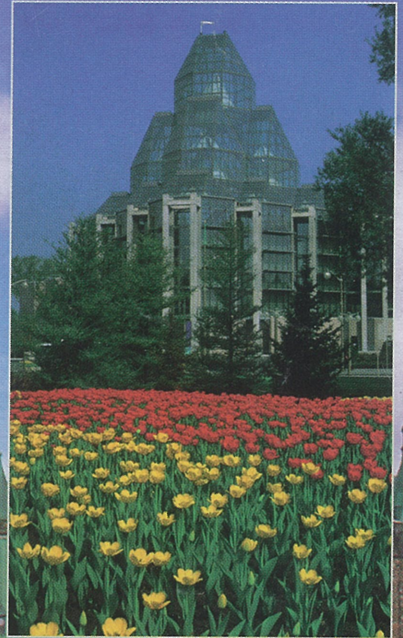
Canadian Operating Room Nursing Journal

Published Quarterly. Vol. 15, N0.1, March/April, 1997



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United States	$ 22.00	
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Canadian Operating Room Nursing Journal is indexed in *Index Medicus,* the Cumulative Index to Nursing and Allied Health Literature.
I.S.S.N. No.-0712-6778
Canadian Publications Mail Product
Sales Agreement No. 0584304

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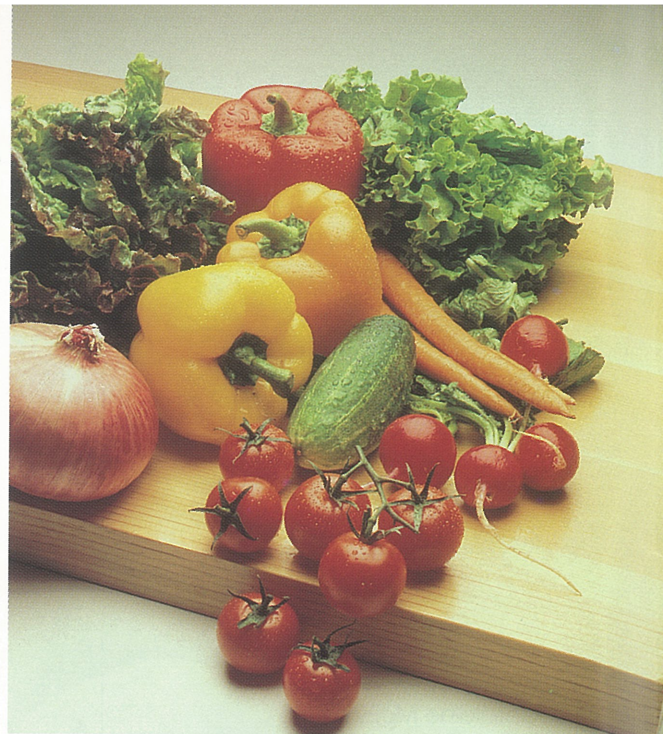

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Are You Prepared to Serve Your Association ?

By Vija Hay, RN, CPN(C)

At the April ORNAC Board of Directors meeting, nominated candidates will stand for election to Executive positions. This prompted my thoughts to turn upon the issue of operating room nurses volunteering to become leaders at regional, provincial, and national levels.

In today's climate, volunteer time is becoming more limited, and the supply of volunteers who are willing to, and capable of, spending time on association business is decreasing. People are already overcommitted, and uncertain futures make it difficult to take on yet another commitment. We have been fortunate that so many operating room nurses have been willing to be actively involved. The success of ORNAC can be attributed to their knowledge, ability and commitment.

The pamphlet "Welcome To The Board" (which is given to all new board members) states: "being a board member is an honorable position which has obligations, expectations and responsibilities." What it does not refer to is the requirement of time and work associated with fulfilling this role. Depending on a member's level of involvement, this can be considerable. In the near future, association jobs will become even more difficult and challenging as we create greater awareness about the role of our association and perioperative practice, and the need to look for more partnerships in public debates regarding these issues.

The board of a volunteer association such as ORNAC represents the ownership of the organization, just as a business board represents its stockholders. The board governs on behalf of persons who are not seated at the table. Therefore, the power of the board of an association is not as individuals, but as a group.

To be an effective member in the creation of a productive board, a member should:

- Share the same vision - work on same priorities;
- Build consensus;
- Strive for accountability in the board's job;
- Participate in the productivity of the group;
- Carry individual responsibilities in the pursuit of quality;
- Cherish diversity and viewpoints;
- Be prepared to participate responsibly and do the homework;
- Be proactive - be an active participant; and
- Support the board's final choice

I know our membership is comprised of O.R. nurses with a wealth of knowledge, ability and commitment to fulfill the role on the board. Don't be intimidated or overwhelmed by the expectations of a board position. Get involved at the regional level of your Operating Room Group, let your name stand for office, and/or volunteer for a committee. This will provide the ground work and experience necessary to move to provincial and possibly national levels. We need creative thinkers who can bring a fresh perspective to the issues facing ORNAC and perioperative nursing, and to ensure that the work continues to enhance the future of perioperative practice and quality care of surgical patients.

Association work is not only fascinating, stimulating, and a great learning experience, but it allows board members to be truly successful strategic leaders. Take the challenge: become a leader in an O.R. nurses association. Our professional future could depend on the effective participation of operating room nurses across the country.

Vija Hay, Consultant, Surgical Services, Ottawa, is President of the Operating Room Nurses Association of Canada.

ORNAC Elections - April, 1997

Nominations for Office

Submitted by **Jackie Waisman,** Past President
ORNAC. Chair - Nomination Committee

Get to know your nominees for the positions of President Elect, Treasurer and Secretary. Each nominee has provided their biographical information and a photo so that you can become better acquainted with those committing their time and energy to your Association. Elections will be held on April 27, 1997 in Ottawa. Election results will be published in the June issue of the Journal.

Marlene Hill
Nominated for President Elect

Marlene Hill is a staff nurse in the Operating Room, Queen Elizabeth Hospital, in Charlottetown, Prince Edward Island.

Professional Activities

ORNAC Board Member 1989-1993. Currently serving second term as ORNAC Treasurer, 1993-1997.
Chairperson of Finance Committee since 1993.
Chairperson of Standards/Education Committee since April, 1996.
Coordinator for the publishing of the ORNAC Standards document in 1998.

Objectives for ORNAC

- Continue to lobby the importance of staffing Operating Rooms with Registered Nurses.
- Support and encourage Advanced Nursing Practice roles.
- Continue to promote ORNAC as a viable, worthwhile Association.

Dahlia Robinson
Nominated for President Elect

Dahlia (D) Robinson is the Clinical Coordinator General Surgery (adults and pediatrics) at the University of Alberta Hospital in Edmonton, Alberta.

Professional Activities

ORNAA: Past President ORNAA 1996-1998
President North Central Operating Room Nurses of Alberta

ORNAC: Board Member 1992-1996
Member of Advanced Nursing Practice Committee
Member of French Translation Committee

Objectives for ORNAC

- Promote the role of the Registered Nurse within the Operating Room, incorporating our expanded roles of Perioperative Nurse-Anaesthesia , and Perioperative Nurse- Surgery.
- Promote the CNA Perioperative exam.
- Promote science based research to support our roles.

ORNAC has been proactive in the creation of the expanded roles for the Registered Nurse within the Operating Room, and has worked collaboratively with the Canadian Nurses Association to create the certification exam. In a health care system which is continually evolving, these efforts can help formulate our future. *Promotion* of our roles to our colleagues, the public, and to major decision makers will demonstrate why the Registered Nurse is the health care discipline of choice for our patients.

Shelly Zareski
Nominated for Treasurer

Shelley Zareski is the Clinical Coordinator in the Operating Room, IWK- Grace Health Center, Halifax, N.S. She is the 1996 Recipient of the *Excellence in Nursing Practice Award* (Atlantic Region).

Professional Activities

ORNANS Past President of Operating Room Nurses Association of Nova Scotia.
ORNAC Board Member 1992-1996.
Chairperson of Awards Committee.
Member of Bylaws Committee.
Member of Finance Committee.

Objectives for ORNAC

- Maintain ORNAC's high profile in the nursing community.
- Promote and support the role of the Registered Nurse in the Perioperative setting.
- Encourage membership in provincial associations.
- Promote Perioperative Certification.

Corina Balcom
Nominated for Secretary

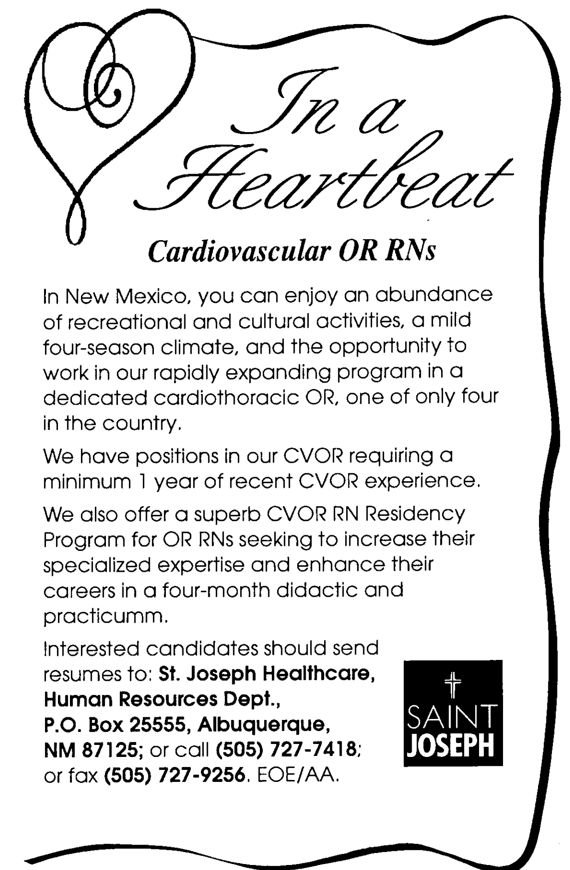
Corina Balcom is Nurse Manager of Perioperative Services, Region 7 Hospital Corporation, Miramichi, N.B. Brunswick.

