January 1970

The Canadian Nurse

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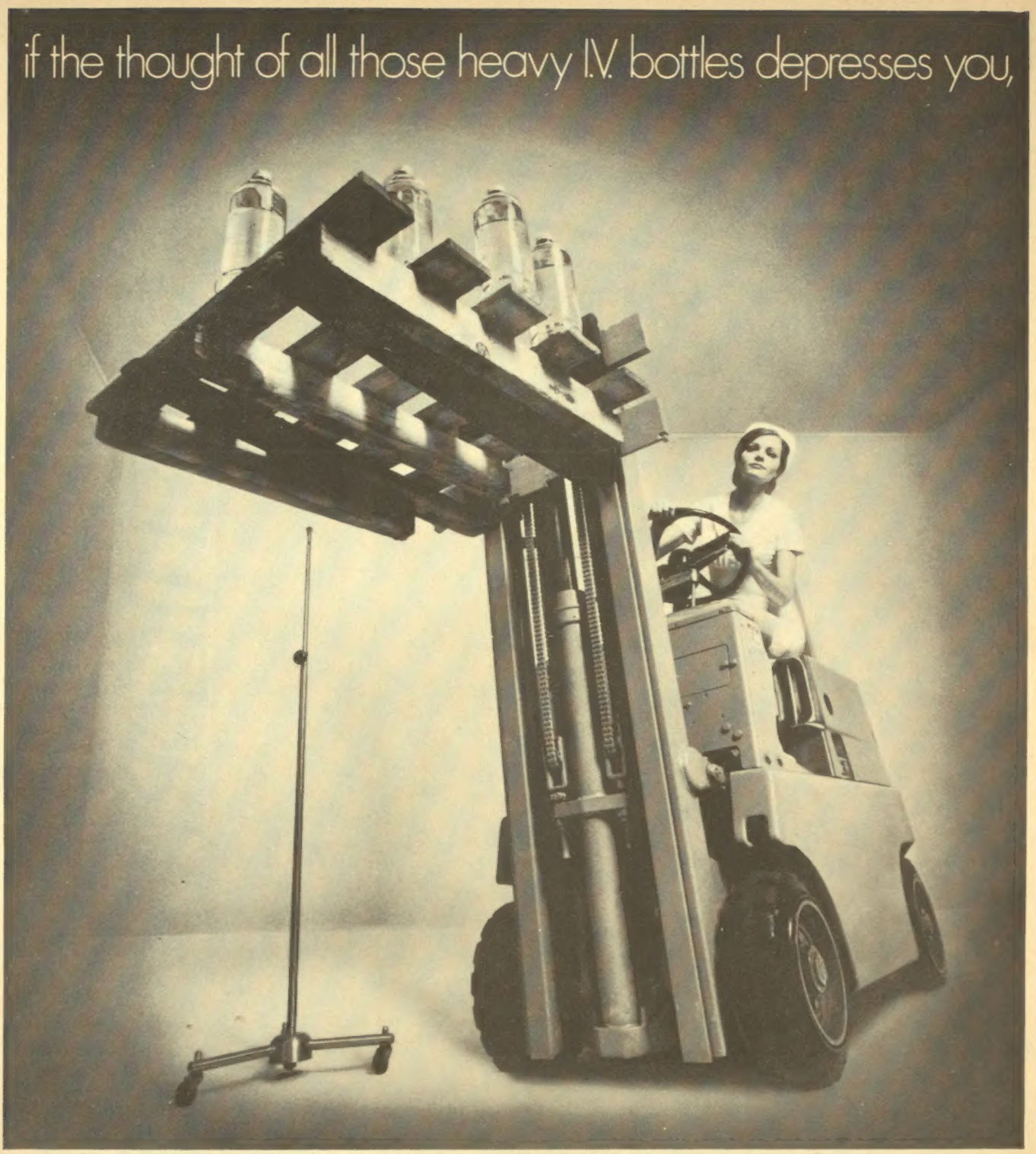

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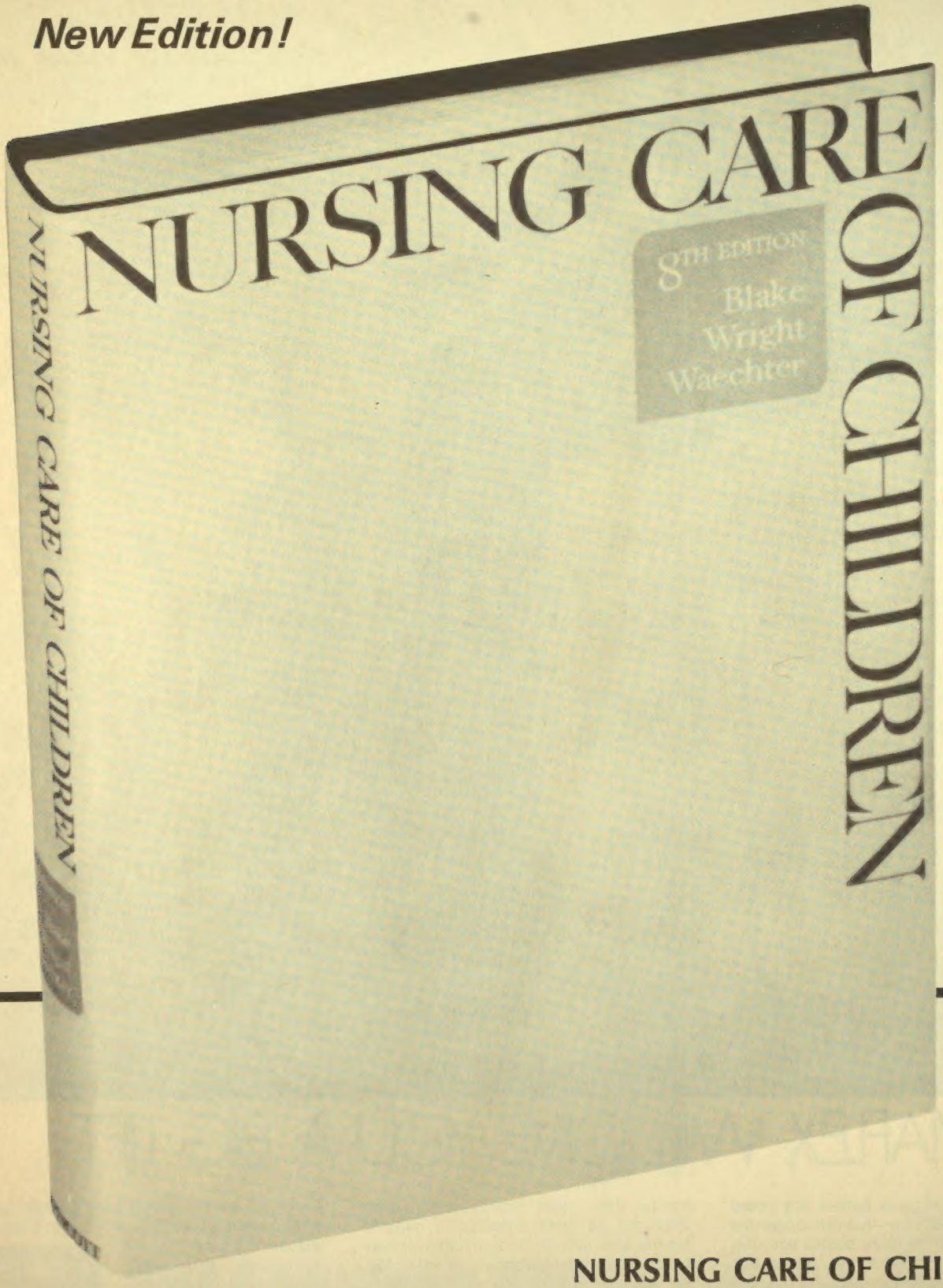

NURSING CARE OF CHILDREN
(formerly Essentials of Pediatric Nursing)
By Florence G. Blake, R.N., M.A., F. Howell Wright, M.D., and Eugenia H. Waechter, R.N., Ph.D.
586 Pages 188 Illustrations 8th Edition
January, 1970 $10.00

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The Canadian Nurse

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Executive Director: **Helen K. Mussallem** • Editor: **Virginia A. Lindabury** • Assistant Editor: **Eleanor B. Mitchell** • Editorial Assistant: **Carol A. Kotlarsky** • Circulation Manager: **Beryl Darling** • Advertising Manager: **Ruth H. Baumel** • **Subscription Rates:** Canada: One Year, $4.50; two years, $8.00. Foreign: One Year, $5.00; two years, $9.00. Single copies: 50 cents each. Make cheques or money orders payable to the Canadian Nurses' Association. • **Change of Address:** Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

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In his 1938 best seller *The Summing Up,* W. Somerset Maugham wrote: "There is a sort of man who pays no attention to his good actions, but is tormented by his bad ones. This is the type who most often writes about himself. He leaves out his redeeming qualities, and so appears only weak, unprincipled . . . ."

When reading this passage we tried to think of a writer who would fit Maugham's description, but drew a blank. Last month, as we prepared to write this editorial, his words came back to us. We still couldn't remember any autobiographer who had emphasized his own bad qualities, but we could identify a *profession* — our own — which practices self-degradation to the extreme.

Well, let's look at nursing in the sixties. Was it as bad as some critics in our profession would have us believe? Did we really fail in the past decade to live up to our former standards of patient care? We think not.

Here are a few reasons why we believe our colleagues deserve kudos for their work in the sixties:

- Nurses have shown an amazing flexibility in adjusting to the ever-increasing use of complex machines and computers, which certainly came into their own in the sixties. At the same time these nurses have retained their interest in the patient as a person — a feat that few other members of the health team have managed.
- The old master-slave relationship between doctor and nurse has almost disappeared, mainly because nurses have convinced physicians that patients are better served when a colleague relationship prevails. Mind you, the death rattles of this traditional relationship can still be heard and will require some attention in the seventies, but they are definitely becoming feebler.
- Despite many obstacles, nurse educators have had considerable success in placing nursing education where it should be — in educational institutions. There is still some kicking and screaming going on as the "schools" are torn away from their hospital womb, but this ruckus comes from a source other than RNs and students.
- Finally, nurses in the sixties have made their demands known to employers and government as never before. Our hope for the seventies is that this "militancy," as some call it, will be directed toward demands for better patient care and for laws concerning social issues that affect the health of all citizens. — **V.A.L.**

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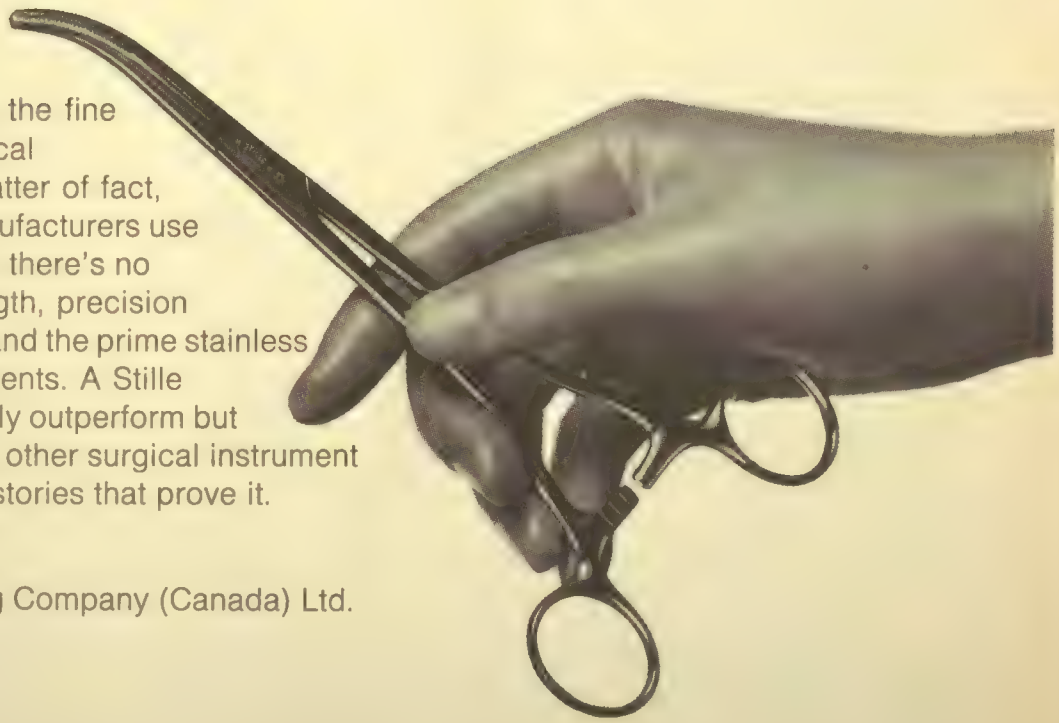

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news

Government Rejects CNA Project

Ottawa. – The federal government has refused to fund a nursing education project submitted by the Canadian Nurses' Association in the Spring of 1969. At the same time the government has agreed to fund several projects submitted by the Canadian Hospital Association, apparently including a study on nursing education.

