

Winter 1990

## Beacon Light: Winter 1990/1991

St. Cloud Hospital

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# BEACON LIGHT

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*The sudden death of her husband, Bert, has forced Ann LaFrence into an unwelcome, uninvited independence.*

## Death and Dying

People die in many ways, in many places. At one time, we may imagine, people died in caves, sheltering from the cold, or in the woods, delirious from some infection. But once our hunting and gathering ancestors settled, people began to die at home. That still seems the natural way. Perhaps all of us would choose to end our days at home, peacefully, dying of some painless natural cause. But in reality many people die in nursing homes, or in hospitals. At Saint Cloud Hospital we know that some of our patients will die. We accept the responsibility that gives us. It's a part of our role to help dying patients and those who grieve for them.

*This Beacon Light is about death and dying.*

## When a death brings the world crashing down

On May 5, 1990, Alison LaFrence, daughter of Ann and Bert LaFrence, got married. Her two brothers' wives, both pregnant, were bridesmaids. "Great bridesmaids," people quipped.

It was a big, hugely enjoyable wedding, and Ann LaFrence beamed when she talked about it. Ann beamed whenever she talked about her family: Alison, the brilliant medical student, first in her class; Alison's twin, Andy, the likeable and steady CPA; Matt, the hyperactive, underachieving child with the high IQ, now an insurance executive; and husband Bert, a specialist in international taxation and finance, recently retired company controller, part-time tax consultant, Ann's steady chauffeur and best friend.

Just ten days later, Ann's world crashed. During the night a sixth sense alerted her that Bert wasn't breathing normally; she couldn't wake him. She followed the ambulance to the hospital, where doctors told her Bert had suffered a massive stroke, and that no medical intervention could offer him any kind of useful life. Bert LaFrence, age 62, died on May 16 surrounded by family and friends. He never regained consciousness.

In the days that followed Ann was able to cry, but still not grasp the enormity of how her life had changed. A week later she was back at work, red eyed, fraying at the edges.

Ann's work as Saint Cloud Hospital's oncology data coordinator puts her in touch with death daily. The tiny office she shares is crammed with stacks of abstracted cases, medical records and studies that threaten to spill over every surface. These are the paper trails of cancer in Central Minnesota. The names from those cases came to haunt her.

In June she attended a memorial service for patients who had died at the hospital in May. It was difficult for her. "I went by myself, and I shouldn't have. I thought it was going to be a rather impersonal service, but it wasn't. The names of the dead are read, and I knew so many of those names, and I had known some of them for so long, that they had become like an extended family."

When she attended a hospital support group the same thing happened. Her mind, which is professionally trained to seize on details, was unusually sharp. As she heard the names of spouses of cancer victims, the treatment history of the dead filled her mind. "It was too much for me. I had to leave the group and get my support elsewhere. I felt as though they were shifting their grief on to me. They weren't, but it felt that way."

Ann was not a stranger to death. She and Bert had faced a painful loss together in 1988. Bert's 85-year-old mother, Mary, had suffered a stroke, her second, putting her into a deep coma. The family discussed its options, talking to physicians and also to members of the hospital's ethics committee and spiritual care department. They decided that Mary should be allowed to die without intervention other than

*Grief continued on page 2*

BEACON  
LIGHT



## "The Living Will:" respect for patients' wishes

There are many circumstances in which a person who would otherwise die may be kept alive through medical efforts.

In some circumstances, such as the use of dialysis to maintain the life of somebody with kidney disease, the quality of life maintained is high. In other circumstances the quality of life may deteriorate to the point where some onlookers think, "I wouldn't want to live like that."

Many people with strong feelings about the health care they would want to receive in those circumstances are discussing their wishes with family and friends, and completing a health care declaration, or "Living Will."

The health care declaration ensures that a patient's wishes regarding his or her health care are carried out when that patient has a terminal condition and is no longer able to make decisions. "So long as the patient is able to respond, by squeezing a hand, or blinking an eye, the patient is in control. The health care declaration guarantees that once a patient's decision-making ability leaves, nobody else can come in and change the decisions that patient would make," said Alice Frechette, medical records manager.

