

# Caring

## HEADLINES

January 6, 2005

## 2004 Macaluso Awards: *celebrating excellence in clinical practice*

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When senior vice president for Patient Care, Jeanette Ives Erickson, RN, took the podium in O'Keeffe Auditorium on December 9, 2004, four exceptional clinicians from four different departments within Patient Care Services became the most recent trustees of the Stephanie Macaluso legacy. This year's recipients of The Stephanie M. Macaluso Excellence in Clinical Practice Award are: Betty Ann Burns-Britton, RN; Danielle Doucette, RRT; Alison Squadrito, PT; and Mary Louisa Zwirner, LICSW.

After thanking the Macaluso Revue Board for their work in selecting this year's

recipients, Ives Erickson invited nurse manager, Keith Perleberg, RN, to address the gathering. Perleberg spoke about, "Leadership as a Catalyst for Recognition." Said Perleberg, "Something transformative happens when someone we look up to breathes life into our potential by naming our gifts and calling them forth."

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Senior vice president for Patient Care, Jeanette Ives Erickson, RN (right); and nurse manager, Keith Perleberg, RN, with Macaluso award recipients (l-r): Betty Ann Burns-Britton, RN; Mary Louisa Zwirner, LICSW; Danielle Doucette, RRT; and Alison Squadrito, PT.

**MGH** Patient Care Services

Working together to shape the future

*A graduate of Northeastern University, Betty Ann has practiced at MGH for 25 years, the past six on Phillips House 21. Betty Ann has studied ethics at the MGH Institute of Health Professions and developed considerable knowledge and skill in this area. She is a resource for patients, families, and colleagues as they grapple with difficult health decisions. She brings calmness, clarity, and compassion to every situation. Betty Ann is often the first to raise the difficult questions and the last to leave the patient's side, bringing comfort, faith, and dignity at the end of life.*

## Clinical Narrative

I am a nurse on Phillips House 21, a medical floor where the nurses and other members of the inter-disciplinary team provide care to an increasingly complex population of general medical, oncology, and palliative care patients. Many patients come to MGH as a last hope for curative treatment. Because of that, I often find myself trying to help patients, when therapy options fail, to realize they're dying in the hope that they can come to terms with their death. I try to help patients and families do and say the things that need to be said before they die.

Mr. M's case was a little different. He didn't come looking for curative treatment. I met Mr. M, a 76-year-old man, when he was admitted with pneumonia. Mr. M was refusing treatment, saying he just wanted to die. He'd had multiple hospital admissions over the past year for various problems related to his numerous medical problems, none of which was really terminal. When I first met Mr. M, I introduced myself and did a quick physical exam, to which he responded, "I don't

know why you're doing that; I'm here to die."

I asked Mr. M what he meant. He explained he had nothing to live for. His wife and only daughter had both died of cancer; he had no family; and all his close friends had died. I felt immediate empathy for him, thinking his life must be very lonely, while also wondering if he was clinically depressed. I decided to confront him and asked, "Are you depressed about all of that?"

He said, "No. And don't go getting some doctor for me to talk too. You'll just be wasting your time. I won't take any medicine, and I don't want to live like this anymore."

I decided to back off. "Is there anything I can do for you right now?" I asked.

"Can you help me die?" he said.

I said I couldn't as it wasn't ethically or legally permissible to do so. I did tell him that I could ensure he would be kept comfortable and asked if he was in any pain. He said no, and I noted that he didn't appear to be in pain.

I spoke with Mr. M's physician about my con-

cern that he might be depressed. I fully realized that in the setting of his many chronic medical problems, he might also be facing his own mortality, timely for him, after the loss of his wife, daughter, and so many friends. The physician, who had a long relationship with Mr. M, confirmed my assessment that he was letting go after a long road alone battling his chronic illnesses. The physician had tried Mr. M on antidepressants to no avail. The physician reported that Mr. M was not interested in talking to a psychiatrist.

I returned to Mr. M's room and slowly resumed my nursing assessment. I wouldn't give up on him. I asked if he had a religious preference. Mr. M said, "No." I asked if he'd like to talk with a hospital chaplain. He again replied, "No. I don't believe in God."

I decided to place a Social Services consult, thinking, "Surely, one of us on the team will connect with him." Mr. M interrupted my thoughts about Social Services with a request that I go away and leave him alone. I decided to respect his

wishes, for the time being.

I made frequent visits to Mr. M's room. My philosophy of nursing is that every patient has a story to tell that makes him or her unique. As a nurse, if I can learn each patient's story, I can find a way to intervene effectively and treat each patient with dignity. For Mr. M, this was a challenge, but I wasn't about to give up. Mr. M needed to know he was cared for, and I was going to find a way for him to feel that care in spite of his resistance. I resorted to an approach that some believe to be old fashioned, but I have found to be very effective. I like to be involved in providing morning care to my patients, especially patients for whom direct conversations may be difficult. I prepared to bathe Mr. M—he had no objections. When bathing a patient, I can assess his physical status and continue to assess his mood through conversations. I've found

that while providing the physical care of 'washing up,' many patients will begin to share feelings about how their illness has affected them and other concerns.

