

Canadian  
**Operating Room** Nursing Journal

Volume 9, No. 2, May/June, 1991

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**BANFF '91**

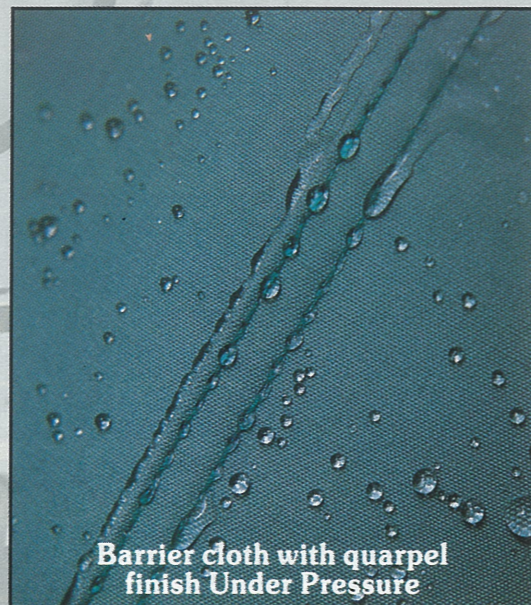
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# Canadian Operating Room Nursing Journal

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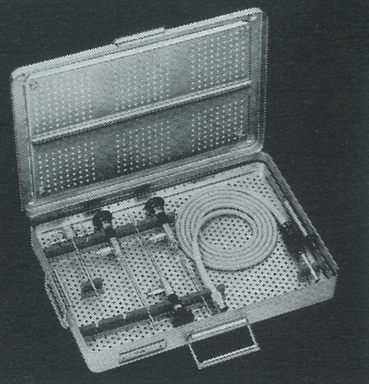
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## Behind Our Sterile Doors

By Gloria Stephens

The physical location of the Operating Room emphasises isolation. Furthermore, O.R. nurses have set up a multitude of barriers because of aseptic practices. Thus, of necessity, we have excluded other personnel from entering this 'sterile sanctum'. Consequently, we have suffered on two counts. Firstly, we may not be totally aware of what is happening in nursing generally, and secondly, we have not informed other nursing levels of the transition which has occurred in operating room nursing concepts.

It is evident to me that we must become more publicity conscious and recognize that communication is a two-way street.

How much do we know about our patients before and after surgery? We are in a position to know more about the preoperative needs of the patients and the effect of the surgical procedure, and also how the actual surgery will affect the patient post-operatively. And yet, we haven't taken adequate advantage of this factor to communicate to other nurses involved with the patient. To my knowledge, few, if any, nurses' notes are utilized to advise what has occurred to the patient while in the O.R. The anaesthesia record gives the scant information that the recovery room nurses receive.

Consider the course followed by the surgical patient: Pre-operative, Operative, Post-operative. The operation is the middle segment of the surgical treatment of the patient. Any way one looks at it, the O.R. nurse is a vital part of surgical nursing. It is the operating room nurse who fulfills the circle of "continuity of care"; who acts as the patient's advocate; and who maintains Standards of care.

We live in a society which increasingly leans toward specialization. The Registered Nurses' role in the Operating Room must be preserved and expanded. On this we agree, but this will only come about if nurses speak out and are willing to explore and broaden their horizons. Are we standing still, or moving forward with the times? We must take the step into the new decade, no longer having the excuse of "no time!"

Realistically, we should aim at new concepts of approaching our nursing care instead of abdicating functions, such as allowing the Respiriologist to assist the Anaesthetist, rather than the O.R. Nurse. Why do we allow these things to happen?

Hurdles which we possibly will encounter include: budget, time and cooperation of the surgeons/management. But first, we must convince our co-workers and other related services, through staff development and continuous education that a new approach is mandatory to the survival of the operating room nurse specialty.

We must think about our role in all facets of nursing, not exclusively, O.R. service. To be specific – if patients are to receive the care to which they are entitled, we must accept the fact that a new "breed" of nurse is required in the operating room. Are we prepared to meet these new challenges?

As for the student, he/she will receive O.R. experience if we account for the following statements to the satisfaction of the nursing educators:

1. Identify the unique aspects of O.R. Nursing.
2. Illustrate the need for a professional nurse in making judgements, in a supportive role, and in carrying out continuity of care.
3. Select learning experiences with relevant procedures demonstrated.
4. Emphasize quality learning experience rather than quantity.
5. Develop a nursing-care plan with examples.

To ensure our place in the ranks of the true professional, we all must think, question, evaluate and act.

Gloria Stephens is President of the Operating Room Nurses Association of Canada, and the Clinical Instructor, St. Paul's Hospital, Vancouver, B.C.



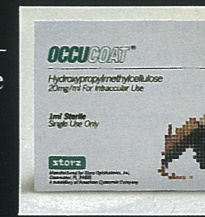
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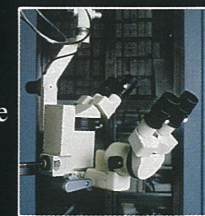
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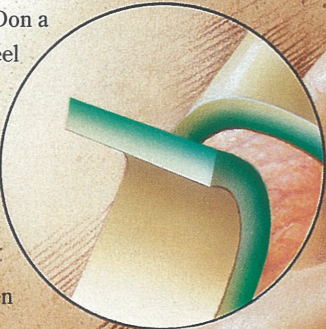
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## Perioperative Nursing Rounds : Bladder Neck Suspension

By Wendy Lawson, R.N. and Fran Irving, R.N.

The goal of this article is to share experience and knowledge as it was researched for Perioperative Nursing rounds at our hospital.

There are many names for this procedure. Bladder Neck Suspension, Endoscopic Suspension of the Vesicle Neck, Suburethral Sling, Needle Suspension of the Urethra, and quite probably more than this. Information on a subject such as this is scarce, therefore it is important for us to share what knowledge we have with each other in our specialty.

The indications for this procedure are, 1) Genuine stress incontinence, 2) cases where previous surgery has failed, 3) obese patients with incontinence, 4) urethral erosion due to long term urethral catheterization and neurological disease. This procedure is also only performed on women.

As Figure 1 indicates, the urinary system lies behind and below the peritoneum that surrounds the organs in the abdominal cavity. The lower urinary tract consists of the bladder, the urethra and the internal and external sphincters of the urethra. The bladder is located behind the symphysis pubis. It is a hollow sac composed of the detrusor muscle which consists of three (3) interwoven muscular layers, that stretches to allow the bladder to hold urine, and a triangular shaped muscle called the trigone. The trigone is found at the base of the bladder and during urination keeps the ureteral orifices closed and opens the bladder outlet. The base of the bladder is the only fixed portion, which allows the bladder to stretch a great deal. The normal bladder of a continent adult holds between 300-500 mls. but is capable of stretching to hold over 1000 mls. After 600 mls. has collected it is difficult to contain in the bladder as the intravesicular pressure becomes greater than the intraurethral pressure. These pressures must be equal if continence is to be maintained.

The act of voiding involves the co-ordination of several complex mechanisms of the body: (1) the

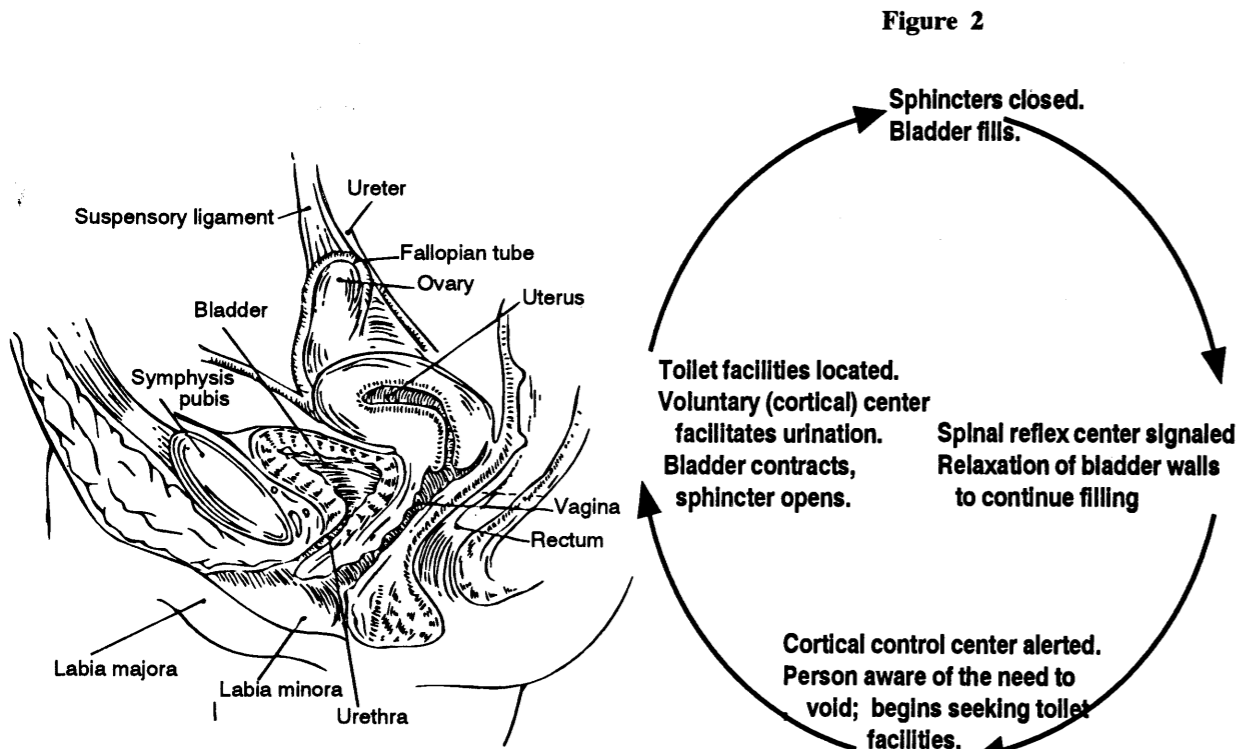
lower urinary tract, (2) the spinal cord, and (3) the frontal lobe of the cerebral cortex which is the centre for conscious control of urination.

The bladder fills and the sphincters close. The spinal reflex centre is signalled to relax the detrusor muscles to allow the bladder to continue to fill. The cortical centre is triggered and the person becomes aware of the need to void and begins to look for a bathroom. When appropriate facilities are found, the cortical centre then helps urination by causing the bladder to contract and the sphincters to open. A defect or interruption in any phase of this cycle can lead to incontinence.