According to CNA executive director Helen K. Mussallem, CNA was one of several health associations invited by the department of national health and welfare to submit projects for possible funding under the new national health grants. Because of the limited time for submissions and the belief that one study rather than several might receive favorable consideration, the CNA submitted only one project design, Dr. Mussallem said. The topic was "Factors Preventing Registered Nurses from Achieving Their Educational Goals."

A letter was later received from the minister of health stating that CNA's project had not been approved. The minister gave no reason for his decision.

The Canadian Hospital Association sought federal grants for four major projects, according to the September 1969 issue of Canadian Hospital News. One project listed was "the study of the performance in the hospital situation of the graduates of the two and three-year courses in nursing." An article in the November 14 issue of the *Saskatoon Star Phoenix* quotes the CHA president, L.R. Adshead, as saying that this study is being fully underwritten by the federal government.

The CNA board of directors, at its meeting November 4-7, expressed concern about the CHA's proposal to conduct a study to evaluate the performance of graduates of two- and three-year diploma programs. The board believed that such a study would be premature since the number of graduates of two-year programs is still small and since most two-year programs have graduated only one class at the most. The board directed the CNA executive director to write to CHA, relaying CNA's interest in the research and indicating that studies on this subject are already being carried out in several provinces.

The federal government recently announced its approval of two other CHA projects: $9,050 will be granted to CHA by the government to help finance a national symposium on computer applications in the health field; and money will be funded to CHA for a study on the transfer of functions among medical, nursing, and paramedical personnel.

Four nurses from Trinidad currently studying at the Clarke Institute of Psychiatry are from left: Maria Keith, Hollis Lashley, Josephine Parris and Barbara Harding.

Federal Grant for CMHA

Ottawa. – A $15,400 grant has been approved for the Canadian Mental Health Association under terms of the new National Health Grant. Approval of the grant was announced by national health and welfare minister John Monro.

The money will assist a CMHA project to examine methods of developing effective preventative programs for mental health within the existing structure of public health services. The project's goal is to coordinate mental health services with the public health services that have been developed and are available in most parts of the country.

Activities of the project include an examination of present public health programs across Canada, with particular attention being focused on their mental health implications. The program includes visits to communities in British Columbia, Saskatchewan, Ontario, Quebec, and Nova Scotia.

Trinidad Nursing Instructors Train At Clarke Institute

Toronto, Ont. – As part of the ongoing psychiatric aid program operating in Trinidad and Tobago under the auspices of the Canadian External Aid, four nursing instructors from Trinidad are spending six months at the Clarke Institute of Psychiatry to obtain further experience in psychiatric nursing and nursing education. The nurses were able to come to Canada because of scholarships awarded by the Canadian International Development Agency.

The technical aid project for Trinidad and Tobago is administered by the Clarke Institute under the direction of Dr. W.J. Stauble. He has been responsible for recruiting the Canadian group working in Trinidad and has visited Trinidad once or twice a year since the program commenced in 1966.

On these visits Dr. Stauble reviews the work of the Canadian group and meets with psychiatrists, university and government personnel to maintain continuity and director for the program. The primary aim of the training program is to raise the level of nursing education at the various hospital schools in Trinidad and Tobago.

(Continued on page 6)

(Continued from page 5)

The four nurses are: Barbara Harding, Josephine Parris, and Hollis Lashley, nurse instructors at St. Ann's Hospital, Port of Spain; and Maria Keith, who is on the nursing staff of the Caura Chest Hospital, Port of Spain, as head nurse and administrator of the inservice training program.

Members Appointed To Ad Hoc Committee On CNA Testing Service

Ottawa. – Nine members have been appointed to the ad hoc committee on CNA Testing Service by the executive committee of the Canadian Nurses' Association.

The members of the ad hoc committee are: Dr. Dorothy Colquhoun, director of testing services, Registered Nurses' Association of Ontario; Dr. Mildred Katzell, director, Measurement & Evaluation, National League for Nursing, Inc., New York; Barbara Kuhn, nurse educator, Association of Nurses of the Province of Quebec; Joan Macdonald, director of the College of Nurses of Ontario; Irene Leckie, professor, School of Nursing, University of New Brunswick; Alice Baumgart, associate professor, University of British Columbia School of Nursing; Sister Mary Felicitas, CNA president; Ernest Van Raalte, CNA General Manager; and George Hynna, CNA lawyer.

The CNA Board of Directors decided to set up this committee to develop a recommended structure for the CNA Testing Service. At the same time, the board directed that the ad hoc committee should be composed of two psychometricians, two representatives of registering bodies, two representatives of clinical nursing, one representative from business, and one from law.

The first meeting of the ad hoc committee was held at CNA House December 11-13, 1969.

CNF Scholarship Fund Gets Boost From CNA

Ottawa. – This year the Canadian Nurses' Foundation can count on its scholarship fund climbing to at least $30,000. This guarantee comes from the Canadian Nurses' Association.

The CNA board of directors agreed in November that CNA would make up the difference if the CNF scholarship fund did not reach a minimum of $30,000.

Helen K. Mussallem, executive director of CNA and secretary-treasurer of CNF, pointed out to the CNA board that CNF's scholarship fund is made up entirely of contributions, whereas the general fund is made up of membership fees. The membership fees could be transferred to help pay the operating and administrative expenses of CNF, if directed by members at the CNF annual meeting. These operating expenses are now absorbed by C.N.A., Dr. Mussallem, explained.

In 1969-70, over $41,000 was awarded to CNF scholars. After the full amount of these awards is paid this month, only $16,000 will remain in the CNF scholarship fund.

Any registered nurse can become a regular member of CNF by paying an annual fee of $2. Cheques or money orders should be sent to: CNF, 50 The Driveway, Ottawa 4, Ontario. Business firms, corporations, and associations can also be sustaining members or patrons of CNF by paying the required fee for these categories.

Individuals or groups can contribute gifts or donations, which are also tax deductible. The Foundation has received donations from CNA, nurses' associations at provincial, district, and chapter levels, individual nurses, and business firms.

Playhouse Is Hub Of CNA Biennial

Fredericton, N.B. – The Playhouse theatre will be the hub of events when up to 1,000 nurses gather here June 14 to 19, 1970 for the biennial convention of the Canadian Nurses' Association. All business sessions will take place in this modern structure with its Georgian architectural motif, centrally located and on the banks of the Saint John River.

The theatre accommodates 1,000 persons; seats are spaced and graded for viewing effectiveness. The stage is 30 feet deep and has an elevator-controlled forestage that can adjust to three different levels.

Complementing the theatre and adjacent to it is the Long Gallery, an ideal setting for art displays and collections.

Used for professional and amateur drama, the Playhouse is the setting for a wide variety of other cultural events, including concerts and ballet. It is also in heavy demand for community and university purposes.

The Playhouse was a gift to the province from the late Lord Beaverbrook; it is presently supported by the Beaverbrook Canadian Foundation.

Nurses At Yellowknife From Association

Yellowknife, N.W.T. – The newest registered nurses' association in Canada was incorporated here last May, *The Canadian Nurse* learned at press time.

Elected officers of the Yellowknife Registered Nurses' Association are: Marilyn Robertson, president; Ollie Sinclair, vice-president; Barbra Bromley, second vice-president; Jeanette Plaami, secreta-

ry; Eileen Wry, treasurer; and Elaine Richinger, past-president.

The YRNA now wants to form a Northwest Territories Registered Nurses' Association, and has written to the Canadian Nurses' Association and several Communities asking for comments and suggestions.

CCHA Moves To Accredit Extended Care Centers

Toronto, Ont. – Early in 1970 the Canadian Council on Hospital Accreditation will expand its program to include accreditation of extended care centers across Canada.

The new program will be voluntary, the same as the established program in the acute general hospital field. It will be open to institutions and agencies offering health care to patients whose stay is over an extended period.

According to CCHA's definition, an extended care center is one that provides the necessary nursing and medical care with other required services as well as personal assistance with the acts of daily living. These centers may operate under voluntary, proprietary, or governmental auspices. Hospitals for the chronically ill, convalescent hospitals, nursing homes, home care agencies, and a variety of service organizations that span or include these kinds of care may become eligible on application.

"We are indebted to the W.K. Kellogg Foundation for their encouragement and their support in the form of a substantial grant to prepare a program and to implement it," said Dr. R.S. Duggan, chairman of the CCHA Board.

Work on the new program began in May 1968. Project Director was Dr. Michel Gingras, now medical director of Jean Talon Hospital, Montreal. He was assisted by Nicole Du Mouchel, CCHA nursing consultant.

The accrediting process will follow essentially the same pattern as that of the acute general field. A survey date is assigned to the eligible applicant four to eight weeks before the visit. A survey report is also prepared before the visit to provide a background of basic and current information necessary for accreditation.

An experienced nurse surveyor will take part in each survey and will be assisted in selected situations by a doctor or administrator. After appraisal of the completed report by CCHA's executive office and board, the center will be notified of the accreditation status awarded.

Accredited centers will be visited every three years unless some important issue requires earlier reassessment. Provisionally accredited centers are resurveyed in one year. Non-accredited may seek resurvey when ready for reassessment.

Organization and beginning costs will come from the Kellogg grant and from the Council. The ongoing program will be self-supporting from fee-for-survey charges, which will range from $300.00 to $500.00, depending on the size of the extended care center. There are some 3,000 such centers in Canada. A target of at least 100 surveys has been set for 1970.

Both the standards and an accreditation guide book for extended care centers to interpret the standards, are now available.

New Nursing Consultant Joins DNHW Studies Team

Ottawa – Beverly M. Du Gas became the first nursing consultant in the Health Manpower Studies Section of the Health Resources Directorate, Department of National Health and Welfare, in August 1969.

As nursing consultant, Dr. Du Gas collaborates with a medical consultant, an economist, and a statistician to gather data on the numbers and distribution of health manpower and to make projections of future needs for health personnel throughout Canada. This team plans to carry out studies in attrition, mobility, work patterns, and regional disparity of health personnel, utilization of personnel already available, and preparation of health workers. It also hopes to stimulate research by individuals, university schools of nursing, and other groups.

New Look For VON

More than 700 members of the Victorian Order of Nurses are now wearing a new uniform. A navy blue shift with three-quarter sleeves and white notched collar (left) replaces the shirt-waist style worn for the past five years. The summer dress (not shown) is peacock blue with short sleeves. The new navy blue top coat (right) is cut on straight lines with raglan sleeves. VON nurses now wear a navy Breton sailor hat, which shows the Order's crest. An ear covering of navy wool jersey in a scarf style may be attached to the hat for winter wear.

Dr. Du Gas is working with the research and advisory services of the Canadian Nurses' Association to gather statistics on nurses, and to set up ongoing research. Studies on mobility, attrition, and career patterns of nurses are particularly needed, Dr. Du Gas told *The Canadian Nurse.* She pointed out that CNA has gathered more statistics on its members than has any other professional association in Canada.

Dr. Du Gas is a graduate of The Vancouver General Hospital School of Nursing, has a bachelor of arts degree from the University of British Columbia, a master's degree in nursing school administration from the University of Washington in Seattle, and a doctoral degree in adult education from UBC. She has worked as a staff nurse in Seattle, San Francisco, and Vancouver; an instructor in San Francisco and Vancouver; and associate director of nursing (education) at The Vancouver General Hospital. From 1965 to 1967 Dr. Du Gas was a nurse educator with the World Health Organization in Chandigarh, India.

The new nursing consultant is co-author of the book *Fundamentals of Patient Care; a Comprehensive Approach to Nursing* by Kozier and Du Gas, a text that has sold thousands of copies in the United States and Canada since its publication by W.B. Saunders in 1967.

Dr. Beverly Du Gas, nursing consultant, and Dr. George P. Evans, medical consultant, work together on health manpower studies for the Department of National Health and Welfare. Dr. Evans is head of the team, which also includes an economist and a statistician. This team is carrying out studies on health personnel in Canada.

Teaching Problems Discussed At RNAO-OHA Conference

Toronto, Ont. – A professor of education who believes that group discussions tend to be too chairman-oriented, made 190 nurses create their own learning program as part of the conference for senior nurse adminstrators in Toronto November 24 - 27.

Dr. William S. Griffith, assistant

professor of education at the University of Chicago, presented a session on "Continuing staff development – the director's challenge" at the conference, which was jointly sponsored by the Registered Nurses' Association of Ontario and the Ontario Hospital Association.

