

VINCENT'S RESOLUTIONARY SENSE

The book has been closed on 2016. Resolutions have been made, which surely some are already failing. As we look ahead, it is always wise to peer into the looking glass of time past for us to focus on improvement. A glance back to the [January 2013](#) Issue of the Links may be worth a peek, just to see the progress we have made.

For the January 2017 issue, Erin Wells reminds us of those precious moments that can go by in a flash if we don't pause and try to suspend time for our memory. The goal is seizing such opportunities, especially those that might bring us everything we ever wanted, and even if we have just one shot. But there are those difficult and stressful moments we do not want to recall or face, instead preferring to just let them slip away. Therefore, we just might want to lose ourselves in the music. Umm, I wonder [where I got these thoughts from](#)? Such thoughts are conjured up by Monica Horn and Leah Cruz on the Fine Art of Music Theory for our patients, particularly the pediatric population. Then Rebecca Lewis shares with us the unrivaled importance of time, dedication and devotion to help a nurse capture their opportunity in becoming a master VAD coordinator in her article on Ventricular Assist Device Mentorships, while Linda Staley gives us the supremely important Paradigm Shift: End-of-Life Care with Destination Therapy LVAD. Tara Bolden, Susan Chernenko and Nikki Marks provide us some unrivaled insights on Nurse Practitioners and Patients with Prolonged Lung Transplant Hospitalizations. Of special interest, we have Stephanie Pouch's Patient Safety Alert – Report of Contaminated Organ Preservation Solution. And finally, from the Editor's Corner, there is the refulgent reflection by the inimitable Allan Glanville on How Do We Care?

Happy New Year!

IN THE SPOTLIGHT: Moments in Time

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"Time has a wonderful way of showing us what really matters" – Margaret Peters

I have been trying to think of a way to tie in an out with the old, in with the new theme for this article without it being a little too over the top or cheesy. Last week, this popped up on my Facebook feed:

My entire life can be summed up in one sentence "...well that didn't go as planned."

I reposted and added I wouldn't have it any other way. The last 11 years have been a roller coaster to say the least. 7 moves, 6 jobs in 6 states, several significant family losses, 3 transplant centers, 2 fur babies and 1 husband later I never would have mapped out this path for my life. Truth be told, if there had been a category in our senior year book for most likely to never leave Louisiana, I would have taken that prize easily. This also explains why I have always felt "where do you see yourself in 5 years" is an awful interview question.

I imagine the "this didn't go as planned" sentiment rings quite true for our patients and families as well. Most never could have imagined this is where their path would lead, but face the journey with equal parts grace and grit. Time is often measured in transplant anniversaries and a countdown clock forever linked to those looming survival statistics we share the first time they see us. They learn to treasure every precious moment in a way most of us can only aspire to.

I have very clear memories of my grandmother telling me time goes by faster and faster the older you get. The older I get, the more I realize she wasn't really speaking about hours or minutes, but moments in time. The ones that tend to come so softly, so quietly, and in the blink of an eye are gone. It's not that time is getting shorter; our lives just keep getting busier. This is why no matter how much time we get with our loved ones, 10 years or 65 or 90, it's never enough. It's not more time we want, but more of those precious moments in time.

As I recently shared with someone, I sometimes feel like my days are one giant Outlook calendar reminder after the next. To that end, my resolution for 2017 is to grab every moment and be present amidst the meetings, the deadlines and the to-do lists. After all, it is the number one piece of advice I have given my patients over the years.

Disclosure statement: The author has no conflicts of interest to disclose.

The Fine Art of Music Therapy

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It has been said that music may be thought of as a universal language for expressing thoughts or feelings. As an escape, to perhaps "lose yourself in the music" there's a lift above the clouds to seize it all. Many of us find solace in listening to our favorite selections while going to and from work to help inspire anticipated management of daily interactions or to cope with stress accumulated by the end of the day. Of course, when we arrive to work or home from work, gravity "snaps us back to reality."

