

## Newsletter Themes Year 2000

The editorial staff is soliciting newsletter articles with the following themes for the upcoming year:

### THEME: Managing Information Overload / Simplifying External Tasks

Publication Date: April 15, 2000      Submission Deadline: March 1, 2000

### THEME: Skills & Tools for Applying Quality Improvement Processes

Publication Date: August 15, 2000      Submission Deadline: July 1, 2000

### THEME: Tricks, Gizmo's & Gadgets for Patient Education

Publication Date: December 15, 2000      Submission Deadline: November 1, 2000

If you would like to contribute a 250-500 word article to Progress Notes, please submit your article (attach as .doc (MS Word file) or .wpd (Word Perfect file) via Email to [spoulin@vgernet.net](mailto:spoulin@vgernet.net) by the submission date. If you do not have access to electronic mail, send a disk to: **Berkshire AHEC, 60 Charles St., Pittsfield, MA, 01201.**

***We also welcome your announcements, suggestions, and stories.***

# Progress Notes

A Newsletter of the Massachusetts Chronic Disease Improvement Network (MCDIN)

Volume 3, No. 3

December 1999

## From the Editors

We have two exciting announcements for you in this issue of Progress Notes - our new name and the opening of our web site. As you may have noticed from the masthead, we have dropped the cumbersome and separate acronyms MAIN (Massachusetts Asthma Improvement Network) and DQIN (Diabetes Quality Improvement Network), in favor of a single name that better reflects our goals and purpose - the Massachusetts Chronic Disease Improvement Network (MCDIN). We realized the need for a change following conversations during the past few months with program participants, professional colleagues in public and private health care settings, Network members, funders, and our Advisory Board. What we have learned is that people are reading the newsletter, attending our educational programs, and are interested in what the Network is doing, but they wanted something more. Enter MCDIN. This new name underscores our broader chronic disease focus as well as a commitment to providing our members with the best information on evidence-based medicine, quality improvement techniques, and chronic illness. In the coming year, we will maintain a strong focus on asthma and diabetes through articles in Progress Notes and web pages specifically targeted to each. We continue to welcome your ideas, suggestions, and input and encourage you to contact us. Emails can be sent to Sue Poulin at [spoulin@vgernet.net](mailto:spoulin@vgernet.net).



Massachusetts Chronic Disease Improvement Network

*"sharing approaches...improving lives"*

## Practicing Culturally Sensitive Pediatrics

Lee M. Pachter, DO, Director of the Pediatric Asthma Clinic, Saint Francis Hospital and Medical Center, Hartford, CT

Excerpted from: Practicing Culturally Sensitive Pediatrics, (Contemporary Pediatrics, Vol. 14, No. 9, 1997).

Culturally sensitive health care is just what it sounds like. Such care respects the beliefs, attitudes, and cultural lifestyles of patients. It acknowledges that concepts of health and illness are influenced by patient's ethnic values, religious beliefs, linguistic considerations, and cultural orientation. It accepts that the patient's perspective on the meaning of illness is an important clinical concern, in addition to the physiologic aspects of the disease.

Culturally sensitive health care also acknowledges variations in beliefs and practices within a group. Rather than stereotyping individuals based on their cultural or ethnic affiliations, physicians should be aware of specific beliefs, values, and behaviors common in a group.

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## A Model for Cultural Competency in Health Care

Glenn Flores, MD, Assistant Professor of Pediatrics & Public Health, Boston University Schools of Medicine & Public Health

Cultural competency is defined as the recognition of and appropriate response to key cultural features that affect clinical care. Since understanding cultural norms and values clearly affect the quality and effectiveness of the clinician-patient encounter, it is very important for the provider to be knowledgeable about, and sensitive to culturally significant determinants. The information provided below was developed by Glenn Flores, MD, and offers a tool that can be used in a variety of clinical settings regardless of the patient's ethnicity.

