



# CANSW VOICE

Volume 2010 Issue 2



## Canadian Association of Nephrology Social Workers 32<sup>nd</sup> Annual Conference Ethical Mountains in Nephrology Social Work

October 14-16<sup>th</sup>, 2010  
Banff Park Lodge  
Banff Alberta Canada



JANSSEN-ORTHO



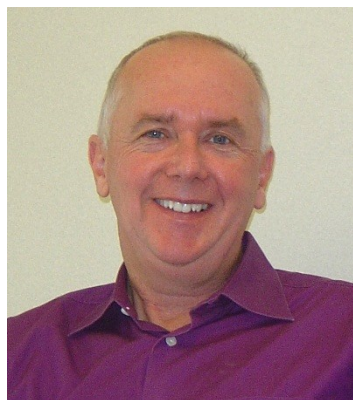
Register online at [www.cansw.org](http://www.cansw.org) or by mail  
with the registration package included on pages 25-33.

# CANSW VOICE

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## Message from the Editor



**Lyle Stockwell MSW, RSW**

**Your feedback is welcome.**

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or (905) 576-8711 ext.6913**

## Dialysis Museum



**Automatic PD Cycling Machine: 1964**

Used with permission from Home Dialysis Central  
<http://www.homedialysis.org/>



**Douglas Parsons - 2010 Recipient  
of The Kidney Foundation of Canada's  
Inspiration Award  
*People Making a Difference***

Douglas Parsons is a Social Worker who has focused more than 27 years on the treatment of individuals and families who suffer from the loss of kidney function. For the last 27 years, Doug has been a major contributor to The Kidney Foundation and has served in a wide variety of roles at the regional, provincial and national levels. He has had major input in developing the Foundation's peer support volunteer training program and has Chaired the National Patient Services Committee for the past 5 years.

Doug has served as a moderator and facilitator at countless dialysis educational programs. He has been a member of the board of directors for the Southwestern Ontario Chapter of The Kidney Foundation and chair of the Patient Services Committee, chair of the March Drive Campaign Committee and chair of the former Greater Ontario Branch Patient Services Committee. Doug has been a member of the Canadian Association of Nephrology Social Workers for 27 years.

Doug is currently a member of The Kidney Foundation of Canada, Ontario Branch, Board of Directors. He is an active member of the Association of Social Work Field Practice Educators and finds time to dedicate himself to several other charitable causes.

Doug is the recipient of the Mary Lou Karley Award, the George DeVeber Lifetime Achievement Award, and the Ontario Provincial Volunteer Award for The Kidney Foundation of Canada.

Doug is a deserving recipient of this tribute as his actions have led not only to the improvement of The Kidney Foundation but have had a direct positive impact on patients and their families for over 27 years.

**Doug Congratulations,**....respectfully submitted Angie Tuovinen, Vice President CANSW



Dianne Kurina RSW  
President, CANSW—ACTSN

## Message from the President

Welcome to the Spring edition of The Voice... Special thanks to Lyle Stockwell for all of his hard work in, once again, bringing our CANSW newsletter to life! I do have a few updates on some of the projects CANSW has been working on as well as some new information to share with you:

### **The Development of a Joint Task Force on Transportation with the Kidney Foundation of Canada.**

We continue to be very excited about this collaboration! The Kidney Foundation of Canada has recently filled some key positions in their organization that have had become vacant due to some well deserved retirements. A special welcome to Nadine Valk who is the new National Director of

Programs and Public Policy for the Kidney Foundation of Canada. Nadine and our CANSW Vice President, Angie Tuovinen have just started the ball rolling on this much anticipated project. Watch for more information over the CANSW listserv and anticipate some great discussions at our annual conference!

### **Our 32<sup>nd</sup> Annual CANSW Conference in Banff, Alberta.**

Our conference planning committee has been busy and everything is really coming together for our upcoming national conference in beautiful Banff, Alberta. Be sure to mark your calendars for October 14<sup>th</sup> -16<sup>th</sup>, 2010 and plan to attend! The title for this year's conference is "**Ethical Mountains in Nephrology Social Work**". More information is available in this edition of The Voice as well as on the CANSW webpage.

### **A New Look and Feel to the CANSW Website.**

Gary Petingola and our website designer continue their hard work on revitalizing our CANSW website. It shouldn't be long now!

**Webinar Capabilities.** Gary Petingola continues to work his magic and has recently advised the CANSW Executive that the National Kidney Foundation (NKF) in the United States has graciously agreed to allow CANSW to use their networking site to host online webinars for our membership. This will allow CANSW to provide its members nation wide with the opportunity to attend educational sessions on their computers at home or in their offices. We will be sure to update our members about this exciting learning opportunity via the CANSW listserv once some of the finer details have been worked out. Please keep in mind that we will need participation from our CANSW members (as both participants and presenters) for this endeavor to be a success. If you have an area of interest or expertise and would be willing to share a presentation with your CANSW colleagues, please let us know!

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...President's message continued

**Depression Fact Sheet.** The Kidney Foundation of Canada will soon be offering a new resource online. With the assistance of some of our CANSW members, they have recently modified a depression fact sheet that was previously produced through AMGEN. Very special thanks to Sarb Basra, Adrien Handler, Francine Prosser, and Linda Church for sharing their time and expertise for this project. The new fact sheet, "Dealing with Depression" will soon be available in both French and English on the Kidney Foundation of Canada's website [www.kidney.ca](http://www.kidney.ca).

**CANSW Executive Nominations.** Are you looking for the opportunity to network with some great renal professionals across the country? Are you interested in collaborating with some great partners, including the Kidney Foundation of Canada, to make a difference on a national level? Are you looking for something new and meaningful to do? Do we have the opportunity for you! Consider joining the CANSW Executive Committee or nominating an interested colleague. If you would like more information about the positions that will be coming available in the Fall, please email Shirley Pulkkinen directly at [PulkkinenS@sah.on.ca](mailto:PulkkinenS@sah.on.ca) and watch for more information coming soon over the CANSW listserv.

Wishing you a wonderful summer... Hope to see you in Banff!

Dianne



3 Days. 100 Kilometres. 1 United Front Against Kidney Disease.

[www.KidneyMarch.ca](http://www.KidneyMarch.ca)  
(866) 9 KMARCH



**The Kidney Foundation is putting kidney disease and organ donation on the map in a big way and your CANSW President, Dianne Kurina is going to be there!**

**Dianne's Kidney March update:** I am so excited about this event! My training is going well, however, my dog (Finn) is not convinced that he likes to go for such long walks at 6:00 a.m when he could be sleeping. The Kidney Foundation of Canada is still looking for more marchers and volunteer crew members... As well, donations of support are always welcome and very much appreciated. Please visit the following links if you are interested in making a difference...

[www.kidneymarch.ca](http://www.kidneymarch.ca)

**Stay posted for news of Dianne's progress or, better yet, join her by participating as a fellow marcher, volunteering at the event, or sponsoring your CANSW President on the website!**

# Opportunity Knocks, Quietly.

## Registered Disability Savings Plans (RDSP)

prepared by Matheis Team Financial



For 25 years Matheis Team Financial has delivered a concierge service approach for individuals, families and businesses. Located in Pickering, ON at 1101 Kingston Road, our knowledge and expertise is supported by our full, accredited [financial planning](#) and [wealth management](#) practice. In addition, we are an experienced, innovative, full-service consulting firm, providing [employee benefits](#), [compensation](#), [organizational](#) and [human resources solutions](#) to individuals, business owners and companies across North America.

The Canadian Government announced the creation of the world's first Registered Disability Savings Plan (RDSP) as part of the 2008 Federal Budget. The first plans became available to the public in December 2008. It is estimated that potentially 500,000 Canadians with disabilities could benefit from having a RDSP.

**The most exciting feature of a RDSP is the potential to attract annual contributions from the Federal Government called the [Canada Disability Savings Bond](#) and the [Canada Disability Savings Grant](#).**

In the first year, learning more about the plans and finding out which institutions offered them was an exercise in frustration. Many disabled Canadians and their families who were interested in setting up a RDSP were greeted by limited information and then not being able to find a provider who could explain the program properly. It's now almost two years later and the feedback has not changed much. Speaking as representatives of the financial industry in Canada we are disappointed that only the 5 banks offer RDSPs and the staff who are properly trained to explain them are few and far between. In assisting our own clients we have actually had to sit with them in bank branches to assist staff in getting their plans established.

