Dare to dream of better endings.
For nearly a century, U of T Nursing has helped shape nursing education, research, practice and health policy. Today we continue to blaze a trail as one of the premier nursing programs in the world, supporting the next generation of nurses and helping to ensure the health and well-being of Canadians and people around the globe.

The campaign for Bloomberg Nursing signals a new era for our Faculty. We celebrate the leadership of those who have supported our transformation over the past century as we prepare to embark on the next chapter of our remarkable journey.

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Cover: Emily Cooper
Health commentator and columnist André Picard recently described Canada as a “dismal place to die.” Indeed, Canada has a way to go to match its peer countries in providing access to palliative care. Only between 16 and 30 per cent of Canadians benefit from palliative care before death.

Death and taxes come to us all. But despite the inevitability of death, it is surprisingly difficult to talk about end of life. Silence has consequences. Instead of health professionals developing a plan of care with the patient and family over the course of the illness trajectory, they fail to push the “pause button” and step back to review the patient’s goals and circumstances. This failure to initiate end-of-life discussions can lead to patients – who may desperately need comfort measures and supportive care – getting stuck in the acute health care system and being subjected to aggressive, futile measures. In the process, family members who experience an unsupportive or insensitive environment can be severely traumatized, not just by the death, but by the way the death took place.

This issue of Pulse asks: How can we support health professionals in avoiding avoidance behaviours regarding end-of-life discussions? What kind of care can be provided at the end of life? How do we shift care of the dying out of acute care and expand palliative care across the system?

Dr. Doris Howell, RBC Chair, Oncology Nursing Research and Education, is an international expert in palliative care; particularly, in symptom management. Other U of T Nursing researchers are working with practitioners to prepare them to have end-of-life conversations. In areas as diverse as dialysis, end-stage renal disease, cancer and HIV/AIDS, nurses need support and education to open up possibilities for patients and their families to talk about how they want to live their remaining days.

The glare of publicity over high-profile controversies – such as physician-assisted suicide, the withdrawal of life-sustaining treatment in ICUs, and the role of living wills and planned directives – depicts care providers, and patients and families in opposing camps. To prevent a gulf from developing between health professionals and clients, our faculty and alumni are continuing to innovate in partnership with patients and families. They’re mentoring our students to be knowledgeable, mindful and courageous in dealing with the end of life. Having difficult conversations early and often can transform the final journey into a partnership and, ultimately, a life-affirming event.

SIOBAN NELSON, RN, PhD, FAAN, FCAHS
Until we see death and dying as part of the continuum of care, Canada will remain a poor place to die

If you live in a middle- or high-income country anywhere in the world, it’s highly likely that you will eventually die of a non-communicable disease (NCD), such as cancer, cardiovascular disease, respiratory disease or diabetes, or a combination of these chronic conditions. Over the next decade, even the poorest countries in Africa are predicted to follow suit. In the meantime, these diseases – dubbed the “Big Four” – dominate health care systems from Hanoi to Halifax, from Mumbai to Madrid.

French historian Philippe Ariès in his 1981 landmark book, *The Hour of Our Death*, tracked attitudes toward death and dying in Western society from the Middle Ages to the late 20th century. Ariès’ controversial work describes contemporary society as death denying and under the illusion that modern medicine can somehow conquer death. He argues that death has become equated with science failing, and conceived as shocking and horrific to contemporary sensibilities. He notes the great effort that’s made to make death invisible.

This critique of modern medicine’s attitude to dying – with its use of battle metaphors such as “war on disease” – is echoed in Margaret Edson’s 1991 play *Wit*, which follows the harrowing treatment and final days of an English professor with ovarian cancer. The Pulitzer Prize-winning play contains profound and eloquent reflections on the way the main character’s body had become the battleground for medicine’s fight against the disease that was killing her.

Other heated issues related to death and dying include physician assisted suicide, much highlighted by recent moves in Quebec; advanced directives and their legal standing; as well as the immensely challenging question of end of life in the ICU. All of these painful and polarizing debates reflect a widespread unease and confusion about the place of death in contemporary society. They also question the role of health professionals and the health care system in end-of-life care.

Given the certainty of death, it is strange that we find it such a struggle at the system level. Perhaps the system is aligned with society’s rather warped view of death.

HOW WE DIE
In 1900, the most common cause of death was the direct or indirect result of infectious disease. In a wonderful interactive infographic, the New England Journal of Medicine published a retrospective analysis of causes of death in the United States since 1900. In those early years, influenza and pneumonia took number 1 place, followed by tuberculosis and then gastrointestinal infections.

The victory over infectious disease as a major cause of death in middle- and high-income countries over the first decades of the 20th century is clear. The credit for the epidemiological transformation, though, is claimed by medicine and public health alike. (Medicine argues better treatment, public health better prevention.)

Our modern health-care system arose when infectious disease was the leading cause of death. It created efficient, effective systems to diagnose and treat acute life-threatening infections, trauma and sudden illness. Although treating these medical problems is definitely important, the main causes of death are now neither sudden nor unexpected.

Consider today’s leading causes of death. According to WHO, more than 36-million people around the world die of NCDs every year. About 80 per cent of these individuals die from the Big Four: 17.3-million people die of cardiovascular disease, followed by cancer (7.6 million), respiratory diseases (4.2 million) and diabetes (1.3 million). Globally, we are all victims of the same risk factors: tobacco use, physical inactivity, unhealthy diets and the harmful use of alcohol.

TWO CONUNDRUMS
This dramatic change in the main causes of death has created two big conundrums. First, we have an acute health-care system that excels at patching people up and sending them on their way, while primary and community care remains desperately underdeveloped in most parts of the world. In Canada, we are struggling to meet the current demand for services. Stuck as we are in our current model, we lack the capacity to extend our services to adequately provide the health-promotion and disease-prevention initiatives we so clearly need to reduce the number of people tracking toward death from an NCD.

Second, we already have millions of people who suffer from one or more NCD, and as the disease or diseases progress, these individuals will struggle to manage their conditions.
IT'S LITTLE WONDER THAT THE ANGER AND FRUSTRATION OF FAMILIES AND PATIENTS IS SPILLING INTO THE HEADLINES AND THE COURTS
symptoms and need increasing support and compassion – support the system currently has no mechanism to offer.

One distressing aspect of these conundrums is that we know so much about them. No revelation is required – the data are all there. For example, a European study published in 2011 in the British Medical Journal of Supportive and Palliative Care looked at the way Europeans were dying. Undertaking a retrospective audit of 4.5-million deaths in the European Union, the authors differentiated between “sudden” and “non-acute” deaths. Of the 4.5-million deaths, they identified almost half as non-acute. A non-acute death conceivably have been prepared for and managed quite differently than a sudden death – perhaps it could have taken place at home or in a hospice, and it most certainly could have benefitted from a palliative service. Without such forethought and planning, the vast majority of these deaths would have occurred in the busy emergency rooms, medical-surgical units and ICUs of high-paced acute hospitals.

These deaths create enormous pressures on the acute system and are far from optimal for the patient and family. It’s little wonder that the anger and frustration of families and patients is spilling into the headlines and the courts. It is a problem we can see coming. In fact, it’s already here.

**A DYING CONCERN**

How do we step back and create a humane, compassionate approach that doesn’t treat every death as a sudden, unexpected event requiring all measures to preserve life? The European study authors call for short- and long-term palliative care strategies. What would these strategies look like?

A critical piece is training our health professionals in palliative and end-of-life care. In Canada, a great deal of energy is going into providing better training for physicians and nurses in this area. Students need to learn how to have difficult conversations, how to support patients and families as they make ongoing adjustments over the illness trajectory, and how and when to make critical choices.

