about.
While each nurse is responsible for his or her own patients, everyone has a global view of what’s going on in the department. We all pitch in to help one another.”

—Debra Sadowski, R.N., ED supervisor

emergency nurse is all about. There’s a big difference between being empathetic and sympathetic. We are able to look at a situation from the patient’s point of view, which is crucial if we’re going to be helpful.

Carol: Emotion is not a bad thing for an emergency nurse. When people see you with tears in your eyes as you’re trying to explain what’s wrong, they know you’re feeling badly for them and wishing the situation could be better. They see you’re not just treating them as another person to push through the system and get out the door.

The Spirit: Are some times of the day or week busier than others?

Bob: It’s really hard to predict when you’ll be the busiest. It depends on many factors such as the weather and what’s going on around the city. For instance, we always expect accidents after the first snowfall of the season or when there’s a big Brewers game going on.

Rebecca: Every day is a busy day. Right now it’s 9:30 on a Wednesday morning and you might not expect much to be going on. Yet, we have two patients in every room. There are seven people experiencing acute chest pain and each one requires a full team of people. There is a person whose right side is numb who is probably suffering a cerebral aneurysm. Two people are in severe respiratory distress, one person has a subdural hematoma, and one has a probable kidney stone. This is only a portion of the cases we’re handling right now. There is no time in this department when the potential does not exist for it to be absolutely crazy with one case more acute than the next one. But, if you walked out there right now, you would never know how much is going on because we have learned how to manage multiple crises efficiently and keep everything running smoothly.

Debra: While each nurse is responsible for his or her own patients, everyone has a global view of what’s going on in the department. We all pitch in to help one another.

The Spirit: Does it take a special kind of personality to be an emergency nurse?

Rebecca: When people go into nursing, I think there is always a self-selection process that reflects your strengths and weaknesses. Some people like long-term care

Terry Winkel, R.N., prepares a patient’s medications.

Health unit coordinators, Barbara Boyle and Christine Lindahl, are important members of the emergency team. Here they’re taking lab results off the computer.
"I've heard people describe us as 'adrenaline junkies.' In some respects that's true, but I would rather describe us as people who thrive on challenge and the opportunity to make a difference."

—Rebecca Long, R.N., director, emergency department

and choose specialties like rehab or family practice. Others like to work with children. Emergency nurses are crisis-oriented. I've heard people describe us as "adrenaline junkies." In some respects that's true, but I would rather describe us as people who thrive on challenge and the opportunity to make a difference. People who work here have chosen this department and wouldn't give it up for better paying positions in long-term care situations. This is what we want to do. I believe the people who work in this emergency department are unique. Their value systems are right in line. They value what's important. Family and friends are a priority to them because they see the fragility of life every day.

The Spirit: Is it frustrating not to follow a case through to its conclusion?

Carol: This is a common criticism of emergency nursing, but I think most of us like dealing with the immediate crisis, knowing we've done our best, and then moving on. We always have the option of checking up on patients to see how they're doing. For instance, last week I took care of a 16-year-old girl who had been seriously injured in a car accident. She was very sick and we couldn't reach her parents to approve surgery. We finally had to petition the courts to assume her custody to get permission to operate. I spent five hours holding her hand before she went into surgery. Later, I did go to see her on the floor because I was concerned and wanted her to know that we did care about her.

Kristine: Just because we're in an emergency setting doesn't mean we don't have a fairly constant patient population. We do develop relationships with people. Many days, I can walk into the waiting room and see several familiar patients who have chronic problems or who use St. Luke's regularly as their family's emergency room.

The Spirit: Are domestic abuse and child abuse common problems?

Kristine: Unfortunately, yes. However, our nursing staff has a high level of awareness about recognizing and handling abuse situations. Alice Kramer, who is on our staff as a clinical nurse specialist, is a specialist in domestic abuse and provides ongoing training for us on these issues. (See the article on page 15 for more details on the ED's domestic abuse program.)
"I think we need to emphasize the general excellence in everything we do. We are on the cutting edge of technology. The resources we have available for patients are extensive and state-of-the-art."

—Debra Sadowski, R.N., ED supervisor

Jeanne: I don’t mind dealing with these situations because I feel I might make an impact on someone’s life. I might be that one link a person needs that says somebody cared enough to listen and somebody was suspicious enough to ask if I’m safe. The person may then take the last step to get out of a bad situation.

The Spirit: How do you deal with language differences?

Rebecca: We’re working very hard to respond to the multi-cultural aspect of our patient population. We have developed flip charts and translation aids for our Spanish-speaking population, and several nurses and physicians either speak or are learning Spanish. We also have access to people who speak other languages. We recognize how hard it must be to have a medical crisis and not be able to communicate.

Carol: I believe that our management support and involvement is truly unusual. The management people in our department, such as Rebecca and Debra, are very much there with us when we need them. Right off the top of my head, I can think of three recent situations when things were pretty hectic around here—when four different people needed me to hold their hands at the same time and I really had to be running around, doing all the things it takes to make sure they were taken care of quickly. In each case, Debra and Rebecca were right there to help, holding a patient’s hand and pitching in any way they were needed. I’ve never seen that happen anywhere else in my nursing career.
Rebecca: That's because we're frustrated practitioners. Our hearts are at the bedside. While it's not in my job description or Debra's to do anything that's patient care-related, we make choices to be where we're needed. That's why I wear scrubs rather than high heels and a suit. I'm in and out of this department 50 times a day. I appreciate the opportunity to do little things for patients—answer a call light, get a glass of water, bring a bedpan.

