

# Caring

HEADLINES

July 5, 2001

## Somewhere... Stephanie is smiling!

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#### special Issue

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For an event that is as reliably celebratory and uplifting as this one always is, there sure are a lot of tears at the bi-annual presentations of the Stephanie M. Macaluso Expertise in Clinical Practice Awards. There is, it would seem, a direct connection

between clinical excellence and the heart strings of MGH caregivers and non-caregivers alike.

The 2001 summer Macaluso awards were presented on Thursday, June 21, to four exemplary clinicians representing Nursing, Social Services, and Respiratory Care. They are: Neila Altobelli, RRT, respiratory therapist;

Connie Dahlin, RN, advanced practice nurse for the Palliative Care Service; Sylvia Gordon, LICSW, clinical social worker at the MGH Revere Health Center; and Catherine O'Malley, RN, peri-operative staff nurse.

Though the event focused on honoring these four clinicians, *continued on page 12*



Jeanette Ives Erickson, RN, senior vice president for Patient Care (right) with summer 2001 Macaluso award recipients (l-r): Cathy O'Malley, RN; Connie Dahlin, RN; Sylvia Gordon, LICSW; and Neila Altobelli, RRT.

**MGH** Patient Care Services  
Working together to shape the future

## About Neila...

*A graduate of the Massachusetts General Hospital Respiratory Therapy Technician Program and Bunker Hill Community College, Neila is currently pursuing a bachelor of Arts degree at Salem State College. She has been employed as a respiratory therapist at MGH since 1978. Her career has been characterized by intellectual curiosity, clinical expertise, and a commitment to the education of students and clinicians throughout Patient Care Services. Neila appreciates all of the issues surrounding respiratory care and supports her patients with creativity, a wealth of experience, and a complete understanding of current technology.*

*Her focus is always on what the patient is experiencing.*

*Her calm, compassionate presence at the bedside and her ability to reach out to patients and their families bring great comfort at a most difficult time.*



Neila Altobelli, RRT  
respiratory therapist

## Clinical Narrative

My name is Neila Altobelli, and I have been a respiratory therapist at MGH for 23 years. In my current position, I work as a "float" therapist. As a float I have the opportunity to participate in the respiratory-care management of a wide variety of patients of all different ages, presenting with various diseases. Some of these patients have very unstable respiratory conditions due to injury and/or infections. The management of their respiratory status can significantly impact their hospital course. Patients who have suffered severe burns very often present with respiratory complications and are a challenge to manage.

A few months ago I was scheduled to work in the Burn ICU. One of the patients was a 34-year-old woman who had been a victim of an explosion; she suffered second- and third-degree burns over 73% of her body. Due to the severity of her burns and inhalation injury to her lungs, she had required immediate intubation and mechanical ventilation. Initially, it had been relatively easy to provide adequate oxygenation and ventilation with the ventilator. But three days later, her blood level of oxygen was low and carbon dioxide was high, so the ventilator parameters were increased. I had been told in report that her respiratory status was somewhat unstable.

This particular morning she was scheduled for surgery. Within an hour after she left for the operating room I received a call to bring her ventilator due to difficulty in maintaining her oxygenation using an anesthesia machine or manual ventilator. I quickly gathered all the equipment I needed to run the ventilator in the operating room. On my way I was anticipating what parameter changes I could possibly make to improve her oxygenation. Upon my arrival, the anesthesiologist was manually ventilating and her oxygen saturation was in the low nineties. Once I set up the ventilator and connected the patient I immediately presented my suggestions for increasing ventilator parameters to the

senior surgical resident and the attending surgeon. They agreed, so I quickly increased the oxygen percentage, positive end expiratory pressure (PEEP), and pressure control level on the machine.

The patient's oxygen saturation improved and stabilized over the next fifteen minutes. The anesthesiologist and surgeons were satisfied with the patient's respiratory status at this point, so they continued with the surgery. I asked if they needed me to stay with this patient any longer, or if I should leave them my pager number so they could call me if the patient's status changed. They were comfortable with me leaving the operating room as long as they

could reach me. A few hours later they called to ask for my assistance in returning the patient to the Burn ICU. Both the attending surgeon and the surgical resident told me that her respiratory status had been stable during the surgery, and they thanked me for my prompt assistance. I felt very grateful that I was able to use my skills to help manage a patient in this unusual setting and allow the patient to have the critical surgery she needed. Later that day, I was able to wean the oxygen percentage, the positive end expiratory pressure, and the pressure control down to pre-operative levels.

The next day I was working in the Burn ICU again. This patient

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was scheduled for surgery again, but this time the procedure the surgeons planned to do was a little more complicated. They wanted to close a large abdominal wound. They anticipated that this would compromise her respiratory status even more, so the attending surgeon requested the ventilator and my presence for the whole time she would be in the operating room. I was glad to be of assistance so I arranged coverage for my other patients.

After safely transporting the patient to the operating room and connecting her to the ventilator, I reviewed the goals with the surgeons. Then I adjusted her ventilator settings to achieve acceptable oxygenation and ventilation. A blood test was done to confirm this. However, once her abdomen was closed, her respiratory status was compromised as we had anticipated. Her oxygen saturation and volumes had decreased markedly despite having already received higher pressures and oxygen percentage. In anticipation of this, I had already thought ahead to the next step. I suggested to the surgeons that I change the ventilator mode from pre-set pressure to pre-set volume mode so that I could

ensure the patient would receive an adequate volume to fully expand her lungs. The attending surgeon agreed as long as I limited the amount of pressure delivered to her lungs. I was able to do this by changing several ventilator parameters over several minutes.

Gradually her oxygen saturation increased to the mid-nineties, which was acceptable to the surgeons. Her cardiovascular status also stabilized. At this time, I was able to listen to her breath sounds and assess if she needed any

aerosolized bronchodilator medication for wheezing and/or secretion clearance. I thought both treatments might help decrease her pressures. After suctioning her endotracheal tube, removing some significant mucous plugs, and giving her bronchodilator treatment for the wheezing, her ventilator pressures decreased. I informed the surgeons.