While washing him up, I asked Mr. M questions about his wife, how many years they had been married, how they met, what he had done for a living. He lived locally and had been a fisherman all his life. He loved his work. He'd had one daughter who died of cancer and felt it wasn't fair for a daughter to die before a parent. Mr. M said he had led a good life, but over the past couple of years, he could no longer take care of himself and was living in a nursing home. He had been in the hospital many times with pneumonia and was tired of living. He didn't want to live like this anymore. Mr. M was frustrated because he had always been independent and now could no longer take care of himself.

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Betty Ann Burns-Britton, RN  
staff nurse, Phillips House 21

I asked Mr. M if he was afraid to die, he said, "No." Again, I asked if he believed in God; again, he said, "No. If there were a God he wouldn't have taken my daughter before me."

I said, "Do you think if there were a God it wouldn't have worked out that way?" I said the one thing I knew for sure as a nurse was that we're all going to die. We just don't know when. I said it makes sense that the old should die before the young, a father before his daughter. But I did believe in God, or a higher being, or whatever you want to call it. I told him that the reason his daughter died before him might be unclear now, but maybe we'd find explanations for such tragedies when we die.

Intuition told me that my exploration of these spiritual questions was right in the nurse-patient relationship at that moment. "What do you think happens when you die?" I asked.

"You just die, and that's it."

I said, "Does that scare you?"

He said, "No."

I shared with Mr. M that I had read a great deal about people who were dying and I had taken care of many patients who died. Several patients said, before dying, that they saw relatives in the room coming to greet them. One man I took care of, who had been revived after a near-death experience, said it was beautiful and peace-

ful on the other side.' The only way we'll know for sure is when our time comes, and most of us won't have control over that.

I asked Mr. M if he would listen to a true story. I told him about a woman I'd known who was dying of cancer, and she and her friend knew that death was near. The idea of being separated from one another by death was very difficult. I suggested the friend ask the dying woman to somehow let her know that she was all right after she died. The friend loved to garden, and her favorite flower was a rose. During the winter after her friend died, with snow on the ground, the friend looked out the window, and in the middle of her

front yard there was a yellow rose. She knew that her dear friend was all right; she had found safe passage, and this gave her great peace.

I told Mr. M he could interpret the story any way he wanted. After a brief silence, I asked him if he'd let me know he was all right after he died.

He asked me, "Do you know how to fish?"

I said, "Yes," and shared that when I was a young girl, my grandfather had taught me to fish (I even put the worms on the hook!). Mr. M didn't answer my question; he just smiled.

For the remainder of the day, I checked in frequently with Mr. M, asking if I could get him anything; he consistently

said No, but it was a softer No than before. I brought in some water and ice chips and left them on the end table. Before going home, I went in and said goodbye and told Mr. M I wouldn't be back until Saturday (it was Thursday). I asked a compassionate nurse colleague to care for Mr. M in my absence. I introduced him to Jan and let him know she would be taking care of him.

Mr. M died the next day, but before he died he told my colleague, "Tell your friend, when she goes fishing, I'll be the biggest fish. Then she'll know I'm okay."

I will never forget Mr. M. Once again, the privilege of being a nurse had enriched my life.

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

What a wonderful example of compassionate tenacity. Despite Mr. M's clear wish to be left alone, Betty Ann trusted her instincts and intuition and was able to forge a relationship with Mr. M based on trust, concern, and a profound difference of opinion about what happens in the 'hereafter.' Asking Mr. M to give her a sign after he died was a beautiful, caring gesture, one that allowed Mr. M to have something to look forward to.

In addition to excellent nursing care, Betty Ann gave Mr. M a sense of purpose and belonging in his final hours.

Thank-you, Betty Ann.



Phillips House 21 staff nurse, Betty Ann Burns-Britton, RN, with patient, Margaret Cataldo

*A graduate of Quinnipiac College, Danielle has been a respiratory therapist at MGH for nine years. Danielle cares primarily for patients in the Newborn and Pediatric Intensive Care units where equipment and technology can be as daunting as a life-threatening diagnosis. Even in this complex setting, Danielle's focus never leaves the child and the family. She is frequently sought out by other members of the healthcare team for her knowledge and insight. Whether it's arranging for the Coast Guard to bring a sick child to MGH or navigating a sea of technology to allow a parent to hold her premature baby, Danielle's first concern is always the care and safety of her patient.*

## Clinical Narrative

My name is Danielle Doucette, and I am a registered respiratory therapist. I have worked at MGH for nearly nine years. I specialize in the care of critically ill newborns and pediatric patients, but I care for adult patients, too. This narrative is about a patient experience that led to a change in practice at MGH. It took place in the early afternoon on Ellison 13, the antepartum and postpartum unit.