What if we could help sick children and their families cope with illness and hospitalization through music? Historically, therapeutic use of music has been documented for rehabilitative purposes back to Orpheus and the Ancient Greeks over 2500 years ago. Patients with medical conditions including pain syndromes, neurological disorders, childhood illness-related developmental delays, psychiatric conditions or anxiety states, memory problems and communication deficits have benefited greatly from music therapy. Children who have severe heart failure awaiting heart transplantation in a hospital setting are particularly vulnerable to having acquired these conditions as well.

What is Music Therapy?

According to the American Music Therapy Association (www.musictherapy.org), "Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music Therapy is an established health profession in which music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals. After assessing the strengths and needs of each client, the qualified music therapist provides the indicated treatment including creating, singing, moving to, and/or listening to music. Through musical involvement in the therapeutic context, clients' abilities are strengthened and transferred to other areas of their lives. Music therapy also provides avenues for communication that can be helpful to those who find it difficult to express themselves in words. Research in music therapy supports its effectiveness in many areas such as: overall physical rehabilitation and facilitating movement, increasing people's motivation to become engaged in their treatment, providing emotional support for clients and their families, and providing an outlet for expression of feelings."

Hospital Program Example

Children's Hospital Los Angeles has the Mark Taper and Johnny Mercer Artists Program which offers Expressive Arts Therapies. The team consists of trained and certified Art Therapists, a Dance/Movement Therapist, and Music Therapists. Music Therapy, Art Therapy, and

Dance/Movement Therapy can be offered to all patients at Children's Hospital Los Angeles. Medical professionals who have access to the patient's chart can place a referral to request any of these therapies for their patients just as they would order medications. The Expressive Arts Therapies team does their best to assess the patient within 72 hours of receiving the referral. The department is also under the Family Centered Care Support Services umbrella, which means we not only support the patient but we also provide services for the whole family.

Along with providing benefits to a wide variety of diagnoses, as stated above, music therapy can also be used with patients of all ages. Specially trained NICCU Music Therapists see premature babies as young as 24 weeks gestational period to assist with decrease in agitation, appropriate sensory stimulation, and teaching families how best to interact with their babies at this stage. The team provides services to all ages from infant to toddler, school age, teen and even young adults in their early 20s who have been coming to Children's Hospital Los Angeles for ongoing treatment.

Real Life Cases

Music therapy has seemed to greatly benefit children of all ages. Infants and toddlers who have severe heart failure awaiting heart transplant are often agitated, irritable, and alone at times due to the often long term hospitalization. For these patients, our music therapy sessions focus on helping decrease their agitation, promote appropriate socialization, and introduce developmentally appropriate stimuli through the use of musical interventions.

Through live vocal and rhythmic cues, sleep is promoted after dressing changes and other common bedside procedures, which can be difficult for very young patients. Though it may look like we are just singing to these patients there is so much more. Music Therapists pay attention to facial affect and body language, vital signs, the current environment and how it may affect the baby as a whole. Music Therapists are trained to understand the appropriate tempo and volume that is best for their developmental stage. In these moments music therapists are able to build rapport with the patient to help normalize the hospital environment and decrease the patients' fear of staff, which is common in the pediatric setting.

Pre-school/school age patients tend to be more active and more physically engaged than the infants and toddlers. This music therapy focus would be on providing autonomy and socialization, encouraging emotion identification and emotional self-expression, as well as reaching developmental milestones and encouraging family bonding if family is present. These patients should engage through music therapy interventions involving musical stories and musical play to encourage expression of thoughts and feelings about hospitalization. For example, one patient's favorite song was Disney's *Tangled* song "When Will My Life Begin." The song is sung by Rapunzel who is trapped in a castle and is singing about all the things she does in a day while stuck in her castle. This patient connected her hospitalization to being like Rapunzel in this castle through connecting with the metaphor. She was able to use music to help externalize her thoughts and feelings regarding hospitalization even when not directly asked. Continued music therapy sessions with this patient led to the patient creating songs about her own hospitalization, waiting for her heart, and her future hopes for after her discharge from the hospital.

