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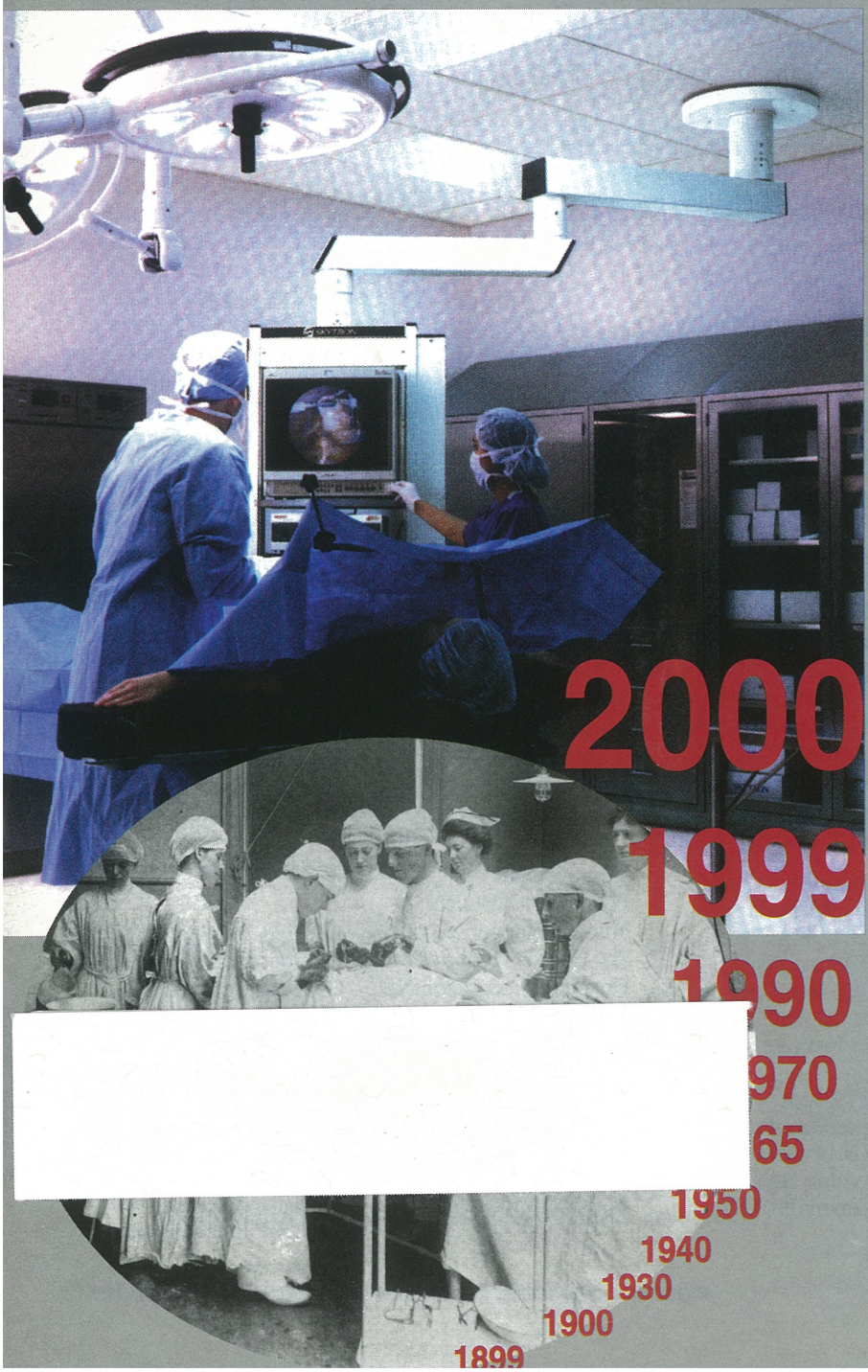

What Makes Your Day ?

A study of the Quality Worklife of O.R. Nurses

Winnipeg's Pediatric Cardiac Inquest:

- An O.R. Nursing Perspective
- The Ethical Issues
- The Parents

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Editorial Contents

Cover Photos: In the light of two shadeless bulbs the surgical team (circa 1899) works without face masks. Photo courtesy Toronto Western Hospital. The 2000 state-of-the-art OR theatre photo courtesy McDavis Sales & Service.

As We Begin The New Millennium

By Marlene Hill, RN, CPN(C)

The media has been highlighting major events that have transpired during this past century - technological changes that have occurred, the great strides in telecommunication, transportation advances and adjustments in the workplace. Inventions were created and modified in an attempt to create an atmosphere that is 'user and environmentally friendly'. Our universe has dramatically changed.

What will the future bring? Will changes occur at the sky-rocketing pace evident in the late 1900's? In this address, I will dwell on one area that has changed dramatically and another that, although some progress in its decline has been made, still requires much attention.

Gone are the days where nurses were hired to full-time positions upon graduation and remained in the same institution until retirement. Financial restraint, restructuring of health care delivery, and the shift from diploma to baccalaureate programs are some examples of change that have made a great impact on the nursing profession. Today, some of our members are investigating other areas of employment and alternate careers.

Further reduction in the number of practicing registered nurses will continue to negatively affect Canada's delivery of health care.

On the other hand, the image of nursing, if enhanced, could attract people in other careers looking for a change. The public has always thought highly of registered nurses.

Government and health care leaders must be innovative and develop ways to increase the number of graduating nursing students, enable RNs to remain in Canada to practice, and encourage existing registered nurses to continue employment in the field of nursing.

Canadian Nurses Association, (CNA) has identified the problem of the 'shortage of nurses' and is endeavouring to develop strategies to resolve this issue. We, as perioperative registered nurses, can also affect the future of nursing by:

- encouraging students to enroll in nursing programs;
- assisting nursing students and new staff members, treating them with courtesy and respect;
- working with CNA to supply solutions; and
- providing government agencies with attractive yet realistic incentives for Canadian RNs working in other countries to return to Canada for employment, (including the return of those who have left the field of nursing for other careers).

Now is the time to speak up and be pro-active rather than re-active. The evolution of nursing is occurring and we can each help guide the process in a positive way.

The area that has been in decline but still requires much attention is smoking addiction. Hopefully, the target audience will have diminished by this printing.

The Media is predicting that people will use the 2000 milestone as a special date to start improving life-styles, i.e. exercising, eating sensibly by following Canada's Food Guide, improving relationships with families, and/or quitting undesirable habits, i.e. smoking, excessive alcohol intake, etc.

Until several years ago I was one of those 'smokers'. I knew all the dangers of smoking but the urge was too strong - I was and always will be addicted.

One day while routinely checking my BP, I discovered it had elevated somewhat. I was shocked! The last sign of being at a high risk for heart and stroke disease had been reached. Major changes had to be made; reality finally set in.

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, Prince Edward Island.

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

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

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

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

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

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

Correction

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

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

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

Winnipeg's Pediatric Cardiac Inquest - A Nursing Perspective

By Carol J. Youngson, RN

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

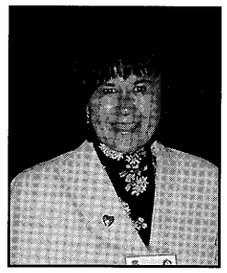
Our story will ring true to all nurses who have been in the front lines of the health care system, because that is what nurses are ...the front line caregiver. One of my colleagues put it so well... " we are the ones who hear, see and do for those who cannot".

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

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

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

Author



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Our Concerns Were Reported to the Head of Pediatrics

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

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

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

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

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

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

The Inquest

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

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

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

Nursing Needed Separate Legal Standing

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

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

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

MARN Support

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

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

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

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

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

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

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

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

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

Inquest Recommendations

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

Winnipeg's Pediatric Cardiac Inquest: The Ethical Issues

By Irene Hinam, RN

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

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

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

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

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

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

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

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

Beginning of a Nightmare

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

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

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

Author

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

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

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

Constant Questions from ICU Staff

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

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

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

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

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

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

The Ordeal of the Inquest

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

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

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

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

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

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

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

Ethical Issues

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

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

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

Moral Uncertainty

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

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

Moral Dilemma

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

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

Moral Distress

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

According to the 1994 CNA Code of Ethics:

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

We were experiencing these feelings. The Code further states:

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

Joan felt she was not able to reassure parents when

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

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

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

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

Reporting Unsafe Practices

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

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

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

Moral Residue

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

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

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

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

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

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

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

What Makes Your Day ?

A Study of the Quality of Worklife of OR Nurses

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

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

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

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

Introduction

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

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

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

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

Good Nursing Care

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

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Author

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

tion and endeavours to address issues of concern. As Walker (1996) reports:

The bill, drafted by the American Nurses Association consists of three major components: disclosure of nursing staff numbers by healthcare institutions, *whistle blower* protection for any nurse who reports unsafe care practices in his or her facility, and economic impact studies of any pending health care provider mergers (p 119).

It is an interesting commentary that, in order to achieve action, nurses' concerns for patient care must be brought to the legislators. Even more interesting is that nurses fear censorship and job loss for doing so. Agencies are beginning to take a serious look at mergers and restructuring and the link between cost saving measures and patient outcomes.

Continually Diminishing Resources

The concept of "more for less" continues to be demanded of the healthcare system. Healthcare professionals are proficient at managing the technical side of the demanded changes however, very little is known about how the change affects the people involved. Nurses continue to provide services to the public with continually diminishing resources. Working with fewer resources results in greater demands on nurses and increases the stress in the workplace. The impact of the work environment can be far reaching and personal, depending on the individual. The worklife of nurses is of particular interest as it relates to the provision of healthcare. My study focused on how organizational and environmental variables affect the quality of worklife of operating room nurses.