Professional Activities

NBORN: Member of New Brunswick Operating Room Nurses Group since 1985. Currently Past President.
ORNAC: Board Member 1992-1995.
Secretary of ORNAC since 1995.
Member of Standards/Education Committee. Responsible for arranging Telemedicine Canada sessions 1994-1996.

Objectives for ORNAC

- Maintain and improve communication between Board Members.
- Promote and lobby for Advanced Nursing Practice roles in both Anaesthesia and Surgery.
- Provide support for the Registered Nurse in Operating Rooms across the country.



Patient-Centered Care in the OR: Is This Possible?

By Anna Gabrielson RN, BSN

Operating rooms have long been known as care giving areas where the primary focus can often be on constantly evolving technology, not on a patient's needs as a person. Focusing on patients' needs by respecting and understanding their values, preferences and expressed needs is the foundation of patient-center care as described by Gertis et al (1993). Therefore, patient-centered care is an approach that consciously adopts the patient's perspective. However, in a high technological area such as an operating room, professionals feel the time required to 'keep up' with new technologies cuts into the time available to spend with patients. The great strides in science and technology have made an impact on the value and definition of caring. I agree that this is a 'catch 22' as both are important: the technology and the needs of the patient. However, in using the concepts of relational care found in current nursing literature, operating room nurses can evolve from a technically dominant care-giving paradigm towards a humanistic paradigm that focuses on the patient's expressed needs. This paper will present care-giving concepts from current nursing literature and how these concepts can be applied to operating room settings.

Abstract

Patient-centered care can be practiced in high technology areas such as the operating room if care-givers develop an attitude of seeing their care delivery through the patient's eyes. Through caring interactions with our patients, we can find out what matters most to them. It seems that the more complex our technology and the more bureaucratic our hospitals have become, the less respect and positive regard is being communicated to patients. In addition, time is becoming increasingly scarce in our busy operating rooms. However, it is not how much time we spend with our patients. Instead, it is how we are with our patients in these stressful moments before surgery. Using concepts of relational care discussed in current nursing literature, nurses can evolve from a technically dominant care-giving paradigm towards a humanistic paradigm that focuses on the patient's expressed needs. This enables our clients to experience health and healing in their context.

Literature Review

Due to the paucity in literature specifically focusing on patient centered care in operating rooms, literature that addresses caring in the nursing profession in general is applied to operating room nursing. Aiken and Aiken (1973) claim that respect and positive regard is communicated through concern for a patient's feelings, experiences, and potentials. However, the more complex our technology the less time there is to communicate respect and positive regard. Also Gray (1993) argues that caring is not just about "making nice." It is about taking time and energy to share concerns when those concerns are present. Gadow (1985) maintains that the image of a caring person is of one who is tender, sympathetic and supportive rather than detached and efficient. Gadow adds that caring is concern for the dignity of patients which is threatened by technology and experts. Specialized nurses tend to take over the care of bits of the patient rather than total patient care. Furthermore, Hawthorne & Yurlovich (1995) claim that nurses appear to function in systems where the focus is no longer on the client as a person but on the outcome to be achieved; a problem to be solved.

Author

Anna Gabrielson, RN, BSN, is a Staff Nurse at the Surgical Day Centre, Vancouver Hospital, Vancouver, B.C. She has been an operating room nurse for 26 years with experience in Alberta, Switzerland, Sweden, and the West Indies.

Enhancing Our Care Delivery Using the Caring Concepts

A compassionate connectedness can be fostered by using full eye contact and an unhurried approach with warmth and acceptance of the client as a whole person. Through touch, the nurse can assist the patient to overcome the depersonalization that often characterizes a patient's experience in the health care setting (Fry,1989). Since hands and eyes are our most developed means of both receiving and altering the world, touch can affirm to the patient that he or she is a person rather than an object. However, I will mention that the caregiver should be discriminating, using intuition and experience to determine if touch would be therapeutic for his/her client.

Sherwood (1993) asserts that patients who experience this connected relationship in a crisis time found it to be a source of comfort. There was reassurance of being seen, being heard, and being with. I recognize that we are working within increasing time constraints with little possibility of changing. It is not how much time we spend with the patient, but rather how we are with the patient. An accepting, understanding approach with a situation-appropriate smile directed at the client could make a big difference in his/her psychological wellbeing.

Another issue that I will address is the general lack of encouragement for family involvement in the care giving process in our operating rooms. Three years ago a study cited by Gordon (1994) found that altering rigid visiting policies had a positive impact on client and family anxiety. It is important to remember that high technology and nursing procedures cannot replace the comforting presence of a caring family.

Recently, we permitted a family member to be present throughout her elderly mother's surgical intervention and post anesthetic recovery. We followed a rigid protocol in acquiring the medical director's approval and signature before this could happen. The surgical procedure was performed under a local anesthetic with narcotic sedation. Consequently, the client was able to communicate with her adult daughter throughout her operation. I felt and could see that the patient was comfortable, both physically and psychologically, in the context of surrounding high technology operated by masked strangers. This experience demonstrated to me that we could open our doors even wider and perhaps let a family member come into the operating room until the anesthetic is given. I know that being alone on an operating room table can be frightening to many patients, even though very few openly articulate this.

Another issue that requires some critical thinking is the strictly enforced dress code for the clients. Patients are asked to replace all their clothing with a flimsy hospital gown. The gown is usually a one-layer cotton blend that provides little warmth in the air-conditioned surgical suite. Many patients are having minor procedures on their fingers and toes, therefore the 'strip down' is an unnecessary and uncomfortable process for the patient. We need to examine this ritual for patients undergoing minor surgical procedures.

Gordon (1994) asks the question: should nurses continue to enforce rules that threaten patient autonomy and their sense of survival? By sense of survival, Gordon is referring to situations of patients who wear neck strings or bracelets which they feel protects them and their spirit during a crisis. Most operating rooms today still continue to impose rules that forbid any jewelry or special garments. Perhaps we could be more flexible in certain situations after we have explored with the patient what he or she would need to feel more secure and less afraid.

We also need to begin asking our patients what is concerning them the most in the stressful moments before surgery. We cannot make any assumptions about what it is the patient wants to know: sometimes it can be a concern about a family member at home for whom they feel responsible. We also cannot make the assumption that the patient would like to know all the technical details of procedures. In some (or most) cases, this could cause more stress for the patient. Patient-centered care is practiced when nurses approach their patients as whole persons in their context and their situation instead of an object or 'category of illness.'

Conclusion

Patient-centered care can be practiced in high technology areas such as the operating room if the caregivers develop an attitude of seeing their care delivery through the patient's eyes. Through caring interactions with our patients, we can determine what matters most to them. It seems that the more complex our technology and the more bureaucratic our hospitals have become, the less respect and positive regard is communicated to patients. In addition, time is becoming increasingly scarce in our busy operating rooms. Interactions with our patients in the stressful moments before surgery should take precedence over how *much* time is spent. Using the concepts of relational care I have discussed, nurses can evolve from a technically dominant care-giving paradigm toward a humanistic paradigm that focuses on the patient's expressed needs. This will enable our clients to experience health and healing in their context. ■

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Why Do A Whipples ?

By Tracy Lebek, RN, BSc & Holli McLennan, RN

Much literature has been written over the years on "how to do a *Whipples* procedure." Just as many articles can be found on "should we do a Whipples?" What quality of life are we giving these patients by performing a Whipples? This is not a very upbeat topic, but by looking at it from a moral or ethical aspect, the next time we scrub for a pancreatic tumor, we will know a bit more about these tumors and understand why it is better "not to do a Whipples."

In my experience, when you put a group of surgeons together in a room, there is not much on which they agree. But, when you put a group of general surgeons together to discuss carcinoma of the pancreas, there is one subject on which they will agree. It is clear to all of them that pancreatic cancer is increasing but the cure rate remains dismal. For people with cancer of the pancreas, resection of the tumor has not significantly altered the natural history of the disease. For instance, in 1990, 2,750 people were newly diagnosed with pancreatic adenocarcinoma and 2,700 died of the disease (MacFarlane, 1991). Even careful pre-selection of patients for radical surgery does not alter the less than 2% five - year survival rate (MacFarlane, 1991; Cooperman, 1989). So why do a Whipples?

In general surgery circles, a Whipples is considered a high risk, challenging, macho procedure that is in the fast lane, on the cutting edge of surgery. Well, we are happy to report that, in our country, more general surgeons believe that surgery for tumor of the pancreas should be relegated to a more palliative role (MacFarlane, 1991; Wade et al, 1994). Cutting, just for the sake of cutting, is not the answer.

Much literature has been written on the surgical options available for people with pancreatic carcinoma. But, let us not forget the quality of life for these patients. One of the most difficult decisions for a surgeon to make is when *not* to intervene. Often we are tempted to use the means available when the most humane approach would be to relieve the pain, and prepare the patient and family for death. Many surgeons now see management of pancreatic carcinoma as palliative and not curative (MacFarlane, 1991). A case can be made *not* to do the surgery and thus, leave the patient in as much comfort as possible.

Suggestions have been made that smoking, dietary factors like caffeine, and chemical and industrial carcinogens have been linked to possible reasons for the development of these tumors (MacFarlane, 1991; Cooperman, 1989). But, then again, could we not link those factors to almost any tumor?

Early diagnosis of a pancreatic tumor is almost impossible. The patient is asymptomatic until the tumor develops one of three characteristics:

1) becomes large enough to compress the common bile duct;
2) invades the retroperitoneal tissue; and
3) obstructs the flow of abdominal lymph.

The result is symptoms of jaundice, pain, or ascites, respectively (MacFarlane, 1 991).

Criteria were developed to help a surgeon determine if a Whipples should be performed (MacFarlane, 1991). The criteria are as follows:

1) the absence of metastasis to the peritoneum;
2) no periportal lymph node involvement; and

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Tracy Lebek, RN, BSc and Holli McLennan, RN, are staff nurses in the Operating Room, London Health Sciences Centre, University Campus, London, Ontario.

