Sailing into the Millennium: New Waters, New Realities

Dr. Tim Porter-O'Grady, EdD, PhD

What I want to do is challenge your frame of reference, challenge your mental models, challenge not what you know, but how you know it. I want to challenge the way in which you see your relationship to your practice, to healthcare and to the world, and within that challenge begin to create a new context, a new frame of reference for thinking about who we are, where we're going and what it means.

We are all aware of the fact that we are in the midst of major social change. The issue now is to recognize that we are in an age of global change. You need to really understand the significance of that so we can begin to pinpoint what it means for us individually, and as professionals, as those who will be writing the script for the age into which we are moving.

What will be the work required of you at the personal level, professional level and of course the collective level. What will be your individual obligation so that you can begin to discern from your own work, from your own thinking, and your own relationships, what part you will play in creating the future.

As a gerontologist I was reading in the Journal of Gerontology that we now know that the unstressed normative lifespan for the human species is 135 years. Are you ready?

Nobody is confident, nor competent

During this journey into the new age, if you don't have a sense of humour you need to die now. There's going to be a lot of things unfolding in healthcare that are going to require a deeply embedded sense of humour. The wonderful thing about moving into a new age is we don't know what we're doing. Nobody knows what they're doing. When your leaders appear as though they are confident, know they are not. The more somebody appears competent, the more suspicious you have to be of them. That's traumatic. Think about how traumatic that is for us. Nobody is confident nor competent any longer.

The Industrial Age has ended

What are the competencies that are going to be demanded of the world we haven't yet formed but we're moving into without our consent? What are we taking with us and what are we leaving behind?

As we move into a new age we have level playing fields. We're all operating at the same level of ignorance. We're all at the beginning of a new template.

We are at the end of the Industrial Age, the end of a reality that you know. If you are over the age of 18, you were born in the Industrial Age. Now it's ended. Think about what that implies. In what age did you get your values, your knowledge, your experience? The Industrial age. We're at the end of that age, the end of healthcare as we know it, the end of nursing practice as we know it.

Today we are at exactly the same place in the transition to a new age as Florence Nightingale was 100 years ago. She was essentially doing what she was doing at the beginning of the Industrial Age. She was codifying, creating a science component to the art of nursing and formalizing the basic foundations of nursing. She had a tremendous influence on the whole process of organizing, managing and delivering healthcare services. She wrote the first manual of hospital organization for the military. She was a very gifted woman at a very critical time in the transition to a new age. We're at the same time, 100 years hence that Florence was when she was adjusting and adapting to the realities of an Industrial Age.

What part of Florence do we now need to create a new framework for practice. Where we're going is fundamentally different from where we've been. A part of the discernment that needs to occur as we move over the paradynamic boundaries into a new age, is what goes with us from our history. What do we take with us and what do we leave behind?

Nurses are tremendously attached to their rituals and routines. There's rumour that OR nurses are especially attached to rituals and routines. Dispel the rumour by your behaviour. Just think of all of the drama of change that you've gone through as perioperative nurses. Think about the history of perioperative services. Remember 25 years ago today, 83% of the people who came to surgical services were inpatients. Today, 86% of those who come for perioperative services in North America are out-patients. Why? Because it's possible! That's a sign post. It's trying to tell you something. It's trying to make something clear. Think about the activity and the percentage of activity spent on specific kinds of surgical procedures that is not spent anymore because technology has made it possible. Know that 75% of the surgical procedures you are doing in your ORs today will not be present. You've heard that before, but think about what it means for you, your work, your role, your position, your skill set, and think about what it means in terms of the drama that is now playing out and how those rituals and routines will have to be clearly assessed.

When nurses see a new change coming, we design a new form for it. We want to be able to control that change. Many of us are in the OR because we're escapees. There's a sense of order in the OR. When you open the doors you see the impact of technology - a part of the purpose of technology is to create the disorder necessary for you not to hang on to the order. Order is an impediment to change. Part of what we have to do in our journey is to unbundle our attachment to where we were, then engage and embrace the drama of the change. Recognize that at the cusp of a new age the script is unwritten, and we get to write it. That is both a blessing and a curse.

Chaos Serves a Purpose in the Process of Change

I've worked in every province in Canada; with the exception of PEI, and found that every province is in the chaos of transformation. Different chaos, same transformation. People who don't live in Canada think that Canada has one health system. We all know that is not true. Every province is committed to doing it differently.

Clearly it's the drama of the chaos of change. Chaos is an essential constituent of the change itself. It's a requisite. We're moving out of a framework that we know a great deal about and moving into a framework we know very little about and one we must construct as we go. Fortunately the universe and an age change provides us a transitional process. It provides the noise, the cultural framework.

Chaos serves a purpose. The purpose of chaos is to unbundle your attachment to the age you're leaving. The chaos makes so much noise that you can no longer cope with where you are. If you cope, you accommodate. If you accommodate, you slow the process of change. The purpose of chaos is to make nonsense of what once made sense. The purpose of chaos is make your work increasingly impossible to do. Is it working? The purpose of chaos is to make the work you have to do greater than the work you've already done. The purpose of chaos is to confuse your understanding about change. It's to make you uncertain as to where you are with regard to the change.