Another part of the solution is teaching learners how to look after themselves and their colleagues. Burnout leads to a loss of compassion and high stress levels, which seriously affect both the quality of care and the health of the care provider. Mentorship is key if students are to develop the skills to offer consolation, compassion and high-level supportive care to patients and their families.

Teamwork is also a major element of quality end-of-life care. Despite what one may imagine from fictional portrayals of intense doctor-patient relationships, there are many important team members who have a role to play in high-quality end-of-life care. Health professionals need to forge good relationships with the patient and family, and also with other health care providers. To achieve quality collaborative care, it takes interprofessional training between physicians, nurses, social workers, chaplains and any number of other professionals.

Regardless of how humane our health professionals may be as individuals, or how effective they are as advocates, end-of-life care is ultimately a system issue. Until the system gives some space to step off the acute pathway – to develop a plan to help with the sometimes-slow, sometimes-rapid transition from disease and symptom management to palliative care and end-of-life planning – then it will not be available to the tens of thousands of Canadians each year who will experience a non-sudden, predictable death.

**SHIFTING THE SYSTEM**

The lack of access to palliative care services in Canada is already a serious problem. It’s estimated that only a dismal 16 to 30 per cent of the patients who need palliative care actually receive it. It is difficult to see how, with our current poor performance in palliative care, we will be able to accommodate the anticipated increase in non-acute deaths with the demographic shift of the baby boomers and their chronic disease burden.

The issue is fundamentally about models of care and resources. Countries with exemplary palliative-care services have created models of care through dedicated funding streams. They’ve had strong advocacy and leadership from a coalition made up of the public and members of the health professions. The compassionate reasons for ensuring all citizens, wherever they live, have access to palliative care should stand as a prima facie argument that policy-makers respect and honour. Sadly, this is not the case. So the second strand of the argument needs to be built on the sheer inefficiency of having non-acute deaths taking place in busy ERs, and medical and surgical units.

In a sense, the way Canadians die is perhaps the most telling measure of the failure of the system to effectively adapt and respond to the needs of its citizens. While the hospital remains the core service-provider, and primary care is largely limited to access to a physician for a single problem consultation, and community care is the underfunded poor relation to medical services, we will never develop the capacity to offer Canadians the supportive care and compassion they need at end of life.

Nurses have an enormous role to play in improving end-of-life care. From direct case-management models for patients with chronic disease, to integrated palliative-care services such as those in the U.K. and Australia, nurses can provide the leadership and transformative energy to reframe the care of those with an NCD. A new way of care needs nurses to be fully deployed in health-promotion and disease-prevention programs, deeply involved in symptom support and patient self-management education, and leading integrative and multidisciplinary programs of supportive and end-of-life care.

Until we see death and dying as part of the continuum of care, and invest in the education and service development needed to meet current and future needs, Canada will remain a poor place to die for so many of our citizens. Other countries do better. They use their nurses and strong interprofessional teams to create a compassionate environment for those dying from a chronic disease. We can too.

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BMJ Support Palliat Care. doi:10.1136/bmjspcare-2011-000162


**Note:**

The illustration on page 5 is credited to Bloomberg Nursing.
While a patient may be eager to talk about his impending death, his nurse might not know what to say...
In the master’s program at U of T Nursing, Trish Murphy-Kane gained the understanding that part of her role as a clinical nurse specialist is to identify gaps in practice and develop initiatives to improve practice. So she decided to help bridge the communication chasm that can develop between a nurse and a dying patient and his or her family. “Some nurses don’t know how to bring up the topic of death; they can’t find the words,” she says. “Patients, though, usually want to talk about the fact that they are dying. Death can be the elephant in the room.”

To kick-start a conversation about dying with a patient, Murphy-Kane, MN OT6, uses a single question: What do you understand about your illness? “I talk about the importance of this question with nurses all the time,” says Murphy-Kane, who practises in the palliative care unit at Princess Margaret Cancer Centre. “The question leads you to where the patient is at, and can open up the conversation and move you away from your own agenda.” She finds a related question – What do you want to know about your illness? – useful when the patient is too sick for a full discussion. If the patient doesn’t want to discuss his or her health status, she asks: Is there someone you would like me to speak to?

Anne Moulton, a Bloomberg PhD student, is investigating the nurse’s role in end-of-life discussions with patients diagnosed with end-stage renal disease. “Research shows that patients want to have these conversations and are waiting for their health care provider to initiate them,” she says.

These discussions are particularly urgent when patients are reaching the final stages of kidney failure because death is so imminent, says Moulton, a haemodialysis educator at St. Joseph’s Healthcare Hamilton. “Still, many nurses are reluctant to discuss death, and patients receiving dialysis treatments need to know their prognosis...
and that they have options regarding their end-of-life care. Thirty per cent of patients aged 65 to 74 who are starting dialysis need to know they have a mere five-year survival rate. They need to know that if their quality of life deteriorates to the point where it no longer seems worth living, they have options, such as stopping dialysis.

As death draws nearer, the nurse’s main role can expand from caring for the patient to caring for and supporting the family. “It’s not always clear to the family that the patient is dying,” warns Murphy-Kane, who is also a U of T Nursing adjunct faculty member. “You really can’t assume anything.”

**SPEAKING WITH THE FAMILY**

At a family meeting, Murphy-Kane might open an end-of-life conversation by adapting her all-important question to: What do you understand about your loved one’s condition? Then, she follows with: Help me to understand what you understand.

If a patient’s daughter points out that her father has rallied before and Murphy-Kane knows this time he won’t, she says, “I’m as hopeful as you are, but I wouldn’t be doing my job if I didn’t tell you that things could go the opposite way. What we’re seeing is leading us to think he may not rally as he did in the past. We may need to start thinking about what I call a ‘backup plan.’” These few sentences can launch a conversation about the patient’s wishes regarding end-of-life care.

Should Murphy-Kane recognize that the family members aren’t accepting that death is close, she gently leads them to coming to this realization on their own. She asks, “What have you been seeing to indicate he’s getting better?” The daughter might say she has been waiting for Dad to squeeze her hand. If he hasn’t been, Murphy-Kane would say: I’m so sorry that this isn’t happening. Then she’d sit quietly with the daughter and just be present.

**WHEN WORDS FAIL**

“It took me a long time to learn to sit in silence,” continues Murphy-Kane, who has been a palliative care nurse for 15 years. “The patients and families have taught me that my place is just to be with them. Eye contact and simply being present can do more than words.” Murphy-Kane deters other staff from minimizing the impact of the death on the family by saying clichés such as “This was meant to be” or “He’s at peace now.” Instead of saying “I know how you must feel,” she says, “I can only imagine how hard this is.”

And what if a nurse really doesn’t know what to say? Murphy-Kane advises, “Be present and empathetic in your interactions as you say, ‘I don’t know what to say.’”

**MANAGING DEATH ANXIETY**

As a nurse practitioner providing palliative care, Ildico Tettero sees herself as a midwife to dying patients and their family members. “I coach patients and families through a very emotional time in their lives,” explains Tettero, whose compassion and reassuring confidence was recognized with a 2012 Toronto Star Nightingale Award.

In the outpatient cancer clinic at Joseph Brant Hospital in Burlington, Ontario, she gives emotional and practical support to families caring for a dying loved one at home. “I try to normalize death,” says Tettero, MN OT. “The body will at some point in time fail. Death is part of life and not something to be feared.”

Tettero credits her mother, who was also a nurse, for her pragmatic attitude toward death. Wanting to address end of life head on, Tettero prefers the words “death” and “dying” over “passed away” and other euphemisms. “I might ask the patient, ‘Have you thought about where you want to die?’ Sometimes the family members are surprised, but the patient is usually relieved.”

