

Canadian  
**Operating Room**  
Nursing Journal

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- ❑ Repositioning Nursing  
Keynote Address by  
Dr. Ginette Rodger
- ❑ ORNAC's 17th National  
Conference Coverage
- ❑ An OR Nurse's  
Cancer Management
- ❑ Dealing With  
Difficult People



Canadian Operating Room Nurses Association of Canada

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# Canadian Operating Room Nursing Journal

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### Editorial Contents

- 4 Coverage of ORNAC's 17th National Conference/Banff 2001** (All Photos By Marg Ensminger, RN)
- 10 Transitions and Challenges**  
The President's Message  
By Mary Knight, RN, BScN, MN, CPN(C)
- 11 The New Millennium: a Surgical Odyssey (Conference Keynote Address)**  
By Ginette Lemire Rodger, RN, PhD
- 18 Open Letter to:** All Perioperative Nurses who wrote the 2001 CNA Certification Exam
- 19 ORNAC In A Nutshell**  
By Margaret Farley (ORNAC Secretary)
- 21 Dealing With Difficult People**  
By Sharon Keenan-Hayes, RN, BScN, CPMHN(C)
- 26 Cancer Management: What a Daunting Experience**  
By Regina Leonard, RN, CPN(C)

**Cover:** ORNAC President Mary Knight (upper right), The Banff 2001 Planners, Keynote speakers: Dr. Ginette Rodger and Chief Roy Henry Vickers, & singer Sydney Montieth.

**2** ORNAC Board  
**10** President's Message  
**18** Author Info & Award  
**28** ORNAC Bursaries  
**29** Calendar & News  
**35** Research Grant  
**39** News & Careers

# ORNAC's 17th National Conference 2001

**Banff, Alberta:** From Australia, Colorado, Newfoundland, the Yukon, the NWT, and all the rest of Canada, a total of 784 delegates gathered in this magnificent mountain resort to hear over 25 speakers and create new memories of good times with old and new friends. The 17th National Conference of the Operating Room Nurses Association of Canada was considered a huge success with full registration, and 87 exhibitors in 146 booths. The educational component, social events-The Brewster BBQ Night and the Odyssey Farewell Banquet set the bar for future conferences a little higher, says President Mary Knight in her first presidential message- p. 10.

Keynote speaker Dr. Ginette Rodger told nurses to abandon false notions of control and accept the reality of change in the workplace, and especially the speed of change. Her address starts on page 11.

Speaker Diane Miller said 40% of nurses' work is unpredictable and recommended we all enrol in the University of Perpetual Learning.

Dr. Robert Buckman, comic, oncology physician and professor taught the nurses how to break bad news, but mostly how to laugh. These speakers' addresses will appear in future issues of this Journal.

▼ The Piper leads delegates across the street to Officially Open the Exhibits: LtoR Warren Morrison of Stryker Canada (NEAC Chairman), Gloria Nemecek (Conference Chairperson), and Kim McLennan-Robbins (Conference Co-chair).



▲ **The J&J Drake Thompson Editorial Award Winner is Muriel Shewchuk** (left) shown with Marlene Hill, ORNAC Past-President. Muriel won for her article "The Future of Nursing in the Operating Rooms of Canada: Are you in the Front Car of the Perioperative Train". The article was published in the December, 2000 issue of this Journal (Vol. 18, No. 4). Peter Steinman, President of Johnson & Johnson Medical Products presented the award plaque and \$3000 prize at the Conference Opening.

▼ **Dr. Ginette Lemire Rodger**, CNA President and Vice President, Ottawa General, delivered the Val Shirreff Memorial Lecture. Her presentation starts on page 11. **Chief Roy Henry Vickers** was the Closing Keynote speaker on "Meeting the Challenge of Life". See page 38 for a report on his address.



**ORNAC Board - 2001/2002** (Back row: LtoR) Rob Richardson, Tina Kennah, Line Boucher, Peggy Ziegler, Linda Socha, Kim McLennan-Robbins, Lyn Thorne, Susan Bell, Diana Mabbett, Lucette McLean, Marla Ewen, Charlotte Roach, and Ray Larkin. **Front row: LtoR-** Laura Ellsworth, Lynn Anderson, Kathy Bruce, Shelly Zareski, Donna Farid, Marlene Hill, Mary Knight, Margaret Farley, Claire Tremblay, Theresa Thomas, Janice Sheppard and Marcy McKay.

Four-year old Sydney Montieth singing *O' Canada* during the opening ceremonies charmed the nurses and engendered nationalist pride in the 784 Banff delegates.



▲ **2001/2003 ORNAC Executive:** (LtoR) Sheila Billiard (Treasurer), Marlene Hill (Past-President), Mary Knight (President), Gloria Nemecek (President-Elect), and Margaret Farley (Secretary).



Sheila Allen, (left) President of the Association of periOperative Registered Nurses (AORN) from the US, is shown with the Banff Conference Chairperson Gloria Nemecek. Sheila will host many Canadians at the AORN 2001 World Conference this September 2- 7 in Christchurch, New Zealand. See page 34 for more information.



3M Health Care became a Silver Sponsor of CORL Network. Shown ( LtoR) Shannon Anderson, 3M Health Care, Sherri Lawson, Muriel Shewchuk (CORL Leader), Val Zellermeier, St. Michael's, Toronto, Bev Borst, 3M Health Care, and Pat Pocock, CORL Leader.



The 17th National ORNAC Planning Committee should take-a-bow. LtoR - Kim McLennan-Robbins, Pat Petersen, Rosemary Strand, Marilyn Starling, Nadine Englehart, Kendall O'Brien, Barb Willis, Carol Neil, Heather Perl, and chairperson Gloria Nemecek.



## CORL Network meets in Banff

The Canadian Operating Room Leadership Network (CORL) is the dream of two outstanding and dedicated perioperative nurse executives - Muriel Shewchuk and Pat Pocock. Their vision is to give perioperative leaders, whoever they are, the opportunity to come together, network, mentor, guide, learn and share knowledge at all levels of perioperative nursing. For the first time CORL's program of leadership sessions were held during the ORNAC Conference week.

Everybody attending reports the star of the show was Sister Carol who addressed "Ethics and Leadership". Running a close second were the sessions on Benchmarking with speakers: Randy Heizer, Pat Pocock, Muriel Shewchuk, and Val Zellermeier.

(These speakers are all invited and strongly encouraged to **e:mail** their presentation for the fall and winter issues of this Journal.

Muriel Shewchuk, **Sister Carol Taylor** (Director, Center for Clinical Bioethics & Assistant Professor of Nursing, Georgetown University Medical Center, Washington, DC), and (right) Pat Pocock, London Health Sciences Centre.

LtoR - Randy Heizer (Principal Consultant J & J Consulting Services, a Gold Sponsor of CORL Network), Val Zellermeier (Program Director Perioperative & Critical Care Services, St. Michael's - Toronto), Muriel Shewchuk (CORL Leader), Sherri Lawson (Director Surgical Services, London Health Sciences Centre), Pat Pocock (CORL Leader) and Ian Lawson, General Manager SIP - a Gold Sponsor.



## Winners !!!

Everybody attending the Banff Conference went away a winner, but some got a little extra.

- Joanne Mathews, Mississauga, ON won the Early Bird draw - a free registration !

- Rosemary Atwell, Ottawa, ON won the "Steris Canada" free trip to the AORN Conference in California in 2002 ! *It couldn't happen to a nicer person.*

- Dr. Garth Warnock donated his honorarium back to ORNAC asking that it be awarded to the cost of registration for two O.R. nurses. Lucky winners were Shirley Dueck, Saskatoon, SK, and Barb Mundy, Calgary, AB.



**National Exhibitor's Advisory Committee 2001:** LtoR Sylvain Chatier (SoluMed Inc), Lianne MacMillan (Allegiance Healthcare Canada), Mary Knight (ORNAC President), Bradd Hara (Trudell Medical), Warren Morrison (Stryker Canada), and missing Jeffrey Wilson (Gynecare).

**National Exhibitor's Advisory Committee 1999/2001.** LtoR - Warren Morrison, Stryker Canada, Marlene Hill (ORNAC Past President), Lianne MacMillan (Allegiance Healthcare Canada), Bradd Hara (Trudell Medical Marketing Ltd.) and Denis Thompson (Steris Canada). Missing from the photo Jeffrey Wilson (Gynecare).





▲ **J&J Souvenir Print Presentation:**

J&J presented a beautiful souvenir print painted by Canmore, Alberta artist Marilyn Kinsella to all ORNAC delegates. (LtoR) Marlene Hill (ORNAC), Marilyn Kinsella, Peter Steinman, President Johnson&Johnson Medical Products, and Gloria Nemecek.



▲ Monique Perazzelli is presented the **Isabelle Adams Award of Excellence in Perioperative Nursing** by Cathy Bruce (photo right) ORNAC Awards Chairperson.

The Isabelle Adams Award was established on the initiative of the Operating Room Nurses of Quebec in 1987. The first award was presented in 1988 in Vancouver to Gloria Stevens, and is presented on the year of the national conference, if there is an appropriate candidate. The Award is given to an outstanding perioperative nurse who has made a major commitment and a significant contribution to the speciality.

The Award reflects the practice and ideals of Mrs. Isabelle Adams of Montreal, and is one of high peer recognition.

Monique has achieved her BScN and an MBA and has over 25 years experience in the perioperative field in hospitals, in information technology and with the Quebec Ministry of Health. She has served on both the CIISOQ/CORNQ Executive and Board and been the Quebec representative to the National ORNAC Board.



▲ **Allegiance \$5000 Research Grant Winner -**

Linda Socha of Saskatoon, Sask. Her winning project is "A Study to Determine Patient Outcomes and Cost Comparison with the Implementation of the Registered Nurse First Assistant Role. Mary Knight, ORNAC President (centre), is shown with Allegiance Healthcare Canada President Gord LaFortune.

ORNAC/Johnson&Johnson Medical Products **Scholarship Winners:** LtoR - Theresa Markowski (Ontario), Antonia Bartlett, (Ontario), Peter Steinman (President J & J Medical Products), Kathy Bruce (Awards Chairperson), and Katherine Radcliffe (Ontario).



**Smith & Nephew Fun Run:** Over 150 OR nurses got out early Sunday morning for the invigorating mountain air and refreshments. Some of the earlybird runners are shown above.



The Red Piper Closed the Exhibits.