Sometimes we have the pleasure of working with the family who are present with the patient. It is beneficial to encourage positive family engagement with the patient to help promote family cohesion, open communication amongst family members, and an opportunity to bond with each other in a new and different way. Families can write songs to one another, or write a song together about what they are going through or what their hopes are for the rest of their hospitalization. Families may engage in music making which can involve playing instruments or singing together. This promotes open communication through listening to each other musically and reflecting upon the music together, decreases stress for the patient and families through active music making as a release, and encourages family bonding as a whole.

Perhaps one of the most memorable experiences recalled was with a patient who was with a teenager who was awaiting a heart transplant. The music therapist met her the week after she got her VAD. During the initial meeting and assessment session she was able to talk about her hospital journey so far and put it into a song. This music therapy intervention helped encourage externalization of her feelings and provided a safe space for processing her feelings about her past experiences in the hospital, her new VAD, and the unknown road ahead. She was able to share her knowledge of the VAD and the process of awaiting a heart transplant which reinforced her acceptance of her situation and helped validate any feelings she had.

Another music therapy intervention used with her involved asking her what song would describe how she is felt that particular day. On one of her tougher days in the hospital she was able to share a pop song that described how she felt about the medical staff. She was not able to say how she felt before the song, but after listening to the song she was more open to sharing what she thought and felt. Music provided her with an emotional outlet and gateway to help externalize her feelings.

At the end of her hospitalization and after she got her heart and recovered, she met the therapist with a smile and was excited to share songs she had written on her own time about what she was feeling. Music therapy sessions introduced her to a healthy coping mechanism she could continue to use during and after her hospitalization.

Reflections

Every December for the last six years, the ISHLT Links Newsletter has exposed us to some Great Master Composers: [Dvorak](#), [Beethoven](#), [Mozart](#), [Berlioz](#), [Tchaikovsky](#) and [Mahler](#) - to broaden our armamentarium for our patients and ourselves with our expanded horizon of classical music. It was Hans Christian Andersen who penned, "Where words fail, music speaks." Henry Wadsworth Longfellow asserted, "Music is the universal language of mankind." Whether comfort, consolation, expression or just plain entertainment: **life without music really would B!**

Disclosure statement: The authors have no conflicts of interest to disclose.

Ventricular Assist Device Mentorships

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Mentoring is a crucial step in a new nurse becoming a competent nurse. It takes months to learn the many tasks and processes within a hospital, much less master them. The mentoring process nurtures the nurse during a crucial time, establishing habits that could extend through the nurses career. This highly sensitive time is crucial in developing successful nurses! It is no different as a ventricular assist device (VAD) coordinator.

Whether a coordinator has moved from the bedside or another type of role, the transition to becoming a VAD coordinator takes time and patience to master the multitude of skills required. One must learn how to manage the patients on device and the devices themselves, how to triage call, the intricacies of program management such as a staff education and regulatory requirements, how to manage emergencies in the community, how to run clinic, manage patients in a myriad of non-cardiac procedures, etc. The VAD coordinator role description demands fluidity as the challenges that present to programs and patients are continually changing.

There are many challenges a VAD coordinator faces on a day to day basis, so how can one master all necessary skills and foster the transition from novice to expert? Aside from the months of training into one's particular program, finding a mentor within the larger mechanical circulatory support (MCS) community can be hugely beneficial in providing new insights, broadening perspective, and learning new and valuable skills.

There are mentorship opportunities through ISHLT [1]. In addition, the International Consortium of Circulatory Assist Clinicians (ICCAC) [2] offers a VAD coordinator mentorship. Mentors can offer recommendations on literature to read, perspectives on how a different program is run, answer questions one may have, and offer resources for getting more involved in the MCS community.

