The Magazine of Columbia University School of Nursing

THE POWER OF NURSING NARRATIVES

BOOK EXCERPT: THE SHIFT BY THERESA BROWN, RN

Columbia Nursing

Spring 2015

NURSING CARE FOR VETERANS
LEAVING A LEGACY: 
WHY I PLAN TO GIVE BACK TO COLUMBIA NURSING

COLUMBIA NURSING gave me the foundation for a productive, rewarding, and satisfying career in nursing. Without Columbia Nursing, I would not have developed the skills that have helped to propel me forward in my career and in my life. Columbia Nursing faculty member Dorothy Reilly was my first educational mentor, instilling in me the importance of a professional and educational ethos that started me on the path to graduate education. She taught me about mentoring: how to be mentored and how to mentor.

Columbia Nursing, specifically the Class of ’64, was my family for almost two years. When I arrived at the school as a transfer student, I was embraced by my classmates. We comforted each other through many emotionally charged situations, creating bonds that have lasted a lifetime. These connections shaped my nursing career as well as my personal life.

My husband and I wish to leave a legacy because we feel it further defines our purpose in life. As we plan for the future, we feel it is important for our family to be included in our legacy, so our planned giving and estate planning include my Columbia Nursing family. It is my honor and good fortune to include Columbia Nursing so that it can carry on the work I was so fortunate to have benefited from.

It’s wonderful knowing that by planning a bequest now, I am able to give to Columbia Nursing in ways I won’t be able to in my lifetime.

Won’t you consider making Columbia Nursing part of your legacy?
– Keville Frederickson Tomasson ’64, PhD

For more information about planned giving, please contact Janice Rafferty Grady at jar2272@columbia.edu or 212.305.1088.
his issue of *Columbia Nursing* offers three articles highlighting how nurses are indispensable in delivering the right care, at the right time, in the right place.

As our nation shifts increasingly toward non-hospital-based acute care, nurses are playing a leading role in helping patients move safely from one care site to another. In our cover story, *Nurses and Veterans: Healing Invisible Wounds* on page 8, Kathleen Capitulo ’02, PhD, FAAN, chief nurse executive at the James J. Peters VA Medical Center in the Bronx, stresses the importance of this responsibility in coordinating hospital-based interdisciplinary teams as well as providing home-based care to veterans.

Women comprise 14 percent of active-duty service members, 18 percent of reserves, and 8 percent of all living veterans. Capitulo has been at the forefront in ensuring that our health care system is responsive to the often unique needs of these female veterans. In addition, she has been active in the design of a new women’s health clinic at the Bronx center.

The article also features Dennis Graham ’93 ’08, PhD, a Vietnam War veteran. He believes that nurses who have served in the military bring a special brand of sensitivity to the clinical arena by picking up cues arising from patients’ prior military service that non-veterans may miss. This is especially important today, when veterans increasingly seek care in civilian hospitals, many of which do not require past military service to be recorded in the medical record.

One of the hallmarks of nursing is taking an account of a patient’s history and background when providing care. Our students learn about this holistic approach in several ways, including writing narratives about the patients they care for as well as their own similar experiences. “Nursing Narratives” on page 14, highlights the fact that writing sharpens the ability to observe clinically relevant details. It also enables students to explore their own feelings as they surface during these emotionally charged encounters.

The best of nursing is on display in our excerpt on page 18 from the forthcoming book by Theresa Brown RN, *The Shift: One Nurse, 12 Hours, 4 Patients’ Lives* (Algonquin Books). Brown, who contributes to “The Opinionator” column in *The New York Times*, offers a captivating portrait of life on a hospital oncology floor. In powerful and moving language, she illuminates the science and art of nursing amid challenging patients, stressed co-workers, taxing medical technology, and the sometimes murky world of hospital bureaucracy. Readers will come away with renewed appreciation for how nurses use their wits and wisdom to navigate a hospital’s pressurized environment while never failing to put the patient first.

Expertly trained clinicians adept at providing care in a highly technical environment; skilled communicators attuned to the totality of their patients’ backgrounds and experiences; team players who move patients smoothly and safely through a variety of health care settings: these are just some of the roles nurses play, showing why our field offers one of the most challenging and rewarding careers anywhere. I hope you enjoy this issue of the magazine.

**BOBBIE BERKOWITZ, PhD, RN, FAAN**
Dean, Columbia University School of Nursing
Mary O’Neil Mundinger Professor of Nursing
Senior Vice President, Columbia University Medical Center
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ON THE COVER:
Illustration by Davide Bonazzi.
Student writing assignments deepen their ability to empathize and provide better patient care.

Accompany The New York Times columnist Theresa Brown, RN, as she navigates the hectic and demanding world of nursing on a hospital oncology unit in an excerpt from her forthcoming book.
choosing maternity care is one of the most daunting decisions facing first-time moms, and a new study suggests that it’s a choice shaped by a number of misconceptions about the role different types of clinicians can play in the birthing process. In the United States, the vast majority of babies are delivered in hospitals by obstetrician-gynecologists, even though midwives can provide a safe alternative with fewer medical interventions.

“Most people don’t realize that midwives are highly trained professionals with extensive clinical experience and qualified to assist their client’s birth of a child at a hospital, birthing center, or in her home,” says study author Adriana Arcia, PhD, assistant professor at Columbia Nursing. The study was published in the Journal of Perinatal Education. “Their education and training enables them to collaborate fully with an obstetrician, and transfer care if necessary.”

The vast majority of women—82 percent—said they expected an obstetrician to deliver their baby, while about 11 percent anticipated having a midwife at the birth, according to the study, which surveyed first-time moms to understand how they chose a provider to deliver their baby.

Women prioritized safety regardless of birth setting—which could mean that women who planned to birth at home perceived different risks than did women who planned to birth in the hospital. Women described physicians as “experts” with the “best knowledge” while midwives were seen as “warmer” and “more personal.” Some women in the survey also said that they didn’t know there were alternatives to having a physician deliver their baby in a hospital.

In reality, though, women with uncomplicated pregnancies can have a safe and satisfying birth with a midwife, Arcia says. Midwives are less likely than physicians to overuse interventions such as spinal or epidural anesthesia, forceps deliveries, and cesarean sections. In addition to knowing the complexities of birthing a child, midwives are fully prepared to handle a birth emergency, including when to transfer to a higher level of care, if necessary.

“These findings highlight the need for more comprehensive childbirth education,” Arcia says. “Women who want to have a partner in a more natural birth experience that centers around listening to their body and letting the process unfold on its own timetable may want to consider a midwife instead of a physician. For some women, a physician is the right choice, but it’s not a choice they should make because they have no idea what midwives can do.”

Arcia suggests women interview several care providers to get a sense of their approach to birthing. Among the questions she suggests women ask are: How does the care provider feel about assisting in a natural, unmedicated birth; what is the provider’s cesarean rate; what is the provider’s induction rate; and if labor has to be induced or augmented, what methods are recommended?

A total of 220 women completed the survey, and more than half of them were 18 or 19 years old. On average, they were about 12 weeks pregnant, though women up to 20 weeks pregnant were invited to participate in the survey.

This research was supported in part by grants from the Beta Tau Chapter of Sigma Theta Tau International Honor Society of Nursing and the Florida Nurses Foundation.
Many Coroners and Medical Examiners Can’t Handle Mass Fatalities

Many coroners and medical examiners aren’t prepared to deal with mass fatalities from a major disaster, whether a hurricane, tornado, plane crash, or act of terrorism—a lapse that can force families and communities to endure unnecessary delays in identifying victims and moving forward with their lives. For many of the nation’s coroners and medical examiners, just 25 additional fatalities over a two-day period would be too much to handle, according to a study published in the journal BMC Public Health.

“A mass fatality incident can completely overwhelm local and even national capacity to respond and accurately account for all of the victims, and this causes needless hardship for so many people who are already suffering as survivors of a catastrophic disaster,” says study co-author Jacqueline Merrill, PhD, FAAN, associate professor at Columbia Nursing, with an interdisciplinary appointment in the department of Biomedical Informatics.

To assess preparedness, Merrill was part of an interdisciplinary research team that invited medical examiners and coroners to complete an online survey with questions about disaster planning, available resources, and the willingness and ability of their staff to respond. There are an estimated 900 to 1,000 medical examiners and coroners in the U.S., and 122 people completed the survey. Most respondents were medical examiners and coroners, but a few were forensic pathologists or local law enforcement officials.

One in five medical examiners and coroners lacks refrigerated storage for remains. One in four has no plan in place to transport remains, conduct postmortem examinations, or find surviving relatives of victims.

Most coroners and medical examiners surveyed indicated that they have a written mass fatality plan covering essential details such as morgue services, human remains recovery, and command center control. However, in many cases they reported that their plans fail to address how to credential and manage volunteers, how to provide relief for staff, and how to get reimbursement for disaster relief efforts.

The results in Massachusetts suggest that the practice environment for NPs in New York can improve as the state’s NP Modernization Act took effect this year.

Mike Poghosyan, PhD, lead author of the study, published in Health Care Management Review. The NP Modernization Act, passed as part of the New York State budget last year, will allow experienced NPs to practice independently, without direct supervision from a physician.

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A research team led by Poghosyan surveyed a cross-section of NPs in New York and Massachusetts who worked in a variety of primary care settings to see how state policy and the type of employer influenced NPs’ perception of their practice environment. The survey asked NPs about five aspects of their work experiences: physician relations, administration relations, support and resources, visibility and comprehension of their role, and independence of practice. Massachusetts bested New York on every variable.

The study found that plans for backup workers and supplies are also incomplete. Most resource networks include local emergency management officials, funeral home operators, first responders, and local and state health officials. Fewer coroners and medical examiners have ready access to nearby forensic specialists and law enforcement to assist with investigations, and few are in contact with faith-based organizations that can provide support to victims.

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At the same time, laws are only one piece of the puzzle. In both states, NPs gave a lower score on each variable in hospital-affiliated clinics than they did for physician offices or community health centers. In particular, NPs ranked their ability to practice independently as significantly lower in hospital-affiliated settings. Hospitals generally have large administrative structures, and are governed by multiple committees that may not have NP representation. As a result, NPs may not have enough input in decision making or sufficient opportunity to promote their role in patient care, the study says.

“Practice managers and administrators set the tone for the workplace, and these findings suggest that in many instances they may need to institute changes to provide more support to NPs,” Poghosyan says. “Policies at the practice level and the state level are starting to recognize that supporting independent practice for NPs helps improve the quality and timeliness of patient care. We need to see this trend continue and permeate the culture of more workplaces.”

The research was funded in part by the Agency for Healthcare Research and Quality.

New York Law Offers Nurses More Recognition, Responsibility

If past experience is anything to go by, nurse practitioners in New York State are poised to get a lot more recognition for their contributions to primary care. In Massachusetts, after laws went on the books allowing NPs to provide primary care, nurses got more recognition for their contributions to patient care and had better relationships with physicians and administrators than colleagues in New York, according to a study of the practice environment in both states before New York’s Nurse Practitioners Modernization Act took effect this year.