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3) absence of invasion of the superior mesenteric and portal vessels.

If a Whipples resection cannot be performed, the following operations may be carried out with the intent of improving symptoms of pain, jaundice, or gastric outlet obstruction:

1) gastrojejunostomy;
2) cholecystojejunostomy;
3) cholecystoduodenostomy; and,
4) choledocoduodenostomy.

What is the future of this disease? At this point, it remains fairly dismal. Early diagnosis is needed but, in order to do that, better epidemiology studies are required to determine high risk population groups. MacFarlane (1991) believes that management of pancreatic carcinoma will not change until a sensitive chemotherapeutic agent is developed.

We could look at the financial aspect and ask the question, "can we afford to do these procedures when the five-year survival rate is so low?" With shrinking health care dollars, we need to look at what we are spending our money on, in order to identify areas where we can reduce spending. But, we, as a society, value each individual life. To decide a surgical procedure, or any procedure which cannot be performed due to financial reasons, is not morally acceptable regardless of the low survival rate.

As perioperative nurses and patient advocates, we often think that, if we could just "cut it out," everything will be OK. The patient will be cured. But everything is not always OK and the patient is not always cured. So the next time you scrub and you can't do the Whipples procedure, think about your patient and think about your patient's family. You are probably still involved in the best possible treatment the patient can receive. Remember the old adage, "a chance to cut is a chance to cure?" Not always. ■

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From Theory to Perioperative Practice with Parse

By Mariana Markovic, RN, CPN(C)

Applying a nursing theory requires an understanding of how theory, practice and the discipline are entwined. Nursing practice, according to Parse (1987), is the performing art of the science of nursing, it is the reflection of the nursing theory behind it. The theory is the substance of nursing knowledge and its definition reflects a regard for the discipline itself. While the theory describes, explains and predicts the phenomenon of nursing, its usefulness is in the ability to guide nursing practice. Considering practice separately from theory cannot be done as it is the integration of values, beliefs and ethics embedded in the theory which creates the base of the discipline (Cody & Mitchell, 1992).

Abstract

The operating room nurse today is often thought of as a task skilled, highly technical, process oriented, and efficient member of the operating room team. Too often her/his nursing education and preparation in practice, theory and discipline are overlooked. Perioperative nursing as a specialty is an important, vital factor in the success of the planned surgical intervention. Perioperative nursing practice involves caring for the patient; it is patient-centered rather than task oriented. The RN combines both the physiologic and psychosocial aspects of nursing in delivery of care. This is reflective of the theoretical model used to plan effective nursing care. The RN interacting with the preoperative patient has a focus on being in true presence with the patient (Parse, 1987). The interrelationship sets in motion utilization of theory, reflecting nursing knowledge and practice.

This paper on applied theory presents Parse's nursing theory of *Human Becoming*. It applies the theory to a specific clinical situation and it describes how it guides nurses in practice. I have chosen the clinical specialty of perioperative nursing to illustrate its application. Here the limited time nurses have to be with the patient is part of the challenge in choosing a theory to provide a comfortable experience for the patient as well as the nurse. Parse's practice methodology provides nurses with a model for practice that focuses on the quality of life as it is humanly lived. The intent is to take the theory of *Human Becoming* and implement it in the present nursing practice. In a patient nurse relationship Parse's theory of nursing, compared to other theories in practice, is very different and complex in its theoretical approach. In applying the theory to the clinical situation my intent is to be consistent with Parse's interpretation by using her language. To introduce the theory of *Human Becoming* in the perioperative setting it is necessary to give some orientation to its fundamental principles.

The dimensions and processes of practice methodology in accordance with Parse (1987), are applied to an interrelationship with Mr. Cecil. Mr. Cecil is a gentleman of fifty-nine years, who is about to undergo elective surgery. He has no record of previous admissions to the hospital and feels somewhat overwhelmed with the process. Mr. Cecil's diagnoses of

Author

Mariana Markovic, RN, CPN(C), is a staff nurse in the Operating room at the McMaster Division of the Hamilton Health Care Corporation, Hamilton, Ontario. She is presently enrolled in the BScN program at McMaster University and a member of the Advanced Practice Committee, of the Operating Room Nurses Association of Ontario.

stenosed right carotid artery has made him a candidate for right carotid endarterectomy. His health history is unmarked except for the present weakness in his right hand and arm related to his carotid artery stenosis. He communicates well in English, which is his second language. He speaks Italian at home with his wife and one of the three adult children still at home. His wife and one son accompanied him to the operating room holding area. The on-going communication among the three suggested a very close and supportive relationship. Dr. Reno, his surgeon is an old friend of a number of years. Dr. Reno also looked after Mr. Cecil's father two years earlier. Mr. Cecil's father died in the operating room as a result of an inoperable high thoracic aneurysm. When I met with Mr. Cecil he looked up and said, "I want all of this to be over with." This short interaction clearly identified that the fear of surgery and its outcome was the major nursing problem requiring a great deal of attention as the time of surgery drew near.

The nursing approach to Mr. Cecil's clinical situation will exemplify the practice methodology of Parse's theory perspective. In this view, the goal for the nurse is to participate with Mr. Cecil to enhance his quality of life through being a true presence as he explores the meaning of his personal situation and chooses ways to move beyond his present health situation. To understand the meaning of the surgical intervention from Mr. Cecil's view requires being with him and listening to any unresolved feelings or conflicts he may have about the surgical procedure. The role of the nurse is to assist Mr. Cecil in affirming his reasons for the surgical intervention and to help him to focus beyond his imminent surgery. The goal of the nursing practice and its theory approach that I hope to achieve is that Mr. Cecil will have a peaceful disposition at the time of surgery and a positive outlook during his time of recovery.

My attention was drawn to the theory of *Human Becoming* by Parse in her presentation of nursing rooted in human sciences as an alternative to ideas of nursing grounded in the natural sciences. Her critique of nursing based on natural sciences made me identify with the present state of the operating room, where traditional nursing practice is problem focused. Identification and labelling of patients' experiences are often the same as that of the procedure itself. Undergoing surgery to correct a problem is solving it by the process of eliminating it. In this traditional approach, nursing and diagnostic processes are viewed as central to nursing and health. Parse's view, in contrast, suggests that understanding the meaning of health from the patient's perspective is crucial to giving meaning to quality of a human's total experience with health (Parse, 1981). The human being's qualitative participation with health is Parse's definition of a science rooted in humans. The essence of nursing according to Parse (1987), is the relationship between the nurse and patient or family. Nurses using this belief system view human relationships and life processes as much more than the identification, management, or elimination of problems, and they participate with the individuals to enhance their quality of life.

In perioperative nursing practice much of the process involves following institutional policies and procedures. Guiding nursing activities are existing or potential problems. Interaction with the patient is establishing interviews directed at confirming information related to the patient's health condition. The time spent with the patient is used to offer information regarding surgical intervention and give reassurance towards outcomes. Perioperative nursing practice has its values on the basis of efficiency, time-management skills, and technical expertise (Mitchell & Copplestone, 1990). However, nursing practice is not limited to a list of performed activities according to surgical procedure or identified problems. An assumption of theory based practice according to Parse is that nurses do more than carry out predetermined, standardized policies and procedures, which implies that the way a nurse structures knowledge and practice offer the patient something unique. Thus, explaining that the need exists for a theory based practice, if only to articulate this uniqueness to the nursing discipline in actualization of an autonomous science (Cody & Mitchell,1992).

Parse identifies perioperative traditional problem-focused approach in nursing practice as having a base in the natural sciences. In 1987 she redefined and presented this view of nursing as the *totality paradigm.* In this view, man is a combination of biological, psychological, sociological, and spiritual factors. Nursing approach in this paradigm attempts to quantify man and illness. The goal of nursing in *totality paradigm* lies in promotion of health and prevention of illness (Parse, 1991). This, in my experience, is somewhat limiting in view of the nursing practice methodology in the perioperative setting. It is the assumption that the patient arriving to the operating room has confirmed diagnoses and information of his/her prognosis. The surgical intervention is resultant of the patient's choice and a decision making process that has taken place already. Suggesting that the nursing intervention in the perioperative setting has limits to providing measures of physical comfort as the patient awaits the surgical intervention to begin.

Parse challenges this traditional approach to guide nursing practice by defining nursing as a human science and offers the view of the *simultaneity paradigm* (Parse, 1988). Parse's theory of *Human Becoming* is of this new perspective that views man as a unitary human being in continuous, mutual interaction with the environment. Its emphasis is on caring and healing rather than illness. The goal of the *simultaneity paradigm* is to view health as a process of becoming. The quality of life lived is the essence of its nursing approach and practice (Wesley,1992).

According to Parse, theory, values and beliefs evolve with the patient who structures meaning in very personal and unique ways. Health is a process of being and becoming. It cannot stand analysis from an outsider's view because its interpretation comes from the individual's perspective. The nursing goal is to help the patient through the experience, not change them, but to enhance the quality of life from the person's perspective. The clinical situation of the surgical event from Mr. Cecil's perspective exemplifies how we reveal the meaning of the event and the way we move through the process together. The nurse in perioperative setting is in continuous movement with the patient into the surgical intervention and beyond, after all she is the patient's advocate through the time of unconsciousness until the patient resumes ownership of their health situation.

Surgery from Parse's perspective is a crucial event in a person's life. The meaning of the event from the patient's perspective is revealed when the person relates thoughts and feelings of the situation with themselves, the nurse, and others in a nurse-family situation. It is the understanding that each individual is an active participant in their health (Parse 1987). Consequently, patients such as Mr. Cecil, undergoing elective surgery, are active participants in the perioperative process. The crucial belief within Parse's theory is that human beings know their way and freely choose from options in situations, both reflectively and pre-reflectively all at once.

