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# Preoperative Anxiety



# Canadian Operating Room Nursing Journal

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## Where Are You When We Need You?

By Gloria Stephens

"Where are you when we need you", could be a cry from patients in many operating rooms throughout Canada.

For too long, operating room nurses have been silent and impassive when it comes to identifying and overcoming conditions in the operating room that inhibit professional practice.

The Operating Room Nurses Association of Canada (ORNAC) published a position statement "Staffing the Operating Room", 1988, which includes guidelines for staffing an operating room with a rationale. One of the items states: "... Each case or surgical procedure must be staffed by a minimum of two Registered Nurses. Depending on the acuity level of the patient and/or the complexity of the procedure, it may be necessary for additional Registered Nurses to be present in the Operating Room to provide care."

A few years ago the staffing for surgical cases was met by planning for a scrub and circulating nurse for each operating room. This strategy can no longer apply, and everyone, (from government down) must be educated to the reason staffing needs have changed.

Advances in technology have had a major impact on operating room nursing (*Canadian Operating Room Nursing Journal*, Vol.10, No.1, Mar/Apr, 1992). This technology requires monitoring, maintenance and operation of very sophisticated equipment. There are many cases where one circulating nurse cannot meet a patient's total needs and at the same time be responsible to give complete attention to ECG's, lasers, and monitoring equipment. Now many procedures require two circulating nurses, especially during change-over time and/or start up. This is not a new concept as the ORNAC Position statement of '88 clearly states.

Economics is governing our practice and many hospital administrators and governments are looking

for any means to control financial output. Since one of the major cost of health-care delivery is salaries, professional positions are being cut, sliced or replaced with a different category of worker. It is important to make everyone aware of the changes taking place. Colleges in many provinces are developing programs with the thought of producing a more economical employee but not necessarily looking at the level of care required. This may be 'false economy' for several reasons: (to name a few), introducing another strata or layer of worker may cause conflict of job role; communication problems will arise; more coordination will be required; more orientation time; and, potential competence level reduced. Besides these issues, there is always union involvement. These proposed new workers may have a salary that matches or becomes more than registered nurses who are more knowledgeable and flexible because of the broad base education.

It is not a matter of protecting 'turf' as the majority of operating room nurses have a deep, compelling commitment to administering care to the surgical patient. OR nurses truly live by the professional standards recommended by ORNAC.

If we believe in our nursing profession's philosophy, mission and standards then it is time for each and every operating room nurse to look at the forces shaping our future as professionals. It is time to create our own force with aggressive, assertive and dynamic shaping. We must immediately stop being a victim and take on a proactive leadership role. The strength comes from the operating room staff nurse who has the ability and power to create a counterforce that could control these other forces that appear to be shaping our future. Together we must redefine the role and scope of operating room/perioperative nurses, using our

professional skills. (The revised ORNAC Recommended Standards will soon be in print. Within the document, competencies of the professional registered nurse are clearly outlined which may help in redefining the role and scope of the O.R. nurse).

A lot of lip service is given the term "continuity of care" but to make it a reality, we as operating room nurses, must stand up and be counted and fight for the patient's right to have a professional registered nurse provide their care while undergoing the surgical intervention.

We have a more educated public, and the standards of care have improved and are still improving and with this, our patient's expectations are increased, and rightly so.

The time has never been more critical to collectively adapt strategies which will convince administrators and government leaders that in this day of such complex and difficult procedures the person to meet the challenge of quality patient care is the qualified professional registered nurse. If we do this, then the phrase "Where are you when we need you" will not be heard.

Operating room nurses must realize that, even individually, they can be a force to be reckoned with and can play an extremely important role by keeping their eyes and ears open as one monitors what is happening in the health care field. One important role would be keeping the Executives of the Provinces informed as to concerns, suggestions, and changes occurring. There are many avenues to communicate feedback of all descriptions. Some of these avenues may be through your MP, professional registered nurses associations, operating room interest groups and the executive of the Operating Room Nurses Association of Canada. There is always a way to be heard if you truly believe in the importance of the issue.

I believe that operating room nurses in the 90's will provide more intense, expanded, and efficient delivery of care to the surgical patient. During the 90's the role of the perioperative nurse will be redefined and it is up to US if we have an active part in defining this new role and scope of nursing. I know from personal experience that O.R. nurses have the motivation, knowledge and the courage to help shape their future. All that is needed is the vision. The responsibility is yours!

*Gloria Stephens is currently President of the Operating Room Nurses Association of Canada, and a Nurse Clinician/OR, St. Paul's Hospital, Vancouver, B.C.*

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# Preoperative Functional Anxiety:

## A Conceptual Framework

By Marie McEachern, R.N., B.Sc.N., M.S. A.

### Introduction

It is widely recognized that patients who enter the hospital for surgery encounter physical and psychological stressors which elicit a response of anxiety. The ability to cope with anxiety and maintain control affects their postoperative recovery (Lindeman and Stetzer, 1973; Lindeman, 1974; Johnson, 1984).

Traditionally, health care professionals in the operating room have focused their practice on treating the "surgical procedure" and nursing groups of patients according to procedural categories. The problem arises when related physiological and psychological responses of the patient occur which impact the individual's illness and recovery. Neither the patient nor the professional may recognize these additional variables underlying the individual's capacity to cope with the reason for hospitalization.

Nurses can predict the degree of anxiety for the majority of patients based on the predicted outcome of surgery. These can be listed categorically for nursing according to the impact of the surgery on the person and their response. The following is a proposed list of surgical categories for nursing in order of decreasing anxiety based on the author's experience:

1. loss of body part
2. loss of function
3. diagnostic
4. curative
5. cosmetic

Each of these categories potentially elicit a lesser or greater degree of anxiety from the patient depending upon the impact of the surgery on the patient's lifestyle. This will enable nurses to predict the majority of patients who will have a higher level of anxiety preoperatively and consequently a poorer postoperative recovery (Janis, 1958).

In this paper, the author will develop a conceptual framework for understanding the biopsychosocial phenomena of preoperative functional anxiety and the related concepts of coping, personal control and postoperative recovery.

### The Phenomenon of Functional Preoperative Anxiety

Nursing literature defines anxiety as a natural response to certain environmental and psychological factors. It is a feeling of apprehension or dread felt in response to a threatening situation or loss (Carriera, Lindsey and West, 1986). Clinical nursing researchers

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### Abstract

Preoperative functional anxiety is an important phenomenon for the patient undergoing surgical intervention. Functional anxiety facilitates the patient's ability to cope with surgery. Personal control enhances the patient's coping and modifies anxiety to a functional level. The phenomenon of preoperative functional anxiety and related concepts of coping and locus of control have a direct effect on the concept of postoperative recovery. Current research is focusing primarily on preoperative anxiety levels and postoperative recovery. There is a need for further nursing research to develop nursing theory about the concepts of coping and personal control as they relate to preoperative functional anxiety and postoperative recovery. This paper focuses on the development of a conceptual framework for understanding the biopsychosocial phenomenon of preoperative functional anxiety.

have re-examined sources of preoperative anxiety. The major concerns expressed by individuals about to experience surgical intervention are: fear of death, pain and discomfort, the unknown, destruction of body image, separation from their normal environment, loss of control and feelings of helplessness (Carnevali, 1966).

Anxiety is the psychological response to a specific stress or (surgery) while stress is the non specific response of the entire person to any stressor (Jasmin & Trygstad, 1979). The individuals perception of surgery creates anxiety which will activate physiological responses.

Functional anxiety leads to learning and an improved ability to cope. Disfunctional anxiety leads to illness, undesirable behavioural changes or death (Clarke, 1984).

