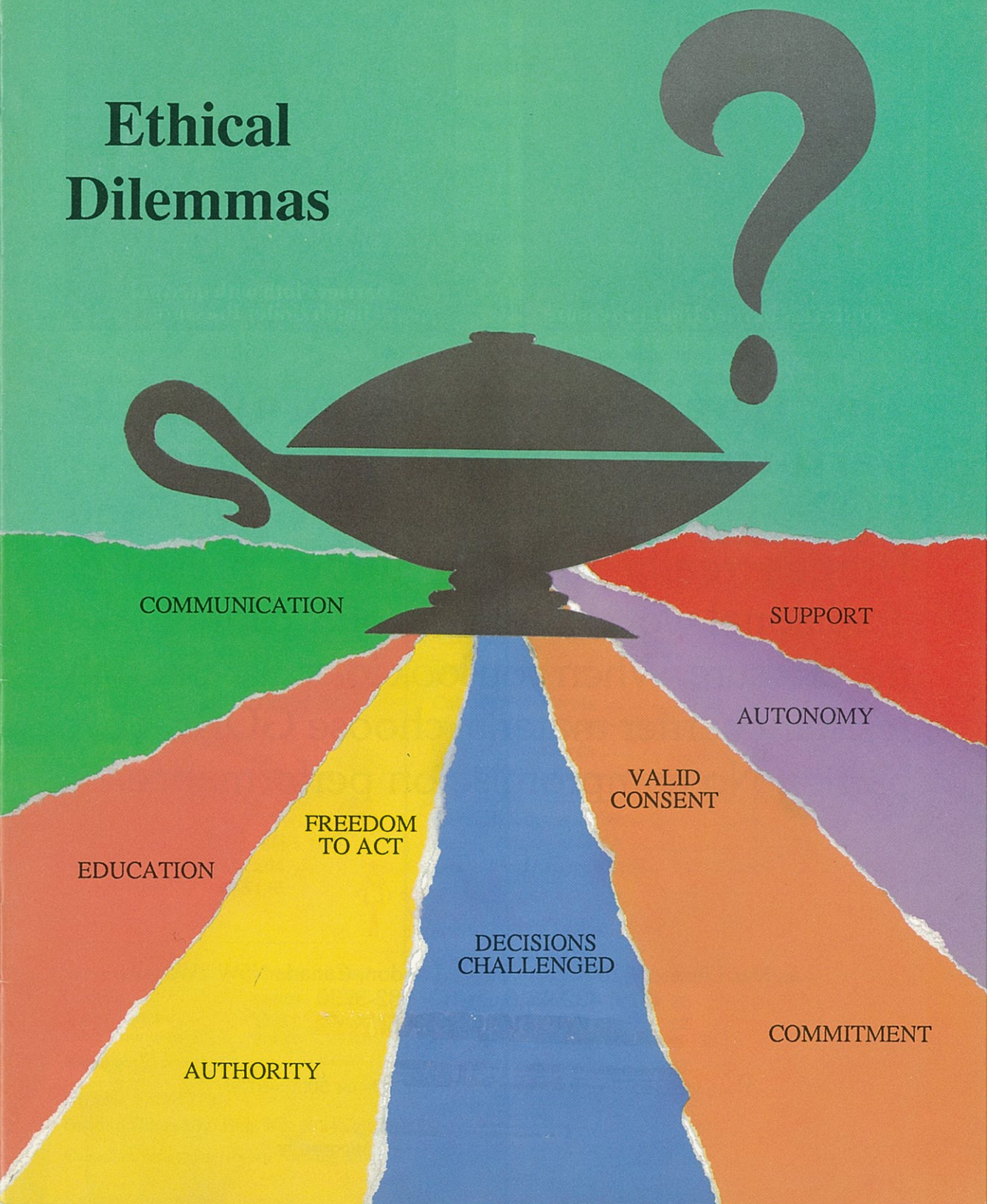
CANADIAN
Operating Room Nursing Journal
Volume 7, Number 2, April/May, 1989

Ethical Dilemmas



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The artificial urinary sphincter (AUS) is an implanted prosthesis used to correct incontinence problems in patients who are totally incontinent and who have not responded to drug therapy or catheterization. In this submission, the specific surgical concerns relating to this procedure as followed at the Hospital for Sick Children in Toronto are summarized.

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Nurses focus on different aspects of ethical issues than do the other medical/health care professions: doctors, administrators and related health care authorities. Nurses, for example, are more interested in the ethical issues of patient satisfaction, self-management and education. Those not in the nursing field who review this research do so with skepticism.

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From time to time almost every health care facility faces a nursing shortage. What are the legal ramifications for those institutions faced with shortages, and what are the legal implications for nurses who must fill the manpower void?

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Calendar of Events

May 31, Toronto, Ontario: "Legal Issues in Nursing Practice," Latvian Centre. (Sponsored by Centennial College, School of Health Sciences. (416) 694-3241, ext. 3351).

June 1 - 3, Corner Brook, Newfoundland:
10th Annual Conference, Newfoundland and Labrador Operating Room Nurses Association, Glynmill Inn. (Contact Angela Lemoine, P.R., P.O. Box 67 W.E.P.S., Corner Brook, Newfoundland A2H 3J0).

June 11 - 13, Winnipeg, Manitoba:
3rd Biennial Conference of the Manitoba Operating Room Nurses Association, Delta Hotel. (Contact Bev Popowich, Co-ordinator, O.R. PAR, and Day Surgery, Misericordia General Hospital, 99 Cornish Ave., Winnipeg, MB R3M 1E2 (204) 774-6581).

June 11 - 13, Winnipeg, Manitoba:
Second Biennial Conference, Manitoba Association of Post Anaesthesia Nurses (PACU), Westin Hotel. (Contact Jan Borlase, Conference Chairperson, 99 Cornish Avenue, Winnipeg, MB R3C 1A2).

August 28 - September 1, Vienna, Austria
Sixth World Conference of Operating Room Nurses, Austria Centre, Vienna. (Details, AORN Meeting Services Department, 10170 East Mississippi Avenue, Denver, Colorado 80231).

September 15 - 17, Saskatoon, Sask.:
5th Annual Saskatchewan Operating Room Nurses Group Conference. Sheraton Cavalier Hotel, Saskatoon. (Contact Darlene Stuttard, Provincial Co-ordinator, City Hospital, 7th Ave. & Queen Street, Saskatoon, SK. S7K 0M7 (306) 934-8030).

September 28 - 29, North Bay, Ontario:
15th Annual Conference, Northern Ontario Operating Room Interest Group - NOORIG. (For details Mary Rankin, North Bay Civic Hospital, 750 Scollard Street, North Bay, Ontario P1B 1C1).

October 4 - 6, Montreal, Quebec:
23rd Annual Provincial Conference, L'association des infirmiers(es) des salles d'operation du Quebec, Centre des Congres de Laval a Laval, Montreal, Quebec. (Contact Monique Dugay, Hopital General LaSalle, 8585 Terrasse Champlain, LaSalle, Quebec H8P 1C1 (514) 365-1510).

October 19 - 22, Medicine Hat, Alberta:
Annual Provincial Conference, Operating Room Nurses of Alberta, Medicine Hat Lodge and Cypress Centre. (For more information contact Marge Ensminger, Chairperson, 340 - 14th Street North East, Medicine Hat, Alberta T1A 5V8 (403) 527-2122).

April 2 - 6, 1990, Toronto, Ontario:
11th National Operating Room Nurses Conference, Harbour Castle (Westin) Hotel. **Delegates** contact Audrey MacDonald, Operating Room, Mount Sinai Hospital, 600 University Avenue, Toronto, Ontario M5G 1X5. **Exhibitors** contact Valerie Shirreff, Operating Room, Mississauga Hospital, 100 Queensway West, Mississauga, Ontario L5B 1B8).

