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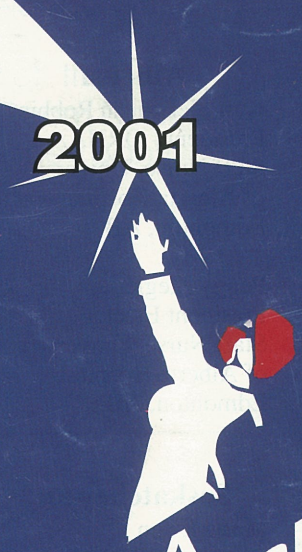

A Surgical Odyssey

- Ethical Competence
- O. R. Staff Education
- Liposuction

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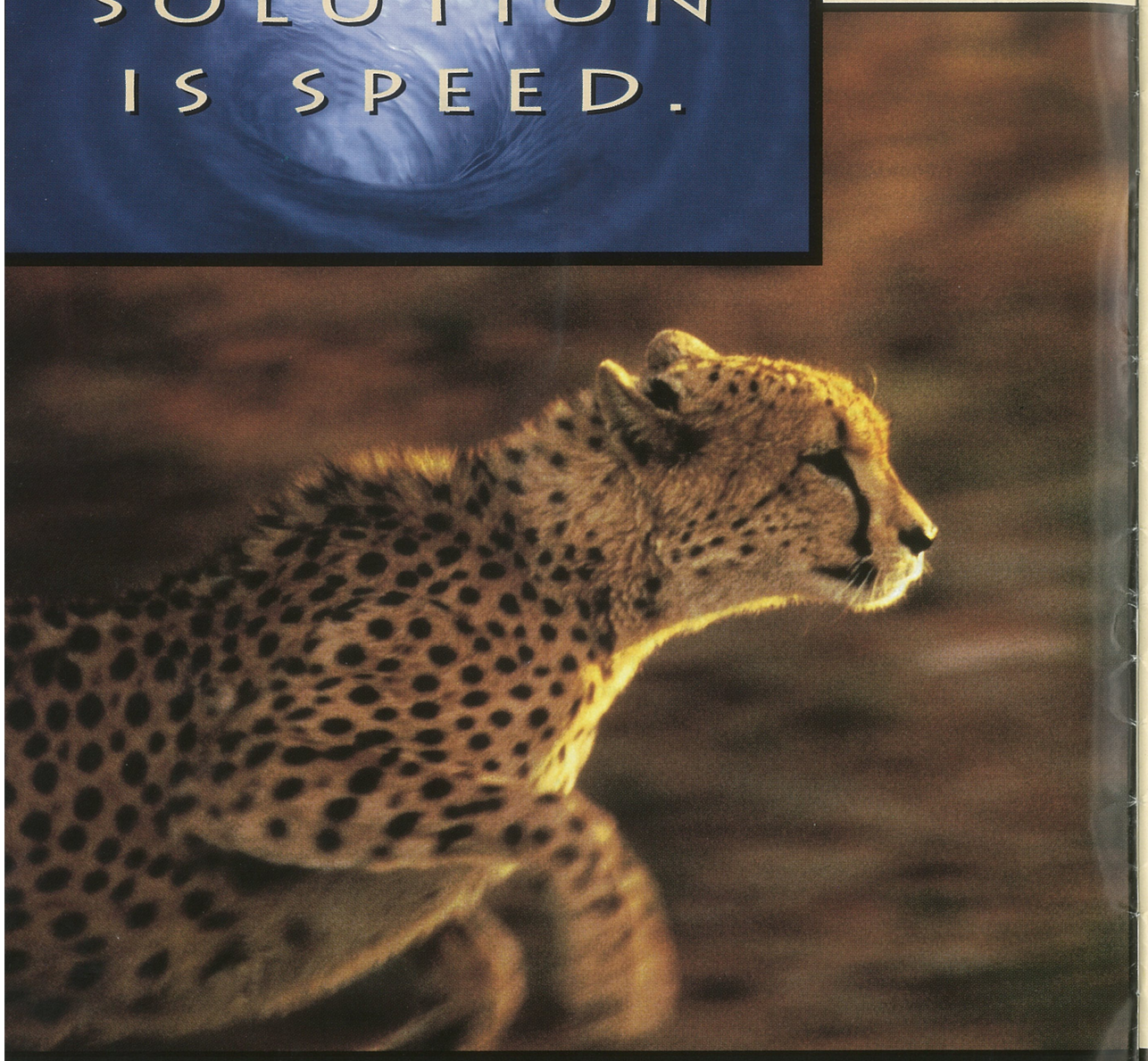
Editorial Contents

THE SOLUTION IS SPEED.



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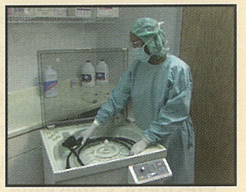

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Harassment in the Workplace

By Marlene Hill, RN, CPN(C)

The very important basic principle of *"Refuse to accept or condone any form of harassment"* was intentionally omitted from a previous President's message titled "Basic Principles" (June, 2000 CORNJ) as I thought it deserved to be given special and separate consideration. For proper timing, it was necessary to present the messages on "Certification" and "Standards" first.

It seems that highly motivated and assertive individuals are attracted to the OR - a place which can, at times, be remarkably stressful and hectic.

I am of the "old school" where you quickly learned to develop a "thick skin" if you wished to remain in the operating room and enjoy a long career in perioperative nursing. The following address reflects my thoughts only, so differing opinions may occur.

Physical and sexual harassment must not be accepted or condoned. Evidence of this should be reported to the appropriate personnel as soon as possible.

Some people are considerate and employ good basic principles displaying an even temper in calm as well as in emergency/tense situations. These individuals are well liked and receive great respect from other members of the operating room team.

I have kept **verbal abuse** separate from other forms of harassment because, although it should not be tolerated, there are times when causes for it may be explained to some extent. Examples of where it may be advisable to let common sense prevail by disregarding the unpleasantness until a later time when the matter of concern can be discussed privately include:

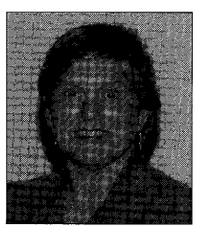
- When haemorrhage or other crisis occurs and the tense surgeon lashes out at the nearest team member, the scrub nurse;
- When a patient's condition rapidly deteriorates and the anaesthetist requires much help in a short period of time; and
- When a surgeon finds himself/herself with inexperienced personnel during a complex procedure and becomes frustrated.

Verbal harassment emotionally injures the individual to whom it is directed. However, the damage done may be lessened if the offender makes amends with words like "I'm sorry" and "thank you", when the situation becomes less tense. Following the procedure, if steps are not taken by the offending physician/individual to make amends and resolve the issue, the victim should approach the offender privately. If no satisfaction is gained, or if the abused person is not comfortable in confronting the abuser by herself/himself, it is appropriate for the registered nurse in charge of the OR theatre to help defend the victim by confirming with the offender and perioperative nurse manager that a wrongful act was committed and that a resolution is expected.

To my way of thinking, an already tense situation could be aggravated if the verbally-wronged person addresses the harassment at the time by speaking strongly to the offender or by threatening to vacate the room. We must remember that the delivery of quality patient care cannot be compromised.