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MOBILE APP HELPS NURSES DIAGNOSE OBESITY, SMOKING, AND DEPRESSION

Smartphones and tablets may hold the key to getting more nurses to diagnose patients with chronic health issues like obesity, smoking, and depression—three of the leading causes of preventable death and disability. A customized mobile app in which evidence-based guidelines for spotting and treating these chronic health problems were integrated to provide clinical decision support made nurses much more likely to catch these issues during routine exams, according to a study published in the *Journal for Nurse Practitioners*.

“What clinicians need is decision support tools that fit into their work flow and remind them of evidence-based practices,” says lead study author Suzanne Bakken, PhD, FAAN, Alumni Professor of Nursing and professor of biomedical informatics at Columbia Nursing. “Our app focused specifically on the work that nurse practitioners do to identify health problems, counsel patients, and coordinate care plans, resulting in higher diagnosis rates and more opportunities for intervention. Nurses may be aware of the best practices, but the app provides a reminder to assess key areas, even when the patient is there for another reason or when the exam isn’t long enough to discuss every single potential health problem that a patient might have.”

The study evaluated diagnosis rates for tobacco use, adult and pediatric depression, and obesity during 34,349 patient exams conducted by 363 registered nurses enrolled in nurse practitioner programs at Columbia Nursing. Students were randomly assigned to use mobile apps with or without decision support for guideline-based care.

For each of the health issues studied, mobile apps with decision support features resulted in significantly higher diagnosis rates than apps with only bare-bones tools for recording results from a patient exam. Increased diagnosis rates with decision support were:

- Seven times more obese and overweight (33.9% vs. 4.8%)
- Five times more tobacco use (11.9% vs. 2.3%)
- Forty-four times more adult depression (8.8% vs. 0.2%)
- Four times more pediatric depression (4.6% vs. 1.1%)

The app may have worked because, unlike software aimed at physicians that focuses more on diagnostic codes needed for medical billing, it prompted nurse practitioners to follow evidence-based clinical guidelines to screen, diagnose, and manage specific conditions and encouraged detailed conversations with patients about their health, Bakken says.

For tobacco screening, for example, the app prompted nurses to ask not just about cigarettes but also about other products such as chewing tobacco. To diagnose patients who are overweight or obese, the app calculated body-mass index to quickly pinpoint people who might benefit from weight-loss counseling and other interventions. And with depression, the app prompted nurses to ask a series of questions to make it easier to identify patients with depressive symptoms.

The study was funded by a grant from the National Institute of Nursing Research.
Elderly patients admitted to intensive care units (ICUs) are about 35 percent more likely to die within five years of leaving the hospital if they develop an infection during their stay, a Columbia Nursing study finds. Preventing two of the most common health care-associated infections—bloodstream infections caused by central lines and pneumonia caused by ventilators—can increase the odds that these patients survive and reduce the cost of their care by more than $150,000, according to a study published in the American Journal of Infection Control.

“Any death from preventable infections is one too many,” says senior study author Patricia Stone, PhD, FAAN, director of the Center for Health Policy at Columbia Nursing. “We’ve known for decades what works to prevent infections and save lives. Now, our study shows just how much money can be saved by investing in prevention.”

The study looked at outcomes for 17,537 elderly Medicare patients admitted to 31 hospitals in 2002 to assess the cost and effectiveness of infection prevention efforts. Then, the researchers used an additional five years of Medicare claims data to assess the long-term outcomes and health costs attributed to health care-associated infections.

While 57 percent of all the elderly ICU patients died within five years, the researchers found that infections made death more likely. For those who developed central line-associated bloodstream infections, or CLABSI, 75 percent died within five years, as did 77 percent of those who developed ventilator-associated pneumonia, or VAP.

Effective prevention programs for CLABSI resulted in an estimated gain of 15.55 years of life on average for all patients treated in the ICU, the study found. Central line catheters deliver lifesaving medicines and nutrition. Without proper insertion, utilization, and maintenance, catheters can also transmit deadly infections to the bloodstream. Simple infection prevention measures include hand washing before handling the catheter and immediately changing the dressing around the central line if it gets wet or dirty.

Efforts to prevent VAP resulted in an estimated gain of 10.84 years of life on average for all patients treated in the ICU. Ventilators—machines that force air into the lungs when patients can’t breathe on their own—can cause infections when patients lie flat in bed for long periods of time. Keeping patients elevated in bed, with the head higher than the feet, is one simple precaution that can help prevent pneumonia.

On average, the ongoing cost of running an infection prevention program in the ICU is about $145,000, the study found. Prevention efforts reduced ICU costs by $174,713 per patient for each instance of CLABSI, and by $163,090 for VAP.

Health care-associated infections kill an estimated 75,000 Americans a year and create approximately $33 billion in excess medical costs. The U.S. Centers for Disease Control and Prevention first linked infection rates to prevention programs in the 1970s. Research since then has shown that checklists and other targeted infection-control practices can make a significant dent in infection rates.

The study was funded by a grant from the National Institute of Nursing Research.
It's a quiet morning following Presidents Day at the telephone triage center at the James J. Peters Veterans Affairs Medical Center in the Bronx. Nurse practitioner Sophy Koyithara, manager of the center, is relishing the relative calm after weathering the deluge of calls flooding into the center over the long weekend, when all VA health facilities throughout the country were closed. On the Monday holiday alone, Koyithara's team of 13 nurses answered 834 calls from veterans up and down the Eastern Seaboard, dealing with matters ranging from the everyday to the life-threatening. “We got calls from veterans with foot pain and those with questions about medication,” said Koyithara, “and then we had people who were experiencing symptoms of heart attacks and strokes and needed immediate emergency treatment.”

It was during this flurry that Koyithara received a call from a distraught veteran who said he was standing on the edge of a bridge, contemplating jumping to his death. Koyithara kept the man talking on the phone for an hour and a half while the police searched a 200-mile radius for the location of the bridge. Using information the vet had given about where he lived in Pennsylvania, the direction he set out in, and how much gas was in his car, miraculously, the police found the veteran and successfully coaxed him from the bridge. Unfortunately, this kind of call comes in all too often. Nurses at the Bronx VA telephone triage center receive an average of four to five suicide calls a day—nights between 4 p.m. and 7 a.m., on weekends, and during holidays. “The nurses here are our most important resource,” said Koyithara. “They are highly experienced clinically and great communicators who save lives every day.”

At VA health centers as well as in civilian settings throughout the U.S., nurses play an integral role in caring for the nation’s 22 million veterans and 3 million active service and reserve members. This is a diverse population that includes frail, elderly vets who served in World War II, Korea, and Vietnam as well as some 2.8 million U.S. troops who have been deployed since October 2001 to support operations in Afghanistan and Iraq.

The VA is the largest employer of nurses in the nation. Its 90,000 nurse professionals lead primary care teams, work directly with homeless vets, provide screening and treatment for mental health conditions such as post-traumatic stress disorder and substance abuse, and spearhead new efforts to offer health care services to the growing number of women in the military.

“Nurses fit nicely into the model of caring for vets and the military,” said General William Bester, a former chief of the Army Nurse Corps and 32-year veteran who is now senior adviser to the Jonas Veterans Healthcare Program. The Jonas initiative supports doctoral-level (PhD and DNP) education for nurses who will be involved in all levels of veterans' health care, from direct patient care to administration and policy. “By training, nurses are focused on the medical and psychosocial aspects of their patients’ lives, including dealing with family, employment, and other potential sources of stress. They

NURSES AND VETERANS:
HEALING INVISIBLE WOUNDS
BY NAOMI FREUNDLICH
NURSES AND VETERANS:
do a wonderful job of communicating, which is one of the strongest benefits they bring to caring for veterans,” added Bester.

The Department of Veterans Affairs is undergoing a major overhaul, spurred by an investigation conducted by the VA’s Office of the Inspector General into improper scheduling practices and long wait times for appointments at a VA facility in Phoenix that led to the deaths of at least 40 veterans. The investigation was extended to 93 other VA facilities, and confirmed that delays and waiting-list problems were widespread throughout the system. The IG investigators called for “immediate and substantive changes,” writing: “This report cannot capture the personal disappointment, frustration, and loss of faith of individual veterans and their family members with a health care system that often could not respond to their mental and physical health needs in a timely manner.” Other reports, including one by the RAND Corporation, found that in particular “there is a large gap between the need for mental health services and the use of those services” by the increasing number of veterans returning from Iraq and Afghanistan.

In August 2014, Congress passed a $15 billion emergency funding bill that expands access to non-VA health care facilities for veterans unable to receive timely appointments or who live 40 miles or more from a VA medical facility. The bill also includes $5 billion to enable the VA to hire more doctors and nurses and approximately $1.3 billion to finance leases for 27 new VA facilities nationwide. Finally, the increased funding is designed to improve care for victims of post-traumatic stress disorder and military sexual trauma and those suffering from traumatic brain injuries (the so-called “invisible wounds of war” that are more prevalent among veterans who have served in Iraq and Afghanistan).

The VA estimates that some 11 to 20 percent of veterans who served in Iraq or Afghanistan suffer from post-traumatic stress disorder in a given year, and that 30 percent of Vietnam veterans have experienced the disorder in their lifetimes. According to General Bester, 1 million veterans have been diagnosed with one or more mental health problems while 50 percent of those have been diagnosed with at least two disorders. This large volume of psychological illness plays out in escalating suicide figures: In 2014, there was a 44 percent increase in suicides in male veterans under the age of 30 and an 11 percent increase in females in the same age bracket. An average of 22 veterans commit suicide each day.

Mental health nurses play an important role in dealing with the increase in mental health problems and related concerns among veterans. For example, there are 1.4 million veterans at risk of homelessness due to poverty, poor living conditions, and lack of support networks. Ellen Flanagan, MSN, works with homeless vets every day as part of the Housing First Assertive Community Treatment team at the VA’s New York Harbor Healthcare Center in Brooklyn. Her outreach team, which includes a peer counselor who is a veteran himself, finds homeless vets living on the street or in the park and works to get them into permanent housing as a first step toward recovery.

“We have one vet in her early fifties who lives on the street, is delusional, and refuses to come to the clinic to get services,” said Flanagan. “She thinks she is actually working in the park, so we do street outreach for her, going to the park or train station or wherever she’s staying. I do a psychiatric evaluation, provide meds, and we offer to bring her to transitional housing.”

The team works in partnership with New York City’s Department of Homeless Services and can procure Section 8 vouchers for veterans, which can be used to pay rent in select apartments around the city. So far the woman has refused housing, so the regular visits continue. “We make sure that she’s safe and bring her food, blankets, clothing, and gloves, just trying to gain her trust,” said Flanagan.

It takes time, but there are successes. One homeless vet went from the streets to transitional housing in a shelter for veterans and eventually moved into a Section 8 apartment. Flanagan’s team connected him to a Harbor Healthcare VA clinic, where he has access to health services and support groups, including one that provided job training. The veteran received help with substance abuse and began taking psychiatric medication to treat his underlying mental illness. “Eventually he entered a work therapy program and got a job working at the VA,” said Flanagan. The team still visits the vet weekly and has even helped him find furniture and supplies for his apartment.