General Journal Information

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Canadian Journal of Nursing Administration
Ontario Nursing Home Journal.

Implanting an artificial urinary sphincter

By Marion H. McLean, R.N.

The artificial urinary sphincter (AUS) is an internally implanted prosthesis used to correct urinary incontinence problems. While the AUS has successfully been implanted in both adults and children, the following summary specifically concerns surgical procedures followed at the Hospital for Sick Children in Toronto, Ontario.

More than sixty AUSs have been implanted in children aged four to nineteen at the Hospital for Sick Children. All of these patients were totally incontinent and had not responded to drug therapy or intermittent catheterization.

Anatomy and physiology

The urinary bladder is a hollow muscular viscus that acts as a reservoir for urine until micturition occurs. The floor of the bladder is composed of the trigone, which is triangular. The three corners of the trigone correspond to the orifices of the ureters and the bladder neck (opening of the urethra). The bladder fills with urine, thereby expanding into the abdominal cavity. **(See Figure 1)**

The process of bladder evacuation appears to be initiated by nerve cells from the sacral divisions of the autonomic nervous system. These sacral reflex centres are controlled by higher voluntary centres in the brain. Stimulation of the sacral centres results in contraction of the bladder muscles and relaxation of the bladder outlet sphincters. Muscle tone maintains closure of the sphincters when the bladder is at rest, thus enabling continence. Neurogenic bladder and bladder exstrophy (the congenital turning inside out of the bladder) usually result in lack of adequate storage capacity and emptying problems.

How the implant works

The artificial urinary sphincter consists of three main parts:

1. a control pump
2. an occlusive cuff
3. a pressure-regulating balloon

When implanted, the prosthesis simulates normal spincter function by opening and closing the urethra at the patient's control.

When the patient wishes to void, he or she squeezes the control pump (implanted in the scrotum or labium) several times. This causes the fluid that pressurizes the cuff to move from the cuff to the pressure-regulating balloon. **(See Figure 2)**

The cuff opens and the urine passes through the urethra. The cuff is then automatically repressurized by fluid moving back from the balloon through the pump, thus closing the urethra within minutes.

The occlusive cuff implanted at the bladder neck closes the urethra by applying pressure circumferentially. A connector links the cuff's tubing with tubing from the control pump. The pressure-regu-

lating balloon, implanted in the prevesical space, controls the amount of pressure exerted by the occlusive cuff. The surgeon usually selects the lowest pressure needed to maintain closure of the bladder neck.

The control pump is implanted in the soft tissue of the scrotum or labium. The upper part of the pump contains the resistor and valves needed to transfer the fluid to and from the cuff. The bottom half of the control pump is a bulb which the patient squeezes to transfer fluid within the device.

Patient selection

The AUS is considered for patients with socially incapacitating incontinence which has not responded to more conservative measures, for example:

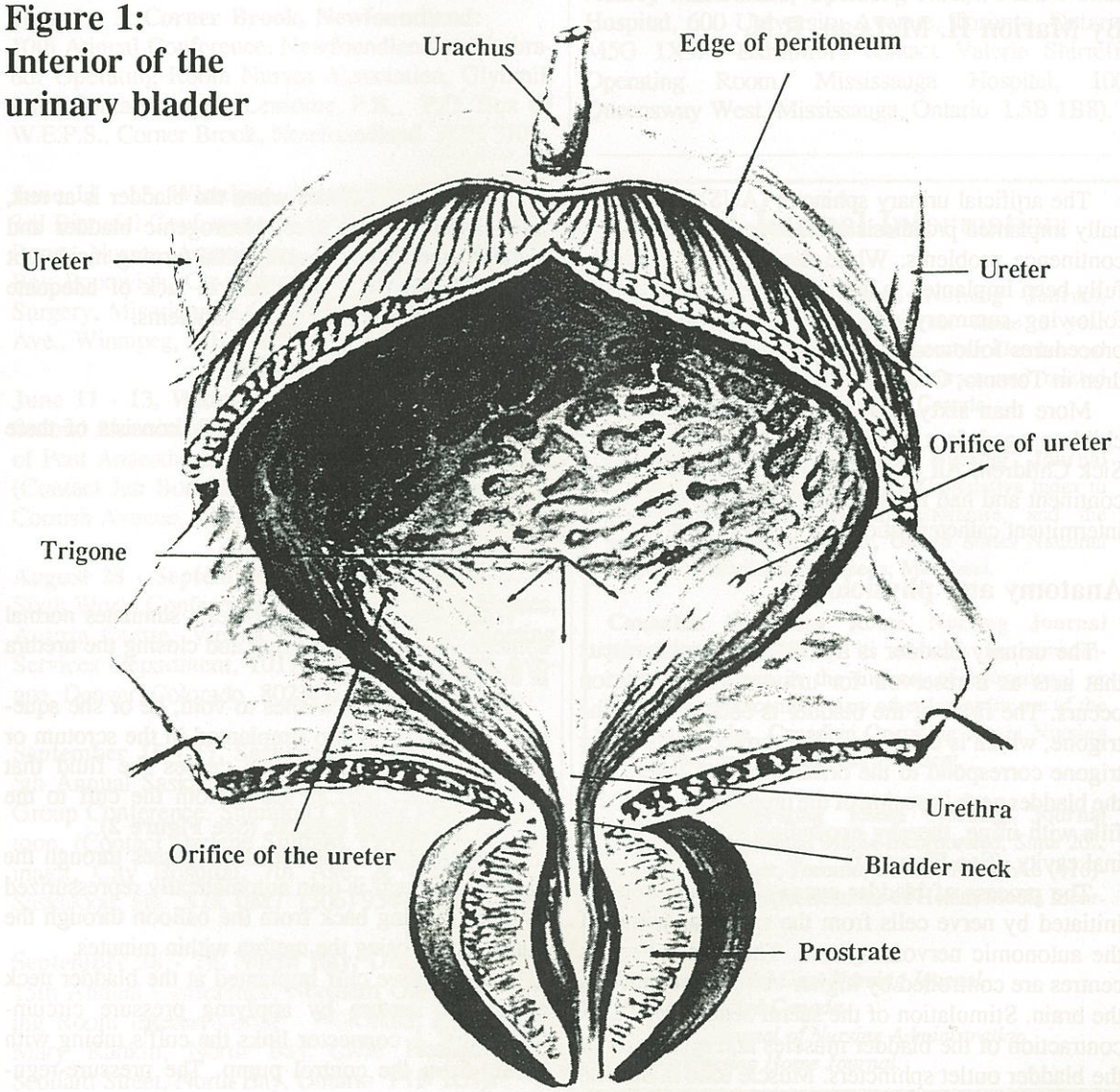
- intermittent catheterization
- the use of anticholineric agents to control hyperreflexia and improve functional bladder capacity as well as storage capacities; and
- other surgical procedures

Previous surgery

Previous surgical procedures may have included bowel augmentation to increase the capacity and compliance of the bladder or a combination of bladder neck reconstruction and vesicourethral suspension to improve bladder outlet resistance. Also, there must be viable tissue at the cuff site for successful implantation of the AUS.

The patient and family must be well motivated, cooperative and compliant. The child has to demonstrate an ability to empty the bladder completely or

Figure 1: Interior of the urinary bladder



be trained in the use of intermittent catheterization.

