My objective is to provide an incentive to those who are afflicted with this addiction and to encourage them with ways that I found beneficial in dealing with the nasty habit.

My doctor's advice was to try the 'patch'. Now, I thank those responsible for such an aid as it helped me achieve my goal to give up cigarettes. The medication was not covered by Blue Cross and in the end that was a Godsend as, being Scotch, I kept reminding myself what the cost would be if I regressed and had to begin again.

We are all creatures of habit and certain areas require adjustment if addictions are to be contained/ conquered. Examples include:

- Listen to smoking cessation/relaxation tapes;
- Drink plenty of fluids excluding alcohol, tea, or coffee to rid the body of harmful agents more quickly;
- Temporarily, some weight gain will occur, so resign yourself to the fact. This may be decreased, however, by keeping foods, i.e. vegetable sticks and fruit, readily available and within sight in the fridge;
- Replace the after-meal cigarette with a form of exercise as this helps to lessen weight gain, reduces craving, and increases energy levels;
- At first, attend movies instead of parties where alcohol will be served;
- Replace a 'favorite chair' with another in which you did not smoke; and
- In the beginning, choose the company of non-smokers to lessen temptation.

Come join the many who have decided to regain control of their lives. It is not easy but, believe me, it's worth the effort!

On behalf of the ORNAC Board and Executive, I wish you happiness, good health, and prosperity in the new Millennium. May your dreams come true and your goals be realized. ■

Correction

Canadian Post Basic OR Education Programs were listed in the June, 1999 issue of the Journal (p 5 & 6) as "ORNAC Approved". Only two programs are approved by ORNAC- St. Paul's Hospital Perioperative Nursing Program, Vancouver, BC, and SAIST Wascana Campus Program, Regina, SK. See pages 28 and 29 of this current issue (December, 1999,) for full details.

The editor apologizes for this error and any inconvenience caused by the publication of this misinformation. All other Programs listed have not as yet applied to receive ORNAC's endorsement.

The criteria for ORNAC's Approval Process is being revised and five other programs have applied to receive an application. Updates will appear in early issues of the Journal in 2000.

Winnipeg's Pediatric Cardiac Inquest - A Nursing Perspective

By Carol J. Youngson, RN

What happened to my colleagues and me over the past 5 years is something that every nurse has experienced in some way and to some degree in his or her career. What happened to us can happen to any nurse - anywhere.

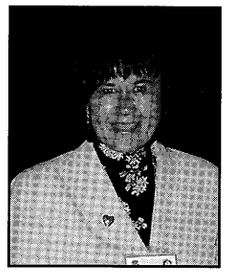
Our story will ring true to all nurses who have been in the front lines of the health care system, because that is what nurses are ...the front line caregiver. One of my colleagues put it so well... " we are the ones who hear, see and do for those who cannot".

Patient advocacy is so important to nurses - it is the foundation upon which we build the trust of our patients and their families. In 1994, as nurses involved in the pediatric cardiac program, we tried to advocate for our patients and were not allowed to do so, thus putting us in a situation of moral compromise.

In 1994, I was the nurse in charge of the Pediatric Cardiac Operating Room at the Health Sciences Center in Winnipeg. I held this position for several years and was looking forward to working with a new surgeon, Dr. Jonah Odim, who had been recruited from the United States. Our previous surgeon, Dr. Kim Duncan left the hospital in June, 1993 to practice in the U.S. About eight months later Dr. Odim arrived to take his place. The Cardiac Team was pleased that the Centre had been able to attract a physician with such impressive credentials. We were told he had an Ivy League Education, years of training, and perhaps most impressive was his training at Boston Hospital For Sick Children, a world-renown center for pediatric cardiac surgery. Our expectation as a team was that we would restart the Cardiac Program on a gradual basis beginning with low risk cases, and then to eventually increase the complexity of the procedures as we got to know each other and gain familiarity with the procedure.