Years ago you could see a change coming. Now you don't know when one change begins and another ends. Five changes are going on at any given time and you don't know when anyone of them started, or if anyone of them will end. You don't know for sure if there is an end to any of it.

An age change occurs at the convergence of three forces: sociopolitical forces, economic forces and technological forces. Those three forces are always changing.

Stephen Hawking says that change is not something you grab, see or hold. Change is a dynamic. It is the only constant in the universe. Somebody said to him... "When the universe was created ...?" He said "Stop for a minute, you need to know something.

Author

Tim Porter-O'Grady is Senior Partner in the International Health Care Consulting firm - Tim Porter-O'Grady Associates Inc. His focus is systems innovation and creativity as applied to the delivery of health services. He is on the graduate faculty of Emery University, Atlanta, Georgia, and has authored over 130 articles and book chapters, and published over 10 books. He is listed in several different categories of *"Who's Who in America"*. Dr. O'Grady is a member of the New York Academy of Sciences and a Fellow in the American Academy of Nursing. The article is an abridged version of his three-hour presentation to the 16th National ORNAC Conference, Halifax, June, 1999. His conference presentation was sponsored by Johnson & Johnson Medical Products.

It's not finished. It's still in creation. It's still unfolding. It's not over yet". He says change is a continuous, cyclical and endless dynamic that has direction and motion. It is not a straight line and it is not a thing. It is embedded in the experience of the universe. It is a part of our experience. Change is the only constant. [Editor's note: Stephen Hawking, is the brilliant theoretical physicist of big bang and black hole fame. His book *"A Brief History of Time"* spent over four years on the London Sunday Times Bestseller list - the longest run for any book in history. Hawking is confined to a wheelchair because he has Lou Gehrig's Disease].

Change Is Not Optional

There are only two questions you can ask about change: (i) what does it mean to me; and, (ii) what am I going to do about it?

There are people in your organizations that still believe that change is optional. We have to tell them it is not optional. When somebody says "I'm not going to change". You have to say "thank you for letting me know. I'll keep an eye on you. Your suffering will be an inspiration to us all".

The issue is not whether you will change. Nobody is the same as they were a year ago, or 20 years ago. There is no part of our civilization that even resembles that of 100 years ago. We are not consciously, organizationally, systematically, culturally or socially the same. Tomorrow we will be even less the same than we were yesterday.

The question is not about whether or not you will change, it's about how you will change, your willingness to confront the chaos of essential change in a transformational age.

Do you remember the day you agreed to take this journey into the new age? Let me ask the same question another way - do you own a microwave oven? That's the day! You didn't agree to go into this new age through any conscious choice. You agreed to go into this new age through the resonating choices that advance the quality of your life. Everyday you made one of those choices, you took one step further into an age you can now no longer escape. We are already into the new age.

Positively or negative change ?

The universe uses two kinds of energy. It only has two kinds - positive energy and negative energy. The universe will use both to create change. It doesn't care if uses all the energy it has. The black hole is the combination of negative energy, a bursting star is the combination of positive energy. All of that energy is present in the universe. You can change positively or negatively, but you will change.

Change is always moving. There is an invisible band of reality that goes around you and the change you see, regardless of what you do. The band of reality will eventually snap to wherever the degree of pressure requires you to be. That's negative energy. Without consent, without any opportunity to transition, to process, to adjust or to adapt - you will be where ever you are required to be. That's how negative energy works. The thing that is missing is engagement, consent, affirmation and participation. If you see that change is coming, ask yourself "what does this mean to me, and what am I going to do about it?" The minute you say that and engage it, the change is the positive exchange of energy.

The positive exchange of energy is the change that comes from the engagement. In the engagement you discern meaning, value, impact, response, formation, process, construction - doing all of that as we're moving in concert. Through the positive exchange, we're moving to where we're inevitably going to be.

You can choose the way in which you want to change. When somebody says "I'm not going to change" - I say "this will be very interesting for you because you will. The issue is how painful you want it to be." You have the choice over the degree of pain or you have the choice to create the framework, the resonance and the impact of that change in your life by giving it form through the exercise of positive energy.

Everybody doesn't have to change. A commitment has been made by 5% of the people not to change. They're smarter than we are, they've already held us hostage. The 5% are so noisy and aggressive that it looks like there numbers are greater. They are holding us hostage. 95% of human resource policies and procedures are to protect the 5% dysfunctional from the functional. We can no longer afford to be held hostage by those who aren't going change, and it's not necessary for everybody to change. When somebody says they don't want to go where you are going - help them go where they want to go. We're already on our way. The train is leaving the station. Help them with their bags and let them get off.

We've got too much work to do. We've got too much script to write. We've got too much healthcare to change.

Think of the impact of technology on our lives and how it has changed everything. Think of the technology in perioperative services. Remember when cholecystectomy was a six-week experience? It was major surgery, now it's day surgery. Why? Because it's possible.

The Impact of Technology

I've worn thick glasses since I was 8 years old. I'm very, very near sighted. A few months ago I decided to correct that problem. In 7.5 minutes I went from very, very near sighted to 20/16 vision. I can read the numbers on the thermostat at the back of the room.