It is never too late to learn something new as a VAD coordinator. Become a mentor or mentee today!

Disclosure statement: The author has no conflicts of interest to disclose.

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Paradigm Shift: End-of-Life Care with a Destination Therapy LVAD

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How does one handle end-of-life care with a Destination Therapy (DT) LVAD? Should it begin during the selection process, prior to advanced therapies being started or performed? How does the LVAD team ensure that the quality of life of the patient and family goals are realistic and being met? When is the right time and place to engage the hospice team for end-of-life care in a DT LVAD so that the patient and family are availed of the most support from the service? How do these questions get answered within your DT LVAD program and among your interdisciplinary team?

In 2014, the Joint Commission recognized the importance of the palliative care team as part of the VAD interdisciplinary team. The Joint Commission required program leaders to integrate the palliative care team within the program's core LVAD team. Incorporating the palliative care team within the VAD programs has resulted in enhanced support for the patient and family throughout the progression of life while on LVAD support. As technology continues to advance regarding mechanical support, and patients are living longer with advanced therapies to manage end-stage heart failure, it is crucial to have the palliative care team involved with the DT LVAD programs.

The palliative care team members can consult with patients and families prior to implant of the DT LVAD, promoting open discussions regarding the goals of LVAD patient care, and what quality of life means to the patient and family. This collaboration can help patients and families cope during the major decision-making process regarding the implant of the DT LVAD. The palliative care team also assists the patient and family in managing the quality-of-life issues associated with an advanced disease such as end-stage heart failure, and use of advanced therapies with DT LVAD.

The palliative care team integration with the core VAD team has provided patients and families a comprehensive assessment and treatment of the physical, psychosocial, and spiritual aspects of patient care prior to a DT LVAD being implanted. This teamwork continues throughout the progression of life while the patient is on the DT LVAD until end-of-life care is required. The development of a positive patient-and-caregiver relationship between the DT LVAD patient and the palliative care team over the years while a patient is on support can enhance the transition to end-of-life care when hospice services are required.

I have been an NP VAD Coordinator for more than 10 years in a busy Tertiary Care Transplant/VAD program in the Southwestern USA. In the beginning of our program, end-of-life care with an LVAD typically occurred in the hospital ICU setting. Consultation with our palliative hospice team for end-of-life care too often occurred only within the patient's last 24-48 hours of life. We also did not

have many options available to individualize the end-of-life care for a patient with an LVAD to meet the patient and family goals and needs.

As a NP VAD Coordinator, I have seen a paradigm shift in the last 2-3 years regarding end-of-life care and the DT LVAD patient. The integration of the palliative care team within the interdisciplinary VAD team has allowed end-of-life care to be individualized, and to meet the needs of the patients and families with the DT LVAD. These conversations are occurring earlier and often prior to LVAD complications, progression of aging complications, or worsening heart failure occurring while on LVAD support. I have seen more VAD patients and families choose end-of-life care to be at home, with hospice assistance, and have observed these services being offered and started earlier. This shift may help to reduce the caregiver stress, burden, and burnout resulting from the challenges of end-of-life care.

It truly takes an interdisciplinary team to care for the DT LVAD patient and family, and to provide compassionate end-of-life care. I would like to leave you with the following questions -- "How is the palliative care team used within your LVAD program, and have you seen a paradigm shift regarding end-of-life care with an LVAD?"

Disclosure statement: The author has no conflicts of interest to disclose.