Many of her patients ask what dying will be like, wanting to know if it will be painful or if they’ll slip into a coma. Knowing that fear of the unknown can be worse than reality, she explains that they’ll get weaker, lose their appetite and reach out less to others. Often, Tettero will hand the patient and family a brochure that details the physical and emotional changes to expect.

Endlessly positive, Tettero prefers the words “death” and “dying” over “passed away” and other euphemisms. “I might ask the patient, ‘Have you thought about where you want to die?’ Sometimes the family members are surprised, but the patient is usually relieved.”

Another way Tettero has expressed her positive attitude toward death is by supporting an initiative to have the hospital change its “Do Not Resuscitate” order to “Allow Natural Death.” As she explains, “It takes out the negativity.”
Death in the Curriculum

The Power of Four

Bloomberg undergraduates tackle the hard issues

Karolina Gielarowiec

Micaela Hardy-Moffat

Erin Telegdi

Benjamin Soer
At the annual Canadian Nursing Students’ Association (CNSA) conference, undergraduates have an opportunity to propose ways to improve the curriculum. At this year’s conference in Halifax, students presented 15 policy statements. Three of those papers were from U of T Nursing students.

In January, two of our students flew to Halifax to present their proposals in person at the CNSA National Assembly. They defended their resolutions and position statements in an auditorium packed with nursing students as well as the CNSA board of directors.

TEACH US ABOUT DYING
“Benjamin Soer, approach Microphone 3,” instructed the CNSA president. “Support your resolution that it be mandatory for nursing students to be educated about end of life.”

Soer stood up and felt his stomach drop. Then, as he started to explain the need to recognize the physical signs of active dying, his confidence started to grow. “By knowing when to advocate for pain medications and discontinuing curative treatments, nurses will be able to help ease the patient’s pain and discomfort. And we need to be better prepared to meet the emotional, spiritual and practical needs of the patient and family during end-of-life care. When it comes to the dying patient, nurses are in a unique position to really make a difference.”

He went on to explain that, depending on a nursing student’s clinical placements, the student can graduate without caring for a dying patient or even being exposed to death. At a placement in the veterans’ wing at Sunnybrook Health Sciences Centre, Soer cared for a patient who he learned died a couple of weeks later. And he led a seminar on death and dying for his adult persistent illness class. Soer’s commitment to including end-of-life care in the curriculum, though, grew from an event in his personal life. “I recently experienced the death of my grandfather,” he confides. “Death is not easy, and nursing is not for the faint of heart.”

After some debate in the National Assembly, Soer’s resolution passed. In the following days, Soer was surprised when other delegates approached him to shake his hand or pat him on the back. “So many people told me they need more education about death and dying,” he says.

CNSA, the national voice of Canada’s nursing students, advocates to nursing schools and nursing education stakeholders on issues that affect nursing students now and in their future practice. Since Soer’s resolution passed, CNSA has posted it on its website and is now petitioning Canadian nursing schools on the necessity for including death and dying in their programs. “I felt I made a difference across the country,” says Soer. “I learned that if you put in the effort, anyone can make a policy change.”

TEACH US HOW TO ADVOCATE
“Advocating will definitely be part of my nursing career,” says Erin Telegdi who presented the “Political Activism Competency” resolution to the National Assembly. Telegdi spoke on how nurses experience the impact of health care policy, and are in a unique and crucial position to advocate for change. She asked CNSA to encourage nursing students to adopt leadership roles as political and policy advocates. She asked the association to encourage nursing schools to teach students how to write and defend policy initiatives. CNSA accepted the resolution.

“I think U of T’s faculty and curriculum are pretty progressive, but that’s not the case across Canada,” says Telegdi. “A lot of nursing students don’t realize that nurses not only can be leaders for change, but need to be. Our professional standards require us to advocate for equity and justice so we can provide optimal care to our patients and the communities in which we practise. I believe nursing is an inherently political act.”

In her second year, Telegdi had the opportunity to practice political activism in her community health course. Lecturer Joanne Louis asked the class to prepare a proposal for a population’s health issue. Telegdi proposed a community-based initiative to make the area around Casey House, a facility for individuals living with HIV/AIDS, a zone that’s free from HIV/AIDS stigma.

Micaela Hardy-Moffat, who contributed to the resolution, points out that many students enter nursing knowing little about policy development. As an example, Hardy-Moffat puts forward her own academic history. Her first degree is in fine art; specifically, drawing and painting.

“An amazing way to learn advocacy would be to shadow a nurse advocate,” she suggests. “The more students know, the more politically active they can become.” When Hardy-Moffat begins practising, she has every intention of advocating for change. “It’ll start with one patient who will shine the spotlight on an issue, and then I will most certainly step forward.”

RECOGNIZE HORIZONTAL VIOLENCE
Karolina Gielarowicz’s “Position Statement on Horizontal Violence” notes that horizontal violence (defined as bullying and aggressive behaviours between nurses) is rarely formally acknowledged in the undergraduate curriculum, even though research shows that most nursing students experience some sort of aggression in their clinical placements.

Not that Gielarowicz needs a research paper to know that students can be the target of horizontal violence. She has experienced it in nearly all of her placements. “While the majority of nurses have been good, some nurses pick on student nurses,” she says. “They put us down.” The problem isn’t unique to Toronto. At the CNSA National Assembly, nursing students from British Columbia presented a similar proposal. The CNSA will amalgamate the two resolutions and debate it at next year’s conference.

“I want to make sure that horizontal violence is mentioned at some point in the curriculum and that nursing students are given coping strategies to deal with it.”
Gielarowiec continues. “It’s wrong to send students out there without warning them about horizontal violence. It’s the reality.”

Some of Gielarowiec’s classmates, unaware of the prevalence of horizontal violence, were blindsided by it. Gielarowiec recalls running into a classmate who was standing in a bus shelter and crying. In a placement, a nurse had told her, “You should know how to do this. You don’t have any skills.” Between tears, the student questioned why she had chosen nursing. “Maybe I should have been an accountant or a computer technician,” she said.

“Nursing relies on teamwork and communication,” argues Gielarowiec. “Horizontal violence can have direct and adverse consequences on patient safety and competent care. And it affects the professional development of nursing students and their integration into the workforce as new nurses.”

Gielarowiec, who graduates this spring, is bracing herself for the horizontal violence she expects to experience as a new nurse. “For sure I’m getting ready for it,” she says. “I’m planning to respond to every negative comment with kindness.”

While faculty, staff and students have long been aware of the importance of welcoming nursing students to a unit, for the most part the profession has viewed poor staff attitudes toward students as beyond anyone’s control. At the service level, there are multiple initiatives to address unit climate, and to change a culture that tolerates horizontal violence and bullying. For learners, the issue tends to fall down the divide between the service provider and the educational institution.

“At Bloomberg, we’re addressing this issue directly,” says Dean Sioban Nelson. “Three years ago, we began to provide student feedback to our hospital partners as part of an innovative 360-degree review of each clinical placement. In an online review, students evaluate themselves, their preceptor or clinical instructor, and the site where they had their practicum. It’s no surprise to us at U of T Nursing that the students evaluate their practice experience extremely highly. This is a real good-news story for our partners. We know they put a great deal of effort into providing a quality environment for learners, and it really does show in the student evaluations. However if students are not welcome, feel poorly treated and see practice that distresses them, the students report that too.