Based on my results the attending surgeon decided to perform a flexible bronchoscopy to remove any more mucous plugs that may

have been in her distal airways. The patient tolerated this procedure quite well considering how unstable she had been earlier in the operating room. I then helped the anesthesiologist and surgeons transport the patient back to the Burn ICU by manually ventilating her with 100% oxygen to ensure her oxygen saturation and vital signs remained stable.

Upon returning to the ICU, I discussed with the surgeons how I might be able to further adjust the ventilator to

improve her gas exchange while decreasing her oxygen percentage from 100%. I wanted to gradually increase the volume and PEEP and gradually decrease the oxygen percentage. They agreed with my plan. So, during the rest of the day, while following her blood levels of oxygen and carbon dioxide, I was able to increase the volume and PEEP and decrease the oxygen percentage on the ventilator. I was in regular communication with the senior surgical resident

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Altobelli provides routine care and assessment of ventilated patient, James Wyllie.

## About Connie...

*A graduate of the MGH Institute of Health Professions, Connie has spent her entire professional career caring for oncology patients and their families. Working with dying patients lead Connie to what would become her abiding passion: ensuring that terminally ill patients end their days free of pain in a setting that provides physical and emotional comfort. She has published and lectured extensively throughout the country on the care and treatment of patients at the end of life. In a society that shies away from talking about death, Connie brings honesty and compassion to conversations with patients. She assists families in talking with, and listening to, their loved ones about difficult decisions at the end of life. In direct interactions with other members of the healthcare team and by role-modeling, Connie ensures that every patient's life ends with comfort and dignity.*



Constance Dahlin, RN, MSN, CS, OCNS, CHPN  
advanced practice nurse, Palliative Care Service

## Clinical Narrative

My name is Connie Dahlin. For 3 years, the focus of my practice has been with patients at the end of their lives. Since the inception of the Palliative Care Service in 1996, I have been the advanced practice nurse for the service. Frequently, I am asked to help with disposition. However, what often is framed as "discharge planning" usually becomes more encompassing.

Recently, I was asked to see a patient on White 12. Sue was a 38-year-old woman who had a brain tumor. She had been diagnosed three years earlier. Since she had received maximal treatment, consisting of radiation and chemotherapy, she was

well known on the unit. Sue had been maintaining herself at home. However, she had been admitted to the hospital with more frequent, painful headaches, fatigue, weakness, and double vision. Steroids were no longer helping and further chemotherapy was not appropriate. The healthcare team recognized that Sue was declining. Though the consult was for disposition planning, it became clear that pain management and support were also issues to be addressed.

When I first entered Sue's room on a Tuesday afternoon, several people were there. There were lots of pictures and personal items on the windowsill, cards and homemade drawings on the wall, and a cot

stuffed in the corner. I could hardly see Sue lying in her bed. I went to her and introduced myself. "I am Connie, the nurse with the Palliative Care Service."

Unlike many patients, she replied warmly, "I was expecting you."

I asked, "How are you?"

She said, "I have been better; I have pain that comes and goes. But I only take the medications when it gets bad."

I suggested continuous IV pain medications. We discussed the merits and burdens. She agreed, "If I had less pain, I could do more." Sue then proceeded to introduce her family members. She was married to Richard her husband of 15 years. To-

gether, they were the devoted parents of Max 3, and Tara, 12. She also had two sisters and parents who lived nearby. The whole family was interacting quite happily, and Sue was enjoying their company. It was clear to me that her family was the best medicine on this day. I suggested that I return Wednesday, and she agreed.

I returned the next morning. Sue was waiting for me. She was eager to tell me her version of her disease history, including the course of treatments, medications, and symptoms. Her story conveyed her intelligence, her attention to detail, her active participation in her treatment, and her attempt to have some control in what is most

often an incurable disease. She was clear in understanding the progression of her tumor, and her prognosis. Sue said calmly, "Things don't look so good. I have been fighting and I have great doctors, and this unit is wonderful, but this is a brain tumor after all." Though she had been reluctant to have continuous pain medication, she explained, "I feel better; though at times I'm a little fuzzy. I was worried about taking too much medication at home around the children." She added, "Now I can focus on my arrangements. I need to make sure everything is in order." However, she wanted to include her husband in making any plans. I offered to contact Richard and she

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agreed. Being aware of his commitments to his children, I asked what time he would visit and if I could meet with him then. He would be in the next morning after he dropped the children off at school.

The next day, I met Richard in the hallway while Sue was receiving personal care. We went to a private area to talk. Richard told me how Sue's illness had affected him and the children. He said, "I know Sue is not going to get better." I gauged that Richard well understood Sue's disease. He added, "It is so hard to be here all the time when the kids need me. I feel torn, I know they need some down time at home, just to be kids. I wish Sue would let her family stay with her." Richard was being incredibly stretched while attempting to maintain some sense of normalcy. He wanted to be with his dying wife. Yet, he realized that his children needed his support, now as well as after Sue's death. I could see he was exhausted. My heart went out to him. As a parent, I could only imagine the stress of trying to take care of a terminally ill spouse and trying to be there for the children while they grappled with a very sick mother. I asked if he wanted me to facilitate a conversa-

tion about this issue. He said yes with an expression of gratitude and relief.

When Sue was done with her personal care, Richard and I went into her room. Immediately Sue asked, "How am I going to die?" Though I am comfortable discussing death and dying, it is critical to assess the patient's fears and concerns. As I explored Sue's concern, it was clear to me that this question came from fear. Sue revealed an experience she had had the first night she was at

MGH when she was diagnosed with her brain tumor. She had been in a double room and the woman next to her had died in horrible respiratory distress.

After pausing to find the necessary balance between detail and reassurance, I proceeded to give Sue all of the possible dying scenarios. With each possibility, I included further explanation of how we would prevent discomfort and pain.

When she seemed reassured that she would not suffer, I asked her

what her priorities were in her remaining time. Not surprisingly, Sue stated, "I want to be with my family and friends." She asked, "But how much do you think my children understand. My three-year-old can't understand much, can he?" Sue cried and said, "It's so unfair to leave him at such a young age." Richard took Sue's hand and they both expressed how difficult this was. After a few minutes, Sue stopped crying. She said she really did know how much her children

understood. We discussed their ability to cope based on their developmental understanding.