Over the 10 months, we were to learn that what looks good on paper does not necessarily translate into practice. Almost immediately, we began to see problems with technical issues in the operating room. Problems included children who were encountering excessively long pump runs, surgical repairs failing and having to be redone, and bleeding far in excess than what we had experienced in the past. What we had always considered routine cases, were turning into marathons with infants and children with severe and life threatening complications. About a month into the program we had done several cases. Some cases had gone well, but three patients out of the three Ventricular Septal Defect repairs that had been performed by Dr. Odim were dead. These cases were considered low to medium risk and had, in the past, been routine for us. In all three cases the child had bled to death.

Author



Carol J. Youngson, RN, has over 20 years experience in adult and pediatric heart surgery. She was Charge Nurse, Pediatric Cardiac Surgery, Health Sciences Centre, Winnipeg, during the events described in this article.

She is currently Investigator for Chief Medical Examiner, Manitoba Department of Justice. This is an adaptation of her team presention to the16th National Operating Room Nurses Association Conference, Halifax, June, 1999.

Two of the three little patients had to have their repairs redone because the initial repair had failed or leaked.

The second child, a nine-month old named Jessica Ulimaume, went to the Pediatric Intensive Care Unit (PICU) on Extra Corporeal Membrane Oxygenator machine (ECMO) which is a form of bypass used as a last ditch attempt to support a patient who is unable to maintain adequate blood pressure and oxygenation. Three days later the surgeon decided to remove this child from the ECMO machine without any OR staff present. Apparently this was how it had been done in Boston, but it was not what our PICU staff was familiar with, or comfortable with. While decannulating the infant, a piece of tubing was left unclamped and the baby bled out through it before anyone noticed. As well, the cannulation site on the right atrium was torn and the surgeon was left to clamp off the hole on this tiny heart with his fingers because there were no surgical instruments (or OR staff) at the bedside.

Interestingly, this child's parents were never told of this and it was not until the Inquest was in progress that they were made aware of the reason for their child's death. Nothing was written in the surgical notes, the progress notes or any where at all in the patient's chart to indicate that this event had taken place.

Over a period of about 10 months our Nursing Management repeatedly took our concerns to the hospital administration. Although our nursing superiors took our concerns very seriously and tried to pass them on up the chain of command to the appropriate department heads, beyond that, not much was done about this serious situation.

During this period I was privately making notes on my computer at home about some of these incidents, documention that proved to be very important later.

It wasn't until the 5th death occurred, in May, 1994, that the program was examined, and only after the cardiac anesthetists, who shared our concerns about what was happening, threatened to withdraw their services.

One should note that to that date (May, 1944) we had done 11 open-heart procedures on 10 patients. That put our mortality rate for open heart surgery at 50 percent. We were doing closed cases as well, but that is not factored into this. A committee, known as the Wiseman Committee, was set up to review the program to date. I was the only nurse on that committee along with several doctors. There was no other nursing representation either from the ICU's or the Variety Heart Center. Over the next few months we met to review the cases to date. At no time were the real issues addressed - the real issues being surgical competence, communication problems, and a program moving too fast.

Again of interest, is the fact that when nursing concerns were discussed at these meetings, no mention of that discussion appeared in the minutes taken by the chairman Dr. Nathan Wiseman.

Over the summer, we did only low risk cases. For the most part, the outcomes were good, although we were still seeing serious technical problems in the OR, and some hair-raising and near fatal mishaps occurred.

In the fall of 1994, under pressure from Dr. Niels Giddins, then Chief of Cardiology, and Dr. Odim, the pediatric cardiac surgeon, we again embarked on a full program. Once again, the patients started to die and once again nursing went through the proper channels to report their concerns. It again appeared that no one with authority was prepared to do anything about the situation. Some of the OR staff in frustration started talking amongst themselves, trying to decide what the right course of action would be. Should we talk to the parents? Should we talk to the media? Where could we go to be heard?

I found that I could no longer go to the waiting room to take a child out its parent's arms and into that OR. I assigned that job to some of the other nurses who didn't do cardiac cases on a daily basis. It was just too hard. I wanted to tell these parents to take their child and run!