While I was under that drape for my procedure, I said to myself: What glass grinder am I doing out of a job? What frame maker will no longer have work because this will be the normative way of correcting vision problems in 10 years or less? The oculist will no longer have employment because there's certainly no need for that role and what about the ophthalmologist? Was my guilt sufficient enough to keep me from having the procedure? Of course it wasn't, here I am. My vision is 20/16. Why? Because it's possible. That's the message we need to keep.

We are moving into a new world because of the possibilities that are inherent in technology. It creates new realities, creates a new understanding of our conditions and our circumstances. As we change, as we age, and as we move, technology is going to create increasing difficulties in terms of what we know and how we know it. Just think of the drama of that change as we begin to confront new realities. Think about computer technology and what it has done for the world.

The Impact of Computer Technology

National boundaries, for good or for ill, are becoming more and more artificial. Today, $70 billion dollars will move across the global stage. There was a time not too long ago when economics was a national enterprise. Economics is now a global enterprise and now we are driven by global intricacies. The market never closes.

The issue here is to begin to recognize that on a global stage the realities are different. The sociopolitical issues are different. Much of the social-political reconstruction is a response to technology.

Let me raise one of the most delicate and most important significant political issues of the time - do we need parliament if we can vote on the Internet? How does the Internet alter the democratic process? What if you can get all of the issues and information to everyone? The Internet makes information available everyone. Think about the drama of that, and it's impact on us.

In the past six years we doubled the capacity of all the knowledge we aggregated over past 5000 years. Think about what that implies. You can now access all of that knowledge, wherever you are, if you have the technology. Those of you, who are not computer literate, if you're worried about the future, you can stop now. If you're not computer literate, you don't have one.

Knowledge will double every six months

Computers are the future. Everyday you live, it becomes more and more personal in terms of how it affects your life and what it does to your life.

Did you know that your work is now greater than your ability to do it, because there's more to your work than you'll ever know. Our understanding of that is growing quantumly every year. Look at what's going to happen to knowledge in the next five years. Its going to double, then double again. In 10 years we will double the capacity to know every six months. Can you cope? Think about what that implies. Today you are gaining a dawning reality that you don't know enough to do what you do. More importantly, everybody else is beginning to know that too. They can access the same information you can. Where? *Netscape.com. Netscape.com* is the window to every piece of medical information available in the globe. Anything that is documented anywhere, visualized, codified in terms of medical information is already available to whom? To anybody who wants to access it. You can never, ever again know enough to do your work. How does that affect competence? You can never, ever be competent again. What you don't know is greater than what you do know. In the age that we're leaving, the Industrial Age, we valued knowing. We valued the capacity for knowing. We valued knowledge, and we spent a lot of time getting it.

Take a look at me. I'm a very well educated person. If you didn't know that, now you know. What do I know all about? Yesterday's stuff. My contextual framework, learning and experiential framework is firmly grounded in an age we're leaving. I now realize that I can never know everything I need to know in order to be able to thrive in the age into which I'm moving. Now, I have to unbundle my attachment to knowing because I realize that as I cross the paradynamic boundary into the new age, the new reality is not about knowing. It's about

accessing. In the old age we needed to know how to know. In the new age, we need to know how to access and think of how that changes us. Think of the challenge that it creates. We can never know enough. Think of what it does to physician practice.

The Patient - Physician Relationship

In my own practice in Atlanta, one of our primary physicians came in with an Internet printout and says... "Look at what they're bringing". They're bringing the Internet printouts now. They're writing their questions underneath, and I don't understand what it says...".

Think about the implications here. The physician can no longer be what the physician once was. The physician can no longer be the centre of knowing because it's now possible for me to know more about what I'm interested in knowing than he or she does, simply because of access.

I have access to this knowledge on the Internet. I may not be skilled yet at the questions, but I'm getting skilled at the process. The more skilled I become, the more I make of it, the more I'm going to be able to access what I need. Then I'm going to bring that to the physician and my role with the physician will change because I'm no longer going to the physician for what he knows. So how will this change our relationship with the physician?

What if knowledge the physician has about the diagnosis he's about to make is only 10% of the available knowledge related to that diagnosis? What if it's your diagnosis? How do you feel about that? The physician is making a judgment about your future, your health, your condition and the therapeutic intervention on only 10% of the available knowledge, and you know it. How does that change your relationship with the physician? And how does it change the very character of healthcare delivery. It creates new realities, new priorities, a whole new framework for those priorities. Our priorities are changing.

Chemotherapeutic technology is decreasing the dollars devoted to surgical intervention. Surgical intervention as we know it today is in it's last days. New priorities emerge, a new frame of reference. As perioperative services change, as they become less intensive, less invasive, less functional, and become more focused and more mobile, how will it change what you do, who you are and where you do it?

Nurses are still trying to do what patients no longer need. Why? Because it's possible. Do you think the patient wants to stay for you? It's time for a reality orientation. Our colleagues on the floor don't realize that the bed is on wheels and it's rolling towards the door. The nurse is saying "come back", you didn't get everything I have to offer. We want to do in five days what we once did in 10. We want to do in an hour what we once did in a day. Colleagues, it's not possible.