Debra: When talking about St. Luke's and what is so special in our emergency department, I think we need to emphasize the general excellence in everything we do. We are on the cutting edge of technology. The resources we have available for patients are extensive and state-of-the-art. In particular, because St. Luke's is a major cardiac center, we are able to offer patients the latest in cardiac expertise whatever their problems may be. This excellence came very close to home for me a few weeks ago. My husband was brought in here after a cardiac arrest. Within minutes, he was in the cath lab and his blocked artery was being opened up. (See the article beginning on page 2 for more details about this situation.) When I described this experience to my nursing instructor at Marquette, she said, "You must have such faith in your team." She's right. I do. As soon as my son called to say my husband was having problems, I made sure the paramedics were bringing him right here to St. Luke's.

"As soon as my son called to say my husband was having problems, I made sure the paramedics were bringing him right here to St. Luke's."

—Debra Sadowski, R.N., ED supervisor
Advanced practice nurses give St. Luke’s an edge

St. Luke’s emergency department is unique because it has two dedicated advanced nurse practitioners who work with the staff and community on important issues related to practicing emergency nursing. Alice Kramer, RN, MS, and Marcia Williams, RN, MSN, are clinical nurse specialists with significant support roles in the emergency department.

Alice is responsible for the clinical development of the emergency staff which involves workshops, training sessions, and one-on-one teaching. In her position, she designs and coordinates orientation for all new nurses in the department and is also in charge of ongoing continuing education for the nursing staff. She says, “I see myself as a mentor and a coach.” In addition, Alice is involved in such projects as the automation of the department and research investigations.

One especially relevant focus of Alice’s work is raising staff awareness of issues related to domestic abuse. She says, “My goal is to help the staff recognize these issues, ask the right questions, and provide appropriate referrals to patients.” In addition to working on these issues in the St. Luke’s emergency department, Alice is active on an Aurora corporate task force that is collaborating with community agencies to develop programs related to domestic violence.

Alice emphasizes that domestic abuse is a serious problem faced in emergency departments throughout the country. National data says that anywhere from 35 percent to 50 percent of adult women who come through a typical emergency department, particularly with injuries, are victims of domestic abuse, whether it’s related to an immediate incident or to the cumulative effects of abuse. These figures suggest that St. Luke’s emergency department may see at least ten women a day who are victims of abuse; however, only a few of these women identify themselves this way. It’s up to the emergency staff to recognize the symptoms and ask the right questions.

Alice says, “The importance of dealing with domestic abuse issues cannot be overemphasized for an emergency department staff. There are obvious connections between a person’s healthcare risks and living in violence. Asking a question as simple as ‘Do you feel safe?’ can uncover a tremendous opportunity to prevent further abuse. Uncovering these issues and providing appropriate referrals is far more important to a person’s future well-being than treating the immediate migraine headache or broken arm.”

Alice continues, “We want the community to know that at St. Luke’s we are especially sensitive to domestic abuse issues and we will provide opportunities for victims to seek help. All staff members at St. Luke’s go through training related to domestic abuse when they first join the staff and then on an ongoing basis. The result is that we have a high level of awareness.

“It is unusual for an emergency department to have dedicated support staff. We’re very fortunate that St. Luke’s has seen the wisdom of providing the kind of advanced support Marcia and I can contribute to the department and to the community.”

—Alice Kramer, R.N., M.S.
“The importance of dealing with domestic abuse issues cannot be overemphasized for an emergency department staff. There are obvious connections between a person’s healthcare risks and living in violence.”

—Alice Kramer, R.N., M.S.

Marcia Williams, R.N., M.S.N., provides crisis support for the emergency department staff.

and can be very helpful to people who are domestic abuse victims.”

It is particularly appropriate that Alice Kramer was recently named a co-recipient of the Advocate of the Year Award by the Milwaukee Women’s Center for her work on domestic violence issues in the community.

Marcia Williams focuses on helping both the staff and the community deal with traumatic incidents that might otherwise become debilitating. Marcia conducts workshops on topics such as grief management, suicide evaluation, and crisis team building. As all the nurses interviewed for this issue of The Spirit of St. Luke’s indicated, emergency department nurses and other staff members are very appreciative of the critical incident stress debriefings which Marcia and other trained members of St. Luke’s Crisis Team conduct after a particularly emotional event—such as the death of a child, or dealing with fire, accident, or shooting victims. During these debriefings, staff members have a chance to express their feelings about a difficult incident so that they can continue to do their jobs.

Marcia says, “When people in caring professions, such as nursing, are repeatedly exposed to the pain and suffering of other people, they may experience ‘compassion fatigue’ which can affect their ability to care for their patients. We conduct these debriefings to assist them in the healing process so they can carry on with their professional lives. These debriefings also help staff members go home and lead normal lives with their families.”

As an important service to the community, Marcia also conducts debriefings for “first responders,” such as fire fighters and police officers who have handled an especially traumatic incident.

Both Marcia and Alice recognize the uniqueness of their roles at St. Luke’s. Alice Kramer emphasizes, “It is unusual for an emergency department to have dedicated support staff. We’re very fortunate that St. Luke’s has seen the wisdom of providing the kind of advanced support Marcia and I can contribute to the department and to the community.”

Marcia adds, “The level of sophistication and wide range of mental health services offered in our emergency department are unique and provide tremendous benefits to the community.”
Why we give . . .

The following generous supporters of St. Luke’s Medical Center explain why they have chosen to make contributions to St. Luke’s

Mark Vogel

Mark Vogel, who has been a physical therapy assistant at St. Luke’s for eight years, is chair of the Employee Philanthropy Club. He says, “Our club tries to educate St. Luke’s employees about the importance of philanthropy to the hospital. Rather than targeting some dollar amount, our goal is to increase the percentage of participating employees. Employees are starting to understand that even small donations can mean a lot. As the healthcare environment changes, St. Luke’s is going to need more charitable support to maintain the high level of quality care it has today.”

In his position at St. Luke’s, Mark works with both inpatients and outpatients to improve their strength and flexibility. He says, “I do what it takes to help patients improve and get on with their lives.”