A study reported by Prescott (1993) states that, "a recent survey of 663 hospital CEOs asked the executives to rank order ten factors that contribute to hospital quality. Nursing care was ranked as the most important of the ten factors 97.3%" (p. 195). Other variables such as the patient's health status, living conditions, and financial status, together with the resources available to the health care providers are also contributors to patient outcomes. While a number of variables are responsible for patient outcomes and many disciplines are involved, central to hospital patient care is the nurse. Nurses and the care they provide to patients, are pivotal to the resultant patient outcomes. Job satisfaction and a quality work environment contribute to the achievement of positive patient and staff outcomes.

Magnet hospitals have been named for their ability to attract and retain highly qualified nursing staff by providing such things as:

- a visible director of nurses,
- participatory management,
- primary nursing,
- educational opportunities, and
- other factors related to the quality of worklife.

Though morbidity and mortality rates at magnet hospitals may be lower than other hospitals in this comparative analysis, further research is required to identify and analyze other potential contributing variables. However, there is little doubt that attracting and retaining a highly qualified professional nursing staff contributes in a positive way to patient outcomes. Attracting and retaining such nursing staff is thought to be related to the quality of worklife of the employing institution or hospital.

A quality work environment is one in which the goals and needs of the organization are met while at the same time meeting the goals and needs of the employees. From a nursing perspective, the classic definition penned by O'Brien-Pallas, Baumann, and Villeneuve in 1994 defines a quality work environment as:

> "One in which the needs and goals of the individual nurse are met at the same time as the patient or client is assisted to reach his or her individual health goals - and where both outcomes are realized within the cost and quality framework mandated by the organization".

They further acknowledge that quality of worklife is a complex and multivariate phenomenon containing many interrelated parameters. This topic became a study in itself, however, the main thing that all researchers agree on is that close attention to quality of worklife variables by management can foster a more humanistic work environment. The humanistic work environment serves the basic needs of the staff together with the higher level needs of continued growth and improved performance.

Internal Variables

Other internal variables are related to the nature of the work. The organization of day-to-day activities, the degree of technology, the availability of equipment and supplies, as well as administrative issues, such as policies, benefits, and opportunities for advancement are thought to influence nurse and patient outcomes.

Rapid changes in technology, shorter hospital stays and continuous changes in patient acuity and demographics have resulted in client demands on the system that are different than they were five years ago. Reductions in funding have resulted in more community-based services, fewer hospital beds, and changes in care delivery personnel.

Dissatisfaction with the work place has been identified as an important element in the turnover rate of OR nurses. Has the introduction of the multiskilled worker had an influence on this dissatisfaction?

Since the care provided to healthcare consumers is dependent on those who work in the healthcare system such as operating room nurses, satisfaction with the work environment should be considered in order to attract and retain highly qualified nurses which prompted my interest in this subject and resulted in the following research questions.

Research Questions

The questions I decided to ask were:

1. What do OR nurses identify as the significant factors affecting their quality of worklife ?

2. What do OR nurses feel they can influence and/or change in the work environment ?

3. Are OR nurses involved in decisions related to changes in the work environment ?

Subsidiary questions:

1. What effect, if any, does organizational structure have on the perceived quality of worklife of OR nurses ?

2. Does the presence or absence of a formalized nursing department have any effect on the perceived quality of worklife of OR nurses ?

3. Do OR nurses perceive that working with multiskilled workers has any effect on their quality of worklife ?

4. Are OR nurses provided with an opportunity to make recommendations to management for improvements to their quality of worklife ?

First Step - Organizational Culture

When evaluating an organization and the level of satisfaction at its workplace, the first step the researcher undertakes is an examination of the organizational culture.

Culture is a way of explaining and understanding human behaviour, belief systems, values, and ideologies, as well as culturally specific personality types. It has to do with norms, symbols, and rituals.

• Shared values create organizational culture.

Although being a part of the group is important for feelings of belonging and connectedness, it is equally important that the individual feels a sense of compatibility between his or her personal values and that of the organization. One of the things I learned is the importance of *person-culture fit* and the necessity of congruency between an individual's values and those of an organization. Individuals are likely to be attracted to an organization that they perceive as having values that correspond to their own. Similarly, organizations tend to attract individuals who are likely to share their values.

Identifying an organization's culture is the first step in the assessment process. Culture is grounded in an organization's history. It reflects the fundamental values and philosophy that define the organization's view of itself and its ultimate mission. Through informal and formal networks, members learn the values, attitudes, expected behaviours, and social knowledge that define the boundaries of appropriate behavioural responses. This allows members to participate in organizational activities in an appropriate and acceptable way.

Assessing Organizational Culture

An assessment of organizational culture should include:

• **Material symbols** - such as the logo and organizational symbols that recognize status, years of service, or quality performance.

• **Behavioural symbols** - the ritualistic actions that reflect important values or assumptions that are part of the culture. Staff who remain close to their unit during their break so they are available should an emergency occur are examples of such behaviour.

• **Verbal Symbols** - recruitment or advertising brochures, orientation materials, and stories from history and tradition. "While negative stories allow members to distance themselves psychologically from the organization, positive stories convey a sense of unity" (L.Hughes, 1990, p 17).

• **Structural Characteristics** include the internal and external structure of the organization. The physical structure, organizational chart, policies, and procedures which define dress code and expected behaviours are all components of the structural characteristics. Formal and informal channels of communication must be considered when examining these characteristics.

The culture of an organization is steeped in its history. Experiences shared by members are important because they influence decisions based on issues such as whether possible promotional opportunities exist as a reward for loyal service. Cultural values have a significant effect on the voluntary survival

rates of professional staff. Stability in the workplace is inextricably bound to issues of culture and the fit between the individual, held values, and the culture of the organization.

Hospitals and Organizational Culture

Whether we like to admit it or not, organizational culture plays a dominant role in the decision-making process in health care. The allocation of funding, approval of programs, and creation of centres of excellence are examples of decisions which determine the components of health care provided. Decisions regarding life support systems and life extending procedures are made in consideration of the resources available. Since values determine organizational culture, it is crucial that patients and their families examine the values of the health care organization to which they turn for care. If the person/patient's values fit with those of the hospital, there is likely to be less anxiety in a time of need.

People must have confidence in their hospital and its ability to meet their needs as little else matters in life if one does not have health and can't get help when required. When one's very survival is threatened, all aspects of daily living take on new meaning.

Canadians value good health and they have great pride in their health care system.

Methodology of the Study

The basic framework for this research is the case study which consists of the examination of the influence of organizational and environmental variables on the quality of worklife of OR nurses.

A variety of different sources were used to gather the information for this study such as: an examination of all available documentation, interviews, site visits, variations in structural layout of the facility, and other items as appropriate.

Site data collection was completed at a 250 bed acute care hospital located in downtown Toronto. The facility was founded in 1911 and is an academic health centre affiliated with the University of Toronto. There are six operating theaters with 15 Registered Nurses (RNs) and six Registered Practical Nurses (RPNs). At the time of this study, (1996) the hospital had been organized under a Program Management structure for five years. The site was chosen for a variety of reasons such as its:

- affiliation with the University of Toronto and its role as an academic health centre;
- organizational structure which consists of Program Management;
- change activity and the continuing uncertainty of its role in health care;
- staff mix which utilizes both RNs and RPNs;
- interest in research and in being an active participant; and,
- variety of surgical services and medical services offered.

Respondents represent a broad cross section of experience in nursing. In operating room nursing specifically, experience ranges from a low of three (3) years to a high of thirty-one (31) years.

Study Findings

Firstly, I'll share with you what I learned that did NOT have any great influence on the quality of worklife of OR nurses and then progressively look at what DOES matter in their daily life.

Weak or Negligible Influences:

While the literature suggests that organizational structure, leadership, and organizational learning can influence the quality of worklife, findings in this study do not support this suggestion. Respondents are willing to discuss these issues but readily admit that they know little about them, do not concern themselves with them, and are seldom affected by them in the workplace.

OR nurses in this study are preoccupied with operating room matters and have little interest in organizational affairs.

Organizational Structure

One of the motivating factors which prompted my choice of study was the increasing emphasis on restructuring and reengineering as the answer to the current dilemma in health care. Hospitals across the United States and Canada have been rushing to change the work environment and reporting structures. The literature now abounds with the merit of such change. Claims are made by Leatt, Lemieux-Charles and Aird (1994) that there is improved accountability and effectiveness and that decision-making is decentralized to the "point of action" resulting in individual caregivers being empowered to make decisions.

On the other hand, a report published by the Registered Nurses' Association of Ontario (1994) indicates that just the opposite may be true as they note that many program management structures enhance the **centralization of decision-making** with the physician or someone other than the nurse. In addition, they suggest that program management may accomplish the reverse of shared governance which can result in disempowerment of the caregivers.

There is little substantive data in the literature that demonstrates a relationship between organizational structure and decentralization, quality of worklife, or the actual work done at all levels. This is confirmed by a study reported by Hales and Tamangani in 1996. Their study focuses on the differences between centralized organizations and decentralized organizations. Many of the current restructuring efforts in business, industry, and health care claim that the end result is decentralization and increased efficiency.

The findings of the Hales and Tamangani (1996) study concur with findings in this study in that no definitive link between organizational structure and influence in the work place can be established.