At this point, I gently suggested, "I think having Richard home at night would help Max and Tara to cope." She began to cry again. I explained, "It's hard for Richard to do everything, and everything the children have known is out of sorts. Right now, to have some routine could be helpful. Do you think that would be possible? Your family, your sis-

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Dahlin (center) confers with colleagues, Beth MacLellan, RN, case manager (left), and Sheryn Dungan, LICSW, clinical social worker for the Palliative Care Service.

## About Sylvia...

*A graduate of the University of Michigan, Sylvia received her MSW from Simmons College. In 1987 she became the first full-time social worker at the MGH Revere Health Center, which serves a very diverse patient population. Many clients have immigrated from countries torn apart by war. Many come to America knowing no one. How does a person recover from the trauma of what they have seen and experienced in a war-ravaged homeland? Luckily for many of these clients, Sylvia is the answer to that question. With great sensitivity, expertise, and perseverance, Sylvia works with clients to help them unlock and give voice to those painful memories. She builds trust so they can unburden themselves to her and learn to live with the memory of what they have survived.*



Sylvia Gordon, LICSW, MSW  
lead social worker, MGH Revere Health Center

## Clinical Narrative

My name is Sylvia Gordon, and I am a clinical social worker at the MGH Revere Health Center.

Dr. G called and asked me to be of help to him in assessing Sophana, a 45-year-old Cambodian woman who presented to him with a wide variety of vague medical problems. He had examined her and found no significant medical findings that would account for her various symptoms. She seemed depressed to him, but she was unwilling to talk very much and could not give him information about herself or her family. He was worried; he wanted to be sure she wasn't suicidal and that she would be safe if he sent her home.

I happily agreed to see Sophana. I went to his office to meet her and escort her to my office where I wanted our work to begin. On my way to get her, I began to think about the common physical complaints that depressed Cambodian patients usually present with, wondering if these would be the symptoms that concerned this patient. Based upon my experience working with Cambodians, I knew they almost never came in to report feeling depressed. This was usually masked in a physical complaint, such as headache, eye pain, or dizziness.

I was able to contact the Cambodian translator I had trained to work with me in Mental Health, and she met us

at my office. My ongoing struggle with Cambodian patients was developing a relationship with them so that they would feel comfortable returning. Social work tools don't include stethoscopes, medications, or bandages. Nor do we rely upon intricate products of technology. The basic tool we use is the relationship we have with a patient. But how do you develop a relationship with a patient who is meeting with you just because her doctor referred her, who has no idea what a social worker is or does because mental health services and social work don't exist in Cambodia?

This process is further complicated by the introduction of a third party to the interview:

the interpreter. This addition raises so many other questions. Will the patient trust the interpreter (who is always a member of their community)? How will I know if my questions are being properly translated so the essence of my question remains? Does the interpreter understand the concept that my question represents? And when the lengthy answer given by the patient to the interpreter is translated back to me in amazingly abbreviated fashion, how can I be sure I'm getting the information and feelings the patient is describing? Are there words in Khmer that translate my questions in the same way I ask them? These are only a few of the issues that complicate the process

of relating to a patient through an interpreter.

At the MGH Revere Health Center, we have a large Cambodian population in our practice. Prior to working at the Health Center, I had never met anyone from Cambodia, knew virtually nothing about the country or its history, and certainly knew nothing about their culture. After being hired, I quickly took a course at the Boston University School of Social Work entitled, "Working with Cambodian Clients." This gave me lots of information, but also increased my anxiety! I learned about the horrific trauma that survivors of the Pol Pot regime had lived through, and truly wondered how I would be able to

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help these holocaust survivors without offending the wonderful values and traditions of their culture.

Sophana quietly entered my office and took a seat. She looked sad and bewildered. I was familiar with the pattern suggested by many of my earlier meetings with patients. I had always tried to be welcoming, respectful, and caring, all qualities that are important in the culture. With the help of an interpreter, I had always asked many questions that I normally ask my English-speaking patients. Cambodians seemed disinterested in my questions, which generally concerned basic individual and family history. More often than not, they had no idea of dates (they didn't know their own birth dates or the birth dates of any of their family members). They watched as I took notes, but again showed no outward interest in the fact that I was writing anything at all. I spent a great deal of time trying to explain what a social worker did. I went into detail that I normally would not do, and with all this needing to be translated, our first meeting was longer than the usual 45-50 minutes. I had tried to explain to patients the value, as I saw it, of having a safe

place to process the horror of their Pol Pot experiences and to deal with their adjustment to a new country.

Patients rarely initiated any of our conversation, yet answered my questions quietly and briefly. A few patients would talk a little about their traumatic history, crying as they did so, and then quickly shut down. I would listen with tears in my eyes. Yet getting them to return was always a problem. With each new person, I varied my explanation of how I

hoped continuing sessions would be of help. I learned some Cambodian words; I bowed as patients entered and exited my office; I asked patients to teach me about their culture. I had learned a lot by the time my meeting with Sophana took place, but I was still looking for the key to the relationship question.

Sophana listened intently as my interpreter explained about social workers helping people who were very sad, a newer and briefer explanation I was trying.

She was able to tell me that she was a widow, that her husband had been killed by the Khmer Rouge, leaving her with five children, three of whom had either been killed or died of untreated illnesses during the Pol Pot regime. Suddenly I had a new idea! I gambled by asking her if her parents were still alive. Tearfully, she told me about their deaths. I told her I knew that in her culture one did not talk to outsiders about family problems or worries. She agreed that this was

so. I told her I knew that the only people they would talk to would be family, and usually, primarily their own parents. Again she agreed, seeming pleased that I knew and understood this. With great courage and warmth, I smilingly asked her if I could be her "American family." I told her that I would try to help her as her own family would if she was still in Cambodia. She smiled, a truly genuine and grateful smile, and I knew a relationship had begun. I

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Gordon (right) reviews notes with Outreach worker/interpreter, Sonantea Ouk.