The VA health care system deploys team care for veterans, homeless and otherwise, by linking each vet with a designated care unit, a model similar to many medical homes in civilian health care. The focus is on providing long-term collaborative care that aims at treating the whole patient, not just separate illnesses or conditions. The emphasis is on wellness and preventive care as well as linking vets to supportive services in mental health, job training, and for the frailest patients, home-based primary care.

According to Kathleen Capitulo ’02, PhD, FAAN, chief nurse executive at the Bronx VA, “Nurses practice in an interdisciplinary team, coordinating complex care, including telehealth.” In home-based primary care, for example, nurse practitioners serve as the primary provider and RNs coordinate all of the care, furnishing follow-up and feedback to vets in their homes. “We put all primary care into this team model four years ago and have been very successful,” said Capitulo. “We have seen a decrease in hospital admissions for patients and do a fabulous job of keeping people out of hospital, with higher patient satisfaction compared to the private sector.”

Capitulo, whose career focused on women’s health and maternal-child health before she joined the VA, extended the team-based care approach to the women’s health program at the Bronx VA and the VA community practice in White Plains, N.Y. Women currently make
Kathleen Capitulo ‘02, PhD, FAAN (center) with nurse veterans Blossom Ferguson (left) and Tashany Myers (right) at the James J. Peters Veterans Affairs Medical Center in the Bronx.

PHOTO BY JÖRG MEYER
Dennis Graham ’93 ’08, PhD holding his medals at the Manhattan campus of the VA NY Harbor Healthcare system.
up 8.1 percent of all living veterans and comprise some 14.5 percent of service members in active duty and 18 percent of the reserves. “The VA has been responsive to the unique needs of female veterans, recognizing that the one-size-fits-all approach doesn’t fit women,” said Capitulo. “Women have shared with us that while they are equal, their needs are different.” An expert in qualitative nursing research, Capitulo facilitated focus groups with female veterans and providers to improve care, services, education, and the design of the new women’s health clinic. There is a separate, child-friendly waiting room for women; five-day-per-week coverage for gynecology; a full spectrum of gynecological surgery; and soon, on-site mammography. James J. Peters is one of two VAs in the nation to have a pediatrics clinic, providing well child care and immunizations to children.

In some of the focus groups, more than half the women said that they had witnessed or experienced military sexual trauma (MST). The team now includes a social worker—a retired New York City police officer with experience in the sex-crime unit—who provides counseling in groups and for individuals. “Our job is to provide a healing environment for those who have experienced MST.”

A significant number of nurses and nurse leaders in the VA health care system have served in the military themselves. Still, the VA health care system does not require that a veteran’s past service history be part of his or her electronic health record, so adverse events that may be related to that service may be missed. That’s why veterans often arrive for appointments at VA hospitals and clinics wearing baseball caps, T-shirts, and jackets emblazoned with logos that let doctors and nurses know what war they’ve fought or served in. Providers are even less inclined to ask about prior service when veterans seek care outside of the VA. In a given year, only 27 percent of veterans receive their care from the VA. The rest are likely to use civilian hospitals, clinics, and private offices. This is especially common for recent veterans of the Iraq and Afghanistan conflicts who served in the reserves and return to their homes in small towns far from military bases and VA clinics or centers.

Dennis Graham ’93 ’08, PhD, believes this needs to change. A Vietnam vet who recently retired as director of the nurse practitioner program at Memorial Sloan Kettering Cancer Center, he feels strongly that a patient’s experience as a veteran can play a major role in an illness, especially a serious one. During their service, veterans may have been exposed to radiation, Agent Orange, anti-malarial drugs, or noxious fumes linked to cancer or immune system disorders. Those who served in Iraq and Afghanistan may have respiratory conditions linked to open-air burn pits, may have experienced traumatic brain injury from improvised explosive devices, or be suffering from post-traumatic stress disorder or sexual trauma. “I asked a patient during a pre-op admission if he had served in the military and he said that he had been in the Korean War,” said Graham. “He told me he still has dreams about it. His wife added that he is restless at night. I reported this to the surgical team and nursing staff. After surgery, the patient had an episode of severe hallucinations and night terror. The psychiatry service was consulted, but they were unaware of his veteran status.

I told them about his service in Korea and his reports of dreams and nighttime restlessness and they changed his therapy. Not knowing his experience as a combat veteran could have led the psychiatric team to treat for postoperative delirium and not night terror.”

The American Academy of Nursing recognizes the importance of identifying veterans in civilian health care settings and has launched a national initiative centered on the question, “Have you ever served in the military?” According to Cheryl Sullivan, CEO of the academy, the organization distributes a pocket card that leads nurses through a series of questions that include: “Have you or someone close to you ever served in the military—when did you serve; what was your job in the military; did you experience enemy fire or combat; or do you know if you were exposed to chemicals or gases?” Sullivan says that because nurses are “health care’s equivalent to boots on the ground,” they are in a position to make sure that this vital information is obtained and recorded, potentially helping improve the health care provided to the nation’s veterans and their families.

The “Have You Ever Served” initiative is part of a larger commitment to veteran care from the nursing profession. More than 150 of America’s nursing organizations and over 450 nursing schools in 50 states and territories are part of the Joining Forces effort spearheaded by the White House and First Lady Michelle Obama to better serve the nation’s veterans and their families. Nursing leaders have committed to educating current and future nurses on how to recognize and care for those suffering from combat-related conditions and symptoms. According to the American Nurses Association, this effort is expected to reach more than 3 million nurses in nearly every health care setting and every community in America. As an example of the effort’s thrust, the American Nurses Foundation recently launched a web-based post-traumatic stress disorder toolkit that is available to all registered nurses, and describes how to identify, assess, and refer veterans suffering from the condition.

Nursing research is at the heart of developing new evidence-based treatments and interventions for the invisible wounds of war, such as post-traumatic stress disorder as well as the more visible injuries and conditions of battle. In the clinical arena, nursing emphasizes communication, intimate contact with patients, and a dedication to treating the whole person. When combined with training to better understand military culture, an ability to listen and respond without judgment, and respect for military service, these attributes render nurse professionals essential participants in improving care for those who have put themselves in harm’s way.
Nursing Narratives

Student writing assignments deepen their ability to empathize and provide better patient care.

Photographs by Jörg Meyer

NOTE: All patient names have been changed to protect privacy.
The first year of nursing school is intense, nonstop, and leaves little time for reflection. Because of this, students tend to focus more on the scientific knowledge than the emotional, social, and psychological aspects of nursing. Assistant Professor Jeanne Churchill, DNP, who directs the ETP program’s five-week pediatrics rotation, wanted to change that. She had personally discovered that writing about nursing’s non-medical elements gave her the critical distance to explore her feelings about her own clinical experiences. Her students also needed this distance, to step back and remember why they went into the profession: to take care of human beings, not just diseases.

Churchill began assigning narratives to help students reflect on the quality of their interactions with patients. “I wanted them to explore the personal impact of their experiences, and how their feelings and reactions could help them become better nurses.”

One such student was Brian Lohotsky. The first-year ETP student wrote about Lauren, an eighteen-year-old patient who had been admitted for acute asthma exacerbation. Lohotsky was on the third day of his pediatrics rotation at NewYork-Presbyterian Hospital when he was assigned to care for Lauren. Medical personnel had stabilized her, and during the course of her recovery, she began to open up to him. She was a single mother with a sick child at home, had a boyfriend and dreamed of attending medical school. She also had a history of intubation for acute asthma exacerbation, and dreaded the procedure, fearing it might further separate her from her daughter. Lohotsky’s assignment to write about this episode focused on Lauren’s fear:

She grieved that she couldn’t breathe, that the albuterol wasn’t working, that she wanted to shower, that she wanted to go home, that she missed her daughter. And again that she missed her daughter. And again.

By writing Lauren’s story, Lohotsky recognized that, “She wasn’t just a kid having an asthma attack. She had in the back of her mind her kid, her schooling, her boyfriend.”

Describing the scene for Churchill’s class gave him clarity about the kind of nurse he hopes to be. “She just needed a little bit of reassurance, which would have helped her just as much as the medications,” he says. “If you’re preoccupied with administering meds and looking at numbers, and not looking a patient in the eye and using your own social radar, you’re going to miss the individual reaction that your patient is having.” He adds, “When I’m a nurse and actually practicing in a situation like Lauren’s, I would probably ask the supervising health care provider if there might not be another option besides medication.”

**BUILDING SELF-CONFIDENCE**
Writing about their clinical experiences helps students notice the small things that make a difference, says Churchill, which can play an important role in the healing process. These small things can be as simple as spending time with a sick adolescent, as Lohotsky
did; or, as another student wrote, holding the hand of a developmentally disabled boy, Izzy, who had been admitted to the pediatric intensive care unit for respiratory failure, and one month later, still depended on a c-pap machine to breathe:

I just held his hand; told him that he was doing a great job, and made sure that he knew that in that moment I was there for him. Then it happened. That moment in time when I was able to physically see his body relax, just a little bit. His breathing became just a bit less laborious, and more regular. His pulse dropped only by a few digits. However, for him, that tiny step made all the difference in the world.

TREATING THE ENTIRE FAMILY
To expand students’ appreciation of the significance of their role during a birth, Laura Zeidenstein, DNP, director of Columbia’s Nurse Midwifery program, also assigns reflective writing. She says the essays and poems she has students write boost their confidence in their own usefulness, as did one assignment to write a poem about their hands during birth. “Their hands are a big part of what students do,” she says. “Writing about their hands helps them learn to trust in themselves as clinicians.”

Writing about her hands helped Tiana Miller-Breland ’12 ’14, understand that even as a nurse midwifery student, she brought needed skills to a woman’s labor and birth. “I realized that while I’m waiting, even in my stillness, I’m assessing and thinking with my hands,” says Miller-Breland, who wrote:

We, hands, are here to watch, to wait, to anticipate. To protect, support, prevent. To guide, to reach, to rest. To stretch. To flex, to elevate, to grasp. To grip, to Hold, to clamp. To cut, to dry, to catch. To welcome, to present.

To help students understand how to care for the whole family, Zeidenstein has them write from the perspectives of the expectant parents, as well as the soon-to-be birthed baby. Birgit Dugan ’10 ’12, described one father’s anxiety during his wife’s labor:

I’m biting my nails, pacing the floor, on the verge of tears. I hate that you’re crying out in pain and I can’t take it away. I feel helpless.
First year ETP student
Lindsay Wright
Reflective writing is a centuries-old tradition, notably associated with physician-authors such as Anton Chekov, William Carlos Williams, Oliver Sacks, and Atul Gawande. But it is Rita Charon, MD, PhD, who is credited with formalizing the discipline of narrative medicine, which helps clinicians connect with patients by honing their skills of perception, and helping them process their emotions about their clinical encounters.

Charon recognized the need for narrative medicine during her early days as an internist. She noticed, as she asked patients about their head-to-toe aches and pains, that what they really wanted was to tell her their stories. So, she began listening. Paying careful attention to her patients’ words, facial expressions, body language, and silences would help her know them as people rather than illnesses, and make her a better doctor.