Incontinence is one of the most humiliating and degrading experiences one can have. Because of the shame and humiliation it causes, people voluntarily withdraw from society and any social experiences. They wish to avoid the embarrassment of the smell and shame of soiled clothing and furniture. Incontinence is not just a disruption of function experienced by the elderly. Even teenagers have been afflicted with incontinence. Until recently little has been done regarding research, interest or attention for incontinent members of our society.

Our discussion will concentrate on stress incontinence. Men are rarely affected with stress incontinence, because of their longer urethra. A long tube has greater resistance than a short one therefore it is easier to maintain equal intravesicular pressure and intraurethral pressure in men. It is also rarely seen among women who have had no children. The incidence is increased with obesity and abdominal masses, and may accelerate after menopause.

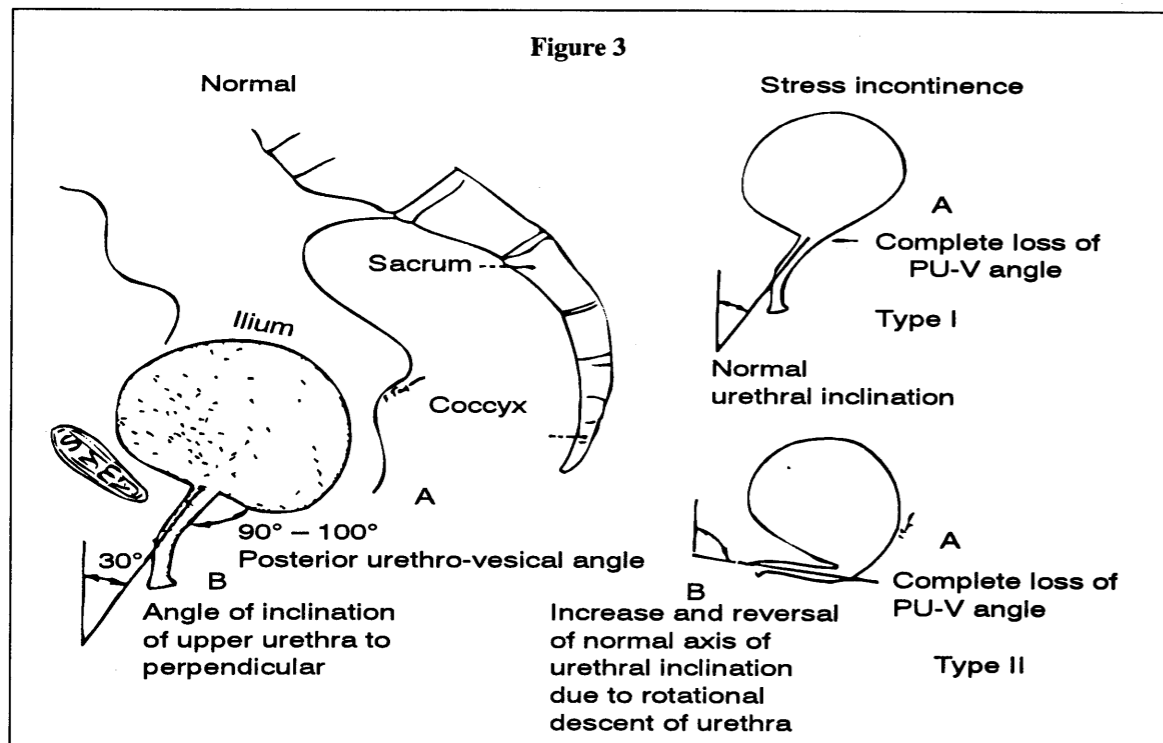
There are many other causes of incontinence that will affect the bladder and necessitate this procedure such as: (1) bladder neck and pelvic muscle weakness due to trauma, childbirth, or vaginal surgery, (2) urinary tract infections, and vaginitis.



Gruendemann, B.J. Meeker, M.H. (1983) *Alexander's Care for the Patient in Surgery*, Eighth edition. C.V. Mosby Co.: Saint Louis, Miss.

Palmer, M.H. (1985) *Urinary Incontinence*. Slack Inc.: New Jersey.

**1-4. Cycle of micturition.**



Palmer, M.H. (1985) *Urinary Incontinence*. Slack

Figure 4

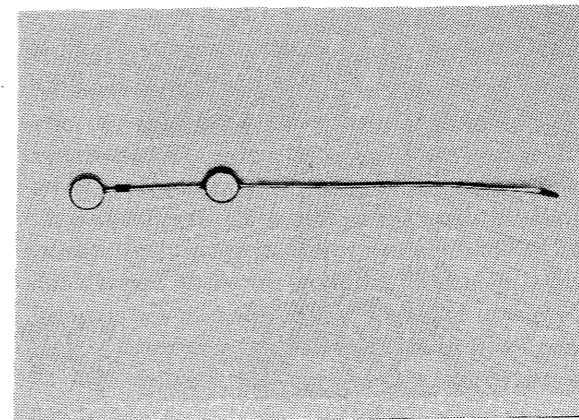


Photo: Courtesy of St. Boniface General Hospital Photography Department.

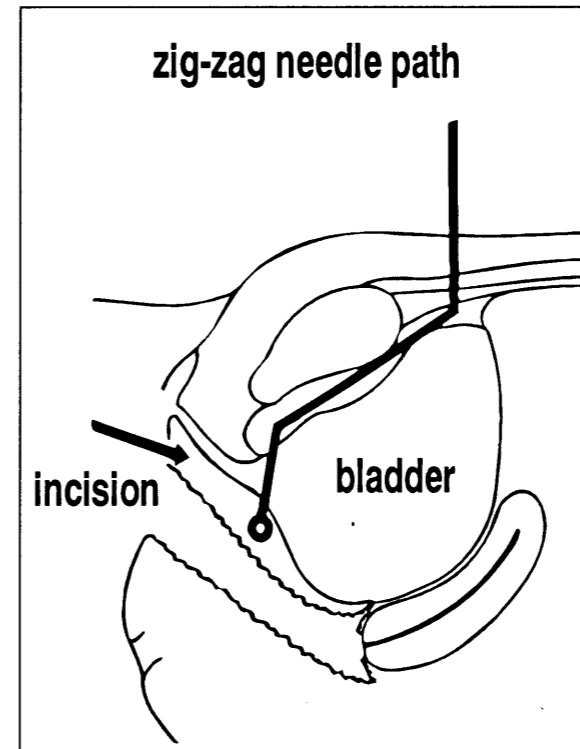
The onset of stress incontinence is gradual and the signs and symptoms are 1) a feeling of heaviness in the pelvis, 2) complaints that everything feels that is "falling out of the vagina" when standing, 3) backache, 4) the symptoms are worse at the end of the day, 5) a weakening of the bladder and urethral support, e.g. cystocele, 6) loss of urine when abdominal pressure is increased, for example when one coughs, laughs, or sneezes. When there is loss of tone in the muscles in the pelvis, the bladder falls below the pelvic floor and the muscles are unable to provide counter pressure when abdominal pressure is suddenly increased.

In the continent person, the posterior urethro-vesicle angle of the bladder is between 90 and 100 degrees. When this angle is lost, incontinence occurs. There is type I and type II stress incontinence. The posterior vesicular angle is close to 180 degrees. During surgery the urethral vesicle junction is found by inserting a foley catheter and blowing up the balloon. The junction is found where the balloon can be palpated via the vagina.

The assessment of stress incontinence is made by a thorough physical exam, urinalysis, residual urines and cystometrograms. Cystoscopy and I.V.P. should be done if any other abnormality is suspected.

Once a correct diagnosis has been established and the decision to correct the condition by surgery has been made arrangements are made by the surgeon.

Figure 5



Brochure from: R. Laborie Surgical Ltd. c/o Fermcare Ltd.

**Preoperative Events**

The patient is admitted the day before surgery. This patient has already been through an extensive workup and genuine stress incontinence is the diagnosis. The average hospital stay is two-three days. Preop antibiotics, usually Ancef, are given. Antibiotics are also given 24 hours post-operatively as a prophylactic. No vaginal prep is needed preop.

**The Procedure**

The procedure itself is a simple one for all involved, ie: patient, surgeon and the perioperative nurse. Anesthesia is by general or spinal. The patient is placed in lithotomy position and prepped. Full draping is then applied.

The surgeon first inserts a #16Fr. foley catheter. The balloon is inflated and the catheter is plugged. Two small suprapubic incisions are then made. These are approximately two (2) cms. long and are two (2) finger widths above the symphysis pubis and two (2) finger widths lateral to the midline.

The urethrovesical junction is then located by vagi-

nal palpation of the balloon of the catheter. The Nottingham needle (see photoFigure 4.) is then passed blindly from the suprapubic incisions through the rectus fascia and retropubic space, positioned next to the urethrovaginal junction and brought out through the vagina.

The foley is removed and a cystoscopy is done. Indentation of the bladder neck can be seen with movement of the needle. This verifies correct placement. The foley is then replaced and plugged. #2 Nylon is threaded through the Nottingham needle and pulled from the vagina to the suprapubic incision and tagged with a halstead. The posterior end of the Nylon is then loaded to an eyed needle and sutured onto the vaginal wall. The free needle is then removed.

The Nottingham needle is again passed through the same suprapubic incision (approximately 1-2 cm away) and the posterior Nylon tail is threaded and pulled through the suprapubic incision. The foley is removed and proper placement is again checked. If the suture is in the bladder, the suture is removed and reinserted.

The identical procedure is done on the other side. Prior to tying the sutures, a cystoscopy is done. While looking at the bladder neck, the assistant will lift on the sutures and the repair can be visualized. The surgeon can actually test his sutures by filling the bladder, removing the cystoscope and pressing on the bladder while lifting on the sutures.

The sutures do not encircle the bladder neck but elevate the bladder neck by traction on adjacent fascia.

The skin is then closed with 1/2" steristrips. The foley is left in postoperatively.

There are small variations to the procedure according to doctor's preferences. Such as when and how many cystoscopies are done. They can be performed after each threading of the suture or it can be done after both sutures are placed. The final result is the same. If the suture is in the bladder, it is removed and reinserted.

Variations were also found in articles, where some surgeons were incising the anterior vaginal wall and dissecting it from the urethra to the bladder base. The method I've explained is passage of the needle through vaginal punctures.

Some surgeons, instead of suturing the Nylon to the vaginal wall, thread a dacron patch or tube onto the Nylon. This is to avoid the possibility of the suture cutting through the tissues after it has been tied.