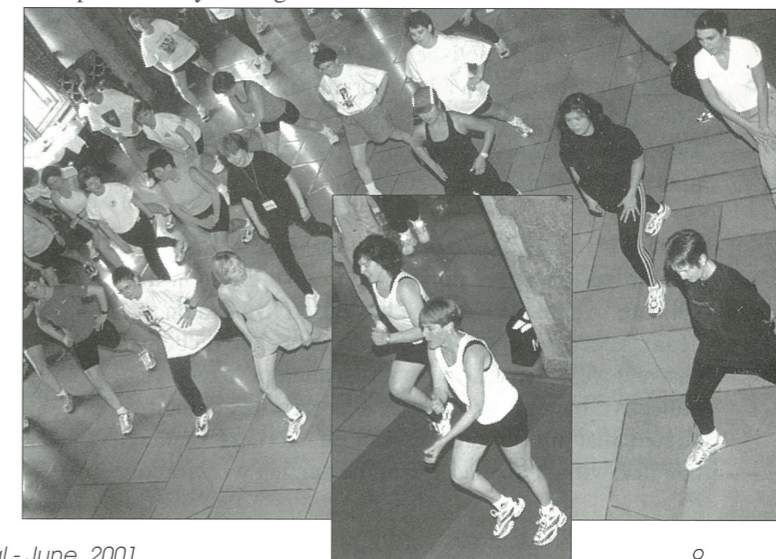


▲ **1999/2001 ORNAC Executive:** LtoR - Margaret Farley, Mary Knight, Marlene Hill, Donna Farid and Shelly Zareski. Shelly and Donna leave the ORNAC executive after ten years of dedicated service.

▼ **Odyssey Farewell Banquet.**

Comedian Todd Butler says Goodnight Ladies !

▼ Lynn Walters (foreground) leads the daily (huff huff, puff puff) Aerobics sponsored by Getinge Castle.



# Transitions and Challenges

By Mary Knight, RN, BScN, MN, CPN(C)

Another National Conference has come and gone, and wonderful memories have been created. Once again, the bar has been raised! On behalf of ORNAC, I would like to congratulate the 2001 National Conference Planning Committee on a very successful event, which truly took us on "A Surgical Odyssey". This edition of our Journal showcases many of the events and celebrations from Banff, and shows why we arrived at home exhausted!

For those of you unable to go to Banff, planning is well underway for the 18<sup>th</sup> National ORNAC Conference "Planting Ideas, Reaping Rewards" which will be held in Winnipeg, June 8-12, 2003. Start to plan your fundraisers now!

The ORNAC Board meetings are also a time to bid farewell to our outgoing Executive Board members. Donna Farid, Past President and Shelly Zareski, Treasurer both completed their terms on the ORNAC Board. Thank you for a job well done, and enjoy your newly found time! New members on the Executive are Gloria Nemecek, President-Elect and Sheila Biliard, Treasurer - welcome!

Our Editor and Publisher will be retiring this year. Agnes and Ron Forster have produced our Journal since 1983, a significant contribution to perioperative nursing in Canada! Thank you, and best wishes as you plan your well-deserved retirement.

This is indeed a time of transitions and challenges in both perioperative nursing and our profession in general. A nursing shortage has raised its head once again. Elective surgeries are being cancelled on both east and west coasts as negotiators attempt to resolve collective bargaining issues. Research has demonstrated that nurses are the sickest workers in the country, with more than 8% of the nursing workforce

absent in any given week because of sickness (Shamian & Villeneuve, 2000). And the Romanow Commission, established by the federal government, will begin to critically look at our healthcare system.

The Canadian Health Services Research Foundation has recently released a paper commissioned to answer two questions: "What is the impact of the working environment on the health of the nursing workforce (and thereby its impact on patient outcomes)" and, "What effective solutions could be implemented"? The report, "Commitment and Care: The benefits of a healthy workplace for nurses, their patients and the system" summarizes ideas for improving working conditions in healthcare, and can be found on their website: [www.chsrf.ca](http://www.chsrf.ca)

As perioperative nurses, we care for our patients when they are unable to advocate for themselves, and are dependent on our expertise and professionalism. According to Buresh & Gordon (2000), silent nurses are devalued. It is time to tell our stories and let the world know what we truly do. □

## References

- Buresh, B. & Gordon, S. (2000, Fourth Quarter). From Silence to Voice. *Journal of Nursing Scholarship*. pp.330 - 331.
- Shamian, J. & Villeneuve, M. (Fall 2000). Building a national nursing agenda: A timely response for the sickest workers in the country. *Hospital Quarterly*, pp. 16,18.

Mary Knight, RN, BScN, MN, CPN(C), is President of the Operating Room Nurses Association of Canada. She is Project/Systems Coordinator, Adult OR, Health Sciences Centre, Winnipeg, Manitoba.

# The New Millennium: a Surgical Odyssey

By Ginette Lemire Rodger, RN, PhD.

## Introduction

I am delighted to join you for your national conference to present the keynote address and to have the opportunity to meet many of you, particularly in this wonderful rocky mountains setting.

Having lived the last ten years in Alberta and being an avid hiker and skier, I am partial to this scenery, so much so that during my studies for my PhD. in Nursing at the University of Alberta, when came time to write my work. I packed cases of books and articles, and went to Jasper and worked surrounded by the rockies. My belief is that in such a grandiose place no one can do mediocre work. So, I know you will have a great conference.

The new millennium a surgical odyssey - the theme of your meeting seems especially appropriate, given all of the changes that we, as nurses, have lived through during the past decade. Odyssey aptly describes not only the breadth of the changes that have shaken our profession, but the tremendous revolution that has affected society as a whole - on a scale unprecedented in previous recorded history - as we move from the post-industrial age to the new information age.

While governments, policy makers and decision makers are trying to guide this social transition, we health professionals are calling for immediate action to ensure the current health care survives the transformation and grows to meet the demands of the public. Positioning nursing is then key to influence the future health services.

First, I will comment on the characteristics of the odyssey. Secondly, I will highlight the major impact on health care and nursing, and thirdly, I will conclude with ways to reposition nursing, both at the individual and collective levels.

## I The Surgical Odyssey

The dictionary defines odyssey as a long series of wanderings, especially when filled with notable experiences, hardships etc. (Webster, 1989).

We have lived, and we are still living, in many work sites with a series of wanderings. Some of you as far back as five to six years ago (when the so-called reform started), and others are still in the midst of it.

Two years ago we and the public experienced a major unrest of nurses. Nurses, concerned with the uncertainty in health care and the quality of care, sounded the alarm from one end of the country to the other. This year, again, as negotiation resume nurses are concerned with the professional impact of new health policies and realities.

At the same time many new initiatives and opportunities are developing such as, new roles in surgery (nurses as first assistant), new techniques both inside and outside the OR doors, changes in professional nursing status, safety approaches, ethical dilemmas, legal issues, leadership, to name a few.

These wanderings as mentioned above are part and parcel of a much larger phenomenon A move from the post-industrial age to the information age. (Champy 1995) writes that we constitute the last generation of the industrial age and the first generation of the third wave.

## Author

Ginette Lemire Rodger, RN, PhD, is the Chief of Nursing, Ottawa Hospital, Ottawa, Ontario, and President of the Canadian Nurses Association. Dr. Rodgers delivered the Valerie Shirreff Memorial Keynote Address at the 17th National Conference of the Operating Room Nurses Association of Canada in Banff, Alberta, April, 2001. This is an abridged version of her presentation.

Odyssey is one of many words that describes the transformation that is taking place. Words such as paradox, chaos, network, globalization, complexity, unpredictability, systems are now part of the vocabulary of the information age or the new age! All these definitions seem to include many elements that are conflictual and unpredictable. They are not new but more visible and their presence felt more than ever before. They are part and parcel of the transformation taking place in health care and nursing.

### Definitions of Chaos, Complexity and Paradox

Chaos is understood to mean a sense of disorder, complete confusion, total lack of organization but in fact it has found a new meaning since the 1970's. The chaos theory originated in mathematics and physics during that period. It can be defined as a complex state in which apparent randomness of a system is really constrained by a type of order that is nonlinear (Hamilton, West, Cheri, Mackey & Fisher, 1994, p. 15).

Hidden within (what appear as) disorganization is a deeper structure of order. What may seem random is actually part of a larger pattern. In chaos theory, unpredictability, or apparent randomness, is seen as intrinsic to the system, not extraneous or aberrant. For example: If 700 balloons were to be released in this room their action would be unpredictable, chaotic. However, if one were able to measure the speed of deflating, the room temperature, speed, placement, texture, etc., the action of the balloons could be determined.

Dr. Halzberg and Dr. Cornelissen' theories on Chronobiology (circadian rhythms: 24 hours; circaseptan: 7 days; circatrigintan: one month; circannual: one year, etc), are now being examined.

We are all now paying attention to the phenomena we easily could previously ignore. Several journals are now dedicated to this concept, (e.g.) complexity and chaos in nursing.

Complexity is a more general and better understood concept. The hospital is a complex system. Complex systems have a great many independent agents interacting with each other in a great many ways. As a result, these systems are dynamic - they're always changing, and they behave in a non-linear fashion, and they may not react proportionately to inputs. Small inputs can have large effects, and large inputs can have small or no effect. Or, the same input may have different effects at different times. This makes the behaviour of complex systems difficult or even impossible to predict (Vicenzi, White & Begun,

1997, p. 26)

Examples: Complexity of individual clients, research on nurse-client interactions, organizations.

**Paradox:** the term paradox comes from para, meaning beyond what is thought, and orthodox, meaning conventional or commonly accepted. So paradox means statements or propositions seemingly self-contradictory or contrary to commonly accepted opinion (Webster Encyclopedia - Unabridged Dictionary of the English Language, 1989, p.1046).

Example: a request for a custom-made, high quality, low cost health service, provided now. Well, it won't be cheap and it won't be provided now.

There is no doubt that western philosophers have greatly influenced our understanding of paradox. In particular, the development of logic, mathematics, physics and philosophy left no room for paradox. The reality was described solely in terms of either/or categories. The dominant view in the development of knowledge, through science, uses logic as the validating process of scientific inquiry.

As you know, the logical vision of the world has been challenged, particularly, by the advent of quantum physics. The complementary principle which acknowledges that all things in the universe are interconnected and that the universe consists of overlapping and sometimes paradoxical views of reality, played a major part in legitimizing the paradox phenomenon in science.

So, these scientific developments have heightened our consciousness of paradox. Other events have also contributed to this consciousness. With exposure to other world views, such as those held by oriental philosophers, it has become more difficult to ignore paradoxes and comfortably choose the one view that will ensure that we live happily ever after.

All these definitions seem to include many elements that are conflictual and unpredictable. They are not new but more visible and their presence felt more than ever before. They are part and parcel of the transformation taking place in health care and nursing. Let us now look at their impact.

### Impact on Health Care

Health care reform has definitely been the vehicle to destabilize the established order and brought to the forefront many of the latent paradoxes, complexities and chaotic situation. By the early 1990's. governments in Canada were finally setting the stage for the transformation and there was a consensus from all provincial advisory committees, task forces, premiers'

or royal commissions on what would be an appropriate model of health care for the next millennium. Many of the reforms now being implemented are based on provincial consensus. Mhatre & Deber (1992) reviewed and critically analyzed the policy options of all these provincial reports. Eight recurring themes were present and many of them represent different polarities or paradoxes with the current health care reality.