In light of significant delays getting plans opened since December 2008 and also in recognition of families that cannot contribute each year, the 2010 Federal Budget proposes a 10 year carry forward of Grant and Bond entitlements. So, if you haven't opened a RDSP yet you will soon be able to catch up! There are other important related announcements as part of the 2010 budget too.

### What is a RDSP?

A Registered Disability Savings Plan is a savings or investment account that is registered with Canada Revenue Agency (CRA) and therefore permits money to be saved on a tax-deferred basis. Being able to defer income tax on the growth of your savings is a very important benefit to *all* types of registered plans including RDSPs, RRSPs and RESPs. Unlike other registered plans, the RDSP does not get scrutinized as part of an asset or income test when qualifying for important provincial disability income support programs.

## The 5 most important rules governing a RDSP

### Rule #1

Only an individual who qualifies for the Disability Tax Credit (see next page for details) with CRA and is a Canadian citizen with a valid SIN can be a beneficiary of a RDSP. In the case of a minor child a parent or legal guardian can establish and direct the plan. Family members and/or friends can also contribute to the plan on behalf of the beneficiary. Also, someone in the family must have filed an income tax return with CRA in the two previous years in order to receive the Grant or Bond.

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### **Rule #2**

Contributions can be made to a RDSP up to the end of the year the beneficiary turns 59. Government of Canada Disability Savings Grant and Savings Bond payments will only be made to the plan up to the end of the year the beneficiary turns 49.

### **Rule #3**

**Lower income families (currently under \$21,947) DO NOT have to make a contribution in order to attract the \$1,000 Savings Bond contribution from the Federal Government.** This makes The RDSP a very important plan for persons with disabilities whose family does not have the financial ability to make contributions. If your family income was between \$21,947 and less than \$39,065 then you will earn a piece of the Canada Savings Bond and if your family income was greater than \$39,065 then you are disqualified from attracting the Savings Bond and your attention turns to the Canada Disability Savings Grant.

### **Rule #4**

To qualify for the full \$3,500 Canada Disability Savings Grant each year your family income must be less than or equal to a certain threshold (currently \$78,130) and you must contribute \$1,500 of your own money to your plan in the calendar year. You get a Grant of **\$3 for every \$1 of the first \$500 contributed** (\$1,500 maximum Grant), and **\$2 for every \$1 of the next \$1,000 contributed** (\$1,000 maximum Grant). Families with income over \$77,664 are eligible for a dollar for dollar Grant on the first \$1,000. Your funds can earn income tax free for the life of the plan, so it is really important to save as much as you can each year.

### **Rule #5**

Income cannot start being taken from the RDSP until 10 years has lapsed from the date of the last Canada Disability Savings Grant or Bond payments to the plan. Otherwise those entitlements must be repaid.

## **What is a Disability Tax Credit?**

In order to open a Registered Disability Savings Plan, you must first have a **Disability Tax Credit Certificate** approved by Canada Revenue Agency.

Individuals who have a severe and prolonged impairment in mental or physical functions can apply for the Disability Tax Credit. It is a non-refundable tax credit used to reduce income tax payable on your tax return. The Disability Tax Credit amount for 2009 was \$7,196, and is deducted from your income before taxes. All or part of this amount may be transferred to your spouse or common-law partner, or another supporting person.

To be eligible for the Disability Tax Credit, a qualified practitioner certifies on form T2201 that you have a severe and prolonged impairment. The Canada Revenue Agency must approve your certificate. Impairments must cause you to be **markedly restricted**, and can include: life-sustaining therapy (includes dialysis), and/or problems with vision, speaking, hearing, walking, feeding, dressing, elimination (bowel and bladder functions), and mental functions necessary for everyday life.

You may qualify to have previous years tax returns reassessed if you missed this deduction in the past (maximum is 10 years prior), but you must apply for this in writing.

**See your renal social worker for forms and assistance obtaining a certificate.**

Additional information can be found at:

[www.cra.gc.ca/disability](http://www.cra.gc.ca/disability)

or see Guide RC4065, *Medical and Disability Related Information*.

## Chasing Miracles: How far is too far when caring for a sick pet?

By Christie Keith—posted in a Blog on Pet Connection March 3, 2010

<http://www.petconnection.com/blog/2010/03/03/chasing-miracles/>

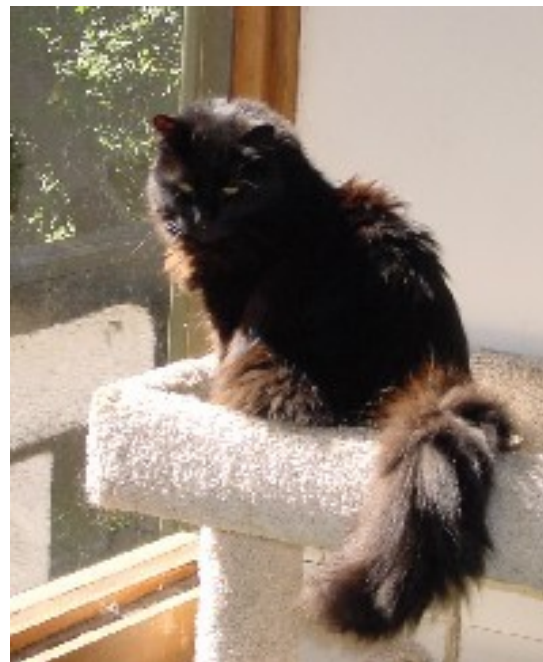
When Dr. Becker posted yesterday about kidney disease and a cat named Puff who beat the odds to live into his second decade, my first thoughts turned to Samson, a senior kitty I adopted when he was 15.

When I took him to the veterinarian for his first check-up, she was pessimistic. He had “ten years of deferred dental work,” needed all his teeth extracted, and was in renal failure. “He has maybe a year,” she said.

Samson lived to be 18 and a half, healthy, active and loved for all of it. Even three days before he finally breathed his last, he was still purring, playing and eating.

But then a second, darker memory came to mind. My dog Bran was 4 years old, and had never been sick a day in his life, when he was diagnosed with kidney failure.

It didn't seem too terrible at first. He got finicky about eating one day, but the next day he was fine. The day after that he was finicky again, and then he started to vomit, so we headed for the vet.



She drew some blood, gave him some fluids and medication for his stomach and sent us home until the test results came back. He didn't seem very sick.

The test results indicated kidney failure, so we took him to a specialist in another town. He still didn't seem very sick, but his kidney values were so bad that the specialist was extremely concerned. We hospitalized him. We did more tests. We treated what we thought he had (leptospirosis), until that was ruled out by the tests.

We dug deeper. We did more tests. He was getting sicker. I took time off from work. I slept at the vet hospital, or in my car, or in a hotel room. I tried to hand-feed him, but he just vomited, so we gave him intravenous nutrition.

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He got even sicker. His kidneys got worse. We still had no diagnosis. My vet bill at that moment was over \$4,000. I cashed in my savings and paid it.

My vet suggested I take him to UC Davis. I hesitated. They wouldn't let me stay with him at the hospital, and I was at a state-of-the-art specialty practice already. I asked her, "What can they do there that you can't do here?"

"Dialysis," she answered bluntly.

I went. And on the way, I called my credit card company and negotiated my credit limit upward, to cover the cost of dialysis. Fortunately, the person I spoke to was a dog lover, and he put the credit increase through on the spot.

At Davis, they were not optimistic, but did offer me a little hope. Some of the worst possibilities had been ruled out, and a few of his symptoms had actually improved, even though his kidneys were clearly worse. If this was a bacterial infection of some kind, the vets told me, dialysis might keep him alive while the antibiotics cured the infection, and he might recover. It wasn't impossible.

He was only 4 years old. I'd held him in my hands when he was born. So I told them to go ahead. They put in the dialysis catheter and took a kidney tissue sample while he was anesthetized. I borrowed \$2,000 from my mother.

The next day, he went into respiratory failure, and we put him to sleep.

I'd made the last 10 days of his life miserable with tests, tubes and hospitalization. I'd spent over \$10,000, more than half of it borrowed. I'd let my professional and personal lives go completely to hell while I sat next to my dog on the hospital floor, stroking his head and hoping for a miracle. If I'd known how it would end, I'd have put him to sleep the first day.