## About Cathy...

*A graduate of the Massachusetts General Hospital School of Nursing, Cathy received her bachelor of Science and her master's degree in Nursing from the University of Massachusetts. Prior to joining the staff of the Main Operating Room, Cathy practiced in critical care, academia, and quality review. In her current role, Cathy greets patients before they enter the OR suite. She talks with them about their worries and concerns and prepares them for what to expect. She knows that if patients are calm and focused while going under anesthesia, they are more likely to wake up in a calmer state. Cathy coordinates the needs of the surgeon, anesthesiologist and the scrub technician. Through her collaboration with her colleagues during surgery, Cathy ensures that the entire team's focus is on the patient.*



Catherine O'Malley, RN, MS  
operating room staff nurse

## Clinical Narrative

My name is Catherine O'Malley, and I have been a nurse for 22 years. Currently, I am a peri-operative staff nurse in the Main OR. The ringing phone broke the silence of a somber OR—the surgeon relaying the request for the grieving family. They wanted to see Mr. L before he was sent to the morgue. This was a case where all the stops had been pulled, everything possible done, it was obvious to anyone observing the room. A lot still needed to be done, both in terms of patient care and administratively (inputting quantitative and qualitative data into the computerized intra-operative record). I was imagining the time span was already too long for

the family. Plastic tubes of all dimensions were egressing from every orifice as well as the neck, groin, and arms. Dried blood and moist bodily fluids veiled the patient and the OR bed, all the result of the constant pumping of blood products and the seepage of fluids from the surgical sites. My colleague and I bathed him, put on a fresh gown, and placed him on the stretcher. The last touch before retrieving the family was to have his shock of pure white hair neatly combed. Not sure which side he parted it on, I brushed it to the right, hoping it was correct, wishing I had noticed when I first greeted him on his way into the OR.

He had arrived with a cadre of doctors and

nurses. As in any emergency, there was a lot of commotion, but organized commotion. Similar to an orchestra, each section playing its part and then going full force into a fast tempo allegro. It was his tall stature and calm demeanor that struck me when I first met him. He was in his early 70s, lying in the stretcher with his feet hanging over the edge. It seemed like he was taking it all in, did not project a scared or anxious look in his eyes. I edged my way in between two anesthesiologists and whispered in his ear who I was and that we were going to take good care of him in the OR. I gave his fingers a squeeze, the rest of his hand was already taped to the IV board that kept his A-line

intact. Soon we were all in concert. The whole OR team (surgical technician, surgeons, the anesthesia team and the nurses) worked feverishly, doing everything possible for Mr. L. But his body could not endure it all. As soon as the adrenaline subsided from the locomotive pace we kept, I was spent. Adding to that was a layer of dread, anticipating the grief of the family.

As a nurse of 22 years, I consider myself experienced and able to handle all situations with empathy and compassion. I knew how important it was for his family to see him now rather than later in the funeral home. It is part of what they need to see and feel in order to begin that walk down

the road of life without their loved one. That is all they asked, and it was the least I could do for them. I changed into a clean pair of scrubs, tidied up my clogs, and was ready to meet the grieving family. There were several members of Mr. L's family in the Gray family waiting area. His daughter and sister wanted to see him. As we walked back to the OR, I wanted to prepare them for what they would see since the tubes and dressings needed to remain intact. They talked of his first outing to the bank the other day, and how he was feeling better, eating. "He had just turned the corner," since his initial operation several months before. I was engaged in their stories

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and felt I was getting to know what Mr. L had gone through these last months. At one point Mr. L's sister said to me, "This must be a very hard part of your job." Although I had dreaded this part of my day, it didn't feel 'hard' at that point. They were lovely people just trying to piece together an unexpectedly tragic end to their day. It took me by surprise because it was as if she had read my mind before I came to meet them. How could she think of anyone else's feelings during her grief? Was my veneer of support showing a big crack? I felt like I was not doing my job, providing comfort and guidance to them. Mr. L's sister was comforting me!

I brought them to a quiet and private area of the OR to see Mr. L. Although I wanted them to have their private moments with him, I stayed initially, wanting to make sure they would be able to handle seeing him at peace. I touched Mr. L's hand and told them it was alright to hug and kiss him if they wanted. There were chairs in place and I told them they could stay as long as they wished. Soon after, both Mr. L's daughter and sister said they were ready to leave. Upon leaving his

room, his daughter broke into tears, saying he had been both "mother and father" to her since her mom died when she was 19. I must admit I don't remember what I said to her as a reply but something did come out of my mouth as I hugged her.

"You must hear this all the time, but he was a wonderful person," said his sister. I don't hear it that often was my silent thought.

"It sounds like he was lucky to have you as family," was my reply. They asked ques-

tions regarding when to call the funeral home and where Mr. L would spend the night if they hadn't yet contacted the funeral home. We returned to the Gray family area where they thanked me for bringing them to the OR. We hugged and said good-bye.

Caring for patients in the OR is sometimes similar to seeing one slide of a presentation taken from the carousel. It can be quick or it can linger on the screen. You have a short period of time to get to know the patient, allay anxieties,

explain things and answer their questions, allow him or her to get to know and trust you, act as the patient and family's advocate. That's why we are here; that is the purest level of nursing.

Bringing loved ones to the OR after a patient dies happens occasionally. With Mr. L's family, I realized I got more strength and comfort from his daughter and sister during this interaction than I gave them. I needed to know more about Mr. L than I realized. Hearing how

he fit into their family gave me some semblance of closure. I think talking with his family and getting a better glimpse into his life helped me process that evening.

**Comments by  
Jeanette Ives  
Erickson, RN, MS,  
senior vice president  
for Patient Care and  
chief nurse**

The operating room is one of the most highly technical areas in the hospital. But despite that, Cathy shows us the importance of hu-

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## Clinical Narrative (Altobelli)

*continued from page 3*

who wrote the orders for the agreed-upon ventilator changes as needed.

Her blood tests slowly improved. The next day when I checked on her, the blood tests were within normal range on much less oxygen. Over several months she had many more surgical procedures and required continued mechanical ventilation, but her respiratory status had stabilized. Periodically after that I took care of her in the ICU and was pleased with her progress. She gradually improved, weaned off the ventilator, and moved out of the Burn ICU.