“Our hospital partners need this feedback if they are to do anything about poor attitudes toward students,” continues Nelson. “If you want to manage something you have to measure it. With these detailed reports across units and clinics, including trend data and qualitative comments, our hospital partners have exactly what they need to address the issues. In partnership with Bloomberg Nursing, they can start to target the units and clinics where they need to focus their energies. Our affiliated partners are as committed as we are to ensuring high-quality student experiences. We now have what we need to address this issue.”
Nurses can be the first to recognize that a patient is dying,” says Assistant Professor Doris Leung, who recently led a study that highlighted the tension nurses experience between their inside knowledge that a patient is dying and their desire to protect the family from distress. “A nurse might not tell anyone that a patient is on a protracted journey of dying. Instead, she might pull up the white sheet to conceal the patient’s suffering from the family.”

Some nurses feel that having a conversation with the family about transitioning their loved one from critical care to end-of-life care is their responsibility, counters Associate Professor Elizabeth Peter. “Many nurses, though, recognize they don’t have the skills to have this conversation and, ideally, it should be a team responsibility.”

People with a chronic disease are living longer, more robust lives. “Interventions such as antibiotics, steroids and dialysis can make you feel pretty good even if you have multiple chronic diseases,” says Leung, MN 9T9, PhD 1T0. “The transition to death is getting longer. You may not even know when death is coming because you have no pain. You can feel good for so long and then one day, while you’re out buying groceries, you might have a heart attack or have trouble breathing.”

U of T Nursing researchers are braving a new frontier. They’re exploring the moral, ethical and clinical minefield that can accompany shifting the care of a patient from cure to comfort. “To help patients and their families make these transitions, there are promising strategies – such as regular family conferences, and routine palliative and ethical consultations – but there is still a need to better define the conditions under which end-of-life care is started or delayed,” says Leung. “We want to be able to improve the quality of care for the patient and the family.”

“EVERYONE SEEMS TO THINK THAT THEIR MOM WILL BE THE ONE IN A HUNDRED TO BEAT THE DISEASE, EVEN IF THE PATIENT’S ORGANS ARE FAILING”
— Associate Professor Elizabeth Peter

The family may feel that choosing end-of-life care is giving up on their loved one. “Families see it as their responsibility to do everything, and can you blame them?” asks Peter, MScN 9T1. “We live in a death-denying society. On TV, sick people jump out of bed and are cured. Every time you turn on the news, you hear about another medical advance.”

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Who hasn’t been captivated by a story of an individual who survived a life-threatening illness despite all odds? “Everyone seems to think that their mom will be the one in a hundred to beat the disease, even if the patient’s organs are failing,” says Dr. Peter.

The hospital milieu can intensify the family’s resolve to press on in treating the disease instead of acknowledging that their loved one is dying. “Hospitals are on a cure trajectory,” she says. “The attitude is: You just have to keep on trying.” The belief that death can be beaten if you only try, try, try may mean giving a dying patient chemotherapy, radiation, surgery and any number of other available treatments.

DEATH IN THE ICU
In Canada, 10 to 20 per cent of deaths occur in the ICU, and the majority of these deaths are preceded by a decision to withhold or withdraw life support. “This situation points to the need to develop interventions that give the patient and family realistic expectations of ICU care and that support their decision-making,” says Leung, whose doctoral dissertation
PHOTO: KALDOOR

explored how cancer nurses respond to the threat of patient mortality.

“Providing futile treatments can make nurses feel guilty,” she continues. “It’s very stressful for the nurses who feel like they’re inflicting suffering on the patient. They’re causing physical pain when, for example, they turn a patient whose muscles are wasting and skin is breaking down.

“And the patient is suffering psychosocially. She can’t speak and can’t even look out the window. All she might be able to do is try to pull out her tubing and mouth, ‘No more.’”

FOREVER HOPEFUL
Providing curative treatment to someone near death can cause enormous moral distress for nurses, agrees Peter, who is conducting a study with Lecturer Anne Simmonds, MN OT1, PhD IT0, and Shan Mohammed, BScN 0T4, MN 0T6, a Bloomberg doctoral student and lecturer, to better understand nurses’ moral understanding of aggressive care.

“Nurses talk about these situations a lot. Many nurses think it would be better for the patient to experience a peaceful death, but both nurses and physicians have difficulty having conversations about death.”

In the office two doors down the hall from Peter in the Bloomberg Nursing building, Leung is studying a growing group of patients in the ICU, the chronically critically ill. These individuals require prolonged life support, including mechanical ventilation, and typically have multiple health problems that only worsen with complications from ICU treatments.

“How do you transition them? Do we recognize they’re dying?” asks Leung. “This situation is not natural, it’s a man-made problem. It’s the monster we’ve created.”

Assistant Professor Doris Leung has researched how cancer nurses respond to the threat of patient mortality.
Paediatric palliative care celebrates the child’s life
When I worked in pediatric oncology, I was drawn to the kids who weren’t going to make it,” says Assistant Professor Kimberley Widger. “The small things I could do for the families would make such a big difference.”

Years later, Widger’s trailblazing research in pediatric palliative care confirmed the extent to which the parents of a dying child appreciate a health professional smiling at them, making eye contact, and taking the time to get to know who they are and what they might need. It also determined that a single incident of poor communication or one insensitive comment can continue to distress parents for years.

Caring for a dying child and his or her family requires a repertoire of finely honed attitudes and skills, yet research to inform this care is scant. As Widger points out, the field is filled with unanswered questions: What matters most to patients and their families? What are the bereavement needs of parents after their child has died? Can better pediatric palliative care reduce the incidence and severity of parental depression? And how can you best measure that? Widger hopes to begin to answer these questions through her own research and by fostering research at the Hospital for Sick Children as a nursing research associate with the Paediatric Advanced Care Team.

What researchers do know is that in Canada, health care providers often fall short of meeting the needs of parents and their dying child. For example, the research of Widger, PhD IT2, and others reveals that dying children can experience a great deal of pain and suffering from poorly treated symptoms. Widger, Professor Bonnie Stevens, MSn 8T3, and Janet Yamada, BSsn 8T6, PhD 1T1, are taking action to correct this wrong. They were recently awarded a grant from the Canadian Institutes of Health Research that will enable them to study pain management in children with a life-threatening illness and start the process of developing practice guidelines.

Through her research and clinical experiences, though, Widger is already certain about one thing: many parents want to be partners in the care of their dying child. “Professionals may be experts about the disease, but parents are experts on their child,” she says. “Parents want health professionals to seek out and respect their opinions, observations and concerns.”

WHAT WE NEED
In her previous clinical roles, Widger would empower patients and families by asking them about any special wishes or needs they may have. “A teenage boy, who was almost 16, had always wanted to drive a car, so we arranged to get him out on a racetrack,” recalls Widger.

Parents of a younger child often want to be involved in typical parenting activities, such as bathing, feeding and holding the child, even if they need to do them in a tangle of technology. “These activities allow parents to bond with their child and, sometimes, to say goodbye,” she explains.

Widger’s research on families facing a potentially life-limiting illness hit home this past fall when her niece, who is six, was diagnosed with leukemia. “I feel my eyes are opening to the pure shock and horror that parents go through at diagnosis, as well as to the daily worries and stress of parenting a child with cancer,” she says.

WHEN TO BEGIN
“Palliative care - with its focus on optimal pain and symptom management, quality of life and fostering family connections – should be provided from the time of diagnosis of an illness such as cancer,” continues Widger. “But many parents, including my sister, do not want to be approached about palliative care early in the illness because of its association with death.”

Lisa Pearlman, MN 9T6, experiences the same contrary reaction to the word “palliative” at Children’s Hospital at London Health Sciences Centre. “People dread contact with palliative care, and I address that fear right away,” she says. “Palliative care is not about dying; it’s about living the best quality of life possible.”