On Grey Cup Sunday, 1994, my worst nightmare came true. All year, I had watched this surgeon struggle with the cannulation of these tiny vessels, often tearing them in the process. I was sure that this would eventually result in a death of a child in the OR, and on this day I saw it happen. The repair on Jesse Maguire's heart was complete and things were looking pretty hopeful for this tiny three-day-old baby. As I looked away at my back table in the OR for an instant I heard a gasp. I looked back at the heart and saw that the aortic cannula, which supplies oxygenated blood to the child from the bypass machine, had been knocked out! There ensued several minutes of desperate manipulation to try to get the cannula back in. In

doing so the surgeon tore, and thus destroyed the aortic repair that he had just completed, millimetres from the cannula site. He now had to redo it. This meant more bypass time for an infant too small to tolerate such a lengthy procedure and Baby Jesse died on the OR table after 13 hours of surgery.

Our Concerns Were Reported to the Head of Pediatrics

This time, I took my concerns to Dr. Brian Postl, at that time, the Head of Pediatrics. He promised me that he would look into the situation. However it was not until another neonate died a few weeks later, after what was in our experience a routine, low risk surgery, that the Department of Neonatology finally had enough. Too many of their patients had either died under questionable circumstances, or had unusual and severe post operative complications. Right before Christmas, 1994, the program was shut down, and Dr. Jonah Odim was encouraged to take a "vacation". By then, 12 children were dead. They were:

Gary Caribou,
Jesica Ulimaume,
Vinay Goyal,
Daniel Terziski,
Alyssa Still,
Shalyn Pilar,
Aric Baumen,
Marietess Capili,
Ashton Feakes,
Erica Bichel,
Jesse Maguire, and
Erin Petkau.

An external review conducted by a cardiac surgeon and a cardiac anesthetist from The Toronto Hospital for Sick Children was conducted and found numerous problems with the pediatric cardiac program.

On Valentines Day, 1995 the Health Sciences Centre sent out a press release stating that the program was:

> "Under review for six-months because the patient outcomes have not achieved the standards which the hospital hopes for."

Parents of the deceased children demanded answers. Why weren't they told about these problems? Why weren't they told that this was Dr. Jonah Odim's first job? Why weren't they told about the slow down in May and the Wiseman Committee? And perhaps most important, why weren't they given the option to take their children elsewhere, especially the complex, high-risk cases?

The Inquest

The aforementioned are some of the questions that formed the basis for the Pediatric Cardiac Inquest which has the dubious distinction of being the longest running Inquest in Canadian history to date. The Inquest began in March,1996 and I testified for 13 days over a period of about six-weeks in the fall of that year. Five of those days were under cross-examination by the lawyer for the surgeon. I was also cross-examined by lawyers for the anesthetists, the Health Sciences Center and the families.

Members of the patients' families, parents, grandparents etc., sat in the gallery while I testified. Sometimes I would see or hear them weeping as I related the events I had witnessed concerning their infant or child. It was very difficult to talk about the details of a child's death knowing that the parents were there in the room listening.

In the fall of 1995, as the Inquest was beginning, and after reviewing the notes that I had made at home about some of the events I had witnessed in the OR, the Health Sciences Center decided that the evidence provided by nursing could prove to be a "conflict of interest" for the Center. We were advised by the H.S.C. that we should seek our own legal council. In other words, it seemed to us at that time that our employer had set us adrift.

Nursing Needed Separate Legal Standing

We were unable to secure legal council from the Canadian Nurses Protection Society, because we were not being sued, so we approached Manitoba Association of Registered Nurses (MARN) for help. We were desperate and terrified.

Isobel Boyle, the Director of Patient Services at Children's set up a meeting with MARN. I will never forget it. Diana Davidson-Dick, then the Executive Director of MARN and Beth Kidd listened to our story.The Board of Directors of the MARN was approached on our behalf. Diana had been involved in the Grange Inquiry in Toronto investigating Susan Nelles. Our situation seemed all too familiar to her and it was clear that nursing needed separate legal standing.

Diana sat in the courtroom during the Inquest as several of us testified. She was a visible reminder of the fact that the MARN was behind us. I feel very strongly, based on my experience in that courtroom, that if we had to depend on the Hospital to act on our behalf, we might be in a very different situation today. We feel we owe the MARN a huge debt of gratitude, (I will never complain about my dues again).