At the Hospital for Sick Children, prospective implantees are interviewed by a surgeon, staff of the Urodynamic Department and a nurse from urology. The head nurse on the urology ward has developed a thorough teaching program, both pre-operatively and post-operatively, for the children and parents.

Surgical intervention

Pre-operatively, the patient is placed on a bowel routine to empty the rectum. Prophylactic antibiotics are given pre-operatively (and for five days post-operatively). Meticulous precautions are taken to provide a dust-free and lint-free atmosphere in order to avoid blockage by debris of the flow resistors in the control assemby. Instruments and basin sets are wrapped in paper; the surgical team wears paper gowns and hats; tables are draped with paper drapes, with a U-shaped paper patient drape used.

A separate lint-free, high stand is prepared with instruments which have been rinsed twice in sterile water. This high stand is covered until the device is assembled. The tips of forceps are covered with silicone to prevent damage when handling components of the device. Also, "Do Not Enter" signs are placed on doors leading into the operating room in order to reduce traffic flow.

The patient is positioned supinely in a slightly "frog-legged" manner and prepped from nipple line to knees, including perineal area and vaginal prep for female patients.

Surgical Procedure

A Pfannenstiel incision is made through skin, subcutaneous tissue, and muscle. The muscle is divided longitudinally at the midline and dissected from the peritoneum. A Dennis Brown ring retractor is used for retraction. The obliterated umbilical vessels are tied and cut, and cautery is used to incise the bladder and the urine is suctioned out.

The bladder neck is dissected, and a cuff sizer is passed around the bladder neck to determine the exact cuff size. The bladder is sutured closed in three layers. The permanent cuff is passed around the bladder

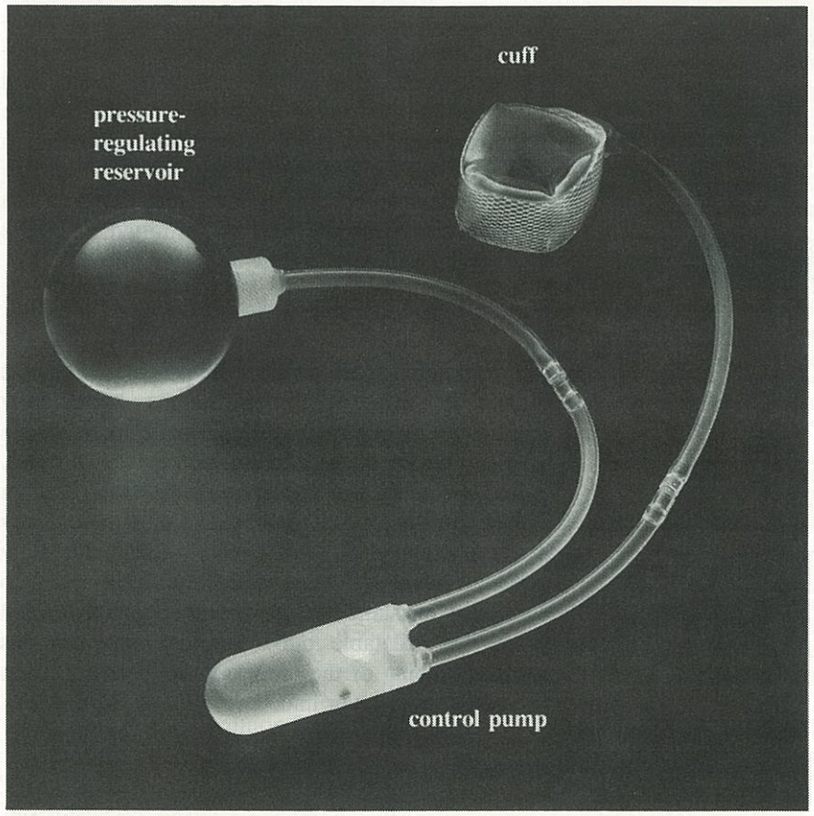
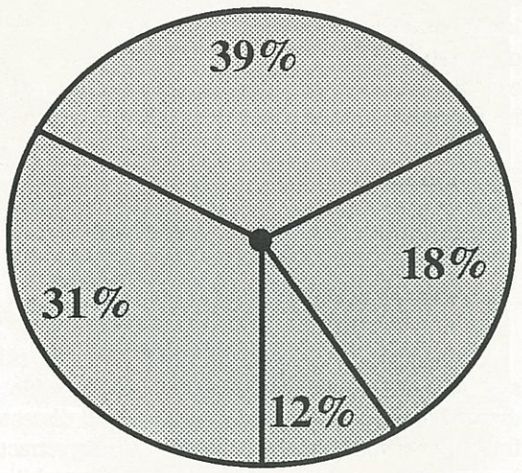


Figure 2: Artificial Urinary sphincter implant

When implanted, the prosthesis (consisting of a control pump, an occlusive cuff, a pressure-regulating balloon or reservoir and connecting (tubing) simulates normal spincter function by opening and closing the urethra at the control of the patient.

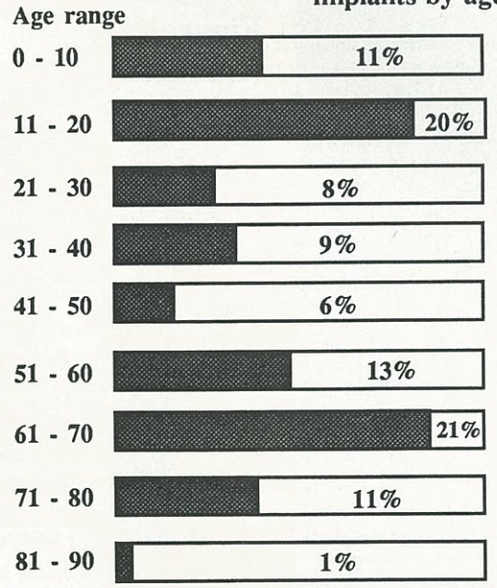


Urinary sphincter implants by cause of urinary incontinence

39%	Urinary tract or prostrate surgery
31%	Birth defects
18%	Spinal cord or pelvic injury
12%	Neurologic dysfunctions/other

Source AMS - Pfizer Hospital Products, Guelph, Ontario

Percentage of artificial urinary implants by age



neck and the ends of the cuff are sutured in place. The peritoneum is opened in the upper quadrant and an angled tubing passer is used to pass the tubing and balloon into the peritoneal cavity. The balloon is left in place and the peritoneum is closed. A deep pocket is created in the labium or scrotum, using Hegar dilators, to receive the pump.

Before the instruments in the lint-free high stand are used for testing and connection of components, the members of the team double-wash their gloves to remove all blood and debris. A large plastic aperture drape is placed over the operative area. The AUS is filled with a contrast medium and the intra-operative pressure measurements are performed before assembly, prior to implantation, and are repeated after the sphincter is in place. The urethral occlusion pressure is monitored intra-operatively.

The connective tubing is trimmed to fit the patient, to avoid kinking, and connections are made. The lint-free tray of instruments is removed from the field and kept sterile. The wound is irrigated with an antibiotic solution and closed in the routine method. A foly catheter is inserted into the urethra. Finally, the abdomen is X-rayed to confirm the absence of kinks in the tubing and the correct position of the cuff, balloon and pump.

Post-operative care

After surgery, patients are taught to pump the sphincter and intermittent catheterization is introduced with accurate charting of residuals. Urodynamic testing is done on a daily basis, and ultrasound is performed to check for residual urine after voiding. An X-ray is taken before discharge to check for kinking or other dysfunction of the urinary implant device. For six months after surgery, no sports or strenuous activities are permitted, and there is a regular routine of follow-up appointments.

