

Matt Loscalzo Transcript

September 2, 2026

Mei (00:11)

Welcome to the palliative social work oral history project, where we capture the legacy of palliative social work profession. My name is Mei and I'm here with Terry Altilio and we are delighted and honored to welcome Matt Lascalzo today. So, thank you so much, Matt, for being here with us.

Matt (00:30)

It's an honor to be here.

Mei (00:31)

For those who don't know Matt, can you tell the listeners a little bit about yourself?

Matt (00:35)

Yes, I can. One of the best things that I ever did when I was at Sloan Kettering was to hire Terry Altilio. I could tell you that's the kind of judgment that I had. I chased her for years and she let her son's education get in the way of my needs. So, I have always coped with that. I began at Sloan Kettering in 1980 where we started the first supportive care program in the country in a comprehensive cancer center. And that's where I learned how to fly. And we created a number of innovative programs there, which I'll tell you about later. and I was there for 13 years when I was recruited to Johns Hopkins Oncology Center, where I stayed for nine years first as director of social work, then as the director of patient and family services. And I was there working with James Zabora, whose name will come up again later, because he was a moving force and a huge part of what I was to take on, which was biopsychosocial screening. And then for a short stint, for three years, I was at Eastern Virginia Medical School as an associate dean In the School of Health Professions in the medical school before I was recruited to UCSD to start a supportive care program there like I did at Eastern Virginia Medical School. And then I thought I was going to be in San Diego for the rest of my life and life had other plans. And 19 years ago, I was recruited to City of Hope National Medical Center to set up a supportive care program. And the number one demand that I had was not about money or stature or title, but that I would create an integrated interdisciplinary program, which would include all the mental health professionals, palliative care physicians, nurses. And we started with about 15 people when I got there, and now it's about 215 people. And now I'm here now, really being honored by you asking me to talk with you, with you and Terry, Mei

Terry (02:35)

What's so interesting, Matt, as I was listening to your story of the our early history is that one of the things that's so really special about Matt. So, I'll give you an example. I was working in Northern Westchester Hospital, community hospital, and I had gone to Memorial Sloan Kettering to learn about cognitive behavioral therapies, to learn about what is an oncology social worker? I had I had no healthcare experience. So, I went to Memorial and I met Matt and we learned how to be an oncology social worker. There were three days of cognitive behavioral interventions, fantastic courses. And I think you know about this aspect of Matt's creativity. And so, then I went back to Northern Westchester Hospital. I wanted you all to come up and teach at our hospital because we had a network of oncology social workers. And what you said to me is, okay, we will come, but you have to be a part of it. And that is the wisdom of Matt. Paying it forward. Right. Yeah. So, I was. I did some talk. I have no idea what it was. You were helpful. I did it, did some semblance of a talk, and then Matt said, if you want to come to Memorial Sloan Kettering, let me know. I went down to Memorial Sloan Kettering and then I learned palliative care and so on and so forth. It's a wonderful example of bringing people forward.

Matt (03:52)

That's the nicest thing you could have said to me, Terry.

Mei (03:55)

Hearing both of you talk, yesterday during our advisory council for the oral history project, we're talking about how amazing it is that it becomes like an organic way how people get connected in our field. And that's something that we wanted to capture in these oral history projects. I'm really glad that we got a chance to learn a little bit about that. And Matt, one of the things - this is a palliative care oral history project. And one of the things that we discussed in the advisory council is the overlap between oncology social work and palliative social worker and I've also participated in the psychosocial training for pain management at City of Hope. And I think of the skills of oncology social work to bring psychosocial perspective into the symptom management world, which is heavily medicine driven. Can you tell us a little bit more about what brought you into creating training and including mental health professionals in the field of medicine while we maintain our scope of practice as social workers.

Matt (04:59)

Well, I am happy to answer any questions that you have, but I have to invite Terry to join in at any time to add or take away or to disagree so we can have one of our many debates going back and forth. I always learn a lot when she and I do that. I don't know of any medical system. I don't know of any medical illness. I don't know about any medical issue that it does not have a biopsychosocial spiritual correlate. I just don't know how you pull a person apart like that. And before supportive care really came into its own, that is what was going on for many, many years. And in my professional life and in my private life with the really death of family members. It just reinforced that for me. So, I don't know how to really separate those out. So everywhere I have been, everywhere from Sloan Kettering on, we had an integrated interdisciplinary team, not just people waiting at a bus stop. It was people driving the bus, people making sure that we were all on the bus at the same time.