The problem is we never do know how it will end. From necessity, we do a kind of emotional and financial triage without the single most important piece of information: Will it be worth it?

For people with little or no money in the budget for veterinary care, that triage might be painful but simple. There's no point in debating the merits of a diagnostic procedure or treatment that you can't afford. But even if finances aren't tight, the incredible array of technologies available in veterinary practice today can burn through the most generous pet care budget in days, and can be bewildering to pet owners.

Surgeries that were once unheard-of in veterinary medicine — such as organ transplants — are now being done on pets. Chemotherapy, arthroscopic and laser surgeries, hip replacements, MRIs and nearly every form of sophisticated medical treatment or diagnostic procedure known to human medicine is available in animal practice, too.

And while people with insurance find a big chunk of their own medical bills doesn't come out of their own pocket, very few people have veterinary insurance for their pets. Those who do rarely find it covers intensive diagnostics or the most expensive therapies.

I wrote about this for my SFGate.com column a few years ago, and interviewed leading veterinary cardiologist Dr. Paul Pion, president and co-founder of the [Veterinary Information Network](#).

He agreed that veterinary medicine today offers choices that can overwhelm pet owners, particularly in the area of diagnostic testing. "We can do a much better job of diagnosing things than we ever could," he said. "Today's veterinarian is a different vet from James Herriot, whose diagnostic methods were things like the laying on of hands, and smelling."

But Pion doesn't see technology as being the main source of veterinary medical miracles. "Things are being diagnosed earlier. Owners are watching them more. They're bringing them in when something can be done. And veterinarians are detecting more. It's not just the technology, it's having the relationship with the vet."

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## Who's going to die today?

Article By: Alan Cameron

Thu, 08 Apr 2010 13:58

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iafrica.com  
good stuff

Thursday at midday encapsulates a microcosm of the issues specialists face in state hospitals. Each week medics in Cape Town's Groote Schuur Hospital gather to decide which patients under their care will receive treatment. One or two of an average of eight patients will be helped, others may be transferred — but most will die.

The healthiest and most likely to respond well to treatment are given priority — like 16-year-old [Marie Martins](#). Martins then finds out that hospital beds in George are full and she is number three on the waiting list. When you need treatment three times daily, even a teenager can hear the sands of time in that statement.

### 'Sent home to die'

The newspapers catch wind of what happens when the state decides to cap budgets on expensive health care and the headline 'Sent home to die' appears. National Renal Care, an organisation that provides dialysis machinery to hospitals, steps in and tells Marie and her family that they will sponsor all her treatment "indefinitely". NRC will pay for Marie's treatment "until there is availability at a public unit [a state hospital] or transplant," CEO Noleen Phillipson said.

It's something that the NRC has done before, and will do again. A tragedy is averted, and a teenager breathes today because of a corporation's good will.

If you're on medical aid, you want to make sure that end-stage kidney disease treatment is covered to the nth degree in the fine print. Here is why.

Your kidneys filter 200 litres of blood every day and you need one to survive. They're made to last a lifetime, but sometimes they don't and the cost of keeping you alive — estimated at R20 000 each month — with dialysis treatment is just too expensive for the approximately 22 500 South Africans who experience end stage kidney failure each year.

That's where the government steps in. For those without appropriate medical-aid cover, state hospitals keep people alive. But without the budget to treat everyone who needs it, doctors and the government should place a greater focus on prevention, says Professor Brian Rayner, Head of Nephrology and Hypertension at Groote Schuur Hospital. This can come in the form of "early recognition and appropriate treatment of those at risk by screening for kidney disease".

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### **Transplant team on 24-hour standby**

Transplant can be a permanent solution for those on daily dialysis, and the demand is so great that the National Organ Foundation has a team on 24-hour standby to retrieve organs from available donors anywhere in the country. They ensure that donation doesn't delay the funeral or scar the body.

The catch is that if organs are to be eligible for transplant they need to keep functioning after the body has died. Those who are pronounced brain-dead in hospitals and kept alive by machines are ideal donors, said Philippa Douglas, the Executive Director of the National Organ Foundation.

To deal with a lack of donation and treatment, patients are often turned away after being assessed. As kidney failure often only occurs after a long list of medical complications, those with the greatest chances of survival are bumped up the treatment queue. This is why, as an otherwise healthy teenager, Martins is eligible for treatment. That she lived near a renal dialysis centre and had a clean and dry home environment helped her cause.

A [2006 study](#) of 2442 end-stage kidney disease patients between 1988 and 2003 found that 52 percent weren't offered treatment and those more likely to be accepted for treatment were aged 20-40 years, white, employed, married, non-diabetic and lived near a dialysis centre. Almost 60 percent of patients were denied treatment because of social factors relating to poverty. If you're probably going to catch TB or can't get through to the dialysis machine three times a week, there is little financial point in treating you.

But isn't receiving health care from the state a human right? Mr. Soobramoney, a now-famous patient who was sent home to die, decided to [ask that of the Minister of Health](#) in the Constitutional Court.

ESCR-Net, a human rights website, records the significance of the case: "This was the first case in South Africa in which the Constitutional Court had to decide on the constitutional right to health care for everybody in light of the problem of scarce resources for the funding of the health care system. The Court accepted that rationing of resources is integral to health service delivery in the public sector even though this might support ongoing inequities between the private and public sector. However, the Court implied that there might be grounds for the challenge of executive policies if such policies were unreasonable or if they were not applied fairly and reasonably."

### **The human cost**

Medical staff don't cut hospital budgets or make policy that forces treatment rationing across departments; they just have to work within the structures given to them. But being the bearer of bad news takes its toll. "This is extremely stressful to all concerned, particularly to kidney specialists, social workers and kidney nurses who face this reality every day of their life. To tell someone straight to their face that they are not eligible for a life-saving treatment is nerve-wracking to say the least," Prof Rayner notes.

"Of course the patient has the worst deal — he or she with full awareness dies slowly over several weeks unable to eat, nauseous vomiting and breathless, and feeling abandoned by the state that they have supported over many years."

## Six Reasons why suffering is normal By Ben Klemper

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**Do you ever feel as if your life is about suffering?**

**Do you ever feel that you suffer needlessly?**

I recently read a story in which a woman carried her dead son to Prince Siddhartha and asked the prince to revive him. The prince told the mother to go to each house in the village and obtain a mustard seed from each family that had never known suffering. On her return with the mustard seeds he would consider her request. The distraught woman began knocking on each door in search of the family that had never known suffering but could not find one.

In our contemporary society, we are told that if only we have the latest gadget, dress in the latest fashion, or stay current with the latest news, then we will know happiness and no longer suffer. If the latest gadgets, fashions, or news don't alleviate our suffering or bring us happiness, there are pills and beverages (some legal, some not) that we can take to bring us happiness and eliminate our suffering. What modern society fails to accept is that suffering is the part of life that makes us more fully human. Here are six reasons why suffering is a normal part of life:

### **1) Suffering makes us human.**

Suffering and adversity has existed as long as human beings have. When we suffer we are connected to the common fate of the people who came before us and the people who will come after us.

### **2) Suffering is only as bad as we make it.**

If we believe we are entitled to a life of comfort, then a life that consists of suffering is simply unfair, and who likes an unfair world? But if we believe that life is about growth and that growth entails a degree of pain and suffering, then there is nothing unfair about it.

### **3) Suffering gives us a greater appreciation of the moments of comfort.**

If life were comfortable 24/7, we wouldn't be able to appreciate the moments of comfort. There would be nothing to compare comfort to. This is analogous to a marathon runner. If there were no suffering in running a marathon there would be no comfort, and certainly no sense of accomplishment, in crossing the finish line. Mountain climbers voluntarily endure excruciating suffering, often for weeks on end, in their attempt to reach the summit. They risk their lives, endure high altitude sickness, bottomless crevasses and glaciers, mountain storms, snow blindness, and sudden storms all to experience the several moments of magnificent comfort and satisfaction the mountain summit has to offer.

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#### **4) Suffering can include the most profound happiness within it.**

We often think of suffering and happiness as exclusive. This couldn't be further from the truth. Often the greatest happiness is found within suffering precisely because it is painful. Mahatma Gandhi, Nelson Mandela and Sitting Bull, to name but a few, endured great suffering at the hands of others. It is implausible to think that they did not experience happiness (and even delight) within the suffering they experienced knowing that they were achieving greatness and actualizing their potential (and the potential of their people) through the hardships they suffered.