Complications

Prior to having the surgery, the patient and parents should be aware of complications which may necessitate the removal of the implant. Leaks in the cuff or balloon occur in a low percentage of cases. Blood or debris that contaminate the fluid used in filling the device at the time of implantation may become trapped in the check valves and flow resistors of the control assembly. This leads to increased resistance to the passage of fluid to and from the inflatable cuff. Surgical complications include kinking of the tubing, inadequate occlusion pressures, erosions or infection.

Results and conclusion

Between 1980 and 1984, forty-four patients had an AUS implanted at the Hospital For Sick Children in Toronto. Ninety percent have been rendered socially continent. Of these, 63 percent are completely dry, and 27 percent have achieved satisfactory continence with only minor damp episodes. In 70 percent of the patients, good or satisfactory continence was achieved without a single revision. Continence was achieved in another 10 percent following a single revision and 10 percent required multiple revisions to attain satisfactory continence.

Improvements in the design of the urinary sphincter implants have resulted in better results with the device. The change in self-esteem of children with an AUS is remarkable. Not having to wear diapers any longer helps them to feel more "normal." Plus, they increase activities, socialize more and become more independent. ■

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About the author

Marion H. McLean is a staff member, Surgical Unit, Urology Department, Hospital for Sick Children, Toronto, Ontario. She is a graduate of both the Registered Nursing Program and Post-graduate Operating Room Course, Humber College, Toronto.

The ethical dilemmas of being an O.R. nurse

By Michael M. Burgess, Ph.D.

As a philosopher working in the ethics of health care, I see the problems of ethics and nursing, of health care institutions and nurses and the particular problems of the nursing profession itself, from a different perspective than nurses, or physicians, or even union leaders.

In the ethical review of nursing research, I have noticed that the type of research proposed by nurses, and the attitudes of some members of the research committees, make it difficult for this research to receive approval. Specifically, nurses tend to be interested in issues of patient satisfaction, self-management and education. Physician and scientific reviewers' skepticism of the value of these goals, and the validity of the research methods employed, often interfere with ethical approvals.

In ethical case consultation, problems may arise due to a lack of communication. Though often not intended, this lack of communication shows a lack of respect for the people (nurses) who must live with the decisions and treatments. For example, in one case, the nurses involved did not understand the need to support a family's choice of apparently meaningless surgery because the family treated the physician as the only decision-maker, and the physician did not explain the situation to the nurses.

It is obvious that nurses focus on different aspects of ethical issues. They will often suggest a procedure without commiting themselves ethically. In one case example, a patient accepted heroic measures. The nurses, however, saw the emotional pressure exerted by the physician and the family, and personally agreed with the patient's earlier rejection of the measures. The nurses realized that there was no easy answer, but questioned the validity of the consent. But there is nothing wrong in accepting treatment for the sake of one's family. The nurses had sought an ethical justification to challenge a decision with which they were uncomfortable.

The personal research of this writer lies in how present institutional and societal arrangements create, obscure, or resolve ethical problems. The ultimate goal of ethical research is to suggest viable alternatives. But this proves a more difficult task than might first appear. For example, on close scrutiny, consent to surgery is rarely valid informed consent. More detailed forms would not help and would formalize the procedure in a non-constructive manner. The problem is the relationship between the (nurse) informer and the person consenting, when the patient is not seen as responsible for the choice. The institutional setting requires that we pretend that they (patients) are (responsible), rather than really giving them the responsibility.

Role implications

The heavy professionalism and institutionalization of health care means that one is usually arguing for educated patient and public participation in individual health care decisions and health policy. Ethical analyses of the kind and power wielded by physicians in medical encounters have implications for the responsibilities and role of nurses.

Nurses are caught in a web of relationships which limit the exercise of their professional competence and ethics. The broad professional autonomy of the medical profession limits much nursing practice. This is compounded by the hierarchical organization of the hospital, where administrators are concerned with limiting fiscal freedom and legal liability.

Spending more time with patients than either physicians or administrators, the nurse must provide care consistent with such institutional authorities,

"...the more that you feel unjustly or unethically treated by the health care system, the less compuction you will have in treating those with less power than you in the same manner."

observing the resulting inadequacies in patient care, often bearing the brunt of patient frustration and hostility, and risking formal or informal sanctions if one challenges the directives. The little region of professional discretion some nurses attain is usually creatively constructed by playing these two institutional authorities against each other. This is hardly the exercise of professional autonomy, which is premised on the recognition of competence and the need for freedom to apply professional judgement.

Professionalization of nursing

Professional autonomy is a popular phrase, and one mark of a profession. Theoretically, professional autonomy is based on ability and competence, and is a claim that professionals ought to have the freedom to exercise their professional judgement on consenting clients. Nurses' professional autonomy is limited by conflict with the medical profession's autonomy, concerns of hospital administration, and social conventions and attitudes. Hesitating to educate a patient who has unrealistic expectations and is about to be discharged following knee surgery, or calling the physician on call to authorize medicines are both cases of limitations of nurses' professional autonomy. In both cases, the judgement has been made by the nurses, but they must seek authorization before exercising their professional abilities.

Reimbursement for professional services is theoretically based on the extent of training for a position, the level of responsibility, and the number of hours worked relative to other professionals in a similar job market. Perhaps physicians, social workers and teachers are good comparison groups, although physicians typically train about twice as long. Nurses' reimbursement is limited by efforts to control costs of health care, limitation of responsibility by health care institutions and the medical profession, and sexism. For example, as health care economist Robert Evans has indicated, physicians still maintain income levels by increased intensity of servicing under fee-for-service billing. Social work, another well-known female dominated profession, is faced with decreased pay and increased accountability and case loads.

Legitimacy, or a culture's acceptance of professional roles, is theoretically based on client's voluntary relationship, or public and political groups consulting with a professional group. Nurses' legitimacy is limited by culturally and politically entrenched groups (i.e., physicians, hospital administration, seniority), attitudes supporting the status quo (conservatism of finances and health care, cure orientation), and internal conflict (what degree do nurses need to perform the tasks currently part of their job, and what should their jobs become?). For example, there is no good reason not to address the persistent inequities in access to health care in rural populations, and the high cost of providing very basic services through the emergency room, through nurse practitioner programs, as has been done in the United States.

The resolution of these problems of professional recognition must involve political action, likely through unions. As a family practitioner remarked in a class on ethics for medical students, the more that you feel unjustly or unethically treated by the health care system, the less compuction you will have in treating those with less power than you in the same manner. That does not justify it, but patients will suffer from the current mistreatment of nurses within the health care system. Nurses should fight for these changes for their own sake, not patients'. To argue for professional advancement so that patients might benefit is suspicious, and likely to stimulate distrust. People who are happy with their employment situations do better work, and nurses' work has to do with patients. That is probably as strong as the connection should be. If nurses want professional advancement, they should do it for themselves!

Moral responsibilities

Nurses' professional competencies and relationships define their moral responsibilities. In addition to the normal moral responsibilities which we all have as persons, nurses add professional moral duties. It should be mentioned that this relation-based notion of ethics is different from many more traditional theories, and is strongly based on work in the areas of practical ethics and feminism. But I find the use of rights (implied through duties and reponsibilities) pretty confusing and often meaningless; so I prefer this (relationship) approach for its concreteness and humaneness.

Nurses have moral responsibilities to each other. These responsibilities are often labelled col-

leagueality, mutual respect, honesty, and loyality. Nurses should be supportive of each other emotionally, communicate concerns directly and recognize each other's commitments. When you have a problem, talk to all involved who may be affected by your action. Correct each other "by going to the source," rather than reporting to those in authority.