Three major themes have surfaced from Parse's philosophical assumptions. They are meaning, rhythmicity, and cotranscendence (Parse, 1981, 1987). Each theme leads to a principle in theory of *Human Becoming*. The principles personify the beliefs expressed in the assumptions. **Principle 1**: Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging (Parse, 1981). This principle asserts that reality is continuously cocreated by assigning meaning based on past, present, and future, and has expression through language by means of values and images or symbols. **Principle 2**: Cocreating rhythmic patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating (Parse,1981). This principle means that *human being* has a continuous unfolding rythm of coconstituting patterns of interacting with the world, including revealing-concealing (simultaneously disclosing some aspects of self while hiding others), enabling-limiting (as man moves in one direction, man is limited in movement in another), and connecting-separating (as man links with one phenomenon, man unlinks with another, leading to greater complexity). **Principle 3**: Cotranscending with the possibles is powering unique ways of originating in the process of transforming (Parse, 1981). This principle asserts that human beings move beyond the actual in interrelationships with others and propels into the future by incarnating intentions and actions in moving toward possibilities. Transforming occurs through originating and powering, a process of man-environment-energy interchange with recognition of continuous affirmation of self. Illustration of these three principles and their concepts follows in Appendix A, where they are shown in relationship to/with each other (Parse, 1981).

In my interrelationship with Mr. Cecil I used and worked through the practice dimensions of the Human Becoming theory. My nursing approach focus was on the meaning of Mr. Cecil's lived experiences. By being truly present with him, I attended to the unfolding of the meaning, while engaging with the shifting flow of rhythm as Mr. Cecil moved beyond the moment (his fear of the imminent surgical intervention) . In admitting the patient to the perioperative holding area it is my responsibility to check Mr. Cecil's chart for information such as known allergies and potential complications in order to complete the perioperative information sheet. Although Parse's theory focuses on the individual's meaning of the lived experience, the nurse still fulfills institutional policies and procedures when required to do so. Maintaining environmental safety and assisting with procedures are important for the surgical process, but they alone do not constitute nursing practice (Mitchell & Copplestone, 1990). The discussion itself, how the nurse is with the patient and how the evaluation of the goal of enhanced quality of life is achieved is what makes the difference (Parse, 1987).

When I approached Mr. Cecil he looked up and

said, "I want all of this to be over with." Looking directly at Mr. Cecil I asked him to tell me what he meant. Mr. Cecil said he had been afraid long enough, and that he did not want to live without taking part in family life. Mr. Cecil said he was fearful about having surgery, but he had made up his mind that it was worth the risk to be able to live actively with his family and be free of fear and pain. He further went on to talk about hiking and bicycling with his family and how much the family outings meant to him.

I then inquired of Mr. Cecil to tell me more about his fear of the surgery. Mr. Cecil said he was afraid that something may go wrong with the surgery, that there may be something that was omitted or did not show on his angiogram and that it may be inoperable. He started to talk about his father's failed surgery then stopped and said, 'I know this is silly, it doesn't make any sense that I'm talking this way. I have decided to believe that things will work out, I must trust to go on. I guess I just needed to talk about it. I know I may not come out of this completely. I know there is a chance that things may go wrong and that there are many complications that may affect me." He further explained that he prepared for the worst with his family, and that he was not afraid because he trusted Dr. Reno. His father's death was sudden and at last he was able to put it behind him.

I asked Mr. Cecil if he could see himself after the surgery and what he hoped would happen. He said he knew he was going to wake up, and that he hoped he had the strength to deal with the post operative pain. When asked what might give him strength, he thought for a moment and said he could see his family waiting for him and that it helped to keep them in his mind.

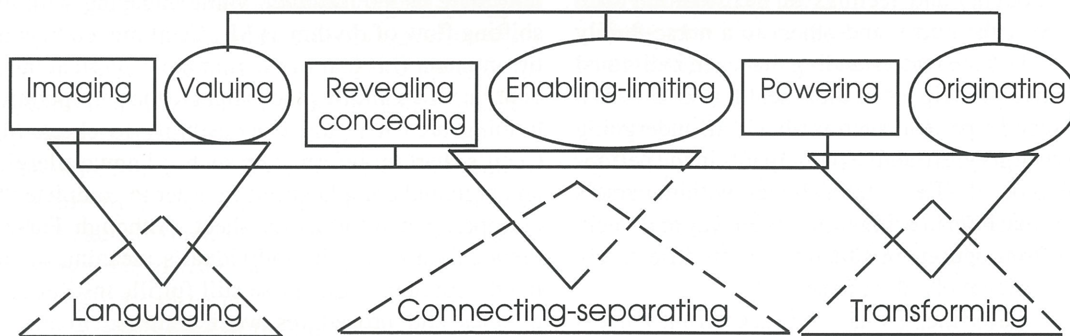
Seeking depth and clarity about the person's thoughts and feelings exemplifies Parse's first practice dimension - *illuminating meaning* through explicating. *Illuminating meaning* is shedding light through uncovering what was, is, and will be, as it is appearing now. It happens in explicating what is at this moment that is fleeting. Explicating is a process of making clear what is appearing now through languaging (Parse, 1987). In this process, the nurse guides Mr. Cecil, to reveal what he is thinking and feeling. Talking about his thoughts and feelings allows him to discover new insight in the process of self-discovery. The process of explicating thoughts and feelings in itself sheds a new light on the situation. Often the thoughts and

Appendix A

Principle 1: Structuring meaning multidimensionally is cocreting reality through the languaging of valuing and imaging.

Principle 2: Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating.

Principle 3: Cotranscending with the possibles is powering unique ways of originating in the process of transforming.



Relationship of the concepts in the **squares:** Powering is a way of revealing and concealing imaging.
Relationship of the concept in the **ovals:** Originating is a manifestation of enabling and limiting valuing.
Relationship of the concepts in the **triangles:** Transforming unfolds in the languaging of connecting and separating.

Relationships of principles, concepts, and theoretical structures of man-living-health. (From Parse, R.R. Man-living-health: a theory of nursing, New York, N.Y., 1981, John Wiley & Sons, Inc, p 69)

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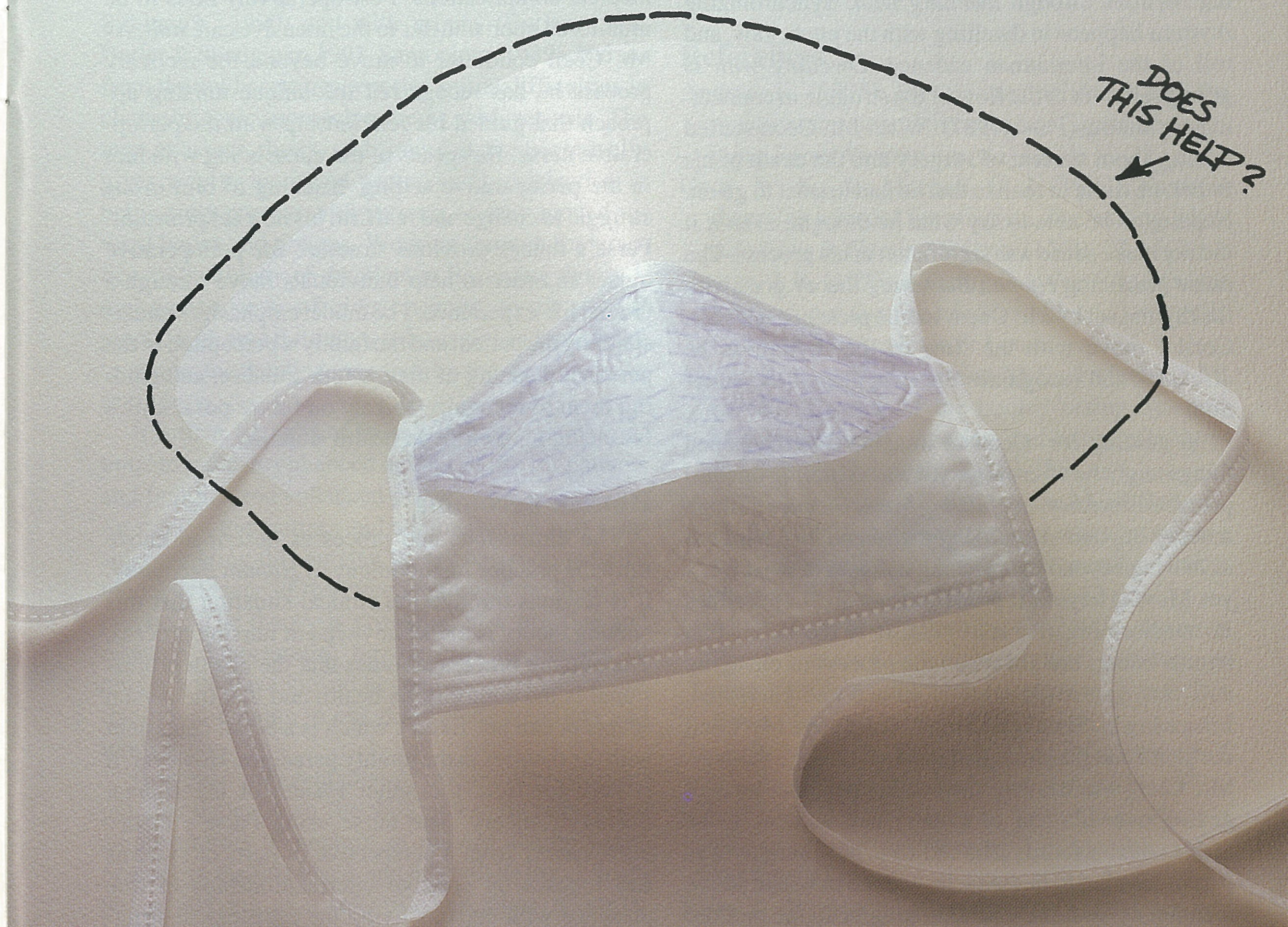

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feelings discussed have been lying dormant beneath the surface for some time. Speaking thoughts of fear, Mr. Cecil connected with the moment in the presence of the nurse, leading him to view the familiar from a different perspective.