The declaration contains various sections regarding specific types of health care decisions, such as tube feeding, as well as a space for naming a proxy to make health care decisions for the declarant. To the mind of nursing supervisor

Karen Kleinschmidt, who sits on the hospital's ethics committee, naming a proxy is perhaps the most valuable part of the Living Will. "It ensures that the physician knows who to go to when those difficult decisions have to be made. The spouse may seem like the obvious person, but maybe a couple have different ideas; or maybe the spouse was killed in the same accident as the person who now has brain damage, and the physician finds that the children have different ideas. Naming a proxy and a second proxy

ensures that the physician goes to the right person."

Completed health care declarations are kept with patient files in medical records. The declaration is put onto the medical chart with every admit, and a note is made on the progress notes so that the doctor is aware of

it. If the doctor isn't prepared to go along with the patient's wishes, he or she has to inform the patient. A revocation form is also attached, so that the patient may change the declaration.

"The primary nurse has a responsibility to make sure the physician knows that the declaration is there, and to act as a patient advocate," Kleinschmidt said. "Sometimes a patient does not understand, and it helps if a nurse can sit and explain what the doctors have said. The nurse can help the family understand what is happening, and make sure that everybody communicates." Communication is at

the heart of the declaration, Kleinschmidt said, because it ensures that the patient and the person directing care are on the same track.

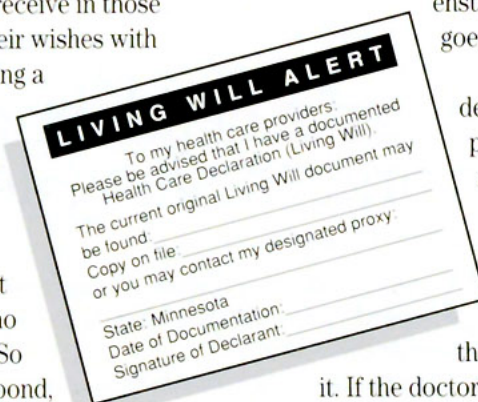
According to Frechette, people should review their declaration yearly or more often. New diagnoses or health conditions or personal affairs could change the situation. People should have a copy at the hospital, a copy with their family physician, and also other copies with their family or proxy.

Health care declarations can raise legal or ethical issues. Some of them were predicted by the Adult Health Care Decisions Act. For example, it states that "Nothing in this chapter may be construed to condone, authorize, or approve mercy killing, euthanasia, suicide, or assisted suicide." However, if a situation does arise that poses an ethical issue the hospital's ethics committee is available for consultation.

Interest in the Living Will is high, and Frechette and Kleinschmidt give talks on the subject almost every week. Perhaps as a result of that, there has been a surge in how many the hospital is processing.

Packets containing a standard health care declaration as well as advice and information regarding its completion are available from the medical records office. Since Minnesota's Adult Health Care Decisions Act was passed in 1989, the hospital is bound to follow the wishes in health care declarations.

—JOHN L. PEPPER



## Counseling: when the grief is too much



Saint Cloud Hospital's Counseling Center provides professional assistance to those struggling with grief.

At any given time, each of the Center's counselors is likely to have one or two patients for whom grief is the stated, primary need for counseling, said Steve Vincent, Center manager. And for many other patients, unresolved grief is an underlying cause of their problems.

"It is not uncommon for people to come to us immediately after the death of a loved one because they are reeling emotionally, and recognize that they need help. But oftentimes people come to us much later, after one or two years. In these cases the loss of a person close to them is not recognized as an important factor in their situation, which may be something like depression or marital problems. Then when we do a history we see a time coincidence with, say, the death of a parent, which makes us ask questions," Vincent said.

It is normal for people to pass through stages of grief which include shock, denial, anger, depression, and acceptance. To reach acceptance

people need to somehow replace the meaning in their life which is missing, Vincent said. "Clearly, you can't replace a person, but you may replace the significant aspect of your life with some other relationship or activity."