I was called to Ellison 13 to assist a colleague. She wanted me to help evaluate a patient, 'Alice,' who was 16 weeks pregnant and had asthma. Immediately upon entering the room, I noticed that Alice was in trouble. She was very short of breath and unable to say more than two words at a time. She was using accessory muscles and not aerating well. Experience told me that these were signs of severe distress. I called the nurse and tried to start an albuterol nebulizer treatment. I was told that Alice had just had a nebulizer treatment

and there was no order for nebulizer treatments to be given more frequently. I asked the nurse to page the obstetrician while I continued to assess and monitor Alice, including checking her oxygen saturation and trying to keep her calm. When the obstetrician called, I explained the situation to her and recommended three 'stacked' albuterol nebulizer treatments, and I suggested that Alice be transferred to another unit for closer monitoring. She told me to go ahead and start the nebulizer treatments and she would ask a colleague of hers to come to the unit to evaluate Alice. Upon arrival, the other doctor agreed that Alice was in severe distress and needed to be transferred.

With this increased activity at her bedside and talk of transferring, Alice's respiratory rate and heart rate increased. Knowing that anxiety can exacerbate asthma attacks, I knew Alice's situation would be compounded by her pregnancy and the anxiety

she was feeling about her baby's well-being. I sat with Alice and explained very calmly what was happening. I told her she would be having a series of nebulizer treatments and that the medication was safe for both her and her baby. I explained how important it was for her to stay calm and focus on her breathing. I let her know that she would be moving to a room on the Labor and Delivery Unit so that she and the baby could be monitored more closely. I assured her I'd stay with her and work with her until her breathing improved. She seemed to trust me. She focused on her breathing and began to calm down.

We transferred Alice upstairs where I started the second nebulizer treatment. As I was monitoring Alice, I overheard the nurses giving report in her room. There appeared to be questions about how to mix albuterol and atrovent and what the correct dose was. I took the opportunity to explain the correct dosing and how the

two medications should be mixed.

After the second nebulizer treatment, Alice was breathing easier and aerating better. A resident came in to draw blood gas. I stayed with Alice to ease her anxiety. By the time she finished the third nebulizer treatment, Alice was able to complete full sentences, her voice had improved, her labored breathing was better, and she was aerating with much less effort. Alice felt she had returned to (close to) her baseline breathing, so I felt comfortable leaving.

I discussed the dosing issue with Alice's doctor and gave some further recommendations. He was concerned about Alice's asthma-management and consulted Pulmonary Medicine for some input on her care. After Alice was stabilized, she was transferred to a medical unit for the rest of her stay at MGH.

This patient situation suggested to me that there was a need for more education about asthma care and treatment. I didn't know how often OB patients presented with asthma, but I thought it would be a good idea for staff to be prepared just in case. I contacted the OB clinical nurse specialist and she was delighted to hear from me. She said they didn't get many acute asthmatic patients on their unit, but that she had noticed a recent increase in the number of women presenting with asthma. I did some research on basic respiratory changes during pregnancy and how pregnancy affects asthma, and I prepared an insertive presentation. I have started providing training sessions for nurses on the obstetrical units to educate them about asthma, medications, triggers, and equipment.

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Danielle Doucette, RRT  
senior staff respiratory therapist



I've conducted inservice training sessions on all shifts—days, nights, and weekends. As a rotating clinician myself, I felt it was important to offer this education to all shifts.

I soon realized that many pregnant women who needed to be evaluated and/or admitted to MGH came through the Triage Area on Blake 14. There was no system in place to identify

asthmatic patients not admitted through the ED, so this population, though very small, never had the opportunity to receive asthma education from a respiratory therapist. I discussed this issue with the OB clinical nurse specialist and my supervisors. We are currently working together to ensure that all pregnant women with asthma receive the appropriate

patient-education when they arrive at MGH. Once this is accomplished, I can help educate other therapists and the nursing staff around specific issues related to asthma and pregnancy.

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

The first thing we notice about this narrative is the high quality of

care Danielle provided to Alice during a very stressful time. She put Alice at ease by reassuring her about the safety of the medications; she relieved her symptoms, recommending a 'stacked' nebulizer treatment; and she advocated for her to be moved to a unit where she could be more closely monitored while she was in respiratory distress.

But Danielle did

more than that. She looked beyond this one isolated case and saw an opportunity for patient- and staff-education around the care and treatment of pregnant women with asthma. She took action to raise awareness and implement changes in practice that would benefit future patients. What a wonderful outcome.

Thank-you, Danielle.



Respiratory therapist, Danielle Doucette, RRT, with young patient in the Neonatal Intensive Care Unit

*A graduate of Harvard University, Alison received her master's degree in Physical Therapy from Duke University and her transitional DPT from the MGH Institute of Health Professions. Alison is a board-certified geriatric clinical specialist. Her ability to incorporate the special needs of the elderly into the daily care and thinking of all members of the care team has made her an invaluable resource to patients and colleagues alike. Alison is active on committees seeking to improve the care of patients of size, ensuring that all patients receive the highest quality care available.*

## Clinical Narrative

'Gail' transferred to our medical intensive care unit (MICU) three months after a stroke that left her profoundly impaired with aphasia and severe spastic hemiplegia. Intensive, multi-disciplinary therapy had facilitated some recovery of function in a rehabilitation hospital, but she now lay sedated and somnolent in a hospital bed, an aspiration pneumonia causing her to require ventilator and pressor support to live.