Not only does Pearlman educate parents about the meaning of “palliative” - which she defines as an approach to the total care of the child with a life-limiting illness – she needs to inform her colleagues about its meaning as well. She would like

EACH YEAR, ABOUT 3,500 CHILDREN UNDER THE AGE OF 19 DIE IN CANADA; MOST ARE UNDER THE AGE OF ONE. IN ADDITION, THERE ARE 2,600 STILLBIRTHS EVERY YEAR. LESS THAN FIVE PER CENT OF THE CHILDREN AND FAMILIES WHO COULD BENEFIT FROM PALLIATIVE CARE SERVICES RECEIVE THEM.

— From a 2004 study led by
Assistant Professor Kimberley Widger
physicians and teams to refer patients to her service weeks, months if not years earlier than they do now. “If I can engage the children and their parents early on we can talk about how they want to live their life. And it’s necessary to address pain and symptom management issues early to minimize distress and ease suffering,” says Pearlman, who earned a post-master’s NP diploma at U of T Nursing in 2001. “When a cure is no longer possible or supportive/restorative treatments are no longer effective, the questions I always ask are: What is important to the child? What is important to the family?”

She recounts the case of a family who expressed that it was paramount for them to take their child home and to church. The child required mechanical suctioning, and for religious reasons the family’s home and community don’t have electricity. “How can I make this happen for the family?” Pearlman asked herself. “Sometimes I need to be a bit of an engineer, and in this case I sat down with the family and determined that they could use a thick straw to suck out the secretions.”

In another case, a 14-year-old girl with metastatic cancer wanted a leave-of-absence from the hospital to go shopping. She was slowly dying and extremely weak, but passionate about buying new clothes. The young woman was receiving palliative chemotherapy and knew she had to limit her exposure to public places.

Again Pearlman asked, “How can I make this happen?” She knew the teen was fatigued so probably wouldn’t stay at the mall for long. And what if she wore a mask, went in the mall’s off-hours, and agreed not to touch the banisters and door handles? “I’m extremely committed to being a patient advocate,” says Pearlman. “I focus on what the child and the family can do to achieve their goals. In the end, the teen went shopping, sat in a wheelchair and picked out about a dozen outfits. She was extremely satisfied to have had this opportunity and to be able to wear her new clothes at the hospital.”

THE TINIEST OF PATIENTS
In a neonatal intensive care unit (NICU), a baby can die long before being passionate about anything. In the SickKids NICU, eight to 10 per cent of the tiny patients don’t survive, which translates into five to eight infant deaths every month, reports Lori Ives-Baine, MN OT9, the palliative care and bereavement co-ordinator of the hospital’s Neonatology Program. Some of the babies die soon after arriving on the unit, forcing parents to say hello and goodbye in a few hours.

“No specific interventions will meet the needs of every individual or family,” says Ives-Baine. “Care can only be optimized by connecting with the patient and the family, and carefully assessing their specific and individual needs. Optimal care is all about the valuable family relationships.”

Some parents ask to take their baby outside to see the sunshine,” she continues. “We’ve adapted a stroller with our respiratory colleagues to make that happen. Taking the baby out for a walk gives the family a chance to be a family.”

The nursing care doesn’t stop when a baby dies. “I can’t change the outcome, but I can walk with the family in their grief,” says Ives-Baine. “The grieving never ends, but it gets less. We stay in touch with many of the families for years.” The parents experience what Ives-Baine calls “grief bursts.” For example, the parents may have a grief burst when they see the other children on the block heading off for their first day of school and realize that had their son lived, he would be starting junior kindergarten, too. “Grief isn’t just about death, it’s about all of the losses.”

CARING FOR THE CARE PROVIDERS
While doing her master’s at U of T Nursing, Ives-Baine researched what supports need to be in place for nurses who practise in the NICU. “They need to know that their care is valuable,” she emphasizes, “and they need a place to talk.”

“You don’t process what’s going on when you’re in the middle of it,” agrees Anne Simmonds, MN OT1, PhD IT0. “Nurses need time and a space to sort through the issues of moral distress and caregiver anguish that can result when, for example, a baby dies.”

Simmonds, who most recently practised in high-risk obstetrics, fondly recalls one unit’s tradition of afternoon tea. “No matter what was happening, it was always ‘Tea at Two.’
You knew someone was putting the kettle on, and you could go and care for yourself and each other.” She would like to take the tradition a step further and integrate facilitated conversations into the practice environment. “What if we had regular nursing rounds on compassion?” asks Simmonds, who is a Bloomberg Nursing lecturer. “Maybe they could include an ethicist and a social worker and focus on morally challenging cases that linger in nurses’ minds and continue to weigh on them in their everyday practice.”

Simmonds is exploring the connection between mindfulness and compassion. “Mindfulness has been transformational for me,” she says, adding that it informs both her clinical and academic work. “Mindfulness isn’t simply about sharpening attention. Rather, it’s about taking an interest in what’s happening now with an attitude of compassion and openness instead of trying to control or judge the experience.”

Investigators have found that mindfulness increases empathy and compassion for others – and yourself. Simmonds cites a study that found that mindfulness training increased self-compassion in health care providers and led to a decline in the stress and negative emotions that are often associated with compassion fatigue.

Before going into a patient room where a baby is dying, Simmonds recommends pausing outside the door and taking a brief moment to breathe and relax. “Instead of just carrying on, check in with yourself and say, ‘This is hard, this is sad.’ Staying connected to yourself will help you connect with the parents. Trying to stay detached as a form of self-protection can lead to burnout.”

Then Simmonds shrugs and articulates what many nurses fear most, and why they’re hesitant to take the time to pause outside a room in which an infant is taking her last breaths. “The fear is that if they acknowledge their feelings, they may not be able to go into that room.”

**Creating a Legacy**

When Lori Ives-Baine began practising in the SickKids NICU almost 24 years ago, all a nurse could offer bereaved parents was a few Polaroid photographs and inked footprints of their precious baby. Today, with the parents’ consent, a nurse will take as many as 400 digital photographs of the family and burn the photos onto a CD. Nurses will create 3D plaster moulds of a parent holding the baby’s tiny foot or hand. They’ll get out water paints and guide the parents and the other children in the family in creating a family portrait that includes all of their handprints, including the new baby’s.

These tangible reminders help the family accept the life of their child and the reality of the death, explains the alumna. “Some bereaved parents cling to the mementos as proof that their child existed.”

While the baby is alive, the nurses help create the child’s legacy by assisting the family in articulating their story. “Maybe in pregnancy the baby was very active, and the mother imagined the baby would grow up to be an acrobat – that’s part of their story,” says Ives-Baine. “And every baby has a character. We help the parents describe their child’s personality.” In the process, the nurses celebrate the parents’ connection with their infant. “We ask, ‘Whose feet does the baby have? Do you think he has your nose?’”

After the baby dies, Ives-Baine encourages ongoing legacy building, which may include funeral planning and attending the NICU’s annual Remembrance Gathering. Ives-Baine also gently reminds them that even though their baby has died, they never stop being a parent. She tells them, “You’re the only mommy and daddy your baby ever had.”

U of T Nursing thanks Channing and Troy Wilson for sharing photos and hand- and footprints of their beloved baby, Avery.
A former cabinet minister, the Honourable Sharon Carstairs continues to advocate for improved end-of-life care

Shortly after being appointed to the Senate of Canada in 1994, I became a member of the Senate Social Committee on Euthanasia and Assisted Suicide. In our 1995 report Of Life and Death, we had no unanimity on either euthanasia or assisted suicide, but we were unanimous in concluding that Canadians were not dying well. Many were dying in intractable pain; others were hooked up to machines they had neither requested nor wanted. This led me on a path to help change the way Canadians die.