In every province, we are experiencing the changes of governments determined to bring about a new era. The new health care reality should have been easier to understand because it was in line with many fundamental values of health care professionals such as nurses (such as increase community support, promotion and prevention of disease and injury).

### The Force, Speed, and Complexity of the Changes

Every one is taken aback by the force, the speed and the complexity of the changes underway. The force of the change is so powerful that it challenges the most basic values of professions, of health services and of society. It questions the scope of professional practice, dismantles infrastructures that have supported professional practice to date and creates new models of relationships, to name of few. If we were considering only the changes in health care, the force may not be as important but we are simultaneously affected by the profound social shift described by Toffler (1995) in his book, "The Third Wave". A social upheaval created by the replacement of the industrial age by the (e.g.) the high technology, network relationships and the information age. The transition that is taking place in health care is compounded by the effects of other social phenomenon (such as globalization, neo-conservatism,) that modify the rules of the game and impact on the reform which may not have been foreseen and create further paradoxes.

The speed of the change is also quite startling. Erickson (1963) predicted that the rate of change would continue to accelerate up to the as-yet-unreached limits of human and institutional adaptability and that we would face multiple changes at the same time. Today, we are living and experiencing it in an intense way. In fact, the speed of change with its own volition, has been integrated and accelerated as part of current strategies. The time line for changes in health care is often very short, in spite of the fact that health care is known as one of the most complex industries in the world. Even today we have not reached the limit of change. Therefore, as nurses we need to find ways

to reposition ourselves so that the acceleration cannot totally eat us up. This is the danger that is in this transition.

The complexity of change in health care is also worth analyzing. Under the label of health care reform, the complexity can be conceptualized as the three R's: the Reduction in health expenditures, the Redesigning of health care services and the Reform of the health care system.

### Health Care Polarities

One way to visualize the impact on health care is by highlighting the paradoxes and the polarities that are very visible in the health care environment today:

- The pull between the promotion/prevention health care - and curative care;
- The pull between the importance of quality/qualitative care and quantitative care (hard numbers);
- The approach of care versus the approach of cure;
- The ecological pull, being in line with society and the environment versus being in an industrial/manufacturing model;
- The multi-disciplinary approach versus the gatekeeper;
- The community and the hospital;
- The pull between the public and the private; and
- The reform versus reduce/redesign.

### Impact on nursing:

The new era is more and more visible in all domains of clinical practice (to more or less degree - depending if your work place is still very much in the industrial era or the information era) how do you know?

We know that the route ahead includes fixed-financing for health coupled with evidence-based funded practice and outcome-driven strategies in health and professional services; repositioning of services for the third wave. Toffler (1995) point out that the organizational model of the third wave will have the following characteristics: semi-autonomous units with little standardization of work, preference for self-design, self-management and individuality, decentralization of services and evidence of integration, contracting and distribution of work among different people at different locations.

If you had told me 10 years ago that I would be practicing today totally differently in a facility with four sites and 3,600 nurses and creating our own environment, I wouldn't have believed you.

The other influence of this reality is also the cost of providing services; other respected authors such as Peter Druker (1992) see the route ahead with minimal

structures and working smarter.

Mintzberg (1997) echoes the need to reduce management but work in a better integrated fashion. Differentiation between disciplines is inevitable, but healthcare should develop a higher level of integration.

The route ahead is challenging for health professionals, and the shortage of nurses is part of this odyssey.

### Shortage of Nurses

There is no doubt that, as the backbone of the health care system, nurses have borne the brunt of health care transformation. We have suffered, first-hand, the effects of the past decade of cuts: widespread layoffs and increased workloads for those who remained.

The figures in the Ryten Report (1997) commissioned by the Canadian Nurses Association (CNA) tell a serious story.

- Nearly 50 per cent of Canada's 228,000 nurses now work in part-time jobs. Job security is not a given any more. Full time positions are scarce. (Canada has the world's worst record for fulltime positions. The U.S. fulltime rate is 66%).
- More new graduates are working part-time, or for several employers, than at any other time in the past decade.
- With the massive cuts to nursing staff, the increased numbers of critically ill patients and constantly changing practice environments, patient-to-staff ratios are higher than ever before.
- In the past 10 years, this ratio has risen from one nurse for every 123 patients to one nurse for every 133 patients.
- With heavier patient loads, fewer RNs and an increased use of assistive personnel, we, as nurses, have little time to build quality relationships with our clients and co-workers. As a result, nurses are worried about patient outcomes and are living paradoxical situations, (e.g.) great care versus poor care!
- The compromises nurses have had to make just to survive in this environment have led to high levels of stress, absenteeism, job dissatisfaction and burnout.

Nurses enjoy the dubious distinction of having the highest rate of injury and sick leave of any professional group in Canada, (6.2 days for other workers - compared with 3 weeks for nurses).

Canada's nurses feel distressed at not being able to provide the kind of care they have been educated to provide, and the kind of care we want to give: the very things that prompted us to go into nursing in the first place.

So little wonder that the number one issue for nurses is the nursing shortage, just as health care is the number one issue for all Canadians.

Nurses make up an astonishing 75 per cent of Canada's health human resources. Yet, more than 25 per cent of nurses will retire in the next decade, just when Canada's aging population puts even greater demands on our already strapped health care system.

With an aging nursing workforce - the average nurse in Canada is 47. (A large group of perioperative nurses will soon leave the workforce, so who will replace them and mentor the new graduates?)

Nursing graduates have declined, from a high of 10,000 in the 1970s to a low of just over 4,000 at present. The number of new people entering our profession is less than the number retiring.

Added to this is the fact that, in 1995, 2 out of 10 nursing graduates opted out of the nursing profession.

So where does that leave us? The CNA Ryten Report predicts that by 2011 the nursing shortage in Canada could be as high as 113,000 nurses!

Even now, there aren't enough nurses in full-time positions to ensure an experienced nursing workforce for Canada's aging population, especially in rural areas and northern communities, and in certain specialties such as emergency, critical and intensive care, and in perioperative nursing.

### Nursing Knowledge/Nursing Research

There is a knowledge revolution that does and will further affect not only the explosion of knowledge, the speed of dissemination but also the infrastructure of knowledge.

Everywhere now, in health care, we hear knowledge words such as: evidence-based practice; outcomes research; and, impact/accountability.

We have evidence that colleges and universities (which are still fairly bureaucratic) are challenged by distance education, by computer-mediated learning, by entrepreneurship in the area of research. The same is occurring in the research foundations that use to be a place of expertise and scholarly competition for support.

Not anymore! The world is open universities, additional acceptable places of learning, and virtual foundations.

I recently met Dr. Bezancon, head of the International Development Research Council (IDRC), in fact he was reorganizing his foundation and moving to a virtual research council, for the virtual reality.

Our newfound capacity to know and use knowledge will force an integration of knowledge in all spheres and endeavours.

Example:

#1 incontinence nurse, ph.d.  
clinical bladder control  
research, clinics, teaching  
half university / half agency  
#2 mental health nurse, ph.d.  
pharmacology  
molecular biology

### Nursing Research

The growth in nursing research is phenomenal over the last ten year. For the first time in the 1999, the federal budget allotted 25 million to create a nursing research fund, to strengthen research on the issues facing practitioners, specialist, and educators.

This year, we have strong empirical evidence that the reform has had major impact on nursing. The evidence confirms what we knew instinctively, that environments that foster strong professional practice provide for better client outcomes, and greater job satisfaction for nurses.

Research is an effective tool in this new era, and nursing is thriving !

### ICT's

A significant impact in nursing will come from the information and communications technologies - or "ICT's" as they are commonly referred to. ICT's will revolutionize our ability to capture important information about the role we play in health care and help advance nursing practice.

At the 1994 United Nations roundtable on global change: social conflict or harmony? Dr. Bezancon, head of IDRC wrote:

"The world economy is experiencing profound transformations. Scientific and technological advances have become the main determinants of the paths that much of the world community will take in the new millennium. As a consequence, those who have access to the products of scientific and technological research - as well as the ability to understand, absorb and make use of them -

will exert an ever increasing influence in the conduct of human affairs. We are beginning to accept and internalize the tight coupling that exists between human beings and the physical and biological world. ...We are beginning to realize that advances in information technology are creating a new level of reality (virtual reality, cyberspace) that lies in between the tangible and real world which has been with us since time immemorial and the world of abstract concepts. ...We are becoming aware of our newfound capacity for consciously altering the direction of human evolution, and of the possibility to overcome the limitations of an individual's biological and genetic hardware. ...All this suggests that, as the new millennium approaches, humanity is in the midst of a bewildering transition something that cannot clearly yet be visualized".

As OR nurses you are living this reality with all the advances of technology so you have a good grasp of this impact.

The profession as a whole is also developing and/or using many icts such as: telehealth; info sante; nursing telepractice; patient education; (infirmiere virtuelle ... virtual nurse day surgery); info net; knowledge sythesis; nurse @ work; and the web, to name few.

With this new complex reality, that is not predictable what is the route to follow?

### Repositioning Nursing

This odyssey brings with it the need to reposition our profession for the new era. It is challenging no doubt, but essential.

### Individual Strategies

Muff (1994) summarizes the situation as follows:

"We face many paradoxes today, situations that seem to have no good answers, where forces are in opposition and may have both a legitimate claim. We try to mediate at the crossroads, that difficult place where client needs, professional issues, and institutional demands intersect. We grapple to hold the various pieces together, needing not only to be caregivers, but visionaries as well. We long for wisdom to guide us; we search for answers. Somehow, we have come to believe that if we could just find the answer to paradoxical situations, we would have an end to conflict and ethical dilemmas".

She goes on to explain that the strategies most often used to deal with paradoxes are either analyzing or theorizing, taking sides or integrating opposites to blur the boundaries between them to create a fictitious blend. She believes none of these tactics are helpful in the long run.

There are no ready-made solutions for dealing with paradoxes, but in my view, there are important tools that guide the choices we make. Vicenzi, White, Begun (1997) offered some strategies based on the science of chaos and complexity to help us shape the future and advance our patient and professional interests.

1. Abandon false notions of control: impossible to have control in a non-linear world. Issues management! Move with the flow!

2. Accept the reality of change: may need to grieve for the good old days; but create a good new way; (change locator this pm);

3. Accept the unpredictability of the future, including the uncertainty of your job: This is very difficult. Job security is one of our natural assumptions, basic to who we are, our financial base, and our relationships. Keep your resume current; continually review your knowledge and skills; i.e. what are you good at. Have the sense of preparedness required to grasp opportunity.

4. Keep learning: re-invent yourself, re-examine yourself; take responsibility to be up-to-date (continuing education) and develop new skills in your area of interest; be creative and inventive; ride the wave.

5. Build Relationships: partnership, more interdependent in health care and in the community; join forces with groups and other professionals; isolation creates apathy and death.