#### **5) Suffering is not an indictment of our self-worth.**

In Western culture, there is a deeply rooted belief that any type of suffering, whether it be financial, physical, emotional, familial, etc., is the result of being "unworthy." If we believe this to be true, then our legitimate suffering is compounded with needless suffering. Success and comfort are like wheels. Those who are on top will one day be at the bottom and those who are on the bottom will one day be on the top. Bear in mind that our suffering in no way reflects who we are as people. Oftentimes, worthy and decent people suffer while cruel and indecent people experience seeming comfort.

#### **6) Suffering is a normal part of parenting, marriage, working, and every other worthwhile endeavor.**

If we are in a constant state of suffering and anguish then something is most likely not as it optimally should be. However, periodic suffering in all areas of life is normal. Every good marriage has periods of discord and uncertainty. Every healthy parent/child relationship goes through phases of disrespect and resentment with our children or parents not doing what we think they ought to be doing and us not doing what they think we ought to be doing. Jobs, homes, neighborhoods, and communities enter and leave our lives based on need, interest, and a variety of other factors, which are often based on suffering. Lobsters are soft animals with hard shells that do not grow. When lobsters outgrow their shells they climb into a rock cleft. They face the uncertainty of being swallowed up by another animal or of being swept away by the current. Yet imagine if lobsters stifled their discomfort rather than using it as a catalyst for growth: they would be a miniature species. We can emulate lobsters by accepting suffering as a sign that its time for growth and renewal. The bottom line is that periodic suffering is part of every aspect of our lives and it need not be "bad." Suffering is what it is and what we make of it. Not pleasant, but generally not unbearable or unacceptable.

Take a moment and ask yourself what you accomplish through the suffering you endure.

The main thing to remember is that comfort is very much a state of mind attained by self-growth, personal development, and doing good for others and for ourselves.

*Ben Klempner, LMSW, founder and editor of Effective Family Communication, trained as a social worker at the Barry University School of Social Work, in Miami Shores, Florida. He has worked with a large and diverse variety of peoples. His accomplishments include writing several books and helping individuals and families work through issues such as: Anger Management, Addiction Recovery, Marriage Counseling, Family Therapy, Career Counseling, Depression, Grief, Anxiety.*

## Other Social Work News: U.S. library hires social worker for homeless

### In the ongoing recession, libraries are dealing with more people than ever

By Evelyn Nieves - Associated Press. Reprinted with permission.

Every day, when the main library opens, John Banks is waiting to get inside. He finds a spot and stays until closing time. Then his wheelchair takes him back to the bus terminal where he spends his nights.

Like many homeless public library patrons, all Banks wants is a clean, safe place to sit in peace. He does not want to talk to anyone. He does not want anyone to talk to him. The day he decides he wants help, he knows what to do: ask for the library's social worker.

The main branch of the San Francisco Public Library, where hundreds of homeless people spend every day, is the first in the country to keep a full-time social worker on hand, according to the American Library Association.

Cities across the country are trying different approaches to deal with patrons who use bathroom sinks as showers or toilet stalls as drug dens. In Philadelphia and San Francisco, libraries have hired homeless patrons to work as bathroom attendants who guide others to drop-in centers or churches where they can bathe.

In Portland, Oregon, the downtown library is trying a penalty system for patrons who commit infractions \_ banishing them from the library for a day for shoving, three years for fighting.

While San Francisco is the first to hire a social worker, other libraries may follow. As the economy languishes and cities shut down social programs, public libraries are becoming repositories for those who have been kicked out and turned away from everywhere else.

Camila Alire, president of the Chicago-based ALA, said that while libraries long have provided refuge for the down and out, anecdotal reports underscore that they are dealing with more people than ever with mental health problems and basic needs such as food and shelter.

"Public libraries are trying their best to serve their users and people who have traditionally been nonusers," Alire said. "I hope that what the San Francisco Public Library has done by hiring a social worker serves as a model, because these people are educated and trained to help these patrons who have every right to use the public library system."

More libraries across the country are hiring therapists to train staff members how to handle stressful patrons. Edmond Otis, a psychotherapist, trains librarians how to talk to patrons who may be mentally ill or on drugs.



**John Banks, who is homeless, sits in his wheelchair at the San Francisco Public Library in San Francisco, California on Jan. 29. Libraries have long been refuges for the down and out, but now the problem is getting worse.**

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## U.S. library hires social worker continued...

"There is a gigantic homeless population that basically 'passes,' except nobody knows where they sleep," Otis said. "That population is growing. But we're looking at the mentally ill and drug addicted. And there are ways of talking to someone." That includes remaining calm, treating all patrons with respect, and setting rules and sticking to them, he said.

Some libraries are dealing with large numbers of destitute patrons. In San Francisco, the main library, a six-story building with gleaming glass walls, is located in the Civic Center, where many homeless people congregate. It is near a neighborhood of single room occupancy hotels, soup kitchens and other service providers for the very poor. Some mornings, just after it opens, the library seems to have more people who appear to be homeless, wearing some of their clothes and carrying the rest, than not.

Frank Bunnell, who is 53, comes every day carrying a large duffle bag and a blanket. "Sometimes I fall asleep here," he said.



**Frank Bunnell, who is homeless, reads at the San Francisco Public Library in San Francisco, California on Jan. 29. The main branch of the San Francisco Public Library, where hundreds of homeless people spend every day, is the first in the country to keep a full-time social worker on hand, according to the American Library Association.**

For years, said Karen Strauss, the assistant chief librarian of the main branch, staff members could do little more than empathize with the desperate regulars who spend their days sitting among the stacks, reading, or just sitting, some with body odor that lingers in the air when they leave.

When other patrons have complained about the disturbances caused by mentally ill or drug addicted patrons, all the library could do was call its officer, a full-time city police sergeant.

Last year, the library decided to partner with the Department of Public Health to hire Leah Esguerra. As resident social worker. Esguerra's delicate task is making herself visible and available to those who might want help without intruding on the privacy of those who do not.

She estimates that she has helped 200 people in the last six months, not all of them homeless or lacking basic needs. "Some people are depressed because they can't find a job," she said. "Or they've lost a loved one. When people ask for me, I go to them. Or through word of mouth those who haven't asked know about me."

John Banks, who is 40 and cannot remember how long he has lived unsheltered, or how it happened, said he might ask for Esguerra one day. For now, if he could blend into the walls, he would. That cannot be, not with his wheelchair stacked high with all he owns, like a pickup truck. To accommodate it, he must stick to open space, usually on the third floor near the computer station, where so many people can see him.

He does not read well, he said, so he skips the books and magazines, knowing the staff will let him be. Yes, he said the other day, he might call for the social worker soon. "I've got all this laundry to do," he said, gesturing to large plastic bags filled with clothes behind his back. "Maybe she can help with that."

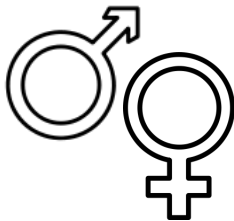
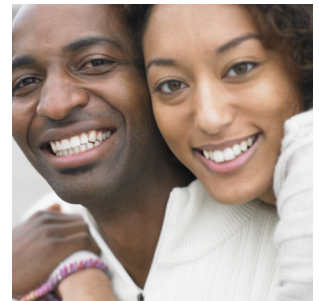
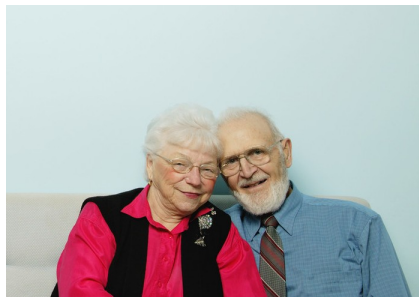
*Evelyn Nieves is an Associated Press writer.*

# *Sexuality and Sexual Functioning with Kidney Disease*

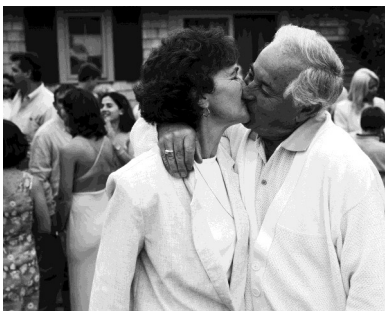
Adrien Handler MSW, RSW



*Sexual problems are not uncommon for individuals who have Kidney Disease.*



## Sex



- ♥ Sex is a basic human function and a fundamental part of life.
- ♥ Sex involves the physical, psychological and emotional.
- ♥ Sex affects general well-being and overall quality of life.