Nurses Appear to Absorb the Impact of Changes

The initiatives now underway in Canada focus on reducing costs and improving efficiency through changing administrative structures such as case management and program management. Redesigning the work of the front-line nurse is neither a high priority nor a visible objective *(Donner, Semogas, and Blythe, 1994, p. 14)*. However, very little is known about the impact of the organizational structure on nursing satisfaction. Nurses appear to absorb the impact of changes in the delivery of health care while very little attention is directed to their work environment and the consequences of restructuring.

As the controversy continues, my research examined the impact of organizational design on the quality of worklife of caregivers who are at the point of action in the operating room. As suggested by various scholars, the findings in this study confirm that organizational structure is a weak independent variable with little influence on the quality of worklife of operating room nurses. Not one of the respondents indicates that their daily work environment is affected by the organizational structure of the research site. Quite the contrary, only one respondent even knew what program management was, and she said that it was changing as we spoke. One must conclude that the many claims that program management and other restructuring efforts result in the empowerment of the caregiver, the transfer of decision-making to the point of action, and shared governance are not substantiated by this study.

Leadership

Hospitals are organizations which are made up of a collection of individuals. Learning is essential to change and the role of the leader in organizational learning cannot be minimized. Various authors note the significant role of the leader as paramount if an organization is to learn and progress *(Argyris, 1976; Fullan, 1993; Garvin, 1993; Hodgkinson, 1991; Leithwood, Dart, Jantzi, and Steinback, 1993; Levitt and March, 1988)*. From respondents in this study, it is evident that few are sure who their leader is at the senior level, are not sure what they do, and don't see any influence on their worklives. An expressed concern for a lack of adherence to standards emphasizes the potential impact on patient outcomes when there is no one at the helm directing and monitoring nursing care.

With the introduction of program management and similar restructuring initiatives, functional departments are absorbed into specific programs so that nurses, social workers, physiotherapists, and pharmacists, to name a few, are now reporting to the program director who is generally a physician. Previously, each of these professionals reported to a manager who directed the activities within their specific departments, such as pharmacy or nursing. Nurses reported to a Director of Nursing who provided leadership to the nursing department. Since other disciplines are not familiar with nursing standards, ethics, and care modalities, concern revolves around how these areas will be monitored and professional care to patients ensured.

Results of this research indicate that lack of a formalized nursing department has no direct relationship to the quality of worklife of operating room nurses. However, there is some concern regarding a lack of visible nursing leadership. Donner et al, stated in 1994 that:

> "It is paradoxical that recently, as the trend toward program management precipitates the elimination of the Chief Nursing Officer as a line manager, nursing staff have been complaining that they are left without professional leadership and advocacy in the organization".

Nurses struggle with attempting to balance the tensions between independence and dependence, autonomy and participation, control and subordination. On the one hand there is a desire to have control and be independent, on the other hand there is a desire to have leaders at the top who will further the interest of respondents. Operating room nurses want the VP-

Nursing to use her authority in a way that enhances their daily working environment and rewards. Not only must nurses see themselves as part of their profession, they must also be able to see themselves as part of the organization. While there is concern about the absence of strong nursing leadership at the top, it clearly does not affect the daily working environment of respondents in this study.

Organizational Learning

Attempts to transplant new business management theories of empowered employees to hospital settings have achieved little success as staff nurses continue to lack control over their worklives (Donner et al, 1994). Staff nurses continue to be under represented on hospital committees and rarely are included in decisions regarding services to be cut. Decentralization of decision-making to the point of action, as an offshoot of program management has not happened at the research site; despite their five years of program management as an organizational structure.

While the trigger that stimulates restructuring and change is financial, justification seems to be required on a philosophical and ethical basis. Perhaps this allows agents of change to appease their conscience and the public that they serve.

Hospital organizations are constantly being bombarded by demands for increased fiscal accountability, improved and enhanced services, and increased efficiencies. The resulting information overload necessitates a sorting and selection process on the part of administrators in order to determine to which of the incoming stimuli they will respond. This in turn affects the organizational learning that takes place and, most commonly, learning is triggered by problems. Other triggers that stimulate learning are opportunities and people. The challenge is to learn how to view a problem as an opportunity and the most valued of employees are those that can do just that - view a problem as an opportunity.

The winning organizations of the future will be flexible, adaptable, and efficient, and will learn quickly, observe accurately, and be able to put their learning to use. Learning is a core value for high-performing health care organizations - they are constantly learning and undertaking new initiatives.

As health care becomes more competitive, organizations need ways of linking information about the wants and needs of the consumer with the fiscal and human resources of the organization charged with meeting those needs. This study demonstrates that organizational learning has no direct influence on the quality of worklife of OR nurses.

What Matters to OR Nurses ?

√ Collaborative Decision-Making

One thing that matters to OR nurses in this study is **Collaborative Decision-Making.**

Canada's Medicare system is being bombarded on all sides and in all provinces as governments attempt to bring costs in line with available resources. Health care workers are being asked to do more with less even though patients in hospital are sicker and stay for shorter periods than previously. Most front line workers complain of a sense of frustration in the face of such cut backs.

That nurses want to be respected, valued, and consulted is well established and reconfirmed in this study. Some nurses are feeling well informed and are consulted while others often feel left out. OR nurses would like to know that their opinion is valued and being consulted is important to them. Even if the input does not change the decision made, at least the staff are provided an opportunity to participate in the process. This is important to all respondents in this study. Although most respondents indicate a sense of resignation to the changes in Medicare funding and the situation that they find themselves in, they also have an ability to turn things around and to put them in a more positive perspective. One nurse says that it is fun and a challenge to put your heads together and try to find ways to make do, make it easier, or try to see what will work, given the equipment and the resources available. This is characteristic of the resilient nature of the OR nurses in this study. In every case, the areas that they are able to influence in the work place are; their ability to work with people, being organized, and able to control their environment. Collaborative decision-making is a positive influence on the quality of worklife of nurses and should be encouraged.

√ Multiskilled Workers

Another item that has an influence on the quality of worklife of OR nurses is - Multiskilled Workers.

The multiskilled worker is one who is trained to provide a variety of services. The multiskilled worker does not have professional education and training as their programs are often six to eight weeks in duration. One author's description of the multiskilled worker is found is this commentary on the generic health care worker.

"A more attractive and cost-saving development in the area of multi-skilling and cross-training is the creation of a whole new breed of generic health care worker. This worker would be partially trained in all health care work and well-skilled in none. This new generic health care worker would not have to be licensed and her job description would fit into none of the existing job classifications nor within any of the traditional health care bargaining units. She would be a little bit of a nurse, a little bit of a lab tech, a little bit of a physiotherapist, a little bit of a perfusionist, a little bit of a housekeeper, a little bit of a clerk, a little bit of a porter and a big bit tired". (Richardson, 1994)

This individual works under the direction of the registered nurse who is responsible for them and the duties performed. At a time when patients in hospital are sicker and require a higher level of care, nurses are being replaced by lesser qualified multiskilled workers. This results in additional responsibility for the nurse who remains in the work place. Results from this study confirm that this is happening.

Concerns related to standards of care, patient safety, increased stress in the work place, job security, and loss of professionalism are expressed by various authors and confirmed by nurses in this study. The impact of this trend on nursing in general and nurses individually is one of concern. The more critical issue, however, is how this trend impacts on patient outcomes which is of paramount importance.

Bits and pieces of departments are assigned to programs whose director may be a physician or other health care professional other than a nurse. Therefore, nursing no longer has authority over jurisdictions which were previously under their direct control and for which they were accountable. Currently, in some hospitals, the Registered Nurse (RN) in the operating room is being replaced by the Registered Practical Nurse (RPN), the Operating Room Technician (ORT), or an unregulated worker with varying background, knowledge, and skills. All of these efforts are an attempt at further cost savings, although, depending on the level on the pay scale and the union to which the worker belongs, other workers may result in little or no savings.

If nurses are to get more autonomy and job satisfaction, Rachlis and Kushner (1994) indicate that major system reform is required. They suggest that nurses should be front and centre in such reform for the following reasons:

- **Numbers**: with over a quarter of a million RNs in the country, nursing is the single largest group of workers in the entire system.
- **Contacts:** nurses also have a long tradition as patient advocates, as the profession closest to consumers. A hospital patient may spend only a few minutes with the doctor each day, while nurses are in and out all the time seeing to his/her needs.
- **Commitment to quality**: nurses have a long history of pursuing quality-of-care issues. A 1989 survey found that licensing agencies for nurses were more likely than those for doctors, optometrists, dentists, and pharmacists to have written standards of practice.
- **Nurses are also consumers:** the vast majority of nurses are women, and women are also the most intensive users of health services. (Rachlis and Kushner, 1994, p. 336).

This debate is not unique to the Canadian health care scene. The recent introduction of the Patient Safety Act of 1996, which has been submitted by the American Nurses Association for consideration by various committees under the Supreme Court of the United States of America, underscores concern for the provision of health care by qualified health care providers.

While Canadians have not progressed to the point of introducing legislation which is similar to the Patient Safety Act of 1996, this possibility looms on the horizon. Persons who have been told that they may not disclose that they are an RN, RPN, or an unregulated health care worker may be experiencing an identity crisis, together with a concern for professional standards of practice. These views are echoed by nurses in this study.

The issue of job security is prominent in the minds of health care workers today. Many professions are experiencing job loses as a result of restructuring and health care is no exception. Worrying each day about whether you will have a job tomorrow is very frightening and unsettling and there is little doubt that the introduction of the multiskilled worker is having an impact on OR nurses.