Synchronizing rhythms

Joining with the patient's thoughts and feelings reflects the second practice dimension - synchronizing rhythms through *dwelling with*. Synchronizing rhythms happens in dwelling with the pitch, yaw, and roll of the interhuman cadence. *Dwelling with* is giving self over to the flow of the struggle in connecting-separating (Parse,1987). When Mr. Cecil started talking about his fear of surgery and the death of his father, he came to realize that he had to trust to go on. Needing to be able to say what he thought, even if it did not make sense was significant in his process. The nurse practicing *Human Becoming* theory goes with the rhythm set by Mr. Cecil. In true presence with Mr. Cecil I move with the flow of the rhythm as he discusses and recognizes the struggles of the situation.

In guiding Mr. Cecil to imagine how he hoped things might be after surgery, I was centering on third practice dimension - *mobilizing transcendence* through moving beyond. *Mobilizing transcendence* happens in moving beyond the meaning moment to what is not yet. Moving beyond is propelling toward the possibles in transforming (Parse, 1987). It is the belief that human beings are always in the process of changing and moving toward what is valued and cherished. Imagining his family waiting for him gave Mr. Cecil the belief and the strength to make it through surgery. Mr. Cecil was moving toward his personal goal of getting over his fear of surgery and wanting to be active with his family. His choice to have surgery was part of his plan to be (what he wanted to be) an active member of his family participating in all the outdoor activities he had grown accustomed to. The *mobilizing transcendence* happens in true presence with the nurse as Mr. Cecil moves beyond the moment, planning to reach his hope illuminated through the process. The moving beyond arises as the rhythmical dwelling of nurse with Mr. Cecil allows for the situation to incarnate new meaning.

The practice dimensions and processes occur all at once as the nurse seeks to clarify the patient's thoughts and feelings while guiding the person to move beyond the surgical experience. The nurse, using Parse's theory, in practice uncovers individual patterns of health through discussions with the patient. These patterns reflect a paradoxical way of thinking. Mr. Cecil revealed a paradoxical pattern when he spoke of being terrified yet not afraid. The nurse encouraged Mr. Cecil to talk about his fear. By speaking about it, Mr. Cecil discovered trust and peace within himself. His fear of surgery kept him from choosing surgical intervention and kept him physically handicapped from involvement with his family outdoor activities.

Mr. Cecil's recovery from surgery was without medical complications. Post-operatively he is to be monitored upon transfer to the intensive care unit. As Mr. Cecil continues to move beyond the recovery process he has recognized the unique nursing approach that guided his relationship with the perioperative nurse. He speaks of the nurse being with him in the perioperative setting, listening to him in his struggle to change and reaffirm his new set priorities. Parse's theory provides structure for perioperative nurses in order to help individuals move through a crucial life experience. The model emphasizes understanding the patient and the family's perception of the personal meaning of their health situation and guiding them to recognize and act on future possibilities for changing their lived health situation.

Human Becoming

The dimensions and processes described above form the practice methodology of *Human Becoming*. It is obvious through the clinical situation that this nursing theory is unlike any type of nursing process. The nursing process assumes that the health professional is the authority on health and that the person adapts or can be "fixed", which is a belief consistent with the theories in the totality paradigm. However, it is very far from the belief system of the *Human Becoming* theory. The nurse using Parse's theory moves away from a perspective of parts or systems and focuses on creative interrelationships in true presence with persons living the paradoxical struggles of everyday life. The focus is on the quality of life from the person's perspective and reflects the uniqueness that human beings cocreate within their worlds (Parse 1987).

Parse's practice methodology is criticized for its lack of biological manifestations and its unique language. Working with her theory in the clinical situation, I can see its limitations in the processing application to the tasks and procedures. However, supporters of her theory Smith and Hudepohl (1990), give reference to "Bio-" as meaning life. Parse's theory does focus on the quality of life, but from the person's perspective. Furthermore, nursing, with roots in a human science, does not rely on concepts from biology or other natural sciences. The language has its roots in human science and is in keeping with "appropriate rules of theory development" (Smith & Hudepohl, 1990). Parse's language is different from the everyday and distinct from that of other sciences, as the theoretical language of an autonomous science must be (Cody & Mitchell, 1992). Parse's practice methodology studies found it to be successful both with individuals (Mitchell, 1988; Mitchell & Pilkington, 1990) and with groups (Butler, 1988, Butler & Snodgrass, 1991, Santopinto, 1989). Nurses from the study settings reported initial difficulties in changing their approach to being with patients. The urge to assess, direct, and "do to" patients gradually gives way to increased professional satisfaction in being truly present with patients as they moved toward hopes and dreams. Working through the practice methodology of the *Human Becoming* theory I, too, gained sense of given meaning to my way of practice. I found the theory to be useful and satisfying to guide the nursing practice in the perioperative setting.

If further findings of Parse's theory practice continue to indicate enhanced quality of life for patients and families and enhanced professional satisfaction for nurses, then nurses and administrators may consider adopting this nursing theory based on practice model evidence of the effectiveness of the theory in practice. The theory is providing new practice and research opportunities for the growing number of nurses who have moved beyond the perspectives of traditional nursing to one that values creativity and innovation.

However, an evaluation of nursing theory based practice depends on the willingness of nurses and administrators to commit to nursing theory based practice in the first place, and this will be the ultimate test of nursing as a scientific discipline (Cody & Mitchell,1992). ■

Glossary

Coconstitution - meaning of a situation, derived from the situation's components.
Health - open process of being and becoming experienced by man; a synthesis of his values.
Imaging - making real the picture of events, ideas, and people to cocreate reality.
Intentionality - man's open involvement and interaction with the world.
Languaging - communication by speaking and moving that reflects a person's images and values to cocreate reality.
Man - patterned, open being who is more than and different from the sum of the parts.
Nursing - interactional science and art that facilitates the becoming of the participants.
Valuing - living of cherished beliefs to structure meaning.

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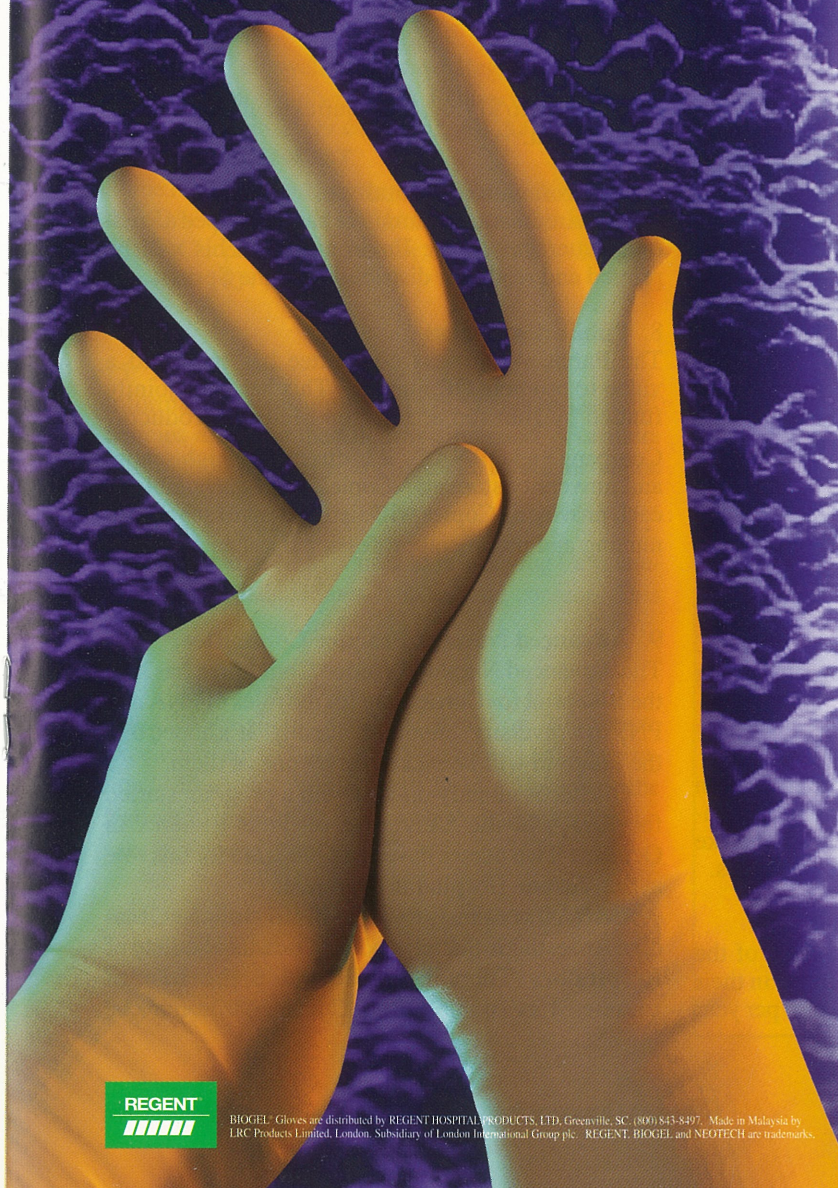

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Highlights of the ORNAC Board Meeting

Saint John's, Newfoundland
September 17 & 18, 1996.

1. The Executive and Board met in conjunction with the Atlantic Conference, and had the opportunity to take in the Conference and the renowned hospitality of the Atlantic provinces.

2. **Nominations.**
Election of new executive will take place in April 1997. Positions to be filled will be president-elect, treasurer, and secretary.

3. **Standards/Education Committee.**
Revision of the Standards document is in progress by the Standards/Education committee and Board members with wide provincial input.
St. Paul's Hospital in Vancouver has been granted a further five year approval for the Post Graduate OR Program.

4. **Canadian Standards Committee.**
Activity at CSA is accelerating once again. ORNAC has a voice in CSA with the President currently sitting on several committees.

5. **The Research Committee.**
The Research Committee will review literature on "Does a Registered Nurse make a Difference in Patient Outcomes?" As other health care workers take over RN duties it is time for us to prove ourselves.

6. **Canadian Operating Room Journal.**
A number of provinces are taking advantage of the offer to include the CORNJ subscription rate in their membership fees. This is available for $8.00 per year as compared to $17.00, but requires total membership involvement.