- 1) Normative Cultural Values
  - Identify those values which affect care
  - Accommodate for them in the clinical encounter

The clinician needs to be familiar with normative cultural values that may affect the health care of ethnic groups commonly encountered in his/her practice. This can be

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Massachusetts Chronic Disease Improvement Network

# MCDIN

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## Practicing (continued from page 1)

There is also as much diversity within groups as between them. Culture is like a painter's palette which offers a variety of colors among which each person can choose to paint his or her own health beliefs portrait.

Physicians constitute a specific cultural group because of the education and training that shaped their beliefs, values, experiences, and practices. Thus every doctor-patient encounter can be considered a cross-cultural experience between the culture of medicine and the culture of the patient. This issue is extremely important when working with patients whose ethnocultural background is different from the doctor's own. As the cultural distance between individuals increases so does the chance for miscommunication.

Cultural beliefs and values affect health care, including how a person conceptualizes illness. People construct an explanatory model for their illness based on their beliefs about its cause, signs and symptoms, and physiological effects, and treatment. This model has much to do with the beliefs, values, and attitudes of the cultural group to which the patient belongs (ethnomedical interpretation), as it does biology and pathophysiology (biomedical interpretation). According to Pachter, a patient's explanatory model for the illness is never entirely ethnomedical or biomedical, but lies somewhere along the continuum of the two viewpoints.

In Dr. Pachter's asthma clinic which serves Puerto Rican children, parents/patients combine folk and biomedical beliefs and practices into a personal approach to illness. He recalled a case concerning Sammy, a 6-year-old Puerto Rican child who was brought into the clinic because of frequent asthma attacks. A health beliefs inventory was taken in order to understand the parent's/patient's explanatory model for the illness. Sammy's mother told Dr. Pachter that her son's asthma worsens when he is exposed to drafts and cold weather, when he overexerts himself, and when he experiences strong emotions. Pachter asked the mother what happens inside the body during an asthma episode. She explained that the breathing tubes go into spasm and become "clogged with mucus." When Sammy experiences *un ataque de asma*, she treats him with *siete jarabes* (a combination of sweet almond, castor oil, wild cherry, licorice, tolu, colcillana, and honey), which she purchased at a *botanica*.

If Sammy's asthma did not improve within an hour, she administered an albuterol treatment. If the aerosol treatment was ineffective, she called the doctor.

How should a clinician react to this particular treatment plan? Dr. Pachter would begin on a positive note by commending the mother for recognizing the attack and intervening promptly. As long as the clinician knows that the syrup contained no harmful ingredients, a bridge can be built between the folk remedy and conventional medical

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## Latest... (continued from page 8)

aged. A final revision of the standards will reflect comments received. Part II of the report discusses the information and research needed to relate the standards to outcomes, and identifies key research areas and questions.

A summary of the recommended standards can be viewed and downloaded at [www.diversity.com](http://www.diversity.com). Please feel free to share the report or information about the website with your colleagues. For more information about the project, contact Julia Puebla-Fortier at Resources for Cross Cultural Health Care at (301) 588-6051 or via Email at [rcchc@aol.com](mailto:rcchc@aol.com).

## Notes

MCDIN is starting a year-long program on practice management in pediatric asthma for primary care practices in Massachusetts. This series, modeled on the successful **Institute for Healthcare Improvement Breakthrough Series**, is scheduled to begin in May 2000 and will be made available at a modest cost. Please call Joanna Ezinga at Berkshire Area Health Education Center at 413-447-2417 for more information about this and other training programs sponsored by MCDIN.

*The Spirit Catches You and You Fall Down*, by Anne Fadiman, is a fascinating new book about a Hmong child with epilepsy.