√ The Magnitude of Change has Created a Climate of Uncertainty

The many changes occurring in healthcare have created a climate of uncertainty; uncertainty of Medicare, of hospitals surviving within the system, and of the stability of the jobs of those providing care to

patients. Every individual and every group is in some change process continually. Identifying the magnitude of such change and understanding how the process is handled by the individual and the group in any given situation is not easy. Incremental to understanding the effect of change on the people involved is the challenge of understanding how such change affects the culture of the organization.

In this study there is a good understanding that the driving force for change is a lack of resources and the government's commitment to meeting their targets related to budgetary reductions. On the other hand, the restraining forces are the very pride that the nurses have in the institution, the desire to continue to provide care to the community that they serve, and a concern for continued employment. Education is a key element if the participative strategy for change is to be successful. From respondents in this study it would appear that education and information sharing has had a role to play. The unit manager is credited with keeping the staff abreast of activity and impending changes in the hospital. Time and again respondents note that their Nursing Unit Administrator does a really good job at keeping them informed.

While administrators or managers in health care attempt to juggle their many responsibilities and at the same time consider all of the available information and guidelines for implementing change, there can be little doubt that numerous issues must be weighed, one against the other, in an attempt to make the right decision and condone change. The majority of nurses acknowledge these difficulties and appreciate being informed and involved in planned changes. There is no doubt that change has a significant influence on the quality of worklife of OR nurses.

√ Organizational Culture

The next influence I found that affects the OR nurses daily life at work is organizational culture.

Culture reflects strongly held values and individuals are likely to be attracted to an organization that they perceive as having values that correspond to their own. It's important to have congruency between an individual's values and those of the organization.

Absolute congruency between all individuals and the organization is not possible. Each individual has personal values which reflect his or her uniqueness. However, a measure of person-culture fit helps the person feel a sense of compatibility between their personal values and that of the organization which increases his or her sense of belonging. Some workers draw from their organization's culture to form a personal sense of identity linking themselves to the values of the organization. The core values expressed in the research site's strategic plan (1994-98) are very clear:

- Compassion and care for patients, their families and our staff;
- Honesty and integrity essential to mutual trust;
- Respect for the rights, opinions and dignity of every individual;
- Excellence in all our endeavours.

These same values are reflected in comments made by respondents who doubtless share these views. Compassion and care for patients, their families and the staff are noted as the nurses talk about thinking first of patient care, comfort, and safety. Others say, "I love it, there's nothing else I'd rather do". Honesty and integrity are evident in comments that reflect dissatisfaction with recent cuts to the health care system. Many will not compromise their values or integrity and provide a lesser standard of care.

Respect for the rights, opinions and dignity of others is also evident in the respondent population of the research site. The importance of standards, policies, and procedures is recognized and even though there are various committees that one must go through, it is acknowledged that they are all in place for a reason. These OR nurses attempt to achieve excellence in all their endeavours and it is clear that all respondents are very committed to the research site. Various of these nurses came to work at the site because of its reputation for high quality care and its striving for excellence.

From personal observations of each and every contact at the research site, two conclusions are drawn; the first is a sense of concern for the future of the facility, while the second is a definite sense of pride in working there. Although services have been cut, beds have been closed, and positions have been deleted, these nurses exhibit a dignity and delight in the work that is being done, and all of them have a sense of ownership and belonging to the hospital. A high degree of congruency between the individuals' values and those of the research site is evident which indicates a person-culture fit with a resulting sense of connectedness.

√ Locus of Control

The next item which influences the quality of worklife of OR nurses is locus of control.

Everyone knows that a critical element of perioperative nursing practice is the ability to anticipate the needs of the surgical team. This ability to anticipate the needs of the team during the surgical procedure ensures that all supplies and equipment are in place and available when required. As the surgeon and anesthesiologist are busy concentrating and performing the special skills of their craft, they depend on the OR nurse to provide for their needs and to assist as required. This, in turn, means that the OR nurse must have knowledge of each and every procedure in great detail as well as the knowledge and skill necessary to anticipate what instruments, supplies, and technology may be used and how to use them. It also means that this skill and knowledge base is utilized in conjunction with the unique needs of the individual patient.

The quality of worklife of any practising nurse is thought to be influenced by various characteristics in the employment environment.

> "Issues such as the organization of day-to-day delivery activities, the degree of technology on the unit, and the availability of equipment and materials are hypothesized to influence nursing worklife"

(O'Brien-Pallas, Baumann et al, 1994, p. 394).

Since the highest degree of technology in the hospital resides in the operating room, it would follow that the issues of day-to-day organization and availability of equipment and materials play a higher role in the daily worklife of the OR nurse than nurses working in other units. One nurse expresses confidence in knowing that she can walk into the operating room in the morning and everything is just the way she left it the afternoon before. Another nurse notes that the preoccupation with being organized and trying to anticipate ahead of time is typical of perioperative nursing. A study of interest reported by Hart (1988) links the types of personalities of OR nurses to job satisfaction. It is suggested that not every nurse can work in an OR setting because certain innate characteristics are required. One such characteristic reported is that of an internal locus of control which is associated with the belief that events are the result of one's own behaviour and are under the control of the individual. Internally controlled individuals are described as assertive, independent, and possessing the ability to appreciate internal rewards. An internal locus of control may be an outstanding personality characteristic of OR nurses. They are described as individuals who need the ability to derive rewards and satisfactions from a job well done based on their own appraisal because they often cannot depend upon others for rewards.

A theory of caring that I found by **Carper (1978)** is one that I would love to see researched (maybe my next project) and it states that, "the obligation to care for another human being involves becoming a certain kind of person - and not merely doing certain kinds of things". If that is true, then it may follow that operating room nurses are, or become, certain kinds of people. Possessing personal knowledge of a specialized nature and using it to provide care for another human being who requires surgical intervention without feelings for that person represents only the work of a technician. There is, in my mind, an erroneous perception of OR nursing as merely a technical function. The caring aspect of perioperative nursing is clearly evident in nurses during this study. Comments that reflect concern for the patient's comfort, safety, and well being are numerous and from all respondents. Little things from keeping the patient warm to acting as the patient advocate are taken very seriously and attended to with dedication and commitment. Anything that interferes with the nurse's ability to meet the needs of the surgical patient can have a negative effect on the quality of worklife of the operating room nurse. Locus of control is an important factor in the daily life of OR nurses.

√ Teamwork

By far the most significant influence on the quality of worklife of OR nurses is teamwork.

A dramatic finding of this study is the importance of teamwork. The repeated reference to teamwork is both surprising and meaningful. The open-ended question of this study asked:

What do operating room nurses identify as the significant factors affecting their quality of worklife? While many items were mentioned by various nurses, only the topic of **teamwork was mentioned voluntarily** by each and every nurse interviewed. There is little doubt that group cohesion is one of the internal factors that influence the worklife of nurses. It is an outcome variable that is measurable, yet is one of a group of many characteristics of the work environment that have received the least amount of research attention. The research conducted in this study confirms that teamwork or group cohesion is a major factor in the quality of worklife of operating room nurses. Members of a highly cohesive group are more energetic in group activities, less likely to be absent from group meetings, happy when the group succeeds,

and sad when it fails. Members of less cohesive groups have less interest and concern for the group's activities. Highly cohesive groups have a sense of camaraderie, group spirit, and oneness.

Factors that contribute to the development of cohesiveness are:

• **Motive base of members.** To the extent that a group meets the individual needs of group members, it will become attractive to group members.

• **Incentive properties of the group**. Cooperative group rewards that encourage interaction can stimulate cohesiveness, particularly when members perform interdependent tasks.

• **Expectancies about outcomes.** Individuals will be more attracted to groups when they feel that group membership will in fact lead to the achievement of personal goals.

• **Comparison level.** According to equity theory, individuals perform an implicit cost-benefit ratio of membership and involvement in one group against alternative paths to goal achievement. This factor is particularly salient for voluntary groups.

• **External threat.** External threats to a group's well-being can strengthen the group's cohesiveness by providing a common enemy. Intergroup conflict often promotes intragroup cohesion.

• **Attitudes of group members**. A central tenet of social psychological theory is that individuals are attracted to others with similar attitudes. It follows, therefore, that homogeneous groups should be more cohesive than heterogeneous groups. (Shortell and Kaluzny, 1994, p.150)

However, cohesiveness must be viewed in the context of the situation; while it can be a positive force in most situations, in others it can reinforce counterproductive norms and practices.

> "If a group's norms favour low productivity, then having a highly cohesive group will likely lead to lower, not higher productivity. Similarly, a highly cohesive group may work against a manager's efforts to involve new members in a group or to have the group interact with other groups" (Shortell and Kaluzny, 1994, p. 150).

There is little doubt that group cohesiveness and a sense of teamwork is of primary importance to the respondents in this study. These OR nurses mention wanting to work with team members who share similar motives and expectancies about outcomes.

There is a sense that attitudes cannot be changed. For this reason, nurses look forward to working with members of the group who share similar attitudes while avoiding or simply tolerating others whose attitude may be dissimilar from their own.

Data from answers to subsequent questions attest to the importance of group cohesiveness. The frequent reference to the people thing, strong personalities, and the team confirms the considerable emphasis on teamwork and group cohesiveness. Additionally, the respondents often refer to who **you** are working with, that the OR is a very social place to work, and that trying to work together is very important. One nurse stated that OR nurses are part of a team and that the nurse is only as good as the weakest link in the team. It is clearly evident that teamwork is very important to the OR nurses in this study and that group cohesiveness plays a significant role in their quality of worklife of OR nurses.