6. Change the World: lead the thinking. Do not get paralyzed. Shape the environment.

## Professional Strategies

To accompany any of these individual strategies, there is a set of professional strategies, as well, a series of tools which will help develop professional strategies as we travel the road of complex change ahead. They are:

### • Knowledge and Professional Values

We must ground nursing in knowledge and be anchored in our values.

### • Leadership and Vision

The movement, growth, and values of a profession are inextricably tied to its leadership (Vance, 1977, p. 230-231). In a time of transition to a new paradigm, the leadership that is called for, is transformational lead-

ership. A leadership that is about change, innovation, and empowerment of others, (Barker, 1990, p.39). Leaders of practice education and research that do not move in parallel, play within the profession or with other stakeholders of the new reality being created. It is not an easy road and the map is not very precise. But how it will be carried out will most likely determine the future of our ability as a profession to contribute in the next century.

## The Visionary Leader

Deveraux (1990) defines vision as the ability to dream and translate those dreams into reality. Baker (1990) considers vision as an image of a possible and desirable future but a future that is realistic, attainable, credible and attractive.

Vision is the ability to dream and translate those dreams into reality, Baker (1990).

A vision has a clear sense of purpose and detailed strategies for attaining the goal.

### • Political Action and Visibility

Political action can be defined as a systematic series of actions which are directed toward influencing others into conformity with a pursued goal.

**Image of nursing** - A national nursing forum is needed to make visible that nurses are: knowledge workers; life and death decision-makers; and managers of billion of dollars of health care resources

**Public trust of the nurse** has been at its highest for three years and the politicians are very attentive!

## National Plan

CNA has been very active to ensure that the nursing voice is heard nationally and internationally. The many issues we are working on, the goals we have given ourselves include:

• Public policy which incorporates the determinants of health and the principles of primary health care and expands the principles of the Canada Health Act across the health continuum.

• Public trust in nurses be maintained, including strategic actions related to education, continuing education, certification (11 specialties with more than 10,000 nurses certified), regulation framework for nursing and nursing resource planning, nursing resource planning, (recruitment and retention national plan - national committee on nursing resources;

• Nursing profession achieves its full potential; Quality practice environment - policy synthesis Standard of Practice in all fields;

Nursing at the policy table every where; and, Maximize scope of practice.

## Leadership in Nursing

It has been said that there is a lost generation of nurses who graduated during the period of reform, and either left the profession or the country. As well, a leadership gap is developing as our senior academics and administrators move towards retirement and nurses in leadership positions retire. Now is the time to exercise all our leadership. We have a responsibility to mentor our young leaders. We need your leadership and influence to move from knowledge to political will and form the political will to action, significant action and this is very challenging.

## Conclusion

In conclusion the surgical odyssey is unfolding in a very difficult and exciting new world. There are many situations in the transformation taking place where we need to be actively involved. We are co-creating organizations/society by either our assertiveness or our passivity, our vision or defeatism, our determination or insecurity, our beliefs and values or the feeling of being a plaything of circumstances. So whether we are active or passive, we are co-creating the transformation.

With the chaos and turmoil in the environment comes the opportunity to renew ourselves, to draw on our vast experience and our proven strength.

Positioning nursing in this odyssey is about taking a pro-active stance and not being deterred by set back.

It is about adopting the philosophy of continuous improvement, being unafraid to explore new territory, embracing new technologies, forging strong partnerships, communicating our successes and reinventing ourselves.

Yes, we do live in chaotic, complex times. But, as Latin American author, Olivero Battista, stated:

**“Rainbows are born out of storms. And the more vigorous the storm, the more beautiful is their magnificent splendour”.** □

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## Submit Your Article to the OR Journal and Win \$3000

The Canadian Operating Room Nursing Journal is intended to serve the information needs of perioperative nurses in hospitals and clinics throughout Canada. Readers include staff nurses, head nurses, nursing supervisors, coordinators, clinical instructors, directors of nursing and other perioperative nurses. The journal is peer-reviewed and published quarterly by Health Media Inc. under the aegis of the Operating Room Nurses Association of Canada (ORNAC).

Manuscripts are reviewed by the editorial review board members appointed by ORNAC, and when necessary by outside experts. Submissions are invited on new surgical procedures, descriptions of new technologies or new programs and educational material. Selection is based chiefly on the following criteria: originality, timeliness and relevance to the needs of the journal's 3,300 OR Nurses.

Preferred length is approximately 10 to 15 typed, double-spaced pages, numbered consecutively throughout (including tables, figures, references, which should be on separate pages). Authors should submit three copies (one should be the original or an excellent photocopy) of the manuscript and include:

1. An abstract summarizing the article.
2. An autobiographical statement that includes the author's full name, current title and academic qualifications. e.g. Jane M. Smith, RN, MNSc, is head nurse, Thoracic Surgery, General Hospital, Perth, ON.

### Open Letter to all nurses who wrote the 2001 CNA Certification exam

The staff of the Canadian Nurses Association (CNA) Certification Program would like to take this opportunity to apologize to the perioperative nurses who wrote the 2001 certification exam and **received incorrect performance profiles** with their results. We are truly sorry for the distress our error may have caused the affected nurses. We have reviewed the internal process for preparing and mailing of performance profiles and steps are now in place so this error will not reoccur.

Several nurses contacted the certification staff to express their concern with the CNA Perioperative Prep Guide. Nurses told us that the degree of difficulty of the practice questions in the Prep Guide does not adequately reflect the degree of difficulty of the actual exam questions. CNA will be reviewing the Prep Guide this summer in order to strengthen it for those nurses who will be writing the 2002 Perioperative Certification exam. We plan to include additional practice questions as an addendum to the Prep Guide that will better reflect the actual exam.

We take this feedback very seriously. All Periop-

The author should submit the original manuscript and two(2) copies for reviewers. A copy of the edited text will be sent to the author for final approval.

References are arranged in alphabetical order by author surname. References are cited in the text by author-date method of citation, e.g. (Smith, 1987). Follow the APA Manual for style when typing the list of References, e.g.:

Smith, M. & Curtis, J. (1987). *Ethics in Nursing* (2nd ed). New York: Oxford University Press.

Share your knowledge, expertise and experience with your operating room nursing colleagues.

### J&J Author Award valued at \$3000

In 1983 with the launching of the Journal, Johnson & Johnson Medical Products committed an annual \$3000 award to be presented to the author of the best article of the year. The award recognizes Canadian nurses who contribute to the advancement of perioperative nursing knowledge and education of their colleagues through the medium of the written article.

The award is presented yearly at a National or Provincial Conference. So, get writing! The Journal needs your articles - especially those describing new surgical procedures and the related nursing care plan.

erative nurses who were not successful in writing the 2001 exam will be offered a **free re-write for the 2002 Perioperative exam**. Those individuals will also receive the revised addendum to the Prep Guide free of charge. The perioperative nurses affected by the above will receive a letter from the CNA this summer.

For more information contact the CNA Certification Program Staff at 1-800-450-5206 or by email: [certification@cna-nurses.ca](mailto:certification@cna-nurses.ca).

### CPN(C) needed for admission to BCIT

The prerequisites for the Registered Nurse First Assistant program offered through the British Columbia Institute of Technology are changing as of January 1, 2002. After this date it will be necessary to have achieved Canadian Nurses Association Certification in Perioperative Nursing prior to acceptance into the program. Registration for the certification exam will no longer be accepted as an admission criterion. For further information, please contact: Karen Sheehan, Course Facilitator, BCIT Perioperative Nursing Program at 1-800-663-6542, local 7079.



# ORNAC in a Nutshell

By Margaret Farley, ORNAC Secretary

- We bid farewell to Executive member Shelly Zareski, Treasurer. Shelly started as a representative of Nova Scotia in Banff in 1991, so it seems fitting that she leaves from the same venue. We also bid farewell to Past President Donna Farid. Rumor has it that Donna was a Board member in 1991 as well. We thank both of these dedicated ladies for their contributions over the years.

- Welcome to the Board is in order for Laura Ellsworth of Newfoundland, Linda Socha of Saskatchewan, and Susan Bell of Ontario who attended their first Board meeting in Banff.

- ORNAC's newly elected Executive members are: Marg Farley, returning as Secretary, Sheila Biliard is Treasurer, President-Elect is Gloria Nemecek.

- Sunday, April 22, 2001 the Executive and Board participated in the Smith & Nephew Fun Walk. A welcome break from the Board meeting to breath in the clean, crisp mountain air and enjoy the company of other delegates. We encountered many creatures, but none of the four-legged variety. Marvellous scenery and company!

- The 17th National ORNAC Chair, Gloria Nemecek of Lethbridge, Alberta and her conference committee have welcomed us to Banff with a varied agenda, a picture perfect venue, and good company. Thank you for your work, assistance, attention and patience. The 17th National ORNAC Conference was a great success!

- Perioperative Programs for Registered Nurses: Core Curriculum and Program Approval Process had their final review and endorsement by the

Board during the Banff board meeting.

- The Canadian Operating Room Leadership Network, (CORL) has achieved affiliate status with ORNAC. Congratulations to Muriel Shewchuk and Pat Pocock for their dedication to this endeavor.

- Monique Perazzelli of Quebec is the recipient of the Isabelle Adams Award for Excellence in Perioperative Nursing. Congratulations Monique!

- The RNFA group had an informal session during the conference and had the chance to provide an updating of the role and its progress in the various provinces. This is the first opportunity this group has had to meet face to face with a national flavor.

- The ORNAC/J&J Scholarship/Bursary winners are: Theresa Markowski of London, Ontario, completing her Bachelor of Nursing Science at the University of Ottawa; Anne Bartlett of Ontario, who is working on her Masters of Health Sciences, University of Athabasca, and Katherine Radcliffe, Ontario, who is working on a Bachelor of Technology of Perioperative Nursing, BCIT. Congratulations ladies!

- Our website, [www.ornac.ca](http://www.ornac.ca), has expanded in leaps and bounds. We now have a discussion forum for you to pose questions to other perioperative nurses. Please visit and comment.

- Muriel Shewchuk of Alberta has won the Drake Thompson Johnson & Johnson writing award for her article in the December, 2000 issue of the *Canadian Operating Room Nursing Journal*. "The Future of Nursing in the Operating Rooms of Canada: Are You in the Front Car of the Perioperative Train?" See

- Winners of the ORNAC Allegiance Research Grant are Linda Socha, Principle Investigator, Marla Ewen and Alicia Ocharek Mattheis of the Royal University Hospital, Saskatoon doing a Study to Determine Patient Outcomes and Cost Comparisons with the Registered Nurse First Assistant [RNFA] Role.

- Hilda Powers of Halifax, the 1999 Allegiance Research winner presented her intraoperative study.

- Mary Knight, International Federation of Perioperative Nurses, (IFPN) Executive Board Member, is about to complete her term as an elected Full Board Member. IFPN continues to grow and evolve.