The patient is not coming back. It's time to mourn the loss. It's a reality orientation that we need. We need it as a wake-up call, a call that's inviting us into a different space and a different relationship with patients.

If you were given a choice between the five-day open heart procedure, or the two-hour procedure, which would you choose? If you chose the two-hour, whose time is no longer required? Whose role is no longer demanded? Whose experience is no longer pertinent to that particular event? That's the drama colleagues. New priorities are emerging.

Shifting Priorities

Our spiritual priorities change when church is over - they become parking lot priorities, because you're determined not to be in the parking lot the same length of time you were in church. I recently left church behind an old couple who may have had the same priorities but not the same pace. Being a tolerant gerontologist I quietly walked behind them. The wind blew up the woman's dress clear over her head and she grabed for her hat. Her husband was horrified. He said "what are you doing grabbing for your hat"? She said, "Look, everything below my neck is 75 years old - this hat is brand new"! She had her priorities in order.

Colleagues, it's time to grab for your hats. Our priorities are shifting and it's time to recognize what that means and where it takes us.

We have is to recognize the the character of the journey is changing. Our work is much larger than we'll ever be able to do and it's changing before our very eyes. Much of the work of this time is to let go. Let go - so we can discern more creatively and more compatibly those things that go with us and those things that stay behind. The very conditions that technology alone created are changing the very character of your relationships in healthcare?

That physician colleague of mine with the computer print out came to a reality that day. He said "I can't be the same physician I once was. They don't come to me any longer for what I know. They are now going to come to me to help them better access what they need to know". Think about that. That requires a different relationship. That requires a different skill set. The next thing he said to me was more important ..."I don't have those skills. It wasn't required. It wasn't essential that I have that kind of relationship. It now demands that I be a partner to this person. I've never been a partner to that person. I've been an ascendant decision-maker. That person came to me because they had to and because of my knowledge and my skill set alone, I had an ascendant relationship with that person". That person making those choices may choose the access and the relationship they will have with the healthcare system. The drama that creates is significant.

Alternative Medicine/Consumer Control

The fastest growing arena of healthcare is alternative medicine. It's growing at 18 times the rate of any healthcare service in the country. Who is control of that growth? The consumer is. Consumers are in control and they pay for it themselves. It's the least validated, least organized, the least substantiated part of healthcare, but it's the fastest growing component because it validates the change in the locus of control that has already occurred - the movement of control of healthcare from the provider to the consumer.

The major role of nursing practice today, at the cusp of the new age, is to transfer the locus of control from provider to consumers and to make sure that the control they have is informed, wise and appropriate. We have to make sure they have the right skill set, not make sure that we do. What if that's the major work? What if the work of the new age is to transfer ownership for decision making from the provider to the person who was once the patient. What if the real goal is to stop providing patient care?

Debedding Healthcare.

Why is the patient a co-dependant, late-stage, passive participating, late engager, too sick to do anything about it player in healthcare at a time when that is no longer a viable model for the future of healthcare? What if the patient is the last thing that we want to have in the emerging healthcare system? What if the dependancy the patient has, we created?

Yes, we do sick good. We're very good at sick. Why? Because we wake up every morning and we pray that those beds will be full so that we'll have a job tomorrow. Now the opportunities, the options and technology is changing the bed as the basic unit of healthcare. What we're in the process of doing is debedding healthcare. You have watched it happen!

In North America, by the year 2010, we will have reduced bed-based healthcare by 637,000 beds. That doesn't mean that people won't be sick, it just means that we will care for them differently. It doesn't mean that people won't need us, it just means that they will need us for different things.

The rate of change in the technology of intervention is now moving at a quantum rate. The outcome of that becomes even more critical when we realize that much of the content of our practice represents what **we were** rather than **what we're becoming**. What if the major work of the profession of nursing now is to assure that people never become patients? How would that change the content of our practice? What if most of the work that you now do in hospitals in the next 20 years will not be done there? Technology is now making it possible so that much of the work of surgery can be done anywhere. Anywhere!! In mobile units.

The age now demands a different frame of reference for who we are and what we do and calls us to a different place. The issue is to recognize that it's going to be noisy, it's going to be traumatic, it's going to be risk-based.

Preparing the Consumer

The consumer needs to be in control, but is unprepared for that control. The consumer is the least prepared for the change going on. What if most of the work of nursing is now preparing the consumer for the accountability the consumer doesn't have? The accountability that was once yours now belongs to the consumer and the accountability that is yours is making the consumer more accountable and therefore more viable. It's a tremendous obligation. It's a noisy place to be. It's a place where there is an entirely different mental model. Think about the changes of the mental model and the change language creates in our mental model. Think about the importance of language.

Remember when safer sex meant your parents were away for the weekend? It doesn't mean that anymore. Language is important. We now have to have a language change. In the old age we took care of patients. In the new age, no more patients. Our goal in healthcare in the new age is to make sure that patients don't happen. Now of course patients will happen, but we want to make sure that that is the diminishing reality in healthcare? In the old age the hospital was the centre of delivering service, in the new age, services are mobile. In the old age, our skill

sets were fixed, finite and functional. In the new age, our skills are forward, flexible and focussed. In the old age, we have a fixed place, a fixed skill set, a process that we went through - in the new age we have a mobile skill set. In the old age, the symbol of advancement in an organization was promotion. In the new age, the symbol of advancement in an organization is mobility. The more mobility you have, the more viability you have.