Dr. Griffith used slides to demonstrate what he described as the basic difficulty of teaching: the various approaches students bring to problem-solving. He asked the audience to identify a configuration within a pattern, then asked two volunteers who had successfully identified the configuration to try to teach the rest of the group to see it as they saw it. "I know it, but I just can't teach it" and "You can tell me that, but I don't perceive it that way," were the ways Dr. Griffith summed up the difficulty the audience and the volunteers had in understanding one another.

Dr. Griffith emphasized the difficulty in communication as he spoke to the group about adult education. He pointed out that unless the student understands the instructor's view of the problem, much of the teaching time can be wasted. Often, he added, the student does not even see that there *is* a problem.

Dr. Griffith listed some guidelines for adult education, and outlined the steps in preparing a program for adult learning. He warned the nurses that students must be involved in the planning process and that they must believe they are being asked to contribute, not merely being asked to accept the instructor's point of view.

Dr. Griffith asked the audience to suggest some of the most difficult problems they face in setting up programs in their own hospitals. The answers included: time for training, motivation, a reluctance of junior staff to assume responsibility, selling the program to the hospital administration, recognizing learning priorities, lack of money and instructors. During the afternoon the participants formed round-table discussion groups to choose one of these topics and to suggest possible answers to the problem; each group appointed a reporter to explain its solution to the rest of the audience.

The conference also included discussion on communications, collective bargaining, and the human relations aspect of nursing administration. A presentation and discussion of the management by objectives program at The Hospital for Sick Children in Toronto was also part of the program.

Canadian Red Cross Fellowship Available For Graduate Study

Toronto, Ont. – The National Nursing Committee of the Canadian Red Cross Society has announced that a fellowship of $3,500 is available for a

nurse to undertake graduate study in an allied profession such as education, law, industrial relations, or architecture.

A candidate's qualifications should include: professional maturity, registration in Canada, at least a baccalaureate degree, and professional experience of not less than five years in which professional leadership has been shown. Preferably, the preparation sought should be for a specific position available and accepted by the candidate. Nurses wishing to study at the doctoral level receive preference.

The deadline for receiving applications is April 1, 1970. Apply to: The National Commissioner, The Canadian Red Cross Society, 95 Wellesley Street East, Toronto, Ontario.

Quebec Registered Nurses Get 20 Percent Wage Increase

Montreal, P.Q. – Over 11,000 registered nurses in Quebec received a 20 percent wage increase in three-year agreements signed by the provincial government and the Association of Hospitals of the province of Quebec in December. The new contract is retroactive to July 1, 1968 and will remain in effect until June 20, 1971.

The previous salary scale for RNs started at $390 a month; the present scale starts at $447. Agreements were also signed for 56,000 non-medical hospital employees, giving total benefits that will cost the provincial government $164,000,000.

The agreements end 18 months of negotiation between the government and AHPQ, and the three independent bargaining groups representing the nurses: the United Nurses of Montreal, the Syndicat professional des infirmières de Québec, and the Alliance des infirmières de Québec.

In an interview with *The Canadian Nurse,* Gloria Blaker, president of the 3,000-member UNM, said that the government agreed to include salary for in-service education personnel in the new contract. Also, she explained, there are now 15 yearly increments instead of seven, giving recognition for eight more years of experience.

Mrs. Blaker said that many other items had not yet been negotiated, but would be discussed in a year's time.

Nurses Hold Education Day

Chilliwack, B.C. – The Fraser Valley district of the Registered Nurses' Association of British Columbia held its seventh education day here in October, 1969.

More than 200 registered nurses and other members of the health team were present to hear Dr. Rae Chittick and Mary Southin, Q.C., discuss the legal and moral aspects of nursing responsibilities. Miss Southin defined legal requirements as the minimum standards of behavior and discussed the many situations that require the nurse to remember the legal responsibilities expected of her.

Dr. Chittick defined the moral requirements as involving the maximum standard of behavior, and reminded the audience that patients expect the nurse to be able to meet their needs at the bedside and in community health care.

Following, a panel dealing with the problems of drug abuse and drug addiction was chaired by Monica D. Angus; president of the RNABC.

Panel members included: Dr. W.P. Brown, psychiatrist and consultant chemotherapist for Riverview Mental Hospital, B.C.; warden, Pat Spence; parole officer, John Phillips of the Matsqui Drug Addiction Institution; and the educational supervisor of the BC Narcotic Addiction Foundation, Bob Hickey. □

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By Audrey Latshaw Sutton, R.N., Case Reviewer, Blue Cross of Philadelphia.

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In clear, precise language, supplemented by more than 850 explicit drawings, Mrs. Sutton tells precisely how to perform hundreds of nursing functions — from intramuscular injection to caring for the patient in hyperbaric oxygen therapy. Among the new sections are ones on reverse isolation, tubeless gastric analysis, IPPB respirators, fluid and electrolyte balance, hypodermoclysis, heart transplants, controlling hemorrhage from esophageal varices, and intra-arterial infusion of anticancer agents.

Nurses by the tens of thousands have found "Sutton" an unparalleled source of current information. It is ideal for the recent graduate who seeks help on how to perform specific procedures, for the nurse returning to practice after an interruption, and for the nurse preparing to transfer from one area of practice to another.

398 pages with 871 illustrations, $8.95. Second edition. Published March, 1969.

Hymovich: NURSING OF CHILDREN
A Guide for Study

By Debra P. Hymovich, University of Florida.

A workbook in pediatric nursing that teaches creative thinking about nursing care problems.

389 pages, illustrated. $5.95. May 1969.

Mercer & O'Connor: FUNDAMENTAL SKILLS IN THE NURSE-PATIENT RELATIONSHIP

By Lianne S. Mercer, formerly of the University of Michigan, and Patricia O'Connor, University of Michigan.

A self-teaching programmed text covering the important skills of interpersonal relations.

192 pages, illustrated. $4.30. May 1969.

Marlow: TEXTBOOK OF PEDIATRIC NURSING 3rd Edition

By Dorothy Marlow, Villanova University.

The most widely used text in its field, "Marlow" has now been thoroughly revised and updated.

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Secor: PATIENT CARE IN RESPIRATORY PROBLEMS

By Jane Secor, Syracuse University.

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Simmons: THE NURSE-PATIENT RELATIONSHIP IN PSYCHIATRIC NURSING

By Janet A Simmons, University of Massachussets.

A workbook to guide the student nurse during her institutional affiliation in psychiatric nursing.

189 pages. $4.05. August 1969.

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names

Jane Y. Aitken (S.R.N., Central Middlesex School of Nursing, London; S.C.M., Western District Hospital, Glasgow; Health Visitor's Certificate, Brocklands College, Weybridge, Surrey; Operating Room Postgraduate Course, Hammersmith Hospital, London; B.N., McGill U., Montreal) has been appointed maternal and child health consultant to the public health nursing division, Saskatchewan Department of Health.

For the past two years, Miss Aitken was regional nursing supervisor of the North Battleford health region, Saskatchewan.

Miss Aitken has also been a public health nurse and assistant to the regional nursing supervisor in the Yorkton, Sask., health region. She has worked as an operating room nurse at University Hospital, Saskatoon, Sask., at the General Hospital in Montreal, and the General Hospital in Kingston, Ontario.

Before she came to Canada, Miss Aitken was a health visitor in the County Health Department, Surrey, England.

Sister Thérère Castonguay (R.N., St. Boniface General H., Man.; B.Sc.N., L'Institut Marguerite d'Youville, U. of Montreal; M.Sc.N., Catholic U. of America, Washington, D.C.; B.A., Marillac College, St. Louis, Missouri) has been appointed director of nursing service, St. Boniface General Hospital, St. Boniface, Manitoba.

Sister Castonguay, a native of Quebec, was previously superintendent of nursing education for the Saskatchewan Department of Education. Before she was appointed to this department, she was director of the school of nursing at Regina Grey Nuns' Hospital. Her varied experience also includes medical-surgical nursing supervision, Maisonneuve Hospital, Montreal; obstetric and operating room supervision, St. Theresa Hospital, Fort Vermilion, Alberta; and assistant director, school of nursing, St. Boniface General Hospital.

The position of associate director of nursing at Victoria Hospital in London, Ontario, has been filled by **Bernice Lewis,** (R.N., Public General Hosp., Chatham, Ont.; cert. in nursing education and B.Sc.N., U. of Western Ontario).

Miss Lewis has held positions of director of nursing at the Public General Hospital in Chatham, and Norfolk General Hospital in Simcoe. She left the post of director of nursing service and education at the St. Thomas-Elgin General Hospital.

Sheila Quinn, executive director of the International Council of Nurses for the past two years, will soon be leaving ICN headquarters in Geneva to return to England. She has accepted a new position as chief nursing officer at the Southampton Group of Hospitals.

Miss Quinn (S.R.N. S.C.M. Sister Tutor Dipl. and B.Sc., economics, U. of London) was appointed to the ICN executive staff in 1961 as director of the new division of social and economic welfare. In 1966 she became deputy executive director of the ICN.

Miss Quinn has worked with national nurses' associations in many parts of the world, studying conditions of work of nurses and giving advice and guidance to the associations in social and economic welfare programs.

Before her appointment to the ICN, Miss Quinn held the positions of night superintendent, administrative sister, and principal sister tutor at the Prince of Wales General Hospital in London.

Ellen J. Pittuck (R.N., Ontario H., Cobourg, Ont.) has retired as director of nursing at the Ontario Hospital School in Orillia, Ontario, a position she held since 1961.

Miss Pittuck, who was born in England, began her nursing career in Cobourg, Ontario, where she became assistant director of nursing and teacher at the Ontario Hospital. Later, she joined the staff of the Ontario Hospital in Orillia, as assistant director of nursing and teacher, before becoming director of nursing.

Active in the Registered Nurses' Association of Ontario, Miss Pittuck was a member of the RNAO finance committee, and was president of the Huronia chapter and District 2 of the RNAO.

Marlene Anger (B.S.N., U. of Saskatchewan) has joined the staff of Mount Royal Junior College, Calgary, Alberta, as a nursing instructor.

Mrs. Anger has worked as a nursing instructor in psychiatry at Foothills Hospital in Calgary, a senior nurse with the Division of Alcoholism in Calgary, a mental health nurse at the Burnaby Mental Health Centre in Vancouver, and as a public health nurse in the Mount View Health Unit in Calgary.

Yolande Cyr (R.N., Edmunston Regional Hosp.; B.Sc.N., U. of Montreal) recently was appointed director of the school of nursing sciences, Edmunston Regional Hospital, Edmunston, N.B.

Mrs. Cyr has served as an instructor for six years, and assistant director of the school for four years. She is regional superintendent of the St. John Ambulance Brigade in the Edmunston area.

The University of British Columbia School of Nursing has announced a number of new faculty appointments.

Helen Elizabeth Elfert (Reg.N., The Hospital for Sick Children, Toronto; B.N., McGill U., Montreal; M.A., New York U.) has been appointed assistant professor.

Mrs. Elfert has worked in various parts of the country. She was a staff nurse at the Kitchener-Waterloo Hospital in Kitchener, Ontario; staff nurse, assistant head nurse, head nurse, and teacher at the Calgary General Hospital, Calgary, Alberta; and lecturer and assistant professor at the School for Graduate Nurses, McGill University, Montreal.

Mrs. Elfert was a 1965-66 Canadian

Nurses' Foundation Fellow.

Kirsten Weber (R.N., Victoria Hospital School of Nursing, Winnipeg; P.H.N. diploma, School of Nursing, U. of British Columbia, Vancouver; B.N., McGill U. School for Graduate Nurses, Montreal; M.S., School of Nursing, U. of California, San Francisco) has been appointed assistant professor at UBC.

Miss Weber has worked as an operating room staff nurse at The Vancouver General Hospital, the Royal Jubilee Hospital in Victoria, B.C., Gentofte Amtsyhus in Copenhagen, Denmark, and as a theatre sister at Croydon General Hospital in Croydon, England.

As a public health nurse, Miss Weber worked for the City of Toronto health department and the British Columbia health branch in Powell River and Port Alberni. She was a PHN supervisor in Prince Rupert, Kelowna, and Trail, British Columbia.

Miss Weber is a member of two committees of the Registered Nurses' Association of British Columbia: nursing service and library policy.

Maude Irene Dolphin (R.N., Royal Victoria H., Montreal; B.M., McGill U.; M.N., U. of Washington, Seatle) has been appointed assistant professor at U.B.C.

Prior to this appointment, Miss Dolphin was assistant professor at the school of nursing, University of Toronto.