At the beginning I mentioned that little has been done to link quality of worklife to outcomes and costs in healthcare. Staff recruitment and retention may well be one of the best cost saving measures available to managers and administrators today. How much does it cost to educate and orient new OR nurses?

Are dollars lost because nurses get burned out, discouraged, or upset with the work environment? We all know these costs are high. Paying attention to the things that matter to OR nurses, the strong influences on their quality of worklife, can pay dividends in the long run.

Summary

From data obtained in this study, the weak or negligible influences on the quality of worklife of OR nurses are:

- Organizational Structure
- Leadership, and
- Organizational Learning.

Things that matter to OR nurses and that influence their quality of worklife are:

• **Collaborative Decision-Making,**
• **Multiskilled Workers,**
• **Change,**
• **Organizational Culture,**
• **Locus of Control**; and the most important influence of all -
• **Teamwork.**

So, now when the question is asked "What Makes Your Day?" The answer is clear - at the end of the day, it all boils down to the most fundamental of all answers - People !

People are involved in collaborative decision-making, multiskilled workers, change, organizational culture, locus of control, and teamwork. These People include the OR nurse, who is involved in collaborative decision-making and all the other items that affect your daily work environment. The people you collaborate with, the people you interact with in the organization, and the people that make up the team - you and everyone around you are responsible for that magic ingredient - Teamwork.

What you say, what you do, and how you behave makes all the difference in the daily worklife of your colleagues. Each and every comment and interaction contributes to the efficiency and effectiveness of the team. Each and every day from this day forward, remember this - remember how important your role is in building a strong and effective team.

At the recent AORN Congress, Joan Rivers shared a favourite saying with us:

"The past is history,
The future a mystery,
Today is a gift from God, that is why it is called the present."

Today is all that we really have - let us make the best of each and every day as we continue to respect and value each member of the team.

Teamwork - our building block of the future - yours, mine, and every other member of the surgical team. Each member can make an enormous contribution - we only need to believe that the "best is yet to be - the best resides in me".

Yes, we can do our part in making our workplace a good one. But we can only do so much. It's time for governments, administrators, and managers to examine the work environment, to identify the kinds of things that motivate nurses to get up in the morning and go to work, and what makes that workplace pleasant enough that they are happy to stay there.

We are hearing about nursing shortages across Canada and the United States. Recruitment and retention strategies are returning to hospitals.

Besides "sign-on" bonuses, it is time for governments and administrators to examine the culture of the workplace.

Questions that must be answered:

• Are nurses included in decisions made?
• Do nurses have what they need to work with?
• Are they given a reasonable workload?
• Are nurses part of a team that values them and their unique contribution to patient care?

In the words of Senator Lucie Pépin (1999):

"We must turn our anger first, into passion, then into action. A hostile or unpleasant workplace must not be tolerated!" With confidence we must be assertive as we look to improve our work environment. Yes, we can do our part, but now it is time for the other stakeholders to pay attention! ■

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Canadian Post Basic OR Education Programs

St. Paul's Hospital Perioperative Nursing Program
1081 Burrard Street, Vancouver, BC V6Z 1Y6
Facilitator: Susan Wynne
Phone: (604)682-2344 x 2338 Fax: (604) 631-5531
E-mail: swynn@stpaulshosp.bc.ca
ORNAC Approved

Type of Program: Full-time study on site.
Length of Program: 6 months.
Entrance Requirements: One year acute care experience, current CPR.

SIAST Wascana Campus
Wascana Parkway, PO Box 556, Regina, SK S4P 3A3
Facilitor: Sheila Koch www.siast.sk.ca
Phone (306) 787-3506 Fax: (306) 787-9561
ORNAC Approved

Type of Program: First 4 weeks. Labs done on site or Saskatoon. Theory may be done via distance. Practical elsewhere. **Length of Program:** 16 weeks equivalent, all courses must be completed within 3 years.
Entrance Requirements: RN with a minimum of 6 months fulltime experience as an RN in an acute care setting.

British Columbia Institute of Technology
(BCIT) Perioperative Nursing Program
3700 Willingdon Ave.Burnaby, BC V5G 3H2
Contact: Marjorie White. Phone: (604) 451-7102
Fax: (604) 454-9731 E-mail: sknoll@bcit.bc.ca

Type of Program: Part-time study, distance education. Students require 33 credits to receive a certificate in perioperative nursing.
Length of Program: 2 years if all the courses taken consecutively (program must be completed within 6 years of commencement of study.)
Entrance Requirements: 2 years relevant experience, current registration, current CPR.

Alberta
University of Alberta Hospital
8440 - 112 St, Edmonton, AB T6G 2B7
Facilitator: Carol Klapstein
Phone: (403) 492-8822 Fax (403) 492-9439

No information available.

Mount Royal College
Calgary, AB
Facilitator: Tobi Siegersma
Phone: (403) 240-6715

Type of Program: Based on ORNAC's Standards of Practice and Competencies of OR Registered Nurses. Purpose is to prepare the RN to become a competent Perioperative RN at a beginning level. Consists of 4 core courses - 2 theory, 1 skills lab and 1 clinical practice course. **Length of course**: N/A

Red Deer Regional Hospital
Red Deer, AB T4N 5S1
Facilitator: Dearla Liivam
Phone: (403) 343-4768

Type of Program: Self Module learning. 4 week skill practice, 6 week preceptor with RN. Recognized for 3 credits toward Bachelor program at University of Athabasca.**Length of Program**: 24 weeks.Offered yearly. **Cost:** $1,500 +books.

Manitoba:
St. Boniface General Hospital
409 Tach Ave. Winnipeg, MB R2H 2A6
Facilitator: Carol Rickey E-mail: crickey@escape.ca
Phone: (204) 237-2585 Fax: (204) 237-2587
(No information available at present.)

Ontario:
Centennial College (**Type of Program:** Part time)
P. O. Box 631, Stn. A, Scarborough, ON M1K 5E9
Facilitator: Johanna Bernstein (416) 289-5000 Ext. 3391
E-Mail AJZB@CENCOL.ON.CA

Ontario:
Algonquin College (**Type of Program:** Part time)
1385 Woodroofe Ave. Nepean, ON
Facilitator: Sherri Pagnan
Phone: (613) 727-2723

Fanshawe College (**Type of Program:** Part time)
London, ON Facilitator: Carol Butler

George Brown College (**Type of Program:** Full time)
Toronto, ON Facilitator: Virginia Warren
E-mail: gbrowbc.on.ca

Ontario:
Georgian College
Barrie, ON

Type of Program: Full time.

Humber College
Toronto, ON
Facilitator: Kathi Johnston

Type of Program: Part time.

Mohawk College
Sanatorium Road
Hamilton, ON, L8N 3Z5
Facilitator: Kathy Radcliffe
Phone: (905) 575-2545

Type of Program: Part time, with a full time clinical component at the end.

Sir Sanford Fleming College
Peterborough, ON
Facilitator: Rosemary Newmaster

Type of Program: Part time.

St. Clair College
Windsor, ON
Facilitator: Jo Ann Dale

Type of Program: Part time.

Quebec:
(No Post-Basic Courses available.)

New Brunswick
South-East Health Care
135 MacBeath Ave. Moncton, NB. EIC 6Z8
Education Coordinator: Sandra Poirier
Phone (w) (506) 857-5390 Fax (w) (506) 857-5382
E-mail sapoirie@nbnet.nb.ca

Type of Program: Self-Directed Learning Module Format **Length of Program:** 2 - 3 years
Entrance Requirement: RN must have two years recent OR experience.

Nova Scotia
There may a program beginning early in 2000.
For more information contact: the Operating Room Nurses Association of Nova Scotia (ORNANS)
President, Sharon Greene, Resource Nurse, OR
IWK Health Centre for Children, Women & Families
5850 University Ave., Box 3070 Halifax, NS
B3J 3G9 Phone: (902) 428-8305
Fax: (902) 420-6477
E-mail: gmh.orsag@iwkgrace.ns.ca

Newfoundland
A Post-Basic OR Course is being developed.
For more information contact: Patricia Harkins
Centre for Nursing Studies
251 Waterford Bridge Rd., Littledale Complex
St. Johns, NF, AlE lE3 Fax: (709) 737-3836

Prince Edward Island
No Post-Basic Courses available.

Yukon/North West Terrritories
No Post-Basic Courses available.

Shouldice Hospital:

Dedicated to the Repair of Hernias

By Beth Stobie, RN, CPN (C)

Dr. Earle Shouldice founded the Shouldice Hospital, a private facility dedicated to the repair of hernias, in 1945. The first hospital opened in a converted house on Church Street in Toronto with a single operating room. As requests for his unique surgery increased, he bought the three adjacent buildings. Finally, in 1953 he purchased a beautiful country estate North of Toronto in Thornhill, and a second hospital was established. In 1969 an eighty-nine bed facility, designed to encourage maximum ambulation and minimize the atmosphere that patients associate with hospitals, was opened at the Thornhill site, and the downtown hospital was closed.

Dr. E. B. Shouldice, the son of the founder, joined the staff in 1962, and it was his planning that created the new hospital. Today ten full-time surgeons perform approximately 7,400 hernia repairs annually in the five operating rooms.