7. **Environmental Committee.**
The Environmental Committee has developed a Position Statement on the Environment. This will be printed and ready for distribution in the Spring.

8. **Public Awareness.**
The Public Awareness committee has produced a video to promote OR nursing. This has been jointly funded by Johnson & Johnson Medical Products Company and ORNAC. It is directed to high school and university students. Copies will be available in each province. Copies will also be sent to schools of nursing and provincial professional associations.

9. **Advanced Nursing Practice Committee.**
The Advanced Nursing Practice Committee has sent the Blueprint for Curriculum for the roles of PNA and PNS to University schools of Nursing. It's hoped that the program will be picked up by one of them.
Quebec is already on-line with a program started for RNFA at the University of Trois-Rivieres in October. Two nurses have been prepared for this role at Ste. Justine Hospital in Montreal.
ORNAC continues to be involved with the Canadian Anaesthetic Society and the Canadian Society of Respiratory Therapists to develop the role of anesthetist assistant. ORNAC also continues to be represented at the NAFTA meetings on the Nurse Anesthetist. Although this role is not in place in Canada, it has been important for us to have input into these meetings.

10. **Canadian Nurses Association.**
CNA is investigating reciprocity between the US and Canada. To date, 907 perioperative nurses have become certified.
President V. Hay and President Elect, D. Farid had attended the CNA Biennial conference in Halifax in June and successfully lobbied to retain the Interest Group (now called Associate Members) Representative on the restructured Board.

13. **National Conference Ottawa, Ontario. April 28 - May 2, 1997.**
Preparations are well underway. Registration will be $385. For non-members, $500. Future conference sites are: Halifax, NS in '99 and Banff, AB 2001.

14. **Status of RN/ORT.**
Some RNs are opting to work as RPNs/LPNs. What is the RNs' status with ORNAC who works as ORT? ORNAC's position is that for membership, ORNAC recognizes RN job status only.

15. **DNR.**
Information regarding changes in "do not resuscitate" policies affecting the OR was circulated. For more information, contact your Provincial Board members.

16. **Latex Labeling.**
An OR nurse in Newfoundland is lobbying for manufacturers to include latex labeling and content. This has been endorsed by ORNAC.

17. **Future Direction.**
What issues should ORNAC focus on to promote excellence ant to function effectively as an organization? President V. Hay will hold a Forum at the National Conference in Ottawa to determine key issues and needs to membership.

Adapted from ORNAC Board Meeting Minutes, September 17 & 18, 1996.
Submitted by **Corina Balcom**
Secretary ORNAC

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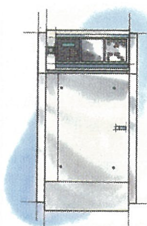

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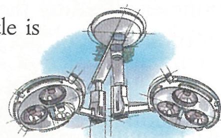

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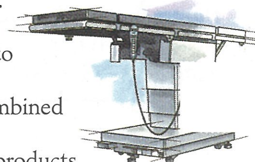

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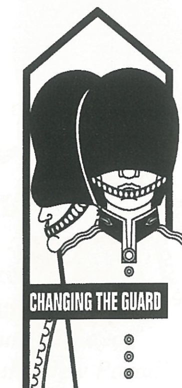
ORNAC '97

April 28 - May 2, 1997

15th National Conference
Ottawa Congress Centre Ottawa,Ontario

"Changing The Guard"
"Reléve de la Garde"



The Conference Planning Committee is working diligently to bring you an exciting conference in Ottawa April 28 - May 2, 1997. The program looks very interesting - something for one and all.

Ottawa is a beautiful city. We hope you will stay a few extra days to visit the Capital Region, so much to see, so much to do! It may be still a little cool, so bring a coat.

The hotels are all within walking distance of the Ottawa Congress Centre. The Westin is designated as the Headquarters Hotel and is adjacent to the Congress Centre - no need to go outside.

We request your support in booking accommodation in the designated hotels by specifying you are an ORNAC Conference delegate. Rooms have been blocked at these hotels at special rates. Non registration at these hotels will negatively impact contractual arrangements with the hotels, with subsequent loss of revenue for ORNAC.

We look forward to seeing you.

Vija Hay, Chair, '97 National Conference.

Speakers & Topics

Judith Shamian - "Skill Mix - Clinical Outcomes."
Jean Reeder, Past President AORN- Keynote Speaker- "Change the Guard and Transform Your Tomorrow."
Kathleen MacMillan - "Positioning Nursing for the Next Millennium:Vanguard or Shadows? "
Kathy Falkenhagen - "Healing the Wounds/Layoff Survivorship in the New Paradigm."
Cindy McDonell - "OR Shopping in the 90's: Indicators of Quality."
Lois Bruning- "Facing up to change."
Dr. H. Stern - "Management of Colorectal Cancer."
Nurallah Rahim - "Shaping the Faces of our Children - An HSC Team Approach."
Toni Labricciosa - Case Study - "Transient Osteoporosis During Pregnancy: The Perioperative Nurses Roles."
Judy Chadwick and Karen Waite - "Implementing a case cost system in OR."
Keith Lowe - "Nursing in a multicultural community."
Cindy McLellan "A new approach to accreditation."
Susan Burnell-Jones - "The MORE Program Meets the O.R. Staff" Experience."
Vivian Quirling- "Hey, what about me?"
Susan Guerra - "Protecting Your Future - Cost Saving Ideas for OR Nurses."
Denise Mazzarella - "RN First Assistant."

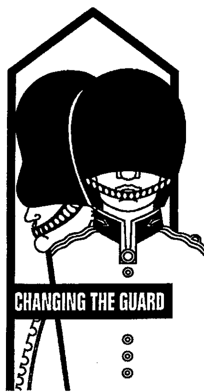
Social Events

Welcoming Reception - Sunday PM, April 27.
MAXXIM Music & Social - Monday, April 28.
Johnson&Johnson Night - Tuesday, April 29.
Embassy Night Dinner - Wednesday, April 30.

Rates & Registraiton

5-day Package	RN Member	RN Non-Member
	$385	$500

5-day Package includes Embassy Night Dinner. Photocopy of Regional/provincial membership must be included with registration form. For registration information contact: Wilma MacDonald #57 - 280 McCellan Road, Nepean, Ontario. K2H 8P8. PH **(613) 829 - 4339.**



Attend the 15th National Conference

ORNAC '97 •
April 28 - May 2, 1997
15th National Conference
Ottawa Congress Centre Ottawa, Ontario

Sponsor: Operating Room Nurses Association of Canada

Program Preview

Sunday, April 27

Afternoon — Floral Demonstration
1900-2200 — Welcome Party***

Monday, April 28th

0630-0730 — Continental Breakfast Sponsored by 3M
0745-0945 — Opening Ceremonies
Valerie Shirreff Memorial Lecture: *Change the Guard and Transform Your Tomorrow.* • **Jean Reeder** Past President AORN
0945-1000 — Health Break
1000-1030 — ORNAC in a Nutshell
1030-1130 — ORNAC Focus Group - *Key and Emerging Issues for the Operating Room Nurse.*
1130-1135 — Opening of Exhibits (See page 30)
1135-1500 — Viewing of Exhibits/Lunch
1515-1630 — Simultaneous Sessions.
Taking Charge: Remembering the Past, Acting on the Present, and Creating the Future.
• **Doris Grinspun.**
1515-1630 — *M.O.R.E. Program Meets the OR Staff.* • **Susan Burnell-Jones.**
Nursing in a Multicultural Society.
•**Keith Lowe.**
1645-1730 — Aerobics by Getinge (Castle)
1930- — MAXXIM - Social Function***

Tuesday, April 29th

0630-0715 — Aerobics by Getinge (Castle)
0630-0800 — Breakfast sponsored by Baxter Corporation
0830-0945 — Simultaneous Sessions. *"Hey, What About Me?" Part 1.*
• **Vivian Quirling.**
Shaping the Faces of our Children: An HSC Team Approach.
• **Nurallah Rahim.**
OR Shopping in the 90's: Indicators of Quality. • **Cindy McDonell.**

Contacts:

Registration
Wilma MacDonald
#57 - 280 McCellan Rd
Nepean, ON
K2H 8P8
(613) 829 - 4339

Exhibitors
Diane Aboud
657 Ingram Cres.
Gloucester, ON
K1J 7A7

Vija Hay	Conference Chair
Rosemarie Atwill	Co-Chair & Hospitality
Mindy Shinoff	Program Convenor
Janet MacCullouch	Protocol/Publicity
Heather Macdonald	Secretary/Treasurer
Diane Aboud	Exhibitors
Araina Clark	Hostesses
Wilma MacDonald	Registration

0945-1015 — Health Break
1015-1130 — Simultaneous Sessions.
"Hey, What About Me?" Part 2.
• **Vivian Quirling.**
Transient Osteoporosis During Pregnancy: A Perioperative Nurse's Role. -**Toni Labricciosa.**
Protecting Your Future: Cost Saving Ideas for OR Nurses. •**SusanGuerra.**
1130-1500 — Viewing of Exhibits/Lunch
1515-1630 — *Facing Up to Change.* •**Lois Bruning.**
Pediatric Burns Follow Up Manage ment in the OR. • **Dr. Jarmuske.**
Positioning Nursing for the Next Millennium: Vanguard or Shadows?
• **Kathleen MacMillan.**
1645-1730 — Aerobics by Getinge (Castle)
1900- — J&J.M.P. Night - Evening Attire, (No jeans).