Miss Dolphin has worked in Montreal as a supervisor at the Alexandra Hospital and a head nurse at the Royal Victoria Hospital. Her experience in British Columbia includes being an instructor at The Vancouver General Hospital; a nurse in the public health unit in Nanaimo, and director of nursing at Nanaimo Regional General Hospital.

For six years Miss Dolphin was a nurse educator with the World Health Organization in Pakistan, Syria, and Mauritius.

Jeanne Marie Hurd (B.A., Ohio Wesleyan U., Delaware, Ohio; M.A., Columbia U., N.Y.; M.N., Yale U. School of Nursing, New Haven, Connecticut) has been appointed clinical instructor in pediatrics at UBC.

Mrs. Hurd has worked as a bedside teacher at Bonnie Burn Tuberculosis Sanitorium, Berkeley Heights, New Jersey; dean of women and nurse at Westminster College, Salt Lake City, Utah; part-time staff nurse at Salt Lake County General Hospital; school nurse at the University of Wyoming in Laramie and Laramie public schools; and nurse–social worker with Operation Head Start in Laramie.

Sister Therese Carignan (R.N., St. Paul H., Vancouver; B.S.N., Seattle U., Seattle, Wash.) has been appointed instructor at the University of British Columbia School of Nursing, Vancouver.

Prior to this appointment, Sister Carignan was director of the Training Centre at Lake of the Woods District Hospital, Kenora, Ontario.

Sister Carignan served as coordinator of inservice education at St. Mary's Hospital, New Westminster, B.C. for one year. Before that she worked as a nursing supervisor at St. Paul Hospital, Vancouver; St. Eugene Hospital, Cranbrook, B.C.; St. Joseph Hospital, Kenora, Ont.; Providence Creche Baby Home in Calgary, Alberta; and night supervisor at Sacred Heart Hospital in McLennan, Alberta.

Barbara Mary Nitins (S.R.N., Middlesex Hospital, London, England; Cert. in industrial nursing, Birmingham U., England; Sister Tutor Diploma, Queen Elizabeth College, London U.) has been appointed instructor at UBC.

A native of Wales, Mrs. Nitins was a nursing sister in Queen Alexander's Royal Army Nursing Corps, a staff nurse at Birmingham Accident Hospital, and a sister tutor at Middlesex Hospital in London, England.

In Canada, Mrs. Nitins has worked as a staff nurse at Toronto East General Hospital, Shaughnessy Hospital in Vancouver, and The Vancouver General Hospital; a private duty nurse in Vancouver; and a part-time clinical instructor at UBC.

Sister Delia Clermont (R.N., St. Boniface H., Manitoba; B.Sc.N.Ed., St. Louis U., St. Louis, Missouri) is the newly-appointed director of the School for Nursing Assistants, La Verendrye Hospital, Fort Frances, Ontario.

Sister Clermont has held a number of positions at St. Boniface General Hospital, as a head nurse, instructor, assistant director, and director of the school of nursing, director of nursing service, and educational director. She has been administrator at La Verendrye Hospital, Holy Cross Hospital in Calgary, and St. Boniface General Hospital.

Sister Clermont has been vice president of the Manitoba Association of Registered Nurses; chairman of MARN's Committee on Nursing Education; and a former member of the CNA executive.

Elizabeth Anne Mowatt is the new director of nursing service at the Saint John General Hospital, Saint John, New Brunswick.

Mrs. Mowatt (R.N., Saint John General H.; dipl., teaching and supervision, and B.N., McGill U.; M.Sc.N., Boston U.) has held the positions of instructor, assistant director of nursing education, assistant director of inservice education, and associate director of nursing at the Saint John General Hospital.

An active member of the New Brunswick Association of Registered Nurses, Mrs. Mowatt has served on several NBARN committees and has been a vice-president.

Lucy Cook (R.N., Moncton H.; Public Health Nursing Dipl., McGill U.) has been appointed assistant director of public health nurses for the Nova Scotia Department of Public Health.

Miss Cook, a native of Nova Scotia, has worked as a nurse at Colchester County Hospital in Truro, and Camp Hill Hospital in Halifax. As a public health nurse, she worked in the Truro office of the department of public health, and was supervisor of public health nursing in the Fundy and Atlantic health units.

Marianne Elizabeth Lacava (R.N., B.S., U. of Connecticut; M.Ed., U. of Hartford) has been appointed advisor in nursing service for the Registered Nurses' Association of Nova Scotia. She will formulate and recommend nursing service projects and programs.

Miss Lacava has held positions as instructor at the St. Francis Hospital School of Nursing, Hartford, Conn., and the Kaiser Foundation Hospital School of Nursing, Oakland, Calif.; as public health staff nurse with the New Britain Visiting Nurse Association, Conn.; and as director of nursing services, Winsted Memorial Hospital, Conn.

For the past two years she has been involved in research for the state of Rhode Island under a U.S.A. public health service contract in the field of reentry of the health professional. Miss Lacava has served as consultant to the New England board of higher education; to the state-wide planning department of Rhode Island; and to the board of directors, state colleges and universities, Rhode Island. She was a member of the Rhode Island governor's advisory commission on vocational rehabilitation. □

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*Kehlmann, W. H.: Mod. Hosp. 84:104, 1955

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dates

February 18-22, 1970
Conference on The Nurse's Reactions and Patient Care, sponsored by the Registered Nurses' Association of Ontario, Geneva Park, Lake Couchiching. Registration fee: RNAO members — $80; non-members — $95. This fee includes meals, double room accommodation, and general-conference expenses. For further information and application forms, write to: Professional Development Department, RNAO, 33 Price Street, Toronto 289, Ontario.

February 24-25, 1970
Institute on Nursing Home Care, Inn-on-the-Park, Toronto. Sponsored by the Registered Nurses' Association of Ontario, Associated Nursing Homes Inc., the Ontario Dental Association, and the Ontario Medical Association. For further information, write to the RNAO Professional Development Department, 33 Price Street, Toronto 289, Ont.

March 20, 1970
Seminar sponsored by The Operating Room Nurses of Greater Toronto, Royal York Hotel, Toronto. Direct inquiries to: Mrs. Jean Hooper, Chairman, Public Relations Committee, The Operating Room Nurses of Greater Toronto, 43 Beaverbrook Avenue, Islington, Ontario.

March 16-18, 1970
Combined doctor-nurse meeting sponsored by the American College of Surgeons, Washington, D.C. No registration fee for nurses. Official housing forms are available from Mr. T. E. McGinnis, Manager of Exhibits and Meeting Arrangements, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611. Miss Doris Kirk, Operating Room Supervisor, The George Washington University Hospital, is chairman of the nurses' program.

March 19-20, 1970
Symposium on "Problems in Delivering Cardiac Care," sponsored by the sub-committee on nurse education of the New York State Heart Assembly's Coronary Heart Disease Committee, Flagship Hotel, Rochester, N.Y. The symposium is directed toward hospital administrators, nursing instructors, nursing service directors, and nursing supervisors. For further information write to: New York State Heart Assembly, Inc., 3 West 29th Street, New York, N.Y. 10001.

April 2-3, 1970
The Changing Role and Function of a Department of Nursing, hospital workshop in Washington, D.C. sponsored by the National League for Nursing. For more information, write to the NLN, 10 Columbus Circle, New York, N.Y. 10019.

April 9-10, 1970
23rd National Conference on Rural Health, Pfister Hotel and Tower, Milwaukee, Wisconsin. Sponsored by the Council on Rural Health, American Medical Association, in cooperation with other organizations. No registration fee. Write to: Council on Rural Health, AMA, 535 North Dearborn Street, Chicago, Illinois 60610, USA.

May 4-7, 1970
First National Operating Room Nurses' Convention, Queen Elizabeth Hotel, Montreal. For further information write to: Mrs. I. Adams, 165 Riverview Drive, Arnprior, Ontario.

May 12-15, 1970
Alberta Association of Registered Nurses Convention, Calgary Inn, Calgary. For further information write to: AARN 10256 - 112 Street, Edmonton, Alberta

June 15-18, 1970
Canadian Conference on Social Welfare Skyline Hotel, Toronto. Tours and talkins at innovative agencies and services are planned. For information write to: The Canadian Welfare Council, 55 Parkdale Ave., Ottawa 3, Ontario.

June 15-19, 1970
Canadian Nurses' Association General Meeting, The Playhouse, Fredericton, New Brunswick.

August 9-14, 1970
Third International Congress of Food Science and Technology, sponsored by the United States Department of Agriculture, Washington, D.C. Further information may be obtained from: Dr. W.A. Gortner, Secretariat, SOS/70 — Third International Congress of Food Science and Technology. U.S. Department of Agriculture, Beltsville, Maryland 20705

October 1970
Symposium in respiratory disease and tuberculosis nursing for registered nurses, the University of Manitoba and The Winnipeg General Hospital. Write to: C.W.L. Jeanes, Executive Secretary, Canadian Tuberculosis and Respiratory Disease Association, 343 O'Connor St., Ottawa 4. □

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.

Teaching Nursescope

The Littmann Teaching Nursescope, developed by the 3M Company, has an ultra slim, diaphragm-type chest-piece to permit placement close to the cuff when obtaining blood pressure. It is designed to allow the nursing student and teacher to listen at the same time.

This training stethoscope is equipped with two headsets. It provides a wide range of pertinent sound with excellent clarity for student and teacher.

Delrin eartips and epoxy-fiberglass, resin diaphragm are virtually unbreakable.

Further information is available from: Medical Products Group, 3M Company, Box 5757, London, Ontario.

Disposable Prep Tray

The shape of this new, disposable prep tray follows the contour of the body in axillary and perineal areas, thus allowing placement of the tray close to the patient. This conserves space at the bedside and gives maximum convenience.

The tray contains all the necessary items for preoperative prepping: razor, sponge impregnated with hexachlorophene, lanolin and castile soap, two cotton-tipped applicators, two soft absorbent towels, one underpad, and one gauze pad.

The special prep razor has a Gillette super stainless steel blade capable of complete prepping without blade replacement. The angle between the nonclogging razor head and double-edged blade is designed for body prep, and the extra long striated handle provides a sure grip.

The tray is divided into two extra deep compartments that provide ample space and fluid capacity for lathering and rinsing. Overall fluid capacity has been increased by 25 percent. A finger grip makes the tray easy to carry even when filled.

Each tray is packed in a tear string plastic film pack, which ensures the cleanliness of all the items until ready for use.

This product is manufactured by Sterilon Corporation, 1505 Washington St., Braintree, Massachusetts 12184. It may be purchased from Canadian distributors in Montreal, Toronto, Quebec City, St. John's, Newfoundland, London, Winnipeg, Calgary, and Vancouver.

Electronic Monitoring System

System 808 is a new medical electronic monitoring and emergency treatment system for use in cardiac care and intensive care units of hospitals.

This system is designed to eliminate the problem of false alarms, and alerts hospital personnel when a potentially dangerous condition threatens the patient. It includes electrical instruments for correcting certain of these conditions.

System 808 is compact and features interchangeable components. It consists of five modular components designed to perform together as a system or as separate specialized units. These components include:

Display Scope 808, the system's waveform display instrument featuring a large screen that can display two traces simultaneously.

Display Writer 808, a waveform documentation unit of the system that provides a written trace of the patient's physiological parameter.

Monitor/Alarm 808, a component that provides an automatic monitoring of patient heart rate by recognizing R-wave amplitude and R-wave frequency characteristics of the patient's electrocardiogram. The dual-purpose sensitivity control significantly reduces false alarms, while assuring recognition of real emergency situations.

Pacemaker 808, a self-contained, battery-powered component, provides immediate pacemaking in cases of cardiac emergency. When attached to other components, it can be automatically activated when the patient's heart-rate drops below a pre-set limit.

Monopulse Defibrillator 808, a self-contained, battery-powered emergency resuscitation instrument, delivers an electrical shock to the fibrillating heart to allow restoration of regular heart action.

These five component modules interconnect neatly through a multipurpose common cable. As new developments occur, they can be plugged in to replace or complement the current System 808

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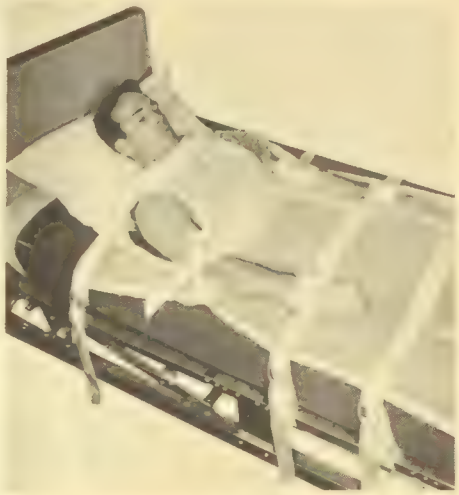
components. This "building block" principle also allows equipment to be speedily shifted as needs of patients vary. Built-in carrying handles and safety stacking devices facilitate the setting up and movement of the components.