Vincent looks for three indicators that people may need counseling to resolve their grief. When grief causes a long-term disruption in a person's ability to function, concern is warranted if, within a month or two, a person is not able to carry on with day-to-day life effectively. Concern is warranted when grief carries on and the pain is unendurable. Normally the symptoms of grief decrease and become manageable. And concern is warranted when a person shows the symptoms of depression. These include sleep disturbance, impairment of concentration or memory, thoughts of death or suicide, feelings of hopelessness, indecisiveness, loss of appetite or compulsive overeating.

"If you see these signs in somebody you know who is grieving the death of a loved one, it's appropriate to say, 'I'm concerned about you,' and to let them know that help is available," Vincent said. —JOHN L. PEPPER

## The spiritual care department: someone to lean on

After years of work with the grieving and dying, Sister Joyce Iten has few answers for people who ask difficult questions about illness, accidents and death. She can only assure the grief-stricken that they will survive the terrible pain of loss, and confirm to the dying her own faith that there is a life after death and a Higher Power available to sustain them.

Sister Joyce is a certified death counselor. As such, and because her position with the hospital is divided between spiritual care and hospice, she is the coordinator of grief support programs. She is knowledgeable about grief, dying, and the ways in which different kinds of death such as suicides or infant loss cause different problems for the living. But very often, she finds, it is simply her presence that is most reassuring for families and patients. "I've learned more about death from dying people than I ever did from classes," she said. "It is a privilege to be with someone who dies, and we (the members of the spiritual care department) try to be with patients and families at the time of death if they want that support."

Spiritual care department members are called to each 'code blue,' the internal emergency page that summons staff to a sudden cardiac or respiratory arrest, and to most deaths in the hospital. They help the family by their presence, and often will pray with them and offer support. "We work with people across denominational lines, and with people who are not religious," said Father Roger Botz, spiritual care manager. "We don't have a set agenda, other than that if they believe there is a God we try to assure them it is a good God, though that may be difficult to

accept."

Many of the long term ill who die in the hospital do so while they are unconscious, Father Roger said. He encourages families to continue to talk to the dying person, and to say their goodbyes, because that helps the grieving close that chapter of their lives. "Each person has his or her own way of grieving, and we validate their feelings. They may be very angry, and that's okay."

What the hospital doesn't want is for families to walk out of the hospital and feel that they have to face their grief alone.

As a result, the hospital provides a variety of services to the grieving, including coordination of four support groups. One is for the parents of infants who died from sudden infant death syndrome; one is for the families of suicides; one is for parents who have lost a child; and one is the hospice adult support group for those who have suffered the loss of a spouse, sibling or parent. People typically remain in the groups for two to three months, and often they will make a return to the group for a few weeks as they progress through stages in their grief.

"The groups provide people with a safe place to talk about how they feel, some reassurance that they will heal, some tools and some knowledge helpful in the grieving process. Our society doesn't help people to grieve. We don't mourn; there is no external display of grief, no sign like a veil or a black armband that signals people to the emotions of a grieving person, and we keep our emotions contained. But our bodies need to grieve. It's a natural response to trauma. The people who can cry and wail and express

their grief openly often tend to heal faster," Sister Joyce said.

Each month the spiritual care department provides a memorial service for those who have died at the hospital during the previous weeks. This service is open to hospital employees, families of patients, and members of the community. People who receive mailed invitations to these services are also included in a holiday season mailing which is intended to help them get through a traditionally difficult time for those who are grieving. They are also invited to a Christmas memorial service at Whitney Center which is sponsored by a number of local organizations.

Twice a year the hospital coordinates a memorial service and common burial at Calvary Cemetery of babies lost to miscarriage or other complications usually before the fourth month of pregnancy. "The hospital does this because families want to know what happened to their baby. They want to know it wasn't flushed down a drain, and that it was treated with respect. After the ceremony we release balloons as a symbol of the spirits of those babies being free. It's a well-attended service," Sister Joyce said.

The final step in grief recovery is for people to rebuild and reinvest their energy into new activities and relationships, said Sister Joyce. "But you can never replace the loss. The loss remains with you forever."