Because of this patient's severe burns and inhalation injury she was a great challenge. It was very gratifying for me to work so closely with the surgical team and have them be receptive to my suggestions while this patient was so critical. I felt my skills were valued and respected. But most of all, I was pleased that I had the opportunity to contribute to the best possible medical care to enable this young woman to survive a terrible accident.

### Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

Neila gives us a rare glimpse into the critical thinking of an expert respiratory therapist. Her narrative shows us the experience she brings, her ability to anticipate what will happen, and her responsiveness at implementing interventions to prevent any negative outcome. Neila knows that her expertise is needed to care for this patient and she makes herself available in a collaborative manner. With the support of her colleagues, she is able to free herself up so that she can support this patient and provide ongoing consultation to the medical team.

To be a "float" therapist requires a great deal of experience and confidence. You never know what you will be faced with. Neila's expert knowledge and skill allow her to work with the medical team in a way that informs their practice and optimizes the patient's options. We are lucky to have her.

Thank-you, Neila.

## Clinical Narrative (Gordon)

*continued from page 7*

knew I had found a meaningful key to beginning a real relationship with my Cambodian patients. They understood "an American family!" Social work services no longer needed to be explained.

I was then able to assess Sophana, gathering the necessary information to determine that she indeed was depressed, was having flashbacks indicating post traumatic stress disorder, but was not actively suicidal. I contacted Dr. G and shared with him the reasons that brought me to this conclusion. I reviewed her symptoms and helped him understand that these were common symptoms masking depression. Together we decided that it would be safe for her to return home. She agreed to a follow-up appointment with me, and she agreed to see a psychiatrist. This was the beginning of many months of work with Sophana where we addressed many issues in her life, such as being alone in a different land, the many losses she had suffered, financial and housing problems, health problems, and serious issues with her children.

I have continued to ask my Cambodian patients if I could be their American family, if we could talk the way they would to their own family if they were here. This breakthrough has enabled me to connect with patients quickly and meaningfully, and has established a different framework for our sessions together. Part of the real joy of working at a health center in the community is the continuity we have with patients. Most recently, Sophana and I have worked together to place her profoundly developmentally delayed son in a residential placement. I know she would not have had the courage to do this without the history of our relationship. It may well have been too shameful for her, and she may have been unable to ask for this help from someone she did not view as "family." It made me so glad that I had finally found a new way of connecting quickly to a group of patients with such intense needs.

### Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

"Can I be your American family?" What do you say about a caregiver who unlocks the key to meaningful communication with an entire population of patients in her community? This revelation has significance, not only for Sophana, but for all of Sylvia's Cambodian patients, and for the Cambodian patients that all of us will care for! This is truly a remarkable breakthrough, and one that must be shared.

This narrative is rich with lessons. Sylvia committed herself to learning about the Cambodian culture. Not only did she take formal classes, she became her own personal database of anecdotal experiences with Cambodian patients until finally, suddenly, it came to her—the culmination of all her interactions: "Can I be your American family?"

We often hear the word 'exquisite' used to describe care at MGH. I can't think of a more appropriate word to describe Sylvia's practice.

Thank-you, Sylvia.

## Clinical Narrative (Dahlin)

*continued from page 5*

ters in particular, are only too eager to help.” Much to my relief and Richard’s, she agreed.

Sue proceeded to review the things she needed to complete and instructions she wanted to give to her family. Richard stated, “Sue has been the one to run the family.”

I said to Sue, “It must be so hard for you to think about leaving your family. You are so involved and have done so much for them.” More tears came. Richard reassured her that he would continue to tell both Max and Tara stories about their mom and what she was like.

I stayed silent while she talked. “There is so much I want to tell the people I love, especially the children,” whispered Sue. We discussed her leaving the children audiotapes and letters to open at certain milestones in their lives. She wanted to avoid videotapes because her appearance had changed so much she felt it would be disturbing. In addition, she wanted certain relatives to visit so she could tell them good-bye.

At this point, she stated, “I don’t want to die in front of the children. It would be too

hard for them and me.” Richard agreed. I assured them we would find an appropriate inpatient setting. Both Sue and Richard were silent and it was apparent they were emotionally exhausted by our discussion. I commended them on all the work they were doing. I explained that this was not easy. I then offered to talk to Sue’s family. They said that would be helpful.

I left the room while Richard sat and comforted Sue. I spoke to Sue’s family in the waiting area where I explained the need for Richard to be home nights. They began to work out a schedule. It was clear they did not need me, as they were quite capable of working this out on their own. As I returned to my office, I paused to reflect on this patient and family. I was amazed at the work Sue was doing and would continue to do. I was relieved that she had a supportive, involved family. I was heartened that I had facilitated a process to relieve some stress for this young family. But mostly, I felt privileged to be a part of this family’s process, as they were doing exceptional work in a very difficult time.

## Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

This narrative is sad and difficult to read, but Connie gives us a wonderful opportunity to look at the special kind of care that is provided to patients at the end of life. Society’s discomfort at dealing with death often forces people to deny it altogether, causing even more pain and suffering for the patient and family. Connie gently guides this family through the painful but much-needed discussions about care options, pain-management, and the need for Richard to spend time at home with their children. We can clearly see the benefit of creating an environment where it is safe and comfortable to have these conversations.

Connie gets to know Sue and Richard. She listens. She is present. She doesn’t shy away from the hard work. All clinicians know that caring for patients at the end of life is challenging and indescribably sad. We can all learn something from the deft and gentle way Connie cared for this family.

Thank-you, Connie.

## Clinical Narrative (O’Malley)

*continued from page 9*

man contact and being present for the patient and the family in this very compelling narrative. It may well be that Cathy’s kind words and her reassuring squeeze of his fingers were the last things Mr. L heard and felt before going under anesthesia. Amid all the necessary activity surrounding this emergency, Cathy took the time to comfort this critically ill man.