Arrington, Renata., Confrancesco, Joseph., Wu, Albert W. (2004). Questionnaires to measure sexual quality of life. *Quality of Life Research*, 13, 1643-1658.



## The Effects of Kidney Disease on Sexuality and Sexual Function

- Other Diseases that also contribute to lowering Sexual Function:
  - **Diabetes**
  - **Cardiovascular Disease (Heart)**
  - **Peripheral Vascular Disease (Circulation)**
  - **Hypertension (Blood Pressure)**
- Medication side effects
  - **body image**
  - **sexual appeal**
  - **low desire**
  - **erectile dysfunction**
  - **fertility**
  - **self-esteem**
  - **depression**

Gajewski, Jerzy B. (1998). Sexual effects of medications and their interaction: implication for men with physical disabilities or chronic illness.

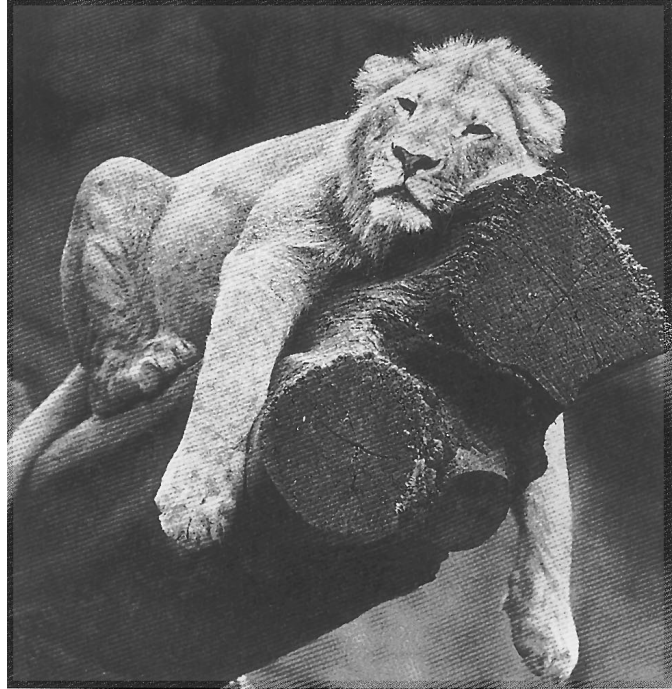
*The Canadian Journal of Human Sexuality*, 7(3), 287-294.

Phillips, Nancy A. (2000). Female sexual dysfunction: Evaluation and treatment. *American Family Physician*, 62(1), 127-36.

# The Effects of Kidney Disease on Sexuality and Sexual Function

## Physical Effects

- Anemia
- Fatigue
- Side effects of medications
- Side effects of dialysis
- Poor sexual functioning



and utterly exhausted.

## Psychological Effects

- Embarrassment
- Poor body image
- Sexual unattractiveness
- Feeling less valuable because of the illness
- Worry about an uncertain future
- Reduced function in home and or work
- Depression

***How you adapt to these changes can contribute to sexual function positively or negatively.***

Wilson, I. B., Cleary, P. D. (1995) Linking clinical variables with health-related quality of life. *JAMA*, 273, 59-65

# Quality of Life

Quality of life has been defined as how a person's sense of well-being comes from satisfaction or dissatisfaction with the aspects of life that are important to the individual.



## Quality of Life and Sexual Function

- *Sexual Function and Sexuality are an important measure of Quality of Life*
- *It's really important to share your feelings and concerns with your spouse/partner.*
- *Having poor sexual functioning reduces quality of life. This in turn can have a negative effect on health and longevity.*



# Dealing with the subject of Kidney Disease, Sexuality, and Sexual Functioning

- Professionals typically wait for the patient to bring up the issue of sex.
- Patients wait for the health professional to approach the topic.
- If your sexual functioning is important to you then speak to your doctor, nurse or social worker in order to get additional information.



Binik, Y. M., Mah, K. (1994). Sexuality and end-stage renal disease: research and clinical recommendations. *Advance in Renal Replacement Therapy*, 1(3), 198-209.

## Social Work Practice with Men at Risk by Rich Furman

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### Excerpt from the Introduction

This book is about men at risk. It is written by a man for both men and women. As with any practice text, my preferred theories, perspectives, and worldviews are deeply ingrained in the chapters. My professional and personal experiences have shaped the way I see men and what I see as possible for them. Additionally, one can never transcend the influence of one's gender, race, ethnicity, or class. These influences are especially important when discussing gender. As much as I have attempted to transcend my own history and prejudices in providing a balanced view of the strengths and weaknesses, needs and challenges of men, I am certain you will find many blind spots. I am also sure that at times your own gender biases will clash with mine. Disagreements and debates among social workers about important issues are healthy. We all must learn to accept the diversity of thought that exists within the profession (and in society) and to appreciate perspectives that differ from our own. Additionally, empirical research or current thinking from important theorists may challenge your gender biases. The cognitive dissonance that you may experience is an important part of the process of professional growth and development.

Since my frame of reference is important, and since many of the case examples are in part based upon my own social work practice, I think it is important for the reader to understand a bit about me in order to properly contextualize this book. This is only fair, because I view the reading of a practice book as a dialogue between author and reader. However, writing this section has been difficult. Men often find it difficult to know precisely how to express themselves. Some of our internalized expectations as men preclude the sharing of personal information, and certainly the sharing of information about our vulnerabilities. Yet, another aspect of my identity makes it easier for me to be open about who I am.

I am a liberal Jewish man from California. Jewish men, even those of us who have been significantly assimilated into the dominant culture, tend to be more comfortable with expressing feelings than those who conform more fully to the hegemonic masculine ideal, a concept I will explore later. I am a 43-year-old heterosexual married man. I am the stepfather of two lovely children aged 11 and 16. I have been with the girls for so long that I often forget that I am not their biological father and usually feel like I am the "real dad." But I do understand the complex issues with which stepfathers must contend.

My close friends are eclectic and diverse. I have spent considerable time working in Latino communities, and I have worked and traveled throughout Latin America. I also was fortunate to have lived in San Francisco for many years and had the opportunity to understand the impact of homophobia on my relationships with other men. I was able to establish deep friendships with gay and bisexual men; this challenged my own notions of masculinity. In so doing, I was compelled to look at my own developing sense of self, and I have since attempted to expand my own notions of what it means to be a man. However, I also recognize the deep and profound effect that homophobia has had upon my understanding of masculine development; I still can hear myself thinking and even saying things that suggest a continued allegiance to certain masculine ideals. Homophobic messages are deeply ingrained in American life. Although society has become more tolerant of non-dominant forms of sexuality and identity, childhood messages are often enduring. It is also important not to overestimate the degree of tolerance and acceptance of other ways of being male, as I will explore later.

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Philosophically, I strongly support equal rights for men and women but am concerned at the lack of “space” within many feminist spaces for assertive heterosexual men like me. At times I have felt judged by groups of women for expressing myself emotionally and assertively. I have had to learn to balance an appreciation for how women have been affected and even oppressed by the emotions of men with the acceptance of my own very Jewish way of feeling and expressing. The intersections of gender, ethnicity, and power are rarely simple.

In part because of my own struggles with my father, friendships with other men have been extremely important to my growth and development. I have also been involved in men’s groups and for years have worked at understanding my own sense of masculinity. My experiences as a man have been both typical and atypical. That I have had experiences and hold ideas that are both universal and idiosyncratic is probably true for all men. Understanding the cultural tendencies of any group must be balanced by each individual’s experiences.

While this book is grounded in the empirical and theoretical literature, it is also an outgrowth of my understanding of what it means to be a man, what it means to be a man in social work, and what it means to provide social work services to men. In writing this book I have been forced to grapple with many paradoxes, which I will discuss throughout the book. For instance, how can I write about the risks of a supposedly privileged population? How can I incorporate the valuable analytic lenses of movements that at times have stood in bitter and diametric opposition to each other (for instance, feminism and certain branches of the men’s movement)? What are the social and political ramifications of such a book? Most important, how can I challenge and demonstrate the costs of the hegemonic model of masculinity (a dominant model that is held up as the ideal yet one to which most men do not, and perhaps should not, measure up) while showing acceptance, support, and appreciation for men who embody many of these traits?