Terry (05:59)

And that's part of the discussion that we were having yesterday in the advisory council, and it's part of what we kind of struggle with on an ongoing basis. And Matt, I told Matt when I saw him at AOSW, I'm still teaching - Matt and Paul Jacobson wrote an article in nineteen ninety on pain for social workers. I don't know if it was for social workers. I think it was. I think it was in AOSW Journal or something, right? And it is a wonderful article because it weaves together how social work has to be, needs to be, ought to insert themselves in pain. And it has some wonderful, wonderful questions that are really, they're easy questions. They're not, high brain kinds of questions. How has pain affected your life? I mean, how simple is that? So, I still teach because there are very few - in spite of the fact the work of that Matt has done over decades and I have done it over decades, there are very few social workers who own pain and feel it as a specialty that they can teach and they can disseminate in the wider professional world. So, I still teach from Matt's article from 1990, which is so amazing to me and it also is so easy for social workers to grasp because it's what you're talking about, Matt. It's about the unified human being. It's not complex. It is not complex. It is about the limits that we set on ourselves in terms of getting involved in what we see as medical aspects, aspects of the work. So, pain, I think, is one of those amazing aspects of the work that we do that Matt has been central to for decades. The other thing that I remember, Matt, and I got to say this out loud because this is another thing you taught me. You said at some point in time, somebody asked you to write an article for a book or something about concrete aspects of what we do, as if the concrete aspects don't have any therapeutic meaning; they don't have any impact on the human being and so on and so forth. And so, you said, of course, of course, I will write that chapter. And then you took the concrete aspects, the discharge planning aspects, the

application for Medicaid, whatever it was, and you wove it into the dynamics of a human being. And so that is something we have to keep thinking about, because in many respects, we've given up the practical and the concrete aspects. So, when you apply for Medicaid, what does that mean in terms of autonomy, dependence, your sense of identity? When you have to sleep in a hospital bed. What does that mean when you're not sharing space with a person that you love? So, I remember that - that's decades ago. You said, of course. So, you taught me also to take opportunities that were that are thrown at us and make them what we want them to be. We can do that. We have that autonomy, we have that knowledge most of the time, and we have that power. We have that power. Yeah. Anyway, with very interesting learning.

Matt (08:56)

Thank you. that's why I fought for five years to get you to finally come down from Westchester County to come to Manhattan. And I know it was terrible traffic for all those years that you were there.

Terry (09:06)

But I took the train, not to worry.

Matt (09:09)

Good, you were wiser than I was. One of the things that we sort of pass over is the impact on physicians and nurses working with the patients we see. And it's pain, it's insomnia, it's fatigue, it's the frustration of your body betraying you. It's - it is the whole package. And these are the areas where we live. That they suffer, I mean our colleagues suffer also, because they often feel so powerless when it goes beyond the medical and who's there, but the people who focus on psychosocial and practical issues. Because every practical issue has some sort of metaphor that is connected to it, has some sense of where am I in this universe? If it's from a headache to losing a limb, to being at the end of life, to not being able to have children that you plan to because of the illness. Every one of those has psychosocial correlates that matter every day, not just in that 20 minute session with the physician. And this is only increased in the age of wealth care supplanting health care where it's the stakeholders now. It's not patients come first, it's the stakeholders come first, unless you're in a nonprofit. And nonprofits are incredibly stressed now to be competitive financially. And with the present zeitgeist coming out of Washington, DC, that's just reinforced with the budget cuts that we've seen for the people who need the resources most. So, thank you for pulling that in, Terry.

Mei (10:47)

One of the questions that I had as you were, Matt, talking about integrating physician, nurses, and collaboratively working with them and integrating the biopsychosocial in medicine. What were some of the opportunities and challenges that you faced as you were completing various projects and developing programs?