### Cultural Competence Resources

Web Sites For:

- Foundations for Better Health Care - [www.fbhc.com](http://www.fbhc.com)
- Georgetown University's National Cultural Competence Center - [www.cultural@gunet.georgetown.edu](mailto:www.cultural@gunet.georgetown.edu)
- Diversity Rx - [www.diversity.com](http://www.diversity.com)

## Dates and Locations of Upcoming Interpreter Trainings in the Area

Location	Contact	Telephone / Dates
Central Mass	Nancy Esparza	508-756-6676 / Date TBA
Pioneer Valley	Arela Bethel	413-787-6756 / Date TBA
Merrimack Valley	Pat Mirisola	978-685-4840 / Date TBA
Boston	Michelle Urbano	617-534-5258 / Feb. 15-28 Boston
Berkshire County	Gay Plungas	413-447-2417 / April 28-29 Gt. Barrington & May 12-13 Pittsfield

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## Practicing (continued from page 2)

therapy. Pachter tells mom that the syrup would be more effective if it is followed with an albuterol treatment immediately. Dr. Pachter approved the folk remedy that Sammy's mom strongly believes in and simultaneously encouraged prompt medical intervention. Everybody is a winner in this situation.

Many physicians do not ask about non-medical therapies for fear of making the patient uncomfortable with these issues. Pachter is successful in eliciting this information by asking his patients a series of questions which are listed in the table to the right. Many of the home and folk therapies the Puerto Rican community uses for asthma have no known bronchodilating or anti-inflammatory effects. So, why do they continue to be passed from one generation to the next?

As mentioned earlier, many Puerto Ricans believe that during an asthma exacerbation the lungs are "clogged with mucus." Many of the folk remedies used for asthma have expectorant, cathartic, purgative, or mild emetic effects and are believed to "get the mucus out of the body." These remedies are not used randomly or idiosyncratically, but are consistent with the patient's belief system.

Even when an agent is potentially harmful or unsafe for a child, you can work with the parent's beliefs not against them by replacing or altering one culturally acceptable treatment with another. One asthma remedy includes witch hazel which contains 14% alcohol. The risk of alcohol toxicity can be reduced by recommending only a capful of witch hazel or replacing it with eucalyptus tea or another ingredient the patient accepts as equally effective.

In the rush to provide quality care to large numbers of patients, history is taking a short cut. We only gather the information we need for a biomedical diagnosis and treatment plan. This approach misses the nuances of the patient's story and can make the difference between a successful and unsuccessful patient encounter. Pachter's model for care is also helpful when working with European-American families as it is with ethnic minority families. It leads to an awareness of common health beliefs and practices in one's community. With this knowledge, the culturally sensitive clinician can assess when a patient is acting on his/her beliefs and negotiate a solution that is acceptable to both parties. Such a solution does not compromise biomedical efficacy, but places the medical plan in a context that respects the patient's beliefs and needs. It calls for an acknowledgment and acceptance of

diversity in the real world.

### TABLE: Asking questions in the right order

#### Folk remedies

"People have told me that there are ways of treating (*illness*) that doctors don't know about. Have you heard of any of these remedies or treatments?"

"What are they?"

"Are they effective?"

"Have you ever tried (*remedy*) for your child's (*illness*)?"

"Are you using it now?"

"Is it helpful?"

#### Folk illness

"What do you think is wrong with your child?"

"Some parents have told me about an illness called (*folk illness*) that doctors aren't aware of. Have you ever heard of it?"

"What is (*illness*)?"

"Has your child ever had it?"

"Do you think your child might have it now?"

## Latest... (continued from page 3)

agencies and policy-makers on both the federal and state levels as well as national organizations have independently developed their own standards and practices. This has resulted in a wide spectrum of ideas about what constitutes appropriate culturally sensitive health care services.

For the first time, a collective effort has been made to develop national standards for cultural competence in healthcare. The United States Department of Health and Human Services Office of Minority Health, in cooperation with the Resources for Cross Cultural Health Care and the Center for the Advancement of Health in Silver Spring, MD, has announced the advanced release of *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda*. The report makes recommendations for national standards for culturally and linguistically appropriate services (CLAS) in health care and proposes a research agenda to investigate the relationship of cultural competence activities to health outcomes.