Grappling with these questions has been personally and professionally valuable and serves as a parallel process for practicing social work with men. Those of you who will work with men in the early twenty-first century (and dare I say that will be nearly all social workers?) must also confront these and similar dilemmas. Each chapter includes exercises that I developed and that are informed by the theoretical and empirical knowledge discussed in the chapter, my social work practice with men, and my experience in teaching undergraduate and graduate social work. The exercises are designed to stimulate self-reflection, which I believe to be one of the most important skills that social workers can possess.

I firmly believe the profession of social work is ready to explore the problems and concerns of men in an open and critical manner. In May 2008 the University of Alabama School of Social Work hosted the first annual National Conference on Social Work with and for Men. This conference brought together dozens of social workers and social work scholars, as well as other practitioners and academics, to explore what we know about social work practice with men. The conference focused on encouraging dialogue about the strengths of men, as well as the normative developmental challenges that men face. Workshops delved into practitioners’ experiences and challenges in providing services to this too-often-underserved population.

The notion of at-risk men may be troubling for some in the social work community (Kosberg 2002; Böhnisch 2008). Critics may cite statistics about income or other economic disparities that heavily favor men, such as women’s wages averaging only 76.5 percent of men’s in 2004 (DeNavas-Walt, Proctor, and Lee 2005). While both men and women experience workplace stress, women experience additional burdens because of the male-oriented culture of the workplace or disproportionate family responsibilities (Blechman and Brownell 1998; Lundberg and Frankenhaeuser 1999). Other authors may carefully explain the well-documented power differentials between men and women (Andersen 2007), clearly exhibited by the prevalence of men in power (Powell and Owen 2007) and by the number of women abused at the hands of men.

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According to Tjaden and Thoennes (2000), each year women report more than five million incidents of violence against them by their intimate partners. The Commonwealth Fund (1999) reports that, depending on the definition used, two to three million women per year are abused by their significant others. Women who have been victimized by men deserve protection; to ensure that women are empowered and safe, men and society must respond by changing the behaviors of men and the social structures that reinforce violence. Thus women experience many psychosocial stressors more frequently or more severely than men. Men have much to improve in their treatment of women, and in their understanding of and determination to change social structures and personal traits and habits that support oppression and discrimination. These structures must be dismantled and replaced. Further, as Faludi (1999) observed, how can we explore the disenfranchisement of men when the identity of their oppressor is not clear, and when they themselves have been identified as oppressors.

My purpose here is not to argue that men are somehow more at risk than women; the premise of this book is that, despite being more privileged than women, many men suffer deeply. Whatever the root causes of various psychosocial problems that men face, regardless of the degree to which men are implicated in the cause or perpetuation of their own pains, many men are hurting and are worthy of help. It is also clear that many problems that men experience lead them to the offices of social workers, many of whom are not fully prepared to help men resolve their dilemmas. Further, while many men have not experienced oppression, many have. Men of color, gay men, and men of diverse religions and cultural backgrounds have been historical targets of discrimination and have often been disadvantaged when attempting to interact with mainstream institutions. The American legacy of discrimination and racism toward African American men remains one of our most significant blemishes.

While numerous articles and books have addressed this problem as it pertains to women, few have done so for men.

An analogous situation can be found in the literature on fathering. Some feminist practitioners and scholars fear that the development of fathering programs will come at the expense of programs geared toward women, and that explorations of the benefits of fathering will be used to diminish the success of female-headed single-parent households (Doherty, Kouneski, and Erickson 1998). However, as Doherty, Kouneski, and Erickson contend, "Only an ecologically sensitive approach to parenting, which views the welfare of fathers, mothers, and children as intertwined and interdependent, can avoid a zero-sum approach to parenting in which fathers' gains become mothers' losses" (277).

Paradoxically, while men may be a privileged group in many sectors in society, as social work clients they are not. In his discussion of services for men who have been raped, Scarce (1997:9) explores many of the complex nuances of power and privilege:

"The more recent gendering of rape as an act of violence against women has occurred for a variety of reasons, not least of which is the fact that approximately 90% of rapes involve female victims. The bulk of political progress and organizational response to rape must be credited to feminist social movement activity since the 1960s, including the understanding that rape is an act of violence and power rather than sexual passion. But where do the 5–10% of rape victims who are male fall in this realm of women-centered knowledge and practice? Very often they may slip through the cracks of an already overburdened and underfunded social service network and a cultural that believes the rape of men to be a laughable impossibility."

Vulnerable men are often misunderstood or pathologized. Men who have a difficult time expressing their feelings are viewed as resistant. Men who express their anger vigorously are accused of being hostile or, worse, abusive. While many angry men are abusive, it is also true that anger serves as a mask for depression for many men (Cochran and Rabinowitz 2000). Men entering treatment are often seen as the generators of their problems and as perpetrators or outsiders.

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Because traditional male cultural norms make it difficult for many men to seek and receive help, the often not-so-subtle message that men are the problem, or are not wanted as clients, serves only to exacerbate matters. While some men are largely responsible for their pain and that of those around them, it is against the interests of the women and children in these men's lives for social work to engage in practices that make men less likely to seek services and to begin the process of change. Many men need help, and making services appealing, accessible, and effective for men is in everyone's best interest. Social work services that do not treat men with empathy, respect, and dignity may fail to prevent or resolve many of the most severe social problems that social workers are dedicated to ameliorating. ...

Finally, I would like to say that many of the principles in this book are applicable to social work practice with women. For example, the discussion of group work with men explores Yalom's (1995) therapeutic factors. Understanding these principles also will help you in your group work practice with women. An important social work skill is to learn how to translate and apply knowledge from one situation to another.

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#### About the Author

Rich Furman, MSW, Ph.D., is associate professor and director of social work at the University of Washington, Tacoma. He is the author of more than 100 books, articles, and book chapters. His most recent books are *Social Work Practice with Latinos: Key Issues and Emerging Themes*, *Navigating Human Service Organizations*, and *Group Work: An Experimental Approach*. He is also the editor, with Nalini Junko Negi, of *Transnational Social Work Practice*.

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## Chasing Miracles

Unfortunately, as with my dog, no matter how many diagnostic tests you run, you don't always get the answers you're looking for. Not even on necropsy (the animal equivalent of a human autopsy) did the vets at UC Davis discover what destroyed my dog's kidneys.

When faced with uncertainty, Pion recommends that pet owners "look the vet in the eye and ask, 'Do you believe this will make a difference? If this were your dog, what would you do?'"

Ultimately, the decision of how far to take the search for answers — and for miracles — is a personal one. Some people go too far, putting their pets through needless stress to chase a cure that is, at best, unlikely. Others give up too soon, or resist digging a little deeper for money to pay for even routine care. Most people, though, just try to walk the difficult line between the extremes and make rational, caring decisions based on their animal's needs as well as their own.

Experienced professionals can help you evaluate the odds. Only you can decide how much you're going to bet, or how long you're going to play.

*Photos: Christie Keith. Copyright 2010 by Christie Keith. Used with permission from the author.*





# CANSW VOICE

Volume 2010 Issue 2



## Canadian Association of Nephrology Social Workers 32<sup>nd</sup> Annual Conference Ethical Mountains in Nephrology Social Work

October 14-16<sup>th</sup>, 2010  
Banff Park Lodge  
Banff Alberta Canada



JANSSEN-ORTHO



### Registration Package

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## **Canadian Association of Nephrology Social Workers (CANSW)**

For 32 years, CANSW has been the only national professional association for social workers specializing in the exciting and demanding field of nephrology. Committed to the highest standards of social work practice, CANSW prides itself on “giving back” to its members by annually presenting low cost, high quality conferences drawing on top speakers from across North America. In recent years, CANSW members have also benefited from a very active exclusive email list server allowing instant consultation and “brain storming” with over one hundred of their peers across the country. In addition, there is a members-only section of the website listing useful resources and templates. For further information about the benefits of becoming a CANSW member please visit our website [www.cansw.org](http://www.cansw.org).