There are many advantages to endoscopic bladder neck suspension:

1. Blood loss and morbidity are less because an open operation is avoided.

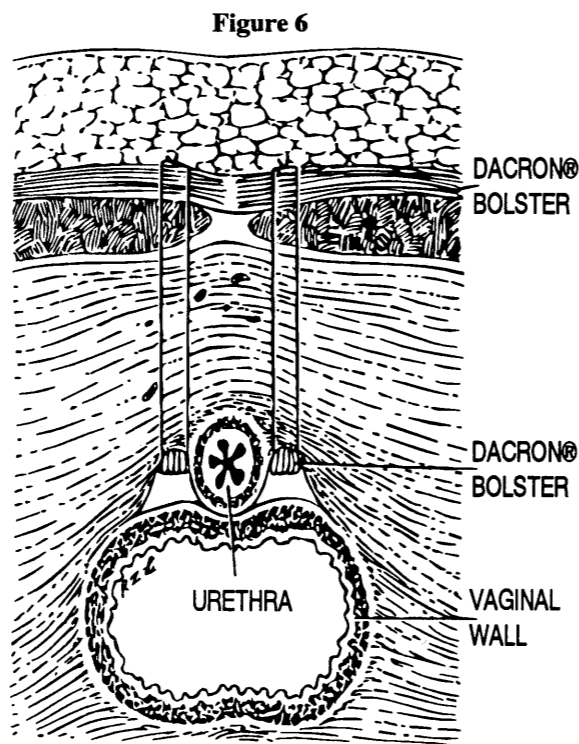


Figure 6  
Cross section of the bladder neck after placement and tying of suspending sutures. Note that the sutures do not encircle the urethra, but elevate the bladder neck by traction on adjacent fascia.

Fowler, J.E. Crowley, J.L. (April '87) Stress urinary incontinence. Endoscopic suspension of vesical neck. *Association of Operating Room Nurses' Journal, AORN* 45, 4.

2. Obesity and/or previous pelvic trauma (including operations) are not contraindications for this procedure.
3. Exact identification of the bladder neck intraoperatively is possible for accurate suture placement.
4. With manual elevation of sutures, the surgeon can determine if incontinence is prevented.

There are some complications but most of these can be fixed:

1. Retention: caused because the sutures are too tight. The worst that can happen then is a return to surgery to have one suture cut - this relieves the retention of urine but maintains continence.
2. Post op infection.

## Postoperative Events

The foley catheter will be removed one day postop. Suprapubic catheters are rarely put in. It's rare for the women to be able to urinate immediately postop. Almost all experience retention and need to be intermittently catheterized. If unable to void on their own after two to three days, self-catheterization is taught and the patient can be discharged. Many women can go up to several months before voiding on their own.

It is understandable that the patient would have concerns re: body image ie: lack of control of voiding, but don't forget, these are women with genuine stress incontinence who are dribbly, who have to worry if they're going to sneeze or laugh. Most don't mind having to catheterize themselves if the long range goal and result will be urinary continence.

## Authors

Wendy Lawson, R.N., is a perioperative nurse at St. Boniface General Hospital, Winnipeg, MB.. She is a St. Boniface General Hospital graduate with varied nursing experiences ranging from ward nursing on the urology unit to perioperative nursing in Hawaii.

Fran Irving, R.N., is also a perioperative nurse at St. Boniface General Hospital. She is a St. Boniface graduate with 28 years of nursing experience. Her practice has involved emergency nursing, V.O.N., day surgery, teaching and perioperative nursing.

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# Problem Solving in Perioperative Nursing

By Mary Knight Kubasiewicz, R.N., M.N.

Problem-solving, which incorporates the decision-making process, is an integral component of all aspects of perioperative nursing practice. The scrub nurse planning how to drape a challenging plastics procedure, the educator developing an orientation program, the administrator choosing surgical equipment and the nurse identifying a clinically-based problem to research will all use problem-solving and decision-making in their deliberations.

Awareness of both the problems and the processes used to resolve them vary with the individual's experience and knowledge, the situation, and the frequency with which the individual is accustomed to making decisions and solving problems.

**Problem** - A doubtful or difficult question or task (Sykes, 1982)

**Problem Solving** - The process by which we search for a correct solution to a problem

**Decision Making** - Choosing among a number of possible alternatives, which may involve making trade-offs among the values given to the different alternatives (Baumann & Deber, 1989).

The simplistic definition of decision-making may be misleading; the process is actually a sequence of events in which a problem is identified, alternatives are generated, the environment is evaluated, values are considered and the decision is implemented.

## The Role of Values in Decision-Making

Values have been described as the basis for all decisions, as they underlie all actions and decisions. What you consider important and relevant is determined by your values, and what is considered important and relevant influences what you observe,

as well as how it is observed (Ford, Trygstad-Durland & Nelms, 1979). So not only do values colour observations, they also determine what is observed. Values therefore influence one's concept of reality.

Values change throughout your lifespan. They are learned through observation of others and through personal experience within a social context. This context varies with new friends, new jobs, education and personal experiences such as illness.

The importance of values in decision-making is that you are aware of the values on which you base your decisions. Making a decision unaware of underlying values is comparable being uninformed, and you risk that your decision may not be consistent with your values. Have you ever asked yourself "Why am I doing this?" Chances are your decision was inconsistent with your values, or you were unaware of how the decision and resulting activity were related to your values (Ford, Trygstad-Durland & Nelms, 1979).

## Applying Values

1. Identification
2. Clarification
3. Priority-setting

There are three activities when values are applied within the decision-making process. The first is to identify your values, which is a very personal exercise. Factors to be considered include your culture and ethnic group, when you were born, geographical location, family values, economic status, religion, occupation, education, life goals, etc.

The second activity is to clarify your values - think about what the statements you identified as

your values really mean to you. For example, do your religious beliefs mean that you will have difficulty working with certain groups of patients? Or is your professional commitment to the provision of safe patient care more important than staying within the overtime budget, justifying your decision to call in that extra nurse?

The last activity is to assign priorities to your values. This is done in the context of each decision - on some days, it may be volunteering to continue with patient care rather than being relieved to go home, which is something we all value!

## Decision-Making Processes

Lancaster and Lancaster (1982) describe two decision-making processes: the normative view and the descriptive view. The normative decision-making model was developed by philosopher Adam Smith, and was based on two assumptions:

1. That the objective of all decisions is to maximize satisfaction; and,
2. That in any situation calling for a decision, all possible choices and the consequences and potential outcome of each are known.

The decision-maker in this model must have complete knowledge of the topic, so that all possible choices, consequences and outcomes can be considered. This requirement for complete information is the major limitation of this process - a seemingly impossible situation.

The descriptive decision-making model, developed by Herbert Simon, assumes that decision-makers are rational people who make decisions on the basis of incomplete information. They are "satisfiers" who tend to look for an acceptable solution, rather than "optimizers" who seek the best possible solution. The descriptive decision making process recognizes that it is not always possible to try to secure complete information due to limitations of time, money or people. Rather, the decision-maker is a person who logically solves problems on the basis of known or easily retrievable information (Lancaster & Lancaster, 1982).

Given the complexities of perioperative nursing, and the constraints of time and resources which often operate in a given situation, the descriptive decision-making model has definite appeal and utility. As the five steps in this process are reviewed, remember that the process is not rigid, nor necessarily sequential.

## Descriptive Model 5 stages

- a) Recognizing the problem
- b) Gathering and processing information
- c) Evaluating alternatives
- d) Deciding, selecting or choosing
- e) Implementing: Post-decision activities

### a) Recognizing the problem

Although it seems simplistic to say so, before a decision can be made, the problem has to be identified. This can be a complex activity because it involves people's perceptions of a situation, which will often differ, and because people's viewpoints are based on their values, as previously mentioned. It is helpful to state the problem as objectively and clearly as possible.

When assessing a problem, it is important to decide the priority level for the problem, and to evaluate its potential for being solved. Joseph Reitz (in Lancaster & Lancaster, 1982) suggested three ways of choosing priorities:

1. Problems are addressed in the order in which they occur;
2. Problems that can be dealt with immediately are given priority over more complex, time-consuming ones; and,
3. Crisis or emergency problems are given priority over all others.

### b) Gathering and Processing Information

In the second stage of problem-solving, the decision-maker performs two separate activities: gathering information about the situation and identifying alternatives. The search for information can be detailed and prolonged, or quick and to the point. However, there are usually two aspects of any search for information - an internal as well as an external component (Lancaster & Lancaster 1982).

The internal search involves examining your own memory for information such as prior experience, knowledge, policies or references you have read or used in the past. The external search involves using others experience and knowledge, using resources and references such as standards or articles, or hiring a consultant. An external search for information can be extensive, and could incorporate surveying other OR's to determine their practices, or

having a computer search performed.

The search for information is affected by:

1. The perceived value and cost of the search - is the problem worth the time required to have a complete search performed?
2. The capabilities of the individual conducting the search - will an extensive search frustrate or assist the decision-maker?
3. Variables related to the specific situation, such as the urgency and type of problem, or the availability of information.

Throughout this stage, the decision-maker processes the available information to identify possible alternatives. This occurs as the information is being gathered - as you read something or talk to someone, an idea may occur - "what if we tried this?". It is important to jot down these ideas or thoughts as they occur for use during the next stage.

#### c) Evaluating Alternatives

The third stage of decision-making is to evaluate all possible alternatives to the situation, including the consequences of each. A simple yet effective way to do this is to list all possible outcomes of each alternative, determine whether each will have a positive or negative effect, and assign a value to each outcome.

The use of three major criteria has been suggested for analyzing alternative solutions to problems: desirability, probability and personal risk taking (Ford et al, 1979). It is important to remember that each of these criteria will assume different weights, dependent on the problem or situation.

**Desirability** is a measure of the individual's preference for a given alternative. Desirability is influenced by many factors, including the situation itself, constraints such as time, resources or policies, and the individual's values, knowledge, skills or past experiences.

**Probability** is the likelihood that the alternative will be successfully implemented and will solve the problem. The individual must subjectively rate each alternative according to these two factors - can it be implemented, and will it solve the problem.

**Personal risk taking** involves evaluating the hazards of a selected alternative in relation to the benefits of that alternative for the individual. There are three aspects to personal risk taking: physical, emotional and social risk.

Evaluating physical risk includes the consideration of any threats to body integrity for either yourself or your patient. In today's environment, it is important to consider whether any alternative has the potential to cause harm through the introduction of toxic substances. In addition, some nurses consider the impact of a product on the environment as a very important aspect of any evaluation.

Emotional risk results from a threat to one's psychological being or self-concept. If an alternative threatens or will change your self-concept, then emotional risk is a factor which needs to be recognized and evaluated.

Social risk includes threats to your role in society. For a perioperative nurse, this could include relationships with patients, co-workers, superiors, subordinates or physicians. If an alternative will change relationships with others, the social risk could be perceived as being too great for the benefit received.