To learn to interpret stories, Charon earned a PhD in English. She found that writing about literature sharpened her ability to perceive. “Until you represent what you’ve seen, you haven’t actually seen it,” she says. “Narrative medicine is not just sympathy. It’s about seeing what is in front of you – that person in the bed or the family in the ICU – in all their complexity.”

Eager to share these insights and skills, Charon began holding workshops for clinicians at Columbia University Medical Center. Studying and reacting to stories, poems, movies, and photographs would heighten their attention to detail and, by extension, patients’ stories. In 2009, she started Columbia University’s Master of Science program in Narrative Medicine, with a goal of training clinicians to launch similar programs at their own schools.

From tradition to discipline

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Special Book Excerpt:

THE SHIFT: 
One Nurse, Twelve Hours, Four Patients’ Lives

By Theresa Brown, RN

Author’s Note: This book came into being because I wanted to write an account that followed a nurse working with patients over the course of a single day. Since hospital nurses may care for patients intensely during a few shifts and then never see them again, writing a longer narrative is more of a challenge than the Opinionator column I occasionally write for The New York Times. As I meditated on how to convey the richness of what nurses do, I realized that every shift is an amazing story and that I had just worked one that would be a great basis for a book.

That day in the hospital I had two patients—renamed Sheila and Mr. Hampton—who seemed, respectively, stable and fairly vulnerable; but appearances were deceiving. This excerpt from The Shift (Algonquin Books, Publication Date: Sept. 22, 2015) shows preparations for Mr. Hampton’s potentially life-threatening chemotherapy treatment, while Sheila waits in pain for a life-saving surgery.

The chapter, called “Paperwork,” contrasts the human side of care with the constant demand for timely record keeping. Balancing those needs is difficult, but as every nurse knows, finding time to treat patients as human beings is one of the job’s greatest rewards.
Mr. Hampton’s weakness, his difficulty breathing, his confusion are all on my mind. Will we save him or push him closer to death? You can only know what you know, a wise friend told me, but so much is on the line here in the hospital I sometimes want to know more than I can.

I pick up the chemo form and really look at it. Chemotherapy orders continue to come on paper. The thinking is that the drugs are so strong, the regimens so specific, that a physical copy of the entire order needs to be in the patient’s chart as well as entered into the computer. I like the tactility of paper, feeling it between my fingers, hearing it snap and crinkle when bent, running the tip of my finger over the slight indentations left by the fellow’s careful printing.

Sheila’s call light goes on. The clock’s running on getting this chemo order to pharmacy, but I’ve got a little time since Mr. Hampton’s son won’t be here before three p.m.

Sheila’s room is so still it seems airless. I peer into the dimness and consciously relax my face before I speak. Sheila looks defeated, exhausted from crying. “Is your belly hurting you?”

She shakes her head. Her sister sits next to her, holding her hand. “We’d like to see a minister,” she says, and her voice catches, “just in case.”

“Right.” This is an easy request. I call the hospital operator and ask her to page the pastor on call.

“Sheila’s brother-in-law surprises me with a question as I’m going out the door. “Do you think it was the ambulance ride that did this? All that bouncing around? She said it was rough.” I stop to consider that.

“I don’t think so.” Lots of people ride in ambulances without having their intestines perforate. “It more likely has to do with her clotting problem and the trouble she was having with her medication.” He nods, then leans back into the chair and I lose him to the corner’s darkness.

I look at Sheila and her sister. “I’ll be back. Call me if you need anything for pain or . . . anything else.”

People react so differently to distress. Sheila and her family could be furious, focusing on our failure to do a CT scan right away, to start the anti-clotting drug without understanding why her belly hurt. They’re not being like that, though; they’re mostly suffering in silence. That’s their portion and it makes my life easier, but I wonder if it serves them. Those who bear up, demanding little, are the reverse version of patients such as Candace Moore. Candace is a wounded Fury—hurt and wanting help, but focused also on justice and some desire for revenge. It’s impossible for Candace to simply endure. She lashes out at everything and everyone, unsure whom to trust since it’s really her disease holding most of the cards in the hospital. I wish I had more time to sit and hold every patient’s hand. To really listen. I think it would make a difference for Candace as well as Sheila. I really do.

My phone rings. “Theresa, just wondering when you’re going to have that Rituxan order?” It’s Pharmacy. “We want to get the chemo going ASAP since they’re not increasing the rate. The docs would rather it didn’t run all night long.”

The chemotherapy order is lying on my medcart where I left it, and I and another nurse have to verify it before the paper goes to Pharmacy. “Yeah. Sorry. I just got it; I’ll start my check now.”
“It’s fine. We’ve got a lot of chemo to do for the other oncology floor and wanted to make sure we finished your Rituxan first.”

“Right. Thanks, Bobby.” So many needs; I’d better get this done.

Focus: the fellow’s calculation of the BSA or body surface area is the first thing to check. We calculate from a verified height and weight, which requires two nurses to weigh and measure Mr. Hampton together. That must have been done yesterday. I double-check by looking it up on the computer—it’s there—and then double-check the math, multiplying Mr. Hampton’s height in centimeters by his weight in kilograms, dividing by 3,600, and taking the square root of that number. The answer comes out in meters squared, which makes no sense and yet it’s what we do.

All of this is just arithmetic, but mistakes slip in. Fellows round down instead of up, use an old weight, plug the numbers into the non-customary formula—these kinds of errors and others have been detected by nurses reviewing chemotherapy orders. The drugs are biohazards so the dose has to be precise: more than enough to cure the patient’s disease might be too much for the patient’s body to tolerate since many of these drugs are toxic enough at the predetermined safe doses.

I use the calculator on my computer desktop and this time the numbers for the BSA and the ordered dose of Rituxan are correct. Good. Now I need to make sure the ordered dose and timing of Mr. Hampton’s Rituxan match the treatment plan specific to his disease. Pulling up chemoregimens.com on my computer (luckily the website is not blocked today) I go to lymphoma and easily find Mr. Hampton’s regimen. Harder are the moments when I can’t find the correct doses listed and a call to the fellow yields the information that they’re using a novel protocol taken from brand-new research. “The article’s in the front of the chart,” the fellow will say, helpfully, but why didn’t she or he just tell me at the start? Often the docs are too busy to think of that detail, but it may also be because MDs have little idea what nurses actually do when we check chemo orders. Do they know that we perform our own independent verification of the math and the ordered regimen? Nurses and doctors—our work is often invisible to each other.

I’m at the final step: I need another nurse to redo my verification. I walk up the hall and there’s Beth at the nurses’ station. I feel uncertain about asking her to help me since I know her daughter’s trip to Kandahar is on her mind, but she sees the order sheet in my hand and says, “You need a checker?”

“Do you have time?”

“Being busy is good,” she says. And then she laughs, “But then you may have to double-check my math. I’m a little preoccupied.” She’s joking; I know how careful she is.

“Any word?” I ask quietly.

“No,” she says, not looking up. She’s pulled a small calculator out of her pocket and is already punching in numbers. “And I’ve decided it’s just too early to worry!” she says, briefly glancing up, but she presses her lips together in a hard line as she compares the calculations.

I see Ray Mason, a long-term patient, on a stretcher on the opposite side of the nurses’ station, near the main door to the floor. He must be on his way to a test. I realize it’s past noon and even though I talked to his wife, Liz, in the hall I haven’t yet gone by to say hi to him. Leaving Beth to her work I walk over.

“Hey,” he says. He’s taken out his nose and ear piercings and looks vulnerable without them. I bend down to the stretcher to hug him.
Something in my face must give away my concern for him because he says, “It’s cool. What will be will be.” He says it in a rush, with little feeling, almost like a mantra. Well, why not invoke karma? There’s nothing else he can do.

“What happened?”

“Just started feeling more and more tired. Got a blood test. Have to do a marrow, but . . .” he shrugs. His relapse isn’t 100 percent confirmed until leukemia cells are detected in a sample of his bone marrow, but he’s resigned to it.

“The thing is, my brother, the super-conservative, will be my donor. I’m worried I’ll end up being like him.” I look at Ray; I can’t tell if he’s kidding or not and decide to go with “not kidding.”

“No!” I tell him, “That’s ridiculous!”

“I don’t know,” he says, “I’ll be getting his entire immune system.”

“Nah,” I tell him. “Your personality won’t change—just your blood cells.”

The escort who’s taking Ray to whatever test he’s having steps up to the stretcher. He’s ready to roll.

“Hey,” I say, “I’m sorry.” They take off toward the elevator and Ray, with his back to me on the stretcher, raises one hand in the air and waves it at me without turning around, friendly, but dismissive. He doesn’t want my pity.

Ray and my exacting patient, Candace Moore, will both receive stem cell transplants. Ray will take donated cells from his brother the Republican—called an allogeneic transplant—and Candace will have her own cells infused—an autologous transplant. Different diseases require different treatments. Ray has the harder road since receiving another person’s stem cells can cause a lot more problems afterwards than getting one’s own back. For both of them, transplant day will arrive with a sense of anticipation and a bit of low-key fanfare.

Candace’s cells, harvested earlier and then frozen solid, will be thawed in a water bath by the cell technician who attends every transplant. The numbers on each bag will be checked and double-checked to make sure she receives only her own cells. As each bag is thawed the nurse will hook it up to Candace’s central line and let it flow in just like any other blood product. The preservative used on the cells, called DMSO, could be dangerous, though. A few unlucky patients have a potentially fatal allergic reaction to it and we have no way of knowing in advance who those patients may be. Because of the risk posed by DMSO we put all patients receiving autologous transplants on a heart monitor, make sure to have oxygen tubing and suction equipment in the room, take vital signs every five minutes, and stay with them at all times. I even give my phone up to the charge nurse.

This is nurses’ work and it’s a privilege to do it. It’s not every day you get to give someone her life back by hanging an IV, checking some vitals, and making sure she continues to breathe deeply since the body eliminates DMSO through respiration.

We say “Happy Birthday” to all transplant patients. The stem cells they receive—whether their own or someone else’s—are needed because we use very high doses of chemotherapy to wipe out their bone marrow’s ability to produce stem cells. The transplant is technically a rescue therapy after they’ve gotten enough chemo to kill their disease, but I like the rebirth analogy better. If donated cells differ in blood type from the patient’s own, that person’s blood type will actually change after transplant. I used to think blood type was as fixed as eye color or having dimples, but it isn’t. It can change, does change, as a side-effect of the treatment given to save someone’s life.

Beth gives me back the Rituxan order. “That’s my call light,” she says, hearing the insistent beep and checking the screen at the nurse’s station for a room number. “Mr. Parrish probably needs help to the bathroom.”

I check that we signed the form in the right place, dated it, wrote down the time: 13:45. I like
that we use military time in the hospital; it avoids confusion. I glance over the order sheet one more time, then leave it in the bin for pharmacy.