Nurse Practitioners and Patients with Prolonged Lung Transplant Hospitalizations

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We all know that the patient with a ten-day post-lung transplant hospital stay is nearing extinction. We sometimes refer to patients with rare conditions as Zebras, however, patients with short stays after lung transplant are now unicorns! All kidding aside, it is a reality that patients' length of stays is becoming increasingly long and more complex. There are a variety of reasons for this, mostly resulting from the success of lung transplantation, and in our program, successful experience with recipients with complex medical issues. Many of our patients are older, have multiple comorbidities, and often have survived the use of life-sustaining treatments like ECLS either as a bridge to transplant, or bridge to recovery. For our patients, this results in what Frank calls "deep illness" (Frank, 1998), a state of illness that is "perceived as lasting, as affecting virtually all life choices and decisions, and as altering identity" (p. 197). This state of being results in significant physical compromise, and can also cause significant financial hardship, emotional stress and negative physical and psychological reactions for caregivers as well.

As Nurse Practitioners (NPs) in the Toronto Lung Transplant Program, we have developed expertise in helping patients and caregivers navigate "deep illness", all the while ensuring consistency in their complex medical care by working as members of a large interdisciplinary team. We help care for over 140 newly transplant recipients per year, and those who are re-admitted with complications in their post-transplant life. The NP role is well suited as part of an interdisciplinary transplant team as NP practice is grounded in nursing theory that emphasizes the development of the nurse-patient relationship over time. With extensive education and training in acute and long term complications of transplantation we are an embedded part of the interdisciplinary team that provides hands-on care for recipients.

As a result of complex care requirements, our practice combines both independent and collaborative practice. We maintain strong collaborative relationships with experts in associated fields in order to manage complications such as infection and rejection, as well as cardiac, neurologic, psychiatric or any other condition a patient may experience. We have strong professional relationships with key members of the interprofessional team and consult and liaise with medicine, pharmacy, physiotherapy, occupational therapy, speech language pathology, social work, spiritual care, and psychiatry to provide optimal care to our patients. At weekly interprofessional rounds, we find creative solutions to some very challenging patient issues

whether it is further optimizing recovery, meeting unconventional patient and family wishes, or simply determining discharge disposition.

Patients and caregivers often experience overwhelming helplessness with so many experts involved in their care, especially during a long recovery. Having a consistent health provider as they recover from a lung transplant assures safe, high quality care as well as psychological reassurance. An important aspect of the NP role is the development of a nurse-patient relationship with patients and their caregivers. We try to maintain consistency in assignment to develop a trusting therapeutic relationship, as well as creating the opportunity for long-term planning and identification of health behavior patterns that may potentially result in future health issues.

As the post-transplant course ebbs and flows, sometimes in health, and sometimes in illness, the NP's relationship with patient and family can help in improving clinical care and outcomes. This continuity of care is not only highly valuable from a clinical perspective, it also provides the framework for a supportive structure for the patient and caregivers. Undergoing a highly-specialized procedure such as lung transplant can create intense levels of stress and anxiety. Having one identified health care provider, such as an NP to turn to throughout their complex clinical course can ease the patient's and support person's anxiety. The close partnership may also be effective in identifying and helping caregivers with higher than usual levels of caregiver stress or burnout.

As the patient's condition improves, goal setting with the family and the interdisciplinary team occurs. Often, the NPs clinical expertise is required to negotiate and plan the discharge disposition. Although our goal is to discharge home, sometimes an alternative end disposition location is required. In these situations, the strength in our position lies in the longitudinal nature of our knowledge and relationship with our patients and their caregivers, our expert knowledge of the healthcare system, and our close working ties to the interprofessional team. The best compromise for end disposition means having excellent communication amongst the various disciplines and other health care providers internally, as well as with those from other organizations. Excellent communication allows for seamless transition to rehabilitation hospitals, home or other institutions. After discharge or transfer, we continue to be involved through out-patient management of labs, medications and during clinic visits.

Ultimately, as technology evolves and we are able to provide lung transplantation to recipients who are older and have more complex medical issues, it is important that we strategize how to best provide ongoing care and support to patients and their caregivers. NPs are ideally suited health care professionals to help guide recipients and their caregivers through "deep illness" into their new health reality after lung transplantation. As part of the Toronto Lung transplant program, we feel fortunate to be part of a transplant program that is known for innovative and compassionate care, and that we can work with so many excellent colleagues from every discipline to help our sickest patients through their post-transplant course.