This message will probably stimulate dialogue among members with differing points of view. Some with more aggressive tendencies or from other schools of thought may disagree with my idea that common sense should prevail in certain verbal harassment cases. However, if we put things in proper perspective, the delivery of the best patient care possible should take priority.

This is the last of my series of President's Messages. I hope you have found them interesting and providing some "food for thought". My term of office as ORNAC President is over at the close of the Banff National Conference. My successor is Mary Knight Kubasiewicz from Winnipeg, Manitoba. She is very knowledgeable and I have full faith that Canadian perioperative registered nurses will indeed benefit from her leadership and guidance.



Marlene Hill, RN, CPN(C), is President of the Operating Room Nurses Association of Canada. She is Staff Nurse, Operating Room, Queen Elizabeth Hospital, Charlottetown, PEI.

My thanks is extended to the many individuals who have supported me during the past two years, to the ORNAC Board and Executive, the provincial conference organizers and delegates who have made me feel so welcome, and the management and OR staff of my institution, the Queen Elizabeth Hospital in Charlottetown, Prince Edward Island, for granting me paid leave to attend the required conferences and meetings, and for providing other thoughtful considerations.

My term of office has allowed me to travel extensively and meet a great deal of fine people. Their kindness and friendship was appreciated and will always be remembered.

As a parting gift, I'll share with you some thought-provoking and very true quotes taken from a wonderful mail- order magazine, "*Successories*":

"1) True leaders are not those who strive to be first, but those who are first to serve and give their all for the success of the team.

2) Teamwork is the ability to work together towards a common vision. The ability to direct individual accomplishment toward organizational objectives. It is the fuel that allows common people to attain uncommon results.

3) The Power of Attitude - *Our lives are not determined by what happens to us, but how we react to what happens, not by what life brings to us, but by the attitude we bring to life. A positive attitude causes a chain reaction of positive thoughts, events and outcomes. It is a catalyst... a spark that creates extraordinary results.*

4) Achievement - *Unless you try to do something beyond what you have already mastered you will never grow.* And last, my favourite:

5) The Essence of a New Day - *This is a beginning of a new day. You have been given this day to use as you will. You can waste it or use it for good. What you do today is important because you are exchanging a day of your life for it. When tomorrow comes, this day will be gone forever; in its place is something that you have left behind... let it be something good".* ❐

World Conference of Surgical Patient Care

September 2 - 7, 2001, Christchurch, New Zealand

AORN and the International Planning Committee, (IPC) have been working diligently to plan and offer a first-class World conference in beautiful New Zealand. A mailout of registration booklets was completed in December, 2000. For those who did not receive it, the information including registration, accessible hotels, program content, social events, hospital tours, and available vacation tour packages, can be obtained through the Internet by contacting www.aorn.org and 'clicking on' World Conference.

Information may also be obtained by contacting: AORN, Inc. Customer Service/World, 2170 S Parker Rd., Suite 300, Denver, CO 8023 -5711, USA.

The conference theme*"Vision for the New Millennium: A new Beginning"* is quite timely and was chosen with the idea of providing interesting educational sessions for delegates either directly or indirectly involved with perioperative nursing care.

Canadians who have been chosen to speak are Catherine Bustard, and co-presenters Valerie Zellemeyer and Pat Pocok. Their topics are *"Oh My Aching Back: Spinal Implants" and "Best Practices and Clinical Outcomes"* respectively. Congratulations on being selected!

During Opening Ceremonies at the last World Conference in Helsinki, it was heart-warming for the representatives carrying her/his nation's flag across the stage to see individuals seated together and waving small flags of their country. It would be lovely to see the Canadian contingent seated together and waiving their flags proudly on the first day so do not forget to pack this item.

It has been past practice for Canadian delegates to dress in coordinating colors of red and white on International Fellowship Night. ORNAC usually provides several accessories that Canadian delegates may purchase for a small fee. The "Canadian attire" will remain the same as in Helsinki, Finland with the red hats and white and red scarves. These will be available for sale in Banff at the ORNAC booth at a cost of $15.00 for both, or, if desired, purchase may be made through the mail by sending a cheque payable to ORNAC for the amount of $18.00 (includes shipping charges) to me at: R. R. #1, Crapaud, PE, C0A 1J0.

On International Fellowship Night, Canadian delegates are invited to meet just inside the front entrance at 1955 hours for a group photo that will be published in the CORNJ along with conference "highlights". Also on this evening, it is customary to exchange small mementos, so come prepared with Logo Pins and Canadian souvenirs as 'give-aways'.

Submitted by Marlene Hill, IPC Planning Member.

Ethical Competence and Perioperative Nursing

By Carol Taylor, CSFN, RN, PhD

2001 A Surgical Odyssey

In this article an experienced nurse ethicist will lead readers in an exploration of the ethical challenges confronting perioperative nurses today. An argument will be made for ethical competence as a core competence for all health care professionals. After distinguishing ethical uncertainty, dilemma and distress, tools to facilitate moral reasoning and ethical decision making are outlined.

Upon completion of this article, perioperative nurses will be able to:

1. Distinguish ethical uncertainty, ethical dilemma, and ethical distress.
2. Identify potential areas of conflict between professional and personal values.
3. Describe ethical competence as a core competence of professional nurses.
4. Apply moral reasoning and ethical decision making skills to ethical dilemmas.

I. Introduction

A. Ethics and Morals

Ethics is systematic inquiry into the principles of right and wrong conduct, of virtue and vice, and of good and evil as they relate to conduct. Many people use the term ethics when describing the professional ethics incorporated into a code of professional conduct, such as nursing codes of ethics.

Morals, although similar in meaning to ethics, usually refer to personal standards of right and wrong. It is important to distinguish ethics from religion, law, custom, and institutional practices. For example, the fact that an action is legal or customary does not in itself make the action morally right.

B. Professional Ethical Conduct

Nurses committed to high-quality care base their practice on professional standards of ethical conduct. The study of professional ethical behavior begins in nursing school, continues in formal and informal discussions with colleagues and peers, and culminates when nurses "try on" and make their own, the behaviors of role models who practice professional nursing that is consistent with high ethical standards. Where do nurses learn the standards for professional ethical behavior? At the very least nurses should understand the ethical theories which dictate and justify professional conduct, be familiar with codes of professional ethics and professional values, and be skilled in using a model of ethical decision making to resolve ethical problems.

C. Theories of Ethics

Ethical theories are systems of reflection that attempt to explain how we ought to live and why. These theories may be broadly categorized as action-guiding theories that answer the question, "What ought I to do?" or character-guiding theories that answer the question - "What kind of person ought I to be?" Action-guiding theories fall into two main categories:

Utilitarian: The rightness or wrongness of an action depends on the consequences the action produces.

Deontologic: An action is right or wrong independent of the consequences it produces.

Nursing ethics, which is a subset of bioethics, is the formal study of the ethical issues that arise in the practice of nursing and of the analysis used by nurses to make ethical judgments. Nurse ethicists frequently use two popular theoretical and practical approaches to doing bioethics: the principle-based approach and the care-based approach.

Author

Carol Taylor, RN, PhD, is Associate Director for Clinical Bioethics, Georgetown University School of Nursing, Washington, DC.

This article was presented as backgound material for her dynamic interactive session at the ORNAC Halifax Conference in 1999, and a reading is ideal preparation for her lecture at the ORNAC National Conference in Banff, 2001.