Change Your Language

There are very few places that you can vertically advance any longer because advancement is now a horizontal equation in a system-driven world. Look at the drama of change. New language. My challenge to you colleagues is to change only two words in your lexicon. See if you can do it. Never use the word patient again. See how it changes your practice forever. Never use the word sick again and see how it changes your work forever. Just try it and see the impact of language.

Language is important and a change of language will be important to you. Try to eliminate those two words and see how difficult it is to get out of your frame of reference. Think about what would happen if the consumer actually did exhibit control in healthcare. Think about the client who comes into your hospital wanting to control just one thing. When the consumer comes to the hospital the last thing we want them to have is an identity. It's not accidental that we strip them naked. We'd send their teeth home if we could.

The Donnelly studies in California indicated that 80% of what a patient receives in a hospital doesn't require that they be naked. They could actually keep their own clothes on. We don't want that because if they did, they'd have an identity and God forbid they should ever act on it. It would throw us into chaos. That's the drama. Think of what we have to unbundle on our way to what technology is creating. Technology is producing the shift in the locus of control to people who are not yet ready to accept it, from people who are not yet ready to transfer it. That's the drama of the new age and critical to our understanding.

Part of the challenge that we have in our journey is to try to discern what are the characteristics of the journey, where it is taking us and what it means to us as we go. The issue isn't whether we're going or not.

Take a look at cardiac services in North America through the introduction of **"staten"?** drugs. The drugs which now lower cholesterol. Look at the impact they have over the next five years in terms of coronary artery surgery and other cardiac procedures. In North American, the introduction of **Staten** drugs will create a reduction from $40 billion in cardiac procedures to $30 billion by 2002. What if your particular hospital services are largely cardiac related?

What does the introduction of only one chemotheraputic process do to our services? What does it do to the mix of economics and activities that we provide? How will it change it.

In Atlanta at Emery University they're doing chemotheraputics now in selective heart cases as the routine. What will chemotherapeutics do to any hospital where 20 or 30% of their surgical or procedural activities are cardiac related? Think about that drama.

Micro Technology Provides Mobility

Technology is growing not at a static rate but at a quantum rate. The more it grows the broader its impact. The more micro the technology, the lower the cost per unit of technology and the more portable it will make us. Increasingly the portability of technology is driving the future of healthcare. What will that portability will do to your practice?

In terms of documentation and communication, I have a computer that I can carry in my pocket. Only this computer is highly mobile and has much more infrastructure in terms of its mobility. This computer has a screen and it has a pencil. When I turn it on and write on the screen, that writing is transferred to text automatically. Whatever I write can be beamed through the satellite back to whoever I'm sending it to as long as they're connected to the same satellite. There's also a camera on this computer that has the potential and the possibility of picturing me on the person who is receiving and picturing them on my receptor set. Beam me up!

This is the device for documenting healthcare for the future. You'll simply carry it in your pocket. When you wake up in the morning and you want to know what the surgical schedule is at home, you'll simply scroll- up your schedule. You'll even bring up your assignment - wherever you are.

Let's say across the city there is a physician who flipped open his computer and put in his code and there is his surgical patient who's lab study was ordered and that patient's name is flashing before him. He punches it and it says "look at lab results". The lab is flashing..... He give the patient an extra dose of whatever ..... Where did he need to be?

If you needed to talk to him, you could dial him up. Hold the computer screen in front of you - why there he is. For the first time in your life you have the physician in the palm of your hands. Where do you need to be? There he is. Why? Because it's possible. Some say technology is inherently alienating - well what do you need to do? Smell his breath?

Tomorrow's Technology Today

This is not tomorrow's technology. The only difference between you and me is that I have the hand held computer today and you don't. That's the only difference. You will be able to manage mobility because increasingly mobility will be the way in which we provide relationships, document our care, and communicate with each other. With my model you don't have to keep notes because it's digitally voice-recorded so that your meeting is compressed in voice-recorded digital processes. You can recall any piece of it you want and so can anybody else with access to it. This is the device that you will have within ten years. Remember, paper documention is a historic process. In two generations from our children's generation, they will not write cursively. Writing cursively will be as historic as pounding letters in tablets. Why? Because it's possible.

We were doing some care planning activities in a hospital a couple of weeks ago, and talking about computerizing a lot of the models and doing the light pen process. One of the nurses sighed and said, "...What's wrong with a cardex?"

Well, there's nothing wrong with the cardex. It's just not the cardex age. It's possible to be different and do it differently and therefore those possibilities will create the essential differences, and we will be increasingly portable in that process. Everyone of us will have that portability. How will it change what we do and how we do it? The greatest impact on future surgery is growth in chemotherapeutic processes which reduce the requirements for surgery. That is the drama that calls us to a different place.

