**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.

those that survived often had very rocky courses. Carol Youngson and myself had taken our concerns to our Head Nurse and to the Director of Patient Services in April, about six weeks after Dr. Odim started.

Shortly after this Carol Youngson and Carol Bower, started documenting all the problems incurred during each case. Joan Borton also reported her concerns about the program to her direct supervisor, as well as to the Director of Patient Services. The Director of Patient Services, Isobel Boyle, listened to all our issues and would discuss these with the Clinical Head of Children's Hospital. Then the anesthetists threatened to withdraw their services and an internal review was finally initiated. As a result, surgery was reduced to low risk cases. It was not until doctors stated their concerns regarding the program that anything was done.

## Constant Questions from ICU Staff

By the end of August, two months after the "slow down", we were back to doing all cases regardless of the difficulty. While doing post-op follow-up on these children that either died later in the ICUs, or that did survive, I was constantly assaulted with questions from the ICU staff as to what was happening in the OR as they were experiencing an increase number of complications. At first I tried not to say much as I wanted to give the new surgeon the benefit of the doubt, but that soon became very difficult. Many who knew me could see my tears of frustration. I would often go home and cry. I had my share of sleepless nights.

The PICU staff were verbalizing concerns to me about the increased complications they were witnessing such as bleeding, pneumothoracesis, the need for both permanent and temporary pacemakers. In fact, at times they were even running out of pacemakers. They also mentioned concerns regarding the increased occurrence of children returning from the OR with their chest left open. Procedures were now being done in the unit that had previously been performed in the OR. An example would be closing an open chest. OR staff were not being called to assist the PICU staff with these operative procedures.

Equipment was being asked for by the surgeon that the PICU staff had never heard of. Yet, when the surgeon was asked what they could put together to have available for him, the response was "I'll use whatever you have". In the end, Carol Youngson and myself met with the Unit teacher to develop a cardiac bin.

PICU staff, at one time, competed to admit the cardiac cases; now staff were trying to avoid these children. Many stated that at one time they were able to give the parents an idea of their child's course in PICU, but now had no idea what to tell them. Children with certain defects that formerly stayed in the unit one or two nights were often there days to weeks.

Seven more children died from August to December. During this time Carol Youngson, Carol Bower and myself again talked to the Director of Patient Services regarding our concerns. As a result, a meeting was arranged with the Clinical Head of Children's Hospital. After this meeting, another cardiac surgeon was appointed to assist Dr. Odim with all high risk surgeries and neonates. This arrangement did not always happen and in December of that year a tiny infant died during relatively low risk surgery and the program was brought to a halt.

The Head of NICU said the unit would no longer refer cases to our program. Again, action was taken only after a physician spoke up. An Inquest into the deaths of 12 children was ordered.

## The Ordeal of the Inquest

At the inquest I testified for seven days, during November/December,1996; most days lasting from 9:00 am. to 4:00 p.m. I was cross examined by seven lawyers and by the end I began to doubt my own self-worth. Before, during and after the Inquest were very stressful times for me. I began to display both physical and mental symptoms of stress. Many medical professionals were critical of our actions. An example: my niece's doctor (who had nothing to do with Children's Hospital) commented to my niece that she could not believe what the nurses were doing to the poor doctor.

> "Did they realize this was his career they were messing with?"

I wonder... Did she realize he was messing with babies' lives?

The Critical Incident Stress Management program gave most of us involved the support that was very helpful. A psychiatric nurse, Elaine Bennett, came to court and supported us during our testimony. Nurses' legal counsel, as arranged by the Manitoba Association of Registered Nurses, Colleen Suche, also prepared us and gave extensive encouragement to handle this ordeal.

During this period I felt a "loss of control" over my life. Decisions were being made for me and some of my time was being dictated. I was thrown into a situation very foreign to me and dealing with new expectations, new language and new people was stressful. The nurses involved organgized a club - the "Broken Hearts Club" and it became my lifeline. The most difflcult time of all, however, must have been what the parents and families of these children were going through. They had to relive the most horrific experience of their lives over and over again, every time they read a paper or heard a news report, or sat in the courtroom.

These parents were unaware of the concerns we all had in 1994 and were not always informed of the details of their child's death. We all expressed our concerns to our nursing superiors as well as the medical administrators. Action was eventually taken, but not soon enough to save these 12 children.

My colleagues and I are all excellent nurses. We love children and we loved our jobs. Having worked in an intensive care unit a total of 13 years, I have seen my share of some of the most horrendous scenarios one can imagine, but I had always felt we had done our best for each and every one of these children and families. In 1994, I did not feel this. I felt sick inside because I knew what was going on was not right. Yet, I felt powerless to stop it. We know we tried, but it was not good enough and these children and families are paying the price!