Mark, who has a 13-year-old daughter, is also involved in many activities outside of work. While he enjoys racquetball and golf, he has a special interest in scuba diving—particularly in the Caribbean. He has a vivid memory of seeing a rare sea creature—a spotted eagle ray—as it lifted off the ocean floor. He recalls, “Suddenly the whole ocean floor moved. It was beautiful.”

In summarizing his philosophy about giving to St. Luke’s, Mark says, “Giving is something you find in your heart. When people ask me where I work, I’m very proud to say I work at St. Luke’s. I feel good about giving back to a hospital that does so much for so many people in the community.”

St. Luke’s Philanthropists Club

St. Luke’s Philanthropists Club is an annual giving club established to honor and recognize annual donors of $100 and above for their charitable support of St. Luke’s Medical Center. Recognition is provided on an annual basis with your name engraved on a brass plaque on a prominent display in the Outpatient Building. Membership benefits also include an invitation to the Annual Dessert Gala.

We cordially invite you to join the many friends of the hospital with your charitable support and become a member of this prestigious honorary organization. Your generosity will have a significant impact on people’s lives. For further information, please call Laverne Schmidt, director of annual giving, at 414-649-7123.
Walter and Dorothy Oestreich

Walter Oestreich has participated as a bicycle rider in the last four national Senior Olympics. He and his wife, Dorothy, have traveled to St. Louis, Syracuse, Baton Rouge, and San Antonio so that he could compete. Given his high level of energy and physical fitness, it’s hard to believe that Walter had heart bypass surgery several years ago. He’s also had surgery on his back, which prevents him from resuming his previous sport of running; however, neither surgery keeps him from leading a full, active life.

Dorothy also has had a number of different surgeries at St. Luke’s for her rheumatoid arthritis, including corrective hand surgery and wrist reconstruction. While she isn’t able to be as physically active as her husband, she enjoys traveling with him and watching him compete.

Dorothy and Walter point out that their family history with St. Luke’s “goes way back.” They recall when their son was in a serious motorcycle accident many years ago. In addition to other injuries, he suffered fractures in both legs. He was cared for at St. Luke’s and is now doing very well as a teacher in the Milwaukee Public Schools. The Oestreichs also have three other children, four grandchildren, and one great-grandchild.

The Oestreichs support St. Luke’s because of their long-time connection to the hospital. Dorothy says, “Our family has been taken care of so well at St. Luke’s. We’ve had many experiences at the hospital and they have all been good ones. We want to support St. Luke’s because it has meant so much to us throughout the years.”

Karl and Irma Roeming

Karl Roeming knows St. Luke’s well. He has had numerous surgeries and other procedures performed at St. Luke’s over the last 20 years and says, “I’ve been a steady patient at St. Luke’s since 1976.” During that time period, Karl has had two heart bypass operations and 14 angioplasty procedures. He has had carotid artery surgery and has had a pacemaker implanted.

Despite all the health problems he has faced, Karl’s spirits are good and he is deeply grateful for the care he has received. He says, “I wouldn’t be here if it wasn’t for the good care I received at St. Luke’s. I definitely believe it’s because of St. Luke’s that I’m alive.”

His wife, Irma, agrees. She says, “St. Luke’s has been wonderful to Karl and to our family.” The Roemings have expressed their appreciation for his care through their contributions to St. Luke’s. They have also designated St. Luke’s in their will. Karl says, “We do what we can to support St. Luke’s because the hospital has supported us in so many ways.”

Karl retired about 15 years ago after working as a jewelry salesman for 45 years. Karl and Irma, who are both Milwaukee natives, have been married for 23 years and have five children between them, including 14 grandchildren and three great grandchildren. They occasionally travel to St. Louis and Colorado to see their children living in those areas.
"You must be a very special person to get your name up there. Someday I'd like my name on that wall."

—Rick Buchman

Jackie Buchman

While Jackie Buchman's 24-year-old son Rick was battling cancer several years ago, she used to walk the halls of St. Luke's Medical Center with him. She recalls, "We always ended up by the Tribute Fund Wall at the entrance to the hospital and Rick thought it was so impressive. He would say, 'You must be a very special person to get your name up there. Someday I'd like my name on that wall.'"

Unfortunately, despite excellent medical care and a fierce determination to win his battle with the persistent sarcoma that was invading his neck and spine, Rick succumbed to the disease about two years ago. After his death, Jackie collected money in a variety of ways through friends and local businesses in an effort to raise $1,000 in order to be listed on the Tribute Fund Wall. Her efforts paid off and Rick's name is now inscribed on a brass plaque.

It's appropriate that Rick's name is on the wall because he was a very special person and he cared about St. Luke's. During his illness, he told his mother he wanted to do something for St. Luke's and the Vince Lombardi Cancer Clinic where he received much of his care. Jackie says, "Rick had a very good experience at St. Luke's. He received excellent care and everyone was so compassionate. When he was especially sick and scared, his 17-year-old sister was allowed to stay with him in his room. The staff at St. Luke's did everything they could to make him comfortable."

Jackie said, "I still find it hard to believe he's not here. He had such a spirit for living and a determination to beat this disease. He was a very athletic person—a runner and weight lifter, and he never smoked. Everyone thought he was strong enough to make it and he never gave up. We do know that he touched many people's lives. Other cancer patients told me what an inspiration he was to them. We always thought he would come out winning in the long run. In many ways, I think he did."
Two special gifts for someone tomorrow

Estate of Edward Ropiak

We first met Ed in 1992 when he walked into our office one warm summer day and told us he was considering a major gift to the hospital. He had seen the recently established Wall of Honor and was impressed with the opportunity to honor his wife’s memory with her name on a permanent plaque. We later learned that he had been a patient at St. Luke’s a number of years ago. Ed worked almost his entire career as a machinist at Perfex. He spent a good deal of his retired years maintaining his duplex and also was an avid race car fan. Almost every Friday, Ed would take the bus to St. Luke’s where he feasted on the coffee shop fish fry and then spent some time visiting with us. Ed remembered the care he received at St. Luke’s, not only with a gift during his lifetime, but also in the form of a bequest to benefit future patients. Ed passed away in 1995 but his gift will be a gift of life for someone at St. Luke’s tomorrow.