Part I of the report contains the proposed 14 recommended standards for assuring cultural competence in healthcare based on the analytical review of laws, regulations, contracts, and standards currently in use by federal and state agencies and other organizations. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards. The standards themselves will be printed in the Federal Register with the announcement of three regional meetings (California, Illinois, and Washington, DC) on the project and several venues for submitting national public comment commencing in early 2000. Public comment is encour-

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## Model (continued from page 1)

accomplished by referring to published materials, consulting with colleagues, and speaking to interpreters and community members from various ethnic groups.

### 2) Language Issues

- Use interpreter services unless fluent in patient's primary language
- Follow guidelines for effective interpreter use
- Encourage efforts to increase foreign language skills of staff and English skills of patients with limited English proficiency

Use of interpreter services is necessary for patients with limited English proficiency. Cultural competence also requires knowledge and skills regarding the effective choice and use of interpreters; for example, not asking children, family members, or untrained hospital support staff to serve as interpreters. Efforts should also be made to increase the foreign language skills of staff and English skills of limited English proficient patients.

### 3) Folk Illnesses & Remedies

- Recognize those that may affect clinical care
- Suggest alternatives to harmful folk remedies
- Accommodate non-judgementally into clinical encounter
- Integrate into biomedical treatment plan whenever possible

Try using this four step method to learn more about what approaches your patients are using: (1) explain that you are aware that a given folk illness exists that doctors may not know about; (2) ask if patient/parent has ever heard about it; (3) ask whether the patient has the illness now; and (4) ask what treatment the patient is receiving for the condition. The clinician should then suggest alternatives to harmful folk remedies, accommodate (non-judgementally) to the folk illness beliefs and practices, and integrate the use of harmless folk remedies into the treatment plan.

### 4) Patient/Parent Beliefs

- Identify those that may affect clinical care
- Suggest alternatives to harmful home remedies
- Carefully explain etiology and treatment rationale for given biomedical conditions

This requires a similar approach to that described above. The clinician needs to identify beliefs that might affect care in a sensitive manner, suggest alternatives if harmful folk remedies are being used, and carefully explain the etiology and treatment rationale for a biomedical condition. Integration of harmless home remedies into the treatment plan should be considered whenever possible.

### 5) Provider Practices

- Maintain vigilance for ethnic disparities in screening, prescriptions, procedures, and outcomes
- When disparities occur, determine problem source and address practices that might be responsible

As discrepancies in health care have been clearly documented, providers and institutions need to be vigilant about disparities in screening, prescriptions, and health outcomes based on ethnicity. Oversight by a quality assurance board may be necessary to monitor, document and eliminate inequalities in care.

### Conclusions:

Cultural differences can lead to important clinical consequences in the patient-provider relationship. Failure to consider a patient's cultural and linguistic issues can result in inaccurate histories, decreased satisfaction, non-adherence, poor continuity of care, less preventive screening, and decreased access to care among other problems. Recognition of and appropriate response to a patient's cultural values is important. Failure to do so results in a variety of adverse clinical consequences. However, the clinician needs to be aware of the dangers of stereotyping. A wealthy Cuban-American family whose family has resided in the U. S. for many generations may have cultural values that are strikingly different from those of a first generation Mexican-American family. By using the five steps outlined above, the clinician will be able to ascertain the unique cultural attributes of each patient, and respond appropriately to the cultural values, language issues, folk illnesses, patient beliefs, and ethnic disparities in health and use of services.