Wednesday, April 30th

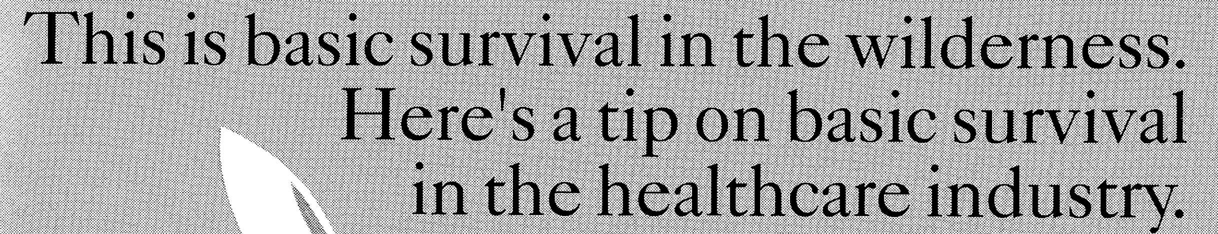
0630-0715 — Aerobics by Getinge (Castle)
0830-0945 — Simultaneous Sessions.
Welcome to the OR Department of Accountability.
• **Thomas John Solitz.**
Arthroscopy Update 1997.
• **Dr. D. Johnston.**
Reuse: Whose Decision Is It?
•**Karen Martz & Anne MacDonald.**
0945-1015 — Health Break
1015-1130 — Simultaneous Sessions. (Repeat)
Welcome to the OR Department of Accountability.
• **Thomas John Solitz.**
Surgery of the Cerebella - Pontine Angle. • **Dr. B. Benoit.**
The Case for Case Costing.
• **Judy Chadwick and Karen Waite.**
1130-1500 — Viewing of Exhibits/Lunch
1515-1630 — Simultaneous Sessions.
Perioperative Professional Nursing Practice & Life Long Learn ing - Are You a Victim or Navigator of Your Personal Learning?
• **Susan Bell & Loretta Morson.**
Management of Colorectal Cancer. -
• **Dr. H. Stern.**
Publish or Perish. • **Agnes Forster.**
1645-1730 — Aerobics by Getinge (Castle)
1830-0100 — "Embassy Night" - National Costume or Evening Attire - No jeans.
1830-1930 — Cocktails
1930-1000 — Dinner/Entertainment/Dance***

Thursday, May 1st

0630-0715 — Aerobics by Getinge (Castle)
0830-0945 — Simultaneous Sessions.
Healing the Wounds - Layoff Survivorship in the New Paradigm.
• **Kathy Falkenhagen.**
RN First Assistant.
US. Experience/Canadian Opportu nity. • **Denise Mazzarella.**
The Law & The OR Nurses. A Guide To Safe Perioperative Practice for the New Millennium. • **Patricia McLean.**
0945-1015 — Health Break
1015-1130 — Simultaneous Sessions.
Taming Tigers: How to Manage Conflict Successfully.
• **Kathy Falkenhagen.**
A New Approach to Accreditation.
• **Cindy McLennan.**
Vancomycin Resistant Enterococci: An OR Perspective. • **Karen Page.**
1130-1500 — Viewing of Exhibits/Lunch
1515-1630 — Simultaneous Sessions.
Seven Habits of Highly Effective Perioperative Nurses that Cause Problems in Personal Lives.
• **Kathleen Gaberson.**
Preoperative Laboratory Investi- gation for Anaesthesia.
• **Dr. Bev Morningstar.**
Chase all Your Blues Away.
• **Angela Jackson.**
1645-1730 — Aerobics by Getinge (Castle).

Friday, May 2nd

0830-0930 — *Skill Mix and Clinical Outcomes.*
• **Judith Shamian.**
0930-1000 — Health Break
1000-1200 — Closing Speaker: *Settling on Your Goals.* • **Charmain Crooks.**
1200-1230 — Closing Ceremonies.



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(Visit our Exhibits and see our advertisement in this issue on page 17

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Alcon Canada Inc.	311
Allergan	112
AMT	507
Ansell Perry	100, 101
Astra Pharma Inc.	328
Artwork Corporation	510
Auto Suture Company, Canada	310, 312
Bard Canada Inc.	607

Baxter Corporation
104, 106, 108, 203, 205, 207 (Visit our exhibits and see our advertisement in this issue on **page 4**).

Becton Dickinson Canada Inc.	407
Canada Microsurgical Ltd.	524
Canadian Hospital Specialties	213
Cancon Medical Inc.	303
Carsen Group Inc.	309
CHCA Computer Systems Inc.	405
CIRCON Corporation	204
Cook Canada Inc.	326
DePuy Canada Ltd.	114
DeRoyal Industries of Canada Inc.	415, 417
DUMEX Medical Surgical Products	308

E.C.I. Medical Technologies Inc. **508**
(Visit our exhibit and see our advertiseent in this issue on **page 2**),

Genzyne Canada	529
Hill-Rom Canada	330
Howmedica International	605
IMMUNO Canada	325
Imperial Surgical	118
Ingram & Bell Medical	404, 406, 408, 410, 412
Instrumentarium	226

Getinge/Castle Canada Ltd. **216, 218, 315,** and **317** (Visit our exhibits and see our advertisement in this issue on **page 24**).

Johnson & Johnson Medical Product
219, 223, 225, 120, 124, 126
(Visit our Exhibits and see our advertisement in this issue on the **back cover**).

Karl Storz Endoscopy	603
Kendall Canada Inc.	509
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MAXXIM Medical Canada Ltd. **322, 324, 421, 423** (Visit our exhibits and see our advertisement in this issue on **pages 28 & 29**).

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Pharmascience Inc.	305
Pilling-Weck	426
Provincial Medical Supplies	206

Regent Hospital Products Ltd. **427**
(Visit us at Exhibits and see our advertisement in this issue on **page 21**).

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(Visit our Exhibits and see our advertisement in this issue on **page 37**).

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Theracur Canada Inc.	425
Trudell Medical	228 - 230
Wright Medical Canada	503
XOMED	511
Zimmer of Canada Ltd.	521- 523

Valleylab Canada **222, 224**
(Visit our Exhibits and see our advertisement in this issue on **page 39**).

Innocence Lost in First Harvesting

By Anna Hagan, RN

My first experience in organ harvesting was last year, from a beautiful teenaged girl. It was a poignant, painful journey from the time the patient was wheeled into the OR, until the final extubation. My story speaks of a mother's loss, of nurse's feelings, and of the helpless despair we sometimes feel in our work, and especially of an innocence lost.

In writing about this experience, something remains forever etched on my soul, which changed my life in a multitude of ways, and touches my reality daily. I have attempted to make sense of the many difficult realities we must face each day, as OR nurses.

It has freed my soul to write about the experience. I am happy to share my thoughts with my colleagues in the OR.

I have been nursing for 10 years, but also continue to be a Yorkville hairstylist, (my career for 20 years prior to nursing) the career which provided the financing to study nursing.

It sounded innocent enough at the beginning. I was called in for an evening shift at the Hospital for Sick Children, and all went smoothly until I heard we were expecting a "Donor" for a "Harvesting". I expected this young woman would have been in an accident, only to realize, as she was wheeled into the OR, her perfect 13 year old body was completely unscathed. She was intubated, her eyes taped shut, her long lashes extending beyond the width of the tape. She had nicked her legs shaving a few days ago. Her sandy blonde hair was in a thick French braid with a beautiful purple bow in it. I could not comprehend what would have caused this girl's untimely death. Aghast, I stepped back as the anaesthetist pointed out the large purple ring around her neck. This beautiful young child, on the verge of womanhood, had hanged herself. Her body was so firm and pristine, like a bud snipped before full bloom.

Immediately, I felt sick. I thought of her parents and how very devastating this must be for them, to give their youngest child's organs away. What a brave and valiant decision but also, what a waste of a life. Later, I discovered this young girl had divulged a secret to a schoolhood chum who then betrayed her confidence, which sent her spiraling down what must have been an intense search for freedom from her betrayal and agony. Her parents had placed her in a boarding school here in Toronto while they lived separately, thousands of miles away in the U.S.A. How alone she must have felt, how desperate she must have been. What, I wonder, could that secret have been? How well I remember what profound meaning everything held and how confusing it was being a teenager. (Even in the security of a two-parent family living in middle class suburbia)! Whatever the secret was, she no longer saw her life as valid or worth protecting. She must have felt so unloved, perhaps even unlovable.

Author

Anna Hagan, RN, has been in nursing 10 years, and is currently a staff nurse at the Hospital for Sick Children, and the Toronto Hospital, Toronto, Ontario. She also trained as a hairstylist and worked for 20 years as a stylist, which provided the funding for her nursing education.

She would have been 14 on December 22, only three days before Christmas. How would anyone that loved her ever enjoy Christmas again? How would her parents or the girl that betrayed her confidence ever find the strength to carry on? I have never felt sick in the O.R., but this case has gone deep into my soul, where an innocence has ended. There is a cloud, black and menacing, that hangs over my gentle spirit. I don't know how to free myself of it or where to put it.

I race home to my children and spouse, to feel their warm loving arms around me. I sneak into my three-year old's room to feel the hot breath from his nostrils on my cheek. My one-year old infant lies curled up between her bunnies and bears, sucking on her lip as she sleeps. God is there in them, as they exist beautifully before me. It is for them that I pray we can always talk things out and support each other. Without the love of your family and friends, without the courage and fortitude allowed us through love, we can never be whole or happy. Contentment is a wonderful place, a place I had longed for, for many years. A place I had found prior to the arrival of our children, a place I cherish more each day.

And so, I send this young girl devoid of brain function to the morgue and then the funeral home, to let the grieving begin for her family. I can't even imagine the void in her mother's soul. How terribly tortured she must be. Her creation, so perfect and beautiful, has been destroyed. Although this child may appear pieced together externally, her blood and guts have been carved and dissected ever so neatly so that someone else may live through her tragedy. Of course, I know there can be happiness for others in her tragedy, but nothing will ever change the indignity she has suffered.

When all the organs are "harvested," the anaesthetist will shut off all life support and there will be silence. A silence so loud it's unbearable to our ears. She will not gasp and snort, nor will she reach up with her arms in an attempt to extubate herself. No. She will lie still forever. The artificial warmth that has maintained her organs' life will soon cool. As the last flicker of life passes, she is wheeled to the morgue to be kept cool until the coroner can assault her body once more. Today I've been robbed. Robbed of an innocence I'll never regain. ■

See: Responses of Perioperative Nurses to Organ Procurement Surgery by Soledad Page, RN, MSN. *Canadian Operating Room Journal* Vol.14, No.4, Nov/December, 1996.