For further information, write to Baxter Laboratories of Canada Limited, 6405 Northam Drive, Malton, Ontario.



Nylon Restraint Net

This new restraint net for hospital use is designed to provide maximum patient restraint. The net is constructed of quick-drying nylon netting that has been reinforced at all stress points. Accessibility is provided for the head, arms, and feet.

The nylon restraint net is available in one size to fit all beds and patients.

This Posey product can be obtained from Enns & Gilmore Ltd., 1033 Rangeview Road, Port Credit, Ont.

New Fluff Underpad

A new Princess Fluff Underpad by Texpack can save hospitals up to 50 percent of their underpad cost.

This underpad introduces numerous exclusive features: deodorant; fire resistancy; dispersion layers quickly spread liquid to use total absorbency of the pad, which saves money and keeps patients more comfortable; bactericide helps reduce cross infection and assists in patient care; dispenser carton results in dispensing ease; paper-tab indexing controls quantity dispensed; and blue top disposal safeguard prevents accidental discarding of underpad with laundry, which can damage laundry equipment.

The underpad has sealed sides with poly overlap. This prevents liquid run-off, and fluff escape at sides reduces the need for pad changes and keeps linen clean and dry. It also has sealed ends that prevent fluff escape, removing the danger of aspiration of fluff.

Samples and literature are available from Texpack Limited, 30-40 Craig Street, Brantford, Ontario. ☐

in a capsule

Hidden talent

Helen K. Mussallem, executive director of the Canadian Nurses' Association, was back in her native British Columbia in October. Something quite unexpected happened to her in Vancouver while she was at the University of British Columbia to deliver the Marion Woodward Lecture. Dr. Mussallem got a "kick" out of the incident, which she enjoys recounting.

She was taken to the UBC stadium to watch the annual homecoming "teacup playoff" football game between the home economics students and the nursing students. The winner of this event wins a golden teacup trophy.

Much to Dr. Mussallem's surprise, she was asked to kick off! "When I say kick," a young uniformed student told her, "kick – but face the camera! "

Considering that this was a "first" for CNA's executive director, her ten and one-half yard kick, which was accompanied by appreciative cheering, was indeed something to be proud of.

Although she had to leave shortly after the kickoff, Dr. Mussallem found out that the nurses won the trophy for the second time in the game's history.

Brighten our new year

We're hoping that you, our readers, enjoy some light moments in the new year. We're also hoping that when you do, you'll share them with us.

As you may have noticed, "In a Capsule" tries to strike a light, bright, humorous note. But this is not always easy. We, here in the depths of CNA House, are not ideally situated for hearing about nurse-patient or nurse-nurse anecdotes that are humorous or interesting.

So please send us accounts of experiences that have made you laugh, or chuckle, or just plain happy. We'll repeat them In A Capsule.

Dance it off

At least one person we know has managed to conquer the North American weight problem without succumbing to expensive clubs and gadgets. Madeleine Shaw, a Toronto geriatric nurse, simply wiggled and bounced off 32 pounds in two months.

According to a story in the *Toronto Daily Star,* Miss Shaw invented the Wiggle Bounce when she bought a stereo and discovered pop rock. "My body reacted to the music," she said. "I couldn't stay still, I began to bounce, wiggle, twist and gyrate for an hour or two at a time." She noticed after the first week that she had lost four pounds, and she's been losing ever since.

Away from it all

Something in the African and Asian diet or way of life seems to prevent the major killing heart diseases that are found in North America and Europe.

The November 1969 issue of *World Health,* published by the World Health Organization, describes new studies of heart function and heart disease in developing countries.

In affluent societies, it is still commonly considered normal for blood pressure to rise with age, particularly after forty. However, among the nomads of northern Kenya, for example, blood pressure remains the same. Although the inhabitants of the Cook Islands do not show a tendency for blood pressure to rise with age, other Polynesians, who are exposed to the modern way of life, do.

To find out the reasons for this, research workers are closely examining food habits, among other factors. In Singapore there are three ethnic communities: Malay, Chinese, and Indian. The Indian community, whose eating habits are quite special, is particularly prone to heart disease. It is hoped that research will be able to find what it is that the Malay and Chinese are eating, or not eating, that acts as a barrier to heart disease. □

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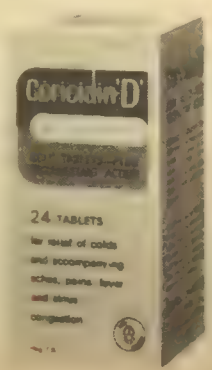

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New in psychiatry: Moditen injectable therapy and follow-up care

A clinic that uses a new drug therapy and brings tried and true public health concepts to community psychiatric care also precipitates a new role for today's nurses.

Aileen Symington, B.Sc.N.

Moditen* therapy involves the use of a new drug that effectively reduces hostility, anxiety, agitation, and hyperactivity. It helps get a psychiatric patient out of hospital and back into the community.

Treatment with Moditen – and other new treatments – are having miraculous results, but discharge from hospital sometimes creates new and different stresses that affect therapy. More is needed – a continuous relationship between care in hospital and care in the community.

In London, Ontario, a special clinic has provided the answer. It has just completed a one-year pilot project that illustrates psychiatry's awakening to follow-up nursing care in the community.

This special clinic, called the Moditen Clinic, is set up at the London Psychiatric Hospital to do two things: first, to permit the use of a new drug that still needs close medical supervision and, second, to provide a follow-up nursing program that helps the patient adjust to community life.

This second purpose is especially necessary as the new drug is rapidly preparing two groups of patients to go back to life outside the hospital:

- those who have developed a psychiatric disorder and are treated and discharged from hospital after a short stay of 28 to 40 days, and
- those who have spent years in a mental hospital and present a mode of life altered by long-term institutional living and characterized by apathy, desocialization, and deteriorated work skills and interests.

In a way, such a clinic is an inevitable outcome of current psychiatric practices. Diagnosis, treatment, and rehabilitation are seen as closely connected, perhaps even as indistinguishable from one another. In this new concept, follow-up care is part of the whole treatment scheme and is planned from the onset.

Follow-up care is now seen to involve the use of supportive interviews, more intensive psychotherapy, group therapy, maintenance electroplexy, routine oral medication, or routine injections. Two or more of the above may be used simultaneously.

In London, our solution was to establish a clinic, closely attached to the

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Mrs. Symington graduated with her bachelor of science in nursing from the University of Western Ontario in 1943, after receiving her diploma from the Victoria Hospital School of Nursing in London, Ontario. She worked for a year with the Victorian Order of Nurses in London, then "retired" to raise four children. Eight years ago she began work as a public health nurse in London; she was seconded to her present position with the Moditen Clinic about one year ago.

*Brand name of injectable fluphenazine enanthate manufactured by Squibb Pharmaceuticals. Much of the information about the drug is taken from the booklet supplied by the manufacturer.

The author (right) with Dr. W. Andrews, director of the Moditen Clinic.

hospital, but at the same time more like a community agency with close liaison with other agencies in the area.

The clinic itself

The clinic was set up in August 1968 through a cooperative arrangement between the hospital and the board of health for London and Middlesex County. Its basic permanent staff was one public health nurse seconded from the public health unit – but the approach to patient care was a team one.

The team consists of a psychiatrist, one or two unit physicians, a ward supervisor, an occupational therapist, one or more social workers, a registered nursing assistant, and the clinic nurse. Sometimes an intern, a psychologist, and a chaplain sit in with the team.

The unit head acts as moderator. Together the group formulates a working diagnosis, establishes short- and long-term goals, and carries these goals out.

Clinics are held Wednesdays from 9:00 a.m. to 5:00 p.m. and Thursdays from 5:30 to 7:30 p.m. The evening clinic was opened for convenience of patients who work during the day or find daytime transportation a major problem. We do make special appointments at other times if necessary.

The number of patients at the clinic has grown from 42 in August 1968 to slightly more than 100 in June 1969. This means that over 200 injections are given every four weeks. Last December it was necessary to ask for an additional nurse to help with the work load. The hospital was able to provide the services of a registered nurse who had served nine years with the Department of Indian and Northern Health Services. This past public health experience has been invaluable.

The actual work at the clinic mainly concerns the continuing of Moditen injections that were started when the individual was an inpatient. To help us supervise this continuing drug therapy, we ask that an information slip about the patient be filled out by the ward clerk or charge nurse and sent to the clinic at the time a patient's discharge or leave of absence is planned.

We try to get to know the patients before they come to us as outpatients. One way is to have the charge nurse arrange for the last injection of Moditen before discharge to be given at the clinic. We believe this makes the transition just a little bit easier.

The usual maintenance dose of Moditen is 50 mgm. (2 cc) every two weeks. In maintenance therapy for patients with schizophrenia, however, there is considerable variation in individual tolerance, response, and duration of action. Close medical supervision is required, especially in the first few weeks.

Appointments are made for the next visit while the patient is at the clinic. Attendance is watched, and if a patient is delinquent, the hospital unit he came from is notified and either the clinic nurse or a social worker gets in touch with him.

We believe it is better therapy for a patient to remember his own clinic date, so we do not remind him.

Charts are kept on each patient in manila folders, complete with a white dosage sheet for date and observations, a green treatment sheet, and a yellow home visit sheet. Filing cards containing pertinent information and total medication records are also kept up-to-date; these are accessible only to professional staff.

In a separate book, we keep records of laboratory work and x-rays, as well as records of special clinics. We also keep pertinent monthly statistics regarding the work of the clinic.

Some might believe the clinic should be in a separate building from the hospital; ours is not. One advantage is that it is convenient to the hospital pharmacy where patients can pick up their pills. We think it is good for them to have this responsibility for reordering their own; however, we do keep careful records of medications as well.

Another advantage of a hospital location is that it enables clinic personnel to work closely with ward personnel. Before discharge of a patient, the clinic nurse and the ward social worker can work together to see that the patient has adequate living quarters. This means that the patient has somewhere to go and that those who will be living with him will understand his illness and the best ways of helping.

At present, the clinic nurse visits patients who have been sent to boarding homes under an "approved homes" plan – somewhat similar to foster care. These early home visits often seem to help the patient reestablish a balanced life pattern and become a useful citizen.

Home visiting

The clinic nurse, because she is a regular employee of the public health unit, is free to make home visits when necessary. It is an excellent theory to try to provide support and encouragement to the patient between his visits to the clinic but, because of the work load, we usually visit only when there is a problem. After we get to know the patient, we can give him much support over the telephone.

The home visits have proven to be of real value. The public-health-trained nurse brings special skills in interviewing, observing, and establishing rapport in strange situations. With her medical knowledge and her great concern for the patient and family, she becomes an ideal liaison person between the doctor and the family. She is sometimes the only one who can help in special situations.

This spring, because the clinic nurse could and did take the time to make repeated visits and gradually was able to overcome a language barrier, she was able to help a family that was seriously split over a question of a tubal ligation. The mother had become a clinic patient following hospitalization for an unsuccessful attempt at infanticide. Another baby would likely have been a disaster to the family because of the mother's fragile emotional balance.

The nurse needed to use all her knowledge of community resources to help this family and even became the one who helped the mother through the admission routine before the surgery.

The drug itself

Naturally, to work in a clinic that is mainly concerned with a specific drug therapy, the nurse must have a thorough knowledge of the drug.

Treatment with fluphenazine enanthate – Moditen Injectable – was introduced in Ontario at the London Psychiatric Hospital in October 1967 by Dr. W.N. Andrews. He had previously used it with excellent results for two years in Yorkton, Saskatchewan. The drug had also been used in England since 1965. It is now being used extensively in Southern Ontario, and two other Moditen clinics have been started in other health units.

The drug is a member of the phenothiazine family, which first came into use about 15 years ago. It is manufactured in such a way that the effects of an intramuscular injection are prolonged for one-to-three weeks, with an average duration of about two weeks.

It is primarily effective in reducing hostility, anxiety, agitation, and hyperactivity. Confusion, hallucinations, and delusions are effected to a lesser degree. The onset of action generally appears in 24 to 72 hours and the effects of the drug on psychotic symptoms become significant within 48 hours.

When the acutely-ill patient becomes more settled on Moditen therapy, he is shifted to maintenance therapy while still in hospital. The dosage is worked out for each individual and is sometimes altered during attendance at the clinic. A patient seldom requires a higher dosage, but occasionally the dosage is reduced.