When Mr. L died in surgery, despite her own fatigue, Cathy quickly shifted gears and thought of the grieving family. She

knew time was of the essence; but she took the time to do post-mortem care and prepare his body for viewing by his loved ones. In a quiet area of the OR, Cathy encouraged Mr. L’s family to hold him and say their good-byes. The pain this family felt is evident. Nothing Cathy could have done would have changed that. But in the midst of this sterile, highly technological setting, Mr. L’s family felt the warmth and compassion of a very caring nurse.

Thank-you, Cathy.

## Call for Nominations

### The Marie C. Petrilli Oncology Nursing Award

Nominations are now being accepted for The Marie C. Petrilli Oncology Nursing Award. This award recognizes the high level of care, compassion and commitment reflected in the nursing care of oncology patients at MGH.

Any nurse throughout MGH who cares for patients with cancer is eligible to be nominated.

Two nurses will be selected.

Each recipient will receive \$1000.

Employees, managers, physicians, patients and/or families may nominate a candidate. Nominations may be made by completing a brief nomination form which will be available on all inpatient units, the Gray and Cancer Center information desks, and in the Cox 1 Cancer Resource Room. A letter of support must accompany the form.

Nominations are due by July 27, 2001  
For more information call Scott Ciesielski  
at 617-726-3130

**Macaluso Awards** *continued from front cover*



Robert Kacmarek,  
Altabelli, and  
Ives Erickson

ical expertise and recognition. Gibbons referred to the clinical narratives written by each of the recipients (as part of their nomination process), and asked, “Why do so many of us take such pride in celebrating the accomplishments of these four clinicians? Why is recognition so important? When we recognize the best in our professions, we make expert care visible. We respect Neila, Connie, Sylvia and Cathy for what they have achieved; they set the ‘gold standard’ for their respective practices. When we honor them we re-affirm our deepest values and our own commitment to excellence. We share in the excitement because we too, are dedicated to making a difference every day.”

the spirit of Stephanie Macaluso, RN, was very much present as many of the award presenters, recipients, and Jeanette Ives Erickson, RN, senior vice president for Patient Care, invoked her memory with great reverence. Ives Erickson, who presided over the ceremony, began by reminding attendees of the numerous contributions Macaluso made to this institution. Said Ives Erickson, “Stephanie taught us well; it is a privilege for us to come together in her honor.”

Before presenting the awards, associate chief nurse for The Center for Clinical & Professional Development, Trish Gibbons, RN, offered her observations on the importance of clin-



Marion Freehan,  
O'Malley, and  
Ives Erickson

As in past years, each recipient was introduced by her respective manager, supervisor, or director, and each had an opportunity to say a few words. Director of Respiratory Care, Robert Kacmarek, RRT, introduced Altabelli, recalling their long history of working together and his growing respect for her practice and expertise over the years.



Bonnie Glass,  
Dahlin, and  
Ives Erickson

Project manager, Bonnie Glass, RN, standing in for a traveling Andrew Billings, MD, medical director of the Palliative Care Service, relayed Billings’ sentiments of praise and appreciation for Dahlin’s work, commitment, and expertise.

Main OR nurse manager, Marion (Bunny) Freehan, RN, introduced O’Malley, the first peri-operative nurse to receive the award. Freehan reflected on O’Malley’s passion for her work, calling her “a nurse’s nurse.”



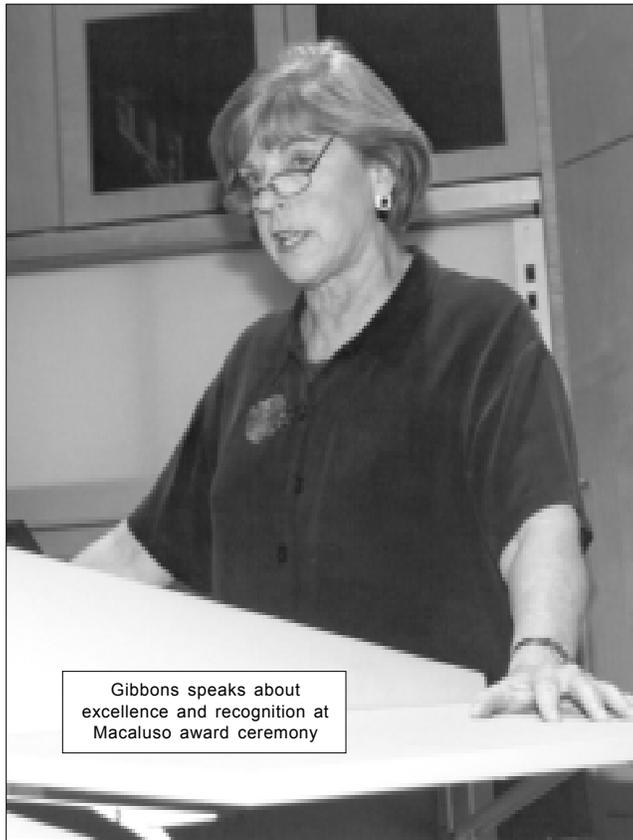
Evelyn Bonander,  
Gordon, and  
Ives Erickson

*continued on next page*

Director of Social Services, Evelyn Bonander, ACSW, introduced Gordon, the first social worker and mental health clinician to work at the MGH Revere Health Center, describing her great courage, energy and ability to engage and connect with her patients.

Gordon was asked to read her clinical narrative, a moving and enlightened account of her experiences working with a Cambodian patient. After the reading, director of PCS Diversity, Deborah Washington, RN, dialogued with Gordon about the important lessons woven into her narrative.

In closing, Ives Erickson observed, "I've been asked if twice a year is too often to give these awards. After today's ceremony... it seems to me that twice a year is not often enough!"