Matt (11:10)

It's - my social work values - talks team, talks family, talks social and I brought those values into everything I try to bring it into everything that I have done. Always thinking about how do we maximize the benefits to patients, families, and to our colleagues, our team members. They matter equally in my book. And when I've, whenever I've been to a new place, one of the first questions I ask the team and knowing that they're going to be nervous about a new person joining them, is who's most important? And inevitably I hear the patient, the patient, the patient. And that's great. I don't try to talk them out of that. But I say, but you spend more awake time at work, than you do at home. And you manage and help people with real serious problems that don't have answers. There's no pill for a lot of the problems that people we support have. So, you are as important as the patient, not more, not less, as important. And then to demonstrate through behaviors the respect for our colleagues, whether it be a nurse or a social worker, a psychologist, a chaplain, an administrative assistant, a secretary, regardless, it's a human being. And our social work values stand for that. So that's always what has driven me in terms of the programs that I've built across the country. I've created an environment where they built themselves, where everyone, this - from the researchers to the secretaries, everyone has a voice and everyone is expected to be a leader. And that that's based on social work values.

Terry (12:48)

It's interesting when... when I've been thinking a lot. You know, we do a lot of talks, Matt, about language and word choice. and we've been thinking an awful lot about the folks who you identify, the secretaries, the home health aides, the people who bring in the food, what they hear in our language, how they are or not engaged in the grief work that goes on. And what they bring back to their communities. That to me is so - that's so social work. If you think person and environment, you think about those folks and you say, What do they hear from us? And how do they bring that back to their communities? They either bring it back in a way that means the community feels more threatened by us, or they bring it back with the compassion that we hope that we have. So, the idea of how we engage at all levels.

other than COVID, you know, I remember COVID, all of a sudden everybody became a hero until they weren't heroes anymore. You know, they were whatever they were before, before COVID. So how we think about team and how we think about what we owe each other in the - in the sort of the humanity of this work, I think is really important message for social workers to carry. If anybody should carry it, we ought to carry it. And we ought to carry the idea that people take what we do back to their communities. Do you know what that means? Yeah. It's interesting.

Matt (14:10)

Yeah.

Terry (14:10)

Took me a really long time to figure that one out though. The one about the community, you know, it was like, huh, you know, these folks can be ambassadors if you, if you honor them in the way that they ought to be honored. Yeah.

Matt (14:22)

Yeah, especially if you start from a place of strength. That no matter what's going on, how do we access the resources within you so we can work as a team? and that goes with the patient, the family, and with our colleagues. Because if our colleagues are doing what we're asking them to, they're reinforcing what we're doing. And you have set up, you know, certainly programs like that. We have set up some programs that focus on seeing what's left, not what's lost only; recognizing what's lost, grieving that, accepting that, but then saying, but what's left to work with? And there's always something left. There's always something that we can do to support someone's humanity. But you have to have that focus and you need to be able to see beyond the situation. And I think for me that's also social work. we go beyond the feelings to what are the feelings teaching us? Feelings are inclinations, not destinations. So, how do we use those feelings to understand what's happening to us, what our heart and soul is trying to tell us? How do we start there to move forward, to move beyond just the emotional static where we are? Because if you're, If you've, if you stay in the feelings, you know, it's hard to get past it because you know, Terry, you, we and I have talked about strengths based for years. And that is - we grow in the stretch. That's when we grow. But we need people to support us and guide us, especially when we're in a really difficult time. It's humanity that pulls us on and says; I'm going to stretch. What am I going to get out of this? How can I learn from this? And there are other people around me. And if I'm the patient or if I'm the family member supporting them, I still have expectations on me in in a compassionate, courageous way. But you need both.

Terry (16:17)

Mm, mm, yeah, yeah.

Mei (16:18)

And I feel like that perspective, Matt, your leadership and Terry your leadership, it all comes down to a trickle-down effect. And when someone is in a position of leadership and guiding a team has that value, the strength base, the compassion not just for the people that we care for, like the patients and families, but to our colleagues, it creates that cohesion in group which ultimately provides good quality patient care and positive outcomes, which is what a lot of healthcare system desire to have. I really appreciated hearing both of you talk about that and how important it is for social work leaders or aspiring leaders to hold on to those values and, and remember why we decided to pursue this profession.

Matt (17:09)

And at every level demonstrate it's more than patient care, it's people care. And people care both in the reality that we care about each other, we're caring for each other, but it's a value system that we have, that we care about people. Regardless of what their situation is we care about them.