It is important to do full blood counts, liver function, blood urea analysis, and urinalysis before the drug is started, to provide a base line. These are repeated every four months at the clinic through a cooperative arrangement with the provincial laboratory.

Moditen is contraindicated for patients with suspected or established subcortical brain damage, patients receiving large doses of hypnotics, patients with blood dyscrasias, hepatitis, severe renal insufficiency, cerebral thrombosis, circulatory collapse, or altered states of consciousness, and patients with severe depression.

It is not recommended during the first trimester of pregnancy, although this is a matter for the individual physician's judgment. It is used with caution in patients with a history of convulsive disorders, and reduced amounts of anesthetic may be required if a patient on Moditen undergoes surgery.

Adverse behavioral effects or oversedation, characterized by drowsiness and lethargy, may occur; relief is obtained by adjusting dosage. Contrast hyperactivity and post-injection insomnia have been noted; conventional sedatives usually bring relief.

Toxic effects on the central nervous system are sometimes noticed. Most frequently reported are reversible extrapyramidal symptoms, such as parkinsonism. Most often observed in our clinic are shaking of the hands, tapping or twitching of a foot, slight facial rigidity, rigidity of arm and leg muscles, and increased restlessness.

These effects are related to the chemical structure of the drug. They largely

The Moditen Clinic team in conference with a patient who has recently been able to return to her work in the community.

The author (right) counseling a patient at the Moditen Clinic. This patient was released from hospital over a year ago, but returns to the Clinic weekly for an injection of Moditen.

depend on the individual patient's sensitivity, but dosage levels and age are also factors.

The doctor usually prescribes an antiparkinsonian agent when Moditen injections are started. Patients must understand the importance of taking these. Many patients on Moditen are against taking pills of any kind. They often omit the antiparkinsonian drugs at first, but because the effects are so uncomfortable they quickly see the value of taking them regularly. Patients with severe reactions occasionally come to the clinic and require an immediate intramuscular injection of an antiparkinsonian agent. The intramuscular injection usually gives symptomatic relief much more quickly than the oral form of the same drug.

Toxic effects on the autonomic nervous system must also be known by the nurse. Hypotension of delayed onset, hypertension, and fluctuation of blood pressure have been reported in the literature, but not seen at our clinic. Blurred vision is reported fairly often; this may disappear spontaneously in a few weeks or may be relieved by changing the antiparkinsonian drug.

Aggravation of glaucoma may occur and so we recommend periodic eye examinations. Frequently a patient may need to wear magnifying glasses for reading or close work for a short period. Dry mouth occurs commonly and we advise the patient to take unsweetened fruit juice twice daily to help activate the salivary glands; increased fluid intake does not help.

Allergic or toxic reactions to the drug itself are quite rare. Cholestatic jaundice has never been observed at our clinic. We had one case of blood cell depression and a reduced dosage soon corrected this. Asthma, dermatological disorders, itching, erythema, or seborrhea have not been reported at the clinic.

Nurses are alerted to watch for metabolic or endocrine effects. Weight changes, peripheral edema, abnormal lactation, menstrual irregularities, impotency in men, and increased libido in women have all been reported.

Case history

An attractive girl in her early thirties, diagnosed as a paranoid schizophrenic and very suicidal, was discharged to the clinic a year ago. She had just started on Moditen and was still extremely hostile and used abusive language.

Today she is living in a pleasant rooming house and is looking for a job. She looks well and has a quick smile and a pleasant word for others, although she is not a talkative person. She receives 75 mgm. of Moditen (3 cc) every 14 days, a recent dosage cut from 4 cc.

This is her longest stay out of hospital in years and she is much happier – and, incidentally, much less of a burden on the tax-payer's pocket. This girl is lonesome, and we at the clinic think how wonderful it would be to have enough staff to find volunteers to serve as a real friend for her, or even to provide her with someone to talk to when necessary.

Conclusion

Moditen appears to do for many psychiatric patients what insulin does for the diabetic. It is rewarding to see the progress made by patients on this drug. We have readmitted some, mainly because of increased environmental stress or because they discontinued the antiparkinsonian drug. But each time, the stay in hospital is shorter.

It is rewarding, too, to see the nurse's role extended into the community. The role of the clinic nurse truly illustrates the changes in nursing predicted for the "future," about a year ago.** □

**Helen K. Mussallem, The changing role of the nurse, *Canad. Nurs.*, Nov. 1968, p. 35

Nurse to the performing arts

The National Arts Centre is alive and well in Ottawa. So well that seven part-time nurses are on staff to take care of the throngs of theater lovers who come daily in pursuit of culture.

Carol Kotlarsky, B.J.

Barbara Duncan, head of the Arts Centre's nursing team, on her way to the main foyer. The red carpeting on the stairs is one of the many colorful features found throughout the Centre.

When seven Ottawa nurses talk about their work in the theater, they are not referring to the operating room.

For them, theater means the glitter and glamour of the Capital's National Arts Centre, also known as "Fort Culture," where the latest in fashion blends with futuristic architecture to capture a mood in tune with the performing arts. Operations here vary from modern poetry, folksong, dance, and drama to orchestra, opera, and ballet. Even Shakespeare can be up-to-date (complete with electronic music) or traditional.

The Arts Centre houses a 2,300-seat opera house-concert hall, an 800-seat theater, a 300-seat experimental studio, and a smaller salon for more intimate gatherings. Whether there is one performance on or three, only one nurse is on duty. She arrives before curtain time and spends most of her time in the first-aid room on the main floor near the opera house, until the theatergoers have gone.

In the words of one young visitor, the nurse is there for people who get overwhelmed by a performance. Although the nurses were hired mainly to look after the public, there is a second nursing room backstage where the performers can be looked after. Another group that the nurses attend to consists of the more than 200 NAC staff members.

Miss Kotlarsky, a graduate of Carleton University's School of Journalism, is presently Editorial Assistant, *The Canadian Nurse*.

The nurses agree that nursing at the Arts Centre is unpredictable. "It is something like emergency and industrial nursing, with lots of common sense needed," explained Barbara Duncan, who is in charge of the nurses. "You are on your own and must play it by ear. You never know *what* is going to happen."

The first-aid room is supplied to remedy the Centre's most common complaints: headaches, cuts, upset stomachs, dizziness, and even sunburns. Antihistamines are stocked for people with allergies. A doctor is on call for serious problems.

Different audiences bring different problems for the nurses. One group, "The Mothers of Invention" – a modern jazz group – attracted crowds of enthusiastic young people, many who arrived barefoot! That evening one man walked into a glass door and cut his brow, adding more excitement.

Mildred Dempsey, who is a full-time nurse at the Ottawa General Hospital during the day, remembers particularly well a concert that drew many older people and many handicapped. A number of the handicapped persons came alone. The Arts Centre has three wheelchairs, but Mrs. Dempsey estimated that close to 15 were needed that evening.

"It was like Grand Central Station," Mrs. Dempsey said. "I felt as though I were running a taxi service." She operated a wheelchair service alone, as all the

ushers were busy. There is a special hallway for people in wheelchairs, which leads into the opera house.

The nurses have discovered that some visitors who need treatment do not seek it, chiefly because they do not want to miss the program. Some, however, visit the nursing room during intermission.

Shirley Klymasz, who also does part-time nursing at the Riverside Hospital of Ottawa, was on duty the evening a woman had a heart attack. This woman insisted that she knew what to do, would not allow the nurse to help her, and refused to go to hospital. The woman phoned her doctor but could not reach him. Although she was alright the next day, she had a few miserable hours that could have been avoided, Mrs. Klymasz said.

One unusual accident involved a young girl who had her pet rabbit with her in the foyer. The rabbit bit her, causing a good deal of bleeding. Gayle Argue, the nurse on duty, phoned the girl's mother and suggested that she take her daughter to a doctor for tetanus antitoxin.

At least four or five people have fallen on the steps leading to the underground garage, and there have been several bad falls in the garage. Not all the falls have been inside the building, though. One girl broke her leg behind the building when she tried to jump from the grass onto the walk, about four feet below. Mrs. Duncan, who was on duty at the time, stayed with her until the ambulance arrived 20 minutes later. The grassy terraces behind the Arts Centre, which lead to the canal, are a favorite gathering place during the summer, especially for teen-agers.

Preparing for the next patient. Although small, the Centre's first-aid room is well-equipped to handle the most common complaints: headaches, cuts, dizziness, allergies, and upset stomachs. A record of each person treated is kept by the nurses.

Intermission in the theater foyer during the Ottawa premiere of "La Visite de la Vieille Dame," performed by Le Théâtre du Capricorne. Opening nights are particularly good occasions for people-watching - but this one was better than most.

One evening a young man who was inebriated appeared on the roof looking for his car. He also had a sprained ankle. The nurse helped him down, and a doorman took him to the garage to look for his "lost" car.

As for accidents occurring during performances, Mrs. Argue remembers one performance of "Les Feux Follets." In one part of the show in which fire was used, a performer burned one of his hands. Mrs. Argue brought him ice cubes, which he proceeded to pop into his mouth and return to dance on his hands.

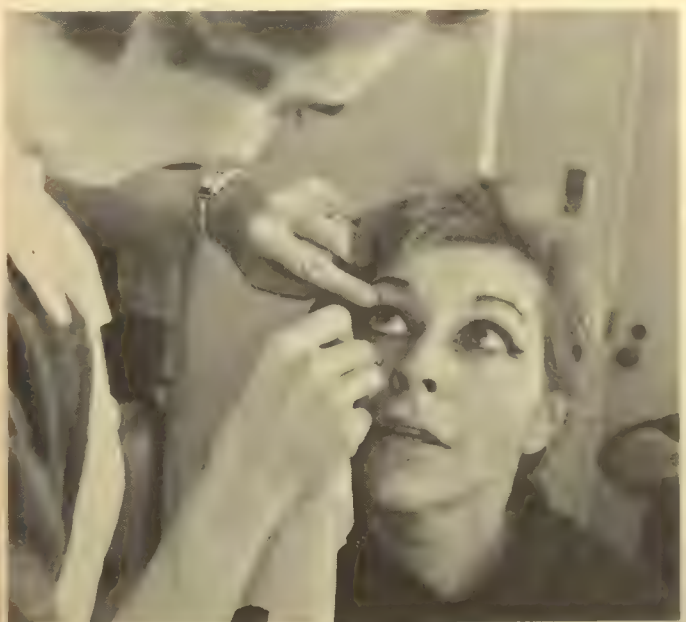
One member of the NAC security staff lives dangerously. The bicycle that he uses for getting around the garage is not large enough for him. He has received some nasty cuts and bruises from several falls on the cement floor, but is always good-natured about being bandaged.

An important part of the nurses' equipment is a pocket pager, which is small and compact. It is convenient for receiving messages anywhere in the building. When a message comes on, there is a whistling sound; once the message is repeated, the noise continues until the right button is pressed. Another button controls the volume.

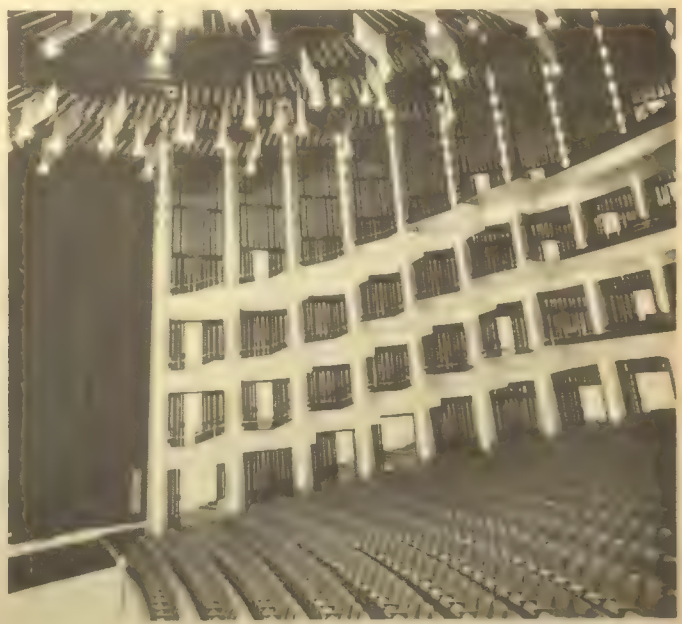
"There is something for everyone at the National Arts Centre," says Mrs. Duncan, referring to the broad range of decoration as well as the variety of entertainment. And not least of the advantages in being a nurse here, Mrs. Duncan points out, is the fun of "people-watching. They come in anything: pyjamas (pantsuits), floor-length gowns, and barefoot."

For the nurses, however, it is still white cap and uniform. □

This front view of the National Arts Centre gives some idea of its multi-faced character. The complex, developed as a series of hexagonal buildings on terraces of varying levels, is situated on six and one-half acres in the heart of downtown Ottawa.