Principle-Based Approach

The principle-based approach to doing bioethics offers specific action guides for practice.

Principle	Moral Rule	Implications for Nursing Practice
Autonomy (self-determination)	Respect the rights of patients or their surrogates to make health care decisions	Provide the information and support patients and families need to make the decision that is right for them; at times this may mean collaborating with other members of the health care team to advocate for the patient.
Nonmaleficence	Avoid causing harm	Seek not to inflict harm and to prevent harm or risk of harm whenever possible.
Beneflcence	Benefit the patient and balance benefits against risks and harms	Commit yourself to actively promote the patient's benefit (health and well-being). Be sensitive to the fact that individuals (patients, family members and professional caregivers) may identify benefits and harms differently. A benefit to one may be a burden to another.
Justice	Give each his /her due; act fairly	Always seek to distribute the benefits, risks and costs of nursing care justly. This may involve recognizing subtle instances of bias and discrimination.
Fidelity	Keep promises	Be faithful to your promise to the public to be competent and to be willing to use your competence to benefit the patients entrusted to your care. Never abandon a patient entrusted to your care without first providing for their needs.

Sadly, there is no foolproof method for identifying which principle is most important when there is conflict among competing principles. Popularized versions of the principle-based approach to bioethics have too frequently resulted in a type of "quandary ethics" that diminishes in importance the everyday ethical concerns of nurses and misleadingly suggests that how ethical dilemmas are resolved is unimportant, so long as one can justify one's recommendation with recourse to a principle.

Care-Based Approach

Dissatisfaction with the principle-based approach to bioethics led many nurses to look to care as the foundation for nursing's moral obligation. The nurse-patient relationship is central to the care-based approach, which directs attention to **the "particulars" of individual** patients who are viewed within the context of their life narrative. The care perspective directs that how I choose to be each time I encounter a patient or colleague is a matter of ethical significance. Ethics is not reduced to a decision to withhold or withdraw life-sustaining treatment. Characteristics of the care perspective include:

- Centrality of the caring relationship,
- Promotion of the dignity and respect of patients as people,
- Attention to the particulars about individual patients,
- Cultivation of responsiveness to others and professional responsibility, and
- A redefinition of fundamental moral skills to include virtues like kindness, attentiveness, empathy, compassion, reliability (Taylor, 1993)

D. Nursing Codes of Ethic

A professional code of ethics provides a framework for making ethical decisions and sets forth professional expectations. Nursing codes of ethics inform both nurses and society of the primary goals and values of the profession. These should be compatible with the nurse's personal value system and moral code.

Canadian Nurses Association Code of Ethics

Health and Well-being: Nurses value health and well-being and assist persons to achieve their optimal level of health in situations of normal health, illness, injury, or in the process of dying.

Choice: Nurses respect and promote the autonomy of clients and help them express their health needs and values and obtain appropriate information and services.

Dignity: Nurses value and advocate the dignity and self-respect of human beings.

Confidentiality: Nurses safeguard the trust of clients so that information learned in the context of a professional relationship is shared outside the health care team only with the client's permission, or as legally required.

Fairness: Nurses apply and promote principles of equity and fairness to assist clients in receiving unbiased treatment and a share of health services and resources proportionate to their needs.

Accountability: Nurses act in a manner consistent with their professional responsibilities and standards of practice.

Practice Environments Conducive to Safe, Competent, and Ethical Care: Nurses advocate practice environments that have the organizational and human support systems and the resource allocations necessary for safe, competent, and ethical nursing care. *From the Canadian Nurses Association. (1997). Code of Ethics for Registered Nurses. Ottawa, Ontario. The Association.*

E. Professional Values

Professional values provide the foundation for nursing practice and guide the nurse's interactions with patients, colleagues, and the public. In 1998 the American Association of Colleges of Nursing identified five values that epitomize the caring, professional nurse. It is important for every nurse to critically examine his or her personal values to see if they match these essential professional values.

1. Altruism is a concern for the welfare and well being of others. In professional practice, altruism is reflected by the nurse's concern for the welfare of patients, other nurses, and other health care providers. Sample professional behaviors include:

- demonstrates understanding of cultures, beliefs and perspectives of others;
- advocates for patients, particularly the most vulnerable;
- takes risks on behalf of patients and colleagues; and
- mentors other professionals.

2. Autonomy is the right to self-determination. Professional practice reflects autonomy when the nurse respects patients' rights to make decisions about their health care. Sample professional behaviors include:

- plans care in partnership with patients;
- honors the right of patients and families to make decisions about health care; and
- provides information so patients can make informed choices.

3. Human dignity is respect for the inherent worth and uniqueness of individuals and populations. In professional practice, human dignity is reflected when the nurse values and respects all patients and colleagues. Sample professional behaviors include:

- provides culturally competent and sensitive care;
- protects the patient's privacy;
- preserves the confidentiality of patients and health care providers; and,
- designs care with sensitivity to individual patient needs.

4. Integrity is acting in accordance with an appropriate code of ethics and accepted standards of practice. Integrity is reflected in professional practice when the nurse provides care based on an ethical framework that is accepted within the profession. Sample professional behaviors include:

- provides honest information to patients and the public;
- documents care accurately and honestly;
- seeks to remedy errors made by self or others; and,
- demonstrates accountability for own actions.

5. Social Justice is upholding moral, legal and humanistic principles. This value is reflected in professional practice when the nurse works to assure equal treatment under law and equal access to quality health care. Sample professional behaviors include:

- supports fairness and nondiscrimination in the delivery of care;
- promotes universal access to health care; and
- encourages legislation and policy consistent

with the advancement of nursing care and health care. *The Essential of Baccalaureate Education for Professional Nursing Practice.(1998).* Washington,DC: American Association of Colleges of Nursing.

II. Ethical Problems and Perioperative Nursing

A. Ethical Problems

1. ethical uncertainty: the nurse senses a concern or problem but is unsure of which ethical values and principles apply;

2. ethical dilemma: two (or more) clear moral principles apply but support mutually inconsistent courses of action; and

3. ethical distress: the nurse knows the right thing to do but institutional constraints make it nearly impossible to pursue the right actions.

B. Reasoning about Ethical Decisions

Nurses need sound analytic skills and the ability to engage in moral reasoning to resolve moral dilemmas and moral distress. Every nurse needs to be confident in using a process of ethical decision making.

1. **Assess the situation (gather data).** Recognize and then describe the situation that gives rise to the ethical problem: Main people involved (their views and interests); Patient's overall nursing, medical and social situation; Relevant legal, administrative, and staff considerations.

2. **Diagnose (identify) the ethical problem.** State the problem clearly. Identify your relationship to the decision. Identify time parameters.

3. **Plan.** Identify options and explore the probable short and long-term consequences of each. Use ethical reasoning to decide upon a course of action which you can justify ethically. Decide upon the course of action you are best able to support. **Consultation with a respected and wise colleague or an institutional ethics committee may be helpful at this point.**

4. **Implement your decision.** Implement your decision and compare the outcome of your action with what you considered and hoped for in advance.

5. **Evaluate your decision.** What have you learned from this process that will help you in the future? How can you improve your reasoning and decision making in the future?