MARN Support

Because of strong leadership at that point in time and the foresight of the MARN Board of Directors, we were able to secure the legal expertise that has been demonstrated time and time again in that courtroom on our behalf. Colleen Suche of the law firm Suche Gange acted on our behalf. We are forever in her debt. She sometimes pushed us beyond what we thought we were capable of doing in that courtroom. . .there were days when I thought I just couldn't go back there again, but she was there with us throughout the whole ordeal, never backing down, always standing up for us, personally and for our profession as a whole.

I am sure every perioperative nurse understands that the situation my colleagues and I found ourselves in 1994 is not unique. Many nurses have observed incompetence and poor patient management in their careers.

How do we balance our conflicting obligations to our patients, colleagues and the institution we work for? In 1994 we were placed in a position of moral distress. Over the past 5 years I have gone through what some might call the stages of Grief.

1. Shock and denial: How could this have happened? Why were nurses' concerns not taken seriously? Was it because we were women and were viewed as over emotional, hysterical, too subjective? All of us were experienced, capable nurses, accustomed to dealing with life threatening situations.

2. Bargaining: If I had worked just a little harder, or tried to get along with the surgeon just a little better, perhaps the situation would have been different. I was in fact blaming myself for some of the problems.

3. Anger: I was angry and disappointed when people with whom I had worked for years failed to act on my concerns. I felt betrayed and undervalued as an experienced professional.

4. Acceptance. I have been able to put a lot of what happened behind me now, knowing that I did all that I could do within my limited power at the time. Hindsight is 20/20 they say. Certainly, if I had known then, what I know now, perhaps I would have done things differently, but to dwell on that is a waste of time.

Because those of us most intimately involved in the events of 1994 and the subsequent inquest have shared so many of these feelings, we formed a support group called *The Broken Hearts Club.* We are a club of six: Irene Hinam, a high risk anaesthesia nurse; Carol Bower, another OR nurse; Joan Borton from the Variety Heart Center; Deb Armitage from NICU; Donna Feser from PICU; and myself. We have added one more member, who is not a nurse, but who has an intimate knowledge of what it means to be one and that is Colleen Suche, our lawyer. We meet from time to time, less frequently now than when we were testifying , over dinner or drinks to talk about issues that arise from time to time. Lately, it is mostly to discuss and plan our speaking engagements of which there have been several. Believe me when I say we are so gratified to know that there is the interest out there.

We know that many of you have experiences of your own to share. Many times I have been approached by a nurse after one of my talks, some in tears, who have a similar situation or experience that they want to share.

Inquest Recommendations

Judge Sinclair who conducted the Inquest is expected to have his recommendations published early in 2000. As you can imagine, it is a monumental task. The Pediatric Cardiac Inquest lasted for 2 1/2 years. There were 278 days of testimony, 86 witnesses, and almost 50,000 pages of evidence on record. It is the first Inquest in Canadian History where registered nurses had separate legal standing. It is also the longest Inquest in Canadian history.

At the conclusion of the Inquest, all parties were asked to submit their own recommendations to the Judge. Nursing submitted a lengthy document from which I will share the highlights.

1. Patients and families must be recognized as members of the decision making team,.ie informed consent cannot occur unless all the information is shared. Marietess Capili's father expressed it so well when he said:

> *"My right to serve my child's best interest was stolen from me by lies and misrepresentation".*

2. Nurses must be equal partners with physicians in Healthcare. That is not just because of the significance of the role of nursing, but to ensure that responsible nursing occurs.

3. Participants in the healthcare system should be held accountable consistent with their authority, power and degree of control. Currently, nurses are accountable, liable and responsible, without the requisite authority, power or influence.

4. Reporting lines must be logical and well known within the facility.

Early in this century, doctors practiced medicine and nurses provided many services more similar to housekeeping duties than patient care. Ás a student nurse in the late 60's, we were taught how to "damp dust" around the patient's unit.

Today, nurses make up the largest profession in health care system, with the highest percentage of women. Studies have shown that higher numbers of Registered Nurses on hospital units are linked to lower mortality rates and decreased lengths of hospital stay. Yet a dangerous trend towards reducing registered nursing care in hospitals has been in evidence over the last few years.