Anatomy of a Hernia

A hernia is an abnormal protrusion of tissue, an organ, or part of an organ, beyond its normal confines through a congenital or acquired defect. Intra-abdominal structures may protrude through the diaphragm, the pelvic floor, or the external abdominal wall. The Shouldice Hospital specializes in the repair of external abdominal wall hernias, which depending on their location, may be classified as indirect, direct, femoral, umbilical, epigastric, interstitial, or incisional. Other rare types are spigelian, lumbar and obturator.

In each groin area is an inguinal canal which contains the spermatic cord in males, and the round ligament in females. The inguinal canal has a natural entrance, then a passageway through the abdominal wall, and then an exit. The posterior wall of the inguinal canal is called the "canal floor". The entire floor must be exposed and it should be split at least halfway for a more effective repair.

- An indirect hernia gets into the inguinal canal through the entrance.
- A direct hernia gets into the canal by breaking through the floor of the passageway.
- A femoral hernia comes through the passageway that the femoral vessels use to get into the leg.
- An interstitial hernia breaks through the abdominal wall muscles anywhere other than the previously named sites.
- An incisional hernia is the result of previous surgery.

Hospitalization and Pre-Operative Procedures

While it is true that men get hernias more often than women, we have operated on men and women of all ages. The number of men to women is a ratio of nine to one (9 to 1).

Patients are seen by the surgeons in the office, which is a walk-in clinic, and any questions are answered. Patients are booked for surgery and given dates for their operations. A patient who is overweight will be instructed to reduce half the excess weight prior to admission. This makes the surgery easier for both the surgeon and the patient, and reduces the risk of recurrence. Better quality tissues under less tension permit a more effective overlapping repair. Concomitant medical problems are stabilized prior to admission.

Today, in the era of increasing outpatient surgery, we appear to be ultra-conservative, as we admit our patients the day before surgery and keep them in the hospital until the second or third postoperative day. A four day stay at the Shouldice Hospital costs less than one day at a General Hospital. We consider outpatient abdominal surgery analogous to driving a car without insurance - no problem if nothing goes wrong - but the situation is totally unpredictable for the first 48 - 72 hours postoperatively.

We are convinced that elderly, and even otherwise healthy young patients, benefit both physically and psychologically from a short period of supervised convalescence. The patients are admitted the afternoon before their surgery; and at that time their general state of health is re-examined.

Anesthesia

We use local infiltration of 1% or 0.5% *Novocain* without *Epinephrine* for 97% of our groin operations. The patient is sedated with *Diazepam* (10-20 mg) orally 90 minutes preoperatively and *Demerol* (25-100 mg) intramuscularly 45 minutes preoperatively. Local anesthesia allows demonstration of the hernia and testing of the repair, if desired, while the operation is in progress. It is a safer anesthetic for the elderly and for patients with cardiac or pulmonary disease. It permits the earliest possible ambulation, the ability to walk away from the operating table, and deep breathing and coughing without discomfort in the immediate postoperative period.

General anesthetics are done for very nervous patients, incisional hernias, and several time recurrent cases which would be too difficult to do under local anesthesia. The hospital has two anesthetists on staff. One gives the general anesthetics, while the other is on standby for the remaining patients.

Bilateral inguinal hernias in children are repaired simultaneously under a general anesthetic. All others, repaired under local anesthesia, are scheduled forty-eight hours apart. Postoperative discomfort is less, and repair of the second hernia remains an option. Occasionally the patient decides to return at a later date if the hernia is small and still asymptomatic.

Operative Procedures

On the day of surgery, patients walk to the pre/post operative room, where they receive their Valium and Demerol. They walk to the operating room assisted by the surgeon and the assistant, and are settled on the OR table. The circulating nurse greets the patient and introduces herself and the scrub nurse. She attaches the ECG leads and pulse oximeter, and checks the blood pressure.

The circulating nurse stays with the patient at the head of the OR table and monitors them throughout the surgery; note that there is an anesthetist on stand by. Patients are encouraged to bring their favorite CD's, which we will play for them during the procedure to help put them at ease. A normal case takes approximately three quarters of an hour.

In the case of a general anesthetic, a nurse is assigned to help the anesthetist start the case, and when the patient is asleep, goes to the Central Service Room to help prepare supplies. She returns to the OR at the end of the procedure and accompanies the patient to the recovery room, monitors the recovery, then transports him or her back to his/her room on the floor with a surgilift.

Regardless of the type of groin hernia, the entire groin region must be explored. Recognition of the anatomy, both normal and abnormal, and thorough dissection are absolutely essential. Multiple hernias on the same side are found in 13 percent of groin hernias.

We use four lines of 34 or 32 gauge stainless steel wire for the repair of the posterior wall of the inguinal canal. Continuous sutures distribute tension evenly, and leave no gaps. Stainless steel wire is inert in the tissues and provides a strong repair.

The muscles of the groin portion of the abdominal wall are arranged in three distinct layers, the external oblique, the internal oblique, and the transversus. We repair the defect, each layer in turn, by overlapping the muscle margins. Mesh is used in extremely rare cases where there has been destruction of the tissue. When it is required and the bowel can be covered with peritoneum, Trelex polypropylene mesh is sewn in with prolene sutures. When the bowel is exposed, Gortex is used instead to avoid adhesions. The mesh is placed below the defect as an underlay.

We use absorbable sutures for the subcutaneous

Author

Beth Stobie, RN, CPN (C), is an operating room nurse at the Shouldice Hospital, Thornhill, Ontario.

closure, and Michel clips for the skin. These clips are removed within forty-eight hours.

In our central service room the RN's make up the local anesthetic *Novocain* solutions. The RN's and RPN's make the wire sutures and sterilize all the supplies needed for surgery. There are three instrument aides who help process instruments and make up the carts which hold supplies for the operating rooms. Normally we do about thirty cases a day.

Post Operative

The local anesthetic patients walk away from the operating table assisted by the surgeon and the assistant, and are then taken back to their rooms in wheelchairs by one of the recovery room nurses. Patients who have had extra sedation such as *Versed* or *Fentanyl* may stay in the recovery room for half an hour or more until ready to return to their rooms on the floor.

The patient remains in bed for four hours postoperatively and then sits at the side of the bed for twenty minutes, before getting up to walk with the aid of a floor nurse. Patients are encouraged to walk as much as possible. They remain on the floor for dinner the day of the surgery, but starting the next day they go to the dining room for meals and participate in a gentle exercise program.

On the first postoperative day half of the Michel clips are removed, and the rest are taken out the following day. The patient goes home on the third postoperative day, usually able to carry on normal life with full unrestricted activities.

Summary

The Shouldice Hospital has been dedicated to the repair of hernias for over fifty-four years, processing over 250,000 cases in that time. The procedure used has been continually refined over the years, and the recurrence rate is less than one percent (1%). Qualified medical personnel from all over the world visit frequently to observe our method of hernia repair.

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Shouldice Hospital Brochure.
Visit the Shouldice Web Site, www.shouldice.com

Acknowledgments

Special thanks to Dr. Michael A. Alexander.

Winnipeg's Pediatric Cardiac Inquest:

The Patient's and Parent's Advocate

By Joan Borton, RN, BN

What happened in 1994 is an extreme example of what could happen to any nurse, in any health care institution anywhere in Canada. It is amazing to me that people now want to interview us and hear us speak, because in 1994 it seemed that no one looked upon us as someone to be listened to, respected or even believed.

My presentation is comprised of other nurses' perceptions, actual patient charts, transcripts from the inquest, but mostly from my own experiences and memories.

During 1994, I was a nurse clinician at the Variety Children's Heart Center, a position I had held since 1987 except for one year during which I taught in the Pediatric Intensive Care Unit.

The role of the nurse clinician, [1] in theory is :

A - Patient Care

- provide clinical expertise to nursing staff;
- provide continuity of patient care by follow up of the patient between ambulatory care and in-patient service; and,
- collaborate with the physician, unit manager and other members of the health care team.

B - Education

- provides education to patients, family and staff in designated ambulatory care and in-patient units.

C - Research

- identify problems for clinical research.

(1. Source: Health Sciences Centre Nurse Clinician Job Description.)

As nurse clinician for the pediatric cardiac surgical program, I was responsible for the slating of the surgeries, the preoperative preparation of the patients and parents, the follow-through of the patients during hospitalization, and coordination of their care upon discharge. As nurse clinicians, (there were two or three of us), we met every parent of every child diagnosed with heart disease. We accompanied the pediatric cardiologist who would explain the anatomy, proposed medical treatment and surgical options. The exception to these patients were the critically ill newborns who were admitted to the Neonatal Intensive Care Unit and subsequently diagnosed. For these babies, the nursing support for the parents was provided by the neonatal nurses and we were peripheral at that point. But upon discharge of these infants, along with other children diagnosed at different times, nursing was present for the outpatient visits, heart catheterizations and preoperative preparation for elective surgery. We would follow the parents and child during the day of surgery, immediately post-op in the PICU, and then on the ward. I stress that the professional relationship between the parents and the nurses was intense and involved, and will illustrate this relationship later when I talk about two of the children. We knew these families, often for years.

The support of the parents was paramount to me in my position. Parents give their child to the doctors and nurses and trust that they will give their child the best possible care. Unfortunately, there is a mortality rate in pediatric cardiac surgery and there is no grief comparable to that which is experienced with the death of a child. Barbara D. Rosof writes:

> "Losing a child is a different kind of loss. Its dimensions are more profound, the swath it cuts across families lives is much broader than any other loss."

You can never prepare a parent for their child's death, but you can given them the knowledge that this is a possibility when the child undergoes cardiac surgery. Along with this knowledge you give them the trust and confidence they require to endure the experience, the surgery, and the hospitalization.