Janis (1958) conducted intensive research on the psychological effects of surgery. His findings indicate that more than 75% of patients expressed a moderate to high degree of preoperative anxiety which increased as the time for surgery approached and peaked in the operating room. One of the most significant findings relates to the relationship between preoperative anxiety and postoperative behaviour. Patients with a moderate amount of preoperative anxiety (functional) developed fewer postoperative emotional symptoms. Patients who manifested high or low preoperative anxiety (dysfunctional) displayed postoperative emotional disturbances. As the anxiety level increases, panic may be produced and the individuals attention is so scattered that goal directed activity is impossible.

### Anxiety as a Physiologic Response

Anxiety as a physiological response to hospitalization and surgery is important to acknowledge due to its potential impact on the individuals ability to cope with surgery and on the postoperative recovery.

The physiological response of anxiety is similar to the stress response and activates the nervous and endocrine systems to maintain a stable internal environment. Perception of stressors causes activation of the sympathetic - adrenal medullary mechanism, the pituitary - adrenocortical mechanism, and the renin-angiotensin mechanism (Boore, 1978; Carriera et al 1986; McConnell, 1987).

The sympathetic response to anxiety causes increased cardiac output, arterial blood pressure, blood glucose concentration, cellular metabolic rate, blood coagulation, lipolysis and mental arousal (Ramsey, 1982). The anterior pituitary releases adrenocorticotrophic

hormone (ACTH) which stimulates production of adrenal corticosteroids; glucocorticoids, mineral corticoids and sex hormones. The main effects of glucocorticoids are impairment of glucose metabolism, a decreased immune response resulting in decreased resistance to infection, and altered blood coagulation. The mineral corticoid response creates excessive secretion of aldosterone consequently increasing retention of sodium and water. This increases blood volume and results in hypertension (Boore, 1978; Ramsey, 1982).

### Application

Stress threshold and tolerance varies with each individual and depends on the psychologic and physiologic state, past experience, culture, the ability to cope and other factors. Nurses must know the point at which functional anxiety becomes dysfunctional stress. This is facilitated by the ability to recognize and assess physical and behavioural responses.

### Coping as a Concept

Coping potentially reduces anxiety either by enabling the individual to deal with the stressor, or to deal with the effects on the individual (Clarke, 1984). The desired outcomes of coping strategies are to regulate emotional responses and promote goal-directed or problem-solving behaviours thus minimizing negative effects (Lazarus, 1977). For the individual who is about to experience surgery, an increased ability to cope will minimize the negative impact of the stress on their psychological and physical well-being (Johnson, 1984).

### Definition

Monat and Lazarus (1977) define coping as "efforts to master conditions of harm, threat or challenge when a routine or automatic response is not readily available" (p.8). The individual will select one response from a repertoire of coping responses based on the perception of the situation and past experience.

Some authors have classified types of coping strategies based on Lazarus's work (Clarke, 1984; McConnell, 1987). There appear to be four major coping strategies. They are: information seeking, direct action, inhibition of action and intrapsychic (Clarke, 1984; McConnell, 1987).

Information seeking provides the patient with information which may give a feeling of control (Thompson, 1981; McConnell, 1987). Direct action

can change the patient, the situation or one's interaction with the situation (McConnell, 1987). Inhibition of action is a tendency to take no action. According to McConnell this occurs when the patient believes there is no way of changing the situation or preventing surgery. Intrapsychic modes are cognitive processes that control the patient's emotions by making him feel more comfortable (McConnell, 1987).

Any mode may be used by the individual to cope with surgery and to decrease anxiety. The individuals' selection and use of a coping strategy will be influenced by a number of factors including previous experience, knowledge, physiologic and psychologic status, culture, beliefs, age, the expected outcome of surgery and which modes were successful in the past.

### Application

Nurses, as the prime caregivers, are in the best position to assess and facilitate the preoperative patient's coping strategies. The majority of nursing research to date has focused on providing information in the form of preoperative visits by operating room nurses to decrease the patient's anxiety to a functional level and consequently increase the ability to cope with the impending surgery (Lindeman and Stetzer, 1973; Lindeman, 1974; Dziurbejko and Larkin, 1978). These studies, however, do not directly measure the patient's coping activity (Johnson, 1984).

The application of coping theory will enable nurses to enhance and facilitate the patient's own ability to cope (Clarke, 1984). Johnson, Christman and Stitt, 1985 propose that for preoperative patients there is a direct relationship between coping strategies and personal control which impact the postoperative outcome.

### Limitations

Nursing research has used outcome measures such as length of hospitalization and analgesia requirements which were not linked to theoretical explanations of coping (Johnson, 1984). Therefore, it is not possible to conclude whether the interventions used in the research have an effect on coping. More research is needed which develops a nursing theory and description of coping with surgery to enhance the care of the preoperative individual.

### Personal Control as a Concept

Personal control has been indicated as a factor which modifies anxiety. It is also believed to enhance

the patient's coping strategies (Johnson, Christman and Stitt, 1985).

### Definition

Perceived control is defined as a general expectancy for internal as opposed to external control of reinforcements. Internal control refers to the perception of events as being a result of one's own actions and therefore, under personal control. External control refers to the perception of events as being unrelated to one's own behaviour and therefore, beyond personal control (Lefcourt, 1976).

Thompson, 1981, defines three types of control; behavioural, cognitive and information. Behavioural control is defined as the belief that behaviour can affect the aversiveness of an event. Cognitive control is the belief that a cognitive strategy can affect the aversiveness of an event. Information about the aversive event can be a warning, or information about sensations, procedures or causes. She believes that cognitive control strategies are the most beneficial.

### Application

Focus of control theory implies that individuals have a choice in how they behave, deal with and react to the surgical experience. Unfortunately, there is a minimal amount of nursing research which tests locus of control theory for surgical patients. Johnson, Christman and Stitt, 1985 conducted a study which focused on the relationship between specific means of achieving personal control and indicators of coping. In this study, concrete sensory information provided to the patient preoperatively increased the patient's perception of control and ability to deal with the postoperative experience. Thompson, 1981, supports this by stating that information may engender feelings of control. Furthermore, information about sensations one will experience will decrease dysfunctional anxiety to a functional level while information about procedures will have no effect.

When surgical patients are given a general anaesthetic, they lose personal control. Their body will take over physiologic control but even this is regulated and monitored by others, the anaesthetist and nurse. Drugs are used to paralyse the patient, he is intubated and respirations are regulated and maintained with a mechanical respirator. The physiologic response of the body is monitored with a variety of instruments including ECG, pulse oximeter, dynamap, oxygen analyser and other. Despite this, the individual's body

ultimately controls the physiologic response to drugs and surgery.

### Limitations

Arakelian (1980) suggests use of the locus of control concept in health care is problematic due to the fact that health behaviours are complex and affected by other factors including support systems, symptoms, costs and accessibility to health care. For the surgical patient, many factors have the potential to influence their sense of personal control. These include past health history, reasons for surgical intervention, physiological manifestations of the illness and anxiety, and personal history.

There is a need for further nursing research to identify coping processes which promote personal control and descriptive studies of personal control in the surgical patient.

### Postoperative Recovery

Coping with surgery involves facing a threat and is facilitated by using information and resources to alleviate anxiety. Janis (1958) observed that patients with high or low levels of anxiety preoperatively (dysfunctional) had a poorer recovery compared to patients with moderate levels of anxiety (functional). However, Wolfer and Davis (1970) concluded in their research that there was no substantial relationship between patient's preoperative level of anxiety and any aspect of their postoperative recovery. They attribute this to the possibility of unreliable and invalid measures. Patient self-ratings were used which are subject to respondent bias and influenced by differences in coping ability.

Failure to cope with surgery may lead to a complicated recovery (Wilson-Barnett & Fordham, 1982). The function of coping focuses on goal directed behaviour. It is assumed that the surgical patient's goal is resumption of usual activities reflected by hospital discharge and resumption of usual activity (Johnson, 1984). However, Johnson believes length of hospitalization may not be a useful measure for coping because of hospital policies and procedures which dictate when patients are discharged.