The MICU resident had consulted Physical Therapy for assistance with airway clearance (chest PT) because Gail had a right lower lobe infiltrate on her chest x-ray. I reviewed the medical record and learned important information about Gail's cardiopulmonary status and how the physicians planned to deal with the critical issues at hand, namely ventilatory failure and hemodynamic instability. There was less information in the chart about Gail's neuromuscular and functional status, which I knew I needed for a complete and accurate evaluation of her physical therapy needs.

After discussing the nurse's assessment and management of Gail's secretions with her, I felt I had enough information to begin my examination.

I quietly entered the room to observe Gail and her environment to begin to gather data for my evaluation. Before attempting to wake her, I noted her vital signs, breathing pattern, posture in the bed, facial expression, skin color, ventilatory-support levels, and other lines and catheters in use, including a minimal amount of white sputum in her suction container. After my initial survey, I introduced myself to Gail, and attempted to rouse her with words and a firm rub, but with no success.

Though Gail's sedation and aphasia prevented her from talking, her room spoke volumes. I was immediately drawn to the picture of Gail displayed above her bed. It showed a vibrant, happy woman who was well dressed and clearly took care of herself. The "Get to Know Me" poster told of her love of family, shopping, and reading, and her stressors includ-

ed feeling out of control. I wondered how aware she was of her current situation and helplessness, which would undoubtedly cause anxiety for her. Throughout my exam, I was careful to explain to Gail what I was doing and why to allay her fears in case she could hear and understand me. Because she was aphasic, I spoke to Gail slowly in simple sentences, used familiar language, and mentioned things that I knew were important to her to optimize my chances of connecting with her.

More pictures and cards adorned the walls, confirming the presence of many friends and family in her life. A thick binder on the bedside table caught my attention. Gail's family had established a communication book in which her family, friends, and care providers could talk to each other. Notes from Gail's physical, occupational, and speech therapists painted a picture of a significantly impaired woman, completely dependent on others to get out of bed and perform all activities of daily living. Nonetheless, the



Alison Squadrino, PT  
geriatric clinical physical therapy specialist

words of her loved ones were hopeful and positive. I read some of the messages such as, "Mom looks great today! She's sitting up in a chair and I think she moved her hand," and "I cut Aunt Gail's hair. I hope you all like it. She smiled at me."

Slowly, I was beginning to understand information about Gail that research shows impacts long-term outcomes after a stroke, such as her previous active lifestyle, the presence of a large, supportive family, and the fact that she had not regained any motor function on her right side in the three months since her stroke.

Gail may have been fighting a pulmonary infection as the chest x-ray noted, but her breath sounds were clear, her breathing pattern was symmetrical, her gas exchange was excellent, and the cough that was stimulated by suctioning was productive of only a small amount of white

sputum. Based on these findings, I didn't think Gail required manual airway clearance techniques to manage excessive, retained secretions. I had done a literature review on the effectiveness of these interventions in patients with pneumonia, and I knew the research didn't support its effectiveness in improving patient outcomes. A combination of my examination findings and my knowledge of the literature led me to conclude that this was not the problem I needed to address with Gail.

The tests I had chosen indicated a different impairment. I was struck by the severity of Gail's spasticity and realized that without intervention, she could lose the range of motion in her joints. She held her right leg in a fully extended position and facilitation techniques to diminish her tone and allow passive range of motion were not successful. It

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would be a challenge to prevent contractures with such spasticity. I felt the best option was to cast Gail's ankle to hold it in a flexed position. The strong push of her foot against a splint might cause skin breakdown and the range-of-motion exercises I could provide wouldn't be enough to counteract the effect of the prolonged periods of time spent in a toe-pointed posture. I looked for positions that would flex Gail's hip and knee for extended periods of time. I placed her on her right side to diminish the sensory input that was facilitating the overactive extensor muscles, and used pillows to hold her leg at an angle.

I discussed my findings and reasoning for not performing manual airway clearance techniques with Gail's medical team. I told them of my intention to cast her ankle to prevent a contracture. They understood and agreed. Though I was comfortable with my decision and choice of intervention, I was less confident in my ability to achieve the optimal position for her ankle, because I hadn't casted many patients with such severe spasticity before. I consulted my colleague, a neurologic clinical specialist, for help and scheduled a time with her and the orthopedic technician for the following day. I wrote a note to Gail's family in the communication book, introducing myself, re-

lating my plan and providing my phone number in case they had any questions. Susan, one of Gail's daughters and her healthcare proxy, wrote back, thanking me for seeing her mother and taking care of her.

Our casting session went smoothly. I discussed the rationale and plan for the cast with Gail's nurse and gave her contact information in case she needed to have it cut off if there were signs of vascular compromise. We reviewed the recommended positions to reduce Gail's spasticity and allow better range of motion. All seemed to be in order, so I left the MICU to work with another patient. Within the hour, I received a page from Gail's nurse asking me to come back. Gail's daughter, Lisa, wanted to speak with me, and she was upset.