The Drama of Aging

Look at the change in the characteristics of aging and the aging population. W are not going to age like our parents aged. Most of us will live until we're 100 years old. Are you ready? It was a shock to me. My parents are living until they're 90, perhaps 100. It's a guarantee that I, barring accident or trauma, am going to live to 100 years old and I'm only prepared to live until I'm 80. That means I have 20 years that I am unprepared for. I have to work much longer than I assumed. I'm not ready for it.

We're not going to be old like our parents. I'm 52 years of age. I 'm not my parents' 52 and neither are you. Our parents aged acutely and we treated them acutely. We are going to age chronicaly. We are going to die one joint at a time. Perioperative nurses know. We're going to have every joint replaced- one joint at a time.

The Implications of Longevity

We cannot afford to maintain the same kind of healthcare system we have today for the population we're becoming. Society can't pay for that kind of healthcare. It is not possible to care for the aging population that we're becoming, in the same way we cared for the aging population we have now, because we haven't got the resources. When we become, in the year 2050, part of the 30% of society over the age of 65, who do you suppose will have the resources to support our demands if we don't change both the demands and the construct of the healthcare system. There aren't enough people there to pay for it. That's a part of the drama.

Over the next 20 years, Canada and the US, are threatened, at the policy level, with a healthcare infrastructure that will kill them both if we don't alter it. The only way we can alter it at this stage is to unbundle the infrastructure to change the character and the location of its unfolding. That includes changing it to serve those who are under-served, and those who are minimally served.

Two Factors Will Alter Healthcare - Cardiac Services and Aging

I bring up two factors that will alter the healthcare system in major ways over the next two decades: cardiac services and aging. Only two factors out of 325 diagnosis related factors that we could have addressed. If I'm only addressing two factors, and you start thinking of the considerable impact just those two factors have on the future of healthcare, imagine the impact when you aggregate those two factors with all 325 indicators.

Colleagues, it is the end of nursing practice as we know it and the beginning of nursing practice as it will become. We're the script writers. If we're not at the table writing the script for the future of healthcare, remember it's getting written. Ask who's writing it and what do they know? Since they don't know any

more than you do, what does the script look like? The issue isn't whether the script is going to happen, the issue is what is the script going to look like and we're not at the table. The script is non-sustainable if those who live it aren't at the table. We are the scriptwiters ! Make sure the players get to that table when the script is being written. That's the challenge.

Hope of the Future

The hope of the future is directly related to how much of a role we play in writing that script for the future. As a profession, we have the strongest role to play. Do you know that we're the only profession of all of the health professions whose primary role is the management of the journey and not of the events. Our primary role is to see that it's the right journey, that the right events are happening, that the patient's journey is an effective one. We're at every place in that experience in order to ensure that when all of the pieces come together the patient's experience has advanced their conditions and their circumstances. We're journey-based folks, we are interested in the patient's journey not in any given event.

My biggest fear is that we're going to hang onto what we were, that we won't embrace what we need to be to act in the best interests of those we serve. How many times have you watched your colleagues holding desperately to activities they needed to give up ? How many of the processes and functions and activities of perioperative practice really need to be handled by the technical folks so that you can be free to handle the important things. The management of the journey, the understanding of the consumer, the decision the consumer makes, the continuum relationship, the relationships in terms of safety, and value, and health, and sustainability. All of those things are our professional obligation so that the functional obligations do not become an impediment; so that the consumer is protected from the dangers that are present in the techology as it's applied; so that the technology applied advances the patient's situation, circumstances and life. In the old age we managed sickness, in the new age we facilitate life process.

Politics and Good Strategy

We have to remember that a part of the drama is the politics of it. I've had nursing colleagues say to me. "Oh, I don't want to be involved. I don't want to play politics". Well colleagues, politics is the science of relationships. Politics is the game of life. If you don't want to play politics, die! It'll be easier on you.

You play politics in every part of your life. When you go home tonight your husband is going to play politics with you. Your kids are playing politics with you every day. Yes, every day.

Do you have kids under the age of 18? Did you know they were aliens? They are the first generation born into the new age and they're barely, barely tolerating you. They're different from how we were different. Why? Because they were born in the new age. When we have problems with our computer, we still think it's the computer's fault. At home, who do you think we get to fix it? Yep, the kids. If you notice that after they've fixed it and it's working, they sigh. Why? Because they know you're never going to make it. They're going to have to tolerate you through the whole experience. It's a different world and a different place. We're moving to a different place. It's going to be hard work, and we have personal work to do as we begin to move into the new age.

Information Infrastructure

We're moving out of institutional structures and into systems. The architecture for the future of healthcare is no longer bricks and mortar, it is the information infrastructure. The information infrastructure is the architecture of the future of healthcare, it's the cornerstone. In Canada, 50% of the capital resources that will be spent over the next decade will be spent on building the information infrastructure across the clinical structure and clinical system. Information efficiency, efficacy and skill sets will be essential to everyone of the practitioners in increasing amounts of percentages of time and skill.

At the personal level, my agenda is twofold. Number one is to become more technically competent and to be able to interface better with the technology that facilitates my ability to connect. Number two is to build relationships with players I haven't learned to like yet.