C. Ethical Competence

Ethically competent perioperative nurses

1. are clinically competent,
2. can be trusted to act in ways that advance the best interests of the patients entrusted to their care,
3. hold themselves and their colleagues accountable for their practice,
4. work collaboratively to advocate for patients, families, communities,
5. mediate ethical conflict among the patient, significant others, the health care team, and other interested parties,
6. critique new health care technologies and changes in the way we define, administer, deliver and finance health care in light of their potential to influence human well-being (Taylor, 1997).

III. Case Applications

Methodology for Values-Conflict Resolution

Recognizing and Acknowledging the Conflict or Uncertainty

While this step of the process seems self-evident, it is often the source of unresolved conflicts. Participants may deny the actual conflict or uncertainty and reject the idea that there are *legitimate* competing ethical principles and values. Resolutions begin by recognizing that others hold legitimate values and have ethical traditions that must be respected and taken into account. Once this step is made, the conflicts become evident and can be acknowledged publicly—regardless of the specific resolution each stakeholder initially finds preferable.

PREREQUISITE: moral sensitivity and responsibility

Gathering Information

In this step of the process participants attempt to learn all they can about the conflict itself. What is the source of the conflict and related uncertainties? What is at stake? What information is needed to facilitate resolution of the conflict? Who are the stakeholders and what are their values and interests? During the data gathering phase it is essential to distinguish factual judgments from *individual or collective perceptions* which may or may not be true.

PREREQUISITE: intellectual humility, openness, respect

Identifying the Stakeholders

Who are the stakeholders in the decision? That is, who will be affected by it, either through responsibility for making decisions or implementing the decision, or experiencing the outcomes of its implementation?

Identifying the Stakeholders' Interests

Each stakeholder should talk freely about his or her perspective on the issue in question. (N.B. It is important for all stakeholders to be present at the table and to have a voice. Examples abound of discrepancies between perceived and actual values/interests of particular individuals and groups.) The aim of this phase is to have people talk freely and fully, without contradiction or analysis, so that all the relevant perspectives and data get put on the table.

Articulating and Ranking Values

Begin by articulating, and listing, the cherished values of each stakeholder group. Rank these so that the most important values of each stakeholder are known to the group at large. Use some process to reach consensus about the core values which then ought to direct the resolution of the problem at hand.

PREREQUISITE: respect and trust

Achieving agreement on a decision will depend in large part on the extent to which the participants in the discussion have gained an appreciation of and respect for the concerns and values of the varying perspectives they represent. Ideally, they come to respect for and trust in one another as honest, decent, well-motivated persons, and not as members of hostile "interest groups."

Identifying the Issue

First, the group, after hearing the different perspectives, tries to define the disputed issue or issues as precisely as possible and identify the reasons for or root causes of the problem. The aim here is for the group to understand the problem as accurately as possible. Second, the group reflects on the various explanations for the problem that have been offered, tests them for their relative adequacy, and sees which best "fits" the data gathered in the first phase of the discussion. The aim of this phase is for all stakeholders to reach a common judgment on the best explanation of the issue, which will also involve the overcoming of partial ignorance or personal bias.

PREREQUISITE: intellectual clarity

Generating Possible Courses of Action

Crafting a response to the issue involves the identification of various plans of actions which are then critiqued in light of the most cherished values of the full group.

PREREQUISITE: critical thinking and creativity

Making the Decision

Ideally a consensus is reached and a decision is made on the basis of a relatively adequate understanding of all the dimensions of the problem and a generous concern for, not necessarily all, but the most cherished among the values of each of the stakeholder representatives.

PREREQUISITE: responsibility and accountability

What is to be done if a group of representatives cannot reach consensus and is deadlocked in opposing positions?

- Redo steps above to make sure participants genuinely understand and empathize with the cherished values of each, so that they may be able to set in priority ranking the most compelling concerns in order to reach consensus.
- Strive anew to creatively and imaginatively design a new course of action in which all the required values are promoted.
- Ask the opposing parties if their disagreement is non-negotiable, i.e., is a matter of serious violation of conscience, or whether they could move ahead with the majority's plan of action, even though it is not their preference.
- Check past history to see if there is precedent for one or other of the opposed positions, and how, and how satisfactorily, the issue was resolved at that time.
- The group might be asked to agree on one of the opposed views on the condition that those who disagree would not be obliged to implement it themselves - if this is organizationally possible.
- If time is not of the essence, the decision can be deferred to give opportunity for further thought and reflection.

Implementing and Evaluating the Decision

Once the decision is made about a possible course of action it is important to discern how best to implement the decision given the interests and values at stake. Likewise, there should be some advance discussion about how best to evaluate the consequences of the selected course of action. The aim of this evaluation is to critique the adequacy of the process used to generate the resolution of this issue in order to facilitate future decision making.

PREREQUISITE: responsibility and accountability

This methodology is adapted from materials from the Woodstock Theological Center, Washington, DC and the Health Policy and Bioethics Consultation Group, Berkeley, CA.

Treatment Decisions

A Systematic Framework to Facilitate Health Care Decision Making and Reduce Ethical Conflict

A. Identifying and Supporting the Appropriate Decision Maker

1. Decision making capacity

a. Decision making capacity versus competence

b. Standards for determining decision making capacity

l) outcome
2) categorization
3) functioning

c. Criteria for determining decisionmaking capacity

l) ability to comprehend information relevant to the decision at hand
2) ability to deliberate in accord with relatively consistent set of values/goals
3) ability to communicate preferences

d. Proof of capacity proportionate to what is at stake

e. Who decides capacity?

2. General Guidelines

a. Persons with intact decision making capacity are self-determining

b. The last competent decision of persons who are variably incapacitated holds

c. Decisions for incapacitated patients who at one time possessed decision making capacity should reflect their identity, decisional history, moral norms.

1) Advance directives
a) living will,
b) durable power of attorney for health care,
c) advance medical directive,
d) documented communication

2) Surrogate Decisionmaker
a) criteria for valid surrogate
(l) must have decisionmaking capacity
(2) must know the patient and his/her values
(3) no undue conflict of interest
(4) no serious emotional conflict
b) legally valid and morally valid surrogacy
c) substituted judgment standard
d). A surrogate decides for a never competent patient using a best interests standard.

B. Ensuring that Treatment Decisions Advance the Best Interests of Patients

1. Criteria for Treatment Decisions

a. Begin with the facts

l) medical facts: diagnosis, natural history of disease, prognosis, treatment options, probable consequence of each option (including no treatment)

2) social facts: patient's identity, decisional history, moral norms; significant relationships; social history; resources

3) goal of therapy:
a) restoration and cure
b) stabilization of functioning
c) preparation for death with dignity and comfort

b. Determine the **effectiveness** of proposed interventions (A treatment is effective to the degree that it reverses or ameliorates the natural progression of the disease)

l) objective medical determination (to the degree that this is possible)

2) should physicians recommend a course of action or merely lay out each option?

c. Use a **benefit-burden analysis** to determine if the benefits of the proposed intervention outweigh the burdens

l) subjective determination which can only be made by the patient or by those who know the patient well

2) determine the moral relevance of third party interests

d. Determine the moral relevance of other variables influencing decisionmaking: age, quality of life considerations, legal considerations, economics, caregiver variables

C. Preventing and Resolving Ethical Conflict

1. Establishing that it falls within the domain of each health care profession and authority of each caregiver to prevent/resolve ethical conflict

2. Employing Strategies to Prevent/Resolve Ethical Conflict

a. Identify patients and caregiving teams at risk for conflict and initiate prevention/resolution strategies

l) identify sources of conflict
2) address sources of conflict openly
3) mediate a resolution - may involve transfer of patient to another attending or another treatment facility
a) communication/documentation
b) interdisciplinary team conference
c) ethics consult/committee meeting

b. Identify ways in which the system needs to change to prevent similar types of conflict in the future

l) new competencies needed
2) new structures/systems of care needed
3) new/modified policies indicated

Bibliography

Beauchamp, T.L. and Childress, J.F. (1994). Principles of biomedical ethics. 4th ed. (New York: Oxford University Press).