As I rode the elevator, I recalled the time my mother was in the hospital. "Try to understand where Lisa is coming from," I told myself. "Her mother is lying in an intensive care unit. She's upset. Understand that this is not easy for her."

Despite my pep talk, I was unprepared for how upset Lisa was, and specifically, with me. She felt it was unacceptable to put a cast on her mother's leg. To her, it seemed cruel to burden Gail with something so uncomfortable and restrictive when she was critically ill and fighting to

live. She demanded I cut it off immediately. I empathized with her fear and respected her strong advocacy, and I told her so, but I was also confident that I had Gail's best interests at heart. I had watched closely for signs that Gail was in pain, and I hadn't seen any. I tried to help Lisa see beyond this intensive-care stay to understand the rationale for my plan. If we didn't preserve her mother's range of motion now, she wouldn't be able to progress well in physical therapy later. Dorsiflexion range of motion is necessary to stand and sit in a wheelchair without risk of skin break-

down. These were reasonable possibilities for Gail in the future, and I wanted her to be ready for them when she was medically stable.

My reasoning and hope for the future didn't help this situation that was quickly escalating. The volume of Lisa's voice and the anger of her words continued to rise and I realized this was not going to be a productive conversation. I reiterated my concern for Lisa's feelings and assured her I would respect their wishes, but I wanted to be sure that Susan, the healthcare proxy, agreed with this decision. I suggested she discuss the issue

with Susan and told her I would return that afternoon to see if the plan of care needed to be modified.

When I came back to the MICU, my heart was pounding as I anticipated another challenging conversation. But Susan was there alone and quickly thanked me for being attentive and careful in my work. She apologized for Lisa's behavior and confirmed my suspicion that Lisa was having difficulty seeing her mother's health fail. I fully appreciated her pain and told Susan not to worry. I asked if she wanted to speak with a social worker. We re-

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Physical therapist, Alison Squadrito, PT, helps patient, Eugene Mahoney, ambulate the halls of White 10

# Mary Louisa Zwirner

January 6, 2005

*Mary received her bachelor of Science degree in Nursing from the University of North Carolina and her master's degree in Nursing from Simmons College. After deciding to change careers, Mary graduated from Boston University's School of Social Work in 1986. She has practiced at MGH for four years as a social worker on White 12 and Bigelow 14. A person of great patience, compassion, and knowledge, Mary knows that every patient has a story to tell. Sometimes through active listening, sometimes with probing questions, and sometimes by providing quiet comfort, Mary unearths possibilities that few others see. She knows that each patient's story contributes to the healing process.*

## Clinical Narrative

*(This is not the clinical narrative that accompanied Mary Zwirner's nomination portfolio; that narrative could not be printed in order to preserve patient confidentiality. This narrative was written in March of 2004)*



Mary Louisa Zwirner, LICSW  
clinical social worker

I have been a clinical social worker for 18 years and have worked at MGH for four years on the Neurology/Neurosurgery unit. The case I'm going to describe involved a 24-year-old woman and her family whom I saw over a two-month hospitalization.

'Terry' was admitted with new onset of seizures. She had a pre-existing diagnosis of systemic lupus erythematosus (since 1997), which had resulted in frequent hospitalizations over the years and led to an official determination of disability. However, she had been functionally independent prior to this admission and shared an apartment with her significant other.

Terry had lost both her parents to complications of HIV infection. Her mother had died when she was 13 years old, and her father when Terry was 18. She and her younger brother had lived with their maternal grandmother after their

mother's death. An older sister moved out on her own at that time. Although the relationship with Terry's significant other deteriorated during this hospitalization, her family of origin, particularly her grandmother, sister, and several aunts, provided a very strong support system. Terry also had a wide circle of friends.

Upon admission to MGH, a lesion was found on Terry's brain. This lesion became the focus of an extensive work-up, which never resulted in a definitive diagnosis. Treatment was empirical and ultimately not successful. Terry's condition gradually deteriorated. She became lethargic and difficult to engage in conversation. Her mental status declined to the extent that she was not verbally communicative for the last two weeks of her life.

The intervention I'd like to share occurred with Terry's grandmother approximately one

month before Terry died. Mrs. M was a devoted mother and grandmother. She had already lost two of her children, and it was evident during this conversation that she was very frightened of losing her granddaughter. For several weeks, she had been staying with Terry around the clock so Terry wouldn't be alone, and to allow her to provide the extra care she wanted Terry to have.

The day that I sat with Mrs. M, she expressed her discouragement with Terry's condition and also with her perception that Terry wasn't trying to help herself. Frequently, Terry refused to work with her physical therapist or even get up to use the bathroom. "She just won't do for herself," said Mrs. M.

Meanwhile, Terry's body was getting weaker and more deconditioned. Mrs. M was concerned that Terry had given up and was using pain medication as an escape rather

than for real need. Mrs. M (a woman in her late 60s) was very tired. It was evident she needed a break, but was unable, as yet, to give herself permission to rest.

As Mrs. M shared with me the losses in her life and her fears and frustrations about Terry, she cried. She talked about the conflict of knowing she needed to take a break to care for herself and the painful feeling of desertion if she left Terry alone. Before this interaction, I hadn't spent much time with Mrs. M; but that day marked the beginning of a strong connection.