There’s a pre-operation assessment that I need to fill out for Sheila and I’ll do that back at my medcart. Before I start the pre-op form, I check on her. I open the door slowly and peer into the dark. “Pain?” I ask her. She nods, just barely. “I’ll get you some more Dilaudid.”

Inside the locked room where we keep our narcotics I punch my code into the Pyxis machine, just as I did this morning, look up Sheila’s name and get the dose of Dilaudid I need. Back at my medcart I draw it up and dilute it as usual.

I chart the med, guessing at the number on the one-to-ten pain scale since it’s subjective and I know she needs it. The few times I’ve been asked to rate my own pain from one to 10 I’ve found it inaccurate and unhelpful. Hurts some, hurts a lot, and oh-my-God give me relief now seems like a more appropriately human scale.

In the room I hold up the syringe, saying nothing. I prepare the IV port and slowly push the drug in while I explain how to best manage pain, “If you can, call me in before it gets so bad; we call that ‘staying ahead of the pain.’ Pain is not physiologically neutral. It stresses the immune system, interrupts sleep, can delay healing. I can also get your dose increased if you need more relief.”

Sheila grimaces, then nods while closing her eyes, taking a sharp breath in. I unscrew the used syringe and attach another filled syringe. “This is saline,” I say, “If I push this in fast it will make sure the drug gets into your system as quickly as possible.” I probably don’t need to do that since she’s got IV fluids running in at such a fast rate, but why not? It makes me feel like I’m doing everything possible for her. I look at the one-quarter full bag of saline that’s running now; she’ll need a new one soon. That’s a small something I can do as well.

“I paged a minister,” I say. “It seems like it’s taking her awhile to get here so I’ll page again. Sometimes it’s good to be the squeaky wheel.”

The sister actually smiles, but Sheila catches a sound in her throat. The brother-in-law is sitting closer to the two of them than he had been, but he has his head down and is staring intently into his lap. He’s unreadable.

An old animated sketch on Sesame Street shows a little girl being instructed by her mother to bring home some basic groceries: a loaf of bread, a container of milk, and a stick of butter. The mother offers to write down the list, but the little girl is sure she can remember. She walks to the store repeating, “A loaf of bread, a container of milk, and a stick of butter,” over and over, and she does remember once she’s there, but only by bringing her mother’s exact words to mind. In the hospital I’m like that little girl on my way to the store, except the trip lasts twelve hours and the items I have to remember are much more varied and potentially consequential.

The computer tells me that the discharge paperwork for Dorothy, my patient who’s been in the hospital for six weeks plus, is ready to complete; she can leave after I’ve done my part. I push Sheila and the Rituxan order to the back of my mind along with all my other to-dos and head up to the nurses’ station. Let me see how quickly I can get Dorothy out of here. Leaving the hospital to go home always makes people glad.
Our faculty’s research continues to create new knowledge that advances health care. Listed are selected articles published by leading peer-reviewed publications.

Suzanne Bakken, PhD, FAAN, Alumni Professor of Nursing and Professor of Biomedical Informatics, was the lead author of “The Effect of a Mobile Health Decision Support System on Diagnosis and Management of Obesity, Tobacco Use, and Depression in Adults and Children,” published in The Journal for Nurse Practitioners. Haomiao Jia, PhD, associate professor of biostatistics, was also an author. Bakken was also an author of “The Clinician in the Driver’s Seat: Part 1—A Drag/Drop User-Composable Electronic Health Record Platform,” published in the Journal of Biomedical Informatics; “The Clinician in the Driver’s Seat: Part 2—Intelligent Uses of Space in a Drag/Drop User-Composable Electronic Health Record,” published in the Journal of Biomedical Informatics; and “Intercepting Wrong-Patient Orders in a Computerized Provider Order Entry System,” published in Annals of Emergency Medicine.

Mary Byrne, PhD, Stone Foundation and Elise D. Fisch Professor of Health Care for the Underserved and Professor of Anesthesiological Sciences, was the lead author of “Prison Nursery Co-residence and Re-entry” and “Attachment Versus Bonding: What’s the Difference?” published in Healthy Generations, from the Center for Leadership Education in Maternal and Child Public Health, University of Minnesota.

Ruth Masterson Creber, PhD, postdoctoral research fellow, was the lead author of “Motivational Interviewing Tailored Interventions for Heart Failure (MITI-HF): Study Design and Methods,” published in Contemporary Clinical Trials.

Karen Desjardins, DNP, assistant dean, Academic Affairs, was the lead author of “Comprehensive Care Coordination: The Time Is Now,” published in Clinical Scholars Review.
Dawn Dowding, PhD, VNSNY Professor of Nursing, was the lead author of “Dashboards for Improving Patient Care: Review of the Literature,” published in International Journal of Medical Informatics. She was also an author of “Pain Assessment for People with Dementia: A Systematic Review of Systematic Reviews of Pain Assessment Tools,” published in BMC Geriatrics, and “Using Realist Reviews to Understand How Health IT Works, For Whom, and in What Circumstances,” published in the Journal of the American Medical Informatics Association.


Michael Greco, DNP, assistant director, Nurse Anesthesia program, was an author of “Assessment and Management of the Patient with Atrial Fibrillation for Ablation,” published in Anesthesiology News. He was a co-author of “Ablation Therapy for Atrial Fibrillation: Implications for Anesthesiologists,” published in the Journal of Cardiothoracic and Vascular Anesthesia.

Sue Greenfield, PhD, associate professor, and Cliff Roberson, DNP, director, Nurse Anesthesia program, authored “Autonomic Nervous System Drugs,” in Chapter 5 of Pharmacology for Nurses.


She was an author of “Basic Concepts and Potential Applications of Genetics and Genomics for Cardiovascular and Stroke Clinicians: A Scientific Statement from the American Heart Association,” published in Circulation: Cardiovascular Genetics.

Jeffrey Kwong, DNP, director, Adult-Gerontology Primary Care Nurse Practitioner program, was the lead author of “Expanding Capacity for Hepatitis C Treatment in the United States: Team-Based Care and Use of Nonphysician Providers,” published in the Journal of the International Association of Providers of AIDS Care.


Rebecca Schnall, PhD, assistant professor, was the lead author of “mHealth Technology as a Persuasive Tool for Treatment, Care and Management of Persons Living with HIV,” published in AIDS and Behavior. Suzanne Bakken, PhD, FAAN, Alumni Professor of Nursing and Professor of Biomedical Informatics, was also an author. Schnall was also the lead author of “Short Message Service Use in Clinical Care through a Simulation Activity,” published in Journal of Nursing Education. In addition, she was an author of “Barriers to and Enablers of Contraceptive Use among Adolescent Females and Their Interest in an Emergency Department-based Intervention,” published in Contraception.

Jingjing Shang, PhD, assistant professor, was the lead author of “Infection in Home Health Care: Results from National Outcome and Assessment Information Set Data,” published in American Journal of Infection Control. Elaine Larson, PhD, FAAN, associate dean for research, and Pat Stone, PhD, FAAN, Centennial Professor of Health Policy, were also authors.


Tanya Smith, PhD, postdoctoral research fellow, was the lead author of “HIV Sexual Risk Behavior in Older Black Women: A Systematic Review,” published in Women's Health Issues. Elaine Larson, PhD, FAAN, associate dean for research, was the co-author.

Pat Stone, PhD, FAAN, Centennial Professor of Health Policy, was an author of “Nurse Workforce Characteristics and Infection Risk in VA Community Living Centers: A Longitudinal Analysis,” published in Medical Care.

Mary Tresgallo, DNP, assistant professor, authored two book chapters in the Handbook of Pediatric Anesthesia, “Postoperative Pain Management in Sickle Cell Disease for Laparoscopic Cholecystectomy” and “Intravenous Patient-Controlled Analgesia.”
From the Alumni Association President

Dear Fellow Columbia Nursing Alumni,

It has been my privilege to serve as president of the Columbia University School of Nursing Alumni Association during 2014–15. I never cease to be impressed by our outstanding alumni community, a vibrant group of more than 12,000 graduates making positive changes around the world and in their local communities. It is an exciting time to be involved with Columbia Nursing — there are many ways for alumni to connect with each other as well as with the school. Each and every one of us has a role to play in making Columbia Nursing an even better place for future generations of nurses.

One focus has been to increase engagement between alumni and current students. This year saw the launch of the Alumni-Student Connection initiative, a collaboration with Columbia Nursing’s student affairs office. It affords students an insider’s view into alumni career paths while allowing graduates to interface with students and help the next generation. The first round of matches occurred during the January intersession, and we look forward to continuing this program during future breaks. The Alumni Association was also pleased to launch a mentoring initiative for doctoral students last fall, connecting PhD and DNP alumni with current students in those programs; this is operated in tandem with the new student-run Doctoral Student Organization. In addition, we continue to organize “Real Talk” programs for students to have candid career conversations with alumni who are out in the work world. The Alumni Admissions Ambassador program has grown in its second year and continues to offer a way to match graduates with admitted students who — as they contemplate which nursing school to attend — can ask questions of alumni volunteers.

Alumni have responded well to recent programs that offered Continuing Nurse Education (CNE) credit, and we plan to continue to offer this option at future events. In November, the Alumni Association organized a presentation on “Scope of Practice: Are We There Yet?” More recently, we partnered with the Center for Health Policy in February to present a panel discussion: “Leading Change: How Nursing Can Shape Health Care Policy.” Both events were robustly attended and included ample reception time for networking among alumni, students, faculty, and nursing colleagues. We reached out to alumni beyond New York to help organize alumni gatherings with the dean or faculty at professional meetings in Orlando, Florida; Portland, Maine; and Wellesley, Massachusetts.

In addition to the various nursing-specific programs, the Alumni Association continues to collaborate closely with the Columbia Alumni Association (CAA) and schools across the University. Columbia Nursing hosted the second annual CUMC Health Care Forum this fall, “Achieving Global Health Equity: Strategies, Challenges, and Champions.” We also partnered with alumni leaders from across the University to present “Strategies on Fighting Ebola: A Columbia University Summit” with faculty and graduate experts from Nursing, Mailman, P&S, the Business School, and the Earth Institute.

If you haven’t been involved lately, I hope we will see you at a future event. Please browse our website (nursing.columbia.edu/alumni) to find opportunities to become involved and deepen your connection with the Columbia Nursing community. You will also find profiles and videos of alumni and students, details on upcoming events, and much more in-depth information about the school as well as links to relevant University and CAA Web pages to learn about events, initiatives, and news about faculty, students, and alumni around the globe.

It is also a great pleasure to note that Angela Clarke Duff ’70 is a 2015 Columbia University Alumni Medalist. A bachelor’s graduate and a long-standing alumni leader, Duff is also the mother of a PNP program graduate — Maureen Duff Furlong ’96 ’00. She is the 14th Columbia Nursing alumnus to receive this distinguished honor conferred by the CAA. Recipients from all Columbia schools were recognized at the University Commencement this spring, and will be honored again at the CAA Alumni Medalist Gala this fall. Bravo, Angela!