Fletcher, J.C. et al. (1995, 1997). *Introduction to Clinical Ethics,* 2nd ed. Frederick, MD: University Publishing Group.

Ethics Workup

The ability to workup the ethical aspects of a case is an essential part of clinical reasoning. The emphasis in the ethics workup is on a sensible progression from the facts of the case to a morally sound decision. An ethics workup (this one or a similar version) may be used by a variety of health professionals, such as physicians, nurses, social workers, etc. With some adjustments, it may be used by lay persons. Using the five principal steps of the ethics workup, health professionals holding a variety of philosophical and religious positions regarding ethics can share a basic framework for thinking about and discussing morally troubling cases.

1. WHAT ARE THE FACTS? It is vitally important to clarify the facts of the case in order to anchor the decision. These facts are both medical and social. For example, both an estimate of prognosis and an understanding of the patient's home situation are often relevant to an ethical decision.

Who are the persons involved? **What** is the diagnosis, prognosis, (therapeutic options)? **What** are the patient preferences, beliefs, values? **When** - Chronology of events, time constraints on decision? **Where** is the medical setting? **Why** - Reasons supporting claims, goals of current care.

Nurses and social workers may be instrumental in ensuring that the patient/family and other nonmedical health professionals understand the medical facts and that the health care team understands pertinent nonmedical information about the patient and family.

2. WHAT IS THE ISSUE? It is necessary to identify the specific ethical issue in the case. The issue may not be ethical, but rather a diagnostic problem or a simple miscommunication.

3. FRAME THE ISSUE: Some health professionals will explore the issue using only one moral approach. Others will eclectically employ a variety of approaches. But no matter what one's underlying moral orientation, the ethical issue at stake in a given case can be framed in terms of several broad areas of concern, representing aspects of the case which may be in ethical conflict. It is therefore useful, if somewhat artificial, to dissect the case apart along the lines of the following areas of concern:

a. Identify the appropriate decisionmaker(s).

b. Apply the critera to be used in reaching clinical decisions.

(i) **The specific biomedical good of the patient:** One should ask, what will advance the biomedical good of the patient? What are the medical options and likely outcomes?

(ii) **The broader goods and interests of the patient:** One should ask, what broader aspects of the patient's good, i.e., the patient's dignity, religious faith, other valued beliefs, relationships, and the particular good of the patient's choice, are pertinent to the decision at hand?

(iii) **The goods and interests of other parties:** Health professionals must also be attentive to the goods and interests of others, e.g., in the distribution of resources. One should ask, what are the concerns of other parties (family, health care professionals, health care institution law, society, etc.) and what differences do they make, morally, in the decisions that need to be made about this case? In deciding about an individual case, however, these concerns should generally not be given as much importance as that afforded the good of the individual patient whom health professionals have pledged to serve.

The physician explains the medical options to the patient/surrogates and if indicated makes a recommendation. The patient/surrogate makes an uncoerced, informed decision. Limits to patient/surrogate autonomy include the bounds of rational medicine/nursing/social work, the probability of direct harm to identifiable third parties, and violation of the consciences of involved health care professionals. In problematic cases the interdisciplinary team may meet to ensure consistency in their recommendations to the patient/surrogate(s).

c. Establish the health care professionals' moral/professional obligations.

Each health care professional must decide what she/he owes the patient, herself/himself, the health care team, the health care institution, and other third parties. Conflicts may present.

4. DECIDE: In clinical ethics, as in all other aspects of clinical care, a decision must be made. There is no simple formula. The answer will require clinical judgment, practical wisdom, and moral argument. The health care professional must ask herself/himself, "What should I do? Where can I get help?" She/he must analyze the data, reflect on it morally, and draw a conclusion. She/he must be prepared to explain her decision and the moral reasons for it. Sources of justification include:

a. The nature of the healthcare professional-patient relationship; compatibility of recommended course of action with aims of profession (internal

morality of profession)

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

c. Ethically relevant considerations:

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

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

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

Advocacy Competencies

A. Supporting Autonomy

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

B. Promoting Patient Wellbeing

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

C. Preventing and Resolving Ethical Conflict

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

Delivering OR Staff Beyond The Basic Orientation

By Yves Panneton, RN, BSc., BBA

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

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

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

(i) The process (how things are or should be done);

(ii) How to teach new skills or re-enforce the current practice;

(iii) The group dynamic; and,

(iv) How the organization adjust to change and/or new situations (Laramee, 1993).

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

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

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

Author

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

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

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

Reflective Practice

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

Quality Assurance Program

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

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

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

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

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

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

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

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

References

Charron, D. (1995). Une introduction à la communication. Québec: Les presses de l'université du Québec.

College of Nurses of Ontario (2000). Quality assurance - reflective practice. Toronto College of Nurses of Ontario.

Fairchild, S . (1996). Perioperative nursing principles and practice. New-York Lippincott.

Gagnon, F.; Lessard, M.; Otis, D. (1997). Qualité et efficience des services de santé et des services sociaux. Québec: Les presses de l'université du Québec.

Heneman, H.; Schawab, D.; Fossum, J.; Dyer, L. (1986). Personal/human resources management. Homewood: Irwin.

Laramée, A. (1993). La communication dans les organisations. Une introduction théorique et pragmatique. Québec: Les presses de l'université du Québec.

Laramée, A. ; Vallée, B. (1991). La recherche en communication. Eléments de méthodologie. Québec: Les presses de l'université du Québec.

Phippen, M.; Wells, M. (1994). Perioperative nursing practice. Montreal : W. B. Saunders Co.

Schon, D. (1987). Educating the reflective practitioner. Toward a new design for teaching and learning in the professions. San-Francisco: Jossey-Bass Inc. Publishers.

Liposuction

An update on one of the most frequently performed and controversial surgeries

By Frank D. Fagan

Liposuction surgery (which includes suction-assisted lipectomy, lipoplasty, lipolysis, liposculpture as well as the more recently introduced techniques - ultrasound-assisted liposuction and power-assisted lipoplasty) has become one of the most frequent major aesthetic surgical procedures performed in the United States (where figures are available) and probably in Canada, according to a recent survey (**ASAPS, 1999**).

This survey, along with a review of a number of current journal articles show that liposuction has come a long way since its introduction in the early 1980s (**Illouz, 1983**).

The medical specialists most commonly associated with liposuction procedures include plastic surgeons, dermatologists, and otolaryngologists.