Interventions which enable the patients to cope with surgery are believed to increase their feelings of personal control. Johnson (1984) argues that some interventions aimed at instructing patients to use specific coping strategies may reduce their sense of personal control by undermining their confidence in

coping strategies which were effective in the past.

A finding among some nursing research studies is that concrete sensory information provided to the patient preoperatively decreased the level of anxiety, improved the ability to cope postoperatively and increased feelings of personal control (Langer, Janis and Wolfer, 1975; Christopherson and Pfeiffer, 1980; Wallace, 1985).

There are other variables which have the potential to affect postoperative recovery. These include the effects of the surgical procedure, i.e. trauma to tissue and the related physiologic response, presence and degree of postoperative complications, the nutritional status of the individual and support systems.

### Implications for Nursing Interventions

Perioperative nursing practice focuses on the individual experiencing surgical intervention. It considers the physiological, social and behavioural variables which affect the individual's response to surgical intervention (McConnell, 1987).

The physiological and psychological concept of preoperative functional anxiety has a major effect on the individual's response to surgery and postoperative recovery. The concepts of coping and personal control are closely linked to preoperative anxiety and also affect the patient's postoperative recovery. Knowledge of these concepts will influence nursing interventions in terms of patient teaching, goal setting, problem solving and communication.

### Conclusion

Research indicates that a patient's ability to cope with surgery is related to anxiety. Patients who have low or high levels of preoperative anxiety (dysfunctional) have a decreased ability to cope, have less sense of personal control and have a poorer postoperative recovery (Janis, 1958) as compared to patients with moderate levels of preoperative anxiety (functional). A moderate degree of preoperative anxiety is followed by absence of, or minimal postoperative emotional disturbance (Lindeman, 1974; Ziemer, 1983; Wallace, 1985).

The operating room is a cold, technical environment. The presence of machines creates an atmosphere of high tech and often low touch as the patient is viewed by some as an object. "The body first has to be entrusted to the professional in order for care to proceed. And the professional, even while reducing the person to an object, redeems the reduction by

restoring a level of function consonant with the patient's own values and purposes... emphatic touch is a means of continually re-establishing the mutuality in which patients are affirmed as persons rather than objects," (Gadow, 1984, p.69).

The conceptual framework developed in this paper provides the nurse with the means to predict the human response to surgery and interrelated concepts associated with the response. This will enable nurses to understand the biopsychosocial phenomena of preoperative functional anxiety.

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# Acute Pain Management: IV Patient Controlled Analgesia Places the Patient in Control

By Lynne Maxwell, R.N., M.S.N.

Health care professionals have long been concerned about assessing and treating acute pain. Nonetheless, between one-half and three quarters of post-operative patients experience inadequate pain relief following surgery.<sup>(4, 9, 15)</sup> Scholars, practitioners and researchers specializing in acute pain encourage health care professionals to examine current practices in the light of new knowledge so that ineffective approaches to acute pain management can be identified and corrected.

Acute pain is pain that results directly from noxious stimulation, that is, tissue damage from mechanical disruption, inflammation, and stretching.<sup>(5)</sup> Potential causes of acute postoperative pain include: surgical incisions with the thoracic, renal, and upper abdominal incisions reported to be the most painful; visceral distention, as with bowel surgery; visceral stimulation, as with surgical procedures of the bladder and uterus; and the presence of catheters and tubes such as urinary catheters and endotracheal tubes. Further, post-operative pain can exacerbate preexisting pain, such as back pain, and may act as a precursor of chronic pain syndrome.<sup>(12)</sup> Uncontrolled acute pain can lead to complications that increase morbidity and mortality.<sup>(1, 4, 12, 14)</sup> Acute pain is commonly managed with analgesic drugs and pain ordinarily subsides as the impairment comes under control.<sup>(5)</sup>

Despite recent pharmacologic advances, traditional approaches to pain management are ineffective in controlling post-operative pain for many adults and children.<sup>(4)</sup> Health care professionals have documented personal experiences with pain to emphasize the problem of acute pain management. Donald (1976), a Scottish professor of obstetrics and one who recalls his experience of open heart surgery, wrote that his post-operative pain 'defied description'. Another physician/author wrote that his postoperative pain manage-

ment was 'a cool and callous disgrace'.<sup>(9)</sup>

Why is this so? The inadequacies of current acute pain management regimens essentially arise from underdosing, delays in administering analgesics and the resultant ineffective serum concentration of these analgesics. Traditional pain management practices, lack of knowledge of the physiology and treatment of pain and myths and biases about pain set the stage for ineffective practice.

Loeser, a physician philosopher, explains the origins of misconceptions about pain by examining the history of medical thought and behaviour. Loeser argues that physicians have been slow to tackle the problem of pain for several reasons:

1. Pain management is not a popular area of concern for physicians since modern physicians are more interested in specialization and technology rather than non-technological problems such as pain.
2. The modern medical model is based on the Cartesian concept of the mind-body dichotomy, however, pain is difficult to explain using this model and is better explained using learning or behavioral models.<sup>(6)</sup>

Since nursing is traditionally aligned with medicine in its perspective on pain management, nurses can learn from Loeser's musings. McCaffrey, a nurse, agrees with Loeser noting that the science of pain is new. McCaffrey points out that the busy, practising nurse often lacks the skill and knowledge to assess and help the patient in pain.<sup>(8)</sup>

## Author

Lynne Maxwell, R.N., M.S.N., is a private consultant who implemented the IV PCA program at St. Paul's Hospital in Vancouver, B.C. This article is part of a major presentation on Pain Management to the April, 1992 BCORNG Conference in Vancouver.



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Nurses and other health care professionals commonly hold and act upon myths and biases about pain that interfere with the assessment and treatment of acute pain. Some myths and biases commonly held follow with the accompanying corrections.<sup>(6,13)</sup>

| Myth   | Correction   |
|--|--|
| 1. Health professionals are the only authorities on pain.              | 1. Only the patient is the authority on his/her own pain.                        |
| 2. Patients who use narcotics regularly are likely to become addicted. | 2. When narcotics are used to relieve pain there is almost no risk of addiction. |
| 3. Clock watching is an early sign of addiction.                       | 3. Clock watching is a sign of underdosing or incorrect drug choice.             |
| 4. Patients should develop a high pain tolerance.                      | 4. Pain tolerance is a unique individual response.                               |

In addition to myths and biases about pain, traditional practices are generally inadequate to treat acute pain. Intramuscular opioids given either 'prn' or as scheduled is the standard for analgesic therapy in acute pain management. With this approach, dosing is based on traditional set patterns (e.g. 75-100 mgs of Demerol q4h PRN) without due concern for patient variability or the patient's subjective experience of pain leading to a tendency by health care professionals to provide inadequate amounts of analgesic medication. The 'prn' order can result in a substantial delay between the time the patient first feels the pain and when the drug is actually absorbed.<sup>(12)</sup> Further, the administration of intermittent, intramuscular narcotics results in peaks of pain and valleys of sedation as the blood levels of the drug fluctuate in response to the serum concentration of the analgesic drug. Ideally, the patient should be kept in an area of analgesia that is achieved by giving small, frequent, intravenous doses of analgesic. This option is not practical given current staffing and economic realities. However, by employing new techniques such as intravenous patient-controlled analgesia, an effective serum concentration of the analgesic drug can be maintained.<sup>(8,9,12)</sup>

IV patient-controlled analgesia (PCA) is an exciting new technique for acute pain management. With this technique, the patient in pain is supplied with a microprocessor-controlled pump which delivers a pre-

determined amount of IV narcotic analgesic when activated by a patient-controlled hand-held device. The dose that the patient receives when the pump is activated is ordered by the physician and programmed into the pump by the nurse or physician. The drug the patient receives is stored in this pump in a syringe attached to a motorized device and controlled by the microprocessor which accurately determines the dose administered to the patient. To avoid over-medication, a lock-out or delay interval of between 4-10 minutes is pre-selected by the physician and programmed into the pump by the nurse. All attempts at activating the pump are registered but the narcotic is delivered only after the delay or lock-out period has passed. The pumps have the additional capacity to deliver a continuous background mode in addition to the patient-controlled mode. While the patient has access to the pump by the hand-held device, nurses and physicians access the microprocessor using a security code. If the patient reports that pain relief is inadequate, the microprocessor can be easily reprogrammed by the nurse or physician using the security code to shorten the lock-out period or increase the dose or both.