After she cried for a while, and with some gentle encouragement from me, Mrs. M seemed to realize that she needed a break from the hospital, and that she would be able to live more or less comfortably with that decision. It was as though she felt good about claiming something for herself. She had talked

ed about how much she had given to Terry (and others in the family) and now she needed to give to herself. She could see that Terry might benefit from her absence as she might be motivated to do more for herself without her grandmother there. I talked with Mrs. M about how the nurses on the unit would support her, and as much as they could, provide extra attention to Terry in her absence. We agreed that I would call her each day after visiting Terry to give her an update. Mrs. M thanked me, saying, "You have helped me so much." She didn't say for sure that she would leave, but when I returned after the weekend, she wasn't there.

Mrs. M and I maintained telephone contact as planned. She stayed home for several days. Other family members visited Terry in the grandmother's absence. When Mrs. M did come in, she

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stayed for the day but left at night. She acknowledged that the rest had been good for her and that Terry had managed without her. Unfortunately, however, Terry's condition continued to decline.

Through my connection with Mrs. M, a relationship with Terry's sister also developed. I became the point person for facilitating communication between the family and the medical team. In the three days before Terry's death, I sat for long periods with Mrs. M and Terry's sister as they made difficult decisions about code status and ultimately, withdrawal of care.

For me as a clinician, the significance of this

intervention lies in its importance as a reminder of the power of sitting with a patient or family member and 'just' listening to their story. They often already know what they need to do, but gain the power and courage to do it only when they've been shored up by the listening presence and affirmation of a clinician. The bond created by such an interaction can be quite strong and lasting (Mrs. M still calls periodically). This case also demonstrates how clinicians may not always have a direct impact on the patient, but they can support the entire family system by working with one or more members of the family.

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

Mary demonstrates the power of being present and the importance of non-judgmental involvement in this beautiful story. She subtly and skillfully helped Mrs. M 'separate' from her granddaughter and make those important end-of-life decisions. We've heard the term, 'good death,' used when a patient is able to die peacefully surrounded by, and with the support of, loved ones. It is also a good death when family members can achieve that same level of peace. And thanks to Mary, Mrs. M was able to do just that.

Thank-you, Mary.



Top right: social worker, Mary Zwirner, LICSW, accepts Partners in Excellence Award from Partners president and CEO, James Mongan, MD.  
Above: Zwirner consults with White 12 nursing colleagues (l-r): Susan Sullivan, RN; Jennifer O'Neill, RN; and Mary Page, RN.

# Macaluso Moments

The legacy continues...



The 2004  
Stephanie M. Macaluso,  
RN, Excellence in Clinical  
Practice Awards



## Macaluso Award Ceremony

*continued from front page*



He compared clinical leaders to artists. When Michelangelo was asked about the statue of David, he said, "I saw an angel in the marble and carved until I set him free." Clinical leaders, said Perleberg, "unlock the potential for excellence in themselves and others until all the angels are set free."

Introducing Burns



Britton, the first award recipient, Ives Erickson read from a letter of nomination written by Ellen Robinson, RN. "Betty Ann is brilliant and soundly based theoretically in the practice of professional nursing. When representing her discipline at the table, Betty Ann is confident, articulate, and persuasive in a non-defensive manner."

Reading from a letter written by Sarah Buck, RN, Ives Erickson said of Doucette, "Danielle is an excellent teacher to her fellow therapists. She has a wonderful way of communicating her skills to staff nurses and physicians. When Danielle is assigned to the PICU, there's an overwhelming sense of calm as we all know

that any crisis will be handled quickly and expertly."

Of Squadrito, colleague, Kristin Parلمان, PT, wrote, "Alison is an expert in physical therapy and has achieved one of the profession's highest clinical positions, that of board certified geriatric clinical specialist. It is not only for her advanced knowledge in the area of Geriatrics, but the breadth of her knowledge, analytical thinking, and spirit of inquiry that she is recognized as a leader and sought out by colleagues as a clinical resource."

Interim director of Social Services, Ann Daniels, LICSW, wrote of Zwirner, "Mary is able to quickly and warmly engage with patients and families. She establishes rapport with people from widely different backgrounds and social situations

from young adults, to the elderly, to families with young children, to people from other cultures. Her respectful, non-judgmental, tactful approach elicits a sense of trust and connection."

As is now tradition, one recipient was asked to read the clinical narrative she submitted as one component of her portfolio. Burns Britton read her narrative (see page 2) then engaged in a dialogue with Perleberg (her nurse manager) about the care she described.

Every year, the recipients of this prestigious award seem to inch the bar higher. And that's exactly the way Stephanie Macaluso would have wanted it—ever improving practice, ever improving patient care.

Congratulations to the 2004 Macaluso award recipients.