Author

Joan Borton, RN, BN, is staff nurse, Children's Clinic, Children's Hospital, Winnipeg. This paper was deliverd to the 16th National ORNAC Conference in Halifax, June, 1999.

With the previous surgeon, I used to say to parents: "Dr. Duncan could operate on my child. I don't have children, but if I did, I would have the confidence in him to do the surgery". This trust was violated in 1994. I came to a point where I could no longer look into the parents' eyes and give them this confidence.

Dr. Jonah Odim started operating at the end of February,1994. After the first death in early March, I felt that this was one of those unexpected post-operative deaths that is part of a cardiac surgical program-any program. After the second death, I went to the other nurse that I worked with and said I had concerns about the program. She also had concerns, but she did not think that either of us could do anything about them. I agreed, but said that I felt since she was my immediate supervisor she should know my concerns. I also asked her to relay them to the medical director. She said she would.

Later on in April, an incident arose that caused me to have a meeting with this nurse and the medical director, Niels Giddins. After the discussion finished, I asked her if she had spoken to him. She said she had not. I turned to him and repeated my concerns. He basically said that he did not have any concerns. I could not believe that he did not perceive any problems. Carol Youngson and Irene Hinam and myself had been meeting by then and talking about the program and the surgeries. I had seen morbidity and mortality that I had not seen before. I knew that Carol had certain issues in the OR, as did Irene.

Talking to Dr. Giddins,Chief of Pediatric Cardiology, did not work, so I went to Isobel Boyle, the Director of Patient Care Services. I walked into her office, sat down, and started to cry. I could barely get the words out. I said: "I want you to know that I have concerns about the surgical program." She acknowledged my concerns and was very supportive. Someone finally listened! She also said: "You've got to get out of there", and I agreed.

Five- month old Alyssa Still

One of the children who died in early May, 1994 was Alyssa Still. She was a five- month old baby girl who was seen in the Cardiology Clinic in March, 1994. Her mom was a young single girl who lived with her own mother in Thunder Bay, Ontario.

Alyssa had been referred by her pediatrician in Thunder Bay. He had tentatively diagnosed the baby with Tetraology of Fallot, so mom and grandma were not intensely shocked or grieved by the diagnosis as explained by the cardiologist.

Because of the distance the family lived from Winnipeg, the plan was to admit Alyssa the next month for a heart catheterization followed by surgery, if the catheterization confirmed the clinical and echo diagnosis.

The heart catheterization went well and surgery was slated for two days later. However, Alyssa's chest x-ray showed right middle lobe infiltrates and the decision was made to postpone the surgery for two to three weeks. The family stayed at our Ronald MacDonald House in Winnipeg. The day prior to Alyssa's scheduled first operation, Daniel Terziski underwent a Norwood procedure and died.

Two weeks later, Dr. Odim performed a Repair of Tetraology of Fallot on Alyssa. She did well. I saw her immediately post-op. I was thrilled and thought that the cardiac team had 'turned the corner' and from now on things would go well.

The next day, I went to PICU to see how Alyssa was doing. She had died. I could not believe it. I went back to the Heart Centre and cried uncontrollably. That was the beginning of the end for me.

I had lost confidence in what the cardiac team was doing. I phoned Alyssa's mom and grandma to offer my condolences and later that day, the other nurse and I visited them at Ronald MacDonald House - a very sad and difficult meeting.

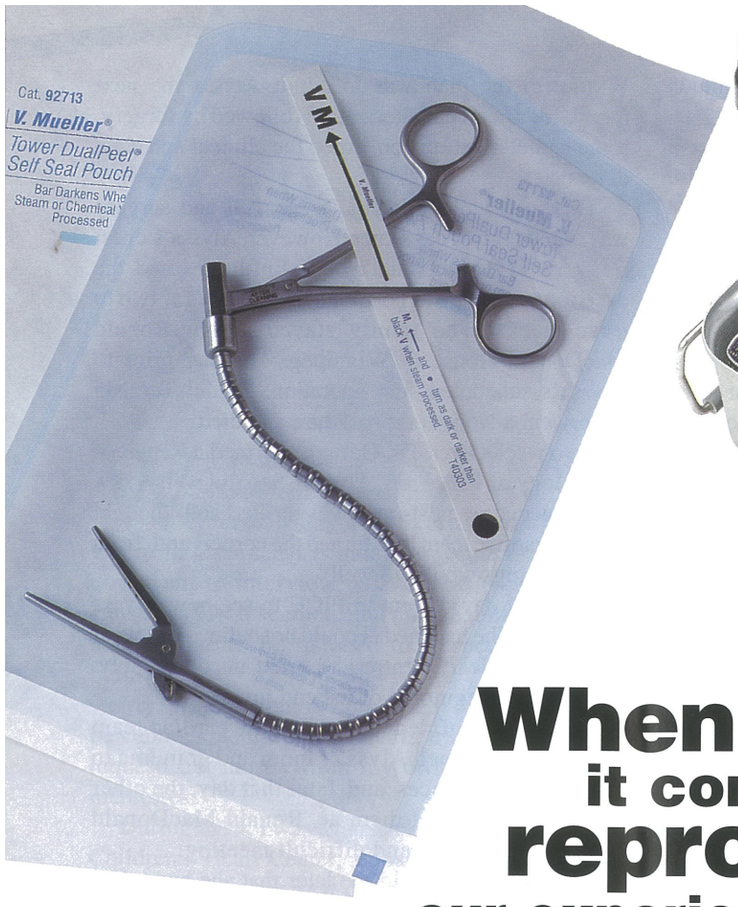
Alyssa's mother told me later that she had a bad feeling about the surgery. She said she was prepared and confident before the first date of surgery, but not at this one. The autopsy confirmed that Alyssa's death was unexplained.

By the middle of May, the anesthetists withdrew their services for high risk surgeries for the purpose of examining the program and ultimately improving it. As stated earlier, Isobel Boyle and I had agreed that I needed to get out of the Heart Centre because I was so upset about the program.

My job changed from doing the principle components of the surgical nurse clinician role to that of the medical nurse clinical role which included heart catheterizations, doing the cardiology clinics and following the cardiology patients in the hospital. This was an interim solution.

The summer of 1994 went fairly well for me. I had three weeks holidays in July and only low risk, closed and open cases were booked. I was looking at positive patient outcomes. However, Carol, Irene and Carol Bower continued to see problems in the OR.

Carol Bower attended a meeting of the Wiseman Committee in August where it was to be decided whether to continue with low risk cases or to start doing more complex cases. She stated the nurses'



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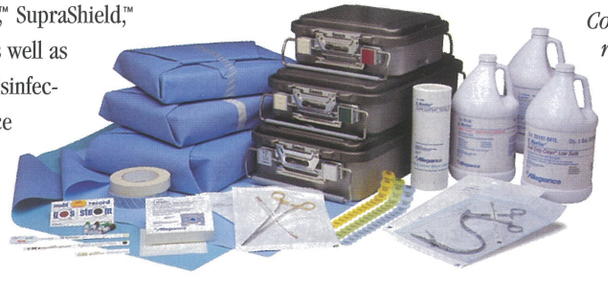

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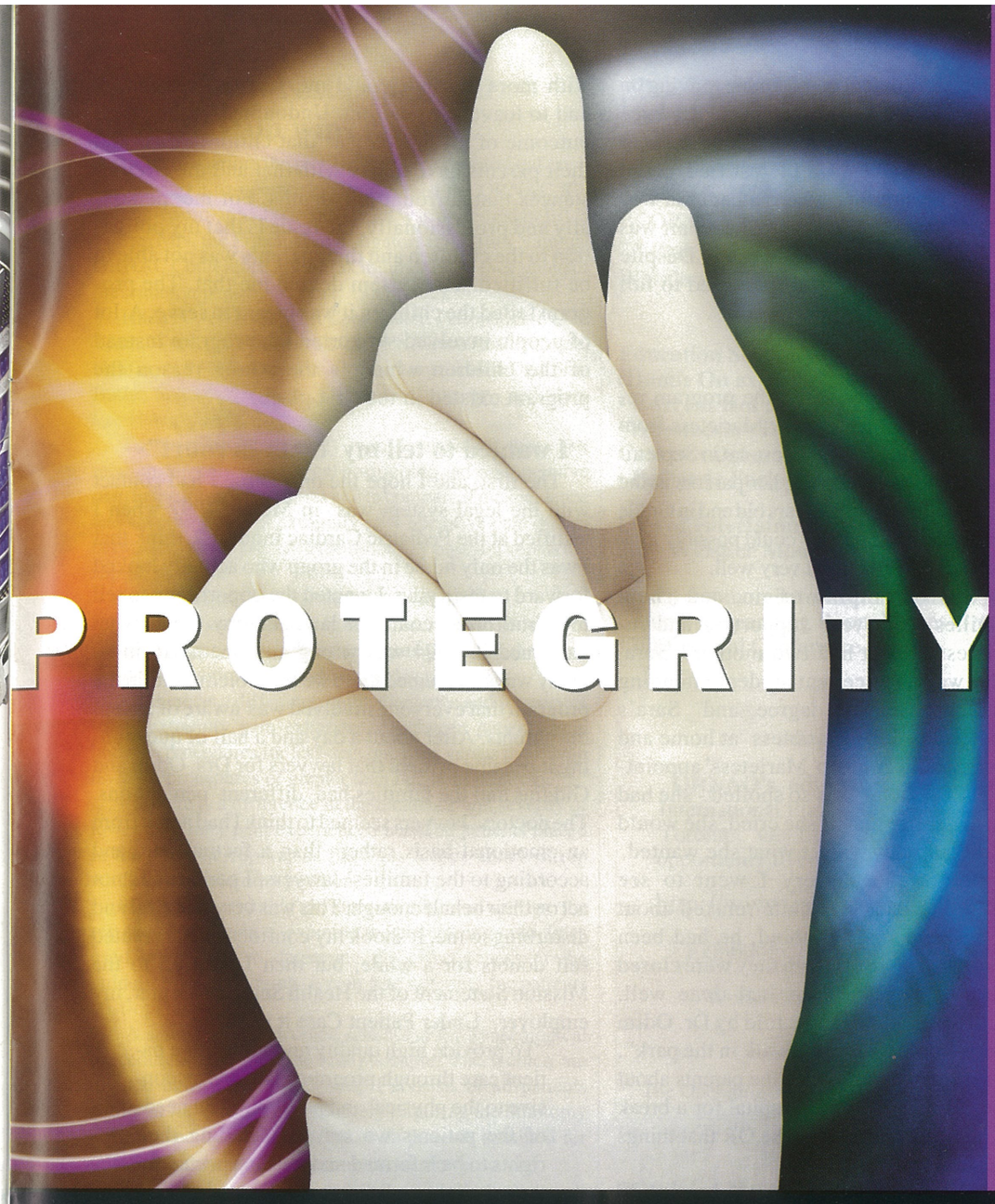