IV PCA has been shown to be effective and, in fact, is currently used in many American and Canadian hospitals. PCA is effective in the control of acute pain because: PCA allows for self-titration by the patient who is best suited to judge his/her level of pain; PCA allows for more flexible dosing thereby compensating for patient variability; and PCA provides analgesia at lower doses of opioid, thus minimizing side effects.<sup>(4,12)</sup> IV PCA is gradually being introduced to hospitals throughout British Columbia. A technique such as PCA that places the patient in control of his or her own pain management challenges long-held beliefs and practices of health care professionals and firmly established hospital systems. However, once in place, IV PCA benefits patients, nurses and hospitals.

Benefits of IV PCA to patients, nurses and hospitals are well documented. The benefits to the patient include satisfaction with acute pain management, less anxiety, improved ambulation, less sedation, improved respiratory function and shorter hospital stay.<sup>(4,12,14)</sup> Benefits to the nurse include caring for patients who are comfortable, saved time in preparing injections, a reduced risk of needle-stick injuries and increased patient satisfaction with care. Benefits to the hospital include increased patient and nurse satisfaction and shorter hospital stays.<sup>(4,12,14)</sup> Ready (1990) points out that although there remains a small risk associated

with using IV PCA, rigorous education programs and specific guidelines for nurses and doctors render IV PCA a high benefit-low risk technique.

The ordeal of acute pain frequently results in suffering for the patient and frustration for the nurse. By placing the patient in control of his or her own pain with techniques such as IV Patient Controlled Analgesia there are benefits for patients, nurses and hospitals.

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## Operating Room Nurses of Ontario (ORNAO) Executive '92-'93 2nd Provincial Conference, Toronto, April, 1992.

(Front row left to right) **Judi Tyndall**, Hamilton & District; **Vija Hay**, Ottawa, President; **Hilda Gatchell**, ORNASCO, Past President. (Back row left to right) **Ann Rodney**, Ottawa; **Jocelyn Staynes**, Hamilton & District; **Sharon Ball**, ORNGT; and **Linda O'Brien**, Northern Ont. Photo Credit: Charles Keary

Dressed in 1940's fashions for the ORNAO dinner & dance are **Ellen Woodward**, Lindsay, Ont. (in the full length dress); **Carolyn LaPorte**, (far right) and **Sharon Ball**, (with cigarette holder) ORNAO Programme Committee Convenor. Good sports all!

**Diana Jorgensen** (left) added extra excitement to a conference session she moderated by slipping-off the podium. After excellent emergency treatment at Mount Sinai she returned for evening social events. **Marion Skeoch**, (right) York Finch General.



Retired - **Jean Mitchell Bain** (left) Jan.'92 from the North York General Hospital, and **Virginia Guardhouse**, May '92 from Queensway General, Toronto. Both will travel and attend some OR conferences.

**Sharon Balkin** (left) Past-president of Alberta OR Nurses and **Marne Simon** Past President of the BCORNG, at the ORNAO annual dinner. Both were in Toronto for the ORNAC Board meetings.



ORNAO conference chairperson **Hilda Gatchell** opens the exhibits with **Bill Keenan**, President, Lac Mac Ltd., chair of the Exhibitor's committee, and **Carole Starr**, convenor of the exhibitor's committee.

Blue Jays **Roberto Alomar** and **John Olerud** sign autographs for OR Nurses at the Bard exhibit. **Jim Lawrence**, Director of Sales, Bard Canada and a Bard Representative look on.



## Report on the 2nd Conference of the Operating Room Nurses Association of Ontario

Pat Mandy, the keynote speaker to the 2nd conference, spoke of the enormous challenges ahead for nurses as they adjust to the proposed changes resulting in the new **Regulated Health Professions Act**.

Ms. Mandy's address (see Vol. 10, No. 2, May/June, 1992, pages 11) set the tone for the three-day conference, "Present Concerns, Future Visions, The Responsibility is Ours".

ORNAO has set up a Task Force to look at the Role of the Perioperative Nurse in relation to the Regulated Health Professions Act and to liaise with the College of Nurses. Task Force members are: Vija Hay, Judi Tyndall, Darlene Beaudet and Sharon Ball.

Vija Hay, 1992/93 ORNAO President, in outlining the work ahead of the association in the coming year, said they would focus on: (i) the Regulated Health Professions Act, (ii) Maintenance of interest group status with CNA, (iii) Liaison with RNAO, and (iv) the Definition of the perioperative nursing role.

Hilda Gatchell was honored with the ORNAO Past President's pin and a special tribute for her years of dedication to the association. In the tribute President Vija Hay said:

"For many years Hilda has been an active member of her Regional Association ORNASCO, ORNAO and ORNAC, having served on the Board of these Associations and on various committees, including conference planning.

During her term as President of ORNAO she widened the horizon of the organization by communicating widely, and by providing an opportunity for members to become more involved in ORNAO business. (Current membership 1,020) Hilda has strived to generate better ties with RNAO to ensure our status with CNA. She has unselfishly dedicated countless hours to the work of ORNAO.

On behalf of Ontario's OR Nurses, I thank Hilda and express our appreciation and recognition of work well done."

### Val Shireff Memorial

The ORNAO Board presented a cheque of \$5,000 to ORNAC in memory of Val Shireff. This donation and others received by the National in Val's memory will be used toward establishing an official office for ORNAC.

Along with four new clinical procedures, a financial analysts and a waste management expert, three highly skilled motivators spoke to the 596 nurse delegates. Performance Motivator Rosalie Wysocki "positively-charged" the nurses with her lecture on personal responsibility and a recommendation to take charge of your life. Ms. Wysocki claims there are three kinds of people: those who make it happen, those who watch it happen to others and those who get up and wonder what happened.

"Attitude is 80% of winning in life...so take charge of your future, your life and your career by stepping out of the comfort zone...if you haven't had failure, you haven't had success."

Ms. Wysocki says that up to age 30 we work on our job skills, after 30 we work on ourself. People today want to know how to work smarter, not harder.

Take charge, she recommended, as everybody is responsible for their own growth and development. "Remember, if it is to be, it is up to me".

She reminded the delegates that they chose nursing as a profession because they cared. Nurses don't burn out, they don't stress out, they empty out, so they must learn to fill themselves up!

"Take charge of your career. Forecast the skills you'll need in your career and then go out and get them", she said. Then she asked for a show of hands in the audience to establish how many nurses could use a computer keyboard. She estimated the raised hands in the audience at 25%.

Ms. Wysocki had hundreds of great motivating expressions or mottos. Here are a few:

- Winners have a game plan. Losers don't know what game is going on.

- Winners keep score but losers don't want to know the score.

- Don't wait for your ship or "opportunity" to come in ..... swim out to it!

- Don't let your minimum be your maximum.

- The secret of success is to stay cool and calm on top and paddle like HELL underneath!