On my journey I met nurses. Some practised in the palliative care unit of an acute care hospital. Others provided palliative care in a long-term care facility or hospice, or in patients’ homes. They spoke to me with a common voice, explaining that they had entered the nursing profession because of a deep commitment to caring for vulnerable people. Each believed that in caring for the dying they were practising bedside nursing in a manner that fulfilled them.

Caring for patients who are dying places incredible stress on nurses. In some cases, a nurse would provide care for only a day or two; still, the nurse would become attached and grieve when the patient took his last breath.

Yet, these nurses continue in palliative care. They told me they stay because it is a special time to spend with patients and their families, and because they can make a real difference in a difficult time. Some nurses try palliative medicine and learn very quickly that they’re not suited to it. Those who remain stay for years and years.

I encountered many palliative-care nurses who had gone above and beyond what could ever be expected of them. One nurse carried a ladder into an acute care room, climbed it and disconnected the smoke alarm so an Aboriginal family could conduct a sweet grass ceremony. I watched as another nurse arranged for a truck to carry a hospital bed to a patient’s house because he wanted to die at home and not in the long-term care facility where he resided. I saw evidence that nurses were baking apple pies to tempt patients to eat. Perhaps my favourite memory, though, is of the nurses who set up a sound system and lit candles in a large vacant bathing room so a dying patient and his wife could share some quiet time together, away from other family members.

It is a terrible experience to die alone and unwanted. Nurses throughout Canada are making a difference by ensuring that as many of us as possible die in the place of our choice supported by caring nurses.

A tireless champion for improving access to quality end-of-life care, the Honourable Sharon Carstairs, PC, was the Minister with Special Responsibility for Palliative Care in Prime Minister Jean Chrétien’s cabinet from 2001 to 2003. The first woman to be named the Deputy Leader of the Government in the Senate contributed to the development of two special reports on the state of palliative care in Canada. Recently, she served on CNA’s National Expert Commission that released A Nursing Call to Action.
Cancer researcher Doris Howell shares her insights on how addressing a patient’s personal experience of a symptom may reduce symptom distress

**Pulse:** When should palliative care begin for cancer patients?

**Howell:** “Palliative care” is a loaded term for patients. It is not end-of-life care. Patients can have palliative care needs early in the cancer trajectory. For example, about 50 per cent of patients with lung cancer present with the symptom of breathlessness, mostly because they have advanced disease at the time the cancer is detected. These patients have a palliative need for the management of breathlessness right from the day of diagnosis.

The landscape has changed for cancer treatment. Today, persons with advanced disease can be living with it as a chronic illness. We used to think there was little we could do to alter the symptom experience at this stage. What we’re learning is that there are interventions that can alter symptom suffering if we focus on maximizing best medical care and attend to the psychological aspects of symptom experience.

**Pulse:** A symptom is more than physical?

**Howell:** Absolutely! The mind and body are inseparable. But many still see symptoms from the traditional biomedical perspective, thinking that if they match the right medication to the symptom it will reduce the severity and the patient’s experience of the symptom. While this is a critical component of effective symptom management, the excitement about the research I’m leading is that it looks at the subjective side of symptoms.

We know patients evaluate their symptoms and attach meaning and significance to them. If we understand how patients think and feel about their symptoms and how they process symptom information, then we can design better interventions. Helping patients reframe some of the ways they think about symptoms is a really, really important part of decreasing symptom distress, including breathlessness.

**Pulse:** I imagine breathlessness is quite terrifying.

**Howell:** There’s a lot of anxiety and fear associated with breathlessness. And the fear and anxiety can worsen the symptom.

A patient might be frightened by the breathlessness and by what it means. He could ask: Does this breathlessness mean my disease is getting worse? Does this mean that I will eventually suffocate?

Being breathless could very well be due to advanced disease. But it could also be due to the patient becoming less physically active, or not using strategies that maximize breathing capacity and reduce fear. Better knowledge of the symptom should help reduce the anxiety and uncertainty.
in the context of the patient’s own environment makes a huge difference. In the second week, patients learn how to manage stress, anxiety and other triggers of breathlessness. The nurse helps the patient make the link between stress, which may only be at a subconscious level, and symptoms such as breathlessness. The nurse then teaches relaxation and meditation skills to handle anxiety, as well as specific ways to calm breathing.

Pulse: Why did you choose nurses for the intervention?
Howell: Disease is the bio-medical presentation, and illness is the patient’s response to it. It’s in the area of illness where nurses can make a great deal of difference.

When the nurse meets the patient for the first time, she doesn’t jump into teaching the skill set. She tries to understand the patient’s perspective on how breathlessness has interrupted his values, goals and quality of daily living. Through this shared understanding, the nurse can surface the thoughts and feelings about the symptom that may interfere with the patient actually adopting the actions that the nurse is teaching him. That’s the beginning of the therapeutic work.

Pulse: Why did you become a researcher?
Howell: I want to help patients optimize their health within illness. This means fully engaging them in the actions they can take as a co-producer of health through interventions that address both the body and mind response to cancer symptoms. It also means transforming health care delivery to attend to the “whole person” experience of an illness.
**U of T Nursing launches Boundless opportunities**

At the Faculty’s Student Awards Ceremony in October, Bloomberg Nursing launched its $25-million Boundless Campaign. “Now, more than ever, we need to support the development of tomorrow’s nurses,” said Dean Sioban Nelson in her opening address. “We need to advance the science and scholarship that underpins their competence, and foster the leadership they’ll bring to the development of quality health care. With the help of our alumni and friends, we will continue to support the best and the brightest to choose nursing.”

At the evening event, 90 students received awards that were funded by alumni as well as friends of U of T Nursing, including Canadian philanthropists Seymour Schulich and the late Bluma Appel. The outstanding generosity of these donors has made a tremendous impact on the educational opportunities we are able to offer our students. Most of our undergraduate students are admitted to Bloomberg Nursing carrying the debt of their first degree. A variety of factors – the demands of long clinical hours, consolidated classes and an extended school term – preclude part-time and summer employment for nursing students. Our endowment for needs-based financial aid is a vital tool that helps us to both attract and maintain top students.

Bloomberg Nursing’s fundraising initiative is part of the university-wide Boundless Campaign, the largest fundraising drive in Canadian university history. The U of T Campaign aims to raise $2 billion to explore the boundless possibilities for global leadership and societal impact. The Campaign’s vision extends far beyond the campus; the vision is to prepare global citizens and meet global challenges.

**Stellar students**

Last fall, more than 99 per cent of the Bloomberg Nursing undergraduates who wrote the Canadian Registered Nurse Examination (CRNE) passed. Of the 157 students who took the gruelling four-hour exam, only one failed.

“I’m not sure what to say about this,” commented Maureen Barry, MScN ’87, our Year 2 undergraduate co-ordinator. “We have always had a high pass rate in our second-entry program. We’ve never had more than three failures in one year, and many years we have a 100 per cent pass rate. Much of this success is because we have very strong students who enter our program.”

Our CRNE pass rate is higher than that of any other Ontario nursing program, but Bloomberg Nursing undergrads are not alone at the top. Our graduate students who write the American Nurses Credentialing Center (ANCC) NP-Paediatric or NP-Adult exam are also a cut above the rest. For example, while the overall pass rate for the NP-Paediatric exam in 2011 was 81 per cent, Bloomberg’s pass rate was a whopping 92 per cent.

Monica Parry, PhD ’08, our director of nurse practitioner programs, attributes the high pass rate, in part, to our Centre for Professional Development. It offers courses to prepare students to write the CRNE and ANCC. “The Centre most definitely deserves a pat on the back,” says Assistant Professor Parry.