New Skill Set for Physicians

Physicians don't realize that the practice of medicine in Canada as it was constructed, is already dead. Physicians have to build a different kind of relationship, they have to be partners. The physician is now a partner with a role to play. That's a new skill set for physicians. Partnership behaviours are behaviours they were never taught. They learned ascendant behaviours. They were the final authority, the ultimate authority. In many of the provinces, there's even legal protection to assure that they are always the final authority. Now that legal protection is no longer adequate to the crisis, and issues, and consumer's concerns that now have to be confronted as a team. In the old days, the basic unit of work in healthcare was the individual. In the new age, the basic unit of work is the team.

Team is a synonym for sustainability. Team and sustainability are essential because no single person creates a sustainable outcome. You can create an incremental outcome but not a sustainable outcome. Sustainable outcomes can only be created through the aggregation of work. What does that mean in practical terms? Nobody can do what you need to do in the perioperative processes alone. The perioperative process is essentially a team-based process. The ability of the patient to thrive is a product of the work of those who did what was necessary to create the conditions of survival and no one person can do that. The greatest lesson for the surgeon is to recognize that the surgeon's skill set, while central and vital to the process, is only one component of what is necessary to the process. If all of the other pieces were missing the surgeon's skill would have no value. But that's a hard lesson for the surgeon to learn.

The Music of The Work

The effectiveness of the surgical procedure is embedded in the concert of work, the flow of the goodness of the process - everything moving effectively - and not simply in the surgeon's skill. So the challenge is to recognize that the sustainability of the patient is the degree of the efficacy and fluidity of the concert and not just the skill set of the surgeon. When I'm going to have surgery, I don't talk to the physician. I call my friends in the OR because they know where the music is. They know where the concert is best played.

Essentially, the circulating nurse is the conductor of the concert. They're the facilitators of the music. Have you ever seen yourself in those terms? That's an essential mental model for the change into which we are moving. The future of healthcare is in every level of service, that relationship, that intersection, that functional interaction is critical to the sustenance of healthcare when the script is health, rather than sickness. That behavioural pattern will be essential to the sustenance of the care we provide. Again, it's a new mental model, it's a new way of looking at it. The politics of building that relationship means being able to confront the issues as they are. Being strategic and wise. Strategy is a part of politics. Politics is just the management of your relationships. We all manage our relationships. Politics is managing your relationships well and recognizing how important strategy is to a character of the relationship.

The issue here is to recognize that we're going to be managing relationships as we build new structures for our future. A part of the understanding is to recognize that at the cusp of the new age, as we cross the paradamatic boundary, as we move into the new age, we as people and organizations are becoming different. We are becoming a learning organization, we are not a hospital any longer. The hospital is what you're unbundling.

Your role as we pass over the paradynamic boundaries, is to make sure the hospital is not the centre of healthcare. Symbolically what you're doing, what you're required to do, is to be to close the door on the Industrial Age and all of its constructs. Then, turn around to perceive what it is we're becoming in the context in which we're becoming. Turning around is important. Part of the unbundling as we pass over to the new age is to become something different. Take a look at the three things that we're going to need to unfold as we become what it is we're becoming: we need to be capacity building; we need a new practice; and, we need to be creating evidence as we create a new healthcare system and move to a new place. It will be very, very important that we do that as a part of our design.

The first thing we need to recognize is that our systems will change as a part of adjusting to the capacity for the future of work. Information technology will now drive the structure of organization. The question that nurses have in the OR is how does information technology adjust what we do clinically, relationally and systematically. How does information technology change what we do clinically, in terms of a relationship with each other, and in terms of the system? How does that information change what I do and what it is I become, and how do I address that?

New Ways of Working

In less than 20 years, as we become more decentralized, most of the surgical procedures done in the surgical suite won't be done in the surgical suite any longer. So a part of your role in looking at your career is beginning to ask yourself some questions: I am not always going to be where I am today. I'm not always going to be located in this place with regard to this service. What does that mean in terms of my mobility, in terms of my fluidity, in terms of my skill set and how does that address how my practice will unfold in the future? There is a nursing shortage in North America - Canada and the United

States. Most of the nursing shortage is in bed-based services. That shortage will never disappear because there are now fewer nurses in the places where there will ultimately be fewer beds. And more nurses are going to places where there are no beds. That is a part of the drama of building new ways of service.

Conclusion

Remember, the script of the old age was late engagement. We waited until people got sick and then provided them good service. Now as technology, economics and sociopolitical change push us over to the other side of the paradigm, what is the script that drives us? What is the role of healthcare? What is the role of your professional practice? Threefold: it's health-driven; it's socially-based; and, it's consumer-orientated, which means that now we have to change the script from late engagement to early engagement, from sick based to health based. From event-driven to continuum driven. Do you see the dramatic shift in the mental model and the service model of the old age to the shift to the model in the new age? Technology now makes it possible for us to follow people's lives. To have in a small world of space all the data which aggregates an individual's life. Now there's dangers in that. There are ethical and legal issues involved in information technology that is digitally-driven. If I can contain all of my patient's life in the palm of my hand, and have every moment of their life as a part of my documentation records, there not ethical, moral, and legal issues involved. That is something we will have to confront in the new age. But now it's possible for us to look at the person we serve in the context of the event within their life, instead of looking at their life in the context of the event, as we did in the old age.