The best of Rosalie's mottos and the one most appropriate to the perioperative nurse is:

- Every job is a self-portrait of the person who did it. **Autograph your work with excellence!**

## "Cinderella doesn't work here anymore" by Louise McCants

Louise McCants, a southern American educator, mother and nurse, is also a funny lady. In a motherly fashion and an amusing deep southern accent this university dean spoke of the secrets to happiness and success, career choices and the future workplace.

"The secret of happiness is freedom, and the secret of freedom is a brave heart", she said. Identify and assess your skills and preferences, then choose a career path to compliment your choices.

She spoke of technical skills, people skills and conceptual skills. For example, she hoped her airline pilot had technical skills, and her surgeon technical and conceptual skills, but a scrub nurse, she said, must have people skills, conceptual abilities and technical skills.

By the year 2000, she predicted all dull, dirty, and dangerous jobs will be automated, removing 25% of the traditional job market positions.

The GUPPIES (Generally Unhappy, and Permanently Poor) will represent about 40% of the population.

The YUPPIES, the high skilled category with lots of training and professional preparation will all be driving around in BMW's. There are still some openings in this category, she said.

"In the world of the future women are going to have to fill these positions, because there are not enough men with sufficient training and ability to fill the openings.... 87% of the graduates coming out of high school in the U.S. do not have the reading and math skills to fill these high-level technical jobs."

Dean McCants urged the OR nurses to actively look for special talent within the profession and urge them to seek educational advancement to fill the high-skills positions opening in the near future.

## Laugh to defuse tension and build team spirit in the workplace

Patty Wooten left nursing to devote herself to helping health care workers bring more humor to their worklife and their patients. Her company is called "Jest For the Health of It".

Ms. Wooten instructed delegates in methods to keep the laughs rolling in the ORs of Ontario. She had an endless supply of graphs, jokes, cartoons, red clown noses and funny hats, all of which she suggested be presented in the OR when the tension level starts to rise. "Your sense of humor is your shock absorber on

life's bumpy road," she said.

"Adopt a willingness to laugh. Learn what is funny to you. Be responsible to see you get regular exposure to humor. Try to laugh at least 20 minutes a day...when you were a child, you used to laugh every 10 minutes."

Ms. Wooten's lecture (or stand-up comedy routine) closed the three-day educational conference which offered OR nurses an opportunity to learn of several new surgical procedures, become empowered through the motivational sessions, network with colleagues, visit exhibits, see instructional films and enjoy all the social events. ■

## Hand-holder comforts elderly cataract surgery patients

A recent *Associated Press* story out of San Leandro, California, tells of a grandmotherly volunteer who for the past four years has comforted 1,200 cataract surgery patients.

Margaret Pickford, 83, is a volunteer hand-holder and proud provider of something high-tech equipment cannot supply: the human touch.

The surgeon, Dr. Stephen Turner, says having Mrs. Pickford in the OR is a way to relax his elderly patients, who are sedated, but remain conscious during the surgery. Staying awake means a quicker recovery and less risk, but is also means patients have to lie still in what can be frightening surroundings, he said.

"They're really sort of shut-off from the outside. By having the hand-holder, they have some connection," he said. "She really calms the patients down quite a bit".

The concept of promoting human contact is a good one, said Dr. Walter Stark, an ophthalmology professor at Johns Hopkins University in Baltimore.

"The anesthesiologists in particular are in agreement that if you sit with the patient...and you reassure them, you can get by with a lot less anesthesia," he said. "The patient realizes they're being treated as an individual and somebody cares about them."

### ORNAC Conference Dates:

National Conference Quebec City - June 6-11, 1993, Vancouver - 1995, Ontario - 1997 and Halifax - 1999.

### OR Nurse Week/Day - November 14

Organize a special event and celebrate! Consult your provincial newsletter for the availability of posters and buttons.



Planning Committee for the **2nd Provincial ORNAO Conference**: (Front row, l to r) **Judi Tyndall**, Brantford; **Carole Starr**, Peterborough; **Mindy Shinoff**, Toronto; **Hilda Gatchell**, Oshawa; **Darlene Beaudet**, Windsor; **Mary Ann McDonald**, Toronto; **Jane Cunningham**, Toronto. (Back l to r) **Janet McCollough**, Toronto; **Jocelyn Staynes**, St. Catharines; **Sharol Ball**, Toronto; **Pattie Crampton**, Ottawa; **Diane Jorgensen**, Toronto; **Vija Hay**, Ottawa; and **Sheila Walter**, Windsor.  
Photo Credit: Charles Keary

**Gloria Stephens**, ORNAC president, brings greetings to the Ontario OR Conference in Toronto. **Hilda Gatchel I**, Ontario's out-going president introduced the national president. Photo Credit: Charles Keary

**Jane Cunningham**, ORNAO Conference Planning committee member with Blue Jay **Todd Stottlemire**. Photo Credit: Gloria Day



Executive & Board/1992 -'93 Operating Room Nurses Association of Ontario



# Conference Calendar

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## Pelvic Pouch Procedure

The Gastrointestinal Program at Mount Sinai Hospital, Toronto, has released *"The Pelvic Pouch Procedure,"* a unique, informative booklet for the health care professional as well as for the patient suffering from Inflammatory Bowel Disease. Copies are available for \$2 each (to help cover production and mailing costs). The booklet explains the surgical procedure and provides valuable educational information for the patient and family. Call (416)586-5359 for more information or send cheque payable to Mount Sinai Hospital - to:

**Karen Witkowski  
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Mount Sinai Hospital,  
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Toronto, Ontario  
M5G 1X5**

**Editor's note:** This booklet has been reviewed and passed on to an IBD patient (a nurse) who was sent home after surgery without an explanation of the procedure and with no dietary information. The patient found the booklet most helpful, especially the dietary information. Check it out!

# Breast Cancer: Recent Progress

By Dr. Ivo A. Olivotto

Breast cancer is the commonest malignancy affecting Canadian women. One in ten women will develop breast cancer sometime in her life. Nearly 15,000 new cases will be diagnosed and over 5,000 women will die of breast cancer in Canada in 1992. These statistics are frightening. There are three ways to reduce morbidity and mortality from breast cancer; prevention, screening and better treatment. This article will review progress which has been made in the past ten years in all three areas.

## Prevention of Breast Cancer

Female sex and advancing age are the most important risk factors for the development of breast cancer. A positive family history, early age at which the menstrual periods start, a late age of menopause, a prior breast cancer or previous biopsy showing atypical proliferation of the cells in the milk ducts also increase the likelihood of breast cancer. None of these factors can be changed by individual behavior modification. What is a woman to do?

Diet is almost certainly important. Unfortunately, the data relating any one dietary factor to risk is conflicting. Excess total calories, animal fat, total fat content and lack of green and orange vegetables in the diet have been implicated but no direct causal relationship with any particular diet has been proven sufficiently to be able to give specific dietary recommendations with confidence. Prudence would dictate that a balanced diet with fewer calories, less total fat and more 'roughage' may reduce premature death from cardiovascular disease and may also reduce the risk of developing breast, colon and possibly other cancers. Studies assessing behavior and diet modification are in the planning phase.

While the lifestyle question is under investigation,

a new study is exploring whether the drug tamoxifen can prevent the development of breast cancer in women at high risk for developing the disease. It is known that the growth of some breast cancers is simulated by the female hormone estrogen. Tamoxifen is a complex molecule with estrogen blocking as well as weak estrogen agonist functions. Tamoxifen has been used successfully to treat women with invasive breast cancer for nearly twenty years. Recent evidence (E.B.C.T.C.G.(I) 1992, Nayfield, 1992) has demonstrated that women who take tamoxifen for two to five years after surgery for one breast cancer have a 35-40% lower chance of developing a second breast cancer when compared to women who do not take tamoxifen. This observation has led to the hypothesis that tamoxifen might also be employed in healthy women, at risk of developing breast cancer, as a prevention strategy.