- Editorial Advisory Committee, under the guidance of Chair, Kim McLennan-Robbins, has undertaken the task of finding a new publisher for the Canadian Operating Room Nursing Journal. Ron and Agnes Forster of Health Media Inc. made a gift of the Journal to ORNAC. We thank you for the opportunity to publish the journal in future, and for your 19 years of service to ORNAC.

- Plans for the 18th National ORNAC Conference are well underway. Winnipeg is the destination, June the month, and 2003 the year.

- Montreal, June, 2005 refers to the 19th National ORNAC Conference.

- ORNAC has received two business proposals for the historic 20th National Conference, in 2007. Where to go? Vancouver or Banff? The decision will be made this fall.

- We had panoramic vistas, mountains of education, an array of exhibits laughter, fun, food, frolic, networking, renewing of old acquaintances, and leadership. Thank you to our Alberta hosts for a Conference not soon forgotten.

- Please join us in Winnipeg, 2003 and help us "Planting Ideas - Reaping Rewards" - the theme of the next National Conference.

- Visit our website [www.ornac.ca](http://www.ornac.ca) for new and more detailed information on ORNAC activities. We now have a discussion forum for you to pose questions to other perioperative nurses. Please visit and comment. □

## Quebec's RNFA's recognized in the Medical Act

The Regulation respecting the acts contemplated in section 31 of the Quebec Medical Act specifying which acts may be performed by classes of persons other than physicians is amended at section 1.01 by adding, after paragraph r, the following:

"s) **"nurse first surgical assistant"**: a nurse having a minimum of three years experience in an operating room, one year of which being in the concerned surgical discipline. Furthermore,

i. he or she is the holder of a baccalaureate in nursing sciences issued by a Quebec university, or he or she has completed at least 60 credits in nursing sciences in the course of a program of university studies other than the program leading to the certificate mentioned in subparagraph ii;

ii. he or she is the holder of a certificate in perioperative nursing care issued by the University of Quebec in Trois-Rivieres;

iii. he or she is the holder, since less than one year, of an attestation confirming the successful results of training in cardio pulmonary resuscitation issued, either by an establishment or an instructor recognized by the Heart and Stroke Foundation of Quebec, either by an establishment affiliated to a Quebec faculty of medicine. □



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# Dealing With Difficult People

By Sharon Keenan-Hayes, BScN, RN, CPMHN(C)

Dealing with difficult people is an art form - not one that necessarily belongs in the health care forum, yet present every day. In order to understand the broader topic, I would like to break down the information into two topics: I. Prevention and Management of Aggressive Behaviour, and II. Difficult People, The Challenge.

## I. Prevention and Management of Aggressive Behaviour

First, a definition of terms:

**Aggressive Behaviour** is "The violation of one person by another through intimidating behaviour, physical attack, and/or coarse and insulting language. This behaviour may be precipitated by feelings of fear, rejection, inferiority, grief, intrusion of personal space or an unknown cause."

**Assertiveness:** The standing up for one's rights in a non aggressive manner

**Aggression:** The acting out of hostile impulses in a violent or destructive manner. This occurs in response to a real or perceived threat and may be related to feelings of anger or fear, to suicidal or homicidal ideations, to a psychotic process, dementia or personality disorder. Aggressive behaviour may develop gradually or occur suddenly and it may involve significant danger to staff and others

**Assault:** The unprovoked acting out of hostile impulses causing physical or emotional injury to others. An assault may be committed without actually touching, or striking, or doing bodily harm to the person of another

**Abuse:** An act of aggression between two people who have an established relationship, (Schultz, J.M. and Dark, S.L, 1980). The terms "Nurse Abuse" and "Patient Abuse" can be more easily understood when taken in this context. In other words, aggressive be-

haviour between a nurse and a patient or a nurse and fellow team member is, in fact, abusive because there is a relationship defining the two roles.

In an article in the Nursing Magazine, "Reflections", published in the third quarter of 1999, the President's Message states: "Nurses care for victims of violence, perpetrators and witnesses to violent acts. The experience of nurses who care for those affected by the violence . . . points out the pervasive nature of violence. In addition, nurses themselves are at risk for violence in their personal lives, in their communities and, unfortunately, in their place of work. Violence in nursing is seldom discussed, and if it is, it is in hushed tones and with a 'thank goodness it's not me' sentiment. . . . No longer will we sit idly by while nurses suffer indignities, from bullying to outright assault. The value of human life is inestimable, and those who serve others, such as nurses, must be protected from attack and shielded from abuse. This is the only way we can go on serving, helping, and healing. . . . No longer should any nurse accept abuse by word or action from another. Abuse, verbal or physical, is an attempt to control others. It is insidious and, if left uncontested, it escalates.

Intimidation becomes humiliation, degradation, and harassment and leads to accusing and blaming. Fear of physical harm or isolation allows the abuse to continue. And when one is abused, others are controlled as well. Nurses can and must stand up to verbal abuse and, more importantly, must insist on being

## Author

Sharon Keenan-Hayes, BScN, RN, CPMHN(C), is a staff nurse on the inpatient psychiatric unit of Queensway-Carlton Hospital, Ottawa. She is an instructor at Algonquin College and a clinical professor in Psychiatry for 3rd year BScN students (psychiatry), University of Ottawa. This article is based on her presentation last year to the Ottawa Regional Operating Room Nurses Association.

safe from physical harm in the workplace. Although absolute security cannot be assured, working conditions in health care must provide adequate protection for nurses and other employees as well as patients and their families. Basic to recruiting and retaining the next generation of nurses is a safe work environment. Nurses care for and about others. It's why you are a nurse. We are courageous, but we don't have to suffer indignities or harm to do our jobs. All we need is respect for our professional work and to be safe. It's little enough to ask," (Sullivan, 1999).

I think this is a very profound, clear, and succinct statement about the risks nurses are facing today in their daily practice. As abusive and aggressive behaviour are accepted more as the norm rather than the exception in our society, caring for patients and their families becomes more and more of a challenge. Violence exists on a continuum from verbal abuse to physical assault to homicide. The escalation can occur quickly. Most workplace assault can be prevented when action is taken early!

I would like to list risk factors which may indicate a propensity to aggressive behaviour. It is, by no means, a complete or exclusive list. This material and much of what I will present throughout this talk is a compilation of courses I have taken and from my 30 years of experience as a psychiatric nurse.

### Risk Factors For Aggression

Risk factors for aggression:

- Young males;
- Low socio-economic status;
- Active psychotic symptoms;
- Medication noncompliance;
- Substance abuse - use of alcohol or addictive drugs;
- Personality disorders;
- Financial and interpersonal dependence on caregivers;
- Previous criminal activity;
- Prior history of aggressive behaviour;
- History of family violence;
- Weapons availability; and,
- Social isolation.

In my opinion, the two most powerful indicators are 'substance abuse' and 'prior history of aggressive behaviour.' Some drug seeking individuals will do "anything" to get medication. And once aggressive behaviour is tolerated within a medical environment, it is almost certain to happen again. Social isolation presents an interesting challenge and is sometimes

hard to understand when it is included in this list. To help illustrate what I mean by social isolation as a risk factor for aggression, I like to tell the story of the well meaning neighbour. The story goes like this: Mr. Jones is an 80 year old widower who has lived on his own for the 10 years since his dear wife died. He has had the same neighbours for 9 of those 10 years. Recently, a new family moved in next door. This new neighbour tried to have a friendly conversation with Mr. Jones over the back fence - kind of like the neighbour in the Tim the Tool Man TV show. Mr. Jones, never having had a conversation with his previous neighbour, shunned these efforts and made it clear by his body language that he did not want to have **that** kind of a relationship with this new neighbour. Guess what? The new neighbour is a nurse and notices a series of scabs on Mr. Jones' face. She makes a caring call to the Public Health Nurse in the neighbourhood and asks if someone could look in on Mr. Jones. Next day, a lovely public health nurse rings Mr. Jones' door bell, the door is opened reluctantly, and Mr. Jones hits the nurse over the head with his cane, indicating loudly that he wants nothing to do with the nurse or the neighbour. A long narrative, but you get the message.

Now, a discussion on the criteria for assessing aggressive behaviour. Risk factors are good things to know but how do we observe behaviour and know that an aggressive incident may be right around the corner?

### Indicators for Assessing Aggressive Behaviour

- increase in motor agitation,
- threatening verbalization or gestures toward real or imagined objects, and
- intensification of affect (i.e. the outward manifestation of a mood).

The person may be ringing their hands at the Emergency desk or at the reception desk of the OR suite, speaking in a loud and strident manner. Their eyes may be bulging and/or staring. Their language may be coarse and insistent. The list can go on and on. Above all, listen to your gut. If you feel uneasy about any of the above behaviours, trust yourself and put safety protocols into motion.

### Prevention of Aggressive Behaviour

- project calm
- move and speak quietly and confidently
- take care with health instruments that can be used as weapons: stethoscope around the neck, scissors in the pocket

- increase knowledge of aggressive behaviour assessment and techniques to deal with an episode
- attend Code White inservices
- take threats seriously and report them
- report suspicious individuals immediately
- voice safety concerns and suggestions to appropriate staff (i.e., unsafe work areas due to inadequate lighting)
- ask all patients receiving any treatment to wear a hospital gown.

The risk factors and indicators are very interesting but What Do I Do When This Actually Happens To Me? The following are lists of Do and Don't Behaviours which will help you manage an aggressive incident in a safe and efficient manner. The goals for this management are: (i) safety of the patient/family member/team member causing the disturbance, (ii) safety for yourself, and (iii) diffusion of the incident.

## Do

- Intervene as soon as you notice agitation at the outset, ascertain where your nearest exit is and move in that direction (the person causing the disturbance will not notice your moving).
- Remove dangerous objects if you can do so without drawing attention ie letter opener into the desk, water pitcher off the nursing station counter
- Decrease stimuli, such as noise.
- Note anything you can use to protect yourself i.e., a chair, cushion or clip board.
- Speak in a normal tone, using normal speed and volume (despite your racing heart and mushy brain)
- Listen. Try to hear the message and respond to it.
- Ask "what is wrong?" - this forces the individual to slow down, think and communicate.
- Be reassuring and suggest positive choices.
- Be flexible - if the individual has a point or negotiates a solution, consider it.
- Acknowledge the individual's right to his/her viewpoint.
- Give personal space.
- If you are part of the problem acknowledge it.
- Remain firm but not aggressive.
- Stay honest - say you are frightened if you are.
- Make use of the Golden Rule - do not express apathy, condescension or be misleading.
- Remember that no matter how hard you try, the aggressive behaviour may persist and escalate.

## Don't

- Get too close.
- Put hands in pockets or behind your back.
- Get backed into a corner or wall.
- Argue. Keep the conversation clear and simple.
- Belittle or dare.
- Reject all of the individual's demands from the start of the confrontation.
- Make threats you can't enforce.
- Use physical intervention on your own.
- Blame yourself if you've done everything possible and the individual becomes violent.