Our major role in healthcare, colleagues, is to reconstruct the hospital. That is our role. That is nurses' role over the next 10 to 15 years. Deconstruct the hospital in order to put healthcare together in a different way in consonance with the drama of technology, politics and economic changes that are driving us. Secondly, nursing practice. The content of our practice is going to be different.

On Monday morning you're going into the OR and you're going to radiate enthusiasm and tell everybody... "It's a whole new world and I have embraced it !" Tell them they're all scriptwiters, and together you are going to write the script for the new age. ■

RNFA Update

By Susan Carver, RNFA

The pilot project at the British Columbia Institute of Technology (BCIT) for the RN First Assistant Course has been in progress since April, 1999. This is a national program done "on-line" and has 17 perioperative nurses from across Canada actively studying and communicating in cyberspace.

The class of 17 registered nurses met this summer in the 'face to face' portion of the program - seven from Ontario, two participants from Saskatchewan and eight from BC.

Meeting together in Burnaby, BC for the week further allowed this first class the time to discuss how they see the future of the RNFA role in Canada. Great friendships were made and a reunion is planned for next year.

The students returned to their respective hospitals fulfilling their internship requirements to the end of the year. Another course has been planned starting in 2000. Information about this course can be accessed through the ORNAC website - **www.ornac.ca**

Marnie Simon, RNFA Program Leader, is to be commended for her work over the past ten years in seeing this course come to fruition. It has been a dream come true for nurses like myself to have access to the Canadian Registered Nurse First Assistant program.

Research is certainly part of a RNFA's role. The nurses from Saskatchewan will be involved in a survey which will show their patient contact during their internship. In Ontario, at the Brantford General Hospital, my colleague Karen Allen and I hope to be involved in a proposed study that asks the question:

"In a Community hospital RNFAs will provide proficient, cost-effective surgical assistants ?"

This study will start in the very near future. These and future studies will hopefully be influential in obtaining funding for this new advanced perioperative nursing role in Canada.

Conference Calendar

October 27 - 30, 1999
Operating Room Nurses Association of Alberta Provincial Conference, "Pinnacle or Precipice". Location - The Lodge at Kananaskis. Contact Connie Schulthess, 703 Penbrooke Rd.S.E., Calgary, AB T2A 3T3

October 30 & 31, 1999
ORNASCO Conference at Pinestone Haliburton. Theme: Relax, Refresh, Rejuvenate. For more information contact Donna Plue or Shirley Shacter @ (705) 325-2237
(705) 325-2692. Hospital: (705) 325-2201

November 15, 1999
Call for Abstracts: Canadian Otolaryngology Head & Neck Nurses 3rd AnnualSymposium, Toronto, ON - May 28, 2000. Deadline for Submissions: November 15, 1999. Contact: Mary Scott @ (416) 340-4665

May 3 - 6, 2000
BCORNG Conference
"A Peak Experience"
Whistler, BC.

2001 in Banff
17th ORNAC Conference - Banff, Alberta. Conference Chairperson Gloria Nemecek.

www@

Websites for Operating Room Nurses:
The Operating Room Nurses Association of Canada website: **www.ornac.ca**

American Operating Room Nurses: **www.aorn.com**

CNO Guide - *"Providing Culturally Sensitive Care"* Spotlighted at International Nursing Conference

A new guide on providing culturally sensitive nursing care, produced by the College of Nurses of Ontario (CNO), the regulatory body for the nursing profession in Ontario, was spotlighted at the International Council of Nurses Conference in London, England this past summer. *The Guide to Nurses for Providing Culturally Sensitive Care* was recently distributed by CNO to its 140,000 members across the province. Four Ontario registered nurses (RNs) with wide experience in different nursing settings presented the document to the London conference.

"It is said that Toronto is one of the most ethnically diverse cities in the world, and other parts of Ontario aren't far behind," says CNO Executive Director Margaret Risk. "Ethnicity is by no means the only component of a person's culture, but this diversity is indicative of the challenges Ontario nurses face in delivering therapeutic care to patients whose culture may be significantly different from their own."

Culturally sensitive care is part of basic nursing practice; CNO identified the nurse's and the client's values and beliefs as key elements in the nurse-client relationship. The *Guide to Nurses for providing Culturally Sensitive Care* was developed through consultation with nurses across the province to help nurses better meet the needs of all clients. It is a core standard of practice document that all Ontario nurses are obliged to be aware of, and to follow.

The *Guide* outlines the basic concepts in learning about culturally sensitive care, and illustrates them with actual case studies. There are several assumptions that form the foundation for providing care that is culturally appropriate. Some of them are:

- Everyone has a culture, and it is not always visible. Culture is much more than just ethnicity, race or religious affiliation.
- Culture is individual. Careful individual assessments are required for each and every client.
- Culture is dynamic. It changes and evolves over time as individuals change over time.
- A nurse's culture is influenced by personal beliefs as well as nursing's professional values.

The nurse works with each client to produce the best possible care outcome.

" This document will be an excellent resource for all Ontario nurses, and we're pleased to have been asked to share it with nursing leaders from around the world," says Ms. Risk. " It's a great credit to all the nurses who participated in its development."