morality of profession)

b. Approaches to ethical inquiry: principle-based ethics, virtue-based ethics, casuistry, feminist/caring/existentialist ethics, theological ethics

c. Ethically relevant considerations:

1) Balancing benefits and harms in the care of patients
2) Disclosure, informed consent, and shared decision making
3) The norms of family life
4) Relationships between clinicians and patients
5) The professional integrity of clinicians
6) Cost-effectiveness and allocation
7) Issues of cultural and religious variation
8) Considerations of power (Fletcher et al.)

d. Grounding and source of ethics: philosophical (based in reason), theological (based in faith), socio-cultural (based in custom).

5. CRITIQUE: It is important to be able to critique the decision that has been made by considering its major objections and then either responding adequately to them or changing one's decision. The health care professional should also seek her/his colleagues' input when time permits, and some cases can be taken to an ethics committee for further reflection. Retrospective analysis is also useful in preparing" for the next time" such a situation is encountered. ❒

Advocacy Competencies

A. Supporting Autonomy

1. Determining and documenting the patient's decisionmaking capacity; ensuring that agency/institutionnl policies specify how this is to be done and identify responsible parties.
2. Protecting the right of patients with decisiomnaking capacity to be self-determining
   a. Facilitate communication and documentation of the patient's preferences
   b. Anticipate the types of treatment decisions that are likely to need to be made
   c. Assist in the preparation of advance directives.
3. Promoting authentic autonomy; Authentic decisions reflect the individual's identity, decisional history, and moral norms
4. Identifying the morally as well as legally valid surrogate decision maker for patients who lack decision making capacity
5. Supporting the surrogate decisionmaker, clarifying the surrogate decisionmaker's role
6. Identifying limits to patient/surrogate autonomy and limits to caregiver autonomy
7. Developing agency/institutional policies which identify the caregivers responsible for and the procedures to be used to identify and support the appropriate decisionmakers.

B. Promoting Patient Wellbeing

1. Clarifying the goal of therapy: Cure and restoration; stabilization of functioning; preparation for a comfortable, dignified death
2. Determining the medical effectiveness of therapy
3. Weighing the benefits and burdens of therapy
4. Ensuring that all interventions are consistent with the overall goal of therapy
5. Ensuring that the patient's priority needs are addressed (bio-psycho-social-spiritual needs)
6. Ensuring continuity of care as patient is transferred among services, and within and without the institution
7. Weighing the moral relevance of third party interests (family, caregiver, institution, society)
8. Identifying and addressing forces within society and the health care system which compromise patient wellbeing

C. Preventing and Resolving Ethical Conflict

1. Establishing that preventing and resolving ethical conflict falls within the authority of all health care professionals engaged in the care of a patient
2. Developing awareness of and sensitivity to the conscious and unconscious sources of conflict
3. Facilitating timely communication among those involved in decisionmaking: one-on-one meetings and periodic meetings of the patient. family and interdisciplinary team to clarify goals and plan of care
4. Documenting pertinent information on the patient record
5. Referring unresolved ethical issues to the ethics consult team or the institutional ethics committee
6. Identifying and addressing system variables which are contributing to recurrent ethical problems.

Delivering OR Staff Beyond The Basic Orientation

By Yves Panneton, RN, BSc., BBA

It is difficult, in the current context of staff shortage and financial restraints, to conduct staff development beyond the orientation. With one hour a week, a global vision and the combination of a few basic strategies, the perioperative educator can push the envelope.

Staff development is a planned process of learning experiences intended to enhance the employee's contribution to organizational goal. The goal is to improve an individual's abilities and bring them in line with existing or anticipated job requirements (Heneman, Schawab, Fossum & Dyer, 1986).

According to the organizational communication model, four areas of the organization should be considered at once when developing an organization. In a nut shell they are:

(i) The process (how things are or should be done);
(ii) How to teach new skills or re-enforce the current practice;
(iii) The group dynamic; and,
(iv) How the organization adjust to change and/or new situations (Laramee, 1993).

The interpretative school in the field of organizational communication states that an organization is the result of an implicit bargaining amongst the player of the organization (Charron, 1995).