Nurses have moral responsibilities to patients and the public. This is obvious. There is, however, a danger in the new emphasis on advocacy. Every health care professional, and lawyers as well, believe themselves to be the patient's advocate. Rather than being better represented, patients' own voices may often be lost in a sea of advocates. I am not suggesting that it is inappropriate to support and represent patients. But do not emulate the now discredited paternal model of the medical profession by deciding what is in the patient's best interests independent of patient participation.

"This was not patient advocacy of a beneficial sort, but an attempt to substitute nurses' judgement for the patient and family's."

Remember the example of the nurses' complaint that patient's consent was not valid because it was influenced by the family and the physician. My analysis was that the nurses disagreed with the quality of life judgement made by the patient's family and physician, and accepted by the patient. This was not patient advocacy of a beneficial sort, but an attempt to substitute nurses' judgement for the patient and family's.

Nurses have moral responsibilities to other health care practitioners and their institutions. They have agreed to work within lines of authority and within particular relationships. This limits their choices and freedom to act. However, where these constrain or encourage apathy or mistreatment, nurses also have responsibiliy to challenge them. For example, when a nurse disagrees with a decision or policy, it should be discussed with the responsible parties. It should not be ignored!

Ethical conflicts

Nurses' professional or personal interests sometimes conflict with their moral responsibilities to patients or other health care professionals. A good example of this was the Alberta nurses' strike in 1988, in which each member was faced with a decision where loyalty and support to colleagues and self-respect conflicted with patient care. It was also complicated because striking seemed to promote patient care in the long term by neglecting it in the short term. But the moral basis for the strike was the right to reasonable work conditions within which to care for patients, including some of those who were neglected in the act of striking.

Self-serving image

A careful analysis should try to determine which action best promoted the moral duties involved. But ethical analysis by nurses which supports the strike will always appear biased and self-serving, even if it is a good analysis. To argue for the strike on the basis of patient interests promotes this self-serving image.

An example of personal interests conflicting with patient interests is surgery and the risk of HIV infection, where confidentiality and patients' equal treatment may be compromised to protect practitioners. Good information on the risk of infection and reasonable universal precautions reduces the moral weight of the personal interest in protection.

Nurses may face ethical issues where responsibilities to patients conflict with responsibilities with colleagues. A well-known case is the Tuma case from the United States. Nurse Jolene Tuma was sanctioned for unprofessional conduct for discussing alternative forms of care with a cancer patient and the family, at the patient's request *(Supreme Court of the State of Idaho, No. 12587, Twin Falls, Idaho, October, 1978; filed April 17, 1979)*. The professional association agreed with the physician that nurse's obligation to the physician not to disclose such information was stronger than the responsibility to answer patients' questions. The suit was overturned in court due to lack of specific requirements in the professional code.

Supportive education

More frequently, the conflict is between patient requests about diagnosis or prognosis and physicians' or families' attempts to keep patients ignorant. The responsibilty of collegiality is not one of blind support, but of supportive education. If a colleague's actions or decisions are not in a patients' interests, discuss it with the colleague. Do not merely withdraw, or ignore your colleague's work.

It is also possible for an ethical issue to arise from conflicts between various responsibilities to

patients. Whenever a patient exercises the right to refuse treatment in a case where you believe they should accept it, or accept in cases where you believe they should refuse, the ethical conflict is between your responsibility to respect patient autonomy and the responsibility to act in the patient's best interet. Typically, the most that you can do is talk to the patient, or to ask the physician to do so.

The dilemma of understaffing

The conflict may also be between responsibilities to different patients, such as in situations of understaffing. The dilemma of how to allocate scarce time is a difficult issue whose best resolution typically requires changes in policy, funding or staffing procedures. Often the best that one can do with the immediate problem is discuss the situation with your colleagues, and explain the situation to patients who may be confused by the change in levels of attention and priority.

Yet another source of ethical issues are conflicts of responsibilities to individual patients with responsibilities to the public, as in cases of contageous or infectious disease, job-related risks, and in lifestyle related illness. When third parties are placed at risk of injury or disease by the action or simply the condition of patients, it is difficult to maintain confidentiality.

Perhaps one of the most important and practical questions to ask of each of these cases is whether disclosure to any source is the least offensive means of protecting those at risk. Furthermore, in many cases disclosure simply will not have an effect, so cannot be justified. Self-righteousness often tempts us to disclose without careful ethical reflection, and these cases try our self-control.

There is a growing interest in surgical research, and as in many forms of medical research, nurses are often faced with the task of informed consent. It is important to realize that patient interests may conflict with research interests. "Research interests" are a complex of investigator, institution, perhaps company and future patients, or the publics' interests in pursuing the research. On the model of clinical trials, all experimental procedures, and additional monitoring, must be well distinguished due to patients' tendencies to assume therapeutic value.

Bioethics - possibilities and impotencies

There are ways that bioethics can assist nurses, although the cliche "No answers" is only a slight exaggeration. Nonetheless, those of us working in bioethics form a supportive community and share some useful methods. The methods of ethical analysis for cases are helpful to learn, but practitioners must watch out for overzealous advocacy. The ability to ethically analyze practical moral issues should lend clarity and humility, not authority. Bioethics may also assist nursing to gain in legitimacy. Working with other professionals, including other ethicists, will help give nursing expertise its proper place in ethical analysis and patient care.

"...professional and personal integrity require that nurses baldly refuse to trade relationships for technique."

"Grassroots" efforts are the most likely to work, and the least authoritarian. It is therefore most appropriate for members of the nursing profession to seek education and form groups with each other and other colleagues in health care. Within hospitals, nursing may gain in recognized legitimacy through their role on ethics consultations, and on ethics committees. On the national scene, the Canadian Bioethics Society requires nursing representation on its executive and encourages participation of nurses in the Society's activities.

Conclusion

In conclusion, I have three comments. First, be bold about professional interests. Just as all persons are due respect of their autonomy, so nurses are owed professional autonomy to exercise their professional competencies.

My second comment is negative. Nurses must be careful about advocacy and avoid the excesses of what could be characterized as paternal physician models. Finally, professional and personal integrity require that nurses baldly refuse to trade relationships for technique. ■

About the author

Michael M. Burgess, Ph.D., is a professor of Medical Bioethics, Faculty of Medicine, University of Calgary, Calgary, Alberta. This submission was taken from an address the author delivered at the Annual Meeting of the Alberta Operating Room Nurses Association held in Edmonton last Fall.

O.R. Nursing: Educational Opportunities

A number of educational institutions and hospitals across Canada have requested that the Journal advise readers of various operating room educational courses that are being offered throughout the country. Described below are recent information releases on operating room educational programs being offered. In future issues, the Journal will publicize details of other O.R. educational programs. This service is free as long as the information provided is relevant to operating room nursing education. This information, in detail, should be sent to:

The Managing Editor, Canadian Operating Room Nursing Journal
214 Merton Street, Suite 202, Toronto, Ontario, M4S 1A6

Centennial College of Applied Arts and Technology School of Health Science

Centennial is offering a new post-graduate program in operating room nursing for registered nurses. It has particular appeal for working nurses residing in or near the Metropolitan Toronto area because of the flexible format offered. The full-time program began in early April. However, beginning in the late summer, one-day and three-days-a-week courses will be offered.

This new, post-diploma program was developed in close co-operation with health care agencies in the community in order to provide specialized training for operating room nurses. It incorporates classroom theory with laboratory and operating room clinical practice. The course is designed to provide a good back-ground for people working in other areas: maternity, outpatient clinics, etc.

The 300-hour program is organized into four modules which can be completed on a full-time or part-time basis. In the first three modules, students are introduced to the clinical experience in Metro Toronto hospitals. In the fourth module, the students spend the entire 120 hours in clinical practice.