Terry (17:29)

Which really, as I was listening to you, Mei I was thinking about we did a talk with somebody, oh Susan Gerbino about Esther Chachkes and Zelda Foster. And in that talk, Susan was talking about leadership, small leadership and big leadership, right? Capital L leadership. As I was listening to you, Mei I was thinking about this idea that in terms of our values, anybody who's wander, any social worker who's wandering a hospital or healthcare setting is leading in the sense that they are asserting what our values are. They may have to figure out how to do that, to stay safe, to protect, you know, depending on their role, but we're good at that. But the silence, the silence is what's demoralizing. The silence doesn't work, just does not work.

Matt (18:14)

Yeah, the silence, as they say, the silence can be deafening. Yeah.

Terry (18:18)

Yeah. Yeah. Yeah.

Matt (18:20)

Yeah. But I'm always struck, Mei and Terry, by how people lack the language and I'm talking about professionals. I'm a member of both AOSW and APOS, and they're different organizations, very much so. But in both of those organizations, what people lack often is the language to know how to talk as a team, to know how to talk to a patient in that strength based language, to know how to ask a question? What is the exact verbiage? Like, how do you get an administrative assistant who is frustrated with a researcher who every Friday drops off a load to work at three o'clock and says, this will take you 20 minutes? And you see it happening. And for us, you know, our antenna goes up. That's unfair. That's oppression. That's not okay. It's just not okay. You could call it whatever you want. Maybe my language is too loose. But we have a role there too. But we have a role there too - to empower that person to say, you know, to the person who is abusing them, and that is abuse, who is abusing them, you know - "When you give me this stuff at the end of the week, I can't help you as much as I could if you gave it to me earlier. You also, to be honest with you, and I hope you understand, I need your help on this. I have a family; I have young children at home. And when you give me work like this, it keeps me from my family. And I know that's not what you want to do." Like, how often have you heard that conversation?

Terry (19:49)

We haven't. Goes underground.

Matt (19:51)

Right, it goes underground. And it goes underground because we don't create teamship, which is leadership, teamship that makes it part of the culture to have those conversations, to say things that are unpleasant. And we have this misunderstanding that if it feels bad, it is bad. No, a lot of times if it feels bad, you're you're doing the right thing. You're speaking up, right? You're like you're saying things like - You know cancer patients, their sense of smell when they get chemotherapy is so sensitive. I got to let you know sometimes your breath is pretty strong. So, if I'm feeling it, I bet the patients do too. That's a gift.

Terry (20:36)

One of the things that I came to after a long time practicing is a couple of things, one of which is to assume the best of intentions. To assume that everybody has good intentions, not just us palliative care folks wandering through the hospital. Everybody has good intentions. and the funny part, Matt ... when I was I went to Matt's presentation at AOSW on the couples program that you're doing, maybe we could spend a little bit of time on that, because it's very, very exciting. And one of the things that you said, and I thought to myself, I've been practicing for however long and I could never figure out how to ask this question.

So, you were talking about when people say to you how much they appreciate what you have done for them. You had a sentence which linked their appreciation to the possibility of other ways of saying thank you, including making donations. Would you share that phrase with us so it's on the website? Because it was just brilliant. It had something to do with. "I can hear your appreciation"... Do you know what I'm talking about?

Matt (21:40)

Sure, I do because I teach this to myself every day. I reteach myself, and I'm giving a talk in two weeks to physicians on how to do this because they're so uncomfortable doing this. This is how to listen for someone who will find meaning in giving back. Right. And you don't ask, you wait until they ask. and they say, you know, you've done such a great job, you really have helped me. And the person who I want, not in my department, is the person who says, oh it's my job, don't worry about it. You know, that's not the person that I want on my team. Okay. The person I want on my team is to realize how much more help we can give to patients and families if we had more resources. And institutions are limited in how much they're willing to give to us. All of them. They all have limits, right? But we aren't victims. Gee whiz, I hear how grateful you are. would it be okay if I had a colleague call you about ways that you can give back? And that could mean volunteering to show people around. You know, that can mean a whole host of things. And that's to be explored what would give you meaning. And for those people who can give money, we raised about \$30 million, \$30 million here at City of Hope National Medical Center for Supportive Care Medicine. So, when I tell people that, they say, How did you do that? I say, I didn't do it. I didn't do it. Every secretary, every psychologist, every psychiatrist, every palliative care doctor, every social worker is trained to listen and not to ask for money because you're not getting this money. You know, if you if you were keeping this money, I could understand there being an ethical issue. There's no ethical issue when someone indicates they want to give back and you have someone call them to see how they want to give back. That's a missed opportunity. And when people give back, they feel better. And we have lots of research that shows that when people give back, we could show it, we see it in the brain, we see it in the behavior, they feel more connected, they feel like they're having a meaningful impact, and they are.