Values play an important part in the evaluation of alternatives. If a nurse with a strong commitment to upholding perioperative nursing standards is faced with an alternative which will improve standards but will be unpopular with co-workers, the consideration of social risk will better enable the nurse to establish priorities.

#### d) Deciding, Selecting or Choosing

The selection of a solution depends on factors such as the number of alternatives available, the quality of those alternatives, and the desirability, probability and risks involved. In many situations, there may be only one logical solution, given the available time, resources and environment.

The selection becomes difficult when there is not one alternative which stands heads and shoulders above all others. Then the ground work done when evaluating the alternatives becomes invaluable and the choice can be based on the consideration of the all factors just discussed.

#### e) Implementing: Post-Decision Activities

Obviously, when a decision has been made, the work is often just beginning. In this final phase of the decision-making process, the decision-maker will use knowledge and skills to implement the solution. The effective use of change theory and communication skills in this process will often be critical factors in its success (Kubasiewicz, 1987). Other post-decision activities which must be developed include monitoring and evaluation.

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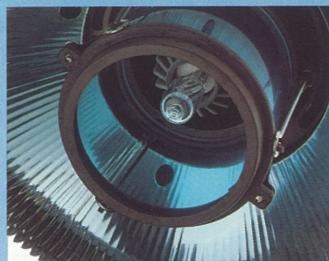
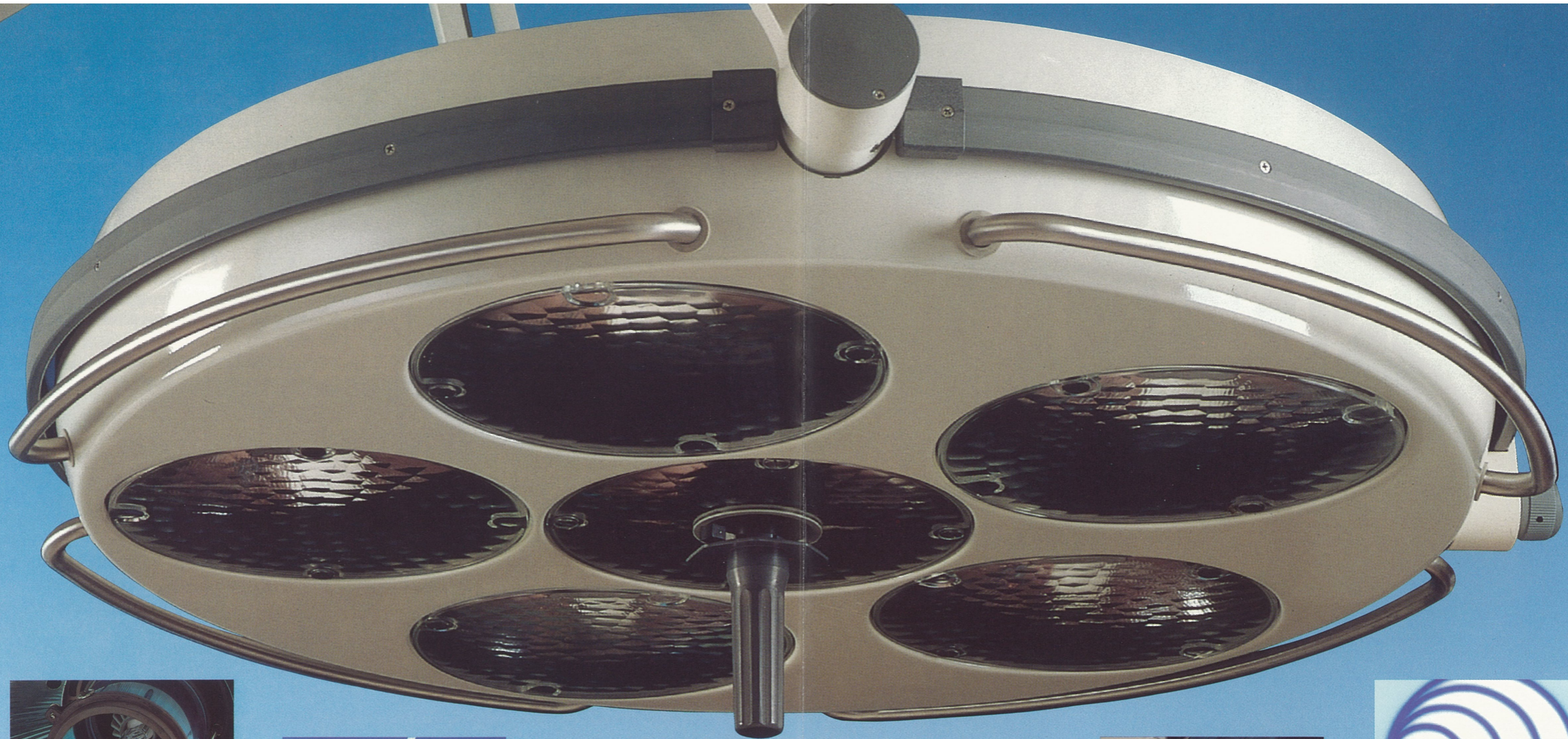
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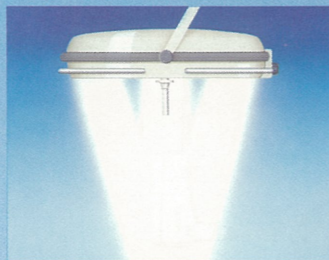




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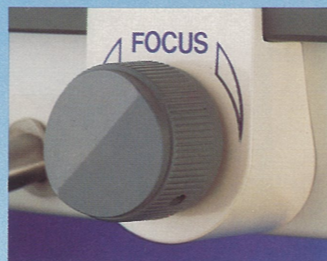
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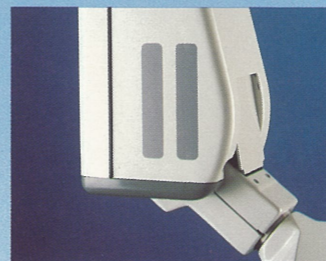
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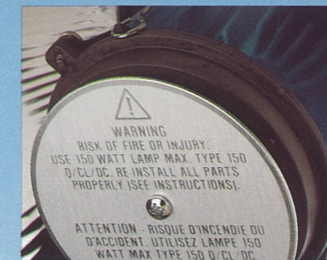


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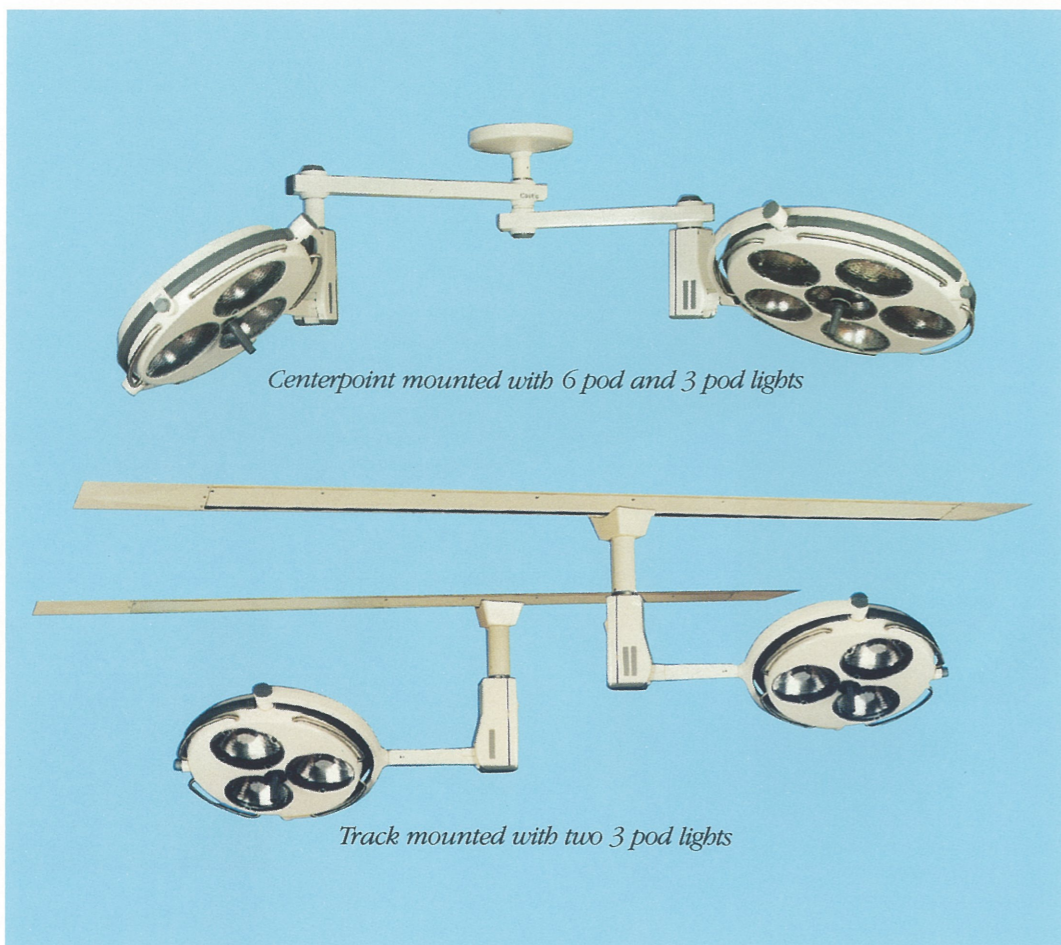
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## Novice and Expert Nurses The Role of Peer Consultation

Sound decision-making skills involve an integration of knowledge of highly sophisticated technological equipment and a thorough understanding of the complex patient problems that are present (Baumann & Bourbonnais, 1983). In a study which compared the planning by expert and novice nurses in drug administration cases of varying complexity, it was found that experts generated more alternative actions, were more specific in evaluating alternative actions, and developed better plans than did novices (Corcoran, 1986).

Experienced nurses are often able to spread their search very quickly over a wide range of possibilities, activating, accepting or rejecting a complex series of related diagnostic categories, indicating a highly complex system of relationships between cues and categories held in their nursing knowledge base. Novice nurses are often unable to bring to consideration such a wide variety of factors. As stated by Prescott, Dennis and Jacox (1987), "The experienced nurses not only knew more about problems and related alternative courses of action than did the inexperienced nurses, but they also possessed more savvy about how to give input".

The major implication of this information is that we must continue to use our expert perioperative nurses to nurture the novices. Novice nurses have no experience with the situations in which they are expected to make decisions. Exposure to the clinical area is essential - there seems to be no other way of obtaining this experience other than actually being there and working with others more experienced in the field (Baumann & Bourbonnais, 1983). The "buddy systems" and preceptor programs found in most OR orientation programs provide this invaluable experience for the novice nurse.