## The Latest in National Cultural Competence Policy

**Julia Puebla-Fortier, Resources for Cross Cultural Health Care**

*"Culture and language have considerable impact on how patients access and respond to healthcare services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:"*

*—Preamble to Recommended Standards for Culturally and Linguistically Appropriate Health Care Services*

Cultural diversity in America has significant implications for health care delivery and policymaking, and the growing need for culturally and linguistically appropriate health care services is attracting attention from health care providers and those who oversee quality assurance. Unfortunately, many health care providers do not have clear guidance on how to prepare for or respond to culturally sensitive situations. Until now, there were no comprehensive nationally recognized standards for cultural or linguistic competence in health care service delivery. Instead,

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## Diabetes Management and Ethnic Food Practices

Joan Hill, Director of Education, Joslin Diabetes Center, Boston

For the diabetes educator, enabling your clients to change their lifestyle as well as their eating habits is one of the greatest challenges. Understanding traditional foods and related dietary customs is critical to working as a team to problem-solve around behaviors that will significantly impact upon the health of your clients. According to Margaret Powers, author of the *Handbook of Diabetes Medical Nutrition Therapy*, foods fall into groups which can be categorized as follows:

<b>Core foods:</b>	Foods eaten on a daily or nearly daily basis
<b>Secondary core foods:</b>	Foods eaten several times each week
<b>Peripheral foods:</b>	Foods that are eaten due to individual preference

Determining what foods fall into which categories and developing eating habits around these food groups can help to determine an individualized approach to a nutritionally-balanced diet that respects culture and ethnicity and ultimately improves outcomes for those living with diabetes.

According to a survey conducted by the United States Census Bureau in 1997, there has been significant increases among the racially, ethnically, culturally, and linguistically diverse populations. This change in demographics impacts the statistics for diabetes among diverse populations as well. According to the National Institutes of Health, the prevalence of diabetes by race and ethnicity is as follows:

<b>African-American</b>	<b>9.6%</b>
<b>Mexican-American</b>	<b>9.6%</b>
<b>Cuban-American</b>	<b>9.1%</b>
<b>Puerto-Rican American</b>	<b>10.9%</b>
<b>White-American</b>	<b>6.2%</b>
<b>Native American</b>	<b>5-50%</b>
<b>Japanese American - Second Generation</b>	<b>18%</b>

The Diabetes Care and Education Practice Group of the American Dietetic Association has developed 10 resources to aid the educator in meeting the dietary needs of their patients from multi-cultural backgrounds. *Ethnic and Regional Food Practices: A Series* publications are available through the American Dietetic Association's, *Catalog of Products and Services* or can be ordered on-line from [www.eatright.org](http://www.eatright.org), or by calling toll free (800) 877-1600 x 5000. The publications are \$8.50 per item for ADA members, \$10.00 per item for non-ADA members. You can order various ethnic Topic Pages by using the following order numbers:

Alaskan Native Food Practices, Customs, and Holidays - Catalog #1697, 24 pp, 1998  
Jewish Food Practices, Customs, and Holidays - Catalog #1654, 27 pp, 1998  
Mexican American Food Practices, Customs, and Holidays - Catalog #1646, 30 pp, 1998  
Chinese American Food Practices, Customs, and Holidays - Catalog #1662, 40 pp, 1998  
Navajo Food Practices, Customs, and Holidays - Catalog# 1700, 28 pp, 1998  
Hmong American Food Practices, Customs, and Holidays - Catalog# 0878, 24 pp, 1992  
Filipino American Food Practices, Customs, and Holidays - Catalog# 1395, 40 pp, 1994  
Indian and Pakistani Food Practices, Customs, and Holidays - Catalog# 1514. 32 pp, 1996  
Soul and Traditional Southern Food Practices, Customs, and Holidays - Catalog# 1441, 29 pp, 1995  
Meal Planning with Mexican American Foods, 1989 Companion piece pamphlets - 4X90765

Another resource center for obtaining material for multi-cultural populations is the:  
National Diabetes Information Clearinghouse  
1 Information Way  
Bethesda, MD 20892 -3560  
301-654-3327

## The Challenges of Children Living with Diabetes - Thoughts from the Kids

Sarah Marshall, Clinical Psychologist, Berkshire Medical Center, Pittsfield

Insulin shots, finger pricks and diet restriction are a few of the many challenges that children with diabetes face on a daily basis. To live with diabetes and remain healthy, it is often best to live each day in a fairly predictable and reliable way. As anyone who has children or has spent anytime with them "reliability" and "predictability" are not exactly the most frequent words used to describe our next generation. Nevertheless, millions of children who have diabetes manage not only to remain healthy, but do so in a way that interferes little with what it means to be a kid.