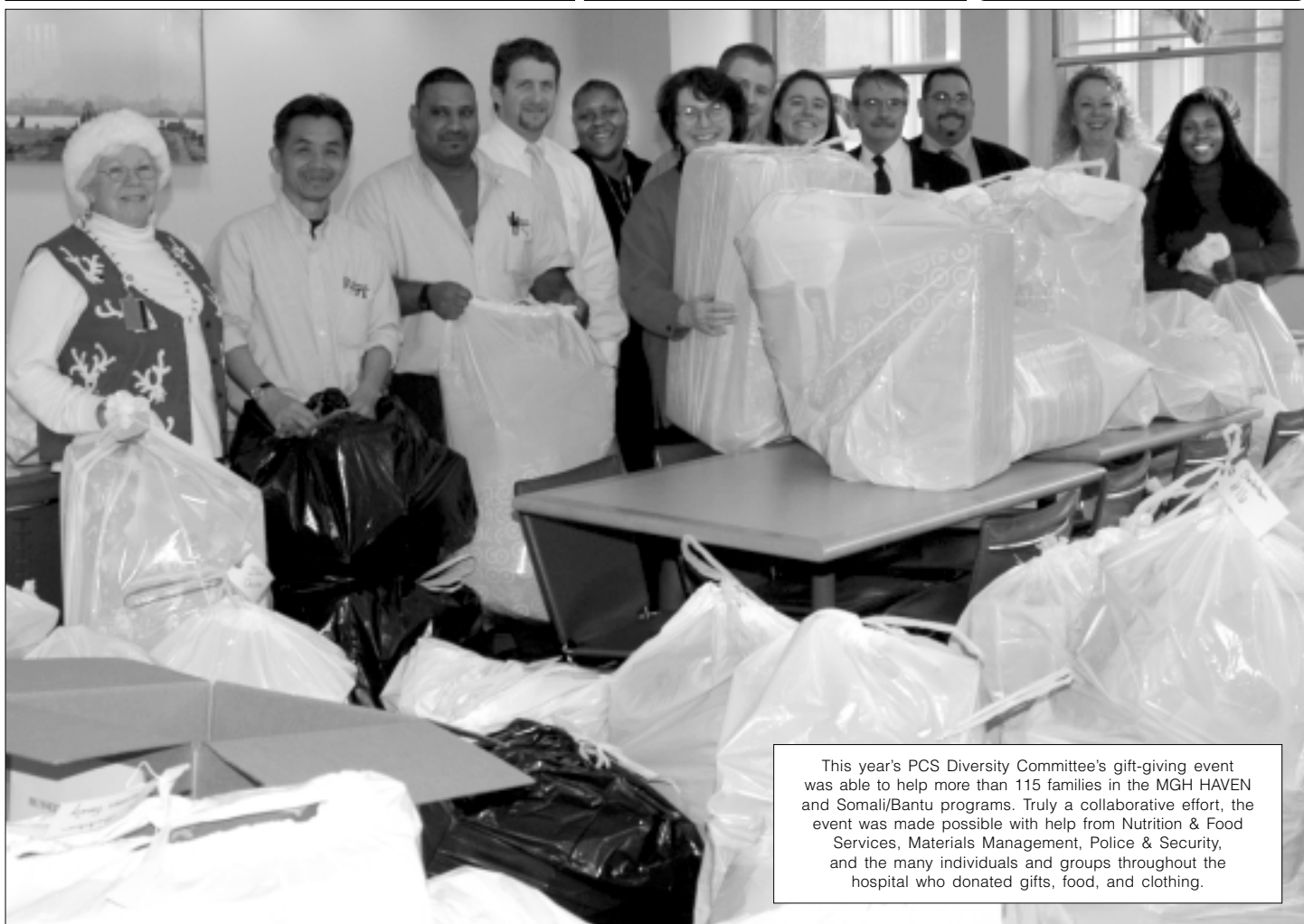




# Holiday Happenings



Joy to  
the  
world



This year's PCS Diversity Committee's gift-giving event was able to help more than 115 families in the MGH HAVEN and Somali/Bantu programs. Truly a collaborative effort, the event was made possible with help from Nutrition & Food Services, Materials Management, Police & Security, and the many individuals and groups throughout the hospital who donated gifts, food, and clothing.

Continued on next page



January 6, 2005

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## Narrative (Squadrito)

*continued from page 7*

viewed the plan of care and she assured me it would be fine with the family, including Lisa.

Gail was diagnosed with tracheomalacia after two failed extubations. She had a tracheal reconstruction and a long hospital course. I remained her physical therapist throughout the admission, though she transferred to several different units. During this time, through an unstated understanding and forgiveness of the situation, Lisa and I were able to move beyond our uncomfortable exchange and work together to care for her mother. Eventually Gail returned to the rehabilitation hospital to continue her recovery and she was able to practice standing without limitation from her ankle range of motion. Perhaps more important to her was the fact that she was also able to be positioned in a wheelchair so that her family could take her to the mall on a day pass.

Unfortunately, Gail was readmitted on several occasions with an aspiration pneumonia. Each time, I got a phone call from Susan or Lisa before she arrived letting me know she was on her way and asking me to find her and provide the physical therapy she needed.