Out of this arises the concept of peer consultation - discussing a particular situation with nursing colleagues to gain their perspectives and experiences. This does not only refer to fellow perioperative nurses, but nurses on other units. In today's rapidly changing, technologically advanced environment, no one person can be an expert in all things. Taking the plunge and asking a nursing colleague for assistance in problem-solving, and making yourself available for return consultations, can only enhance patient care. Don't forget to use your networks - call up the nurses you met at the last OR conference you attended, or a nurse with whom you may have attended a course.

## Research Utilization

The utilization of research in nursing practice refers in general to the product or findings of research. It is a specific use of knowledge which has been proven through the research process, and provides a wealth of information to use throughout the problem solving process. Hunt (1981) outlined five reasons why nurses do not utilize research:

### Why Nurses Do Not Use Research Findings

1. They do not know about them
  2. They do not understand them
  3. They do not believe them
  4. They do not know how to
  5. They are not allowed to
- (Hunt, 1981)

### 1. They do not know about them.

The results of research are not always readily available, because many researchers do not publish their findings, and most theses and dissertations are only found in the library of the university where the research was conducted.

### 2. They do not understand them.

When researchers do publish their findings, they are often written in a style and language which is very difficult to decipher. These reports may be directed towards other researchers, who understand all the terms and concepts. The Schantz and Lindeman article (1982) on how to read research provides an excellent introduction to the research writing style.

### 3. They do not believe them.

One important research activity is to test the assumptions on which we base our practice. Some familiar examples of this could be the length of time for our surgical scrub or the effectiveness of drapes at preventing strike-through. However, it is difficult to change established practice even in the light of factual evidence as shown by the research done by Cruse & Foord (1973) about the preoperative removal of hair, and how long it has taken to adjust practice.

### 4. They do not know how to.

Although this is related to the second reason, the

significant consideration here is that although nurses may understand the research report, they may not identify its significance for their nursing practice. They may wonder whether practice should be changed based on the findings of one research study, or what to do about areas of perioperative nursing such as with preoperative educational interventions in which there are whole fields of research being explored. Good et al (1987) have provided a guide which assists in using research-based knowledge in clinical practice. To promote the utilization of research, there needs to be closer collaboration between researchers and nurses delivering the care, so that research may be driven by the needs of nursing practice.

### 5. They are not allowed to.

The utilization of research findings may be impeded if change is required to the status quo, especially if policies and procedures are involved. Therefore, it is vital that nurse leaders and educators set the climate, and support and promote the utilization of research findings in all aspects of nursing practice.

Marram van Servellen and Stetler (1986) suggest that there are three important steps which must be conducted prior to the implementation of any findings:

1. Validation - a critique must be done of the research to determine whether or not the research design has scientific merit.
2. Comparative evaluation - what is the feasibility and desirability of implementing the findings? Does it "fit" the particular needs of your OR?
3. Decision-making - What type of utilization will there be, if any? Will the information be tucked away for future reference, or will the findings be implemented into your practice?

### Standards

Standards guide nursing practice and provide for quality patient care (O.R.N.A.C., 1986). They also provide a benchmark against which we can measure or evaluate nursing practice. As professionals, nurses are required to maintain certain levels of competence to ensure the public of safe nursing care.

Standards (O.R.N.A.C., 1986, 1988) play a very important role in perioperative problem-solving.

They are a source of valuable information which can be referenced when a problem arises, and can in themselves generate a problem situation - what do you do when you become aware that your practice does not measure up to an accepted standard?

### A Model for Problem-Solving in Perioperative Nursing

In an attempt to pull together the topic of problem-solving in perioperative nursing, a model (see Figure 1) has been developed which identifies two routes into the problem-solving process: either through knowledge, or through a specific situation.

The knowledge driven side of the model is perhaps the less familiar. What happens when you become aware of information, whether it be research findings, recently published standards, or current practice in another institution? We should pause to compare the information with present practice, and determine whether that practice is appropriate. If the practice is appropriate, that is the time to give yourself a pat on the back. If it is not appropriate, you must determine whether or not it is feasible to change. Sometimes you may deliberately decide the time or environment is not conducive to change and decide not to take action. Using change theory (Kubasiewicz, 1987) will assist with this process.

The situation driven side of the model is perhaps what people have in mind when they use the phrase problem-solving. A problem is identified, information is gathered, and there is a "statement of findings" which assists in deciding whether or not a problem exists.

The paths of the two sides of the model merge with the assessment of the feasibility of change. If you decide to take action, then follow the decision-making process discussed earlier. The semicircular arrow on the right integrates the concept of feedback and evaluation into the model.

### Summary

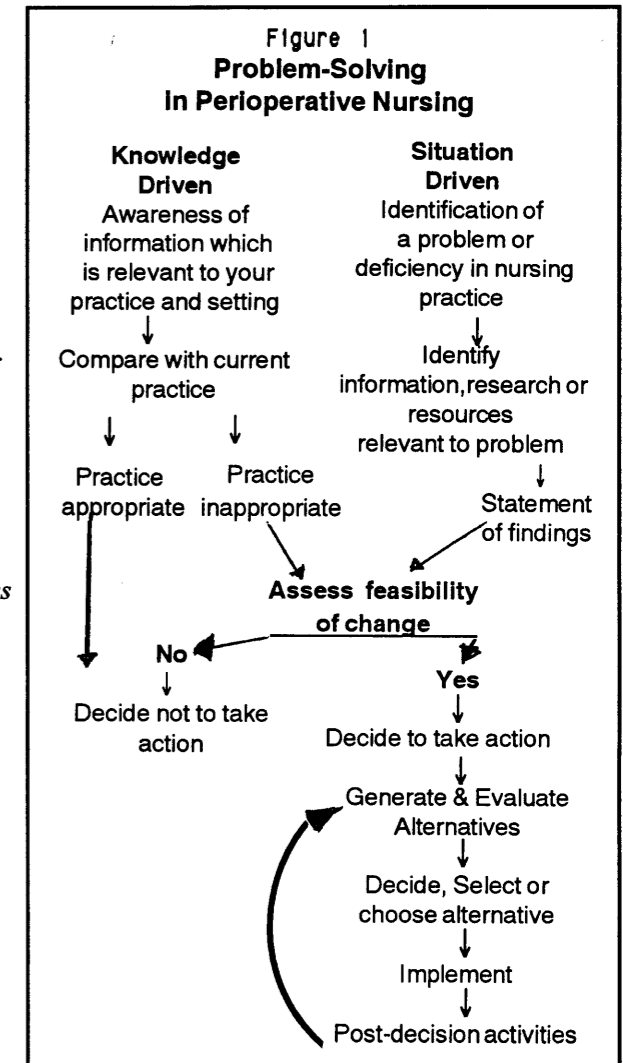
This article has discussed aspects of problem-solving in perioperative nursing. Once a problem has been identified, a decision-making process is used to resolve the situation. The differences in decision-making abilities in novice and expert nurses were discussed, and the value of peer consultation introduced. Research utilization and practice standards were presented both as a means of identifying problems and as a source of alternative solutions to

a problem. Finally, a model was developed which provides a framework identifying two sources of problems in perioperative nursing - those that are knowledge driven, and those that are situation driven. (See Figure 1).

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# How to be an Expert Witness

By L.E. & F.A. Rozovsky

With the increasing amount of litigation in our society, the operating room nurse is bound to become involved in the judicial system. The nurse will become involved in two ways. The first is as a witness for the purpose of advising the court what was seen and what was done. The second is as an outside expert to give the court professional advice.

## What does an Expert Witness do ?

The difference between the ordinary witness and the expert witness is that the ordinary witness simply reports in response to questions by lawyers on the facts. The expert is a professional advisor who presents not facts, but opinions. The expert is from outside and may not be aware of the facts first hand.

Lawyers are becoming increasingly aware of the value of the expert nursing witness and are looking for nurses who can fulfill this role.

The expert is primarily retained as a consultant to advise either counsel for the plaintiff or counsel for the defendant. This may result in meetings with counsel and the drafting of a report. The most common use of the expert nursing witness is to comment on whether appropriate nursing care was performed. On this basis, the court determines whether the defendant was negligent or not. The question is whether the defendant lived up to reasonable nursing standards. The expert is first asked to determine what the reasonable standards are in the circumstances, and secondly whether the defendant met those standards.

Frequently more than one expert is retained. Each side will have their own experts. The views expressed by those experts may differ. The difference may be due to differing assumptions upon which those opinions were based, or the opinions being matters of judgment are simply different. The court is then forced to choose which view will be applied to the case before it. The fact that the court does not accept the views of one expert does not mean that the expert is not competent.

Experts is not retained because of their expertise in performing their professional tasks. They are retained because they are experts in having knowledge about the opinions which they are asked to express.

On being contacted by a lawyer for an expert opinion, the first thing to remember is that the relationship must be completely professional. The relationship

should be set out in a letter. The letter must make clear a number of factors. The first is that the duties of the expert are to be outlined. Is a written report required? Will there be meetings with the lawyer? Will travel be required? Will the expert be involved in discovery proceedings, and possibly a trial? How much advance notice of any proceedings will be given so that the expert can schedule the time ?

The letter must also explicitly outline the fees to be paid. If they do not, the expert should put these fees in writing and require a written acknowledgement before any work is commenced. The fees should be for the preparation of a report or opinion, meetings, appearances at discovery proceedings, appearances at court, and fees for any canceled court appearances for which the expert has prepared. Out of town fees should also be noted. Because of the uncertainty as to how much time will be involved, since there is always the possibility that the matter is settled out of court, the fees should be on a per diem basis rather than on a flat all-inclusive basis. Provision should also be made for any expenses incurred.

Detailed instructions should be sought with respect to the preparation. What are the questions which should be examined? Who can the expert consult ?

If another lawyer or some other person contacts the expert and wishes to discuss the case, no discussion should be had until the expert contacts the lawyer who retained the expert.

The agreement between the expert and the lawyer should state very clearly that it is the lawyer who is hiring the expert and will be responsible for all fees and expenses. It should also state that the experts account will be due when it is billed. The reasons for these precautions are that the lawyer may not want to use his or her own funds and may have difficulty getting paid by the client. A well-run law office usually does not hire experts therefore, until the client has put money in trust for the payment of such expenses.

## The Expert on Trial

To a certain extent the expert is on trial. Since the expert is retained to promote the client's case, the lawyer for the opposing party will do everything to oppose the expert's opinion. There may be an attempt to show that the expert is not very knowledgeable or

experienced in the subject upon which an opinion is being given. Counsel will try to get the expert to make contradictory statement, and to appear as lacking confidence. In order to be an effective expert a number of rules should be observed.