Disclosure statement: The authors have no conflicts of interest to disclose.

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Patient Safety Alert – Report of Contaminated Organ Preservation Solution

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The Centers for Disease Control (CDC), Healthcare Resources and Services Administration (HRSA), Food and Drug Administration (FDA), and the Iowa Department of Public Health (IDPH) are actively investigating a report of bacterial contamination of the organ preservation solution, SPS-1, produced by Organ Recovery Systems (ORS). On December 12, 2016, surgeons observed a foul odor emanating from the organ preservation solution. The CDC and IDPH were notified on December 14, 2016, and samples of SPS-1 from several opened bags grew *Pantoea agglomerans*, *Enterococcus casseliflavus*, and *Streptococcus mitis/oralis* group. The bags with microbial growth were reported from two lots of SPS-1, PBR-0074-330 (expiration 07/01/2018) and PBR-0060-392 (expiration 06/01/2018), and ORS has recalled both lots. All organ procurement organizations (OPOs) and transplant centers need to be aware of the potentially contaminated solution. SPS-1 from the aforementioned lots should not be utilized, and centers have been instructed to recover and return any unused product to ORS.

At present, there have been no known adverse events among patients who received organs treated with the affected SPS-1 lots; however, such patients require close monitoring. Any quality issues or post-transplant adverse events must be reported to local or state health authorities and the FDA's Adverse Event Reporting Program (www.fda.gov), and the Organ Procurement and Transplantation Network (reports may be filed under the Disease Transmissions section of the Improving Patient Safety portal in UNet).

The impact of contaminated organ preservation solution is not entirely clear. However, previous studies suggest that contamination rates range from 27.9% to 38.7% and that infection due to preservation solution contaminants is rare, likely due to the use of perioperative antimicrobial prophylaxis [1-3]. Nonetheless, a malodorous product labelled as sterile must be considered microbiologically contaminated. As illustrated in the current alert, this must trigger an abundance of caution and prompt microbiological testing, evaluation for the mechanism of contamination, close clinical monitoring, and rapid reporting to the appropriate agencies, the manufacturer, and other OPOs and transplant centers.

Disclosure statement: The author has no conflicts of interest to disclose.

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EDITOR'S CORNER: How Do We Care?

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As the old year fades into our memory banks and the New Year begins, it is appropriate to reflect. Do we care and specifically how do we care? How do we care for our sick patients, those being worked up for listing for transplantation, those needing assist devices, those on the active waiting list for whom the bell might toll, those who are struggling with the failure of transplantation to meet their ideals and aspirations, those who have achieved a better quality and duration of life from transplant but fear that their graft might be failing and the broader family of loved ones who sit patiently and quietly (well not always quietly!) as we pontificate about diagnostic investigations, progress and potentially beneficial therapies, all of which come with side effects that are sometimes worse than the underlying condition itself. In large units that are well resourced the thoracic surgeon and pulmonologist do not stand alone. They are flanked by a veritable army of nursing healthcare scientists and allied health clinicians who provide the majority of care and often know more about the day to day thoughts, feelings and activities of their patients than the medical practitioner. This army has its own generals, its own brigades, is populated by clinical nurse consultants, clinical nurse specialists, the all-important lung transplant coordinators and those who work with the physical therapies, our physiotherapists, occupational therapists, our speech therapists and importantly our social workers and psychologists who attend to areas, the importance of which we sometimes underplay. It is these warriors who are the frontline troops who deal with the pain, the anxiety and the suffering of our transplant patients at all phases of their patient care journey. They are often most acutely aware of the stress and anxiety of patients who are on the waiting list and patients who see their graft function slowly slipping away.