The Mitzi L. Dilworth Endowment Fund

Mitzi and Addison Dilworth’s interest in nursing continues with the establishment of a fund to endow nursing education at St. Luke’s. An award is presented biannually to an eligible applicant pursuing formal educational preparation in nursing. The applicant must be enrolled in an accredited registered nursing program in Wisconsin and have been a St. Luke’s employee for at least two years. The awardee must demonstrate a commitment to the profession of nursing. Mrs. Dilworth has since passed away but her husband enjoys meeting the scholarship recipients. This year’s recipient, Jonathan Nass, says, “Without financial assistance we often cannot obtain our future goals. I received the Mitzi Dilworth Scholarship Fund award with pride and appreciation for a community that continues to support nursing education.”

“Without financial assistance we often cannot obtain our future goals. I received the Mitzi Dilworth Scholarship Fund award with pride and appreciation for a community that continues to support nursing education.”

—Jonathan Nass
St. Luke’s Media Rounds

Media Rounds is a regular section in The Spirit of St. Luke’s. This section presents a sampling of stories involving St. Luke’s Medical Center that have been recently published or broadcast. As you will see after reading these moving stories, the news media continue to respond to the public’s desire for health-related news and information. We think our readers will be very interested to see the many exciting stories which are continually evolving at St. Luke’s.

NEW BLOOD TEST QUICKLY DETECTS HEART ATTACK

Milwaukee Journal Sentinel
November 23, 1995
Joe Manning, of the Journal Sentinel staff

A new quick blood test that can detect in most cases if a patient has had an acute heart attack is now being used at St. Luke’s Medical Center emergency room and will soon be used at St. Joseph’s Hospital in Marshfield.

Unlike previous tests, the new test can detect damage that happens specifically to the muscle cells of the heart, said John Tucker, an emergency medicine physician at St. Luke’s.

The test not only will help get people into treatment earlier, but also can rule out the need for more invasive heart-attack diagnostic tests, he said.

Blood tests previously could detect proteins from damaged muscle cells, but could not distinguish between proteins from heart muscle and other muscles of the body, he said.

A classic heart attack occurs when blood flow is suddenly halted to the heart muscle, which kills part of it.

“The most frequent complaint in our emergency department is chest pain,” Tucker said, but “in some patients, it can be difficult to determine whether a heart attack has occurred. This new biochemical marker reduces the confusion because it specifically identifies heart muscle damage.”

According to Wisconsin public health records, there were nearly 11,000 coronary heart disease deaths here in 1993. Heart disease from all causes is the No. 1 killer in Wisconsin, as it is in the United States.

Nationally 4 million people go to a hospital with chest pain, and 900,000 eventually are diagnosed with a heart attack.

The test is designed to detect a protein called troponin-I, which is involved specifically with muscle contractions of the heart. The protein is released into the bloodstream following the death of heart-muscle cells during a heart attack.

About 700,000 people are admitted into critical care units where eventually it is determined they did not have a heart attack. It is hoped that the test can more quickly determine who did or did not have a heart attack.

A second, similar test made by a different firm will become available by the end of the year. That test, which yields results in 20 minutes at the bedside, measures a related protein, troponin T. It will cost the hospital about $30 a test. It is being marketed by the firm Boehringer Mannheim.

The test used by St. Luke’s is manufactured by Dade International of Deerfield, Illinois, and costs about $45.

Richard Collins, a pathologist with Aurora Health Care Laboratories, which services St. Luke’s, said the test would reduce unnecessary hospital admissions.

The troponin-I test was clinically tested on 200 patients at St. Luke’s before being put into use as part of the panel of blood tests done on patients suspected of having had a heart attack, Tucker said.

John Whitcomb, director of emergency services at St. Luke’s, said the test also can determine if someone has had a heart attack within the previous 10 days because the protein remains in the blood that long—longer than any other muscle protein.

The troponin-I test takes about 20 minutes or so using a centralized laboratory to perform. The Cardiac T test uses a kit that needs only a few drops of blood and by the absence or presence of colored lines indicates a positive or negative result.
HELP FOR INDIVIDUALS WHO MAY HAVE GIVEN UP

Reminder Enterprise
February 15, 1996
Jennifer Richter, staff writer

Editor’s note: The names of patients interviewed for this story have been changed to protect their identities.

Don Ritter dreaded mornings. Instead of new beginnings, they promised the same emotional and physical struggles.

After undergoing open-heart surgery, followed by a major heart attack two years ago, Ritter, 56, who lives in Cudahy, was forced to retire early. Family members no longer came to him for advice, in fear of jeopardizing his health.

Ritter felt as though he had no reason to live.
“I’d just get up in the morning and sit in the chair,” he said. “I was suffering from severe depression. I had no direction in my life.”

But Ritter’s perspective began to change a year later when he enrolled in the partial psychiatric treatment program at St. Luke’s South Shore, 5900 S. Lake Drive. The program, which falls between inpatient and outpatient services, reversed his negative thinking and destructive behaviors.

“Without the program, there’s a very good possibility I wouldn’t be here today,” Ritter said. “I was headed down the road to destruction.”

Before seeking help, Ritter said he was slowly, but surely, killing himself. Regardless of his diabetic state, he indulged in alcohol and excessive eating.

“I did everything I could but put a gun to my head,” he said. “And that’s when the doctors intervened.

Partial Hospitalization

Program Coordinator Crista Payton said partial psychiatric hospitalization allows patients to undergo intensive treatment, while living and possibly working in the community. Group therapy is provided from 9 a.m. to 2:15 p.m., up to five days a week.