—JOHN L. PEPPER

Grief - continued from page 1

keeping her hydrated and medicated for relief of possible arthritic pain. The death was expected to occur quite quickly. But the body wasn't ready to die, and she lived for several weeks. "Nobody expected her to live that long, and it was difficult for us to watch her die, but we never regretted the decision. Bert and I talked about it later, and though Bert didn't have a living will I knew that he wouldn't want to live unless he was having a useful life."

Those discussions helped Ann decide that life extending measures not be taken when Bert died; and they helped her take a second step. She insisted that Bert become a donor. "I knew there were no reasons why he shouldn't be a

donor. We had talked about this, and it was what he would have wanted. I thought it was fitting that somebody could benefit." Later, Ann was notified that two recipients had received corneal transplants from Bert, and a young burn victim had received skin and soft tissue from Bert to aid in the healing process.

For three months after Bert's death Ann would say "my middle name is Exodus," because she felt she didn't know where she was going. Now, after eight months, Ann is still grieving, still in pain. The plans she and Bert made and discussed just days before his death mean nothing. Instead, she has struggled to learn all the systems

of house and family maintenance that Bert, the family organizer, took care of; she now knows how to drain the lawn sprinkling system, and how the family's finances stand. She recently traded in Bert's temperamental Volvo for a smaller car, her own car.

She expresses gratitude to the many people who have helped her through, her family, her neighbors, her friends, her workmates, and particularly the hospital's spiritual care department. She is gathering her strength, picking up the pieces, but it's hard, she says. "Death ends a life. It doesn't end a relationship."

—JOHN L. PEPPER





# Organ donor program facing national shortage



Nationally, more than 21,000 individuals are waiting for an organ transplant. It is estimated that about 30 percent of those awaiting heart, lung and liver transplants will die before a suitable donor is found.

In 1989 Saint Cloud Hospital provided two donors of major organs. But that isn't out of line with what is happening around the state. Despite laws requiring that hospital personnel give families of the deceased the option to donate, there are not organs available.

"Lots of factors figure in why there aren't many suitable donors. The main one is you can only be an organ donor if you die because of clinical brain death. The heart can't stop first," said Donna Kamps, assistant manager, critical care. "We have become better at saving the lives of people with serious brain injuries; more people wear seat belts; and fewer people are drinking and driving; which is bad news for people waiting for organs, but it's good news for humanity."

In Minnesota, most organ donors are from the Twin Cities where there is the largest population concentration and thus where more people suffer head trauma from automobile accidents and gunshot wounds.

The matching of organs to donors is coordinated in Minnesota and the Dakotas by LIFESOURCE Upper Midwest Organ Procurement Organization, a non-profit organization. The American Red Cross Transplantation Service coordinates donations of tissues such as skin, bones and ligaments. And the Minnesota Lions Eye Bank coordinates most donations of eye tissue.

According to Julie Zabloski, a procurement transplant coordinator with LIFESOURCE, the organ donation process can be a smooth one. When LIFESOURCE receives a call from a hospital telling them that a donor is available, a procurement transplant coordinator leaves for the hospital immediately. The coordinator checks that the necessary consent form is signed, makes

sure necessary lab work is completed, and evaluates the medical record. If satisfied that the patient (who at this point will be brain dead but sustained by artificial respiration) is a suitable donor, the coordinator conducts a search through fax, telephone, and a national computer network to find organ recipients. Teams from those locations then travel to the donor hospital to remove the organs. Until they arrive the coordinator works with hospital staff to keep the organs viable.

"When a patient is brain dead, the body shuts down all of its control functions. So we have to use medical science to help us maintain the organs' functions until they are removed for transplantation," Zabloski said.

According to Kamps, most families respond positively when approached about the donor program. "It fits in with the Christian tradition of giving, which is so strong in this area, and it is a way that people can feel the death in their family has helped somebody." — JOHN L. PEPPER

## Lives that end too soon

The room is decorated in soft shades of pink and blue. The mobile above the crib plays a soft lullaby. The layette has been packed away for the trip to the hospital.

This beautiful scene can become a shattered memory.

An estimated 15-20 percent of pregnancies end in miscarriage, stillborn or neonatal (newborn) death.