**It’s Nursing Week!**

Bloomberg Nursing marked Nursing Week 2013 with a lively panel discussion titled “The Good, the Bad and the Political – Uncovering National and International Trends.” It probed the many ways that politics, policy and leadership are shaping nursing across Canada and around the world. Presenting the global perspective was the Frances Bloomberg International Distinguished Visiting Professor, Rev. Tom Keighley, who represented the U.K. on the European Union Advisory Committee on nursing training. Presenting the Canadian perspective was Professor Michael Villeneuve, the former executive lead of the CNA’s National Expert Commission. Dean Sioban Nelson provided insights into provincial and national trends and how they affect nurses and the care they deliver.

The event also featured a poster exhibit that gave attendees the opportunity to glimpse the latest research of our trailblazing professors.

At the Awards Ceremony, Melissa Ann Mason (far left), Tina Cheung and Dagmara Kolodziejczyk pose with Byron Bellows and Dean Sioban Nelson. Mason, Cheung and Kolodziejczyk each received a Bluma Appel and Jeannie Butler Graduate Award in Nursing. Bellows and Patrice Merrin Best are co-executors of the estate of Bluma Appel.
Do nurses run in families? They do at Bloomberg Nursing. One alumna’s son followed in her footsteps and enrolled at U of T Nursing. Another alumna’s niece enrolled. And then there’s this mother-daughter duo. Thirty-one years after Ping Mah graduated from U of T Nursing, her daughter Lisa walked into Convocation Hall to collect her nursing degree.

Ping Mah, BScN 8T1: I entered nursing because I was told I had a caring nature. I looked after my baby sister who was born when I was 13, helping to raise her because my mom was working. I was also told there would be job opportunities because there will always be sick people to look after.

And it seemed to me that since nursing was offered at U of T – a high-level learning institution with a great reputation – it would give me a very professional career.

My first job was at Wellesley Hospital, within walking distance from my home. Right away I was put in charge because at the time there were very few RNs with a BScN. I appreciated the opportunity to increase my skills and quite enjoyed being in charge.

I left nursing in 1996 because of downsizing and the many changes within the hospital environment. I decided to take my nursing skills and apply them to an entirely different field – financial services.

Lisa Mah, BScN 1T2: Growing up, I admired my mother as a maternity nurse and prenatal teacher, and I learned so much from her about caring for and being nurturing toward others. The stories she brought home from the hospital sparked my interest in midwifery and caring for children, and eventually led me to pursue nursing.

I chose U of T Nursing because, as a second-entry program, I knew I’d be focusing on nursing. My previous degree, a bachelor of science (honours) in life sciences, had already given me a science background. I also liked that U of T offered clinical placements in some of Toronto’s best hospitals – the Hospital for Sick Children, Princess Margaret and Sunnybrook.

Our Cressy Award winners
U of T Cressy Awards recognize graduating students whose volunteer efforts have improved their faculty, the university and/or the larger community. Bloomberg Nursing has a multitude of inspiring student leaders who qualify for this honour, but we could choose only five deserving students.

Undergraduate recipients
(Klass of 11T3)
Katherine Dunbar received a Cressy Award for her outstanding contributions as the Nursing Undergraduate Society’s (NUS’s) inaugural Student Wellness Co-ordinator. In this role, she led yoga classes, helped organize a Wellness Fair and established an annual nursing student retreat at Hart House Farm. Dunbar also served as a Nursing Student Mentor to two first-year students.

Karolina Gielarowicz assumed responsibility for taking photos of clinical placements, social events and labs for the U of T Nursing yearbook. She participated in the annual Model WHO Conference where she debated the impact of pharmaceutical trials in developing countries and won the Best Delegate Award.

Erin Telegdi, as an NUS Student Council member, served as Co-Chair of the Canadian Nursing Students’ Association’s Career Fair. To ensure the fair’s success, she donated countless hours to connect students with potential nursing employers. Telegdi also initiated a student award competition to encourage students in the development of health care policy.

Graduate recipients
Kate Gent, BScN 0T7, helped further our Primary Health Care – Global Health nurse practitioner area of emphasis by collecting ideas from her fellow students and sharing them with the co-ordinator. Some of the ideas were implemented, contributing to ongoing program development. The master’s student also volunteered at Camp Oochigeas, a camp for children with cancer.

Sheila O’Keefe-McCarthy, MN 0T7, served on the executive of the Graduate Nursing Student Society and as a member of the curriculum and student awards committees. She created the PhD Academic/Research Community of Learners, organizing literature reviews, and mock proposal defence and scientific presentations for her fellow doctoral students. In addition, O’Keefe-McCarthy made outstanding contributions on the Canadian Pain Society’s board of directors.

Throughout the program, I had countless conversations with my mother about my nursing assignments and clinical experiences. Her lifetime of nursing knowledge helped me prioritize nursing care plans and clarify nursing issues in complex situations.

Becoming a paediatric nurse is a dream come true. I work at the Hospital for Sick Children on 7C, the general paediatrics and respiratory medicine unit. Caring for children and families facing acute and chronic illness is a true honour.

And becoming a nurse has brought me closer to my mother. I have a whole new respect for her and what she went through as a nurse. Since we are the only nurses in our large family, we have a special connection as we share our nursing experiences in our own “nursing” language. Whenever I have a rough day at work with a challenging patient or family, I know I can always talk to my mom and she’ll understand.
Mad about Dennis

The Mood Disorders Association of Ontario honoured Professor Cindy-Lee Dennis at its “MAD About You Awards Gala” in February. The annual event recognizes individuals who have made an outstanding effort to improve the lives of those who suffer from depression, anxiety or bipolar disorder.

Dennis received the Hope Inspiration Award for her groundbreaking research into detecting, preventing and treating women with postpartum depression (PPD). “This award is an opportunity to continue educating society about PPD, a condition that affects one in eight women after they give birth,” says Dennis, BScN 971, PhD 979.

Believing that healthy infants and children start with healthy mothers, Dennis has developed innovative ways to prevent PPD, including linking new mothers at risk of PPD with women who have experienced this form of depression. Dennis found that telephone-based support from a peer cut the incidence of PPD by 50 per cent in new mothers with beginning depressive symptoms.

Dennis’s current research focus is on how the perinatal mental health of both mothers and fathers affects infant development.
### Events

#### MAY 22
**Course: OSCE Simulations for Nurse Practitioners**
(Objective Standardized Comprehensive Evaluation) practice assessments. This one-day course will build both your knowledge and your confidence for taking these rigorous evaluations.

**To learn more and register:**
[www.bloomberg.nursing.utoronto.ca/pd](http://www.bloomberg.nursing.utoronto.ca/pd)

#### JUNE 1
**Spring Reunion**
We all have memories of studying nursing at U of T. Share yours with a former classmate at Spring Reunion, and watch your memories not only come alive, but multiply!

Everyone is invited, and you’ll be an honoured guest if you graduated in a year ending in 3 or 8; for example, 1963 or 1988.

All of the nursing events take place in the Bloomberg Nursing building, 155 College St.

9 a.m. Join us for a complimentary buffet breakfast and group photos with your classmates.

10:30 Applaud our distinguished alumni during the Awards Presentation.

11:30 Tour the Nursing Simulation Lab’s intensive care unit, operating room, isolation unit and 12-bed ward where today’s nursing students hone their clinical skills. Start up a conversation with a computerized medical mannequin and check its vital signs.