“We’re able to accomplish treatment in the least-restricted environment,” she said. “Patients are still able to make their connections with family, work and the community.”

St. Luke’s South Shore has offered the program since 1991, but the trend toward partial hospitalization traces back 50 years. Payton said it first surfaced in Russia, where a hospital eliminated beds because of limited funds.

More than a decade later, the trend caught on in the United States. Here, Payton said, partial hospitalization was spurred by mental health legislation geared toward community-oriented treatment.

“The mental health legislation of the 1960s really bolstered the growth of partial hospitalization,” she said, “because it was seen as a financially viable treatment option.”

Payton said the partial psychiatric program treats mainly depressive and schizoid patients, characterized by mood instability and disturbance. The average length of treatment is 12 days.

Partial hospitalization can accomplish any number of goals. It can allow patients, who need more intensive treatment than outpatient services, to avoid hospitalization. It also can decrease hospitalization time for patients undergoing inpatient treatment and returns them to the community faster.

Partial hospitalization patients are treated by inpatient core staff at half the cost. The core staff is made up of a psychiatrist, nurse, occupational therapist and social worker.

Flexible Nature

Payton attributes the program’s success to its flexible structure. Not only do patients learn how to deal with problems, they also can apply the techniques at home and within the community.

“It helped guide me back to work full time,” said Kimberly Craig, 43, another recent graduate of the program. “I couldn’t have done it on my own right away.”

Craig who lives in Greenfield, went from inpatient to partial hospitalization, after suffering from caregiver burnout and severe depression. The education professional had experienced several family illnesses in the past several years, along with a relationship gone sour.

While enrolled in the program, Craig was able to attend treatment twice a week and work the remaining three days.
“For me, partial hospitalization was a lot more productive than inpatient because it’s group work all day,” she said. “You’re constantly working on your thought process.”

Craig said group therapy gives patients the opportunity to hear stories from people in similar situations and receive feedback.

Attitude Adjustment

“It’s about an attitude change that can only come about through talking with others—both therapists and patients,” said Craig. “If they just give you pills, it’s not going to change your cognitive thinking.”

Ritter agreed, saying group therapy rebuilds hope. “It gave me the encouragement I needed,” he said. “In the back of my mind I could see that my problems were minor compared to some of the problems the other patients were experiencing.”

Attitude adjustment isn’t the only aspect patients work on. The program also holds them to individual commitments. For example, Ritter had difficulty sharing his feelings about his heart condition with family members, especially his wife.

“I finally broke down and did it,” he said. “It was easier than I thought it would be. I just needed the encouragement.”

And although both patients say their problems haven’t disappeared, they have learned the attitude and behavioral skills to deal with them.

“The program put my whole life in perspective,” Ritter said. “Now, I get up in the morning and look forward to the day as a new experience.”

NEW CATHETER PROCEDURE USED AT ST. LUKE’S

WTTI-TV (FOX) Channel Six
TV6 Prime Time
December 14, 1995

JULIE FELDMAN, REPORTING: Just a few hours after surgery, and Beverly Reiderer is Christmas shopping. It’s possible, because of a new way to perform a catheter procedure. Doctors can follow Beverly’s heart condition by threading a catheter through a main artery up to her heart. Injecting dye and then taking X-rays. Here’s the breakthrough: now they thread that catheter through her artery in her waist. Before they did it through a vessel in her groin which was deeper and took longer to seal up. The difference?

DR. MATTHEW MICK (ST. LUKE’S MEDICAL CENTER): Predominantly, it’s patient’s comfort. The post procedure care, when done through the leg, is typically four to six hours of bedrest. When the procedure is done through the wrist, it requires one hour of observation, typically sitting up in a chair.

BEVERLY REIDERER (PATIENT): The hole is where he went with the wires. When I had the first one done, when they pulled the tubes out, it was very, very uncomfortable. I mean, it was painful. I thought: well, is that what it’s going to be like in my arm? When they pulled it out in my arm, I didn’t feel anything.

FELDMAN: We checked back, and Beverly is doing just fine. The pictures from the catheter test told doctors Beverly’s heart disease has not gotten any worse during the past year. This means she can now get by taking medicine and getting regular check-ups.
JERRY TAFF, CO-ANCHOR: Can we talk stress here? We all have it, so how can we control it instead of it controlling us? Health Reporter Jodi Lyon is on special assignment to tell us how to keep stress in check.

JODI LYON, REPORTING: Well Jerry, you can minimize the effects of stress by learning to recognize it when you’re experiencing it and by learning methods to manage it. Now, we followed along a single working mom who knows stress and how to keep it all in check.

We’ve all been there—the kids, the bills, the laundry. Meet Christie Potter, a nurse at the St. Luke’s Medical Center Mental Health Unit. A single working mother of two teenage girls who generally handles stress pretty well. But like everyone, she has her moments, especially with her kids.

CHRISTIE POTTER (STRESS PATIENT): I’m a yellah. You know, I’m like, ‘What are you guys doing? You’re driving me nuts!’

LYON: So what should you do when your life is filled with stress? Dr. Michael Brandt is a psychologist and stress expert at St. Luke’s Medical Center.

DR. MICHAEL BRANDT (ST. LUKE’S MEDICAL CENTER): People who are under a lot of stress, a lot of negative stress, often feel that they’re very alone, that it’s only happening to them... ‘My gosh, how can I go on?’ So getting support is, I think, one of the first steps necessary.

LYON: Brandt says support from people in the same situation can normalize your experience. Next, exercise and eat healthy foods. It will make you feel better. Prioritize—let go of the things that are not important. And get organized. It can save you time and worry.

POINTER: I have to pick up this cleaning.

LYON: Christie is pretty good at organization—putting things to do and critical information on her marker board and sharing her experiences with friends.