The program is open to registered nurses with a current certificate of competence from the College of Nurses of Ontario, and at least one year of general staff nurse experience. For more information:
Joanna Bernstein, Director,
Post-graduate O.R. Program,
Centennial College, Warden Woods Campus,
651 Warden Avenue, Box 631, Station "A",
Scarborough, Ontario M1K 5E9.
(416) 694-3241 ext. 3391.

British Columbia Institute of Technology Post Diploma OR Nursing Program

The theory components of this operating room program are presented in modular form for directed, independent study. The clinical component of the introductory level is 10 weeks of full-time clinical instruction that is presently held in selected tertiary care hospitals in Vancouver, B.C.

The advanced level clinical component is available as two-week preceptorships for the individual specialties: orthopaedic, vascular, thoracic, neurosurgery.

Under development at the B.C.I.T. for the post diploma O.R. course is an operating room nursing refresher course combining independent study, introductory theory and clinical instruction through preceptorship; paediatric modules for all levels of the program are to be introduced. Challenge exams based on theory and clinical components are under development as well. For more information:
Marnie Simon, Co-ordinator,
Operating Room Specialty Course,
British Columbia Institute of Technology,
3700 Willingdon Avenue, Burnaby, B.C.
V5G 3H2 (1-800-604) 663-6542.

Humber College of Applied Arts and Technology Health Sciences Division

Humber College has had a Certified Operating Room Nursing Program for Registered Nurses for over 10 years. The program was developed to prepare R.N.s to work in an operating room setting. It is designed to assist the student to acquire increased knowledge of nursing responsibilities during the perioperative period and technical skills required to participate as a surgical team member.

The program would be of interest to registered nurses working in the following nursing areas: emergency, labour and delivery, surgical and outpatient/day surgery. Students with OR experience or an incomplete program may take challenge tests after consultation with the nursing department.

This 320-hour program provides theory, classroom labs and teacher-supervised clinical experience in a flexible format utilizing the ORNAC Recommended Standards of O.R. Nursing Practice and Recommended Technical Standards. Full-time courses (11 weeks) are offered twice yearly - Fall and Spring, with part-time courses running throughout the year.

Humber College's Health Science Division also offers a Certified Operating Room Program for RNAs. This 4-month course is offered October to February on a full-time basis. Theory, class labs and teacher-supervised clinical experience are integrated into this course. For more details, contact:
Susan Schulte Co-ordinator - OR Nursing Programs
Continuing Education - Nursing
Health Sciences Division, Humber College
5 Queenslea Avenue, Westin, Ontario M9N 2K8
(416) 249-8301 ext. 249

Clinical nurse specialist from Edmonton, Alberta to be the recipient of the Drake/Thompson Memorial Editorial Award

The winner of the Drake/Thompson Memorial Editorial Award for 1988 is Donna Prokopczak, B.Sc.N., M.Ed. Donna is Clinical Nurse Specialist, Surgical Suite, University of Alberta Hospitals, Edmonton.

The award is offered annually to the author(s) of submissions that are published in the Canadian Operating Room Nursing Journal. Ms. Prokopczak's article, which appeared in the December, 1988 edition (Volume 6, Number 6), was entitled "Computers in the operating room: an assessment of trends, potential and expectations."

The award, offered by Surgikos Canada and administered through the ORNAC Awards Committee, commemorates the memory of two senior executives of Surgikos Canada who lost their lives in an airline mishap in 1983 - Christopher (Chris) Drake and Gregory (Greg) Thompson.

The award consists of $2,500.00 and a commemorative plaque to be presented at the Opening Ceremonies of the 1989 Alberta Provincial Operating Room Nurses Conference scheduled for Medicine Hat, Alberta, October 19. Ms. Prokopczak's name will also be inscribed on a Master Plaque that is maintained at Surgikos Canada's head office in Peterborough, Ontario.

Donna Prokopczak

1988 winner of the Drake/Thompson Memorial Editorial Award

Previous winners of the Editorial Award are:
1987 - Mary Kubaseiwicz, Manitoba
1986 - Joan Ball - Ontario
1985 - Jerry Rudney, Manitoba
1984 - Jean Savickis, Ontario
1983 - Joanne Teskey, Ontario

The legal implications of nursing shortages

By L.E. and F.A. Rozovsky

From time to time, almost every health facility in the country faces a nursing shortage. What are the legal ramifications for the institutions and for the nurses? In filling the shortages, what are the legal effects and implications?

The duty of the hospital

The Canadian Hospital Accreditation Guidlelines of the Canadian Council on Health Facilities Accreditation set standards for nursing manpower. The guidelines state that there shall be sufficient nurses on duty at all times to give nursing care that requires professional judgement and skills to plan, assign, supervise and evaluate care given.[1]

While the council may deny that it is creating law, that is what is being done. In a lawsuit against a hospital alleging that a nursing shortage caused the patient's injury, the Accreditation Standard may be used as the legally required norm. It may be adopted by the court as the basis for the facility's duty to have an appropriate number of nurses carrying out the tasks which the facility has accepted.

In accepting a task of providing particular services, whether surgical, obstetrical, or intensive care, the hospital is under a legal duty to provide that care according to average, reasonable and prudent standards. If the hospital does not have sufficient staff to meet these standards and as a result causes patient injury, the hospital can be found negligent. A court order will force it to compensate the patient.

If, however, unusual circumstances arise such as an unexpected surge of emergency patients, the hospital may not be found negligent in having too few nurses. This would also apply if there was an unexpected outbreak of staff illness or resignations. The standard for reasonable care is determined by the circumstances of the case. What is reasonable in one set of circumstances may not be in another.

A hospital cannot be expected to have sufficient staffing in anticipation of circumstances which may or may not arise. However, the hospital would be negligent if it was consistently understaffed. A court could find that it had not staffed on a reasonable basis given the functions it was attempting to carry out.

The duty of the nurse

When an institution is short-staffed, how should the nurse react? The first reaction should be to advise the hospital through the appropriate nursing supervisor that there are staff shortages. The hospital is then under a duty to take whatever action is reasonable to deal with these shortages.

As in any situation, the nurse cannot abandon his/her duty to the patient. The law still requires that he/she abide by average, reasonable and prudent nursing standards in the circumstances.

The key is ***"in the circumstances."*** The nurse cannot wash his/her hands of all nursing responsibilities because of short staffing. The nurse must "make the best of a bad lot," even though the standards may not be as high as they would be in better circumstances. The problem becomes serious when a nurse is asked to undertake a task which, because of the shortage, may cause patient injury. Following the same principle, the nurse is expected to act as an average, reasonable, prudent nurse would act in the same or similar circumstances.

Such a standard imposed on the nurse by the nursing profession itself through the courts may require the nurse to refuse to carry out the task. The problem is that, if by refusing to carry out the task the nurse creates a reasonable foreseeablity of patient injury, the task cannot be refused. It must be carried out in a manner which is least likely to cause injury. This creates a dilemma for which there is no definite answer. Only the nurse faced with the problem can make the decision. If the decision is wrong, it is not necessarily negligence. It may be an error in judgement for which the nurse cannot be held responsible, even though the patient has been injured.

1. (1986), Standard No. III, page 36.

Solutions to personnel shortages

1. Close down the service

If a facility cannot abide by average, reasonable prudent standards in the provision of certain services, it must close down those services.The patient is entitled by law to this basic standard of care. Except in unusual circumstances, the hospital that fails to abide by this duty and injures a patient may be considered negligent in a malpractice suit.