Terry (23:44)

Yeah, I was just when I was sitting there thinking to myself, I wish I'd had those words over the last 20 years because I could never figure out how to do it. So, I didn't do it. You know, I didn't do it. So now we've got it someplace where others will hear it and beyond the privilege that they have with you being in the classroom and teaching them. So

Matt (24:06)

Well, I hope so, you know, because you brought up the couples program. We've raised millions of dollars for that. Took years to do it, but in the last couple of years it was about three million. And that supports salaries. And because we have donor money now, the institution is more willing to give money to match it because they know that somebody sees it as important. And when we talk about couples, of course we talk about same and opposite sex, but we talk beyond that, your key support person who is going to be there when you need them most, and to support them from day one by asking a straightforward question, which you heard Terry in in that talk. As a couple, asking them separately and then letting them know we're going to share your outcomes. It takes about 45 seconds to complete this question. What is your perception of the medical situation? Asking them this on the first interaction so we could see, and we see 30% of couples are at opposite poles. Think about the impact. Think about the role of social work in that. The getting them unified against the cancer to start problem solving, to be moving forward. To saying our job is to maximize the benefit of your medical and psychosocial care with a simple question that has four bullets, everything from I expect to be cured, I expect them to be cured, all the way down to - we're going to focus on symptom management and time with my family. This is not a curable illness. We asked them that before they meet with a physician. A social worker asks them that before they meet with the physician. And then we go to the physician and say, they are misaligned. Can you help them? Or they are in alignment. And what the physicians tell us is thank you for doing that. Thank you for opening that door. Because I see them two or three times and the door's not open, it's hard to go back.

Terry (26:00)

Right.

Matt (26:01)

But everyone on this call understands and knows that.

Mei (26:10)

When you start incorporating social work or programs, have you gotten pushback or anything like that from colleagues or medical center? I'm just curious how you would navigate, let's say, starting those surveys or starting a different approach to incorporate social workers into the discussion.

Matt (26:31)

Sometimes there's nothing but pushback. And without pushback, there's no tension. And you need tension for change and for moving forward. At Memorial Sloan Kettering, Terry

and I and others taught people what social work can do for pain management. It was beyond teaching them skills that helped them cope physically by meditation or relaxation, or exercise or sexual function enhancement. It included that, but it included a lot more. And what we find is when you start doing things with whatever time you have and demonstrating value, some of the pushback is relaxed when people see the benefit. But if you say we do compassionate, courageous, fair care - that is an associated experience, but it's not an outcome. An outcome is when someone sees Terry and they walk out of that room ready to do meditation, when they walk out of that room ready to have that difficult conversation with their child, when they walk out of that room thinking, yes, I do have pain, but if I lay on my side, my partner and I can have sex. Or we have to redefine what sexual function is. And you have a person who is comfortable having that language ready and that conversation to have. If you did not have pushback, you're not doing anything real. Without pushback, you know you're, you're just not in the right place. You need to be pushing the edge of the envelope because growth is in the stretch. It's stretching beyond. The same thing happened with biopsychosocial screening. And the hero with biopsychosocial screening, the lone voice in the field was James Zabora. So, Jim was using the brief symptom inventory for years, did his dissertation. And then he recruited me to Hopkins. And the first thing I said is, this is really interesting to use all this time to find out that a person is anxious, and we still don't know why. What about physical pain was the first thing. And that's one of the reasons why he brought me there and why Hopkins brought me there was to help them to start a supportive care team, which we did do. And which we did do. So, you want to look at the who this person is and the world that they are living in. And seeing what we bring to the table, but always remembering people care about self-interest. You have to let the administrators know how the institution is going to benefit. You have to demonstrate to the physicians; this is what I did. And to do it in a language that they value, not social work language, human values, human language, words that they can understand. I got this couple to be working as a team. One of them was having an affair, but they both agree that cancer puts that on hold and they have to apologize and promise to move forward because cancer demands it if you're going to manage it well. Can you make that commitment to me now? Connect, correct, commit. Without a commitment from a patient, from a colleague, you have nothing. All you have is a conversation that you had without a commitment. Commitment is everything.