POINTER: The more you talk, the more adjusted, well-adjusted, you become and I really believe that.

Because when I’m really stressed and I know it, I pick up the phone.

LYON: And she prioritizes. In fact, she waited until February to take her Christmas tree down. It just wasn’t a priority.

POINTER: My daughter said, ‘Mom, what are you going to do? Just dust it every week?’ You know, I thought I’d put hearts on it for Valentine’s Day.

LYON: If you think stress doesn’t have an effect on your body, watch this. It’s called biofeedback. We asked Dr. Brandt to do a test for us. He had Christie imagine the last stressful situation at work, a whopper.

The machines instantly showed there was a lot of electrical activity in the muscle in her forehead. Christie’s heart rate increased and she began to perspire.

DR. MICHAEL BRANDT (ST. LUKE’S MEDICAL CENTER): The machines can be used to learn how to control your body’s reaction to stress, even in life’s most tense moments. And most times, he suggests taking a few deep breaths, which the machine should show has a relaxing effect.

Or say you’re in a meeting, and you feel as if you’re going to explode, push your feet into the ground for ten seconds, release for ten seconds, then do it again. But what about people who say they thrive on stress? Brandt says that attitude comes at an expense to others.

BRANDT: I know some people who intentionally procrastinate so they’re under the gun. And they say that they perform so much better when they’re under the gun. I think there is ultimately a cost to that. I think that there are very few people who can...
work under the gun at a high level of stress and be kind and respectful to others.

POTTER: There’s tons of people working in here that I have to sort out and set up for.

LYON: Christie doesn’t claim to thrive on stress and she doesn’t put things off. In fact, in the forty minutes that we were at her home, she brought the water in, did the dishes, took time for a TV interview, unclogged her laundry chute, then, went off to her daughter’s basketball game.

POTTER: Through the years, things have just fallen into place and taken shape. So, I’m really happy, I have a good life. I’m happy.

LYON: A couple of more tips—avoid alcohol. People under stress are already prone to depression and alcohol is a depressant. And know that you really can’t get rid of some stress. It’s always going to be there, so don’t make that the goal. Instead, just try to manage it.

NEW METHOD STOPS STROKES IN PROGRESS

Milwaukee Journal Sentinel
February 29, 1996
Joe Manning, of the Journal Sentinel staff

No ifs, ands, or buts about it, Richard Schoessow feels he’s very fortunate to be among the first to undergo a new procedure that melted a blood clot in his brain and stopped a stroke dead in its tracks.

But while he was in the throes of a stroke, he could say, “No ifs, ands, or buts about it,” when Arvind Ahuja, a neurosurgeon at St. Luke’s Medical Center, asked him to say it.

Then, while Ahuja administered a drug to dissolve a blood clot that had formed in a vessel in Schoessow’s brain, he asked his patient to repeat the phrase.

As the clot dissipated and blood flow was restored, Schoessow’s ability to pronounce the phrase improved until he was able to say it—with a smile.

Schoessow, 63, was the recipient of an aggressive—though still experimental—treatment in stroke care, in which a clot-dissolving drug called urokinase is squirted directly into the blood via a tiny tube called a catheter threaded into the brain through a blood vessel in the groin.

Ahuja said the procedure shows great promise for stroke victims if it can be done within six hours of the first sign of a brain attack.

In the past nine months, Ahuja has treated 14 patients at St. Luke’s with the procedure.

Nine patients had “significant” improvement following the treatment, Ahuja said. Three improved to a lesser extent and two patients subsequently died despite the treatment . . .

A brain attack occurs when a blood clot forms in, or is carried by, the bloodstream to a vessel in the brain, where it blocks oxygen-rich blood to brain tissue.

Ahuja said the symptoms of stroke can include one-sided numbness or weakness, difficulty speaking, blurred vision, dizziness and severe headache.

Schoessow’s clot developed on an artificial valve in his heart and traveled to his brain while he was at his Wauwatosa home last Tuesday.

“I wasn’t feeling well, so I went into the bedroom to take a nap. When my wife, Joanne, came home, I got up to talk with her, but all that was coming out was garbage. She called the doctor, who told her to get me to the hospital,” he said.

Schoessow said he could think in words, but not speak.

But as a result of the treatment, the retired industrial engineer has suffered no permanent impairment.

Ahuja said the speech areas of Schoessow’s brain were being deprived of oxygen, similar to the brain attack suffered two days earlier by Judy Bruno, 55, of Franklin.

“I was putting on my coat, and I just didn’t feel right and I had to sit down. I could hear people talking but I don’t remember what they were saying. I was scared but I couldn’t talk to express my feelings,” she said.

Her arm was stiff and twisted and her lip was quivering, her husband, Joe, said. Terrified, the family called 911.

Four days later, she walked out of the hospital after the clot-dissolving treatment.
A SECOND HEART IS A SECOND CHANCE AT LIFE

Door County Advocate
March 1, 1996
Keta Steebs, of the Advocate staff

Former Maplewood postmaster Bob Zirbel has had his pre-owned heart only since December 14, but he couldn’t be happier with the trade-in.

“I’ve got the deluxe model,” he smiles, basking in the comfort of his sunny living room. “Whoever had this heart sure took good care of it. All I know about the donor, all I care to know, is that it was a man.”

The donor’s family has already received Zirbel’s heartfelt “thank you” via St. Luke’s Medical Center in Milwaukee — the scene of his December 14 transplant. It’s a hospital, he says, that specializes in the fast-growing transplant business. And he gives it a five-star rating.

“I’ve been there so often I could be a guide,” he says. “I had a defibrillator put in at St. Luke’s in July 1994, after being diagnosed with ventricular tachycardia. What it is is having the electrical impulses in your heart get goofy and run off-course. The defibrillator shocks them back on track.”