In conjunction with Spring Reunion, some classes are planning special events and creating a class award. Contact the Alumni Relations Office for help with your plans. To ensure that your classmates can get in touch with you, send your full name, preferred email address and, if you’ve moved recently, your new mailing address to address.update@utoronto.ca

**Class of 7T3, Basic BSChN:** Celebrate your 40th anniversary! For information on the festivities, contact classmates Vicki Pennick, vpennick@sympatico.ca; Anne Marie (Madigan) Bilan, anniebilan@yahoo.ca; or Chris (Den) Schnall, GSchnall@aol.com.

**To RSVP:** Contact the Alumni Relations Office at development.nursing@utoronto.ca or 416.946.7097. Due to the high volume, we are unable to confirm your RSVP - but we will be expecting you!

**For U of T-wide Spring Reunion**
**Events:** [springreunion.utoronto.ca](http://springreunion.utoronto.ca)

#### JUNE 24/25
**Course: Institute on Nursing Ethics**
Learn how to effectively integrate ethics in practice by recognizing and addressing issues. Develop strategies to facilitate discussions with patients, family members and colleagues, and increase your awareness of the relationship between personal, professional and organizational values within the context of care.

**To learn more and register:**
[www.bloomberg.nursing.utoronto.ca/pd](http://www.bloomberg.nursing.utoronto.ca/pd)

#### SEPT 13/14
**Course: Preparing to Write the Crne**
In this two-day Canadian Registered Nurse Exam (CRNE) preparation course, you will review the exam structure and study approaches to answering multiple-choice questions. You will also develop strategies for learning the required information on medications, laboratory results and diagnostic tests. The second day includes a four-hour mock CRNE, which is graded to help you identify areas requiring additional study. This Centre for Professional Development course is offered in Toronto and Alberta.

**To learn more and register:**
[www.bloomberg.nursing.utoronto.ca/pd](http://www.bloomberg.nursing.utoronto.ca/pd)

#### SEPT 2/3
**Course: Preparing to Write the NP-Primary Health Care Exam**
Learn from NPs who have successfully written the exam for primary health care. The Centre for Professional Development designed this two-day course to help you enhance content knowledge and develop approaches to answering multiple-choice questions.

**To learn more and register:**
[www.bloomberg.nursing.utoronto.ca/pd](http://www.bloomberg.nursing.utoronto.ca/pd)

#### NOV 23
**Course: Institute on Advanced Pain Management Across the Lifespan**
This Centre for Professional Development program, led by Jennifer Stinson, an assistant professor (status), will focus on pain as a prevalent, universal symptom that can have a major impact on individuals, their families and society. It will discuss specific pain assessment and management practices and related diagnostic reasoning and management based on theoretical models and research. The institute is tailored to the learning needs of advanced practice nurses and NPs practising in pain management and/or anaesthesia roles.

**To learn more and register:**
[www.bloomberg.nursing.utoronto.ca/pd](http://www.bloomberg.nursing.utoronto.ca/pd)
Spotlight on Learning

A LESSON IN COMPASSION

When a patient dies at Casey House, the staff light a white candle in the entranceway and keep it lit for 24 hours. Today, the candle might be burning to honour a man who was homeless, and shunned by his family and friends.

Every year, six of our undergraduate students participate in a clinical placement at Casey House, Canada’s first stand-alone treatment facility for people with advanced HIV/AIDS. When Katie Connolly, BScN ’06, did her final 12-week consolidation in Casey House’s community program, she realized she wanted to devote her nursing career to supporting clients at home and in the community. “Many of our patients are terribly isolated, without any support, because the disease is still so stigmatizing and socially charged,” she says.

When Connolly graduated, the Casey

Alumna Katie Connolly (left), a community nurse at Casey House, with students Marvin Cuartero and Alison Perry
House staff, impressed by her compassion, hired her to help individuals with HIV/AIDS in their homes.

“We work with a very diverse clientele, in many neighbourhoods across the city, and some of our clients are homeless or under-housed,” says Connolly. “We always try to meet clients where they are.” The stigma of having HIV/AIDS can raise its head in the health care system, so many of her patients won’t go to a hospital for care. “And my clients who use substances, engage in sex work or live with a mental illness can face even more stigma,” she adds.

Connolly, who raves about the “excellent mentor” she had when she did her placement at Casey House, now mentors Bloomberg students. She takes student nurses with her to visit clients, giving them an up-close glimpse of how stigma and housing (or lack of it) affects health.

HOME SWEET HOME

Marvin Cuartero and Alison Perry, who will graduate this spring, recently completed a 13-week placement at Casey House’s in-patient care facility. For the placement, they spent eight to 12 hours at the house, twice a week.

Perry was impressed by the nursing staff and their level of compassion. “It was an honour to learn from the nurses who were first there at the start of the HIV/AIDS epidemic in Canada,” she says.

Cuartero was taken by the homey environment in the 13-bed facility and by its interprofessional staff. “There’s a physiotherapist, and there are social workers, recreation therapists, nurses, physicians and even a massage therapist.”

To prepare to practise on an interprofessional team, our students can enrol in a variety of collaborative learning activities. One of the most popular is Dying and Death: Psychological, Physical and Spiritual Issues for Health Professionals. In this evening session, our undergrads join students from theology, medicine, occupational therapy, pharmacy, social work and other faculties and departments to understand their roles and responsibilities in meeting the needs of the dying. They also learn how to communicate and be present with an individual and their family before, during and after death.

THE CROSSROADS

“You see palliative and rehabilitation approaches at Casey House,” says Perry. “Some of our patients would get back on their medication and get better. But a lot of them had no intention of going back on their meds or stopping their drug use. By working within a harm reduction framework and remaining nonjudgmental, the nurses taught me a lot about forming therapeutic relationships with clients who are sometimes challenging.”

“It’s about making the patient feel at home,” says Cuartero. “I learned so much at Casey House, especially about providing patient-centred care and compassion in spite of whatever circumstances the patients find themselves in.”

“Death is a natural part of life, and it releases some of our clients from years of suffering and struggle,” adds Connolly. “The ceremonies on World AIDS Day help us remember those we have lost.”

PHOTOS: STEPHEN UHRANEY

Diane Murray, a nurse at Casey House, helping Bloomberg students Marvin Cuartero and Alison Perry
Due in part to the leadership skills of this klatch of women in sensible shoes, nurses started to advance from subservient roles to positions of authority by the 1950s. “Nursing had to pull itself up by its bootstraps to become a profession,” wrote Flo Emory, U of T Nursing’s associate director from 1924 to ’52. “What we did was not done for us by any outside group; what was done was done by nurses themselves.”

No nurse could advance the profession alone, and Emory had a knack for building relationships between U of T Nursing and the wider nursing community. She likely invited Pearl Stevia, Helen McArthur and Edna Moore to the university to inspire our students. Stevia was CNA’s executive secretary (a position later called director) from 1952 to ’63. McArthur was the first national director of nursing services for the Canadian Red Cross Society. Her influence could only be matched by Moore’s, the leading public health nurse in the Ontario Department of Health from 1931 to ’57. Moore humbly received the Florence Nightingale Award for helping rebuild the public health infrastructure in Korea after the Korean War.

Emory, a public health nurse and later president of RNAO and CNA, was at ease with other nursing leaders. Emory liked everyone, and everyone liked her. Our visionary founding director Kathleen Russell, though, pushed the boundaries and unapologetically created waves. Russell – with her hair bobby-pinned in an elegant chignon – was a dreamer in contrast to Emory, who was pragmatic and a peacemaker. If Russell strained a relationship, Emory would step in and repair it. For 28 years, Emory and Russell worked side by side to build U of T Nursing and the nursing profession. Together, they were unstoppable. ☒
“I want to give homeless women a voice in their own health care. I couldn’t do that without these scholarships.”

CLARA JUANDÓ-PRATS
PhD Candidate, Nursing

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