Saint Cloud Hospital (SCH) has developed a program called "Resolve Through Sharing" which responds to the loss that the parents feel when their baby dies.

Ten or twenty years ago when a mother lost a baby, no one was quite sure how to react. A majority of the nurses would come into the room, take the mom's temperature, check her blood pressure, change the bed and leave. "It was a continuous cycle, neither the patient nor the nurse would say anything so the baby's death never got talked about," said Mary Kay Wagner, R.N., one of the perinatal loss nurses.

"The easiest thing for people to say is, 'I am very sorry.' It's important to let the parents know you care and are concerned," added Terri McCaffrey, R.N., Family Birthing Center educator and the other program coordinator.

About three years ago, the entire Family Birthing Center staff and staff members from same day surgery (SDS) and the emergency trauma center (ETC) attended a workshop focused on how nursing staff can effectively relate to families during their difficult time. For

many nurses, it was a time for them to face their own feelings about death.

McCaffrey was pleased to see SDS and ETC staff attend the workshops. "Sometimes people come through the ETC and SDS with a miscarriage and we may not see them. We felt it was important for the staff to feel comfortable handling the situation. These staffs make referrals to our program."

But the program didn't stop with that one workshop, McCaffrey strived to change attitudes. It was important to teach staff members to do anything possible to help the family through the grieving process. "We feel it's the nurse's responsibility to help the parents ask the right questions," said Pat Tschida, another perinatal loss nurse.

The families can spend as much time with their baby as they would like. And they can even have the baby brought back later if they feel they weren't quite done saying good-bye.

The baby is dressed in a little outfit made by volunteers, and professional and Polaroid pictures are taken so the family will have keepsakes. A baby card is made up with the baby's name, weight and height. "At the time the family may not want these things and that's fine. But we keep them so if the family decides they want the picture and card, we can arrange to give them these mementos," McCaffrey said.



"There are no rules with this program. We do whatever we can to meet the family's needs."

The mom can choose to leave the Family Birthing Center (FBC) and stay on 4 northwest, another nursing unit, if that's more comfortable for her. A purple card with a leaf is placed outside her door so the staff is informed about that mother's situation.

Spiritual care and social services also become involved, offering assistance and guidance.

If the baby is over 20 weeks gestational age, a funeral director needs to assist with the burial. For babies under 20 weeks gestational age, the families may bury the baby with the help of a funeral director or they can take part in a common burial conducted every six months. All the families are invited to attend. "We average 75 people at each burial," Wagner said.

As the mothers leave the hospital, they are given a Resolve Through Sharing packet with their baby's mementos including a brochure on Empty Arms, a St. Cloud support group for those who have lost a baby.

The perinatal loss team also like to keep tabs on the moms for a while. "We always give them at least one follow-up call just to see how they're doing physically and emotionally. The mothers really appreciate the phone calls," Tschida said.

— DIANE HAGEMAN

## Health care providers feel the loss too

Life and death. For some, life is the fulfilling and happy time, death is quiet darkness. It can be a frightening concept.

For those in health care, death is viewed more as a part of the cycle of life. It becomes an inevitable part of their work lives, particularly for those who work in an area such as cancer care, where 50 percent of the patients eventually die of their disease.

Dr. Harold Windschitl, who has been a doctor for 31 years and an oncologist (cancer specialist) for a good portion of that time, has developed a certain understanding and acceptance of death. "There are emotions that run deeper than what can be talked about. Certainly, there is a profound sadness — for the families and humanity as a whole for the loss of each person. We feel badly for those families in they have to go on without that person. But it is kind of amazing to me that most families show such maturity at the time of death. Death is a part of life and most people seem to understand that."

That doesn't mean it isn't tough sometimes. "Every doctor has sat down and thought about certain deaths and perhaps shed a tear or two." For him, it can help to stay around the area where the person has died and share mutual support with the family, nurses and other doctors. Sometimes going back to the nurses station or clinic and discussing it with the nursing staff, spiritual care staff or other physicians helps.

It can be particularly difficult when a young person dies. "You think about those deaths over and over. It doesn't make sense to have those lives cut short. But I try to remember that it was something or someone else who caused the problem."