To test this hypothesis a clinical trial was launched April 29, 1992 cooperatively in over 200 cancer centres in Canada and the United States. The plan is to enrol 16,000 healthy, volunteer participants by April, 1994. Women will be randomly assigned to take tamoxifen or placebo (a tablet of no medicinal value) for five years. Table 1 outlines examples of the sorts of women deemed to have a high enough risk of develop-

## Author

Dr. Ivo A. Olivotto, BSc, MD, FRCPC is a Radiation Oncologist at the British Columbia Cancer Agency, Vancouver, B.C., where he is Chairman of the Breast Tumour Group and a Clinical Associate Professor in the Department of Surgery, UBC. This article was prepared by Dr. Olivotto following his presentation to the British Columbia Operating Room Nursing Group, '92 Conference, April, 1992.

**Table 1**  
**Entry Criteria**  
**Breast Cancer Prevention Study**

1. Any woman > age 60.
2. Any woman  $\geq$  age 35 with Lobular Carcinoma In-Situ (LCIS).
3. Women age 35-59 with combinations of risk factors (for example):
  - i. age 35+: one or more first degree relatives with breast cancer and two benign breast biopsies.
  - ii. age 40+: two or more first degree relatives with breast cancer or two benign breast biopsies.
  - iii. age 45+: one or more first degree relatives with breast cancer.
  - iv. age 55+: one or more relatives or first live birth at age 30 or older.

**Table 2**  
**Contact Numbers for the**  
**Breast Cancer Prevention Trial**

|                 |                |
|-----------------|----------------|
| B.C. and Yukon  | 1-604-822-7997 |
| Ontario         | 1-800-263-6750 |
| Quebec          | 1-800-361-4212 |
| Other provinces | 1-416-387-1153 |

five years, approximately 50% of women with involved axillary lymph glands are alive at five years and in excess of 95% of women with mammographically detected cancers, less than 1 cm. in diameter, are alive at ten years. (Figure 1) The goal of screening is to detect cancers when they are small and curable with local treatment alone. Many different technologies have been evaluated in breast screening but only breast self-examination, professional physical examination and mammography are routinely supported.

Breast self-examination (BSE) is a method for a woman to take charge of her health care. It is recommended that women learn how to perform BSE and 'check that they are healthy' once a month. Teaching is best done in one-on-one sessions rather than from pamphlets. Canadian Cancer Society volunteers and nurse practitioners conduct BSE teaching sessions and one's family physician should be familiar with the technique. Perhaps the greatest importance of regular BSE is that a woman will be aware of her own body health and be confident to report new changes to her physician for evaluation.

Multiple international studies have demonstrated a consistent reduction of approximately 30% in breast cancer related mortality for women  $\geq$  50 years old who have regular screening with mammography and physical examination. The data is less convincing for women < 50. Contrary to leaked media reports, there is no evidence that mammography under age 50 is harmful (Allison, 1992). Results of studies in the 40-49 year old age group vary from showing no benefit to a 30% reduction in mortality which was shown in the longest running randomized breast screening study. Results from a study conducted across Canada do not show a reduced mortality from screening women age < 50.

The Screening Mammography Program of B.C. (SMPBC) was established in July, 1988. The SMPBC was the first, universal access, publicly-funded screening mammography program in North America. Among first time attenders, 4.8 women of every 1000 screened are found to have a previously unsuspected cancer

ing breast cancer to be eligible for study participation. Women with a prior diagnosis of cancer, deep venous thrombosis or those planning to become pregnant are not eligible.

The reason to not just start using tamoxifen to prevent breast cancer in high risk women is uncertainty regarding the relative risks and benefits of this drug. Tamoxifen is usually well tolerated but by blocking estrogen actions, it can sometimes cause hot flushes, vaginal dryness and discharge which at times can be quite disabling. A small increased risk of developing blood clots and pulmonary embolism has been observed and for post menopausal women, the weak estrogen agonist action of tamoxifen may stimulate the endometrium to develop neoplasia in a similar fashion as can estrogen replacement therapy.

A carefully designed study is necessary to evaluate tamoxifen's safety and effectiveness in preventing breast cancer before advising healthy women to start taking this medication. Further information about study participation can be obtained by calling your regional contact number in Table 2.

## Screening and Early Diagnosis

Breast cancer takes years to develop from the first malignant cell in the milk duct to a mass which can be felt by a woman in her breast. A woman's chance of survival is directly related to the extent of disease at diagnosis. For example, while less than 5% of women with disease in distant organs at diagnosis are alive at

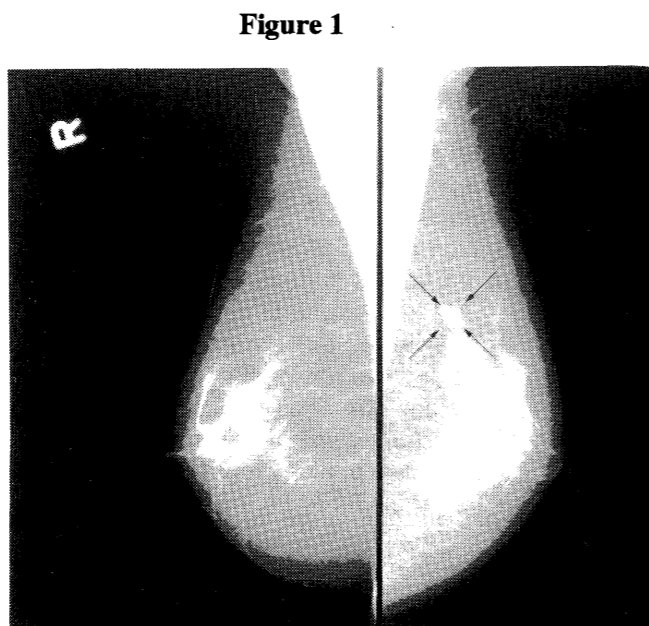
(Figure 1). Many of these cancers are much more curable than if they had been diagnosed only when the woman or her physician were able to feel a lump. There is a realistic expectation that this early detection will translate into a net decrease in premature death from breast cancer. Currently, the SMPBC recommends that women have a yearly mammogram and physical examination of the breasts starting at age 40. Programs in other provinces recommend screening with mammography begin at age 50. Women who are pregnant or lactating, have current breast complaints, a previous breast cancer or breast prosthesis in place require special views of the breast and should be referred to private, diagnostic centres for mammograms. In British Columbia women over 40 can refer themselves or be referred by their physician to an SMPBC centre. By the end of 1993, SMPBC screening centres will be open in Burnaby, Kelowna, Kitimat, Nanaimo, Prince George, Prince Rupert, Terrace, Surrey, Vancouver and Victoria. Two mobile vans serve the interior of the province from Kamloops and Nelson.