Zirbel, a man whose family has no history of heart disease and whose youth was spent logging, fighting a war and working as a shipfitter, seems an unlikely candidate for major heart trouble. His first inkling came in 1983, when, at the age of 35, he became so weak climbing boats he was on the verge of fainting.

At that time, he says, he had been smoking for about 20 years and was a fairly heavy coffee drinker. Both habits were forsworn when his heart started acting up; but abstinence, worthy as it was, didn’t lessen the need for a defibrillator implant. Talking about his early experiences with the machine still makes Zirbel wince.

“I wasn’t as scared dodging bullets in Vietnam as I was with that gizmo inside me,” he says. “I don’t want to frighten anyone off—the controls just needed resetting—but I want to warn people what could happen.”

According to Zirbel, the “gizmo” senses when the heart becomes erratic. It shakes it back to its normal pattern with a “trickle” of current the wearer hardly notices. If the trickle doesn’t work, the sensation is a definite jolt. In Bob’s case there was no trickle. The jolt came first.

“It was like getting kicked in the chest by a horse,” he says. “My machine went off twice in three days, and the symptoms were the same each time. First I felt faint, and then all of a sudden I felt a KABOOM that almost knocked me flat. When you have 750 volts of electricity zapping your body, it’s like getting electrocuted from the inside.”

Zirbel, fortunately, lives in a community with highly skilled paramedics and a hospital equipped to handle emergency situations. After being stabilized for the second time at Door County Memorial Hospital, he was back at St. Luke’s for the needed readjustment. From that time on, his $35,000 sensor worked perfectly.

“I had no further side effects,” he says. “But I was getting weaker right along, and last summer’s hot, humid summer didn’t help. By the time the call came, I had been on the heart transplant waiting list about a year and a half. It usually takes longer, but as long as I had the gizmo to keep me going, I wasn’t too worried.”

The personable Zirbel, whose sense of humor, one suspects, did its part in keeping him going, likens his machine to the black box in an airplane. After being removed, it lets “interrogators” know what happened.

“It tells them everything the machine did, including the time of day a reaction took place,” he laughs. “But for the kind of money it cost, it should open garage doors too. What’s more, I couldn’t even keep it for a souvenir. All defibrillators have to be returned when no longer needed.”

Zirbel’s three-hour surgery went smoothly, and his main concern—having a stroke—proved unfounded. So swift was his recovery, in fact, he was out of the hospital in seven days. While admitting he was one of the quicker guys to leave,” he says today’s recovery time is a far cry from the six to seven weeks it used to take.

He also notes that it is not uncommon for people in the over-60 age group to receive new hearts. The deciding factor, he says, “is being sick enough to need a transplant and well enough to have the rest of your organs in good shape.” Surprisingly, older people do better at fighting rejection than their younger counterparts.

What Zirbel finds even more amazing is that he is one of three men living on one short stretch of road in Maplewood who have had heart transplants in the past decade. When you think of the odds nationwide,
he says, a note of wonder in his voice, it seems almost impossible.

Now retired from the post office, a position he held for the past 10 years, Zirbel is getting back to normal so fast that his good friend Joe Kerscher, as hale and hearty as they come, kiddingly says he wishes he was as healthy. Joe is one of many friends who, despite sometimes dangerous weather conditions, has chauffeured Zirbel to St. Luke’s for appointments.

Others on Zirbel’s arm’s-length list of helpers have helped keep his spirits high by keeping the cards, calls and prayers coming. Wife Judy and children Scott, 17, and Nicole, 16, keep an eagle eye on his welfare at home.

“I can’t thank my family and friends enough,” he says. “But please put in a plug for organ donations. Thanks to improvements in anti-rejection drugs the results are getting better right along, but the need keeps growing.”

The unknown man who signed his donor card is gone—but one gets the feeling that Bob Zirbel is keeping his spirit very much alive.

METAL ‘COIL’ USED TO PREVENT ANEURYSM RUPTURE

Milwaukee Journal Sentinel
December 18, 1995
Joe Manning, of the Journal Sentinel staff

Dangerous bulges in brain blood vessels that can rupture and kill patients are being treated in two Wisconsin hospitals by filling the bulges with thin, metal flexible strands in a delicate, non-surgical procedure.

The platinum alloy strands, not much thicker than a human hair, are threaded into the brain from the groin area, said Arvind Ahuja, a neurosurgeon at St. Luke’s Medical Center.

The procedure is also performed at the University of Wisconsin Hospital and Clinics, Madison.

Filling an aneurysm, which is what the blood vessel bulge is called, depends on its size and can take anywhere from a few inches of the metal strands to several feet, Ahuja said.

About 40,000 people a year are diagnosed in the United States with aneurysms of the brain. Like bulges in the weakened walls of garden hoses, the aneurysms burst in the brains of 28,000 people a year, Ahuja said, causing 10,000 deaths.

Ahuja said the first line of treatment for repair of a balloon-like aneurysm is generally surgery, but in up to 10,000 cases a year surgery cannot be used.

Once the inoperable aneurysm is filled with the strands called coils, the blood pressure inside the aneurysm drops, reducing the risk of rupture. Eventually, tissue grows over the mouth of the aneurysm, closing it off from the bloodstream, Ahuja said.

The treatment, developed in Italy and manufactured by Target Therapeutics of Fremont, California, is called the Guglielmi Detachable Coil (GDC).

“For patients who have inoperable high-risk aneurysms, GDC is the best option for a positive outcome,” Ahuja said.

Ahuja said the coils can prevent a second rupture even after an initial break. In studies of patients with ruptured aneurysms, the GDC-treated patients had a second episode of bleeding in 3 percent of the cases compared with the usual rate of up to 40 percent.