### **Our Conference Theme: Ethical Mountains in Nephrology Social Work:**

Whether you have been in nephrology for many years or are new to the profession, one feature that underlies everything we say or do is the concept of Ethics. The health care system, with its marvelous advances in technology, has presented some real ethical dilemmas that challenge our human core and our relationships with others, including others within the hospitals. What is the right thing to do? If it's the right thing to do, why does it feel so wrong? Just because we can, should we? If we can, why shouldn't we? There are no easy answers to any of the situations that face us in our work with others, just a real dedication to reviewing process and exploring the values systems with our patients and co-workers.

Climbing a mountain might seem easier than resolving an ethical dilemma. However, putting one foot carefully forward with full peripheral awareness of the peaks, crevices, landslides and dangers that abound is critical when attempting the Ethical Mountains that challenge us in our day to day work. We need to have the proper tools to climb these mountains: understanding, appreciation, compassion, empathy and some sensible footwear. Join us to explore Ethics in the Nephrology Social Work world and 'bring some sensible shoes'. The venue will be breathtaking and tempt you to walk a little further.

### **Continuing Education**

12 hours of Continuing Education Units for this conference as per your Professional College.

### **Accommodation:**

We have secured the services of the **Banff Park Lodge** as our conference venue. 222 Lynx Street, Banff, AB T1L 1K5. To make a reservation, call no later than September 13/2010 at (403)762-4433 or toll free 1(800) 661-9266. Reservation can also be made online [www.banffparklodge.com](http://www.banffparklodge.com).  
*Group ID # 11850 PassWord:37005291*

#### *Room Rates (Single or Double Occupancy)*

*Superior Room - \$139.00*

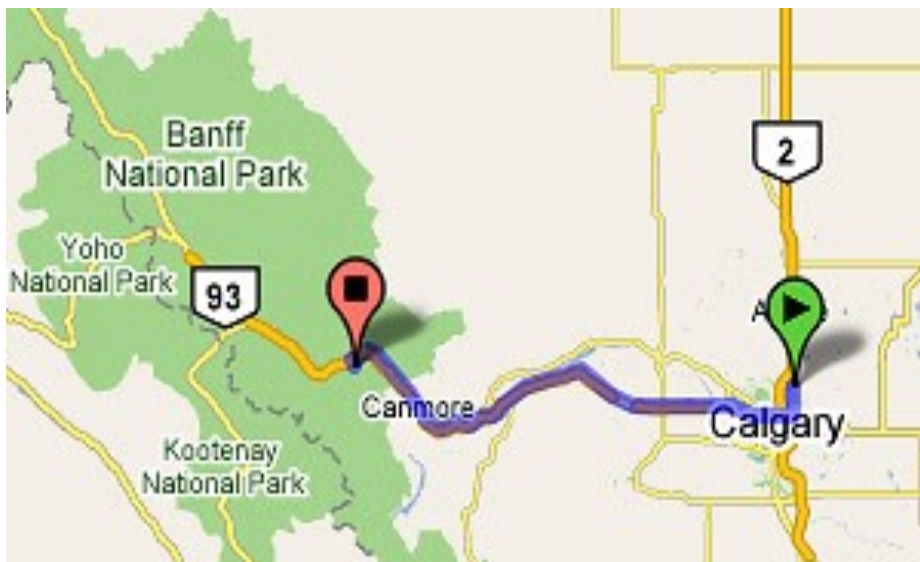
*Deluxe Jacuzzi Room - \$199.00*

*Executive, Parlor or Lodge Suites – \$259.00*

## TRAVEL INFORMATION

### Location of Banff, Alberta

Banff, AB is located approximately 145 km from the Calgary Airport. CANSW members flying into Calgary have options of taking a shuttle bus from the Calgary Airport or renting a vehicle from their preferred car rental dealer.



### West Jet Discount

For those members choosing air flight with West Jet, CANSW is pleased to advise you that a 10% discount will be offered off the best available regular fare at the time of booking (excluding web and promotional fares). These discount rates are available three days before and after our CANSW Conference. Members must make their travel arrangements through the WestJet Specialty Sales Team and quote account number **QC6169** by contacting WestJet's Convention Line at 1-877-952-4696. More information about this company can be found at [www.westjet.com](http://www.westjet.com).

### Enterprise Car Rental

CANSW has received a 5% discount for vehicle rentals through Enterprise Car Rental. To receive this discount, phone 1-800-261-7331 and quote customer **#XVC5020**.

**Please note that you may be able to find better rates for both airfare and car rentals by completing an online search of your own and comparing prices of the services that are available.**

## Driving to Banff Park Lodge

Further driving instructions to get to Banff Park Lodge can be found at

[http://www.banffparklodge.com/hotel/how\\_to\\_get\\_here.html](http://www.banffparklodge.com/hotel/how_to_get_here.html) .

Please note that you will be entering the Banff National Park and will need to stop at the gates to the Park to purchase a National Park Pass. More information about visiting Banff National Park is available by visiting [http://www.pc.gc.ca/pn-np/ab/banff/visit/tarifs-fees\\_e.asp?park=1](http://www.pc.gc.ca/pn-np/ab/banff/visit/tarifs-fees_e.asp?park=1)

## The Banff Airporter Shuttle Bus

Bus shuttles are available for pre-booking from the Calgary Airport to Banff through <http://www.banffairporter.com>. With 20 daily scheduled departures per day between Calgary Intl. Airport and Banff and back, it is easy to connect. Book on line, call or just present yourself at their airport desk, main arrivals level, area C. The shuttle service will deliver you directly to Banff Park Lodge. Round trip shuttle costs approximately \$120.

Contact by phone 7-days a week from 08:00 until 22:30 Mountain Time at 1-888-449-2901 or go to <http://www.banffairporter.com> for more information and to book your transportation.



## CANSW members and Financial Assistance to attend Annual General Meeting

CANSW recognizes that it may be financially difficult at times for CANSW members to attend the AGM. The association would like to support members when fiscally able. Please contact the CANSW President, Dianne Kurina at [dianne.kurina@calgaryhealthregion.ca](mailto:dianne.kurina@calgaryhealthregion.ca) for further information.

### Banff, AB Conference Planning Committee

Dianne Kurina, Lethbridge, AB

Gordon Smith, Edmonton, AB

Lee Woytkiw, Calgary, AB

Neil Thompson, Calgary, AB

Shirley Pulkkinen, Sault Ste. Marie, ON (Chair)