270% increase

In 1998, in the U.S., there were over 218,000 liposuction procedures reported. This represents a 23% increase since 1997, and is almost twice that of any other aesthetic procedure, according to the American Society for Aesthetic Plastic Surgery (ASAPS) in a survey taken in 1998. This survey also found that over half of the patients were between age 19 and 50, and 13% were male (**ASAPS, 2000**).

In an earlier survey, it was reported that there was a 270% increase in liposuction procedures performed on women, and a three-fold increase in men, between 1992 and 1998. This makes liposuction one of the most frequently performed surgical procedures in the country (**ASAPS, 1999**).

Liposuction involves the permanent surgical removal of subcutaneous fat by means of metal cannulas placed through small skin incisions. The cannula is a small tube-like cutting instrument that can be easily inserted under the skin. It mechanically dislodges adipocytes (fat cells), which are then aspirated (by negative pressure suction).

Liposuction targets excess subcutaneous adipose cells that contribute to localized lipodystrophy (a disorder involving the excessive deposition of fat in tissue). The disproportionate number of fat cells in the treated regions are permanently removed, thus remodelling the body contour and aesthetically improving the patient's overall physique. It is expected that any future weight gain or loss will result in a more uniform distribution of fat as the remaining cells hypotrophy or shrink in response to dietary fluctuations. Consequently, weight gain does not result in fat redistribution elsewhere. Implied is that the procedure is designed to achieve greater harmony in body proportions rather than produce weight loss or change in body size.

Patient selection

Successful liposuction is predicated on appropriate patient selection, the surgical/OR staff's expertise, and the patient's awareness of the limits of the procedure. Success is also contingent upon the ability of the overlying skin to retract sufficiently after removal of subcutaneous adipose tissue.

Ideal candidates for this surgery are thought to be healthy individuals in good physical condition (within 30% of ideal weight), with focal areas of lipodystrophy that are resistant to conventional means of improvement, i.e., diet, exercise.

Theoretically, liposuction can be undertaken anywhere there is excess localized subcutaneous fat. However, it is most common on the thighs, legs, abdomen, neck and jowls, upper arms and axillae, breasts, and in flanks and back rolls (**Mladick, 1999**).

Liposuction is a frequent adjunct to conventional (aesthetic) surgical procedures such as face lifting (rhytidectomy), abdominoplasty, breast reduction and breast reconstruction surgery (**Matarasso, 1995**).

An important post-op consideration is that liposuction will not improve other factors that contribute to excessive fullness in an anatomic region such as redundant skin, submuscular fat, muscle and bone. For example, because of fat patterning and distribution changes with age, a large abdominal girth is not amenable to liposuction. Also, no reproducible studies have shown liposuction to permanently improve 'cellulite' deposits.

Non-cosmetic indications for liposuction include treatment for lymphedema (**Brorson, 1998**), axillary hyperhidrosis (excessive sweating), hidradenitis suppurativa, lipomas (fatty tissue tumours), as well as surgical flap elevation and contouring (**Wooden, 1993**). Other non-cosmetic uses include evacuating ruptured silicone-gel breast implants and the removal of post-operative fluid collections.

Peri-operative management

Liposuction can be performed under systemic anaesthesia with supplemental local anaesthesia or with local anaesthesia alone (referred to as super-wet or tumescent techniques). The local anaesthesia is referred to as the wetting solution or infusate. This infusate contains a dilute mixture of lidocaine and epinephrin in a crystalloid solution, which is infiltrated into the subcutaneous fat to provide anaesthesia, analgesia, and hemostasis (**Pitman et al., 1996**).

Since liposuction is now generally performed using a hemostatic infusate that checks bleeding, it has become rare for patients undergoing the procedure to require blood replacement products.

The composition of total aspirate removed typically contains 55% to 90% fat, 20% to 40% infusate, and 0% to 41% blood (**Ibid., 1996**).

The extent of the liposuction depends on patient size, motivation, and number of sites treated. The extent of the aspirate removed may range from a few hundred to several thousand cubic centimetres. A 2-litre liposuction, for instance, represents the removal of almost 17,500 kcal if the tissue were burned as energy.

While guidelines and standards of care do exist, variations in surgical techniques and patient instructions are common. Thus, while routine peri-operative management is possible and advisable, no standards are uniformly applicable to all patients, situations or surgical locales.

Liposuction surgery may be performed in an office, an outpatient clinic, or a hospital, and may be done as an ambulatory procedure or inpatient hospital admission.

Typically, single-site liposuction requires about 1 hour and multiple-site surgery may require an overnight patient admission for observation and monitoring of fluid status, especially if there is a large volume of aspirate, i.e., 4 or 5 L.

Patients are often advised to wear an elastic compression garment for several weeks over the treated sites, which supports the skin as it gradually readjusts to the new contour. Patients can expect to resume their normal activities within a few days after the procedure. They generally achieve their final appearance over several months as edema subsides and skin contraction ensues. Promotion of a healthy lifestyle, including dietary advice, encouragement, and counselling regarding physical activity, and setting realistic weight goals, is an essential aspect of post-op patient management.

Advances in liposuction

There have been a number of recent advances in liposuction technique. Ultrasound-assisted liposuction, which emulsifies fat, has been introduced for use in areas of fibrotic fat. This fat is composed of a higher fibre content as can be found on the back and on the male breast (**Rohrich et al., 1998**).

A variation of the ultrasound technique is external ultrasound, which softens fat prior to its removal by applying ultrasound to the skin surface.

Another new technique is power-assisted lipoplasty, which employs a vibrating cannula.

Probably the most notable advance involves larger volumes of subcutaneous anaesthetic wetting solutions used to infiltrate the fat prior to liposuction. When first introduced, liposuction was performed in a dry environment without subcutaneous anaesthetic infiltration. It is now routine for liposuction procedures to use a wet environment with the addition of a larger volume of wetting

solutions, i.e., superwet formulas (**Klein, 1990**). In the early days of liposuction, most complications were related to the use of excess volumes of lidocaine, epinephrin, and fluid (**Grazer, 2000**).

Complications/Outcomes

Quality-of-life issues are important when considering any aesthetic plastic surgery. A 1998 study showed that in addition to the overall physical improvement that can be obtained through liposuction, there were significant psychological benefits as well. The study reported that, following their liposuction, patients were more self-confident, more satisfied with their appearance, less dissatisfied with their weight, and had considerably higher psychological well-being profiles (**Rankin et al., 1998**). This study also reported that depression scores improved at one month and again at six months after surgery.

The available literature does not make it easy to put a finger on the number and kinds of complications that exist with liposuction. No registry exists for reporting for all the surgeons who perform liposuction, which can be conducted in any number of locales, i.e., office, hospital, etc.

In a survey of plastic surgeons in the U.S. in 1998, the most common complications reported were contour irregularities (0.17%), unplanned or emergency hospital admissions from office/outpatient procedures (0.11%), and prolonged edema (0.9%) (**Rohrich et al., 1999**).

A more recent study (**Grazer, 2000**) found that overall revision or re-operative rates in the U.S. were between 5% and 15%, while rates of fatal complications were in the range of 0.02% to 0.3%.

Those situations reported to be associated with higher complication rates are prolonged procedures, and aspiration of volumes greater than 5 litres (**Daane & Rockwell, 1999**). Other complications include patient dissatisfaction, hematomas, infections, skin burns or hyperpigmentation, irregularities in the skin surface following excessive or subdermal liposuction, and residual contour irregularities requiring secondary treatment.