Gibbons speaks about excellence and recognition at Macaluso award ceremony

### Past and present Macaluso award recipients

#### Original award:

September 5, 1996

- Stephanie Macaluso, RN

July 2, 1998

- May Cadigan, RN
- Pat English, RRT
- Valerie Fullum, LICSW
- Sarah Rozehnal Ward, CCC/SLP

December 17, 1998

- Maureen Beaulieu, RN
- Tessa Goldsmith, CCC/SLP
- Diana Grobman, RN
- Karen Lechner, LICSW
- Donna Slicis, RN

July 1, 1999

- Rochelle Butler, LPN
- Alice Chaput, RN
- Diane Plante, PT
- Louise Sethmann, RN

January 6, 2000

- Elizabeth Johnson, RN
- Sucheta Kamath, CCC/SLP
- Sandra McLaughlin, LICSW
- Fredda Zuckerman, LICSW

June 15, 2000

- Emilyn Bellavia, RN
- Mary Elizabeth McAuley, RN
- Diane McKenna-Yasek, RN
- Marica Wasenius Rie, P T

December 7, 2000

- Gae Burchill, OTR/L
- Pamela DiMack, RN
- Claire Farrell, RN
- Marie Elena Gioiella, LICSW
- Irene Giorgetti, RN
- Lisa Sohl, RN
- Susan Primm Thel, MSW

June 21, 2001

- Neila Altobelli, RRT
- Constance Dahlin, RN
- Sylvia Gordon, LICSW
- Catherine O'Malley, RN

#### Published by:

*Caring Headlines* is published twice each month by the department of Patient Care Services at Massachusetts General Hospital.

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#### Next Publication Date:

July 19, 2001



When/Where	Description	Contact Hours
July 18 7:30–11:30am, 12:00–4:00pm VBK 401	<b>CPR—American Heart Association BLS Re-Training</b> Successful completion of this program re-certifies staff in AHA Basic Life Support. Priority will be given to staff required to have AHA BLS for their job. Others are encouraged to complete unit-based, age-specific mannequin demonstration to meet requirements. Participants must review the new AHA Health Care Provider Manual, which may be borrowed from the CCPD for a returnable \$10 deposit. (Note: class has been extended to 4 hours due to changes in AHA requirements.) Pre-registration is required, as is proof of AHA certification within the last two years. For information, or to register, call The Center for Clinical & Professional Development at 726-3111.	---
July 19 1:30–2:30pm O’Keeffe Auditorium	<b>Nursing Grand Rounds</b> Nursing Grand Rounds are held on the first and third Thursdays of each month. For more information about this session call The Center for Clinical & Professional Development at 726-3111.	1.2
July 23: 7:30am–4:00pm at Mount Auburn Hospital July 24: 8:00am–4:30pm at MGH (VBK6)	<b>Intra-Aortic Balloon Pump Workshop</b> This two-day workshop sponsored by the ICU Educational Consortium is for ICU nurses only. The program will provide a foundation for practice in the care of critically ill patients requiring balloon-pump therapy. Day one hosted by and ICU Consortium hospital; day two held at MGH for MGH staff. To register, or for more information, call The Center for Clinical & Professional Development at 726-3111.	14.4 for completing both days
July 25 8:00am–2:30pm Training Department Charles River Plaza	<b>New Graduate Seminar II</b> This seminar assists new graduate nurses (with the guidance of their mentors) to transition into the role of professional nurse. Seminars focus of skill acquisition, organization and priority-setting, communication and conflict-management, caring practices, and ethical issues. For more information, call The Center for Clinical & Professional Development at 726-3111.	5.4 (contact hours for mentors only)
July 26 8:00am–4:30pm Training Department Charles River Plaza	<b>Caregiver Skills for the New Millennium</b> This program is designed to promote organizational and personal excellence, inspire creativity and personal and professional success in today’s challenging healthcare environment. Topics will include: managing conflict, negotiating, and balancing the personal and psychological costs of caring. To register, or for more information, call The Center for Clinical & Professional Development at 726-3111.	7.2
August 2 7:30–11:30am, 12:00– 4:00pm VBK 401	<b>CPR—American Heart Association BLS Re-Training</b> Successful completion of this program re-certifies staff in AHA Basic Life Support. Priority will be given to staff required to have AHA BLS for their job. Others are encouraged to complete unit-based, age-specific mannequin demonstration to meet requirements. Participants must review the new AHA Health Care Provider Manual, which may be borrowed from the CCPD for a returnable \$10 deposit. (Note: class has been extended to 4 hours due to changes in AHA requirements.) Pre-registration is required, as is proof of AHA certification within the last two years. For information, or to register, call The Center for Clinical & Professional Development at 726-3111.	---
August 2 1:30–2:30pm O’Keeffe Auditorium	<b>Nursing Grand Rounds</b> Nursing Grand Rounds are held on the first and third Thursdays of each month. This presentation will focus on, “Haitian Women’s Health Issues,” presented by Karen Hopcia, RN, and Suzelle Saint-Eloi, RN. For more information, call The Center for Clinical & Professional Development at 726-3111.	1.2
August 3 8:00–11:15am VBK601	<b>Intermediate Arrhythmias</b> This 4-hour program is designed for the nurse who wants to expand his/her knowledge of arrhythmias. The program focuses on atrial arrhythmias junctional arrhythmias and heart blocks, and prepares staff to take the level B arrhythmia exam. For more information, call The Center for Clinical & Professional Development at 726-3111.	3.9
August 3 12:00–4:30pm VBK601	<b>Pacing and Beyond</b> This new and exciting workshop will discuss indications for initiating therapy, fundamentals of the pacemaker system, pacer implantation, international codes/modes of pacing and nursing care. Rhythm-strip analysis will focus on normal functioning and basic trouble-shooting. The session will conclude with a discussion of current and future technology. For more information, call The Center for Clinical & Professional Development at 726-3111.	5.1
Aug. 8, 8:00am–12:30pm August 10 (Exam) 8:00–9:30am Bigelow 4 Amphitheatre	<b>Transfusion Therapy Course (Lecture &amp; Exam)</b> For ICU nurses only. Pre-registration is required. For information, call 6-3632; to register, call The Center for Clinical & Professional Development at 726-3111.	---