In closing, I enjoyed meeting and reconnecting with alumni across the generations at events in the year ahead, much as we did at this year’s Alumni Reunion marking the 10th anniversary of the DNP program, the sixth decade of the school’s Nurse Midwifery program, and the 50th milestone celebration for the Class of ’65. It is always rewarding to have opportunities to celebrate the depth and breadth of the Columbia Nursing alumni community.

Warm regards,

Marty “Marty” Cohn Romney ’81, RN, MS, JD, MPH
Alumni Association President
A Glimpse of some Alumni Events from the Past Year

1: Kent Haina ’14 ’15; Stephanie Maceiras ’14; Thania Lee ’14; Suzanne Black ’14; Amy Rose Taylor ’14; Hannah Blaustein Kasper ’15; Elizabeth Gary ’14 ’15.

2: Christopher Dorion, Dottie Simpson Dorion ’57, and George Dorion at an alumni event in Portland, Maine.

3: Angela Clarke Duff ’70 giving the 2015 graduation address.

4: Alumni touring the site of Columbia Nursing’s future building during 2015 Reunion.

5: Members of the Class of 1965 celebrating their 50th milestone at 2015 Alumni Reunion.
Columbia Nursing celebrated the generosity of its donors and the accomplishments of more than 140 student scholars at the 19th annual scholarship reception on March 3, 2015, at the Columbia Club of New York.
1: Student Michaela Rempp; May Yong ’12 ’14
2: Michael Nilles; Dean Bobbie Berkowitz, PhD, RN, FAAN; Barbara McCooe; Kathleen McCooe Nilles ’89
3: Mary Dickey Lindsay ’45; Sally Shipley Stone ’69; Midge Harrison Fleming ’69
4: Gwendolyn Elaine Mercer ’00; Penelope Buschman, director, Psychiatric Mental Health Nurse Practitioner program
5: Robert Desjardins; Allison Feldman, student; Karen Desjardins, assistant dean of academic affairs
6: Students Meagan Carley, Jenny Shek, Rachel Hollander, Diedre Keane, Carter Elizabeth Hibbs, Jillian Jacob, Kira Prokopakis, Matt Allen, Chelsea Heneghan, and Ashley Gyura
7: Students Alan Schultz and Nicole Molnar; Judy Honig, associate dean of academic and student affairs; Jodi Kunibe, student
8: Megan Christian Wright ’82; Camille Messina, student
9: Jenna Sood, student; Sally Shipley Stone ’69
10: Students Sydney Meckler and Philip Gyura ’14; Mary Dickey Lindsay ’45; George Lindsay
11: Students Hana Conlon, Daniel Billings, Megan Caraway, Angel Garcia de Alba, Tsering Tenzing, and Emily Callahan; Vivian Taylor, associate dean of diversity and cultural affairs; Donna Cill, assistant dean of student affairs; Judy Honig, associate dean of academic and student affairs; and students Jamie Hum and Michelle Ellis
12: Jeannemarie Gelin Baker ’90; Jonas Center for Nursing Excellence founders Barbara and Donald Jonas; Dean Bobbie Berkowitz, PhD, RN, FAAN
13: Students Emily Callahan, Malaika Miller, Astley Robinson, Yuliya Kostina, and Mervnide Pierre

Photographs by Monika Graf and Michael Divito
1930s

Jane T. Whistler ’35 of Laguna Woods, Calif., was featured in a 60 Minutes segment titled “Make It to 90: Do the Wrong Thing.” Whistler mentions that her daily habits include: (1) a pack of Pall Malls, (2) a glass of white wine, and (3) a bowl of vanilla ice cream.

1940s

Marjorie Hutchins Taylor ’45 was in the beauty salon when she noticed someone next to her wearing a blue-and-white-striped blouse. She started a conversation and learned to her amazement that the woman, Ruth Gifford Webb ’45, had attended Presbyterian Hospital School of Nursing and had also graduated from her class. Though they never knew each other while in school, they became fast friends.

Jean Calderwood Wood ’45 and her husband, Ken, now live in Harpswell, Maine. In this picture, she’s second from the right on a boat bringing refugees from Italy to America in 1946.

1950s

Ethel Ernestine Hirsch Crowell ’50, better known as “Ernie,” moved west in 1952 with classmate Marie Krahulik. There, she met her husband and pursued almost every facet of nursing, ending her long career teaching nursing assistants in nursing homes, an area of great need. Crowell and her two grown children love Dobermans, and she is delighted to be caring for one that may as well become a permanent resident in her home in Concord, Calif.

Eva Wohlauer Rollnik ’50 retired from CUMC as quality assurance coordinator of the Inpatient Rehabilitation Service. Since 2005 she has been enjoying life on Hilton Head Island, S.C., with her husband, Morty. They have two children, Elizabeth and Margaret. Elizabeth works as a pediatrician and her husband, Daniel, is an associate professor of
radiology and co-director of the Division of Neuroradiology at the Jefferson University Hospital in Philadelphia. Their son, Daniel, is a junior pre-med student at Columbia University. Margaret is a teacher and lives in Williamstown, Mass. Her daughter, Amy, is a high school senior. Rollnik would love to hear from former classmates.

Rosalie M. Lombard ’51 wrote a memoir, Adventures of a Grenfell Nurse, covering her two years working in Labrador and Newfoundland with the Grenfell Mission in the early 1950s. She writes from The Villages, Fla, and reports that she is doing well.

Nancy Gilbride Hill ’52 writes from Roslindale, Mass., that she is the lucky grandmother of 10. In May 2014 she celebrated “end-of-year events” for three graduates: one from college and two from high school. She continues to spend time in her other home in Brunswick, Maine.

Mary A. Baker ’55 reports from Culver, Ind., where she enjoys golf, tennis, and wonderful friends. She and her husband winter in Naples, Fla. She recently visited Beverly Roberts Mulder ’55 and her husband, Jack, in Homosassa, Fla. They hope to see Alice Rinehart Leddy ’55 and her husband, John, as well. Mary wishes good health for all of her classmates!

Ellen B. Pilling ’55 has been retired for six years and is now living near her daughter in Dayton, Nev. She has two Scottish deerhounds and travels all over the country.

Dorothy “Dottie” Simpson Dorion ’57 participated in the 2015 World Indoor Rowing Championship in Boston and completed the 2,000 meter event in 9:39 (7+ seconds faster than two years ago) and also won her age group and set a new world record for 80–84-year-olds.

1960s

Phyllis C. Leppert ’61 recently retired as professor of obstetrics and gynecology and pathology at Duke University School of Medicine and was named emeritus professor of obstetrics and gynecology. Leppert is on the board of directors of Frontier Nursing University in Hyden, Ky. She is president of the Phyllis and Mark Leppert Foundation, a public charity, which sponsors the Campion Fund, which focuses on conception, pregnancy, and birth through medical research and education.

Helen Blackwood Josey ’62 retired in 2009 as an ANP in occupational health. She graduated from the University of Virginia Emergency Nurse Practitioner program in the 1980s. She lived in Oregon for 45 years and will be moving back to be closer to family (from Las Vegas). Her husband died in 2011.

Katherine Klimacek O’Connor Beiter ’63 wrote Comfort in Dying: Reflections of a Hospice Nurse. She completed the book after a 20-year career that included developing three hospice programs throughout New York State, as well as teaching courses on death and dying at the University of Buffalo School of Nursing. The book responds to often-asked questions like: “How can I help?” “How can I say ‘goodbye?’” “How can I let go?” She shares lessons she learned from working in hospice and the losses of her twin sister, Kathleen Klimacek Manos ’63, as well as her husband.

Barbara Meyers McNagny ’63 credits the excellent knowledge and training she received at Columbia Nursing for her 52 years of highly rewarding work as a bedside nurse. She finds it gratifying that she continues to work two eight-hour weekly night shifts in rehab nursing at Cox Health Systems in Springfield, Mo.

Phebe Thorne ’64 welcomed a new granddaughter, Phebe, in the fall of 2014.

Nancy Goerner DeVries ’65 writes from Newfoundland, N.J, that she lost her husband of 51 years, Robert K. DeVries.

Janet MacKellen Iverson ’65 retired as director of nursing from Piner’s Nursing Home in July 2014. She held the position for more than 26 years.

Dean Bobbie Berkowitz led a nursing delegation to Vietnam in November 2014. Participants pictured in front of the Tran Quoc Pagoda, Hanoi, Vietnam: Back row (left to right) Rich Berkowitz, Nancy Kellett ’61, Darlene Sliwa, Susan Furlaud ’09 ’12, Dian Pastor ’08, Don Pastor. Front row (left to right) Linda Varnadore Thornton ’03 ’06, Dean Bobbie Berkowitz, Sandra McLaughlin Johanson ’64, Phyllis Leppert ’61, Frances Tillery, Kay Watters-Julsing ’64
Christina Grubert Siddens '66 writes from Toledo, Ohio, that she welcomed a new grandson — Luke Robert Siddens. He was born Aug. 21, 2013, and is her first and only grandchild.

1970s

Betty Chin Jung '71 is pleased to announce that two writing assignments she developed for an undergraduate wellness class at Southern Connecticut State University have found an application in public health practice: The Public Health Foundation, a national nonprofit, used these materials on interventions to develop public health programs.

Nanci Simmons McLeskey ’71 is a faculty member at the University of Utah College of Nursing. She teaches nursing students how to care for older adults, especially those with Alzheimer’s disease and patients at the end of life. She anticipates receiving her DNP in 2015, with a focus as a nurse educator.

Deborah Mitchell Devine ’74 notes that she left NYC and hospital nursing 30 years ago to move to Massachusetts and raise her family. She has worked as a high school nurse for the past 17 years, fulfilling a lifelong dream. She loves the challenges and rewards of working as a school nurse. She received an NCSN certification five years ago and has been championing the certification among her district’s 45 RNs as a part of her role as nurse specialist. She hopes to retire in a few years to travel and spend more time with her two, soon to be three, grandchildren.

Kathleen F. Doherty ’77 co-authored a book, Yoga and Grief: A Compassionate Journey Toward Healing. The book provides a gentle approach to coping with grief through the use of yoga, breathing techniques, meditation, and ritual. It emphasizes the body-mind connection and positive self-care and is suitable for people with a wide range of physical abilities. The techniques can be done alone or in a community setting such as hospice or pastoral care support groups.

Valerie Hart Smith ’77 was promoted to professor at the University of Southern Maine, Portland, Maine. She still maintains her private psychotherapy practice in Portland, and has practiced in Massachusetts and Maine since 1979.

Patricia Aikins Murphy ’79, associate professor at University of Utah College of Nursing, was inducted into the American Academy of Nursing in fall 2014.

1980s

Ellen Solely Adkins ’81, based in Columbia, S.C., is a clinical assistant professor of nursing at the University of South Carolina College of Nursing, teaching medical/surgical nursing and health assessment to undergraduates.

Alice Hains Bonner ’81, associate professor of nursing at Northeastern University, was inducted into the American Academy of Nursing in fall 2014.

Alison Brehm ’81 retired a few years ago to care for her husband. She had worked as an adult NP for many years as the director of employee health services in a number of institutions. She notes that taking care of employees is vitally important to the health of a hospital. Brehm has another passion — bioethics — and has served on the NYU Bioethics Committee as well as its IRB, with the focus on the patient’s perspective.