#### Treatment Advances: 1992

Two substantial advances in the management of invasive breast cancer have occurred in the last 10-15 years. The first is that lumpectomy followed by radiation therapy has been proven to provide equivalent local control and survival as does total mastectomy thereby giving a woman an option to save her breast (Olivotto et al, 1991). The second is proof that chemotherapy and/or tamoxifen given immediately following primary therapy increases the chance of survival five and ten years later. (E.B.C.T.C.BG. (I & II), 1992)

#### The Approach To Breast Conservation

Before 1980, very few breast conserving operations were performed in Canada. Today, breast conservation is accepted standard therapy for primary cancers < 5 cm. diameter with or without palpable mobile lymph glands at diagnosis. In certain circumstances however, mastectomy may still be selected. If there are multiple primary tumours or if complete surgical removal cannot be achieved, an unacceptably high rate of recurrent disease in the breast occurs. These women are best served by mastectomy. Even if it appears that complete removal has been achieved surgically, 40% of women relapse in the same site unless radiation therapy is routinely delivered post-operatively. The radiation therapy takes 4-5 weeks of daily treatments at a cancer clinic. Refusal of, or



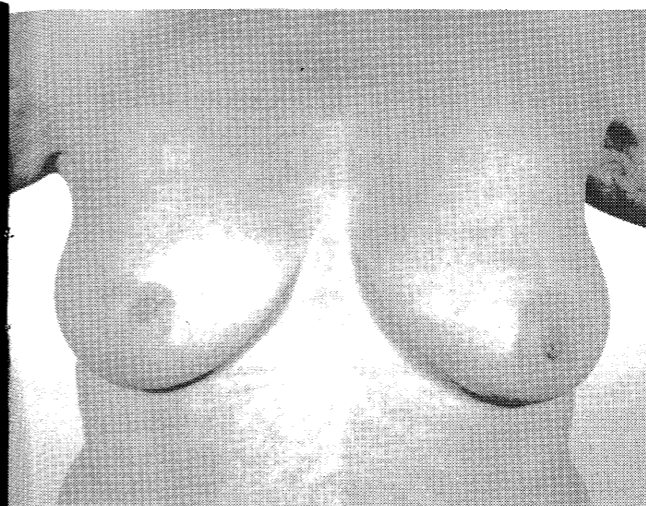
6 mm diameter, non-palpable, invasive ductal carcinoma detected by screening mammography. (reproduced with permission, Canadian Journal of C.M.E.)

inability to tolerate radiation therapy (i.e. patients with lupus erythematosus or scleroderma get excessive fibrosis) or an inability to attend for the daily treatment visits (i.e. elderly or frail individuals) mandate mastectomy as the most appropriate treatment. Beyond these relatively uncommon circumstances, it becomes a question of whether the surgeon can adequately remove the primary tumour while retaining sufficient normal breast tissue to have a good cosmetic symmetry when compared to the contralateral side. This depends upon the size and location of the tumour within a breast of a specific size and shape. Attention to the technical details can result in an excellent cosmetic appearance, figure 2, while achieving local control and survival equivalent to total mastectomy.

It is important to avoid excessive resection of normal breast tissue, to place incisions carefully, achieve hemostasis and to close with a subcuticular technique which avoids ridges, puckering and breast distortion. (Figure 3)

While breast conservation has been shown to be equivalent to mastectomy in terms of survival, it is not necessarily better treatment. The important principle is that women today should be informed of the possibility of breast conservation and be given sufficient

Figure 2



Excellent cosmetic outcome three years after treatment of carcinoma of the right breast with tumorectomy, axillary dissection and radiation therapy.

information and respect to participate in the decision about how their breast tumour will be managed.

#### Adjuvant Systemic Therapy

Adjuvant therapy is treatment added to the primary, curative treatment to reduce the risk of recurrence from presumed residual microscopic disease. In the context of breast cancer after the initial surgery (mastectomy or lumpectomy and axillary dissection) even though no apparent disease can be found on physical examination, blood tests or x-rays, a substantial proportion of women will have the cancer recur and eventually die of disease. In most cases this is due to microscopic disease which has spread throughout the body but remains undetectable at the time of diagnosis. Tamoxifen (an anti-estrogen) and various chemotherapy combinations (drugs capable of killing dividing cancer cells) when given immediately after the primary surgery have been shown to significantly reduce the chance of recurrence and death from breast cancer. (E.B.C.T.C.G. (I-II), 1992).

Response to treatment is determined by age (menopausal status) and certain tumour characteristics. Younger women (< 50) have been shown to derive most benefit from chemotherapy with a small addi-

Figure 3



Poor cosmetic outcome three years after treatment of carcinoma of the left breast due to excessive resection of breast tissue and an incision dissection of the primary site and axilla. Separate incisions avoid the retraction of the nipple due to scar contracture. (reproduced with permission, Canadian Journal of C.M.E.)

tional gain in some individuals by adding tamoxifen or stopping ovarian function. For older women (> 65-70) tamoxifen achieves a similar benefit and the very small additional gain from adding the toxicity of chemotherapy is not usually justified. In the intermediate age range (50-65) the therapy resulting in an optimal balance between benefit and toxicity is related to the hormonal responsiveness of the tumour. Chemical or immunofluorescent measurements can be made at diagnosis to determine the estrogen receptor (ER) content of the tumour cells. Women with ER+ tumours enjoy significant improvements in survival with minimal toxicity when given tamoxifen for two to five years after surgery. A small additional gain may be realized by adding chemotherapy but at the cost of added toxicity. In contrast to what was formerly believed, women with ER- tumours do benefit from tamoxifen but to a smaller degree than those with ER+ tumours. Today, fit women in the 50-65 age group with ER- tumours are often offered chemotherapy followed by tamoxifen.

Much current research is focused on trying to select which women have such a low risk of recurring that the toxicity of adding chemotherapy and/or tamoxifen are not justified. Today we define the 'lowest' risk

group to be those women with solitary primary tumours, < 2 cm in diameter with no invasion of the lymphatics or blood vessels in the breast and no spread to the lymph glands found in the axillary dissection. These 'lowest risk' women are treated with local therapy (mastectomy or lumpectomy plus radiation therapy) alone and are not offered chemotherapy or tamoxifen.

### Summary

Much remains to be learned about this commonest malignancy in women. However, in the past 10-15 years substantial progress has been made in defining optimal treatment for individual women and in recognizing the importance of the patient's input into medical decision making. Women today can save their breast in most circumstances if they elect that approach and can expect a better chance of survival with the judicious use of adjuvant tamoxifen and/or chemotherapy. For the majority of women, early detection has been shown to reduce the chances of dying of breast cancer. Screening mammography, together with physical examination, although available to women over 40, is strongly encouraged for women over 50 on an annual basis. With respect to prevention, the first

ever intervention study is now underway across North America assessing the efficacy and safety of tamoxifen in preventing the development of breast cancer among healthy, high risk women. Future research will hopefully identify those dietary and lifestyle factors which we can modify to reduce the relentless rise in numbers of cases of breast cancer seen in our population.

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# "Reflections on Adelaide" Planning for a World Conference

By Joan Donald, ORNAC Past President

*"Those far away places with strange sounding names  
Far away over the sea  
Those far away places I've been dreaming about  
Are calling, calling me."*

As we edge closer to 1993, our thoughts start drifting toward the next World Conference and the lure of far away places. The World Conference from **September 6 - 10, 1993, is to be held in Adelaide, Australia.**

Having had the privilege of being a member of the International Planning Committee (IPC), I thought it might be interesting to share with you my experience of attending the IPC meeting in Adelaide in May, 1992.

After more than thirty hours of travel time, I was glad to see the lights of Sydney gleaming out into the harbour as our plane landed. Once on the ground, the crew came through the aisles of the plane with sprays which are required by the Department of Agriculture. Although it is reported to be non-toxic, one wonders how effective it can be as an insecticide if it is non-toxic. Once inside the terminal, there were numerous signs warning of a \$50,000 fine if any undeclared edible food products and/or plants were brought into the country. Fellow passengers were frantically checking for leftover snacks and making sure they were listed. One thing I learned the hard way, was that all entrants to Australia must have a visa, in addition to a valid passport. Unfortunately, I had not been told of this and after one full hour with a very exasperated but nice gentleman, I was issued a temporary visa and allowed to proceed. Another three hours of travel and I landed in Adelaide, Australia.

Adelaide is a beautiful city surrounded by a one mile circle of green space. It was fall there and very pleasant, by my standards, even though the leaves

were changed and had fallen from the trees. The people were very polite, gracious and hospitable - now if I could only understand them!