## II. Difficult People: The Challenge

There are two types of difficult people that nurses find in the course of their clinical practice. The information in the following is based on Robert R. Bramson's book *Coping with Difficult People*. I have chosen two categories which he highlights under the broader topic of The Hostile Attackers: Sherman Tanks and Unpredictable Exploders. I encourage all nurses to read this exceptional little book. It will help in dealing with the difficult people in every area of our life, be it the co-worker or the supermarket clerk. There are two things to remember when you interact with the Difficult People in your life:

1.) Anger, itself, is not the problem. Anger is a feeling which can be used very positively to accomplish many things. The problem is the way in which it is expressed - in other words, the behaviour not the feeling.

2.) The problem for you, as the recipient of the anger, depends on the meaning you ascribe to the expressed anger. You need to emerge from an angry encounter the same person you were when you entered. You cannot allow the angry person to "take" anything away from you as a person during the interaction.

### The Sherman Tank

The Sherman Tank is so called because after an interaction with this type of person, you literally feel like you have been run over by "a Sherman Tank."

#### Behaviour:

- Shermans attack.
- They criticize in an arrogant voice and manner.

- They are abusive, abrupt, intimidating and overwhelming.
- They don't only criticize your words or behaviour, but they criticize you, the person.
- They consider their victims to be inferior people worthy of contempt and abuse.
- Some attack crudely and in an obvious way.
- Others attack more insidiously, diminishing their victim's self esteem, bit by bit, until he or she gives in simply to survive.

Smooth Sherman Tanks often attain positions of authority and power, because they are skilled at the attack as well as the follow through, they have a great deal of power in interpersonal situations.

**Response:** They win because they produce in their victims: - Confusion - Mental or Physical Fight, Flight or Fear.

The more confusion and chaos the Sherman Tank causes in the victim, the more he or she pushes.

**Underlying Issues:** Their abrasive nature insulates them from feedback and criticism Their strength is gained from pulverizing others. They need to prove themselves right. They need to feel power in a powerless situation.

## How To Deal With The Sherman Tank

### 1) Stand up for yourself

Speak to the TANK. Don't allow them to feel they have intimidated you into silence. This defuses their first line of attack.

### 2) Let the Tank run down

This takes time. Hold your position.

### 3) Get in. Find an opening

If you wait till they finish a sentence, you could wait a long time. Interrupt. State your case. Don't let the Tank interrupt you.

### 4) Get their attention

Call them by name. Use a straight forward tone of voice. Stand up or have the Tank sit down. Drop a pencil. Look into the eyes of the Tank.

### 5) Speak from your point of view

Use self assertive phrases like, "In my opinion", "Perhaps that is your point of view, but I have another one based on my experience".

### 6) Do Not Fight

You may lose the battle.

You may win the battle but lose the war.

### 7) Be prepared to make up

If the Tank has been stood up to, but not personally defeated, they will respect you and may make friendly overtures towards you. If you are not ready or prepared for this to happen you may react with anger which will impede a productive and valuable future relationship.

## The Unpredictable Exploder

**Behaviour:** They appear calm and cool on the outside, then are sparked by an event (significant or not). They throw temper tantrums. They yell, cry, insult, threaten, blame. Their surprise attacks reduce you to silence, passivity, and inertia. Your fear allows them to manipulate you. They are irritable, touchy, mean and terrifying.

**Underlying Issues:** A temper tantrum is a response to deep threat or frustration. Hostile, angry outbursts are automatic responses. The actual trigger may be unrelated to the behaviour.

## How To Deal With The Unpredictable Exploder

### 1) Let them run down

Like a hot air balloon, let them run out of air. Exploders will suddenly become silent or burst into tears. Get their attention. Stand up. Shout their name. Do something.

### 2) Indicate they have your attention

Let them know you have the same interest as they do in the subject at hand, but you would like to talk to them in a more calm, controlled manner. You may have to repeat your intentions several times, loudly.

### 3) De-escalate the emotion

Some exploders just want to explode and could care less about problem solving. Their explosions keep people away from them, so they don't have the responsibility of being a change agent. Suggest a time out. Exploders get everyone's gut in an uproar. A time out allows the problem solvers, as well as the Exploder, to calm down, compose themselves and regain some measure of rationality.

## Other Tips To Deal Effectively With An Angry Person

Know and understand your own response to anger. Anticipate ineffective responses you might be inclined to give.

Remember, the angry person may be reacting from a position of hurt or unhappiness, not related to the precipitating incident. As soon as you show the angry person that you are interested in listening to his/her hurt, you are no longer, "the enemy."

Let the angry person talk. Allow the angry feeling to spill out and listen in a non judgmental manner.

**Do not** try to introduce logic or information to a person who is filled with strong emotion - at that moment he/she simply does not have the capacity to utilize it.

Accept his/her right to be angry and accept him/her as a person of worth, even though you may not agree with his/ her reasons for being angry. You must also allow the person the right to be wrong.

Show non-verbally that you are listening. Nod affirmatively, pay close attention, and **do not** crowd him/her. React calmly, but with clear meaning. If you are able to get an opening, say: "This is obviously very important to you. I want to hear all about it, but only when you calm down."

If you have been part of the problem, admit it fully and willingly. If you do not, no resolution is possible and the problem can only become more serious.

## Preventing Burnout When Dealing With Difficult People

### 1) Stress management

Share your concerns with your peers, family and friends, and consult the nursing literature on stress management. If the concerns or stresses are serious, seek the counselling of professional stress managers.

Perioperative nursing conferences and nursing groups frequently deal with stress management as it is a universal problem. Don't go it alone. There is plenty of support available.

### 2) Healthy Living Lifestyle

Living a healthy lifestyle which includes proper nutrition, exercise and soul enhancing pleasures like family life, gardening, sports, travel, reading and numerous other hobbies and pastimes strengthens the body and spirit to deal with the stresses of life, especially professional life.

### 3) Recognition

It is very important to recognize that the issues of clients and other team members expressed in verbal and physical abuse or aggressive behaviours do not need to affect you personally. □

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M23193

# Cancer Management: What a Daunting Experience

By Regina Leonard, RN, CPN (C)

I work in a health care institution as an operating room nurse and deal with patients every day. I assist them from admission to the suite, to transport to the operating room and through their anaesthesia, surgery and discharge to Post Anaesthetic Recovery Room. Often, I felt that my presence and skill had assured, calmed and provided the best care to my patients.

Having personally been through the health care system for the past six months, I now have a new appreciation for the patient. I appreciate having had skilled and caring healthcare professionals during my treatments, but I also felt that I was somewhat ownerless in the overall care plan. The past months have been an emotional and physical roller coaster ride. Nothing in my learning or professional experience had prepared me for breast cancer management.

## Discovery

It was my 55th birthday. As is my practice, I completed a breast self-exam at the end of the month. It was not an unusual occurrence to find my breast tissue feeling a little different from the previous check. But this time I felt a pea sized nodule. I refused to panic but decided that I would check it again over the next month. At my next check nothing had changed; it was still present.

## Diagnosis

Although I was not due for my yearly check for another three months, I arranged for a breast check and mammogram. They both proved to be negative to the physician palpation and mammography report. I insisted that there was something there and I requested further checking. I was booked for an ultrasound and possible tissue biopsy.

The ultrasound was completed and as the sonographer completed the test I was able to view the screen and to see the darkening almond sized shadow that appeared at 12 o'clock on my right breast. All indications, according to the sonographer and the physician completing the biopsy, seemed to be that it was a cyst. A biopsy was completed and sent for analysis. For the next eight days I awaited the biopsy report, and when it arrived it indicated invasive carcinoma.

My initial reaction was disbelief, but yet at some level I accepted the news. I accepted the news with a fatalistic anticipation. Had not my mother and my sister died of breast cancer?

## Surgery

Within four days of my report I had a scheduled meeting with a surgeon and a surgical date for segmental breast resection with axillary node biopsy. The surgery was successful. For the following five weeks I recuperated and healed from the surgery. As for the surgery, the worst part of that event was living with the drain.

The final pathology report from the surgical excision was that I had an invasive carcinoma and indications were that I was free of spread to the surrounding tissue, and my axillary nodes were clear. The tumor was 4 cm large and hormone receptive. Given the size of the tumor I was classified as a stage 2 carcinoma (large node negative tumor).

## Author

Regina Leonard, RN, (CPN) C, is a Staff Nurse for the Operative Services at the University of Alberta Hospital, Edmonton, Alberta

## Cancer Treatment

I was referred to the cancer institute for further assessment and treatment options. Given my tumor size I was encouraged to have chemotherapy and radiation. Chemotherapy is used to treat and destroy any potential seeding or spreading of microscopic cells, while the radiation therapy is used specifically to target the tumor site in order to prevent or lessen the chances of a recurrence at this site.

## Fragmented

From diagnosis to discharge the care plan was fragmented. I felt as though I was in "no man's land". This is not a reflection of the care, but rather that I didn't really feel connected to any one caregiver. My care plan moved from family practitioner, to mammography technician, to ultrasonographer, to surgeon, to pathologist, to medical oncologist, to chemotherapy nurses, to radiography oncologist, to radiology technicians. In between these visits I went to labs, admission clinics, pharmacists, physiotherapists, waiting rooms and emergency department.

## Emotionally Draining

The biggest surprise during my entire treatment process was the overwhelming extent of my emotional response. I am normally quite in control, calm and capable of dealing with my emotional domain. From the day of diagnosis to even now, on occasion, I have cried, wept uncontrollably, wailed and moaned. And sometimes all at once! However, I have discovered that tears and fears go with the disease and actually aid in the healing process.

The chemotherapy and radiotherapy left me feeling lethargic. Insomnia overtook me and my physical health diminished considerably. About midway in my chemotherapy, I did myself a favor, and sought counselling from a therapist to help handle my emotional responses. This helped me in recognizing the normalcy of my response, my sadness and my need to accept what was happening to me. As well I attended group therapy for cancer patients. The group provided me with a non-judgmental, supportive and helpful forum. This too helped me to normalize, externalize my fears and better accept what was happening to me.

I have a strong family history of breast cancer. My mother (age 72) and my sister (age 35) died of breast cancer. They both died within a year and a half of their diagnosis. Some of my most frightening and early thoughts were of my own impending death. I am

learning to accept my disease and to view my cancer as unique to me, not to compare it to others, and to view my progress from day to day.

I have been able to work part time throughout the past six months. Other than for surgery and the month off when I was treated for infection, I worked an average of three days a week. Working for me was a great stabilizer and my colleagues were a source of support and strength.

Early in my chemotherapy treatment, at the end of my first drug cycle, I had a number of visitors for a family wedding. My family's presence was a boost to my psyche. At Christmas, at the end of my third drug cycle, one of my sisters came to visit. We visited, entertained and kept busy. The cumulative effects of the chemotherapy, the strain of the season and the immunosuppression left me exhausted and susceptible to infection.