# Offerings —

July 5, 2001

When/Where	Description	Contact Hours
August 8 8:00am–4:30pm Training Department Charles River Plaza	<b>Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other</b> Program will provide a forum for staff to learn about the impact of culture in our lives and interactions with patients, families and co-workers. Topics include understanding and defining the importance of culture; the principles of cultural competency; understanding the dynamics of difference; the culture of Western bio-medicine; and the appropriate use of language services. A variety of interactive exercises will help to illustrate the concepts presented. For more information, call The Center for Clinical & Professional Development at 726-3111.	7.2
August 8 8:00am–2:30pm Training Department Charles River Plaza	<b>New Graduate Seminar I</b> This seminar assists new graduate nurses (with the guidance of their mentors) to transition into the role of professional nurse. Seminars focus of skill acquisition, organization and priority-setting, communication and conflict-management, caring practices, and ethical issues. For more information, call The Center for Clinical & Professional Development at 726-3111.	6.0 (contact hours for mentors only)
August 8 1:30–2:30pm Bigelow 4 Amphitheater	<b>OA/PCA/USA Connections</b> Continuing education session offered for patient care associates, operations associates, and unit service associates. This session is entitled, “Caring for Patients in Restraints.” Pre-registration is not required. For more information, call The Center for Clinical & Professional Development at 726-3111.	---
August 13, 14, 15, 20, 21, 22 7:30am–4:00pm Location TBA	<b>Critical Care in the New Millennium: Core Program</b> For ICU nurses only. This program provides a foundation for practice in the care of critically ill patients. Pick up curriculum books and location directions from the Center for Clinical & Professional Development on Founders 6 before attending program. For more information, call The Center for Clinical & Professional Development at 726-3111.	45.1 for completing all six days
August 14 7:30–11:30am, 12:00–4:00pm VBK 401	<b>CPR—American Heart Association BLS Re-Training</b> Successful completion of this program re-certifies staff in AHA Basic Life Support. Priority will be given to staff required to have AHA BLS for their job. Others are encouraged to complete unit-based, age-specific mannequin demonstration to meet requirements. Participants must review the new AHA Health Care Provider Manual, which may be borrowed from the CCPD for a returnable \$10 deposit. (Note: class has been extended to 4 hours due to changes in AHA requirements.) Pre-registration is required, as is proof of AHA certification within the last two years. For information, or to register, call The Center for Clinical & Professional Development at 726-3111.	---
August 14 7:30–8:30am Patient Family Learning Center	<b>On-Line Patient Education: Tips to Ensure Success</b> This program is geared toward clinicians who have basic Internet navigational skills. The goal is to give staff the tools to find quality patient-education materials to enhance clinical practice and discharge teaching. For more information, call The Center for Clinical & Professional Development at 726-3111.	1.2
August 16 8:00am–5:00pm Wellman Conference Room August 20 8:00am–5:00pm Wellman Conference Room	<b>Advanced Cardiac Life Support (ACLS)—Provider Course</b> Provider course sponsored by MGH Department of Emergency Services. \$120 for MGH/HMS-affiliated employees; \$170 for all others. Registration information and applications are available in Founders 135, or by calling 726-3905. For course information, call Inez McGillivray at 724-4100.	16.8 for completing both days
August 16 1:30–2:30pm O’Keeffe Auditorium	<b>Nursing Grand Rounds</b> Nursing Grand Rounds are held on the first and third Thursdays of each month. For more information about this session call The Center for Clinical & Professional Development at 726-3111.	1.2
August 22 8:00am–2:30pm Training Department Charles River Plaza	<b>New Graduate Seminar II</b> This seminar assists new graduate nurses (with the guidance of their mentors) to transition into the role of professional nurse. Seminars focus of skill acquisition, organization and priority-setting, communication and conflict-management, caring practices, and ethical issues. For more information, call The Center for Clinical & Professional Development at 726-3111.	5.4 (contact hours for mentors only)

## History and background of the Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award

In August of 1996, Jeanette Ives Erickson, RN, senior vice president for Patient Care, formally announced the creation of the Expertise in Clinical Practice Award. The purpose of the award is to recognize direct-care providers whose practice exemplifies the expert application of values put forth in our vision: practice which is caring, innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of leadership and entrepreneurial teamwork.

The first recipient of the award, in 1996, was Stephanie M. Macaluso, RN, thoracic clinical nurse specialist. In honor

of the high standards she set as an expert caregiver, the award is now known as the Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award.

Macaluso embodied the qualities and characteristics of an expert practitioner. She was known for her strong knowledge base, and intuitive skills. She knew when a clinical situation was changing even when common indicators remained unchanged. As an expert coach, she was one on whom peers relied and to whom physicians responded immediately because of her solid, proven track record of sound judgement.

Macaluso did not stand outside of a patient's realm of experi-

ence in her role as clinical teacher. Instead, she truly stood alongside patients conveying empathy and genuine concern. Macaluso's ability to be with patients in a way that acknowledged their shared humanity is the basis of nursing as a caring practice.

Macaluso understood the relationship of health, illness and disease. It was this understanding that led her in her caring work to seek patients' stories. She knew that every illness had a story—plans were thwarted, relationships disturbed, and symptoms became laden with meaning as to what else was going on in a patient's life.

Macaluso had the uncanny ability to put

herself in touch with others and bring the encounter to an intimate level. It's hard to express how she made this contact with patients; maybe it was the way she approached them, the questions she asked, or the language she used. But somehow, they trusted that she knew what she was talking about. This trust and understanding allowed her to connect with patients and promote a sense of caring.

Macaluso had a keen ability to nurture staff and enlist them in her love of patient care. She epitomized the essence of what nursing is truly about.

We continue to celebrate expert practice throughout Patient Care Services. The Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award is now given twice a year. Registered nurses, occupational therapists, respiratory therapists, physical therapists, speech-language

pathologists, social workers and chaplains who provide direct care are eligible for the award and may nominate co-workers whose practice exemplifies the standards described earlier.

Clinicians who are nominated submit a professional portfolio which is reviewed by a selection committee comprised of clinicians, administrators and MGH volunteers. To assist recipients in achieving both personal and professional development, recipients receive tuition and travel expenses to the professional development conference of their choice.

The Stephanie M. Macaluso, RN, Expertise in Clinical Practice Award allows us to publicly re-commit ourselves to the high standard of care we hold for our patients, and contribute to the professional development of the clinicians within Patient Care Services.

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# Caring

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