Studies also found that patients treated with the coils had death rates dramatically lower than those who had not been treated—12.8 percent compared to 62 percent, Ahuja said.
LESS DEEP SLEEP IN BADGERLAND

Shepherd Express
January 25, 1996
Scott Kerr

In Milwaukee and southeast Wisconsin, odds are that more people suffer from sleep disorders than the national average.

Here in the land of brandy and bratwurst, folks far outdo the national averages in two ways—obesity and alcohol consumption. Both can directly contribute to sleep disorders like sleep apnea, where breathing briefly stops.

Dr. Michael Katzoff, a pulmonologist and medical director of St. Luke’s Medical Center’s Sleep Disorders Center, says he sees in his practice both the higher body weight and alcohol consumption of Wisconsinites.

“Here in Milwaukee, I see many people with multiple symptoms” of sleep disorders. Katzoff ticks them off: daytime sleepiness; depression; forgetfulness; libido problems; lack of mental clarity; and irritability.

By contrast, when a sleep problem is corrected and a person begins getting a good night’s sleep, they often become what Katzoff calls “a happy camper.” Gone are irritability and hazy thinking, the hazards of dozing off at work or behind the wheel (sleep disorder sufferers are five to seven times more likely to be involved in a car crash), and frequent dependence on antidepressant medication.

Because sleep’s restorative functions take place during deep sleep, the job never quite gets done when rest is disrupted before deep sleep occurs. That happens when the brain is forced to yank the body back into breathing mode during sleep apnea.

How do obesity and overindulging in drink detract from sound sleep? Katzoff explains that heavier people tend to have more fatty tissues in the throat. When relaxed during sleep, they flutter and vibrate (snoring) and can obstruct air intake—to the point of collapse and breathing stoppage. That’s sleep apnea. As for alcohol, drinking not only releases one’s inhibitions, it further relaxes those throat tissues.

We can thank heredity for much of this.

“Persons who have a large tongue or a large neck will be predisposed to sleep apnea. These things tend to run in families, even the tendency toward obesity,” Katzoff notes.

“If a person has a big bull neck, there will be additional throat tissue which will put pressure on the air passage and affect the air flow.” Larger tonsils or a shorter jaw—both inherited traits—similarly affect nighttime airflow, and thus can contribute to sleep apnea.

Weight and alcohol consumption are both important issues, “but we have to be realistic,” Katzoff says. Because only 5 percent of people are able to lose weight and successfully keep it off, Katzoff says that weight loss as a prescription for sleep apnea is not possible for most. As for alcohol, Katzoff says that factor is best evaluated in full context of the sleep disorder, by a physician.

In mild cases, reducing weight and alcohol may help. In more severe cases, a dental device, night-time breathing aide, or surgery might be recommended, Katzoff says.
Gifts received November and December, 1995

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Marge Bobbe and Lee Marki, director of Women’s Healthcare Services, at WINS reception last fall.
“I enclose my check and request that it be used in whatever way it can aid heart patients in attaining the quality of life that I have enjoyed since 1987, when Dr. Schmahl and Dr. Tector performed open heart surgery on me. I will be forever grateful to the people at St. Luke’s who count!”

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"The care and concern of all those who took care of my brother was wonderful. If this small gift will, in any way, help your research, it will be a comfort to our family."

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Enclosed is a check. This is the least I can do for St. Luke's. I'm doing fine and hope to stay that way. Thanks a lot for your help.” —Grateful patient

Norma McCutcheon, R.N., M.B.A., director of cardiac services, addressing the WINS group.

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Since the stents greatly improved the quality of my husband’s life immensely so he could “jitterbug dance”, walk, etc., I will continue to honor our commitment to St. Luke’s. Our everlasting gratitude to Dr. Dorros and all his fine team.”

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“This contribution was an effort for us, but we believe in and have experienced firsthand, the benefits of the knowledge and experience St. Luke’s has. Also, let it be known, you made us feel very good about our contribution. Your letters of acknowledgement made us feel our donations counted.”

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Charitable giving using life income plans may be one of the best kept secrets in philanthropy!

Many people are surprised to learn that they can make a gift that will benefit them during their lifetime and at the same time help their favorite charity. An example of one of those life income plans is a charitable remainder unitrust.

Mr. and Mrs. Smith, both age 70, own a stock which they bought 30 years ago for $10,000 that is now worth $100,000. The current dividend income from the stock is only 2%, or $2,000 annually. Although the Smiths would like more income from their stock, they are reluctant to sell it and reinvest the proceeds in a higher yielding investment because the sale will generate capital gains tax of $25,200 (28% tax rate times the $90,000 appreciation).

As an alternative to holding the stock or selling it outright, the Smiths establish a Charitable Remainder Unitrust benefiting St. Luke’s Medical Center. The Smiths choose a 7% payout rate—they will receive 7% of the fair market value of the assets in the unitrust each year. The unitrust lets the Smiths benefit from any growth in the value of the trust assets, acting as a hedge against inflation. A unitrust also allows for additional contributions in later years.

The Smiths will realize the following benefits as a result of their unitrust gift:

- an increase in annual income from $2,000 to $7,000 (this income may increase in subsequent years as the value of the trust grows)
- capital gains tax savings of $25,200
- a charitable income tax deduction of $32,500, saving them approximately $9,100 in income tax in a 28% tax bracket (deductions may be carried over to subsequent years)
- a significant gift to St. Luke’s upon the death of the survivor of the Smiths, which they choose to direct to the Cardiovascular Research Fund, an area of particular interest to the Smiths

(Note: these benefits may differ based upon your personal situation.)

If the Smiths desire, there is also a way to replace the value of the stock in their estate so the same amount can also go to their heirs.

Please contact Kelly Sachse, CFP, director of planned giving at St. Luke’s, at 649-7008 if you are interested in learning more about how a charitable trust or other life income plans could provide you with income for life, while allowing you to touch other people’s lives at St. Luke’s through your philanthropy.

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ADDRESS CORRECTION REQUESTED