Janet Cook Ready ’81 was named president, University Medical Center of Princeton at Plainsboro.

Kathleen Kaskela White ’82 coordinates patient and family education at the Medical University of South Carolina (Charleston) after a 30-year career in neonatal nursing. Her focuses include: growth of a PFE department with material production staff, development of health literacy attributes in this academic medical center and its workforce of interprofessional clinicians, and implementation of the enterprise-wide diversity and inclusion strategic plan.

Anna Kienski Woloski Wruble ’82 has a tenured senior lecturer position at the Hadassah Hebrew University School of Nursing and School of Medicine in Jerusalem and is a nurse midwife. She is also a recognized sexuality counselor by the American Academy of Sexuality Educators, Counselors, and Therapists. Her professional pursuits include education, clinical practice, and research in sexuality and intimacy. She is the chair of the undergraduate curriculum committee; a member of numerous university committees; and coordinates as well as lectures at the Hadassah Hebrew University Schools of Medicine and Nursing, where she teaches multiple courses and topics from research methodology to sexual health care for diverse populations and throughout the lifespan on the health illness continuum in both the undergraduate and graduate programs. She is married to Rabbi Morrie Wruble, and they have five children ranging in age from 15 to 27.

Nancy Witterholt Colter ’83 has worked in the outpatient women health services of Elmhurst Hospital since 1995. She often precepts NP students from CUNY and SUNY programs.

Susan Zinone Fox ’84 was named president of White Plains Hospital.

Sara Patterson ’86 was named senior associate dean for corporate philanthropy at the College of Dental Medicine at Columbia University Medical Center.
Adult-Gerontology Primary Care Nurse Practitioner Program (AGPCNP)

Marylou Almanzor '98 returned to Columbia Nursing to receive her Doctor of Nursing Practice (DNP) degree. She reports that she is excited to return to school and flew in from Silicon Valley, Calif., after receiving an award from Johnson & Johnson.

Kevin Browne '92 was appointed deputy chief nursing officer at Memorial Sloan Kettering Cancer Center in July 2014.

Rachel Epstein '11 '14 works in a gastroenterology/hepatology practice in Seattle and recently co-authored two articles with Jeffrey Kwong, DNP, director, Adult-Gerontology Primary Care Nurse Practitioner Program, regarding the expanding NP role in hepatitis C treatment.

Patricia Clark Pappas '91 is pursuing a DNP. Her area of interest is servant leadership in health care disparities. She is a faculty member at Seton Hall University College of Nursing.

Tamar Prager '10 '12 celebrated the birth of her second son, Josiah Harrison, in 2014. She lives in Connecticut with her wife and two sons, and is awaiting the start of an ANP position with a telemedicine startup called Maven.

Josh Raufman '10 '12 was named Most Valuable Player of 2014 by Mount Sinai St. Luke’s Hospital in recognition of exceptional contributions to the hospital and to his department and co-workers.


Nurse Anesthesia

Fern Wasserman Baudo '01 completed the second chapter in her life's work. The first chapter was her degree from Columbia. The second chapter was publishing her first book on advance care planning, *If I Only Knew: Making Medical Choices as We Navigate Through Life’s Journey*. She wrote the book to help people and their families avoid the pain and anguish of end-of-life scenarios without advance directives.

Don Boyd '06, Denise DiGioia '87, Kerry Halle-ran '11, Kim Lanfranca '06, and Laura Hogan Smith '96 '01 were honored with the Nurse Anesthesia Alumni Leadership Award at an event for students and faculty at Columbia Nursing. All five alumni have served as presidents of the New York State Association of Nurse Anesthetists.

Monica Buff Burrell '09 '12 is working as a CRNA at Northside Hospital in Atlanta, Ga. She and her husband, David, are proud new parents of baby Shepherd.

James Doran '02 was appointed to the New Jersey Board of Nursing by Governor Chris Christie.

Pauline Maietta '08 '11 gave the Alumni Address at Visiting Day for admitted students this year. She works as a nurse anesthetist at NewYork-Presbyterian Hospital.

Laura Jean Ridge '08 '10 founded Nursing for All, a nonprofit that supports nurse-led public health initiatives in the developing world. The organization operates six programs in Liberia.

DNP

Gannel Jean-Pierre '13 completed the year-long Louis and Rachel Rudin Foundation postdoctoral fellowship in palliative and end-of-life care. This fellowship provides training for a postdoctoral nurse to be educated as a palliative nurse leader and train other health care professionals. Jean-Pierre participated in a range of inpatient, outpatient, and home-care clinical experiences while being mentored by clinical educators and leaders, and was precepted by both physicians and nurse preceptors.

Patricia Maani-Fogelman '05 works as subinvestigator on Autoantibody Reduction Therapy in Patients with Idiopathic Pulmonary Fibrosis (ART-IPF), at Geisinger Medical Center. Maani-Fogelman published two chapters for Oxford University Press textbooks on palliative medicine.

Andrew Scanlon '10 was one of three finalists and the only NP in the Australian 2014 Victorian Public Health Care awards.
Program Notes and In Memoriam

Janice Smolowitz ’05 was named the senior director of education, research, and professional practice at Mount Sinai Hospital. Previously, she was a faculty member at Columbia Nursing, serving as senior associate dean of clinical affairs, associate dean of practice, director of CAPNA, co-director of the DNP program, and editor of Clinical Scholars Review.

Kris Takamiya ’01 ’07 is a clinical associate professor, psychosocial, and community health at the University of Washington School of Nursing, and has moved into a new home with her husband and two daughters in the Seattle area.

**Janice Smolowitz ’05**

Kris Takamiya ’01 ’07

Wendy Kong ’02 ’05 and her husband, Sam Van, welcomed their daughter, Madison Rose Van, in 2014.

Suzanne Ohmann ’08 worked as an RN legal investigator for the Thomas Rhodes Law Firm in San Antonio, Texas. She is also pursuing an MFA in creative writing at Wilkes University.

Elisheva Schachter-Rosner ’05 has worked at Morgan Stanley Children’s Hospital since 2007. She initially worked on Peds GI/Transplant/Med-Surg, and transferred to Neonatal ICU two years ago. She completed her MSN in nursing education at Ramapo College of New Jersey and precepts new nurses to the unit and provides staff education on various topics, most recently on Remodulin for persistent pulmonary hypertension in neonates. She notes that her husband and three wonderful children keep her smiling.

Carrie Jauron Siefken ’02 was named a 2014 March of Dimes Nurse of the Year. The award recognizes exceptional nurses.

Amy Rose Taylor ’14 was named health policy fellow for the American Association of Nurse Practitioners in Washington, DC. Her duties included assisting governmental affairs staff with researching proposed legislation and coordinating a health policy conference. She also represented the organization at meetings, briefings, and hearings on Capitol Hill.

Jessica Trimble ’09 was the featured speaker at the Sigma Theta Tau International Alpha Zeta Chapter induction ceremony at Columbia Nursing.

**Nurse Midwifery**

Yolanda Alvarez Nitti ’96 was named Nurse of the Year by the National Association of Hispanic Nurses. She serves as associate professor at Miami Dade College, where she teaches for the ASN and BSN nursing programs, and is pursuing a PhD at Barry University. Previously, she worked as a nurse manager and director for several hospitals in New York and Miami.

**Donna Pynn ’90** and **Roseanne Seminara ’89** founded Park Slope Midwives in 1993 and received the Community Service Award from Congregation B’nai Jacob in 2014.

**Tanya McDermott ’09** joined the team in 2012.

**PhD**

Judith Aponte ’04 received the Nursing Excellence GEM (Giving Excellence Meaning) Award in “Advancing and Leading the Profession” from Nurse.com.

Felesia McCovery Bowen ’10 received the Lieberman Humanism Award from Rutgers University College of Nursing. She is also a Robert Wood Johnson Foundation (RWJF) Nurse Faculty Scholar (2014–17). Her research focuses on community-based pediatric asthma care. She wrote a blog post for RWJF: “We Need People to Be Incensed by the Health Inequality That Persists in This Country.”

Eileen Carter ’14 was named associate research scientist at Columbia Nursing and nurse researcher at NewYork-Presbyterian Hospital, as part of a new joint appointment.

Patricia Moreland ’03 ’10 completed a postdoctoral fellowship at the University of North Carolina conducting research in young adults with congenital heart disease. She serves as lead faculty for the Duke University School of Nursing faculty in Rwanda and U.S. specialty lead for pediatric nursing.

**Anita Nirenberg ’96 ’09** received the 2014 Oncology Nursing Society (ONS) Lifetime Achievement Award.

Annie Hofer Rohan ’91 ’10 ’13 was elected a fellow of the New York Academy of Medicine.

**Bobbie Salveson ’11** is the director of the Center for Excellence in Nursing Education (CENE) at the University of Washington School of Nursing in Seattle. The CENE is a skills/simulation lab for undergraduates and DNP students.

**ETP/BS**

Rafaela Maria de la Huerta ’14 received the Distinguished Entry to Practice Graduate Award at the 2014 Columbia Nursing graduation ceremony.

Sally Regin Dreslin ’94 was named the executive deputy commissioner for the New York State Department of Health. She was a panelist for the Columbia Nursing event “Leading Change: How Nursing Can Shape Health Care Policy.”

Ruby Goldstein ’14 gave birth to a daughter, Sari, in 2014.

Kent Haina ’14 has worked as an RN since August 2014 in the ICU at Montefiore New Rochelle Hospital.

Latia Wade Hickerson ’08 is one of the first recipients of a new Future of Nursing Scholars grant from the Robert Wood Johnson Foundation (RWJF) and will receive financial support, mentoring, and leadership development during her doctoral studies at the University of Texas Health Science Center at Houston (UTHealth) School of Nursing.

Kevin Hook ’98 was appointed vice president of nursing practice and education at Genesis HealthCare in Kennett Square, Penn.
Mary Ann Witt ’95 ’07 works as associate professor in the nursing department at College of Mount Saint Vincent, and presented “Impact of Using Live Actors in Senior Nursing Students’ Ability to Assess Mental Health Conditions in a Simulated Home Care Environment” at NewYork-Presbyterian Westchester Division. Her research was funded by Sigma Theta Tau International Honor Society.

**Psychiatric-Mental Health**

Carol-Ann Cenac ’05 ’08 was awarded the 2014–2015 Professional Woman of the Year from the National Association of Professional Women.

Leanne Currie ’04 received the 2014 College of Registered Nurses of British Columbia (CRNBC) award for nursing excellence.

Suhana deLeon-Sanchez ’06 ’09 gave the alumni address at Visiting Day for admitted students in 2014. DeLeon-Sanchez is currently working as a nurse practitioner at Memorial Sloan Kettering Cancer Center and has her own private practice in Brooklyn.

Jennifer Goldstein ’10 ’13 had a letter to the editor published on postpartum depression in The New York Times.

Lois Powell ’92 presented “Spirituality & Healing: A Nursing Perspective” at St. Peter’s Summer Spirituality Series.