Backstage after the first night's performance of "La Visite de la Vieille Dame." Mrs. Duncan removes a speck from eye of actress.



The opera house is a horseshoe-shaped auditorium with three balconies and the latest in lighting and sound systems. The stage area, which is slightly larger than the auditorium, is the second largest in North America.

Public health nurses work with family physicians

An article in the September 1969 issue of The Canadian Nurse reported on the progress of a special project in East York, Ontario, where public health nurses had been assigned to work with private doctors to provide better care for patients. This article describes a similar project in London, Ontario.

D.A. Hutchison, M.D., D.P.H., and Dorothy M. Mumby, B.Sc.N., M.A.

Since May 1968, three public health nurses employed by the London (Ontario) Health Department have been assigned to work with three different groups of family physicians. One nurse works with a group of three general practitioners whose offices are at the Family Medical Centre at St. Joseph's Hospital. The second nurse works with two family physicians who are located in an office in the northeast section of London, and the third nurse works with a group of three physicians whose office is the southeast section of the city.

The stimulus for this project dates back to Dennis Brannan's study done in 1965,[1] which showed that there was little contact between private physicians and public health nurses. The impetus for assigning a nurse directly to the Family Medical Centre followed the preliminary report from the East York Leaside Health Unit project conducted by Phyllis Jones.[2]

Responsibilities of nurses

In setting guidelines for these nurses, the London Health Department stated that the nurses would do health counseling for patients and families at home or in the physician's office. They would plan hospital admission and discharge for patients, and would arrange referrals to other community agencies. It was believed that their knowledge of community resources would be valuable to the physicians. Thus the major duties would be those of any public health nurse in a traditional program.

In addition, it was agreed that the public health nurse's role could be expanded to include other tasks for which she is prepared and which the physicians might wish to delegate to her. Such additional tasks might include preliminary diagnoses, such as in communicable diseases. However, up to the present time this area has been tested infrequently.

We believed that in some situations, where rapport had been established between the district public health nurse and a family, this relationship should not be disturbed. In such cases the nurse has become the liaison person between the physician and the district nurse.

The nurses' responsibilities do not include the traditional bedside nursing care in the homes. This responsibility continues to be assumed by the Victorian Order of Nurses. However, there are occasions when the public health nurse may be visiting homes in which the VON nurse is giving care, and in these situations the PHN may become the liaison between the physician and the visiting nurse.

Family Medical Centre

The first nurse was assigned to the Family Medical Centre in May 1968. The physicians at this Centre are on the faculty of medicine at the University of Western Ontario in the department of community medicine. Their responsibilities include teaching in the university's family practice training centre.

The Centre provides this nurse with office space and clerical assistance and the health department pays her salary and car allowance. She also has the benefit of the health department's personnel policies. She has adjusted her working hours to fit those of the Centre.

This public health nurse was responsible for setting up her own records and method of recording. At the beginning she dictated her notes for typing, but found that her notes were sometimes out of sequence with the physician's notes. She now records her home visits on the physician's progress sheets to make sure they are up-to-date when the patient sees his physician.

The essence of any successful multiprofessional operation is good verbal communication among those involved. There is no substitute for this. Therefore, short discussions on each patient's progress are essential. Questions must be asked and answered if there is to be effective understanding between physician and nurse and if better health care is to result for the patient and his family.

The public health nurse at this Centre has tried with limited success to establish regular meeting times with the physicians.

Dr. Hutchison is Medical Officer of Health and Mrs. Mumby is Director, Public Health Nursing, City of London (Ontario) Health Department.

Busy physicians traditionally seem to be reluctant to set aside even a small block of time on a regular basis for routine reporting. But this is the only way that a good mutual relationship can be established between a physician and nurse, and important patient-related data communicated. After the first few months, these conference times need not be as frequent as at the beginning.

The public health nurse is at the Centre most mornings, and tries to confer with the physicians about patients at this time. In the afternoons she makes home visits as required. She visits families living anywhere within the city of London and the county of Middlesex. To date there have been no referrals outside these areas.

Private practice

The nurse working with the two physicians started her assignment in January 1969, at the request of the senior physician in the practice. She, too, works from the physician's office and is supplied with clerical assistance from his office. She remains a member of the health department staff, enjoying the privileges of personnel policies with the regular staff. She has supervisory assistance available to her and is able to participate in the staff education program at the health department. She does not engage in any routine or clinic activities of the health department, but rather works full-time in the practice.

This nurse has set up her own records and recording system. She dictates her nursing notes, which are typed directly on the physician's progress record by his secretary.

At the beginning this nurse met daily, at 8:30 a.m., with the physician at one of the hospitals to bring him up-to-date on her visits, have her questions answered, and obtain any new referrals. As the confidence of the physician and nurse in each other increased, it was possible to reduce the frequency of contact from daily to two or three times a week. When necessary, the nurse can reach the physician by telephone during his office hours.

Once a week this nurse makes hospital rounds with the physician; at other times she visits patients in hospital to ensure continuity of care and to make plans to visit when the patient is discharged. This seems to be particularly helpful to those patients whom the nurse has known prenatally and whom she will be visiting postnatally.

When a spot check was done of this nurse's caseload in May, 1969, it was found that she was working with approximately 100 families, the same as the nurse at the Family Medical Centre; but 59 of these families had been active with the district public health nurses, compared with 35 in the first nurse's case load. One of the reasons for this is that the physicians in this practice have a relatively higher obstetrical case load than the physicians at the Family Medical Centre.

In this particular practice, the area of maternal and child health seems to be satisfying to all concerned: mother, public health nurse, and physician. After the mother has been discharged from hospital, the nurse visits her as often as necessary.

Previously the physician saw the baby at three weeks of age, again at five or six weeks, at eight or ten weeks, and at twelve weeks of age when immunization started. This schedule has now been reduced to visits at one, two, and three months of age. The physician has found that his time in this area of his practice has been reduced by 30 to 50 percent; he has had to make fewer telephone calls and visits to lessen the anxiety of new mothers. Through guidance and health teaching, the public health nurse has helped to allay these fears. In addition, the susceptible baby does not need to be exposed to the public in the physician's office as frequently as before.

This physician has also observed that he has been relieved of much of his prenatal counseling work load because of the prenatal teaching done by "his" public health nurse. This, in turn, allows

Dr. M. Hickey, left, senior resident at the family medical center, and Dr. B. Hennen, center, lecturer in family medicine on the faculty of medicine at the University of Western Ontario, discuss a patient's progress with Mrs. Marcia Fuller, public health nurse assigned to the family medical center by the London Health Department.

him to devote more time to problems specifically referred to him by the nurse.

Because the public health nurse has her own office in this setting, she is able to do health counseling during the physician's office hours and at other times. This saves her travel time, especially when several prenatal patients are scheduled for appointments the same afternoon.

Group practice

In April 1969, a third public health nurse was assigned to a group practice of three physicians at their request. It was decided that this nurse would continue to carry her school responsibility and the responsibility for any families whose children attended the school. If she found she could not meet all her responsibilities of case load, we would then decide whether or not the school and associated responsibility would be removed, or whether additional assistance would be provided by another public health nurse for the "routine" program in the health agency.

Mrs. Pauline Knierim, left, public health nurse assigned to the private practice by the London Health Department, discusses relaxation exercises with prenatal patient.

Mrs. Knierim, the public health nurse assigned to the private practice, dictates notes for the physician's record. Mrs. Joan McGinnis (top right), the private practice secretary, transcribes the nurse's notes onto the physician's record.

Within two months of this assignment the referrals became backlogged. This resulted from the large number of referrals received and absence of the nurse because of illness. It was also learned that one of the physicians in the practice was moving to a teaching position and would be replaced by another in July.

By mutual agreement, a second nurse was added to the practice to work with the first nurse. Presently, things seem to be going well. Although one public health nurse has resigned, it is expected that she will be replaced. These nurses seem to enjoy having the variety of school responsibility along with the responsibilities related to the physician's group.

The physical working arrangements are somewhat different in this setting. The public health nurses work from the health department office and do not have facilities in the physicians' offices. They also use health department record forms, although pertinent information and case summaries are prepared separately for the family folders in the physician's office. There is no difference, however, in the important area of communication. The public health nurses meet twice weekly at the physicians' offices to discuss their patients' progress and to receive new referrals.

The senior physician in this group has expressed satisfaction in having the public health nurses working so closely with his patients.

Mrs. Jane Guthrie, (right) public health nurse assigned to the group practice by the London Health Department, consults with Mrs. Helen Stearns, supervisor of public health nursing, London Health Department.

Selecting the nurses

In selecting nurses for these positions, we looked for qualities such as maturity, initiative, self-confidence, sense of humor and flexibility. We also considered the ability of the nurse to work independently, her knowledge of the community, and whether she seemed interested in the project.

We kept in mind, too, the following quotation: "From the health departments' point of view an unfavourable aspect of careful selection is that the health visitors are very marriageable."[3]

We thought that at least one difficulty had been overcome by appointing three married nurses and only one single nurse. However, the inevitable has happened: the single nurse has already married and two of the married nurses are pregnant.

The feeling of satisfaction among these nurses is reflected in a statement one of them wrote on her progress report. "I feel that the close liaison with the family physicians has enabled me to offer better public health nursing care to these families than I was able to provide while assigned to a specific geographic district." Another nurse has stated that she would not want to return to a traditional geographic district.

Physicians' response

The requests for nurses to be assigned to work with physicians have come from the physicians themselves. In general, these doctors seem to be satisfied with the arrangement.

Recently, when one nurse was on vacation, the physician made a minimum of referrals to her interim replacement. It would seem that this physician was prepared to wait until "his" public health nurse returned, rather than refer patients to someone whom he did not know well.

Another physician is most anxious that the arrangement with his group of physicians continue and is prepared to discuss partial financial subsidization of "his" public health nurse if this is indicated.

In one of the assignments, communication and interpretation of the public health nurse's function and breadth of activity is a point of some concern and requires further attention.

The future

This article contains only a brief description of what has happened to date. It is recognized that further study and collection of data are essential.

In future we hope to answer some of the following questions: 1. What type of patient is referred by the physicians? What services are given? How many visits per patient are necessary, compared with similar figures for the district public health nurse? 2. How many referrals are made by the nurse to the doctor? 3. How many patient conferences are there between nurse and doctor, compared to contacts between a district public health nurse and the physician? 4. How soon after delivery is the first postpartum visit made, compared with the first visit by the district public health nurse? How many visits are made? How many telephone calls are there from new mothers?

Some readers may believe that the assignment of these PHNs to physicians' offices should have been delayed until research outlines were prepared to collect data from "Day One." Others may believe that some of the kinks should be ironed out before data collection is started.

Only the future will be able to shed some light on which method would be better. There probably will be agreement, however, that the delivery of public health nursing services as part of total comprehensive health care needs to be looked at critically.

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The independent study tour

When lack of time prevents a nurse from undertaking a lengthy period of formal study, an independent study tour may be an alternative, the author suggests. She offers some suggestions, based on her own experience, for those who might wish to set off on their own to study health programs in other countries.

Ethel M. Horn, M.A.

A little over a year ago, certain changes in health care organization in our community convinced me that I needed time to study a trend that was developing in certain areas in Ontario. This trend was the relatively new approach to the health care of families, whereby public health nurses are assigned to work directly with family physicians.

I had several reasons for wanting to find out as much as I could about this new approach to health care. As a teacher of community nursing at the University of Western Ontario, I obviously had a responsibility to keep up-to-date on all aspects of health care. And, too, several public health nurses in our city had recently been assigned by the local health department to work with family physicians who are in private practice, group practice, and a family medical center.*

In addition, the faculties of nursing and medicine at UWO had expressed interest in the possibility of developing a multidisciplinary learning experience from group practices for advanced students in nursing and medicine. We envisioned students from both disciplines working together with the same family. In such an arrangement each would have the opportunity to learn his own contribution and the contribution of others to the community health team.

I decided that as well as studying the programs in our own community, I would explore the roles of the health visitor and the general practitioner in units in Scotland and England. In the units I planned to visit, health visitors are assigned to group practices and the interdisciplinary programs in some instances are well established in the university medical schools.

Planning the visits

There are some steps that anyone planning a visit should take ahead to ensure a degree of success. Initially, it is wise to begin inquiries and readings in periodicals at least a year in advance to compile useful information on trends, innovations in programs, and research in progress in your chosen area of interest. Talking to and corresponding with people who may help you or have a similar interest may prove valuable.