Terry (29:38)

It's really valuable about the idea of tension. Right? If there's no tension, there's there's - no probably no progress, right? the status quo remains. The status quo remains.

Matt (29:50)

And social workers live in that tension realm. We live there. It's already there. We just need to take it and to use it and to go beyond the emotions, learn from the emotions, use the emotions as energy, as petrol to move us forward, but not as an ending point.

Terry (30:08)

You know, I was...I was thinking about - there's a person named - what's her name? She talks about the green room. Joy DeGruy. Joy DeGruy wrote a book called Post Slavery Trauma Syndrome. I think I've got it right. I may not, but she's a social worker. We don't teach her. It's really very interesting, but that's a whole other conversation. And she talks about trauma consequence of slavery and the need for healing. not pathology. She talks about it as a need for healing. And one of the things that she talks about, Matt and Mei, is the Green Room, which is similar to the Green Book that Mr. and Mrs. Green wrote, they wrote it over decades for black families to go down south and stay safe. They would give you hotels and restaurants where you could eat and not be threatened and so on and so forth and stay. And it was called the Green Book. And she says in this book, and what she talks about is that when you're doing this work, you need to know where the green room is. So, as you're talking, Matt, I'm thinking that there are times when you need to know where the safe space is to be able to sit down and say, Do you believe how blah, blah, blah, blah, blah, this conversation that I had with whoever I had it with. So, I think it is important as we do this work to also know where that space is that you can sit down and ventilate and in a trusting, supportive way and not be judged and just, you know, have whatever it is you have to say accepted, accepted. And if you ask for feedback, you get it. But sometimes it's just about ventilation. Sometimes ... and she talks about the green room. I think it's really a amazing concept, construct, sort of to understand that in our settings, sometimes we need to know where the safe space is.

Matt (31:52)

Yes.

Terry (31:53)

Yeah, yeah, yeah.

Matt (31:55)

We matter.

Terry (31:56)

Exactly, exactly.

Mei (31:58)

We need to take care of each other because we as providers are also human beings. And I remember I have a team where we have somewhere like the green room where we all have a shared understanding that this space, there's no judgment, we can say whatever we want. And knowing that outside of this room, we have to wear our professional hat and we do what we do every single day. But there is a special room and it really makes such a big difference with group cohesion, trust, and that's where I felt for me, we've developed a relationship beyond colleagues that when we are working outside of that room, or if we need help, if one of us is experiencing, for instance, countertransference, because of our personal experience meeting with certain patients, we help each other and it happens very organically. And I completely agree with you, Terry, how important that space is for team members to have.

Terry (33:00)

Mm-hmm. Yeah, yeah.

Matt (33:02)

And I would argue that that room is the ultimate of professionalism.

Terry (33:06)

Interesting. Uh-huh.

Matt (33:07)

Think about what it's like if we're all there helping each other to lifting each other up. If we're all there to lift each other up, to give feedback about what helps and what causes growth, and to give feedback about what gets in the way of growth that a person does, and to tell them in ways that they can hear it and grow. Not going underground, not blind copying people, not talking behind people's backs. I once recruited a person, not a social worker, a faculty member. And before they got to City of Hope, we spoke with them about here are the rules: no blind copying, no talking behind anyone's back. We lift each other up, we give positive feedback, in the moment and positive feedback means something that's going to help you to grow, not necessarily make you feel nice. and please, and then we send an email outlining all of this. We did this for everybody. And you know, no blind copying. If you're going to mention someone's name in the email, you need to copy them. Right. And so just basic things, just basic humanistic things that are in our value system, social work value system. And the first day on the job, this person violated half of those things. And they... and I just happened to be walking by. I just happened to be walking by. And someone who was a supervisor was trying to help this human being. And I said, wait a second, wait a second. You just spoke with this person and they're working on it. Why are