## Ethical Issues

I have never taken any formal Ethics Courses, so I consulted Dr. Bryan Magwood,Director of Clinical Ethics Services of Children's Hospital. He was able to assist me with some articles and information.

Throughout all of our careers, there will come a time when most of us confront unsafe practices in the clinical setting. Ethical, legal and professional dilemmas may rear their ugly heads, as they did with us. Unsafe practices can occur as a result of incompetence, complacency, emotional or physical illness, laziness, stress, substance abuse or human error. Nurses are often the first to recognize unsafe practices. What can we do when we identify a situation that places a patient in jeopardy? How do we balance our conflicting obligations to our patients/parents, colleagues, institution, society and to ourselves?

Ethics deals with many kinds of moral problems which have in common that they produce discomfort and disquietude among the people involved.

## Moral Uncertainty

In 1994, those of us most intimately involved experienced feelings of *moral uncertainty*. We asked ourselves: What is wrong here? We had feelings of discomfort, a knot in the pit of our stomachs. These feelings occurred at different times for some of us and the reasons for them sometimes varied according to our job, but we all had them.

Early in 1994, Carol Youngson, Joan Borton and I had the most exposure. Carol and I were in the OR for most of the surgeries; Joan was involved with the children and their families in the planning of surgery and post-operatively. Carol and I discussed our concerns regarding the intra-op problems, and because Joan is a good friend, I was privy to her concerns regarding the kind of cases being undertaken and the information the parents were being told. We started meeting for dinner and asking ourselves - Are we overreacting? Have the patients just been more difficult? Are we comparing Dr. Odim unfairly to our previous surgeon? Soon nurses from PICU and NICU were beginning to ask the same questions.

## Moral Dilemma

For us, this led to a moral dilemma. We all had to reflect and look at what was going on. Yes, there was a problem. What could we do about it? All of us reached this stage at various times. Carol Bower started asking similar questions as she started scrubbing in for more cases.

By the end of April, Joan, Carol and I had all spoken to our direct superiors as well as the Director of Patient Services. We spoke of our concerns, what we were hearing, seeing and the outcomes of the surgeries that were occurring. She in turn spoke to the Clinical Head of Children's Hospital and the Vice President in Administration at Health Sciences Centre.

## Moral Distress

Our moral dilemma soon advanced to *moral distress* as we continued to do more surgeries. In our hearts we felt we knew what the problem was - incompetence. However, we were not sure what the right action was and what the repercussions might be.

According to the 1994 CNA Code of Ethics:

> "Ethical Distress" occurs when nurses "experience the imposition of practices that provoke feelings of guilt, concern or distaste".

We were experiencing these feelings. The Code further states:

> "Nurses have a responsibility to assess the understanding of clients about their care and to provide information and explanation when in possession of the knowledge required to respond accurately".

Joan felt she was not able to reassure parents when

they asked difficult questions. Was the surgeon good? Did he have lots of experience? With the previous surgeon she would volunteer information and feel comfortable saying: "If I had a child I would let him do the surgery". Now she found it hard to give the encouragement she was accustomed to giving. Answers had to be professionally worded. If she said how she really felt - would she lose her job, be sued for slander? Any one of us would have taken those risks if it would solve the problem or stop the program.

The first consideration of a nurse who suspects incompetence must be the welfare of the present patients or potential harm to future patients. The patients' perceived best interest must be of prime concern of the nurses.

Could we tell parents how we really felt? After all, we were not surgeons. Did we have any right to question his skills? Carol was finding it more and more difficult to take a child from their parents' arms, and I was having a more difficult time addressing the questions of NICU and PICU nurses. They were asking: "What's going on in the OR?" Staff no longer wanted to admit these patients as they were so unstable and they did not understand why.

Carol Youngson and Carol Bower had started to document cases in detail. During this period of time we were asking ourselves questions like - What else can we do? Do we quit? Will they hire more junior people to do our job and put the children at even greater risk? Do we go to the media? Will they fire us for that?

## Reporting Unsafe Practices

When a nurse reports unsafe practices, she may face a variety of personal and professional harms or burdens. These can include loss of reputation, job security, sanctions for violating the organizational structure or reprisals from coworkers or supervisors. Some individuals who do not report may suppress the injustices, creating unrelieved moral distress, or worse they may leave the profession.

Loyalty to other professionals must be limited by the good of the patient. Therefore, we as nurses had an obligation to take definitive action on the patient's behalf. As nurses we practice according to our code of ethics. However, we are also obligated to abide by institutional policies, rules and expectations. Nurses are expected to be loyal and support the institution where they practice and certainly do not want to expose them to undue embarrassment, loss of credibility, licensure or certification.