**"I hate having to plan everything. Here I am a teenager! I want to be spontaneous!"** Many children with diabetes, especially the adolescents, resent having to lead the predictable lives that diabetes requires. They want to sleep late and not worry about hypoglycemia if they miss breakfast. They want to eat ice cream and have sleepovers with friends.

The support group at Berkshire Medical Center allows children to share frustrations. They can also give suggestions on how to be spontaneous without interfering with their blood sugar levels. One 14 year-old girl said, "Whenever my friends want to have ice cream, I suggest a bike ride instead. I've got all my friends exercising more than they ever have!" Others in the group have decided to try the insulin pump with the hope that this will allow more spontaneity in their eating patterns.

**"I'm going to get diabetes when I grow up...just like my big brother."** Having a diabetic in the family can create all kinds of challenges. Younger siblings may assume that, just like riding a bike and finally crossing the street alone, they too will develop diabetes. Some siblings may have mixed feelings about this. On the one hand wanting the increased attention that their diabetic sibling naturally gets, and on the other not wanting the insulin shots, finger pricks and food restrictions.

It's very important for families to talk about these issues. Younger siblings should be reassured that it is unlikely that they will get diabetes. However, it would not be good to say "you will never get diabetes" since siblings of diabetic children are at a greater risk for developing this chronic medical condition than those who do not have a diabetic in the family. At support groups, parents share in the ways

they give special attention to their non-diabetic children. Some suggest that siblings become involved in the care of the diabetic. One parent shared, "My ten year old loves helping me prepare the insulin by rolling it in her hands. She feels like she now has an important job in this daily routine."

**"I hate being different...being singled out from my friends."** Each time the nurse comes to the classroom to do a blood check, diabetic children are reminded that they are different from their friends. Some children may actually like this. As one five year old reported, "I feel like I'm cool, especially when my friends see how brave I am for doing my finger prick all by myself without even crying."

Adolescents hate the individualized attention. Teenagers desperately want to fit in and be part of the scene. Having diabetes sets them apart from their peers. For example, they may have to be seen by the nurse everyday; eat special foods at lunchtime; have snacks at a certain time of day; or use the bathroom more frequently because of hyperglycemic related complications. Talking about these issues with other diabetics can be very supportive. As one girl said, "I liked hearing that it was hard for other kids with diabetes to be singled out. What helped me most was hearing from an older sibling who did not have diabetes. He didn't think I was weird. In fact, he thought I was kind of cool taking care of myself and giving myself shots and everything."

The Berkshire Medical Center Pediatric Support Group is a monthly support group for kids of all ages who have Type 1 Diabetes and their families. The group meets together for the first half and has dinner. All of the kids do their blood testing and insulin shots in front of each other providing an opportunity for bonding. For the younger kids, watching the older kids simply "drives home" that they are not alone. The group then breaks into two smaller groups - one for the kids and one for the parents. The *kids* side discusses issues related to having diabetes. Very young children play games and do art projects. The parents' side has a different educational topic presented each month. Topics have included stress within the family as a result of having a diabetic child, Individualized Educational Plans (IEP's) for diabetic children in school, nutrition, and impact on siblings. The group meets every second Tuesday of the month in the Warriner Building at Berkshire Medical Center.

For more information or to make a referral, please call Dr. Marshall at (413) 447-2167. Berkshire Medical Center has a diabetes support group for children living with diabetes and their family members. Dr. Marshall founded