Sometimes it is easiest for him to dive back into his work or to participate in a leisure activity to take his mind off one of his patient's deaths. "There is a certain closeness with the families when a person dies and you can't help but get drawn into that."

The hospital's nursing department encourages its staff to become a part of that closeness. "Our Benedictine philosophy is what guides our attitude here. We believe in life, and death is a part of life. That means that we treat our patients in the most humane and respectful manner until the end of their stay or until they die. This attitude is carried out in all our areas from the emergency trauma center to critical care to home care and hospice," said Sister Kara



Matthew Hommerding cuddles in a quilt made for his mother, Brenda, by a patient who later died.

was crucial that I stayed on their terms. They needed me to be there."

Dealing with death has not or will not become "old hat" for her. Each patient and family is different. "Probably the single most important issue in death and dying is keeping the patient comfortable and supporting the family. When it comes to the end, you're dealing with raw emotions, the technical stuff for the patient becomes almost secondary."

Because nurses do work with death a lot, Hommerding says the staff tries to keep positive and not dwell on the negative. "We do a lot here to keep our patients comfortable and at peace with what is happening to them. Having primary nursing (where one nurse plans the patient's care from admission to discharge) has helped tremendously. Consistency with nurses is so important. A familiar face makes a world of difference."

Hommerding smiles and becomes animated as she talks about some of her patients who died. She still misses them, but her memories are fond ones. She particularly remembers a patient, a woman in her late 40s, who had figured out Hommerding was pregnant before she had told her colleagues. "That woman sewed me the most beautiful baby quilt only one week before she died — it was the quilt my son came home from the hospital in and the one he had his first picture taken with. It meant a lot to me."

— DIANE HAGEMAN

Hennes, vice president of nursing.

For Brenda Hommerding, a registered nurse on the oncology and surgical/medical units, there is a certain pride in being able to work with patients who have cancer. "When I first started here 3 1/2 years ago, I got some ribbing from friends and colleagues about working on the 'dying floor.' Well, I think that attitude has changed. This is a good place to be — we provide excellent comfort care."

It has taken Hommerding time and maturity to develop that positive outlook. She knew when she started she would have to come face-to-face with death sooner or later. And she remembers that first encounter clearly. "I was a new graduate working the night shift. I was very afraid and nervous. I just did what I had to do — prepared the family, updated and encouraged them. But it was like I was on auto pilot. Other nurses really helped me through it."

"We look out for our new people, show them the ropes and support them and allow them the time to be with the family if they want to."

There are times when things become disheartening for Hommerding. Like last May when her grandpa died. She didn't get to be just the granddaughter; she was thrust into the role of nurse and the one to answer all the questions. "It



# Hospice helps families stay together during final months

The right to die with dignity. Unencumbered by machines. Surrounded by loved ones. For many people with terminal illnesses that is their last wish. Saint Cloud Hospital's (SCH) Hospice program makes that wish a reality.

According to Hospice assistant manager Sue Weisbrich, Hospice gives patients back a small part of the control they lost when they were diagnosed. "With a terminal illness so much is out of the patient's control. The illness dictates their lives," Weisbrich explained. "Hospice is one way they can seize at least a little control...a way they can *make* something happen rather than waiting for something to happen to them."

When Andy Vicari was diagnosed with cancer nearly six years ago, he and his wife Eleanor lived in Chisholm, Minn. Their children, Jerry Vicari and Judy Miller, and their families lived in St. Cloud, nearly four hours away.

"As with any progressive, terminal illness you start out so optimistic," Judy said. "You almost convince yourself that he's going to be the one that beats the odds."

But as time went on it became clear that that was not the case. "Our family had a real helpless feeling because we knew the distance was going to be a critical barrier for us," Judy said. So her mother and father moved to St. Cloud to live with her family.

"There was never any doubt in anyone's mind that this was the right thing for us," she said. "You know that there are some things you just won't be able to do. But we knew Dad wanted to be at home. He had a horrible fear of dying in a hospital." Contacting Hospice was the next logical step.