2. Cross-training

In order to fill the personnel gaps, it may be possible to train individuals to take over extra nursing duties. If such individuals are not nurses, great care must be exercised to ensure that they do not contravene nursing legislation.

If they are nurses and being given extra specialist training, they must be able to perform as would the average, reasonable nurse who is specialized in that area. Superficial training may not enable the nurse to meet this standard.

3. Floats

The use of floats who are untrained in the service to which they are sent can create serious legal difficulties for the hospital and the nurses. The grave danger is that they will not be able to meet the legally required standards, will injure patients and attract legal responsibility in a lawsuit.

4. Transfer of functions

Great care must be taken not to transfer functions to those who are not legally entitled to accept them, or to those who cannot maintain the required standards of performing those functions.

5. An in-house registry system

One method of co-ordinating under-staffed areas is to maintain a registry. Such a registry would list those staff nurses who possess qualifications which will enable them to be shifted, or to take on duties outside of their ordinary practice. Such a system must be kept up-to-date. This should eliminate the possibility of staff being moved into work situations in which they are totally inexperienced.

6. Refusal policy

A firm policy must be established in which nurses are advised **not** to take on tasks which they are untrained to carry out. This policy must receive the support of administration and the board of trustees, and be made known to the members of the medical staff. Nurses should not be permitted to take on tasks which they are not capable of. The offer of a member of the medical staff to "take responsibility" or the threat of dismissal from a nursing supervisor should not provide an exception to this rule.

7. Private agencies

Attempts may be made to overcome nursing shortages by contracting for staff with independent private nursing agencies. Even though the substitute nurses are employees of the agency and not the hospital, the hospital is responsible for their negligent acts. The reason is that these nurses are carrying out the hospital's undertaking to the patient. The fact that the hospital is carrying out this obligation by contracting with an agency does not remove its duty to provide services at the required standard. The contract between hospital and agency should specify areas of specialization. Even after the nurses arrive, they should not be expected to carry out functions which a trained hospital nurse could not be asked to perform.

8. Students and foreign recruitment

Use of nursing students to overcome nursing shortages raises the danger that they may not have the ability to perform at the same standard as would the average graduate nurse. By law, they are expected to meet those standards. Special attention should therefore be paid to supervising students.

Assuming that foreign nursing graduates received training equivalent to Canadian standards, an institution which entices foreigners may encounter serious legal contractual problems. A temporary license may not necessarily lead to a permanent license to practice, or a landed immigrant visa. If a contract is signed on that basis, the institution may find itself being sued for breach of contract.

Considering all of these factors, it becomes obvious that nursing shortages can cause considerable legal problems to employing institutions and to individual nurses. The solution is that institutions should adopt nursing shortage policies before such shortages arise. These policies should be written in consultation with legal counsel and should receive the active support of the board of trustees, administration and the nursing staff. ■

About the authors

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

CANADIAN

Operating Room Nursing Journal

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Corner Brook to be site of 10th Annual Conference Newfoundland and Labrador OR Nurses Association

The Newfoundland and Labrador Operating Room Nurses Association will be holding their 10th Annual Conference at the Glynmill Inn in Corner Brook, Newfoundland.

The conference is scheduled for June 1, 2 and 3. For more information, delegates and prospective exhibitors are asked to contact

Angela Lemoine, R.N.
Chairperson
Hospitality and P.R.
P.O. Box 67 W.E.P.S.
Corner Brook, Nfld.
A2H 3J0

Vienna, Austria, site of World OR Conference

The VI World Operating Room Nurses Conference is scheduled for the Austria Centre in Vienna from August 28 to September 1. This conference is sponsored by the Association of Operating Room Nurses (AORN), 10170 East Mississippi Ave., Denver, Colorado 80231, U.S.A.

Canada has been well represented at previous World Conferences, not only in registrations, but in providing speakers. In 1987 in Singapore, six Canadian nurses made presentations at the education sessions.

In Vienna, six Canadian operating room nurses have been chosen to to make addresses:

1. Carol Lenox and Michaline Lamarche (Mississauga Hospital). "Perioperative Care of the Elderly Patient;"
2. Mary Kubasiewicz (CNA), "Perioperative Nursing Research;"
3. Audrey MacDonald (Mount Sinai Hospital, Toronto), "Confrontation, Negotiation and Mediation;"
4. Gloria Stevens (St. Paul's Hospital, Vancouver), "Developments in Pain Management;"
5. Muriel Shewchuk (Foot Hills Hospital, Calgary), "Professional Accountability in the O.R. Team, Setting."

Canadian nurses will be wearing distinct "Canadian attire," particularly during "International Night Fesitivities." This attire will be available in Vienna. Delegates attending are asked to forward $15.00 before July 1 to Ann Robinson, International Planning Committee, 1419 Fort, Montreal, Quebec H3H 2C2

Canadian Headquarters for the conference will be the Hotel-Intercontinental in Vienna.

Manitoba Operating Room Nurses Association preparing for Third Biennial Conference

The Manitoba Operating Room Nurses' Association - MORNA, will be holding its third Biennial Conference in Winnipeg, June 11 to 13 at The Delta on Portage Avenue. Keynote speaker will be Linda K. Groah, R.N., the 1988 recipient of the Award of Excellence in Peri-operative Nursing presented by the American Association of Operating Room Nurses (AORN). She is also a well known writer and educator, having several OR nursing textbooks that are used in both Canada and the United States. Her topic will be "Perioperative Nursing: From Novice to Expert."

Also on the agenda will be Fay Rozovsky, author and consultant on health law, and the *Journal's* legal co-writer with her husband Lorne Rozovsky. As one of the keynote guest speakers, she will discuss "Quality Assurance and Risk Management in the O.R." For a full description of the Conference Program see page 26.

There will also be an exhibition of medical/surgical products. The last M.O.R.N.A. Conference held in 1987 had over 35 companies exhibiting, with over 130 delegates in attendance, a number of them from outside Manitoba.

Delegates and prospective exhibitors interested in more details or wishing to pre-register are requested to contact:

Pat Corey, Chairperson,
Promotion,
M.O.R.N.A. Conference
241 Burland Avenue
Winnipeg, Manitoba
R2N 2S8

Quebec operating room nurses schedule 23rd provincial conference for Montreal in October

The operating Room Nurses Association of Quebec will be holding its 23rd Provincial Conference at the Laval Congress Centre in Montreal from the 4th to 6th of October, 1989.

The theme of the conference is "The Challenge of Year 2000."

The Quebec O.R. conference is the oldest operating room nursing conference in Canada, dating back to the 60s.

Details of the program agenda and registration information will be forthcoming in future issues of the Journal. For enquiries contact:

(1) Monique Duguay, O.R.
Hopital General LaSalle,
8585 Terrasse Champlain,
LaSalle, Quebec H8P 1C1
(514) 365-1510

(2) Claude Marcil, Inf.-Chef,
Centre Hospitalier Lachine
650 - 16ieme Ave.
Lachine, Quebec H8S 3N5
(514) 637-1127

Health protection branch does not condone reuse of disposable medical products

Although some medical devices are labelled "disposable" - for one-time use only - many hospitals clean, re-sterilize, and reuse them more than once.

For the past ten years, innumerable articles, publications and seminars have discussed the pros and cons of this practice. One of the most recent is an article by health care professionals from Health and Welfare Canada and Statistics Canada.[1] It reports the results of a 1986 survey which included all Canadian hospitals.

The purpose of the survey was to determine the extent of the reuse of disposable medical devices intended for "single use only." It was found that 41% of Canadian hospitals regularly reused disposable medical devices, with reuse in hospitals with more than 200 beds significantly higher.