Adverse outcome of liposuction, although infrequently reported, include pulmonary fat embolism, necrotizing fasciitis, infection, pulmonary edema, fluid overload or lidocaine toxicity, toxic shock syndrome and pulmonary embolism (**Barillo et al., 1998**).

Mortality associated with liposuction has mainly been attributed to pulmonary emboli, abdominal/viscus perforations, anaesthesia complications, and fat emboli (**Grazer et al., 2000**). ■

References

- Illouz, Y., Body contouring by lipolysis: a 5-year experience with over 300 cases, *Plastic Reconstructive Surgery*; 72; p.591-97; 1983.
- ASPRS plastic surgery statistics show cosmetic surgery increases in all populations, *Plastic Surgery News*; p.18-19; June, 1999.
- ASAPS 1998 statistics on cosmetic surgery (American Society for Aesthetic Plastic Surgery, accessed Feb., 2000): http://www.surgery.org/statistics.html#1999.
- Mladick, R., Advances in liposuction contouring of calves and ankles, *Plastic Reconstr Surgery*; 104; p.823-31; 1999.
- Brorson, H., Svensson, H., Liposuction combined with controlled compression therapy reduces arm lymphedema more effectively than controlled compression therapy alone, *Plastic Reconstr Surgery*; 102; p.1058-67; 1998.
- Wooden, W., Shestak, K., Newton, E., Ramasastry, S., Liposuction-assisted revision and recontouring of free microvascular tissue transfers, *Aesthetic Plastic Surgery*; 17; p.103-107; 1993.
- Pitman, G., Aker, J., Tripp, Z., Tumescent liposuction: a surgeon's perspective, *Clin Plas Surg*; 23; p.633; 1996.
- Rohrich, R., Beran, S., Kenkel, J., Adams, W., Di Sapaltro, F., Extending the role of liposuction in body contouring with ultrasound-assisted liposuction, *Plastic Reconstructive Surgery*; 101; p.1090-1102; 1998.
- Klein, J., Tumescent technique for regional anesthesia permits lidocaine doses of 35 mg/kg for liposuction, *J of Dermatological Surgical Oncology*; 16; p.248-263; 1990.
- Grazer, F., de Jong, R., Fatal outcomes from liposuction: census survey of cosmetic surgeons, *Plastic Reconstructive Surgery*; 105; p.436-446; 2000.
- Rankin, M., Borah, G., Perry, A., Wey, P., Quality-of-life outcomes after cosmetic surgery, *Plastic Re-constructive Surgery*; 102; p.2139-47; 1998.
- Daane, S., Rockwell, W., Analysis of methods for reporting severe and mortal lipoplasty complications, *Aesthetic Plastic Surgery*; 23; p.303-306; 1999.
- Barillo, D., Cancio, L., Kim, S., Shirani, K., Goodwin, C., Fatal and near-fatal complications of liposuction, *Southern Medical Journal*; 91; p.487-492; 1998.

Frank D. Fagan was editor of the *Canadian Operating Room Nursing Journal* from its inception in 1982 to 1991.

ORNAC

17th National Conference

Banff, Alberta

April 22 - 27, 2001

"The Art of Communication"

Ginette Lemire Rodger, the Chief of Nursing at the Ottawa Hospital and President of the Canadian Nurses Association, will ask delegates in her **keynote** address at the 17th National ORNAC Conference in Banff, how the new millennium will change the working environment for Canada's nurses. She feels the **nursing profession must be repositioned** in this new century with new skills, including: informatics, new knowledge, technical literacy, leadership and political action.

Dr. Rodger has had diversified experience in management, education, research and clinical nursing.She completed a Ph.D. in Nursing at the University of Alberta in 1995. Prior to 1989, she was the Executive Director of the Canadian Nurses Association. From 1974-1981 she was Director of Nursing at Notre-Dame Hospital in Montreal.

She has served on commissions and board of directors of many health, nursing, political and educational organizations and was a successful strategist for many projects.

Opening Ceremonies start at 0800, Monday, April 23rd. Dr. Rodger will speak at 0900, setting the high tone of edification and futurism which will dominate the weeklong conference.

"Liver Transplantation"

Dr. James Shapiro, Director of the Clinical Islet Transplant Program at the University of Alberta in Edmonton, will describe "**Living Donor Split Liver Transplantation**" on Tuesday, April 24th. Dr. Shapiro was recruited to his current position based on his expertise in the management of transplant patients, and on his extensive laboratory work in the field of anti-rejection drug treatments for islet transplantation.

He has received many outstanding awards based on his experimental studies in islet research. Most recently Dr. Shapiro and the Islet Transplantation Group were awarded the "Outstanding Leadership in Alberta Science Award" from the Alberta Science and Technology Foundation (ASTech).

Dr. Shapiro has led the clinical islet transplant program since 1998, and it was his key contributions that led to the development of the "Edmonton Protocol". He is a sought after speaker.

Dr. Robet Buckman is a dynamic, confident and extremely lively speaker who will speak on Tuesday, April 24 at 1515. He presents a fast and **witty look at the art of communication** that starts you laughing, leaves you laughing... and thinking!

In his practice as a medical oncologist at the Toronto-Sunnybrook Cancer Centre, communication has always been of critical importance. As Associate Professor at the University of Toronto Faculty of Medicine, he is one of the leading clinical researchers in communications theory. He designed an innovative course on the subject of doctor-patient relationship, particularly with respect to breaking bad news to patients and families, and the supportive care of the dying and their families, and produced an award-winning set of training videos *(Why Won't They Talk To Me?)*. The course won him the prestigious "Aikins Teaching Award" in 1989. Not surprisingly, his high energy, flair and quick humor has led him to a 20-year Television and authoring career.

Other program topics include: Robotics in Surgery; Dealing with Negativity and Anger Through Humor; Intra-Operative MRI and Neurosurgery; Risk of Blood Borne Pathogens; Adventures in Guatemala; Day Surgery Patient Positioning; Medical Glove Considerations; and, Orthopedics in the 21st Century.

"Social Events"

Monday night - Dress casually for an Old Time **Rock 'n Roll Party**!

Tuesday - Dress casually and warmly for the "Brewster Night". You'll be under the stars in a big warm tent with **country 'n western dining & dancing!** (Tickets @ $25)

Wednesday - a Free Evening to seek out **Banff's Hot Spots** or try your hotel's cuisine.

Thursday's **Western Roast Beef Dinner and Comedy Night** ! (Tickets @ $35 and cash bar). Transportation provided.

"Fitness Events"

Getinge Castle will once again sponsor the daily **Aerobics Class** to keep everybody in great shape. Sunday - Smith & Nephew sponsor the **5K Fun Run**.

Roy Henry Vickers is internationally recognized as one of the best native artists in the world. His presentations are characterized as a journey through life, often turbulent and emotional. Both a teacher and a visionary, Roy Henry Vickers' name is synonymous with peace, passion and a boundless wealth of creative energy. His passion is evident in his extensive involvement and commitment to the challenge of creating *Vision Quest* - a non-profit organization founded by Roy Henry and endorsed by the RCMP and thousands of Canadians. Vision Quest will allow for the raising of funds to develop a national recovery centre.