## CONFERENCE AT A GLANCE

Thursday, October 14, 2010	Friday, October 15, 2010	Saturday, October 16, 2010
<p><b><u>3:00– 5:00 pm</u></b>  <b>Conference Registration</b>            Banff Park Lodge Lobby            Banff, AB</p> <p><b><u>5:15-7:00 pm</u></b>  <b>CANSW Annual General Meeting.</b>            Balkan Restaurant            120 Banff Avenue            Banff, Alberta, Canada            Phone - +1(403)762-3454  <a href="http://www.banffbalkan.ca">www.banffbalkan.ca</a></p> <p><b><u>7:00 pm–9:00 pm</u></b>  <b>Dinner courtesy of CANSW followed by entertainment</b> Balkan Restaurant            120 Banff Avenue            Banff, Alberta, Canada            Phone - +1(403)762-3454  <a href="http://www.banffbalkan.ca">www.banffbalkan.ca</a></p> <div style="text-align: center;">  </div> <p><b>The 2010 CANSW Conference was made possible by the following corporate sponsors:</b>            Genzyme            Janssen-Ortho            Amgen</p> <p><b>Generous donations by the following:</b>            Kidney Foundation of Canada-National Office</p>	<p><b><u>7:30 – 8:45 am</u></b>  <b>Breakfast &amp; Registration</b>            Breakfast courtesy of CANSW  <b>Chinook Room</b></p> <p><b><u>8:30 – 8:45 am</u></b> Welcome</p> <p><b><u>8:45 – 9:15 am</u></b>  <b>Dr. Bashir Jiwani</b>            Introduction to the shared language of ethics that we will be using and that is required knowledge for the understanding and use of the tools that will be introduced.</p> <p><b><u>9:15-9:45</u></b>            Introduction of the tools and use of a case study within the large group to discuss/demonstrate implementation of tools</p> <p><b><u>9:45-10:00 am</u></b> Break</p> <p><b><u>10:00-11:00 pm</u></b> - <b>Dr. Bashir Jiwani</b>            Breakdown into smaller groups to practice using tools with another case study</p> <p><b><u>11:00 -11:45 pm</u></b> - <b>Dr. Bashir Jiwani</b></p> <p><b><u>11:45 – 1:00 pm</u></b> Lunch            Courtesy of CANSW  <b>Chinook Room</b></p> <p><b><u>1:00 – 2:00 pm</u></b>            How to Approach and Deal With Moral Distress</p> <p><b><u>2:00 – 3:00 pm</u></b>            How to Bring Ethics to Life in the Renal World</p> <p><b><u>3:00- 3:15pm</u></b> Break</p> <p><b><u>3:15– 4:45 pm</u></b>  <b>Presentation</b>  <b>Daniela Pizzuto:</b> The Transplant Adherence Program: Continuing education for transplant recipients</p> <p><b><u>4:45-5:00 pm</u></b>  <b>Wrap up for Day</b>  <b>Dinner on your own</b></p>	<p><b><u>7:30 – 8:30 am</u></b>  <b>Breakfast</b>            Courtesy of CANSW  <b>Chinook Room</b></p> <p><b><u>8:30 – 10:00 am</u></b>  <b>Al-Noor Nenshi Nathoo</b>            The Ethics of Difference: Challenges of Human Diversity</p> <p><b><u>10:00 – 10:15</u></b> Break  <b>Alpine Meadows Rm</b></p> <p><b><u>10:15 – 12:00</u></b>  <b>Al-Noor Nenshi Nathoo</b>            Age, Equity and Discrimination: Providing Ethical Care with an Aging Population</p> <p><b><u>12:00 – 1:15</u></b> Lunch            Courtesy of CANSW  <b>Chinook Room</b></p> <p><b><u>1:15 – 2:00</u></b>  <b>Cathy Gillis</b>            Renal Social Workers and the Kidney Foundation of Canada:            Collaboration to Reduce the Burden of Kidney Disease</p> <p><b><u>2:00- 2:15pm</u></b> Break</p> <p><b><u>2:15 – 3:30</u></b>  <b>Michele Fairbairn</b>            Facilitating social justice and personhood as ethical practice</p> <p><b><u>3:30 – 3:45</u></b>  <b>Evaluations/Close</b></p> <div style="text-align: center;">  </div>

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## Keynote Speaker Bashir Jiwani, PhD



Dr. Bashir Jiwani is Ethicist and Director for Fraser Health Ethics Services where his role involves clinical ethics consultation, ethics-based organizational policy analysis, ethics infrastructure development and support, and ongoing ethics education and programming. Bashir is also a member of the Executive for the Canadian Bioethics Society.

Bashir has done over 450 workshops and presentations across the country and internationally on issues in ethics and health ethics. He has spoken to academic audiences, health care administrators, providers, and patients, as well as the lay public.

Previously, Bashir has served as Ethicist and Leader of the Ethics Network for Providence Health Care, Northern Alberta Coordinator for the Provincial Health Ethics Network, and Assistant Adjunct Professor with the John Dossetor Health Ethics Centre at the University of Alberta. He has worked with a number of committees and special task forces including the Joint Oncology Drug Review Ethics Group and the College of Physicians and Surgeons of BC's Ethical Standards and Conduct Review Committee.

Bashir's publications include:

- o Exploring Disparities Between Global HIV/AIDS Funding and Recent Tsunami Relief Efforts.
- o Ethical and Scientific Issues Surrounding Solid Organ Transplantation in HIV Patients
- o A Mandate for Regional Health Ethics Resources,
- o Ethics and Health Resource Allocation: A Primer for Policy Makers
- o An Introduction to Health Ethics Committees: a Professional Guide for the Development of Ethics Resources,

Bashir's academic background is in philosophy and public health. He has a Doctorate from the University of Alberta's Public Health Sciences department and a Master's degree in Applied Ethics, specializing in Bioethics, from UBC. His research interests include ethics and public health policy, health care resource allocation, the work of ethics resources in both clinical and organizational ethics, ethical decision-making, ethics in Islam, bioethics in a multicultural context, and issues in ethics and identity.

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## Keynote Speaker

# Al-Noor Nenshi Nathoo



### Al-Noor Nenshi Nathoo

Al-Noor Nenshi Nathoo is an Ethicist at the Rockyview Hospital, Calgary. He also serves as the Executive Director of the Canadian Bioethics Society and Southern Alberta Coordinator of Provincial Health Ethics Network, Alberta. In this latter role he works with several bioethics committees in the Calgary area.

His background is in the field of ethics and social justice. Al-Noor holds a B.Sc in Biology/Human Genetics and the History and Philosophy of Science (McGill University) and an M.A. in Philosophy (University of Calgary) with a specialty in Ethics, concentrating on issues of poverty and justice. His work in health care includes the areas of cancer research, home care and primary care management. He has worked as a consultant with various Ottawa and Calgary agencies on human rights and international development.

## Conference Speakers



### Daniela Pizzuto, APR:

Account Manager, energi Public Relations.

Manager, Transplant Adherence Program (sponsored by Astellas Pharma Canada, Inc.)

The Transplant Adherence Program (TAP) is a national, bilingual and non-branded initiative that was launched in fall 2009. The Program's objective is to underline the importance of medication adherence, attending all clinic appointments and learning to recognize and respond to the first signs of rejection.

Ms. Pizzuto is a senior communications professional with 10 years of experience in both the public and private sectors. At energi Public Relations, she is an Account Manager responsible for the management and execution of patient education programs. Prior to joining energi PR, she held increasingly responsible positions at Bell Canada, Air Canada Technical Services, the Montreal Port Authority, and crown corporations such as Export Development Canada.

Ms. Pizzuto has obtained her Accreditation in Public Relations designation from the Canadian Public Relations Society, which recognizes excellence in the field and holds a Bachelor of Commerce in Marketing and International Business from McGill University, as well as a Master of Arts in International Relations from Johns Hopkins University. She is fluently trilingual.

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## Conference Speakers

### **Michele Fairbairn**

Michele Fairbairn, MSW has worked extensively in a variety of social work practice and educational settings. She is currently a Renal Social Worker in an Adult Acute Care Inpatient Unit and Adult Outpatient Dialysis Unit at the Royal Jubilee Hospital in Victoria, British Columbia. She is also a Sessional Instructor in the School of Social Work at the University of Victoria, British Columbia. Michele's teaching and research interests focus on anti-oppressive social work knowledge and practice. Michele is also dedicated to strengthening social justice in direct practice, policy and program development, and social work education and research.



### **Cathy Gillis**

Cathy has been employed as a social worker with the renal program at the Queen Elizabeth II Health Science Centre in Halifax for more than 25 years. She received both her BSW and MSW from the Maritime School of Social Work, Dalhousie University.

Cathy is a member of the Nova Scotia Association of Social workers and the Canadian Association of Nephrology Social Workers. She is a past president of CANSW.

Cathy is a long term volunteer with the Kidney Foundation of Canada and has served in many capacities at both the Nova Scotia Branch and the National level. She is currently the chair of the National Patient Services Committee, a member of the National Volunteer Development Committee and immediate Past president of the Nova Scotia Branch.







**32<sup>th</sup> Annual CANSW Conference  
Ethical Mountains in Nephrology Social Work  
October 14-16<sup>th</sup>, 2010  
Banff, AB**

\*\* Registration must be received by Friday, September 10th \*\* or late dues apply\*\*

\*\* Please book your accommodations directly with the hotel - see page 2\*\*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Please check if attending Thursday Annual General Meeting and Evening dinner (cost included in your registration. Please note: dinner tickets for spouses/partners, please include an additional \$35.00)

**CANSW Members:**

**Entire Conference**

- Before September 10th - \$200
- After September 10th- \$225

**CANSW Members:**

**One Day Only – Friday or Saturday (please circle one)**

- Before September 10th - \$125
- After September 10th - \$150

**Non CANSW Members**

**Entire Conference**

- Before - \$400
- After - \$450
- Students - \$125.00

**Non CANSW Members**

**One Day Only – Friday or Saturday (please circle one)**

- Before September 10th \$225
- After September 10th - \$250

**Please send your completed Registration Form along with a cheque payable to CANSW and mail to:**

**Julie MacDonald - Halton Health Care Services  
327 Reynolds Street, Oakville, ON L6J 3L7**

**For more information, please contact Shirley Pulkkinen at 705-759-3434 ext 4168**