Bursary for OR Nurses

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

Eligibility Requirements

The applicant must be a registered nurse who is licensed with the Provincial Professional Association. The applicant must also be an active member of the Provincial Operating Room Nursing Association two consecutive years prior to submitting the application. The individual must be employed, with a primary focus on perioperative nursing, according to the official ORNAC definition.

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

Application Requirements

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

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

This bursary is administered by the ORNAC Awards Committee. The applications are judged by the committee based on established criteria. If there are no suitable applicants, the award will not be presented and funds will be carried over to the next year. Bursary funds are designated specifically for tuition and books. Final approval for disbursement of funds rests with the Awards Committee and the Board.

ORNAC recognizes that the education of perioperative nurses plays a pivotal role in providing a strong and successful national organization.

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5033	Laparoscope	5mm	300mm	30°	$3300
7000	Laparoscope	7mm	300mm	0°	$3000
7030	Laparoscope	7mm	300mm	30°	$3000
7045	Laparoscope	7mm	300mm	45°	$3000
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How to Submit Your Article to the OR Journal

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

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

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

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

All illustrations, graphs, tables, etc. should be clearly labelled and, if necessary, reference should be made as to where they are to be inserted in the text. The author should submit the original manuscript and two(2) copies for reviewers. A copy of the edited text will be sent to the author for final approval.

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

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

Benjamin,G. (1987).Opportunities for nurse entrepreneurs. *Nursing Outlook* 35(4),182-184.

Share your knowledge, expertise and experience with your operating room nursing colleagues across Canada and around the World.

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Authors will receive a letter from the publisher announcing receipt of the article. Later a letter of acceptance and possibly some revisions may be suggested by the editorial review board.

Manuscripts submitted to the Journal **should not** be submitted to another publication or newsletter while under review or awaiting publication.

Award for Authors valued at $3000

In 1983 with the launching of the "Canadian Operating Room Nursing Journal", Johnson & Johnson Medical Products committed an annual $3,000 award to be presented to the author of the best article of the year published in Journal.

The award recognizes Canadian nurses who contribute to the advancement of perioperative nursing knowledge and education of their colleagues through the medium of the Journal.

The Editorial Awards Committee was established in 1983. The first award was presented at the National Conference in Jasper in 1984, and is presented annually at the National ORNAC Conference or at a Provincial Meeting. The recipient receives a plaque as well as the cash award which is administered by ORNAC. This year's Awards Committee Chairperson is Shelly Zareski of Halifax, Nova Scotia.

Conference Calendar

ORNAC '97 - April, 1997
15th National ORNAC Conference
Ottawa,Ontario.
Sponsored by the Canadian Operating Room Nurses Association. For registration contacts and program details please see pages 25-27.

International History of Nursing Conference
June 12-15, 1997
St. Paul's Hospital - Vancouver,B.C.
Planning for the conference, to be held in connection with the 'International Conference on Nursing' (ICN) in Vancouver, June 15-20, is moving on several fronts. The ICN is being held in Canada for the first time, so this is a special event for Canadian Nurses. The International Conference preliminary program and registration form has been mailed out and registrations are coming in. Sixty (60)papers and 11 posters have been accepted by the international review panel. Two plenary panels are planned to present international nursing history perspectives.

Thursday - Nursing and the Royal Canadian Mounted Police will spotlight their shared history in Canada's north, followed by Monique Begin's keynote address on Canada's Health Care System.

There is good response to our call for national costumes and exhibits. Special historical publications are being planned and will be available at the conference. Downtown hotels are at a premium. Conference participants are encouraged to seek accommodations early. This exciting international history event has 15 countries participating to date.

More information through Sheila Rankin Zerr, 5333 Upland Drive, Delta, B.C. V4M 2G3. Tel: (604) 943-3012.

June 26 - 28, 1997
National Neuroscience Conference in Saskatoon, Sask. For more information contact Lori Stricker at (306)766-6407 or (306) 924-2447.

September 8 - 12, 1997
X World Conference of Operating Room Nurses, Toronto Convention Centre, Toronto, Ontario, sponsored by the American Operating Room Nurses Association.

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Telemedicine - Spring 1997

Corina Balcom, Secretary, ORNAC and Member of the Standards/Education Committee responsible for Telemedicine Canada - 1994 - 1996.

Date	Topic	Speakers
April 23, 1997 **X04083**	**Gluteraldyhyde: Risks and Benefits of a Cold Sterilant**	**Lynne Trott**, Clinical Education Consultant, Toronto. Moderator: **Rob Richardson**, Nurse, Operating Room, Trail Regional Hospital, Trail, BC.
May 14, 1997 **X05048**	**Quality Management in Perioperative Nursing**	**Mary Knight Kubasiewicz**, Manager, Operating Room, The Salvation Army Grace Hospital, Winnipeg. Moderator: **Kim Benedict,** Nurse, Orthopaedics OR, Queen Elizabeth Health Centre, Victoria General Site, Halifax, Nova Scotia.
June 4th, 1997 **X06013**	**Perioperative Care RN: First Assistant, Canada's First Program in Place**	**Dr. Michele Côte,** Director, Nursing Module and Professor, Nursing Service, University of Quebec, Trois Rivieres, PQ. **MoniquePerazzelli**, President,Corporation of Operating Room Nurses of Quebec, and Head Nurse, OR, Ste. Justine Hospital, Montreal. Moderator: **Charlene Robinson,** Surgical Services Manager, Cape Breton Regional Hospital Site, Sydney, NS.
June 25, 1997 **X06088**	**Preventing Burnout: Dealing with Stress in the New Work Environment**	**Dr. Lucille Peszat**, Director, Canadian Centre for Stress and Well-Being, Toronto. Moderator: **Corina Balcom**, Nurse Manager, Perioperative Services, Region 7 Hospital Corp. Miramichi Facility, Newcastle, NB.

Telemedicine Canada - Under the Joint auspices of the Faculty of Medicine, University of Toronto and the Toronto Hospital. Contact: Natalie Riegler, Nursing Education Coord. Tel: (416) 599-1234 FAX (416) 598-1848

Letter... information wanted on avoiding reimplantation

As an operating room nurse with a backgound in public health nursing, I became interested in the question of possible neoplastic seeding at the time of surgery. This interest was triggered by an article in the *Medical Post,* September 10, 1996, entitled "Fast Glove Change Pushed," by Pippa Wysing. The writer claims "...surgeons who don't change their gloves and instruments immediately after removing a tumor may inadvertently reimplant cancer cells into their patient".

The OR nurse plays a crucial role in preventing reimplantation of cancer cells at the time of surgery. Metastasis is the commonest cause of death in cancer related disease, and I would like to hear of any techniques which are in use with the aim of preventing reimplantation of tumor cells during surgery. Please write or **E-Mail @ IS . Dal: CA.**

K. Walling, RN, BSc, bpH
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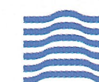

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Will You Let Your Name Stand?

Reasons to Serve Your Association

By Marjorie Phillips, RN

One can think of many reasons for saying "Sorry, No" to the requests "Will you run for office? Will you serve on this committee?" The reasons for saying no come immediately to mind, and are acceptable explanations for declining the opportunity. There are, however, as many reasons for saying yes to a proposal.

If one is asked to take a position, it is a vote of confidence in one's capability. Acceptance assumes reliability to fulfill commitment.

Time

There is never enough time. Executive and committee positions are volunteer roles, not full time jobs. One does not need to give up present activities to be involved. Executives meet approximately four to eight times a year and homework is minimal. Many willingly give many hours of expert work. They are needed and appreciated, as are those who can give limited time. Conference planning committees take little time at start up. For planning, there is a slightly larger time commitment. Executive and committee meetings are held at times and in locations to facilitate members.

Experience and Influence

Experience is an asset but not a necessity to accept executive and committee positions. Experience does afford one the opportunity to share past knowledge, which is helpful. It may also introduce a different method of achieving goals which is beneficial to the organization.

For the inexperienced person, it is a chance to obtain new skills. One should keep in mind when considering a request that those vacating the office are often willing consultants. Experienced members still serving as executives and on committees will be available for guidance. Executive and committee positions require team work, an area in which OR nurses excel.

Serving one's association is an opportunity to influence the direction of one's practice. For example, past committee members have developed OR practice standards, conferences, bursaries, certification exams, newsletters, and an OR Journal, to name a few accomplishments. Through these achievements, OR nurses have been the leaders in the nursing specialties.

An executive or committee is provided with a platform in which the hospital, town, or province can be recognized. It is not accidental that some regions are more influential than others. *People do make a difference.*

Networking

Commitment to the association often results in one meeting nurses from other locations, be it local or abroad. This allows opportunity to network with other operating room nurses. Compared to a busy OR, the meeting room is conducive to an exchange of ideas. Over time one can develop contacts around the globe.

The OR is a special place to practice nursing. Committee work is an opportunity to 'give something back.' A large and enthused membership, anxious to take executive and committee positions, promotes a strong and viable organization.

OR executives and committees have nurse members from all areas of employment. This affords an excellent arena to work together for a common cause: the promotion of OR nursing practice.

Fun

Last but by no means least, executive and committee work is fun. It affords one the opportunity to use one's creativity and experience in a very different way from the OR theatre or executive office. It is rewarding to see ideas come to fruition.

There is always laughter at the meetings - and often food! So next time you are asked "Will you let your name stand?...say Yes ! You will be glad you did.

Marjorie Phillips, RN, General Duty, University of Alberta Hospital operating rooms. Ms Phillips has served on numerous professional and community boards as a committee and executive member.

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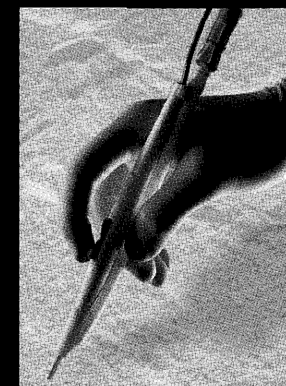

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