Vickers will share with Banff delegates his turbulent and triumphant story of both personal sacrifice and spiritual transformation. Passionate and enlightening, audiences are exposed to an energy almost exclusively focused on the individual living inside ourselves and the importance of being true to our urges and intuitions.

Pre-Conference (hands-on) **Workshops** (must pre-register), Poster Presentations, Bar-B-Q, Welcoming Cocktail Parties, Dinner Dance, Tours, Tours and 27 major speakers will be presented at the Banff Springs Hotel during the week-long event. Register today !

Clockwise:
Ginette Rodgers,
Dr. Shapiro,
Dr. Buckman and
Roy Henry Vickers.

The **Early Bird Winner** is Joanne Matthews of Mississauga, ON. She will receive a FREE Registration !

Register today !

Call Registration Chairperson:
Heather Perl,
Box 193, Calmar, AB T0C 0V0
Phone/Fax **(780) 389 - 3571**
email: gperl@telusplanet.net
VISA accepted.

Leadership Network (CORL)

Banff - April 22 - 27, 2001

The Canadian Operating Room Leadership Network (CORL), provides perioperative leaders, whoever and wherever they are, the opportunity to come together, network, mentor, guide, learn and share knowledge at all levels. Pat Pocock and Muriel Shewchuk spearheaded the development of CORL in 1999 at the ORNAC Conference in Halifax. A second meeting was held in May, 2000. A third learning opportunity is planned in Banff during the 17th ORNAC National Conference. The vision of developing creative, innovative leadership strategies will continue, as will the opportunity to network with colleagues from across Canada.

A preliminary agenda for the Banff meeting is outlined below. The sessions will run concurrently with ORNAC conference sessions.

A Welcoming and CORL Networking Dinner is planned for Monday April 23rd.

Tuesday, April 24th (1000 to 1100) - *Bench-Marking Principles,* "The Canadian Formula". Speakers: Randy Heizer, Val Zellermeyer, and Pat Pocock. (1515-1645) *Bench-Marking:* Implementation, Utilization, Efficiencies and Case Cost Analysis. Speakers: Randy Heizer, Pat Pocock, and Muriel Shewchuk.

Sister Carol Taylor

Al-Noor Nathoo

Wednesday April 25th (1000 - 1100) Recruitment and Retention Strategies in the OR. Speaker: Betty Watt. Leadership Principles, Financial Management (1515-1645). Speakers: Pat Pocock and Muriel Shewchuk.

Thursday, April 26th (0700 - 0830) CORL Network Breakfast. (0830 - 1000) Leadership and Ethics. Speaker: Sister Carol Taylor.

Any questions concerning the agenda or for a discussion regarding CORL Network, call:

Pat Pocock, Phone: (519) 646-6100 ext 65707
St. Joseph's Health Centre, London, ON
email: Pat.Pocock@sjhc.london.on.ca
or
Muriel Shewchuk, Phone: (403) 670 - 4927
Calgary Regional Health Authority
e-mail: muriel.shewchuk@crha-health.ab.ca

Ethics in Cross-Cultural Health Settings

Al-Noor Nathoo will explore the ethical implications of delivering health care in culturally diverse settings. The discussion will help identify biases in our belief systems. Whether the concerns involve abortion, alternative therapies, or any other deeply divisive question, the values of those who provide care and those who receive it, will inevitably clash on occasion. The question of how to deal with these value differences while still maintaining professional integrity. This will be the focus of his session.

Al-Noor Nathoo is currently the Southen Alberta Coordinator and Executive Director for the Provincial Health Ethics Network. His background in health care includes work in the areas of cancer research, home care and primary health care management. He has worked as a consultant with various Calgary and Ottawa agencies on issues of human rights and international development.

Provincial 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 13, 2001
Saskatchewan Operating Room Nurses Group - Meeting in Prince Albert, SK.

September 25-28, 2002
Atlantic Conference Meeting, Charlottetown, PE.

April 24-27, 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.

Blood flow during REM sleep linked to early morning infarcts

If you live near an emergency hospital, you know that pre-dawn is a busy time for ambulance arrivals. Now, researchers in Israel may have discovered why myocardial infarcts and other cardiac events occur more frequently during these early hours.

Researchers at Technion-Israel Institute of Technology in Haifa evaluated peripheral blood flow overnight in 17 adults with mild-to-moderate sleep apnea and in nine healthy controls.

In both groups the researchers found that peripheral or surface arteries were most constricted during rapid eye movement (REM) sleep. Along with the intense brain activity and eye movements associated with REM sleep, the researchers said activation of the sympathetic branch of the autonomic nervous system during REM sleep increases heart rate and blood pressure. "In these studies, we saw robust changes in vasoconstriction and resistance to blood flow during REM sleep. Such marked changes strongly suggest an association between REM sleep and increased cardiac events," said Dr. Peretz Lavie of the Technion Sleep Laboratory.

Although REM sleep occurs throughout the night, duration is longest in the early morning, which may explain the increased incidence of cardiac events at that time of day. (From *Nature Medicine*, June, 2000) ■

Renal failure cut in half by employing tissue-sparing kidney surgery

Radical nephrectomy was first performed in the 1960s and has been the standard of care for patients whose second kidney is cancer-free. In recent years, however, the tissue-sparing procedure in which only the tumor is removed and kidney function is maintained has gained greater acceptance.

In a study reported in the *Mayo Clinic Proceedings* (December, 2000), it appears to be confirmed that the tissue-sparing procedure is associated with a much lower risk of developing kidney failure.

In the study, the outcomes of 164 patients who underwent radical nephrectomy and 164 patients who received nephron-sparing surgery between 1966 and 1999 were examined.

At the most recent follow-up, 77% who underwent radical nephrectomy and 79% who had nephron-sparing surgery were alive and disease-free. However, after ten years follow-up, 22% who had the radical surgery developed chronic renal failure, compared to 11% in the tissue-sparing group. ■

Negligence in the OR leads to trial and subsequent upheld appeal

Last year, a patient (the plaintiff) sued her surgeon and an Ontario hospital for damages from injuries suffered during an ovary removal operation. The initial operation had damaged the plaintiff's ureter, leading to a second operation to correct the problem.

The patient also claimed that she then developed fibromyalgia, which she attributed to the surgeries.

At the trial, the judge found that the surgeon (defendant) had met the requisite standard of care in performing the operation and assessed the patient's total damages at $20,000 but dismissed the action and awarded $300,000 in costs to the defendants.

The plaintiff appealed on the basis that the evidence was misapprehended. She also appealed the damages.

The appeal was allowed. The trial judge had, in fact, misapprehended the evidence. The surgeon should have noticed that the sutures used following the removal of the ovary were too close to the ureter. There was also expert evidence at the trial that the final inspection of the surgery did not meet the required standard of care.

Instead of a dismissal (the result of the trial), a finding of negligence was substituted. There was ample evidence to support the trial judge's findings on the assessment of damages. However, there was no evidence to support the plaintiff's contention that the fibromyalgia (a rheumatic disorder) was surgery-related.

The appeals judgement increased the plaintiff's total damages to $28,000 (from $20,000) to reflect the fact that the damage to the ureter arose from the first operation and not the second. The plaintiff was entitled to the costs of the trial and the appeal.

At what juncture could OR nursing personnel have made a difference? ■

(From *The Lawyers Weekly*, November, 2000)

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