- (1) Obtain and follow instructions from legal counsel, but do not agree to express an opinion which you do not in fact hold.
- (2) Do not over-rehearse your testimony, otherwise it will not sound genuine.
- (3) Be very careful not to make errors in giving testimony either during discovery proceedings nor at the trial, since even minor errors may damage your credibility.
- (4) Do not contradict yourself either within testimony or with anything that you have written or said before unless you are able to explain why you are now giving a different opinion.
- (5) Do not promote the position of the party for whom you are testifying, since it will reduce your credibility as an independent professional.
- (6) Do not appear to be unhappy about being called upon to be in court.
- (7) Do not be hostile, arrogant, flippant, condescending, argumentative, rude or emotional.
- (8) Do not fidget, look about or yawn
- (9) Do not speak in too much technical language, unless you define the terms and phrases you are using.
- (10) Be confident.
- (11) Answer the questions in a straightforward manner by answering the questions that were asked, and only those questions.
- (12) If you do not understand the question or if it cannot be answered in the manner in which it was phrased, do not hesitate to ask the judge for assistance.
- (13) Do not assume that the court is in possession of certain facts.
- (14) Speak slowly, clearly and loudly
- (15) Dress as a professional advisor, which you are.
- (16) Address a male Supreme Court judge as "My Lord" and a female Supreme Court Judge as "M'am". Judges of lower rank such as provincial court and family court judges should be addressed as "Your Honour".
- (17) Do not try to argue the case, since that is the lawyer's job, not the expert's.

Lorne E. Rozovsky, Q.C. is a Halifax lawyer with the firm of Patterson Kitz and adjunct associate professor of law and medicine at Dalhousie University. Fay A. Rozovsky, J.D., M.P.H. is president of LEFAR Health Associates, Inc., a health management consulting firm, and a visiting lecturer in health law at the Harvard School of Public Health.

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### Welcome

The Banff Springs Hotel and surrounding area will provide a perfect setting to share ideas, broaden your education, renew old friendships and begin new ones. From "Mountains to Climb" in Jasper 1984 to "Moving Mountains" in Banff 1991, we signify the changing, ever growing role of the Operating Room Nurse. Reaching one summit inspires us to climb onward and upward to reach another!

Not often does one have the opportunity to meet the challenge of "Moving Mountains, Mastering Skills and Maturing Professionally" and be in a picturesque setting as beautiful as Banff.

A dedicated committee has organized an unforgettable week of experiences for you.

Jackie Waisman, Red Deer, Alberta,  
Conference Chairman - Banff'91

### Social Events

Sunday, May 12

Pemican Firewater Pow Wow (Cocktail Party)

Monday, May 13

Enjoy "Alberta Hospitality" at its best and attend an evening of chowin' down and dancin' at the Country and Western night. Bring a warm Western outfit and prepare for an evening under Alberta skies. Cost included in registration fee, cash bar, transportation from Banff Springs Hotel provided.

Tuesday, May 14

A Nurses Convention Dream - "FREE TIME". The choice of activities is yours from 1300 on so you can enjoy the beauty of Banff. Enjoy skiing and golfing hiking, horseback riding, a visit to the Hot Springs, a ride on the Gondola, or shopping!

Wednesday, May 15

Join your friends at the "Great Canadian Buffet and Dance" at the Banff Springs Hotel from 1800 to 0100. Casual dress. Cost extra.

Thursday, May 16

All delegates are invited to Ethicon Night Enjoy the hospitality of the Johnson & Johnson Companies and be prepared for a wonderful evening. Semi-formal.

### Program

The Alberta O.R.N.A.C. Conference Planning Committee has chosen the theme: "Moving Mountains - Mastering Skills and Maturing Professionally". Using this theme, a program has been developed to enhance the professional growth of nurses. The topics and speakers listed here are subject to change.

### Monday, May 13 Opening Ceremonies

Key Note Speaker: **Ginette Roger, R.N., M.N., Ph.D.** Student, Past Director CNA - Keynote address title - "Moving Mountains, Mastering Skills, Maturing Professionally".

### O.R.N.A.C. Meeting

"Your Organization Moving Mountains"

President: **Gloria Stephens**

and O.R.N.A.C. Executive Member.

### "Malignant Hyperthermia"

**Dr. Richard Bergstrom, Anaesthetist,**  
Royal Alexandra Hospital, Edmonton.

### "Surgical Hypothermia - Not Just Cold Feet"

**Dr. Richard Bergstrom, Anaesthetist.**

### "Legal Implications for O.R. Nurses in the '90's"

Changing public expectations and medical practice impacts on O.R. Nurses' responsibilities and accountability in the '90's. Also includes documentation requirement. His Honor, Judge Allan Fradsham

"How Adults Learn" Professor **Roger Boshier,**  
Adult Education U.B.C.

"How to Promote Adult Learning in a High Stress Area". **Marion Boyd, B.Sc.N., M.Ed.,** Director Critical Care, The Royal Alexandra Hospital, Edmonton, Alberta.

### OPERATING ROOM NURSES ASSOCIATION OF CANADA - BANFF 1991 NATIONAL CONFERENCE

Second Floor Convention Centre - Banff Springs Hotel

EXHIBITORS - BOOTH NUMBERS:

Booth No.:	1 - 86	- Van Horne Ballroom	*	- Foyer A	
	87 - 121	- President's Hall	**	- Suite	
	122 - 150	- Foyer A & B			
ABBOTT LABORATORIES	96, 97			JOHNSON & JOHNSON MEDICAL PRODUCTS INC.	63, 64
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**Tuesday, May 14**

**"The Primacy of Caring in the Operating Room"**  
The results of a research project that identifies the caring activities of O.R. Nurses. **Carol Lenox-McDougall, R.N., B.Sc.N., M.S.N.** - Unit Manager O.R., Milton Hospital, Ontario.

**"The Dynamic Shift from Inpatient to Outpatient Surgery"**. Discusses changes in medical practice, surgical techniques and management of patients requiring day surgery and trends for the future.

**Muriel Shewchuk, R.N., B.Sc.N.,** Director of Nursing - Foothills Hospital, Calgary

**"Make that Successful Career Move"**

**Glenda Wade, R.N., B.Sc.N.,** President of Comprehensive Career Services Ltd.

**"Intraoperative Blood Salvage"**

**Dr. Raymond Martineau, M.D., FRCP(A)** - Anaesthetist Ottawa General Hospital and Clinical Lecturer University of Ottawa.

**"Blood Born Viruses of Concern in the Operating Room"**

Current disease trends, dangers and precautions for blood born viral infections. **Dr. K. Buchanan, M.D.,** Department of Microbiology, University of Calgary.

**Wednesday, May 15**

**"Organ and Tissue Donation and Transplantation - A Cooperative Effort"**

**Janice Mann, R.N.,**

H.O.P.E. Coordinator, Calgary.

**"Coping with the Stress and Distress of Organ Retrieval"**. An insightful look into the emotional management of one of the most difficult O.R. procedures

**Rev. James Strachan, B.A., S.T.M.,** Director of Pastoral Care - Foothills Hospital, Calgary.

**"Islet Cell Transplant"**

**What's in the future for the diabetic patient?**

**Dr. Norman Kneteman, M.D., F.R.C.S. (C)** Associate Professor of Surgery, University of Alberta Hospital, Edmonton.

**"Recharge Your Batteries, Reaching Your Summit, Soar with the Eagles"**. Techniques for O.R. Nurses to survive and thrive in the turbulent '90's

**Melodie Chenevert, R.N., M.N., M.A.**

**"Cadillac Service - Quality Improvement"**

A discussion of the worldwide revolution of improving quality and service while meeting the critical challenge of budgets. **Barry Sheehy, Executive Vice President of "The Achieve Group"**.

**"Canadian Standards Affecting O.R. Nurses in the '90's"**

**Carole Starr, R.N.,** Peterborough Civic Hospital, O.R.N.A.C. Standards Representative to C.S.A.

**Thursday, May 16**

**"Recharge Your Batteries, Reaching Your Summit, Soar with the Eagles"**

**Melodie Chenevert, (Repeat Lecture).**

**"Money Talks - The Changing Face of Hospital Funding"**

**Eric Taylor, Vice President, Finance,** University of Alberta Hospital, Edmonton.

**"Coming Clean - Pre-operative Skin Preparation"**

**Elaine Larson, R.N., Ph.D., F.A.A.N., C.I.C.** Johns Hopkins University, School of Nursing.

**"All the Right Moves - Positioning of the Patient in the O.R."**

**Regina Leonard, R.N., B.Sc.N., M.Ed.**

**"Renovate - Improve Services, Reduce Costs"**

Methods for improving the existing physical environment through renovation to improve service.

**Sarah Doughty, R.N., B.Sc. N., M.N., O.R. Supervisor,** Port Alberni Hospital, B.C.

**"The Greening of the Operating Room"**

O.R.'s generate massive amounts of garbage. Considerations on how to contribute to a safer and greener environment while maintaining standards and costs.

**Herb Dixon, B.Sc.N., Pharmacy, M.Ed.,** Education Consultant, Alberta Hospital Association.

**"The New Frontier in Computerization of the Operating Room"**

**Donna Prokopczak, R.N., B.Sc.N., M.Ed.** Manager/Clinical Nurse Specialist Operating Room Suite, University of Alberta Hospitals, Edmonton.

**Friday, May 17**

**"Reaching the Top"**

Join in the excitement and challenge experienced by Sharon Wood as she shares the ultimate thrill of achievement in conquering Mount Everest.

**Sharon Wood, Mountain Climber - First North American Woman to Climb Mount Everest** is the Closing Speaker.

# Canada and the World

By Joan Donald, Past President(ORNAC)



Canada will welcome the world as the 7th World Conference of Operating Room Nurses comes to Vancouver, British Columbia in September, 1991. This Conference attracts operating room nurses from around the globe.

The World Conference of Operating Room Nurses is sponsored by the Association of Operating Room Nurses, Inc., in response to requests from nurses throughout the world to hold regular meetings to discuss issues facing operating room nurses from every country, and to present a balanced educational program for these professionals.

One always stands in awe at the level of organization and expertise that comes together for a world conference, particularly, considering the history of world conferences is not a lengthy one. The dates and venues for previous world conferences are as follows:

1978	Manila, Philippines
1980	Lausanne, Switzerland
1983	Honolulu, Hawaii
1985	The Hague, Netherlands
1987	Singapore
1989	Vienna, Austria

Canadian operating room nurses have always been interested in the Association of Operating Room Nurses (AORN). They have also been interested in world conferences and many nurses from Canada have attended from the very beginning. Canadian OR nurses have attended as speakers, since as early as 1983, when the Conference was held in Honolulu, Hawaii.