Of hospitals regularly reusing disposable devices, only 38% had written procedures for reuse, and 32% utilized a mechanism for determining the number of times a device was to be reutilized.

Cost analysis studies had been undertaken by only 29% of regular reusers. Items used in respiratory therapy equipment are the most commonly reused devices.

Policy considerations

The Health Protection Branch is often asked about the position which Health and Welfare Canada takes regarding reuse of disposable devices that are sold for single use only. The branch's policy takes into consideration survey findings which reveal that many hospitals which reuse devices have not established on a technical and scientific basis, those important measures needed to assure the safety of patients. These include established scientific limits of the number of reuses, dedicated procedures for cleaning and re-sterilization, rigorous test methods, ongoing device performance monitoring, short and long term patient followup, proper documentation, and consent.

The Health Protection Branch, Health and Welfare Canada takes the position that, since these devices are designed, produced, labelled and sold by the manufacturer for one use only, reuse cannot be recommended.

1. Campbell, C.A., Wells, G.A., Palmer, D.L.: Reuse of disposable medical devices in Canadian Hospitals, Amer. Journal of Infection Control, 1987; 15(5); 196 - 200.

THIRD BIENNIAL CONFERENCE

Manitoba Operating Room Nurses Association

June 11 - 13, 1989
The Delta
Winnipeg, Manitoba

Sunday, June 11

1800 - 2000 Registration
2000 - 2330 Wine and Cheese Reception

Monday, June 12

0730 - 0815 Registration and Breakfast **(Lobby, 11th floor)**

0815 - 0830 Welcome Address/Opening Remarks
(1) Bev Popowich, R.N., MORNA President, Unit Co-ordinator, O.R., P.A.C.U./D.S., Misericordia Hospital, Winnipeg, Manitoba **(11th floor - Delta Ballroom)**

(2) Eva Marie Lessing, R.N., President-elect, MORNA, O.R. Staff Nurse, St. Boniface General Hospital, Winnipeg, Manitoba

0830 - 1600 **Keynote speaker (all day)**
Linda K. Groah, R.N., B.S.N., Director of Nursing, O.R., P.A.R., University of California Hospitals and Clinics, San Francisco, CA

1100 - 1400 **Viewing of Exhibits & Lunch**

1400 - 1630 Concurrent - Substance Abuse: (detection, prevention and treatment)
Guest Speaker: Robert Ramsey, B.A., M.S.W., Past President and Director, Kaiser Substance Abuse Foundation, Vancouver B.C.

1830 - 2130 **Banquet and Entertainment**

Tuesday, June 13

0730 - 0830 Registration and Breakfast

0830 - 1630 Quality Assurance and Risk Management in the O.R.
Guest Speaker: Fay Rozovsky, J.D., M.Ph. (Harvard), Lawyer, Consultant and Author on Health Law

0830 - 1100 **Concurrent Session:**
Assisting with Anaesthesia
(Circulator - How Can You Help?)
Speaker: Dr. L. Nugent, Anaesthetist, St. Boniface General Hospital

1100 - 1400 **Viewing of Exhibits and Lunch**

1400 - 1630 Caring for the Patient with AIDS (Ethical and psychological issues)

Panel Discussion - Speakers:
(1) Dr. Arthur Schafer, Director, Centre for Professional and Applied Ethics, and Head, Section of Biomedical Ethics, University of Manotoba, Faculty of Medicine
(2) Tracy Hildebrandt, R.N., M.N., Nurse Specialist and AIDS Project Nurse, St. Boniface General Hospital
(3) Diane Issacs, Co-ordinator, Village Clinic AIDS Project
(4) Chris Shymko, R.N., OR Staff Nurse, St. Boniface General Hospital

1900 - 2000 **M.O.R.N.A. Annual Meeting**
2000 - 2100 Banquet

(More MORNA Conference details on page 23)

Administrative Coordinator OR/PAR

The Penticton Regional Hospital, a 269 bed hospital, has a vacancy for the Administrative Coordinator OR/PAR to assume responsibility for a 4 theatre OR & 11 bed Recovery Room. This position is responsible for the day-to-day 24 hour function of the OR/PAR which includes budgeting, hiring, scheduling and maintaining standards of patient care. Applicants must have a minimum of 5 years' OR experience supplemented by an OR post-graduate course and management training. Preference will be given to applicants with a Bachelor's degree in Nursing.

For more information and/or applications, please call or write:

Penticton Regional Hospital

Human Resources Department
550 Carmi Avenue
Penticton, B.C. V2A 3G6
Ph: (604) 492-9024 (collect)

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EXPERIENCED O.R. NURSES

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- experience the exhilaration of downhill skiing, wild or calm water sports, hiking to a mountain peak!
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- enrich your life by joining us.

Call or send resume to:

Mrs. P. Janzen
Director of Patient Care
Cranbrook Regional Hospital
13 - 24th Avenue North
Cranbrook, B.C.
V1C 3H9

Telephone: (604) 426-5281

VALLEY HEALTH SERVICES ASSOCIATION

Valley Health Services Association, a Regional Hospital, the main referral Centre for Nova Scotia's beautiful Annapolis Valley for specialties including, Orthopedics, Paediatrics, Obstetrics, Urology, Internal Medicine, Psychiatry, Cardiology, Thoracic and Vascular Surgery, General Medicine and Surgery has immediate openings for the following nursing positions:

OPERATING ROOM/RECOVERY ROOM SUPERVISOR

Qualifications:

- Registered in the Province of Nova Scotia.
- B.N. or B.ScN. or proof of working towards same.
- Advanced preparation in both the clinical and management components of O.R./R.R. Nursing essential.
- Progressive nursing experience in which leadership ability, administrative skills, and competency as a practitioner of nursing has been demonstrated.

TWO OPERATING ROOM NURSES

Qualifications:

- Registered in the Province of Nova Scotia.
- Previous and recent O.R. experience and/or a post basic O.R. course.

Please send complete resume to:

Personnel Department
Valley Health Services Association
Miller Unit
100 Exhibition Street
Kentville, Nova Scotia
B4N 1C4

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Division of **Euroclean Canada Inc**
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Tel: (519) 653-8880
Telex: 069-59481 FAX: (519) 653-8691

ORNAC institutes credentialing process for post basic OR nursing programs

The Operating Room nurses Association of Canada has established a credentialing process for Post Basic Operating Room Nursing Programs. The goal of this approval process is not only to give recognition to quality in operating room nursing education, but also to establish standards that lead to consistency in program curriculae.

The Approval Committee is appointed by the Board of Directors of the Operating Room Nurses Association of Canada, the national organization that represents operating room nurses in all provinces and territories.

Three levels

Institutions who wish their post basic operating room nursing educational programs to be approved must submit their program for review by the committee at least three months prior to the required approval date. Three levels of approval are granted:

1. Full approval
2. Conditional approval
3. Non-approval

Full approval is granted for three years; conditional approval indicates recommended changes to the program are instituted prior to full approval. Approval in this case may be granted for one to three years. Non-approval means that approval is denied as the sponsors have failed to present sufficient evidence that the standards have been met.

Programs denied approval may reapply or appeal the decision. Approved programs that undergo major changes are required to notify ORNAC immediately. A review of the changes will be conducted by the Approval Committee to determine whether the program still qualifies for approval.

An approved program is granted permission to use the ORNAC logo in order to advertise and promote their program.

Prospective students to post basic operating room nursing education enquiring about programs will be provided with a list of approved programs. Further information and credentialing application forms may be obtained by writing to:
Gloria Stephens, Chairman,
Standards Committee,
ORNAC
2864 West 3rd Avenue,
Vancouver, B.C. V6K 1M7

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