Nurses are involved in high-tech care one moment and the next moment they may be doing what many consider trivial work, such as bathing, feeding or just talking to their patient. These trivial tasks don't mean that we are not highly skilled. They allow us to explore our patient's physical and emotional state. This is a key point about nursing that one could miss in our high-tech environment.

Conclusion

Yes, we know how to run the complicated pumps, monitors and other machines at the bedside, and a whole complex of technlogical advances in the OR, but it is our *patient* who is our first and foremost concern. Nursing isn't just a matter of fluffing pillows and providing TLC, it is literally a matter of life and death. Unfortunately we still work within a patriarchal system. All of us who work on the frontlines know that. until nurses are heard and their concerns taken seriously by the medical profession and hospital administration, situations like this described here will continue.

A clear understanding of the role that nurses play in the delivery of patient care, the recognition of the expertise that nurses bring to their work on a day to day basis, as well as meaningful collaboration with our medical colleagues, are the goals we must work toward in the future as we welcome the new millennium.

Our experience was a clear example of how nursing concerns were dismissed in the face of glaring evidence to support them. To reiterate my first comments, and what all nurses know - this tragedy could happen to **Any Nurse - Anywhere.**

Winnipeg's Pediatric Cardiac Inquest: The Ethical Issues

By Irene Hinam, RN

I will begin my case presentation by telling my story and then describing some of the ethical issues that challenged those of us most intimately involved with the Cardiac Surgical Program at Children's Hospital, HSC, Winnipeg, Manitoba in 1994.

As of February, 1994 I had been a registered nurse for 22 years. From 1990 to 1994, I was a High Risk Anesthesia Nurse at the Children's Hospital in Winnipeg, a position I continue to hold. Prior to this I had been the Assistant Head Nurse in the Pediatric Intensive Care Unit at the same hospital for nine years.

In my role as the High Risk Anesthesia Nurse I am responsible for assisting the anesthetists with patient care during cardiac and other high risk surgeries. This includes helping them with the set up of non-invasive and invasive monitoring, preparing medications and infusions, drawing blood, etc. Also in this role, I do follow-up on all postoperative inpatients in PICU, NICU and wards. I have other responsibilities but these are the pertinent ones concerning the cardiac program.

Our cardiac program has had its ups and downs since 1980. In 1986 a cardiac surgeon, Dr. Kim Duncan was hired to set-up our pediatric cardiac program. The program ran under his guidance until 1993 when he left for a new job in the United States. My job until this point had been both challenging and very rewarding.

I had felt we had an excellent program that the province of Manitoba could be proud of and could feel comfortable that their children were receiving the best of care.

All that changed in 1994 .We found out there would be a new surgeon starting in February. My colleagues and I were thrilled as we enjoyed our jobs and felt sad that for almost a year the children of Manitoba requiring heart surgery were being sent elsewhere.

The new surgeon, Dr. Jonah Odim, we were told, would be a great asset to our small program. When asked why he chose to come to Winnipeg he said:

> "I would rather be a big fish in a small pond,
> than a small fish in a big pond".

Beginning of a Nightmare

We started heart surgery in March, 1994. This was the beginning of a nightmare. During the first several cases, as you may have read in Carol Youngson's presentation in this issue of the Journal, the new surgeon was having many problems with his surgical technique. I was away for the first few cases, but on return I also observed he was still having difficulty.

Since I am not an OR nurse I was not at his side constantly, but I had a good view of the operative field on and off throughout the surgery. I therefore felt I was able to make a comparison to our previous surgeon. What I saw was a person that treated the heart, even the newborn heart, very roughly. He took a long time to do the surgery, pump times were often lengthy, bleeding was often excessive, skills appeared careless, and often the children did not do well postop, if they were able to leave the OR at all.

In the first three months we lost five (5) babies and

Author

Irene Hinam, RN, is a Pediatric High Risk Anesthesia Nurse, Children's Hospital, Health Sciences Centre, Winnipeg, Manitoba. She has 27 years experience as a nurse, eight of those years as a high risk anesthesia nurse. This article is based on her presentation to the ORNAC 16th National Conference in Halifax, June, 1999.