The Operating Room Nurses Association of Canada (ORNAC) was formally organized in 1983. From that time on, there has been an expressed interest in participating in world conferences in a more formal sense. The evidence of this was seen as many nurses from Canada attended the world conference in The Hague, in what has now become our traditional red and white outfits.

Following the tremendous amount of enthusiasm that was exhibited at The Hague by the Canadian operating room nurses, President, Val Sherriff, extended a written formal invitation to the AORN to consider Canada as a future site for a world conference. At that time, there was an expressed interest in participating in planning or assisting in any way that Canada could for a future world conference. At the kind invitation of the AORN, Val Sherriff was invited

to participate in the planning of the Singapore conference and was the first Canadian representative to attend the International Planning Committee (IPC).

From that time on, Canadian representatives have been invited to sit as a member of the IPC. This has included Ann Robinson for the planning of the Vienna Conference, and now your Past President for the Vancouver, B.C. Conference. As you will note from any of the conference documents, Canada is now recognized as a regular member of the International Planning Committee which is comprised of members from five countries: Australia, Canada, Japan, United Kingdom and the United States. There are also corresponding members from four countries: Finland, Greece, Italy and Kenya. These members are given the task of designing the program and assisting in program development.

Through Canada's participation on the IPC, we have been represented by numerous speakers and moderators. We now play a leading role in planning for World Conferences.

Canada's early invitation brought an interest from AORN to consider Canada as a future site for a World Conference. A great deal of formal planning and preparation must go into a world conference and the country who invites the conference knows that it may be years from the time of initial invitation until the time when the country is actually chosen to host a conference. This was the case with Canada's invitation. It was extended in the early 80's and it was announced in 1989 that Canada had been chosen for the next world conference to be held in 1991.

We are honored and pleased to have been chosen as the site for the world conference and indeed will welcome both AORN and the world of operating room nurses to our country.

The year 1991 is a year of transition for national conferences for Operating Room Nurses in Canada.

National conferences in Canada had always been held on the even years and they will now be held every second year on the odd year. The decision for this change was made a number of years ago, at the request of one of the provinces. It has not been a decision that has been made lightly and a great deal of discussion has taken place and planning has been extensive in order to provide for this transition. There has been a concern expressed that it is unfortunate that the world conference has come to Canada during this transition

year when we will also be having a national conference. ORNAC's 12th national conference was held in Banff, Alberta, in May of this year.

Although Canada is a participant on the IPC, it is the AORN, who actually sponsor and host the world conference. We are consulted as a committee when planning the various aspects of the program and when helping out in the program development.

However, we are not participants in the selection of the site for the world conference. The Operating Room Nurses Association of Canada did invite the AORN to Canada and we are thrilled that they have accepted our invitation. It has been a tremendous benefit for Canada to be involved on the world stage of operating room nursing and I am sure that our future is secure for continued participation and involvement in planning for world conferences.

I am confident that you will join together with me in extending a hand of friendship as we welcome our Colleagues from around the world, this September 2nd to the 6th, 1991 in Vancouver. Together, each of our smallest efforts will contribute to the global empowerment necessary to ensure our future professional growth and environmental awareness.

Joan Donald, ORNAC Past President

## ORNAC Welcomes the World

This is the first time the World Conference of Operating Room Nurses will be held in North America - so plan to attend and show the World real Canadian Hospitality. The conference takes place in Vancouver, B.C. September 2 to 6, 1991 at the Pan Pacific Hotel and Trade and Convention Centre. The theme is "Global Empowerment: Professional and Environmental".

### Registration Information

AORN is the organizer of the event and all communication - hotel reservations and registration MUST go through the official channels. Registration is limited to 3,500 professional attendees. Registering in advance aids in planning the amount of material necessary to produce this quality meeting.

Three hundred US dollars (\$300) is the required registration fee for the full week. Full week professional registration must be made by June 3, 1991 thru AORN and includes: Attendance at education sessions including credit for continuing education hours, attendance at technical exhibits (3 days), Copy of World Conference Proceedings, Lunch each day of Conference (4 days), Official Program, Registration Materials, Simultaneous reverse translations of English, French, Japanese, German and Italian. Plus International Fellowship Night.

For registration forms and information contact:  
**World Conference/Registration**  
 c/o Association of Operating Room Nurses, Inc.,  
 10170 East Mississippi Avenue,  
 DENVER, Colorado, USA 80231  
 FAX: (303) 752-0299

The daily registration rate is \$75 U.S. and only this daily rate may be purchased in Vancouver at the World Conference Registration Desk.

### International Fellowship Night - Don't miss it!

In the past Canadians attending the World Conference have historically presented a cohesive, supportive and fun-loving group. Since Canada (Vancouver) has been chosen to host the World, it is important to our image to do even better this time. The group, together parades into the Fellowship Night event carrying the ORNAC flag and singing Ca-na-da (the Expo '76 song). It is a very proud moment and so much fun. During the evening, while mixing with everyone from around the world, an exchange of pins, hats, etc. takes place. **International Fellowship Night is Tuesday, September 3rd.** It is a night of entertainment, food and FUN!! Don't miss it.

The Canadian outfit this time will be: red jackets (designed to represent the RCMP jacket); White hats (to look like the RCMP hat used for the musical ride) with the ORNAC logo on the hat. This outfit will be available for pick up at the ORNAC booth at the World Conference Centre in Vancouver. For further information contact Joan Donald. You'll have more fun and really feel part of a great country if you join in and wear our designated outfit

Gloria Stephens, ORNAC President.

It is very important to ORNAC, for the purpose of planning and ordering International Night costumes, that we know how many Canadians will be attending - for the full week or just oneday. If you plan to attend please mail this form to:

Mrs. Joan Donald  
 117 Fairway Boulevard,  
 Riverview, NB, E1B 1T4

### Yes I'll be attending the World!

Name: \_\_\_\_\_ Hospital: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Attending International Night: Yes: \_\_\_ No: \_\_\_  
 Plan to to purchase Canadian Outfit:  
 Yes: \_\_\_ No: \_\_\_\_\_

## Cold laser procedure to correct herniated discs available in near future

Clinical trials have begun to determine the efficacy of a new cold laser procedure for the treatment of herniated disks, or disk prolapse.

The trials at eight medical centres in the U.S. will attempt to replicate the results obtained by Dr. Jordan Davis, chief of spinal surgery at Delray Community Hospital in Delray Beach, Florida.

Dr. Davis suggested the procedure and assisted in the development of the potassium titanyl phosphate (KTP) laser, which he successfully used on more than thirty patients with severe and radiating pain into the legs and lower buttocks.

Use of the KTP laser (manufactured by Laserscope of San Jose California) for automated percutaneous lumbar discectomy, has received approval in the U.S. but not yet in Canada. It is one of the two lasers now being used for outpatient laser discectomies. The other is the YAG laser, whose use results in a much "hotter burn" than the "colder burning" KTP laser.

The traditional surgical procedure (laminectomy) for disk prolapse (herniated disk) takes approximately one hour with the patient remaining hospitalized for four days. Recuperation is approximately six weeks.

A laser discectomy takes approximately 15 minutes under local anaesthesia, with the patient to return to work in three to seven days.

Thus far in the United States, over 600 people have been treated for herniated disks with the hot (YAG) or cold (KTP) lasers. According to a Columbia University research team, which has been using the YAG laser, the success rate

for discectomies using lasers is around 80%. When the procedure fails, a laminectomy is required.

### Contraindications

While most post-op patients report immediate relief after laser discectomy, in others relief from the radiating pain might come weeks or several months after the initial surgery. Also, according to Dr. Jordan Davis of the Delray Hospital, reporting his research at

the Radiology Society of America meeting in Chicago recently, the laser procedure is contraindicated for patients who have a piece of disk extending into the spinal canal or for most patients who suffer problems in the L-5, S-1 area of the lumbar spine. He said it was difficult using any percutaneous procedure in that area of the spine because there is insufficient space for the laser to be inserted into the disk area. ■

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# Conference Calendar

**September 1 - 6, Vancouver, B.C.:** World Conference of Operating Room Nurses, Pan Pacific Hotel. Contact: AORN, 10170 East Mississippi Ave., Denver, Colorado 80231 USA (303) 755-6300.

**September 26 - 27, Toronto, ON.** Management Strategies for Staff Nurses, Royal York Hotel, Toronto. Sponsored by Humber College, Humber College, 205 Humber College Blvd., Etobicoke, ON. M9W 5L7 (416) 675-5077 FAX (416) 675-0135.

**September 26 - 28, Thunder Bay, Ontario:** 9th Biennial Conference, Lakehead Operating Room Nurses Association (LORNA), Valhalla Inn, Thunder Bay. Contact Leona Barr, President, LORNA, 551 Piccadilly Ave., Thunder Bay, Ont. P7B 5C9.

**October 17 - 18, Toronto, Ontario:** 16th Annual Convention, Canadian Intravenous Nurses Association, Sheraton Toronto East Hotel, Kennedy Road, Scarborough (Toronto), Ontario. Contact: Pam Smith, C.I.N.A. (416) 292-0687 FAX (416) 292-1038

**October 18 - 19, Burlington, Ontario:** Annual Regional Conference, Operating Room Nurses Association of Hamilton & District. Holiday Inn, Burlington, Ontario. Contact Alaine Young, Nurse Manager, O.R., Henderson General Hospital, 711 Concession Street, Hamilton, Ont. L8V 1C3.

**November 1st & 2nd, 1991** The Operating Room Nurses Association of South Central Ontario present their Bi-Annual Fall Seminar- "Haliburton Highlites", Pinestone Inn, Haliburton, Ontario. Contact: Kathy Bruce, R.N., c/o Whitby General Hospital, Gordon Street, Whitby, ON. L1N 5T2 FAX: (416) 430-3421

**February 5 - 7, 1992, Calgary, AB:** "Quality of Nursing Life - Taking Charge of Change." An educational forum for nurses sponsored by the Alberta Hospital Association. Abstract requirements from Education Services, 10009 - 108 St., Edmonton, AB T5J 3C5 (403) 498-8403 FAX (403) 498-8465.

**June 6 - 12, 1993, Quebec City, Quebec:** 13th National Conference, Operating Room Nurses Association of Canada (ORNAC).

## An incubation period does not exist for HIV says discoverer of the AIDS virus

The notion of an incubation period between the time of an HIV (human immunological virus) infection and the development of full-blown AIDS has received a sound drubbing.