## Chemotherapy

The chemotherapy treatments left me bald, immunosuppressed, with lowered blood counts and a susceptibility to opportunistic infection. At the beginning of my last of four cycles of chemotherapy I bottomed out with a severe infection from a cold that affected my entire respiratory tract, a cellulitis of my toes and an overall physical unwellness. A month of intravenous and oral antibiotic therapy, bedrest and a mild sedative helped to offset the complications and aided my healing.

## Radiotherapy

The radiotherapy was not as detrimental to my well being as I had anticipated. For twenty five days over a five-week period my affected breast was radiated. My skin became burned in the fourth week and was treated with a steroid cream for the remainder of the treatments, and then with a mild cream following the completion of radiation. The skin reaction healed over the four weeks following my last radiotherapy.

Cancer treatment, for me, was a major part of my life style over a six-month period. I became somewhat dependent on physicians, nurses, radiographers and other health care personnel for my treatment and care. It would be an understatement to say that it has been a bit of a roller coaster ride. But, at the same time, relinquishing my need for treatment and letting go of that need was a difficult thing to do.

On the day of my last treatment, I felt as though I was thrown to the wolves, and a deep sense of loss and abandonment occurred. Cancer management, fol-

low up care and assessment continue but the transition to that was not an easy process. A radiotherapist at the cancer institute asked me near the end of my last treatment "What are you going to do to celebrate?" It took me several days to realize and accept the completion of active treatment. My celebration included a theatre lunch with friends and continues in the knowledge that I am gaining in emotional and physical strength as each day goes by. Life is getting back to normal, or as normal as it will ever get for one who undergoes cancer therapy.

Cancer management has been daunting, fragmented, emotionally draining, frightening and dependent. At the time of this writing, it has been seven months since my initial diagnosis. And one month since my last active treatment. I feel as though I have reached a plateau. I call it my transitional space. There is no active treatment taking place; no indication of disease; no health

care intervention; just living day to day. And for that I am truly thankful. The oncology experts tell me that it will take up to a year for my body to completely rid itself of the full effects of the chemotherapy and radiation. My attitude is positive! Follow up will occur, and I shall continue to have my emotional moments, feel my aches and pains, worry about them to some extent and shall carry on positively with my life celebrating each and every day.

### Conclusion

I continue to work as a Staff Nurse for the Operative Services at the University of Alberta Hospital. The writing of this article has been a soulful and cathartic process. My intention in sharing the story of my treatment and experience with perioperative nurses is to provide a modicum of hope and encouragement to other cancer survivors. □

## ORNAC/Johnson & Johnson Medical Products Bursary

A bursary jointly funded by Johnson & Johnson Medical Products and ORNAC, and administered by the ORNAC Awards Committee, financially assist ORNAC members in furthering their education in areas that will enhance perioperative nursing practice. The Awards Committee, comprised of members from across the country, choose successful applicants in accordance with established selection criteria.

The applicant must be a registered nurse who is licensed with the Provincial Professional Association, employed full time in perioperative nursing practice, or at least .5 FTE or .5 equivalent casual hours in perioperative nursing practice. The applicant must also be an active member of the Provincial Operating Room Nursing Association two consecutive years prior to submitting the application. The individual must be employed, with a primary focus on perioperative nursing.

Funding is available for post basic operating room nursing programs approved by ORNAC, Baccalaureate nursing programs and Masters and Ph.D. nursing programs related to health care and considered an enhancement to existing perioperative employment.

The personal profile / resume must be typed and supporting data enclosed with the completed application form. The application will not be considered if this criteria is not met. This data includes letters of reference as indicated on the application form, photocopies of nursing license, membership in a provincial OR association, perioperative nursing certification (if applicable) and proof of acceptance in an education program.

### Deadline for Submissions

The complete, typed application form and supporting documentation must be submitted to the Chair of the ORNAC Awards Committee before March 15th each year. Late submissions will not be considered.

The applications are judged by the committee based on established criteria. If there are no suitable applicants, the award will not be presented and funds will be carried over to the next year. Bursary funds are designated specifically for tuition and books. Final approval for disbursement of funds rests with the Awards Committee and the ORNAC Board of Directors. At the end of the term, proof of successful completion of the course must be forwarded to the Chair of the Awards Committee in order to close out the file.

ORNAC recognizes that the education of perioperative nurses plays a pivotal role in providing a strong and successful national organization. The ORNAC Executive and Board of Directors appreciates the financial support provided by Johnson & Johnson Medical Products.

Write for a Bursary Application to:

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**Email: kbruce@lakeridgehealth.on.ca**

## The perky, self-confident type enjoys improved chances of stroke recovery

How much influence does personality have on one's ability to recover from a stroke? Well, if you have a perky one, it can be a life-saver.

In a study reported in a recent issue of the *Medical Post*, investigators studied the personalities of 35 stroke patients and followed up their recovery one year later. They determined the patients' pre-stroke personalities through questioning of close relatives.

People who were highly conscious or deep thinkers were most vulnerable to post-stroke depression (which is considered a high risk factor for subsequent strokes).

In contrast, people described as energetic, outgoing, flexible and self-confident were more able to reach a higher level of recovery.

Lead researcher Dr. Lynn Grattan (Ph.D.) believes that a brief neuro-psychological examination could allow health care professionals to take steps to harness the patient's personality strengths and weaknesses in order to guide them through the post-operative rehabilitation period. □

## Osteoporotic fractures identical for men and women

The Osteoporosis Society of Canada (OSC), which recently found in a survey that 72% of Canadian men refuse to take seriously the risk of developing osteoporosis, has a message for them - start worrying.

### Unconcerned

The survey, released early last winter, estimated that one in eight men over age 50 has osteoporosis and that men account for 20% to 35% of osteoporotic fractures. This survey of over 1000 men from across Canada also found that 90% of men had never consulted a physician about osteoporosis and only two of the survey respondents listed it as a serious health concern.

Dr. Rick Adachi, a rheumatologist at St. Joseph's Hospital in Hamilton, Ontario, maintains that the

problem is even worse than the OSC estimates.

In referring to a recent study - the Canadian Multi-centre Osteoporosis Study (CAMOS) - he pointed out that one of the astounding things discovered was that, in men between the ages of 60 and 69, one in five had osteoporotic fractures, which is identical to the incidence found in women.

### Cholesterol connection

And still on the topic of bones, an animal study reported in a recent issue of the *Journal of Bone and Mineral Research*, shows that a high-fat diet dramatically reduces bone density and bone mineral in an animal model. This suggests that high cholesterol may play a role in the development of osteoporosis. □

## Conference Calendar

### September 27 - 29, 2001

Newfoundland and Labrador Operating Room Nurses Association - 23rd Provincial Conference, Holiday Inn, St. John's, NF. Contact: tilleyval@hotmail.com

### October 12 - 13, 2001

ORNAHD's 17th Regional Conference at White Oaks Conference Resort and Spa, Niagara-on-the-Lake, ON. Topics: "Endoluminal Aneurysm Repair", "Explosion; Disaster Response". Registration: Linda Becker c/o Grand River Hospital, Kitchener, On.

### October 13, 2001

Saskatchewan Operating Room Nurses Group - Meeting in Prince Albert, SK.

### September 25-28, 2002

Atlantic Conference Meeting, Charlottetown, PE.

### April 18 - 20, 2002


British Columbia Operating Room Nurses Group - Kelowna, BC.

### May 4-6, 2002

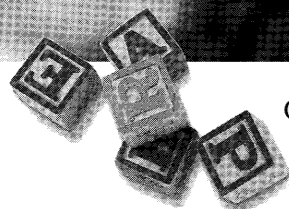
Operating Room Nurses Association of Ontario - Meeting in Windsor, ON.

### October, 2002

Operating Room Nurses Association of Alberta - Meeting in Edmonton, AB.



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For more information on these and other opportunities, please visit us online at  
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Be Someone to look up to.

## Age should not be a primary factor when considering arthroplasty for the elderly

With our aging population, it is considered essential that we keep our elderly independent and ambulant as long as possible. Yet, for the elderly, many are not being considered for arthroplasty primarily because of their age.

This is wrong, says Dr. William Johnston, a co-investigator of a study that looked into the outcomes of total hip and knee arthroplasty in the elderly.

"It is not chronological age, it's physiological age that should determine suitability for surgery," said Dr. Johnston of the University of Alberta in Edmonton, where the study took place. The study was undertaken when it was noticed that patients older than 79 were not being considered for surgery by some surgeons and referring doctors.

The researchers, from the departments of Public Health Sciences and Orthopaedic Surgery, studied 454 arthroplasty patients from two Edmonton-area hospitals from December, 1995 to January, 1997.

Of the hip arthroplasty patients, 83% were be-

tween 55 and 79 years of age, and 17% were 80 or older. Of those who received total knee arthroplasty, 86% were 55 to 79 and 14% were 80 years of age or older.

These patients were evaluated within a month prior to surgery and six months post-op for pain, function, and health-related quality of life factors.

### No age-related differences

The researchers found no age-related differences in joint pain, function or quality of life measures pre-operatively or at six months post-operatively. Furthermore, they also found that after adjusting for potential confounding factors, age was not a significant determinant of pain or function. In fact, regardless of age, all patients in the study had returned to the community at six months post-op.

Johnston, in a news item reported in the March 2001 issue of the *Medical Post*, said he hopes these findings will change the way policymakers deal with the elderly with these painful problems. In addition to the quality of life benefit, there are economic benefits for keeping the elderly ambulatory and independent. □

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## Only 5% of dying Canadians receive quality end-of-life care

The recently released report by the Standing Committee on Social Affairs, Science and Technology of the Canadian Senate shows that little progress has been made in the area of quality end-of-life care since their first report came out six years ago. This 1995 release entitled, *Of Life and Death - final report*, stated that Canadians were dying in needless pain and without adequate palliative care, that support for research into end-of-life care is inadequate, and that a comprehensive, national palliative care strategy needs to be developed.<sup>(1)</sup>

### Issues addressed

In the latest Senate report released last summer (*Quality End-of-Life Care: The Right of Every Canadian*),<sup>(2)</sup> it appears that the senate wants some action taken. Not only does this report address the issues brought up in 1995, it also provides recommendations that could shape palliative care in Canada for years to come.

Canadians are now dying in record numbers, and these numbers will continue to rise as the population ages. Annually, over 220,000 Canadians die, with 75% dying in long-term care facilities and hospitals.<sup>(3)</sup>

The Senate, informed through witnesses and presentations from concerned organizations (i.e., Canadian Palliative Care Association, etc.), was told that "only 5% of dying Canadians will receive integrated interdisciplinary palliative care," i.e., care aimed at alleviating physical, emotional, psychological and spiritual suffering, rather than care that aims for a cure.<sup>(4)</sup>

### Diminishing resources

The Senate was further informed that, since the 1995 report, the number of institutional palliative care beds across the country has been cut as a result of health care restructuring, and that few provinces have designated palliative care as a core service with a specific budget.<sup>(5)</sup> In other words, while the necessity for end-of-life care has reached record levels, the resources required to provide this care are diminishing.