The SCH Hospice program began in 1979 to serve the needs of people like Andy Vicari...people with progressive or advanced illnesses who have less than one year to live. "Hospice care is different than terminal care," Weisbrich said. "We work with the entire family on all levels — physical, emotional, even spiritual. It's a more holistic kind of care."

Hospice uses a team approach. It's the volunteers, the social workers, the chaplains, the nurses, the physicians, the home health aides all working together to provide the most complete care possible during that patient's last days and months. In the initial family conference, a social worker and a nurse meet with family members to explain in depth what services Hospice can provide and help them identify their needs to determine how Hospice can help them best.

According to Weisbrich, one important component of Hospice care is to help families tap into community resources that they probably don't know about or may need help finding.

"Finding things like wheelchairs, hospital beds or even financial assistance is hard when you've never had to do it before," she said.

Judy's first contact with Hospice was through social worker Joyce Halstrom. "I knew when I first talked to her that she and my family could work together," Judy said. "She was a great help."

Judy and her mother, the entire family really, found themselves looking forward to visits by the Hospice team. "It gave my mother a connection — somebody to listen to her concerns and questions," Judy said. "I could see the relief in my mother's physical health. I could see it in Dad. There was this health system that would take care of everything so he didn't have to worry about it anymore."

And with the worries gone, Andy could concentrate on life's simple pleasures. "We hung a bird feeder outside his bedroom window...he loved the outdoors and watching the birds," Judy said. "Even having his little dog up there on the bed with him was a real comfort."

Judy and her family managed most of the physical things themselves. But for families that need more support, Hospice also has a large base of volunteers. They are trained in dealing with terminal illnesses and the stress they create.

"They can't provide medical care, but they do

provide necessary support," Weisbrich said.

Spiritual care is another service provided by Hospice. "Sister Joyce makes a lot of home visits. She might help patients connect with a priest or minister or even introduce them to a parish," Weisbrich said. "It's really individual. We tailor all of our services to meet the patient's needs."

The real difference with Hospice care, though, is the follow-up. For one year after the death Hospice team members remain in contact with the family to see how things are going and help in any way possible. In addition, Sister Joyce moderates several grief support groups and Halstrom just started a new group last year for children ages eight through 12.

"Death is not the end for the family and it's not the end for us either," Weisbrich said. "We grieve as well. We're involved at such a special time we need to know how things are turning out for them and see if we can help."

After a 4 1/2 year battle with cancer, Judy's father died at home in November, 1989. He was surrounded by the people he loved. Just the way he wanted it to be. "My family will never, ever forget the experience. It didn't feel odd at all for him to die at home. It was wonderful," Judy said. "I'm so glad that the Hospice program was available so that we could do it his way."

—LORI J. TIFFANY

# Gifts and Memorials

Saint Cloud Hospital acknowledges the following individuals and organizations who have supported our mission of caring from June 1, 1990 through August 31, 1990.

Contributors' names are listed following the name of the person to whom they pay tribute or purpose they support.

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Together, this year's Holly Ball & Tree Festival raised a record-breaking \$46,000. Judy Miller and Dian Gray co-chaired the Tree Festival. (Inset photo) Together with Holly Ball chair Holly Benson-Suuss, they received certificates of appreciation from hospital president John Frobenius.



This was the fifth year the annual Holly Ball and Tree Festival helped raise money to benefit the Hospice program at SCH. Judy Miller co-chaired the 1990 Tree Festival with Dian Gray. "I've been involved with this event before," Miller said. "But this year the experience meant so much more to me because of my personal experience with Hospice through my dad."

For Miller, Gray and Holly Benson-Suuss, 1990 Holly Ball chair, and more than 150 others, all of the time spent planning the two-day affair was volunteered. Meetings started last February for the event December 1 and 2.

"One of the reasons we're so delighted that the funds that we raise go to the Hospice program, is that cancer affects so many of us in our lives be it through immediate family members or even extended family," Gray said. "And 98 percent of all Hospice patients have some form of cancer."