One of the first lessons learned was that there is no tipping in Australia. What a great thing to learn. In addition, the prices on items are exactly what is paid - no addition of PST, GST or taxes of any kind. On Sunday, May 15, 1992, we gathered bright and early at the Convention Center for our IPC meeting.

Representatives from Australia, Canada, Germany, Japan, United Kingdom and the United States of America were present. Countries represented by corresponding members were Argentina, Finland, Germany, Greece, Italy and Mexico. Everyone was made to feel so welcome and we compared travel notes over our first tea and coffee of the day. A recap of the last World Conference held in Vancouver, B.C. led to some suggestions for change and improvements. The remainder of the morning was spent in brainstorming and sharing of ideas, concerns, topics and items for presentation. Amazingly, we all came with pieces of paper that had almost identical issues listed on them. It very quickly became evident that our theme would evolve with a world wide mutually shared vision.

Following lunch and a stroll outside for some fresh air, we then went on a conducted tour of the Convention Center. What an incredible facility! Whole meeting rooms became transformed before our very eyes as bleachers suddenly recessed into the ceiling and walls moved here and there. The exhibit hall is such that the huge transport vehicles can be driven right into the hall and on site.

Well, back to work and before the afternoon was over we had agreed on our theme of "Strategies for Strength". The topics for presentation were chosen and the next day we expanded on these topics, devel-



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Bruce Miller, Nursing Recruitment, Human Resources Department, Calgary District Hospital Group,  
1035 - 7 Ave. SW Calgary, AB T2P-3E9 Tel. 403-541-2731.

oped objectives and outlines. Unfortunately, the Convention Center is next door to a gambling casino complete with magnificent chandeliers and all. Just a nice stroll through, shouldn't take too long .....

The next day we completed the planning process and took a few minutes to exchange gifts and mementos. We were enthused and excited about what we had accomplished. Next we bid a sad farewell to what has become a close group of friends. Now back home to start the process of selecting suggestions for speakers and hope that Canada is well represented.

In numbers there is strength. At a time when perioperative nursing is feeling threatened, we need to dialogue, to share concerns and to share our strategies for survival.

As the thought of meeting your colleagues from around the world, seeing new places and generally expanding your horizons materializes, start planning

for Adelaide. This 1993 World Conference of Perioperative nursing will provide you with new ideas, new perspectives and hopefully, some "Strategies for Strength".

### Canadian OR nurses will wear a special outfit for Fellowship night

Canadian OR nurses planning to attend the World Conference of Operating Room Nurses in Adelaide, Australia, can purchase their Canadian Outfit ( the cartoon mountie shirt and mountie hat) at the **13th National Operating Room Nurses Conference in Quebec City, June 6th to 11th, 1993.** Those not attending the National in Quebec City can write directly to Gloria Stephens in Vancouver after the Quebec Conference to order an outfit. More information will be published in future issues of the Journal.

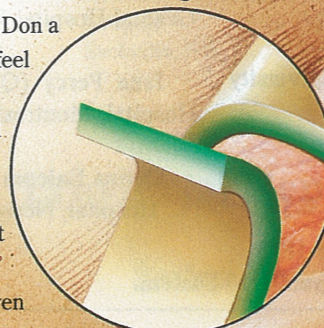


Members of the International Planning Committee include (front row, from left) Masako Hagihara, Japan; Leslie Gilbert, Australia; Joan Donald, Canada; Jan Hixon (co-chair) United States; Lola Fehr (advisor) United States; (back row) Kumeko Saito, Japan; Taeko Miyahara, Japan; Pat Eiszele, Australia; Carol Jones, United Kingdom; Cynthia Spry, United States; Jody Zeman (staff consultant) United States; Narelle Hines (co-chair), Australia; and Rosalinda Vedecnik, Germany. Photo reprinted with permission of Georges France Photograph, Adelaide, Australia.

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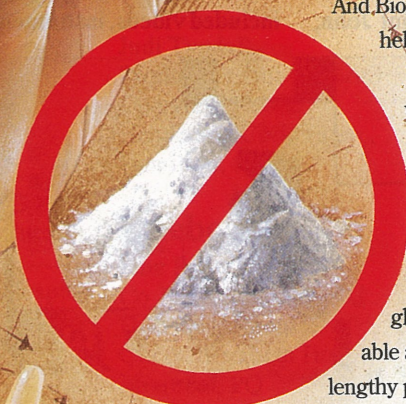


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## Teleconferences

| Date & Topic   | Speaker(s)  | Moderator  |
|--|---|--|
| November 11/92<br>"The Unsuspected Allergy Preventing an Anaphylactic Reaction to Latex" | Judi Tyndall, Donna Rawlins & Sue Smith (Henderson General Hospital, Hamilton, ON.) | Geraldine McEvoy (Montreal General Hospital, PQ.)          |
| December 2/92<br>"Intubation with the Laryngeal Mask"                                    | Rosemary Moase (Prince County Hospital, P.E.I.)                                     | Karen Shuster (Seven Oaks General Hospital, Winnipeg, MN.) |
| January 13/93<br>"Ethical Dilemmas and the O.R. Nurse"                                   | Patricia Rodney (University of British Columbia.)                                   | Jane Percy (Queen Elizabeth Hospital, Montreal, PQ.)       |
| February 3/93<br>"Hysteroscopic Procedures"  | Sally Lazaruk (St. Paul's Hospital, B.C.)   | Corina Balcom (Miramichi Hospital, Newcastle, N.B.)        |

To Book Contact: Phone: (416) 599-1234 Fax: (416) 598-1848

\* Must register three weeks prior to program. Time of Program 1:10 Eastern.

## ORNAC exhibits at Canadian Nurses Association Conference in Saint John, N.B.

Operating Room Nurses Association of Canada (ORNAC) was represented at the June '92 CNA annual convention in Saint John,

N.B. The booth was very popular and all participants showed great interest in the OR display which included videos, instruments, jour-

nals, posters, ORNAC Standards and Position Statements pamphlets. Perioperative nursing was well represented in this exhibit as the material focused on empathy and caring toward the surgical patient. The booth was prepared and coordinated by Sandra Betts with help from New Brunswick Operating Room Group. *Congratulations!*

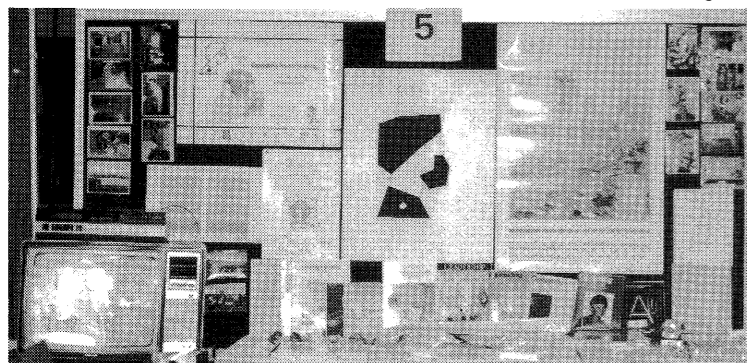
### Editorial Award

Mary Knight-Kubasiewicz is the 1991 winner of the "ORNAC - Johnson & Johnson Medical Products Drake-Thompson Writing Award". The winning article "Problem Solving in Perioperative Nursing" was published in May-June 1991 issue of the *Canadian Operating Room Nursing Journal*.

Mary is currently the Operating Room Manager at the Royal Alexandra Hospital in Edmonton. She also won the 1988 Award.

The Award will be presented in October in Red Deer at the Alberta Provincial OR Conference.

**Muriel G. Shewchuk**  
Awards Chairman  
ORNAC



N.B. ORNG Members (L-R) Past Presidents NBORNG: Sandra Betts, Elizabeth Thompson, Lynn McLaughlin, and President Corina Balcom.



## Canadian Operating Room Nurses Association of Canada Executive and Board of Directors 1992-1993

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