you asking this person? It's your first day on the job. You must be feeling really stressed. I can only imagine, but we don't do that here. So, if you need to do that, go back to that person or come to my office. I'm here all day for you. And within a month or two, they were gone. They just could not be decent to their colleagues. They just could not be honorable. It was just not in their makeup. Their experiences they had prior to getting there were so different. And when you have a green room like they're talking about, you don't get that undermining of a colleague. You get - I'm really scared here. It's a new place. It's so different. I need some extra support. And they should get it. They should get it. But sowing mistrust, because trust is the number one - trust and safety. You can accomplish very little without trust and safety. To me, they're the foundation of leadership and the foundation of team building. And this is a person who, for whatever damage, whatever trauma, clearly trauma happened in their lives, which we saw again and again and again. Without managing that, it is - it's infectious in a negative way. That's hard for some people to hear, and it's hard to do, and it's hard to say. But when you don't help people like that move on, you damage the rest of your team. And there is a cost. There is a cost to not being courageous and compassionate. There is a cost. Be compassionate to the people who are being undermined by this person and take action, which may just be talking to them or talking to HR. Or talking with them to HR or writing an email to HR and copying them and letting them know I'm going to be doing this. Because your colleagues deserve to work with people who are going to lift them up. Someone who pulls them down, there is a consequence to that. You're not being a nice person because you're avoiding unpleasant feelings.

Terry (36:35)

It's interesting. as I was listening to your Matt, I was also thinking about the self and what happens when you don't, when you choose not to confront or figure out how am I going to handle this, how that erodes your own self. You know, I used to think I would either cry or stomp or whatever, get angry, became much easier, just became - life became much easier when I could figure out how to say what needed to be said without being cruel or whatever, just trying to figure it out - rather than silence, because silence - it erodes your spirit, it really does, and your sense of identity. And so, figuring out, helping others also to figure it out - how are we going to intervene with this because it's harmful. You know, that's another thing took me years to figure out is that when you see something that somebody is doing that potentially does harm, and you do not figure out a way, you have abandoned them. You have essentially abandoned them. And that helped me to learn how to, even if it was clumsy - to figure out how I was going to involve myself in certain situations that because if I didn't, if you are a team, or an institution and you see harm being done, you have abandoned the person. You have not given them the chance, if you will, Yeah. Yeah.

Matt (38:01)

And the person and the other people who they're going to impact in an ongoing consistent way. I remember, I have memories of when you came to Sloan Kettering, you spoke with the staff, there were things that I was doing, and you made it very clear that you were not going to do those things. And I found that to be so darn helpful.

Terry (38:20)

I don't remember that.

Matt (38:22)

I do. I can, I can tell you what they are if you really want to know. But it was so helpful to the team because you reoriented them with each person you're going to get something a little different or very different. It wasn't very different. What they got was someone who was fantastic. And they knew it. They knew it right away because you communicated it. You said - Matt did this. I don't do that. I do this, this, and this. And it created a whole new world for the team to think about, widen their view.

Terry (38:51)

There's are some things I really don't remember at all, which is really - that's really fine too. That's really fine. Yep.

Matt (39:00)

Well, it made me a better person. Yeah.

Terry (39:02)

Interesting. What else, Mei?

Mei (39:04)

What else? I wanted to go back to when Matt was talking about the importance of demonstrating value and outcome in terms of how we provide intervention to show value within the interprofessional team. And it made me think about like, for example, I don't write that I provide emotional support. It's quite often, in the field of palliative care, and they provide emotional support and that's something that I've really stopped for the past years or so. I just stopped saying emotional support. My dog provides emotional support, My book provides emotional support, My couch provides emotional support. And I was really thinking about how important it is for - because we do provide good outcome, measurable outcomes that shows value and I just wanted to really address that because it I feel like it's so important for social workers to know the value of that while also we're not

compromising our skill sets that we have. And so, I just I was just really thinking about that as I was hearing Matt

Matt (40:12)