The Holly Ball is sponsored by area businesses who decorate and donate trees to the

silent auction. These trees, along with elaborately decorated swags, mantle pieces, centerpieces, wreaths, wall trees and gingerbread houses, are on display during the Holly Ball for ball-goers to enjoy and bid on.

"Holly Ball's a wonderful kick-off to the holidays," Benson-Suuss said. "Everyone can get out their elegant attire and mingle. It's a Cinderella-like affair."

The Tree Festival, which is held the day after Holly Ball, is just the opposite. It's a family event. People come in their jeans to enjoy the sights and sounds of the holiday season.

The 1990 Holly Ball and Tree Festival once again attracted a sell-out crowd and raised \$46,000 to surpass last year's total of \$43,000.

Sue Weisbrich, Hospice assistant manager, appreciates the importance of Holly Ball and Tree Festival. "Hospice is a very expensive program to run because we need the services of many professional people in order to provide the care and help patients and their families need," she said. "We are just grateful every year that

they have taken us on. To raise that kind of money is very hard."

Planning for the 1991 Holly Ball and Tree Festival will begin again in February. Many volunteers are needed to make it a success. If you are interested in joining the 1991 Holly Ball and Tree Festival team, contact Barbara Brown, SCH volunteer office, 255-5638.

—SHELBY BRUNBERG

## HOSPICE FACTS

- Between the program's start in 1979 and June 30, 1990, Hospice served 1,316 patients
- Hospice has 67 trained volunteers who provided 1,735 hours of service during the last fiscal year
- Hospice team members make 230 visits to patients in their homes each month
- Each month 141 contacts are made to grieving families





### Recovery Plus Women's Outpatient Program Receives \$1,000

Michael L. Fossum, St. Cloud Optimist Club, recently presented a \$1,000 check to Marly Keller (center) and Pat Lamb (right), senior counselors, Recovery Plus women's outpatient program. The money will be used to buy a camera, tape recorders and literature as well as provide transportation and child care services for the women.

## Beacon Bits

### Special X-ray Suite Reveals Blood Vessel Roadways

The hospital has a new \$1,100,000 angiography/interventional radiology suite which allows radiologists to obtain clear X-ray type images of the body's organs and blood vessels, other than those of the heart.

A normal X-ray provides clear images of bones. The specialized equipment of the new suite minimizes the bone images, so that when dye is injected into the blood stream the blood vessels dominate the picture. In this way, the doctor can see blockages, aneurysms (bulges), tumors, and other abnormalities.

Highly detailed images from any perspective can be obtained of any organ without having to move the patient. These images can be maintained on a video screen while the physician performs any of several interventional procedures. For example, a physician may use the suite to perform an embolization, deliberately blocking a blood vessel that is bleeding or supplying a tumor. Being able to see the blood vessel, and track the progress of the catheter inserted into the vessel, makes the procedure safer and more effective.

According to interventional radiologist Dr. Cheryl Walczak, the same buildup of plaque in blood vessels which causes cardiac disease also causes peripheral vascular disease, often in the legs, causing severe discomfort and possibly gangrene. "To relieve the symptoms we may insert a balloon tipped catheter into a blood vessel, and push it through until it reaches a point where the balloon can be inflated to clear the blockage. Or we may perform an atherectomy, where we use the catheter and a small drill to clear the blockage. Or we may use thrombolytic drugs to dissolve the blockage. We've done all those things before. The point is, this new suite allows us to do them better."

Benefits to the patient include avoidance of general anesthesia and surgery, or simplified surgery, reduced hospitalization time and costs, and increased alternatives for treatment, Walczak said. "I have subspecialty training in vascular imaging, and this is the best equipment I have worked on. It's the best available."

### Cancer Unit Opens

Early in December the new oncology (cancer) unit opened on 5 south. The unit is beautifully decorated, and is intended to provide an environment that is comforting, home-like, and supportive. The 24-bed, all private room unit

has been designed to offer patients the opportunity to be active participants in their care, planning and treatment. This unit will provide all the technology of the twentieth century, and the most current cancer care available, without looking sterile. Some of the features on the unit include a kitchen area where patients can prepare some of their own food, a patient library, and hideaway beds so that family members may remain with patients.

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