It is wrong to generalize. Not all surgeons and pulmonologists are divorced and disenfranchised from their patients. Some swing to the other extreme and over identify, usually with individuals with particular problems. In the extreme form, this can be seen as indulging a rescue fantasy but one must not forget the Lazarus syndrome, where to the amazement of all, a patient recovers when all wise counsel had concluded that death was likely if not imminent. The flow on effect of over identification is similar to the phenomenon that occurs in families when there is one very sick child. Occasionally, despite best efforts, the other children do not receive the care and attention they deserve. Perhaps they grow with a greater sense of independence or perhaps they grow with a sense of loss and what determines the outcome is an imponderable. So it is with the majority of our patients, as we tend to focus our care both at a clinician and allied health level on the sickest subset. That may be right and appropriate but spreading stretched resources to adequately cover all patients under our care can sometimes be quite challenging.

So, how do we support the carers? Not specifically the direct carer of the patient, who is usually a close family member, spouse or loved one but those who provide professional care, the nurses and allied health clinicians? The first step is recognition. Recognition that the work that they do is often

intangible and deals with emotions and feelings. As a direct result of which, it may have a negative impact hence there is a large burn out factor for all in the caring professions. Realizing the potential negative impact is a second and perhaps the most critical step of caring for the carer. That means practical support by having sufficient staff and rosters that are not punitive. We must also provide down time and collegial support. The worker who is alone with a troubled patient, who is sharing their pain, and who has no one else to whom to turn, becomes isolated, dysfunctional and non-productive. Our duty of care is not just to our patients but to those who care for our patients, and one could add, ultimately to ourselves. While many of these strategies need significant resources, perhaps the greatest resource is the culture and personality of those who work in these wonderful teams. Each must feel at the same time capable of providing high level care in difficult situations but also supported to do so in the full knowledge that they are well appreciated and have colleagues who understand their role, their concerns, their limitations and the difficulties of dealing with the gulf between hope, expectation and reality.

All of these issues are brought into sharp relief when a patient dies or is about to die. The job continues. There will always be more direct patient care needs but it is the interface with the grieving family which tests the equanimity, professionalism and confidence of our duties and our roles as healthcare practitioners. While we can understand anger, disappointment and loss at an objective level, the confrontation with a grieving spouse or parent, in particular, often stimulates a kaleidoscope of emotions that ultimately ask us to reflect on the adequacy of our decisions, our diagnostic pathways, our management protocols and our commitment to communication with the relatives and the families of our patients. This is where our nurses and our allied health clinicians often are more aware of the feelings and emotions of the family, so we should, as managers, listen intently and humbly and take on board the knowledge and experience they have gained during their relationship with the patient. Insights and opinions are often revealed in casual conversations rather than formal interviews and perhaps this is where patients and relatives feel more comfortable discussing issues that are ultimately very important, with the healthcare team, particularly if they feel the issues will not be appreciated by their surgeon or pulmonologist. The overriding principle here is to value each important link in the chain of healthcare we provide to our transplant recipients at every step of their journey and to value the team that provides that. If we start with that perspective, every member of the team will feel valued and their pain, suffering and loss will be supported by the team. No team member should ever feel disenfranchised from the team. No patient or relative should ever feel that they cannot come to any member of the team to share their feelings and concerns. When functioning well, the team is infinitely greater than the sum of its members.

So to answer the question, do we care and how do we care, is complex but it is naive to say some do and some don't, some do it well and some don't do it well. Our job is to ensure that all do it well, all the time. Also, it is critical that the team is a healthy organism, vital and productive, able to anticipate emotional stress, anxiety, pain, suffering and loss and to deal with those with understanding and compassion. We owe our patients and our team members nothing less.

I trust the year to come brings exciting challenges, new horizons, internal peace and a quiet confidence in individual ability and team ability to provide excellence in service delivery to our most wonderful clientele.

Disclosure statement: The author has no conflicts of interest to disclose.