Yeah, well, I agree with you if that's what if that's what's being put. I'm providing emotional support. I say I'm providing emotional support to the couple to manage the complexity with their children. I provide emotional support, so they know how to talk to each other when one of them is feeling down and out of control. And these things are coming from the patient. So, it's not an end in itself. And I agree with you. I think - is it a valuable thing to do? Yes. Does it play into stereotypes? Yes. But I think when it's - when it's to serve a higher need, it's more understandable for others. I think providing emotional support is valuable. I do. I do. but I think we have to know the context we are in. And we've published a few papers on this and they're all in Google Scholar and in PubMed. and the formula that we've come up with in multiple settings now is to think about values, benefits, outcomes, thinking about who your audience is. Is your audience a middle manager? If it's a middle manager, you know you're going to probably get pushback on anything that's innovative. Their job is to keep the operations going. Right. So, if it's a physician, they're going to want to know, are you helping this patient and enabling me to see more patients because I'm being pressured to see more patients in less time. So, you need to know who you're talking to. One thing that almost never works is bitching and moaning and complaining. Because then people will see you coming down the hallway and they'll want to walk away and I'm talking about the CEO, I'm talking about any colleague. It gets tiresome. So, you want to know who am I speaking to? Identify in your brain is this person a middle manager? They care about operations. Is this person an MBA? They care about mostly money. Is this person an executive? They care about their standing in the field and taking over other hospitals and growing and being known for specific things that they do better than anybody else. So, you want to know what their values are, whoever the person is, what's their values? Is this a person who really cares about patient care? Is this a person who talks about patient care, but they really focused on money? You got to know that. What are their core values, even if you can't talk about it with them? Right. And then you want to talk about, to them, the benefits that they're going to get from having this conversation with me. And if you're going to, if you're going to be telling, and this is a big problem with social work in my perspective and I own it, if you're going to be telling an executive or an MBA about this difficult case you just had, that is a misuse of an opportunity. You need to know what they care about. And that goes to the benefits. What benefits are we getting in this conversation right now? Is it about I met with a bunch of donors? Is it about, I'm giving a national talk, and I get to brag about what we're all doing here? You know, things like that they would value. And for each person it is different. For the nurses, their biggest value is - are you

helping me? Because I'm busy and I have a lot to do and they do. Right. And then the final column is outcomes. Measuring outcomes. And it's hard to measure emotional outcomes. But if you put yourself where you're needed most, where you can have an impact, then you're going to have benefits - less time in the intensive care unit. You want to keep people out of the intensive care unit? Ask them that prognosis question that I shared with you earlier. It has been published. Ask them that. What's your perception of the medical situation? So, from day one, the partner, same and opposite sex, the same from day one, e they're having the conversation. So, it's not like, do you want to go to the intensive care unit? It's like we've already thought about it together as a couple. And we know that if we go that route, here are the implications. If we don't go that route, here are the implications. And the prognosis question asks them, where do you see yourself? And the only one who can really talk about prognosis, that's why it's not called that, is the treating physician. Because they have the scans and they have the knowledge and they have the wisdom and that level of training. So, values, benefits, outcomes, values, benefits, outcomes. Try to get into that formula whenever you're in the hallway, whenever you're meeting any of your colleagues. What do they value? What are the benefits to them for my existence? And what are the outcomes that we can measure? That's probably more than what you wanted to hear. I'm sorry, Mei.

Terry (44:47)

No, it it puts a framework around it's I think it's really important, right? Don't you think, Mei? To have a framework. Right. Yeah, exactly. Exactly.

Mei (44:56)

I was actually waiting for that kind of response. So, thank you. These are practical things that people can take back to which I think is really valuable. So, thank you.

Terry (45:06)

Yeah, yeah. You want to do the last question? We have a last question we ask everybody, Matt. Are you ready for this?

Mei (45:13)

In the course of your professional work, what is one word that has anchored you?

Matt (45:21)

Integrity. It means no matter what the other person is doing, you try to find something good about them. No matter what the other person is doing, you try to get their perspective. And

no matter how much you dislike them, you treat them in a way that you'll be proud of today, tomorrow, and next year.

Terry (45:51)

I think it's kind of a wonderful way to end, don't you think, Mei?

Mei (45:54)

It really is.

Terry (45:56)

So that's a lovely message. Yep. Yep.

Mei (46:00)

I was very excited, Matt, when I first brought it up to advisory council, I really want to interview Matt. And they said, of course. And when I reached out to you, it this is the kind of interview that I imagine because I've heard you talk before, I've been to your presentation. And I feel like many colleagues and even social work students who are aspiring to work in this field. it will touch their heart. So really appreciate you for giving us your time to be part of this interview.

Matt (46:32)

Well, I you know it, really intimidating to have Terry on the line. You have to know that for me. It's really intimidating. She's so smart. And you are also. And thank you. I'm glad to touch the heart, but the place I want is - I want that space between the head and the heart. I want the compassion and I want the courage. And I think we all need to have both.

Terry (46:57)

Thank you, thank you.

Matt (46:58)

Thank you.

Mei (46:59)

Thank you so much.