I have been a physical therapist for nine years and have had extensive experience in many

clinical settings. This experience has helped develop my understanding of the course of recovery from illness and has guided my work with other patients like Gail. While my intervention may not be the most essential at times of critical illness, I do believe my ability to recognize a patient's potential and position her to achieve it is valuable. After all, it might allow a shopper like Gail to return to the mall with her family soon after she leaves our care.

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

This narrative tells, not only the story of Gail's medical experience at MGH, but also of Alison's insightful, methodical, and comprehensive thought processes in providing the necessary and appropriate physical-therapy treatment

for Gail at a critical time in her recovery. As Gail's family struggled to come to grips with Gail's condition, Alison helped them look beyond the moment and understand the importance of the interventions she was recommending. They

soon came to recognize Alison's commitment, skill, and ability, and sought out her services when Gail returned for future admissions.

I think we all feel that Gail will achieve her full potential with Alison's help. Thank-you, Alison.

### Save The Date

#### AMMP's tribute to Martin Luther King, Jr.

The Association of Multicultural Members of Partners presents:

"Living the Dream: a Tribute to the Life of Reverend Dr. Martin Luther King, Jr."

**Friday, January 14, 2005  
8:00-9:00am  
East Garden Dining Room**

### Advanced Practice Clinician Program

"Influenza: high risk groups and management; and the pneumococcal vaccine"

David C. Hooper, MD, chief of Infection Control Unit

**January 7, 2005**

**7:30am (networking and refreshments)  
8:00-9:00am (presentation)  
O'Keefe Auditorium**

1.2 CEUs

For information, call 6-3111

## Past Macaluso Recipients

First 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 S. Bellavia, RN  
Mary Elizabeth McAuley, RN  
Diane McKenna-Yasek, RN  
Marica Wasenius Rie, PT

December 7, 2000

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

June 21, 2001

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

December 13, 2001

Clare Beck, RN  
Anita Carew, RN  
Robert Goulet, RRT  
Kristen Jacobsen, SLP  
Thomas Lynch, RN

June 13, 2002

Sharon Brackett, RN  
Marguerite Hamel-Nardozzi, LICSW  
Mary Lou Kelleher, RN  
Judith Lynch, RN  
Kristin Parlman, PT  
Debra Smith, RN

December 12, 2002

Kathryn Best, RN  
Jennifer Kelliher, RN  
Michael McElhinny, MDiv  
Carol McSheffrey, LICSW  
Jean O'Toole, PT

December 11, 2003

Erica Edwards, RN  
Kimberly Stewart, CCC-SLP  
Cynthia Thibodeau, PT  
Mara Wernick Robinson, PT  
Brenda Whelan, RN

# Educational Offerings

January 6, 2005

When/Where	Description	Contact Hours
January 13 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
January 13 7:30am–12:30pm	<b>Pediatric Advanced Life Support (PALS) Re-Certification Program</b> Wellman Conference Room	---
January 14 12:00–1:00pm	<b>Family Presence During Resuscitation: Exploring the Practice From an Ethical Perspective</b> Walcott Conference Room	---
January 20 8:00am–4:30pm	<b>Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other</b> Training Department, Charles River Plaza	7.2
January 20 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
January 24 and 25 7:30am–4:30pm	<b>Intra-Aortic Balloon Pump Workshop</b> Day 1: NEMC; Day 2: VBK601	14.4 for completing both days
January 26 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
January 26 4:00–5:30pm	<b>Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements</b> FND626	1.8
January 27 8:00am–4:30pm	<b>Workforce Dynamics: Skills for Success</b> Training Department, Charles River Plaza	TBA
January 27 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
January 27 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Management of Difficult Patients.” O’Keeffe Auditorium	1.2
January 28 12:00–4:00pm	<b>Basic Respiratory Nursing Care</b> Ellison 19 Conference Room (1919)	---
January 28 9:30–11:30am	<b>CINAHL: Cumulative Index to Nursing and Allied Health</b> FND626	1.2
January 31 8:00am–4:00pm	<b>Special Procedures/Diagnostic Tests: What You Need to Know</b> O’Keeffe Auditorium	TBA
February 1 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
February 3 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
February 7 8:00am–4:30pm	<b>Different Faces of Quality Improvement: Creating an Environment of Quality and Safety Practice</b> O’Keeffe Auditorium	TBA
February 8 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
February 9 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
February 9 8:00–11:30am	<b>Intermediate Arrhythmias</b> Haber Conference Room	3.9
February 9 12:15–4:30pm	<b>Pacing: Concepts</b> Haber Conference Room	4.5

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111.  
For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

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

In August of 1996, Jeanette Ives Erickson, RN, senior vice president for Patient Care, formally announced the creation of the Excellence in Clinical Practice Award (originally called 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 that 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, Excellence 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 experience in her role as clinical teacher. She 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 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' stor-

ies. She knew that every illness had a story—relationships were disturbed, plans were thwarted, 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 Steph-

anie M. Macaluso, RN, Excellence in Clinical Practice Award is now given annually. 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, Excellence in Clinical Practice Award allows us to publicly re-commit ourselves to the highest standards of care we hold for our patients, and contribute to the on-going professional development of clinicians within Patient Care Services.

# Caring

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