Therefore, to be successful, a staff development program in the operating room should allow a two way exchange between the staff and the perioperative educator. Somehow, it should be able to look at how things are done and what can be done to improve them. When implementing new skills, the program should consider the impact on the group dynamic and offer ways to do adjustments as the new skills are being implemented.

Because staff development has an impact on the operation of the operating room in general, all educative interventions should involve the unit manager, the unit assistant and the perioperative educator. The unit manager facilitates staff development by virtue of his/her authority and orients the development to meet new or anticipated needs for the operating room at hand. The unit assistant acts as a first responder in "ironing out the wrinkles" of the undergoing change. Finally, the perioperative educator provides the knowledge and/or the skills needed by the staff. The perioperative educator can also acts as a "liaison officer" between the operating room and the other units when a change occurring in the operating room has an impact on units/departments outside the operating room. This facilitates the adjustments of the units/departments involved with the operating room.

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To have an educational program that meets the criteria of the organizational communication model, a few strategies are available to the perioperative educator, the unit assistant and the OR manager. One of these strategies is the staff meeting where administrative issues are discussed. This phase is mainly the responsibility of the manager.

The in-service provides learning activities to meet the expectation of the employer. It can also be used to develop specific knowledge, skills or attitude (Phippen & Wells, 1994). For example, it can be used to reinforce proper practice as per AORN and/or ORNAC standards, and to review the use of rarely used equipment or how to operate new equipment introduced to the operating room.

Continuing education activities consist in planned learning activities intended to enhance the education, the practice, the administration, and the research skills of the nurses for the purpose of improving the health of the public (Phippen & Wells, 1994). These activities could be used for two main purposes. The first one is to teach new skills and/or competence to the staff in preparation for an anticipated change in the operating room. The goal is to prepare the staff for the planned change by giving them in advance some of the tools which will be required. The second way to use these activities is to prepare the staff to challenge the Canadian Nurses Association certification in periopeative nursing. A cyclical program can be developed that will address the main objectives of the examination. It provides an opportunity for the new staff to build up their skills and for senior staff an opportunity to refresh their skills.

Reflective Practice

Reflection on action (reflective practice) is thinking back on what we have done in order to discover how our knowing-in-action may have contributed to an unexpected outcome. It may be done after the fact or while in the situation at hand (Schon, 1987). Reflective practice can be used to review a critical incident that has happened in the operating room - discuss what has been done and plan a course of action in case the event happens again. It can be used to review new trends in the operating room (from articles, conference attendance, etc.) and discuss how these could be applied to the operating room at hand. Finally, reflective practice time can be used to discuss current practice in the operating room generally and how overall practice might be improved. It is then an informal forum to discuss quality of care and/or quality of life at work.

Quality Assurance Program

An individualized quality assurance program could be implemented. The College of Nurses of Ontario (2000) has developed an interesting model that can be adapted to develop staff on an individualized basis. The perioperative nurse does a self assessment of her practice. She then asks a peer to do the same assessment on her. Combining the two evaluations, the three things that are done well are identified, as well as three things that could be enhanced to improve the practice of the practitioner. An individual and personal learning plan is then elaborated.

With one hour once a week, an educational program could look as follows:

- Week one - staff meeting.
- Week two - in-service.
- Week three - reflective practice.
- Week four - continuing education.
- Once a year - individualized assessment and learning plan.

One of the aims of the continuing education program is to prepare staff to challenge the Canadian Nurses Association certification exam. Those already certified should received in-house certificate for their participation in educational activities counting towards their re-certification.

Participation in educational activities outside the operating room (workshop, conferences, etc.) should be encouraged and facilitated.

The perioperative educator, the unit manager and the unit assistant are key figures to oversee and coordinate the implementation of the corrective measures resulting from the reflective practice sessions.

The yearly individual assessment should include a self-assessment and the assessment of a peer. The learning plan can be done in collaboration with the perioperative educator.

Using the organizational communication model as a background, the proposed educational program proves to be effective because it provides a forum for discussion and exchange on the practice in the O.R. While providing learning opportunities it takes into consideration staff feedback when implementing new skills in order to facilitate the staff adjustments. And all this in a very simple and cost effective way ! ❐

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