Dr. Robert Gallo, co-discoverer of HIV, addressing a gathering of the Infectious Diseases Society of America meeting in Atlanta recently said that HIV causes disease early on, but reaches a threshold when the bottom drops out of the immune system and opportunistic infections begin appearing.

"There is no clinical latency with HIV," said Dr. Gallo, who is chief of the laboratory of tumor cell biology at the U.S. National Cancer Institute.

"It's (HIV) beginning to do its damage almost surely by day one, and it's just a progressive and slow phenomena until that threshold is reached." ■

## Researcher says six hours sleep nightly enough to maintain daily performance

There is no need to sleep for more than six hours a night, according to Dr. Jim Horne, a leading British sleep researcher at Loughborough University in England.

Speaking at the European Sleep Research meeting held in Strasbourg, France earlier this year, Dr. Horne said that six hours represents "core sleep," and anything more is "optional."

Only about 30% of the last stage of sleep - when dreams occur - is necessary. Following sleep deprivation, he pointed out, we do not make up all the sleep we have lost, only some of it, he explained.

"We do need the first few hours of sleep and we can sleep more if the opportunity is there."

Dr. Horne said it was possible to reduce sleep down to the minimum of six hours by sleeping a little less - perhaps 15 minutes - each week without any harmful effects.

## Wide awake lifestyle preserved

Experimental subjects who had learned to reduce sleep in laboratory studies had been found on follow-up to still have the same wide-awake life-styles while continuing to sleep only six hours nightly.

Initially, there was slightly more daytime sleepiness in those performing on six hours per night. But this sleepiness effect soon disappears, he explained. ■

## A medical perspective of whom bells really toll for

This may not be a very up-lifting subject, but the ancient art of campanology (bell-ringing) with all its ups and downs, is taking a terrible medical toll.

The most common peril to befall the pealers of late is the high speed lift which happens when the bell goes out of balance and the bell pealer forgets to let go of the rope and rockets up at speeds approaching 90 km/hr.

Last year five deaths occurred and 742 were injured while ensconced in the bell towers of the United Kingdom. Included among the injuries were: torn finger nails, face, shoulder, hand and arm bruises, corneal abrasions, rope burns, extracted teeth, lacerations, ruptured ligaments and near hanging. All this give us a better appreciation of what could have happened to Quasi modo. ■

## The GST is really hitting us below the belt now!

Most of us think they've seen the worst that the GST can afflict. Not so fast! Have you heard about the newest GST grab? It's called the Great Sperm Tax!

Yep, our finance minister has seen fit to consider sperm purchased from a sperm bank as a taxable commodity. Women undergoing artificial insemination in Canada pay up to \$200 per month for sperm. According to a *Canadian Press* report, the GST will add another \$14 to the final tally. And this raises the question: is sperm a goods or a service? ■

## An explanation for the antics of our politicians

And for those legislators who pass such outlandish bills as the GST, this medical news story from

Britain can only lead to wishful (albeit vindictive) thinking.

Being an elected member of parliament can be hazardous to your health in the form of germ-ridden droplets of spit that are emitted from the on-going speeches and haranguing that goes on. In fact, one only has to go back to 1904 when the British House of Commons became concerned about the "feelings of lassitude and heaviness" that were overcoming members and which was followed by an inordinate number of MPs getting the flu.

To look into the political epidemic, Dr. Henry Gordon, a bacteriologist, was summoned to investigate. During the summer recess of the House, he went into the debating chamber and set out over 200 open petri dishes containing agar (a form of sea weed considered ideal as a culture medium).

After gargling with a harmless, but living bacillus, and delivering two, hour-long, Shakespearian recitals, the petri dishes were examined. They were all found to be full of bacterial colonies, each one representing a droplet of spit. ■

## Dracula is alive and well... with a dental problem

This one, condensed from the *British Journal of Surgery*, tells of a patient bitten at a Halloween party by a woman dressed as a vampire. The recipient of the bite tried to keep quiet about the whole affair, but eventually had to undergo surgery to remove a 2cm supraclavicular mass - which turned out to be a plastic tooth. ■

## Thumbs down on skiing's most common injury

This is for those intrepid skiers who defy the inclemencies of winter, the dizzying heights of cold,

snow-covered mountains and the almost death-defying surges as they zig-zag down the snow-capped hills: the most common injury in skiing accidents is "skier's thumb." It's not a "macho injury" like a broken leg, but it can be acutely painful and can lead to arthritic conditions.

According to Dr. Joel Grad, professor of orthopaedic Surgery at New York University, if "skier's thumb" is left untreated, the cartilage surrounding the joints can erode, thereby setting the stage for arthritis. To minimize the injury, Dr. Grad recommends ski gloves that have extra padding or stiff reinforcement around the fingers. ■

## Researchers on the lip of an important discovery

Why do they go to the trouble of various tests just to tell us things we already know to be fact!

For example, what is the most sensitive part of a women's face? The lips, naturally; and to be more exact, the borders of the lips!

But not to be outdone by mere heresay, Dr. Jeffrey Posnick, a pediatric plastic surgeon, and his colleagues at the University of Toronto and the Toronto Hospital for Sick Children used special measurement techniques to confirm that, indeed, the borders of the lips are the most sensitive part of a women's face.

The importance of this finding is that plastic and reconstructive surgeons will be able to better understand what their patients are feeling when they receive injections of collagen in order to enlarge the lips.

Also, the findings will provide a measurement allowing physicians to determine with greater precision how well facial sensory nerves are functioning following surgery or an accident. ■

## UK anaesthetist says women should stop taking oral contraceptives prior to major surgery

According to an article published by the Medical Defence Union (MDU), one of Britain's largest medical malpractice organizations, women taking oral contraceptives containing estrogen should be told to stop using them four weeks before major surgery or before surgery to the legs.

Professor A.R. Aitkenhead, an anaesthetist and member of the MDU, authored the article. He also said that women on hormone replacement therapy should be given similar advice.

Although the evidence was relatively small, there did appear to be a significantly increased risk of post-operative thromboembolism in women taking oral contraceptives containing 50ug of estrogen or more.

In cases where oral contraceptives have not been discontinued or following emergency surgery,

low-dose sub-cutaneous heparin should be used prophylactically, he advised. Heparin is an anticoagulant drug used to prevent and treat abnormal blood clotting (thrombosis and embolism).

The risk for oral contraceptives containing less than 50ug was less well defined. Nevertheless, Aitkenhead believes it would be prudent to discontinue their use before surgery.

There was no evidence that progesterone-only oral contraceptives were associated with a risk of post-operative thromboembolism.

As for the prophylactic (preventative) use of heparin Professor Aitkenhead argues that, although the risk of pulmonary embolism might be very small (especially for fit, young patients), it was probably more than the risk of a serious complication of heparin prophylaxis. ■

## The lifesaving ideas on infection control pioneered by Ignaz Semmelweis never accepted during his life

Traditionally, the nurse has been the guardian of aseptic technique. In the O.R., infection control is one of the most important professional considerations for operating room nurses who take it upon themselves to secure and maintain a safe environment for the patient.

Credit for establishing the importance of antisepsis or asepsis - the absence of all disease-producing micro-organisms - goes to the Hungarian physician, Dr. Ignaz Semmelweis, the medical pioneer of antisepsis.

Although he practiced in Vienna as an obstetrician, his contribution to medicine, particularly asepsis technique, is preserved in Budapest, where he was born. The Semmel-

weis Medical Historical Museum is located in the house where he was born in the early 1800s.

It was while Semmelweis was a practicing obstetrician at the Vienna Maternity Hospital that he noticed that the rates of septicemia (blood poisoning) between two maternity wards were remarkably different.

One of the wards, attended by physicians and medical students, had a 12% mortality rate. The other ward, attended by midwives (the 19th century obstetrical nurse) had only a 3% rate.

The difference in mortality rates was not lost on the mothers of Vienna, who would often cry when they found out they had been as-

signed to the ward attended by physicians and medical students.

Semmelweis, in noting the difference in mortality rates, attributed it to the tendency of the medical staff to come straight from dissecting rooms and then examine patients without first washing their hands. The midwives, on the other hand, would wash their hands, and of course were not involved in the dissection of infected, previously deceased mothers.

After instituting a requisite hand-washing with chlorinate of lime prior to entry to his ward, Dr. Semmelweis was able to reduce remarkably the death rate from septicemia.

Unfortunately, Dr. Semmelweis' antiseptic methods were not accepted by the medical profession. Although his methods were accepted by some, many thought they were a waste of time.

Eventually, Dr. Semmelweis' antiseptic methods gained acceptance, but not before he went insane and died. Ironically, Dr. Semmelweis died of septicemia as a result of an infected finger. ■

## Going out with a bang is cremating havoc

Crematorium staff around the world are refusing to handle corpses containing heart pacemakers or implants because they're exploding and damaging furnace equipment and threatening their lives.

The explosions have blown open incinerator doors, dislodged furnace bricks, and caused distress to waiting relatives.

Thus, crematorium companies are refusing to cremate anybody with a pacemaker still in place.

The explosions are caused by the pacemaker batteries. When temperatures rise inside the batteries, they explode similar to gunpowder ignited in a closed pipe. ■

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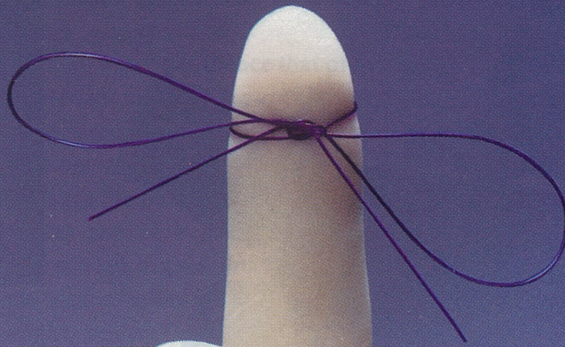
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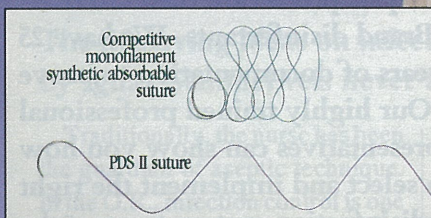
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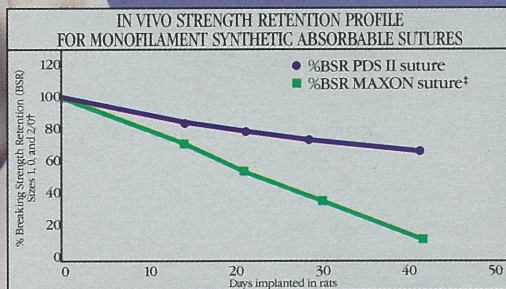


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