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decision that they did not feel comfortable moving on to more difficult cases. She explained that even though the patient outcomes were good, things had not been smooth. At the Inquest Carol testified about one case during the summer where a cannula was knocked out, and another case where the repair was not done correctly and had to be redone. Despite nursing's objections, the program returned to full capacity in September.

Marietess Capili

The first case to be done when the program resumed was Marietess Capili. I knew Marietess from her first week of age until she died post-op in September, 1994. I can remember meeting her parents at the initial clinic visit, both of them 17 years old and in Grade 11. I wondered how these parents could possibly look after this baby, but, they managed very well.

Marietess was of Filipino origin, and both extended families were very supportive and involved. Marietess almost had two mothers, Sara, her mom, who was an excellent student attending University doing a science degree, and Sara's sister. The sister cared for Marietess at home and the two of them would come to Marietess' appointments together. The baby was so spoiled - she had learned early in her life that if she cried, she would turn blue, and could always get what she wanted.

The day before the surgery I went to see Marietess. Ben, her dad, was quite relaxed about the surgery. I assume in his mind, he had been through two surgeries even though they were closed heart operations, and Marietess had done well. Later he would testify that he was told by Dr. Odim that the surgery would be like a " walk in the park".

The day of surgery I went to see the parents about mid afternoon. Sara had left the hospital for a break and Ben said he had a report from the OR that things were moving along.

The next day at work in the cath lab I was told that Marietess had died the previous night. I was stunned. I felt I had failed Marietess and her parents, not only because she died, but because I could not be there for the parents. The autopsy showed that one of the bicaval bidirectional shunts was sutured too narrowly, and caused obstruction to blood flow.

In 1998 after we made a presentation at the Manitoba Association of Registered Nurses annual general meeting, Ben came up to me and said that it helped to hear us speak, it helped with closure.

The program continued until December, 1994 with more morbidity and mortality. Eventually I had to leave my position. Undoubtedly, the worst outcome of all of this was that children died and their parents have to live with that and the circumstances that surround the deaths. For me, personally and professionally, the issue is that my obligation to the children and their parents was not able to be fulfilled. The system denied me that. The program failed the children it was meant to serve. A lot of people involved supported the program instead of the children which is the whole reason the program existed in the first place.

"I wanted to tell my truth in court"

The first, and I hope the only time I had contact with the legal system was in March, 1997 when I testified at the Pediatric Cardiac Inquest. I think that I was the only nurse in the group who actually looked forward to testifying. I wanted the opportunity to tell my truth in a court of law. In my view what happened in 1994 was wrong and unethical, in so many ways. It seemed there were problems within the program that everyone involved was aware of except the parents. After about a day and a half of questioning it became evident that lawyers for Drs. Odim and Giddins and the families had different perceptions. The doctors' lawyers seemed to think I had acted from an emotional basis rather than a factual one, and according to the families' lawyers, I perhaps did not act on their behalf enough. This was very stressful and disturbing to me. It shook my confidence and created self doubts for a while, but then I referred to the Mission Statement of the Health Sciences Center, my employer. Under Patient Care it reads:

> "To provide high quality and innovative patient care through programs that are responsive to the physical and psychological needs of the patients we serve, (including their rights to be informed and to be respected for their beliefs, religious practices and customs)".

The Mission Statement concludes with:

> "The Health Sciencs Centre will pursue this mission in accordance with accepted ethical values recognized by society as a whole as well as those ethical standards adopted by Professional organizations represented in the Centre".

I adhered to this Mission Statement to the best of my ability. One of my questions is: Did others in the organization do the same ? ■

Research on Positioning and Post-Op Pain wins award

A study to examine the relationship between surgical positioning and post-operative pain received the ORNAC Research Award of $5,000. The award was presented to Hilda Power, MN, the Principal Investigator, at the 16th National ORNAC Conference in Halifax in June, 1999. (See photo of presentation page 5, October, 1999 issue).

Hilda Power is Support Coordinator, Perioperative Care Team, Women's Health Program IWK/Grace Health Centre, Halifax, N.S. Other members of the team include Dr. Lorna Butler, School of Nursing, Dalhousie University and Mary Lee Hebert, BscN.

The purpose of the study is to determine if there is a relationship between surgical positioning and postoperative pain in the lower extremities and to compare if the incidence and severity of lower extremity post-operative pain differs between patients placed in the lithotomy position versus the supine position.

Objectives of the study are to determine:

- If there is a difference in the incidence and severity of lower extremity pain between patients placed in the intra-operative positions of lithotomy and supine.
- If there is a difference in the incidence and severity of lower extremity pain experienced between patients who undergo procedures for less than one hour versus those who undergo procedures of greater than one hour duration.
- If there is a difference in the incidence and severity of lower extremity pain experienced between patients placed in the Allen stirrup versus the Sims (candy cane) stirrup while in the lithotomy position.

It is anticipated that perioperative nurses will use the results of this study to examine the positioning guidelines used in the OR to determine the effectiveness of the guidelines in achieving a pain free outcome for patients post-operatively.

A sample of 350 women scheduled for gynecological procedures comprises the study sample. The women are divided into two groups. Group I consists of all patients admitted for gynecological surgery requiring the lithotomy position and Group II consists of all patients admitted for gynecological surgery requiring the supine position.

As of October, 1999 the study has accrued more than half of the required number of participants and hopes to accrue the total number within the next six months.

Correction

On page 5 of the October, 1999 issue the photo cutline - Speakers from the Heart Club, Winnipeg ..."*Events leading up to the death of 14 infants.*" Correct number of deaths is 12. The editor apologizes to readers for this unfortunate error. Please see full coverage of Winnipeg's Pediatric Cardiac Inquest in this issue.

Conference Calendar

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Watch for details in the Feb/March, 2000 issue.

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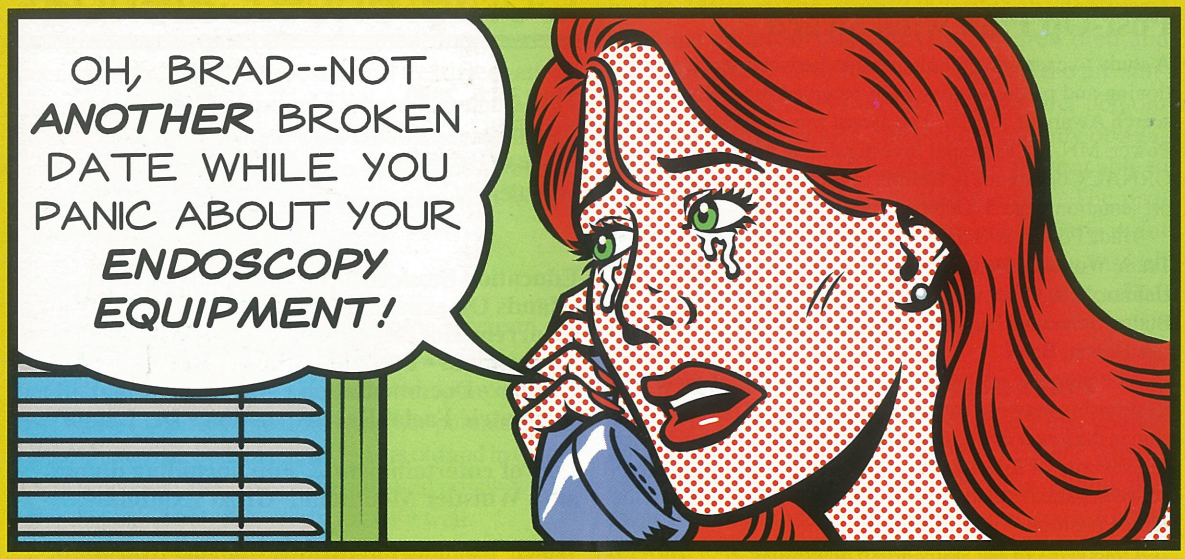
Websites for Operating Room Nurses:
The Operating Room Nurses Association of Canada website: **www.ornac.ca**

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



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