We were in a pickle! We did express our concerns to our direct supervisors, Director of Patient Services and to the Head of Children's Hospital. There were some responses in that there was the formation of the Internal Review, a slowdown in surgery, a surgeon available to assist, and the eventual closure of the program. Most of these responses were the result of physicians coming forward and withdrawing services or not referring patients.

## Moral Residue

In the end there is the *moral residue.* This is the intrinsic and lasting emotional feelings that remain after the inability to have done the right thing. It is a feeling that arises when disempowered by others, such as supervisors, rules and regulations. Disempowerment may also be internal when one may not have the personal strength to do the right thing or was hampered by fear. George Webster and Francoise Baylis (1999), define Moral Residue as:

> "The situation of compromised integrity that involves the setting aside or violation of deeply held beliefs, values and principles that can sear the heart. The passage of time may blunt the acute distress, the profound uncertainty and fear, the guilt and the remorse, but people who have lived through serious moral compromise, carry the remnants of the experience for many years, if not a lifetime".

We all have some moral residue. Some of us feel guilt and some of us feel we did as much as we could. However, we all still ask ourselves - Did we do enough? Should we have been more aggressive?

Since 1994, we have all required some psychological counseling, some, to a greater extent than others. Some required Leaves of Absense for a period of time, especially around the time of testifying. Some of us had physical signs and symptoms that needed addressing.

At this point in time we all are doing well and carrying on. I wish to leave nurses with these thoughts: We as nurses are our patient's advocates. When we see the system failing, we are obligated to speak up no matter the repercussions. Integrity, when compromised, is gone forever and not replaceable.

Remember, this can happen to any nurse, any where. ■

---

[1]George Webster and Francoise Baylis, *"Margin of Error, the Necessity, Inevitability and Ethics of Mistakes in Medicine and Bioethics Consultation,"* 1999, Frederick, Maryland, University Publishing Group.



# What Makes Your Day ?

## A Study of the Quality of Worklife of OR Nurses

**By Dr. Joan Donald, RN, MA(Ed), EdD**

In the movie *Dirty Harry,* Clint Eastwood takes aim at a threatening criminal and says: "Go ahead, Make My Day!" Murder was in his eyes and in the intent of the comment.

We can all remember days in the Operating Room when we might have said to a testy surgeon, a demanding anesthetist, or a disgruntled co-worker "make my day!" We can all remember situations where we could have easily killed the people we had to work with. We hated the institution, the government, administration, the boss and the whole health care system.

Interestingly, nurses are naturally caring individuals and such negative attitudes do not sit easily with them. So what does matter to OR nurses ? What affects their daily lives in the workplace? That is the substance of this presentation.

## Introduction

Canada spends 48.9% of its Gross Domestic Product on healthcare. In Ontario, the Ministry of Health reports that 40% of its budget is spent on people over age 65. This means almost half of the healthcare budget in Ontario is spent on 12% of the people.

In *"Boom, Bust, & Echo"* we are told that grey power, or the full impact of our aging population in Canada will only occur 20 years from now. If we are spending so much of our healthcare dollars on those over 65 today, what will that same healthcare cost us in the year 2020?

Unfortunately, very little is known about the relationship between health spending and health outcomes, an area that requires research, particularly as it relates to nursing care and outcomes. Fortunately, such research is currently underway at the University of Toronto with such noted researchers as Dr. Jean Reeder, Dr. Judith Shamian, and other noted scholars.

All across Canada people are restructuring and doing their own thing as they attempt to salvage our healthcare system. No doubt, change is inevitable if our healthcare system is to survive. Organizational redesign has become the answer to what ails the healthcare system. As Hastings and Waltz (1995) maintain, extensive time, resources, and organizational effort have been invested in major organizational change despite the almost total lack of systematic study of the effectiveness of such programs on the intended outcomes.

## Good Nursing Care

An element of importance to the healthcare system is the quality of worklife of nurses. Links have been made between patient outcomes, health care costs, and the quality of worklife of nurses. Lower patient mortality rates have been identified by Aiken, Smith, and Lake (1994) among a set of hospitals known for good nursing care. While other variables undoubtedly contribute to mortality rates, Prescott (1993) concludes that substantial evidence links staffing to mortality, length of stay, cost, and morbidity outcomes. She further suggests that policy makers should take steps to link cost saving measures to patient and staff outcomes. The introduction of the Patient Safety Act of 1996 in the United States supports this sugges-

---

## Author

Joan Donald, RN, MA (Ed), EdD, at the time of this presentation to the 1999 National ORNAC Conference in Halifax, NS, was Associate Director of Perioperative Services, Mount Sinai Hospital, Toronto. This is an abridged version of her presentation.