Abby Stuthers ’98 works at BRC Human Services, providing mental health treatment to homeless men and women. She notes that it’s a privilege to do this work.

**Pediatric Nurse Practitioner**

Vanessa Battista ’06 ’08 returned to Columbia Nursing in the fall of 2014 to lecture a pediatric palliative care course. She reunited with student Kyung Woon Kim, whom she met in South Korea when teaching a training program on end-of-life care for nurses. Kim plans to return to South Korea after graduation and develop pediatric palliative care programs. Battista developed the pediatric palliative care master's subspecialty program at Boston College’s William F. Connell School of Nursing. She works as a certified pediatric nurse practitioner on the Pediatric Advanced Care Team (PACT) at the Children’s Hospital of Philadelphia.

Marjorie Salas ’12 returned to Columbia Nursing to pursue a DNP and co-founded the Doctoral Student Organization (DSO) with PhD student Jasmine Travers.

**Rehab Nursing**

Beth Oliver ’91, vice resident of cardiac services and clinical operations, Mount Sinai Heart, and 2014 Distinguished Alumni Award recipient, was named Heart and Stroke Lifesaver by the American Heart Association (AHA) “for going above and beyond the call of duty to support the AHA’s mission to build lives free of cardiovascular diseases and stroke.”

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**2014–2015 In Memoriam**

Nancy Sloane Coates ’44 was the wife of the late Benjamin Coates, mother of Theodate Coates and Benjamin Coates Jr., grandmother of Dionicia O’Sullivan and Anatole Xavier Hernandez, and great-grandmother of Sebastian, Oona, and Lucian. Coates was inspired by Florence Nightingale and attended Columbia Nursing, graduating in the same year that she married Benjamin Coates and moved to Haverford, Penn. She was involved in championing causes supporting veterans and the mentally ill. Coates expanded the work of New York’s Musicians Emergency Fund to Philadelphia; helping to organize professional concerts and music therapy for wounded American veterans. She later took an active role with the Community Clothes Charity, which focused on helping numerous local organizations. Coates also served on the women’s committee of the Philadelphia Museum of Art for nearly six decades.

Helen Tripp Davies ’43 grew up in New York’s Gramercy Park and in South Orange, N.J. She graduated from Colby Junior College in 1940, and from the Columbia Presbyterian Hospital School of Nursing in 1943. She served as a head nurse at Presbyterian Hospital’s Institute of Ophthalmology from 1944 to 1946. She retired in 1984 after 17 years as the school nurse at Cranbury Elementary School. She earned a BA from the College of New Jersey in 1971. A member of the First Presbyterian Church of Cranbury for more than 50 years, she served as an elder and deacon and was on various church committees. She served on the school board of Cranbury School for seven and a half years, and was a member of the Women’s Club, the Cranbury Historical Society, and the Nine Holers’ Club at Rossmoor. In addition to her family, she loved world travel, sailing in Maine, playing the piano, and golf.

Betty Foster Gentsch ’52 was a loving wife and mother, devoted grandmother, favorite aunt,
In Memoriam

friend, and volunteer to numerous community organizations.

Anne Jane Jaffe '47 died in Port Washington, N.Y., of colon cancer. She attended the University of New Hampshire and Columbia Presbyterian School of Nursing. Most of her married life was spent in Tenafly, N.J. She was predeceased by her husband of 57 years, Ernst R. Jaffe.

Elizabeth “Bette” Dunlop Jewett '47 was born in Chicago, Ill., and grew up in New Jersey. She graduated from Ridgewood High School in 1942. After two years at New Jersey College for Women, she transferred to Columbia University School of Nursing. Following graduation, she worked at the Neurological Institute at Presbyterian Hospital in New York City. She married Howard Washburn in 1948 and they had three children. She worked as a staff nurse at Lutheran General Hospital in Des Plaines, Ill., and was later appointed director of nursing at Point Pleasant Hospital in Point Pleasant, N.J. Her second marriage, to Arthur Jewett in 1974, added four children to her extended family. Later, she lived in Los Angeles and served as acting director of Kaiser Hospital.

Jane Atkinson Mackenzie ’62 attended Milton Academy, Wellesley College, and Columbia University School of Nursing, where she met her husband, the late Malcolm Mackenzie. They moved to Gates Mills, Ohio, in 1954, and had three children before she completed her nursing degree at Columbia. The family celebrated her graduation from Columbia with the first of many memorable trips to Nova Scotia, Canada, where she later bought and expanded a vacation house in Ingonish overlooking the ocean. She lived her life by Dag Hammarskjöld’s dictum: “In Thy service, not mine.”

Mary Nelson Myers ’64 lost a brief, intense battle with cancer. She graduated from Colby Junior College (now Colby-Sawyer College) in New Hampshire and from Columbia University School of Nursing, and continued with graduate nursing studies at the University of Michigan in Ann Arbor and the School of Public Health at the University of North Carolina-Chapel Hill. She had a long, distinguished career as a state consultant in North Carolina, served as director of the Instructive Visiting Nurse Association in Richmond, Va., and as nursing director for the American Red Cross in Richmond. She ended her nursing career with a return to direct patient care with the Bon Secours Hospice Program in Richmond, from which she retired.

Constance Ella Nissen ’58, a resident of Wheaton, Ill., since 2009, was also a graduate of Northwestern University, McCormick Theological Seminary, and Boston University. She served as a Navy nurse during World War II, a medical missionary in Venezuela, and retired as a professor of nursing at Northern Illinois University.

Harriet Walters Sullivan ’53 died peacefully in 2014. Born in 1930 in Braddock, Penn., she attended the Northfield School in Massachusetts. She later attended Allegheny College in Meadville, Penn., and graduated from Columbia University School of Nursing. She worked in hospital nursing and volunteered with the Red Cross while raising five children with her husband, Richard “Dick” Sullivan. Sullivan later became a political activist and community organizer, and eventually split her time between Leesburg, Va., and the Sullivans’ adopted home of St. John, US Virgin Islands.

Losses in our Community

Ann Bradshaw Barrows ’74
Helen Brandt Battiste ’60
Jean Benner ’42
Carolyn Sywak Bilton ’66
Patricia Brown ’01
Doreen Worthley Brown ’50
Mary Doody Byrne ’73
Nancy Platou Calhoun ’65
Katherine Horton Chalmers ’52
Genevieve Colwell ’75
Dorothy Weinberger Cribbs ’42
Natalee Pheks Cunningham ’47
Ruth Dahl ’48
Jane Mackenzie Davidson ’62
Elizabeth Dockery Disbrow ’59
Anne Dodwell ’88
Barbara Herrin Ertel ’55
Anne Abrahams Fair ’56
Maureen Costello Farrell ’82
Doris Herrington Fuchs ’39
Virginia Gorosh ’69
Estelle Guidice Hartmann ’49
Rodameir Duncan Hatala ’55
Betty Bramlett Henzel ’52
Florence Holl ’45
Elsie Hubbs ’42
Helen Morgan Hunter ’43
Muriel Stearns James ’44
Shoshana Kirschenbaum ’07
Mary Kratz Kraft ’62

Hera Saviois Kwiatkowski ’48
Florence Langell ’71
Laura Flowers LeFevre ’73
Margo Payne Leithard ’74
Marjorie Sharpe Lynch ’61
Marjorie Fitzgerald McKenzie ’43
Winifred Miller Mitchell ’44
Susan Moore ’43
Janet Newill ’48
Karen Thorn Penner ’67
Amy Snellling Perez ’47
Marguerite Peters ’48
Clara Walsh Powley ’39
Lillian Schutte Price ’43
Anne Pinnie Proctor ’47
Evelyn Rathe Rathe ’54
Cecie Reily ’44
Lorraine Rishe ’51
Thora Rusch ’59
Dianne Tashman ’83
Jane Bamford Taylor ’50
Gloria Beach Tenney ’51
Evelyn Mitofsky True ’57
Lillian DeMeyere Vrouvas ’52
Batya Levine Weiner ’12
Jane English Wyatt ’44
Elizabeth Fitting Young ’53
Mary Hicks Ziegler ’69
Anne Wilshusen Zittel ’53
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GLOBAL FELLOWS FUND:
Enables students to study overseas and gain international experience.

STUDENT SCHOLARSHIP FUND:
Ensures deserving students have access to a Columbia education regardless of financial barriers.

TO MAKE A CONTRIBUTION, PLEASE VISIT NURSING.COLUMBIA.EDU/GIVING

Save the Date: Columbia Giving Day 2015 is Wednesday, October 21. If you would like to help promote Columbia Nursing’s Giving Day, contact Janine Handfus, jh2526@columbia.edu.
Then: Presbyterian Hospital nurse Marjorie Johnston ’50 donates blood during an American Red Cross event, 1951.

Now: Assistant Professor Caroline Sullivan takes a patient’s blood pressure at Columbia Nursing’s faculty practice.
Mary Dickey Lindsay ’45 and her family have pledged $1 million to support the skills lab in the school’s new building now under construction. The lab, which will be housed within the building’s Helene Fuld Simulation Center, will be named for Mary Lindsay and her daughter, the late Louise Lindsay Read ’74.

A former director of Columbia Nursing’s alumni association, Mary serves on Columbia Nursing’s Board of Visitors and is an honorary chair of the school’s Campaign Cabinet.

For decades, Mary has been a devoted public servant, volunteering her time and energy to improve health and health care in New York City and beyond. Following her work helping to establish Huntington (NY) Hospital’s first volunteer program for auxiliary services in the early 1960s, she then served as the president and board chair of Planned Parenthood of New York City, followed by a five-year term on the organization’s national board. For 25 years, Mary was a trustee at Cold Spring Harbor Laboratory, which named its child care center after her. Mary also served on the boards of Pathfinder International Fund and Union Theological Seminary, and was a founding member of the American Friends of the United Nations Population Fund (UNPFA).

Louise Read was a Montessori teacher for many years, worked at the Danbury Hospital Birthing Center, and volunteered at Healing the Children Northeast in New Milford, Connecticut. She completed a master’s degree in nurse midwifery from Yale University shortly before she died in 2008.

“This is a wonderful gift that honors a remarkable pair of Columbia Nursing alumnae and helps to underwrite a transformative new home for our new school.”

— Dean Bobbie Berkowitz, PhD, RN, FAAN

To make your tax-deductible contribution today, send a check payable to Columbia University School of Nursing or donate online at nursing.columbia.edu/giving.

For more information, please contact Janice Rafferty Grady at jar2272@columbia.edu or 212.305.1088.
10 FACTS ABOUT THE ROOFTOP TERRACE IN OUR NEW BUILDING:

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• SHADE GARDEN
• MEDICINAL GARDEN
• POLLINATOR GARDEN
• LENAPE GARDEN
• AROMATIC GARDEN
• HERB GARDEN
• EDIBLE GARDEN WITH 170 SQUARE FEET OF EDIBLE AND HERB AREAS

THE TERRACE’S GREEN SPACE WILL ALSO INCLUDE:

• 6 VARIETIES OF TREES
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