Nurses know that the successful management of a dying patient is not measured in days of life endured, but, in quality of life lived. Concerns about quality of life also extend to families, many of whom make tremendous physical, emotional and even financial sacrifices in attending to their loved ones.<sup>(6)</sup>

The Senate also took note of the disturbing lack of research that addresses end-of-life care. Since the Senate's 1995 report, a significant number of Canada's best palliative care researchers have left the country and support for research into end-of-life care remains woefully inadequate.<sup>(3)</sup>

The latest report strongly recommends that resources be designated to bolster research that focuses on end-of-life issues facing Canadians of all ages and all medical conditions. (Continued page 34).

Because some issues are too contentious or controversial for our elected members of the House of Commons to handle, the Canadian Senate (a non-elected body), is periodically asked to deal with them. One such issue centred on the assisted suicide of Sue Rodriguez in the early 90's. Prior to her death, she made a submission to the Supreme Court of Canada arguing that the law against assisted suicide was in contravention of the *Canadian Charter of Rights and Freedom*. The Court, in a slim majority decision, upheld the prohibition against assisted suicide.

In the wake of this slim majority, the Senate was asked to examine the legal, social and ethical aspects of euthanasia and assisted suicide. From this examination originated the 1995 Senate report (*Of life and Death*) referred to above, as well as the more recent deliberations, *Quality End-of-Life Care: The Right of Every Canadian*, which is primarily an examination of the developments since 1995.

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**No End-of-Life-Care** (Continued from page 32).

For the great majority of palliative care advocates who desire to see expeditious, dedicated and constructive changes in this country's commitment to end-of-life care, the Senate report appears to have delivered all that could be asked for.

Will this report gather dust, or will the decision makers and palliative care advocates succeed in taking on the responsibility to ensure that quality end-of-life care is current and accessible to every Canadian?

The preceding has been abridged and edited from a "Commentary" in the *Canadian Medical Association Journal*, March 20, 2001; p.794-95. □

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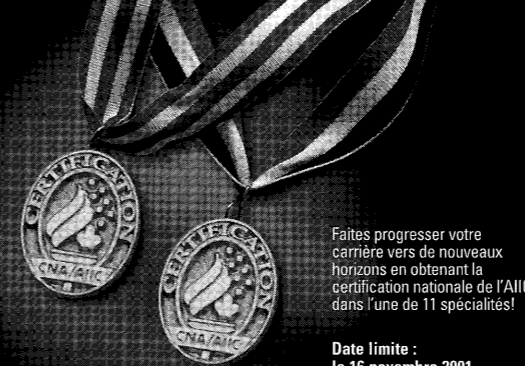
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## Roy Henry Vickers - Banff (continued)

At the end of a dynamic five-day program dealing with paradoxes in nursing, ethical dilemmas, shifts in paradigms, transplantation and all the new and dazzling technology of modern medicine, the final speaker, with his humorous childhood stories and his sharing of the simple truths of life, provided an uplifting closure.

"We are all meant to sing together, we are all meant to dance together, to pull together and sit quietly together", he said. He had delegates pulling together in an imaginary canoe and chanting(singing) his song.

Roy Henry Vickers, hereditary chief, artist, warrior and healer, took the nurses on a delightful journey with stories of his life as a native child in the village of Kitkatlow, 40 miles as the crow flies from Prince Rupert, BC. Then, from childhood his journey to an internationally acclaimed artist, to a drug addict, and finally to a healer.

He dreamed all his youth of being a member of the Royal Canadian Mounted Police. He acquired skill as a horseman and thought..." RCMP - wow! I'm going to go all over the world in the Musical Ride". But a medical exam dashed the young man's dreams. His eyesight was found to be better than one in 10,000 people. His vision is better than most, but, ironically, he could not see the colors correctly.

"I was partially color blind. It broke my heart. In those days [ to enroll in the RCMP ] you had to be over 5'10". I was. You had to have perfect health. I was in good shape. But, you could not be partially color blind. I walked home after the medical because I didn't want anyone to see me crying. It was my whole life dream."

So, he became an artist. He studied the art of his people, and the art of his mother - the Dutch, and the art of the English.

"In 1987, I sat at a round table with the Queen for the second time. She had been presented with one of my paintings. When she entered the room and the bagpipes played and we sang *God Save The Queen*, I cried. I never thought I'd see the day when I'd be looking at her and singing that song".

From 1987 his world turned upside down. Suddenly he was an internationally acclaimed artist, dining with the Queen. He totally lost his privacy with the sudden notoriety and didn't know how to deal with all the emotions that came with the acclaim.

"I turned to whatever would take me out of my emotions. I became like one of many artists the world over - I became a drug addict and an alcoholic".

In time, Roy Henry sought rehabilitation at Meadows - a treatment centre in Arizona which was established specifically to treat native people. While there he learned of the seven emotions: fear,

anger, shame, guilt loneliness, joy and pain. And he learned that with each emotion there is a gift if we process the emotions. The gift that comes with processing fear is strength, and the gift of both pain and joy is healing. Today he is a healer.

While working to establish Vision Quest - a non-profit organization to develop a national recovery centre, he sought the assistance of many professionals and groups.

"Who do you think stepped-up" he asked? Not the local M.L.A., not the teachers, not the superintendants, not the doctors, not the prime minister, not the premier. Who stepped-up to help? The RCMP ! The Commissioner said to me:

"Roy, recovering the truth and strength and beauty of who we are, and living in sobriety and helping others to walk this road of healing, I believe, is crime prevention".

"Whatever you can envision for yourself - no matter how impossible - if you can see yourself, and feel yourself in that position, eventually everything will fall into place and you'll be there", he said.

"You are the centre of the world. You make a difference everywhere you go and if anything is going to pick you up and carry you through life, it will be how much you are able to love yourself unconditionally.

### When someone is having difficulty - lift them up! Sing with them!

How many of us accept ourselves when we are working hard? How many of us feel guilty if we've been taking it easy and cruising? The greatest healing any of us can experience is to love ourselves unconditionally. Every single person we touch will feel it - all hospital workers, doctors, families, and school children. If we can do this, there are changes we can bring about in this society that people are crying for everyday.

When we need a lift, we can go to a conference like this. That's what you're doing here. You're loving each other, pulling together, lifting each other up.

When you see someone who is having difficulty - lift them up! Sing with them. Dance with them. Dancing is warrior work. I know, because I'm a warrior and [ like you nurses ] I am a healer", he said.

"The healing salve, the ointment of the healer", he said, "is story telling". When you're tired and you've lost your energy and need a lift, go to whoever will listen to you, and tell your story. It will help you and it will help them. Everytime I share the simple lessons of life given to me, I am healed. I am worthy. I love myself unconditionally". □

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#### Qualifications:

- Baccalaureate in a Health Care Discipline, Masters preferred.
- Three (3) to five (5) years progressive related experience in health care management **required**, with a proven track record of clinical service and leadership.
- Experience in an Operating Room environment preferred.
- Equivalencies may be considered.

Please forward resume quoting **Competition #OR-017M01/MH** to:

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Misericordia Community Hospital  
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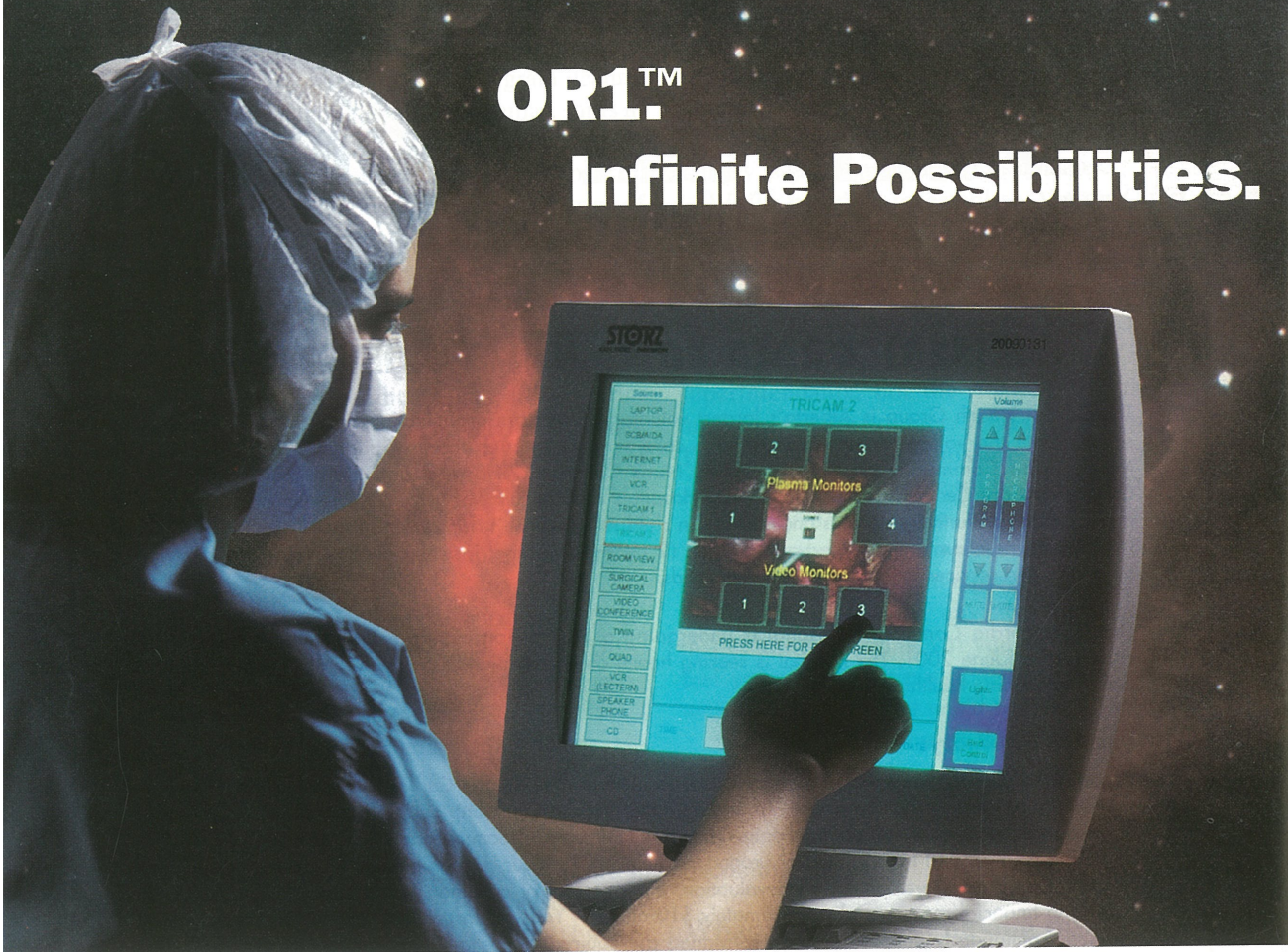
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