I did as much reading as time allowed in Canadian and British publications. I talked to people who were knowledgeable about group practice in Canada and Britain, and wrote to persons who I thought could assist me in becoming familiar with programs, problems, and research in this area. Through this correspondence I received the name and ad-

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*Dorothy Mumby, Public health nurses work with family physicians, *Canad. Nurse 66: 1: 28* January 1970.

dress of a Millbank Fellow who had spent one year in England and Scotland. She had visited extensively and shared her opinions and experiences with me.

It takes considerable time to focus plans and to organize an area of independent study. Writing out a tentative proposal as a starting point helps to restrict the study area for review of the current literature. This is a disciplinary exercise that forces a person to come to grips with the study proposal early. Should you be seeking research or short study funds, you will, in all probability, need to submit an outline of your objectives with your application. Also, an outline is essential if you are going abroad and need to make arrangements through the Canadian Nurses' Association or other nursing groups.

Your subject should not be too restricted. You should look for a broad base in which you can find several overriding interests in education, service, and research. This way you can work with greater ease in these related areas during the tour.

After considerable preparation, my study plan began to take form. I was able to outline four areas of interest that were interrelated. I purposely kept these fairly broad and flexible at this point.

I wrote a succinct statement of the purpose of the tour and briefly reconsidered my areas of interest. The reading, the collaborating and the independent thinking I had done helped me to reclarify my needs and purposes before undertaking the tour. At this point I talked to various individuals who were interested in the project; on my return, these persons helped me to meet with the groups who would share the results of my visits.

The visits begin

The overall plan of the *modus operandi* for an independent study tour should include regular periods of relaxation. Emphasis and consideration need to be given to bi-weekly periods for additional reading, thinking, listening to tapes made, and writing. This, of course, will vary with individuals and with studies.

To rush from one experience that has been stimulating to another before you have had time for a critical thinking period and time to do further necessary reading, defeats the purpose of the study tour. Nor can you compile a report while experiencing new ideas and meeting and interviewing many new people. However, a large portion of the framework of ideas take shape during the thinking periods and can be put on paper in rough form.

In such a study tour it is wise to confine yourself to the original plan as far as possible. There are always temptations to deviate from your original plan. As you begin to move about on the tour you hear from many sources about experimental structures, new research results, and persons who have similar concerns. Though this can be tempting, it is best to deal with these ideas through correspondence. Although this does not substitute for a person-to-person confrontation, correspondence can be very stimulating. I tucked away whatever information I received with the idea that I might be able to help someone else seeking information in the future.

Eight months following my initial planning I began my carefully organized study tour. In retrospect, knowing the correspondence that follows requests and the planning that has to be done by agencies, I would recommend that requests to agencies be made a year in advance. Also, I found that by outlining areas of interest in my original letter of request, my specific needs were known from the outset. Not only was the request area define, but the agency knew the boundary of my interests before I arrived.

My study followed the same pattern in each country. It began with interviews with professors in the social medicine units of the university who were involved in medical education and research in the general practice units. This proved to be a sound background from which to proceed to the next step, that of visiting the local health authority where the health visitor is attached to general practice groups.

My first visits were made in Edinburgh and Aberdeen. Later, I visited Newcastle-Upon-Tyne, Winchester, Hythe, and London. The stimulation of meeting in the university settings, where research was being done; seeing and hearing about the new administrative relationships in the community brought about by health visitor attachments; and seeing new relationships between what I had done in the past and what is being done there, produced some new and exciting ideas.

On two occasions during my month-long study tour, my requests had coincided with two nurses from other countries. These nurses were on their way to the International Council of Nurses' Congress in Montreal. They had stopped in England and Scotland for a period of observation. We had a lively exchange of information about our joint observations and about nursing in our respective countries.

Summary

The study tour helps the participant to take a refreshing look at her own concerns, to broaden her point of view from the provincial to the international scene, to be actively involved in writing about an area of interest, and to be involved with researchers who are experimenting in their work setting.

This form of independent study allows a person to gain a new base for ideas, research, and clinical practice, while viewing and drawing contrasts with the professional scene away from the home setting.

A frequent comment heard about the preparation for a tour is that the reading can be done anytime. In my opinion, if it is not done before and during the tour, the opportunity is lost forever. Once you return to the professional setting, your first obligation is to share information with others. □

idea exchange

Part of display at book fair. Mrs. Gladys Owen, P.H.N., librarian for the Sudbury health unit, and Dr. B.J. Cook, medical office of health, examine the books.

They Came To Our Fair

A little grade seven friend knocked at the door of my office at the Sudbury & District Health Unit and asked, "Could you please help me with a health project?"

A chain reaction began with that simple question. To help her, I checked the school library where the material should have been available, and found little on health.

I began to wonder if all school libraries in the area were so short of literature pertaining to health. And, if so, what would be the best method of getting new material to them? Book fairs had often been used to expose the public to new books – why couldn't a health unit use this method, too?

I discussed my idea with the director of nursing and the medical officer of health. We decided that a book fair could serve several purposes. First, it would show persons of various age groups what material was available on health and the health professions and where it could be obtained. Second, a book fair could be considered as part of inservice education for our own nursing staff. Third, such a project would be good public relations, as the various activities and services of the health unit are not always understood by the public.

As the idea gained momentum, we involved other departments in the health unit. Everyone had something new to add. Eventually we decided upon the broad outline of the project and our book fair was on its way.

Everyone contributed. The Canadian Book Council got in touch with publishers whom they represented, collected books they thought would be helpful, and forwarded them to us in time for our fair; the public library loaned us some book supports, and the local book stores sent us paperbacks on the subjects we had chosen. In the end, we got the books we wanted.

To advertise the fair, letters were sent to all professional groups in Sudbury, inviting them to see the most recent books published on nursing, guidance, and nutrition. Attactively designed,

simple posters were displayed in libraries, shopping areas, schools, and hospitals in the area served by the health unit. Everyone read about the book fair in the "coming events" section in the local papers.

Our public health nurses promoted the book fair and showed posters on their regular television series. Radio announcers urged people to visit the fair.

We decided to hold the book fair in the health unit offices. They were old, crowded, but central, and gave the taxpayers an opportunity to see the building – and how much we needed a new one!

Traffic moved smoothly through a series of small adjoining offices on the main floor, where staff members served as hostesses. We provided a quiet area for browsing, so often lacking at book fairs.

A guest book, strategically located near the dental hygienist's office, where our visitors entered the health unit, helped us to identify those who attended the fair. Later, this information was useful in evaluating the success of the fair.

The dental hygienist spoke with many who were interested in her work. Descriptive material on this relatively new career ran out quickly.

One room was set up to show audiovisual material on sex education for children. The series ran continually, many visitors seeing part, if not all, of it. Parents were pleased to have the opportunity to see what their children might be learning about sex education in school, and librarians were interested in the material available.

The room set aside for medicine and nursing contained many books and recent paperbacks – several available in the French language. Young people and guidance counselors were particularly pleased with the display on "Nursing as a Career." They also had an opportunity to talk with public health nurses about their work.

Another room contained material on psychology and guidance, grouped under broad classifications.

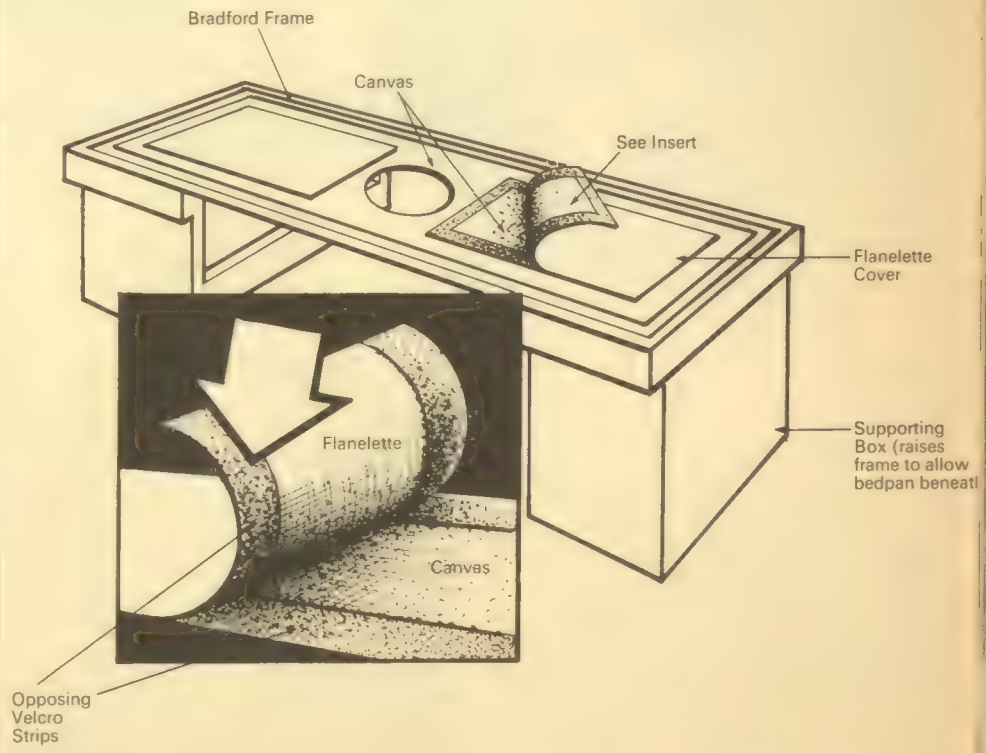
Health inspectors demonstrated their methods of testing water and treating samples and explained the procedures for restaurant inspection. Their materials on pollution were particularly popular.

The health unit nurses set up a mannequin, appropriately dressed with safety helmet, goggles, shoes, and gloves to illustrate one aspect of occupational health. In their hunt for realism, they had been unable to find a male mannequin for our safety display. However, an offer from Eaton's of a bald-headed female form saved the day. Once the helmet, goggles, suit, shoes, and gloves were on, "he" looked real.

Two areas for nutrition and communicable diseases completed the project at the book fair. The nutritionist's display was both attractive and practical.

The book fair was packed away for another time. We had been able to bring the latest professional books and materials to our staff, nurses, teacher-librarians, social workers, guidance counselors, and the general public in our area. We helped to provide my little friend and others like her with good health project materials in their school libraries. – Gladys Owen, Public Health Nurse, Sudbury & District Health Unit, Sudbury, Ontario. □

Bradford Frame Covers



Nurses on pediatric units frequently collect 24-hour urine specimens on children for investigation and diagnostic purposes. Children incapable of cooperating often have a urine collector applied, and to facilitate both collection and hygiene they usually spend the 24 hours lying on a Bradford frame.

Covering the frame's upper and lower canvas segments by pinning or taping sheets is time-consuming and difficult. Also, soiling necessitates re-covering, that is, re-pinning or taping, often repeatedly in a day.

We have sewn triple-thick flanelette squares, made to cover the upper and lower canvas segments exactly. Sewn around the borders of the frame's canvas and the flanelette squares are opposing strips of Velcro.

As seen in the diagram, the covers can be quickly stripped off or firmly attached to the Bradford Frame.

This is comfortable for the child to lie on, extremely simple to handle, and easily laundered. – Maureen Brenchley, formerly employed by the Children's Psychiatric Research Institute, London, Ontario as head nurse of the metabolic investigation unit. □

One little boy with two big problems

How a 10-year-old with cystic fibrosis and serious behavioral problems learned to accept his illness and to trust those who cared for him in hospital.

Dorothy Chapman

Brian Brown, a healthy-appearing 10-year-old with sandy hair and big blue eyes, did not look as though he had a serious congenital disease when he became a patient at The Hospital for Sick Children in Toronto. On admission he had an upper respiratory infection with hoarseness, swollen neck glands, and shortness of breath, and was coughing up copious amounts of white sputum.

Brian's diagnosis was cystic fibrosis, a disease transmitted as a mendelian recessive trait. It was evident from his x-rays, which showed extensive lung damage, that he had not received treatment for at least 10 months.

Brian had another problem that could not be ignored: he behaved abnormally in several ways. He was aggressive when he really wanted to be friendly, and to attract attention he would hit someone or wave his arms in the air. He seemed unable to learn from experience, and had a low level of frustration tolerance.

Family background

Brian's home life seemed to be largely responsible for his behavior. His mother, who is separated from her husband, is the most important person in his life. Brian lives with her during the winter and with his father in the summer.

A nervous woman, Mrs. Brown cries easily, smokes heavily, and is still dependent on her own mother. She does not believe in keeping to routine, sleeps late every morning, and often lets her three young children make their own meals.

Mrs. Brown visited Brian in hospital as often as she was able, but her visits were irregular. Brian showed his disappointment in her by hitting the person nearest him, hanging up the phone on her, refusing his food and treatments. When his mother was with him she appeared concerned about him and quietly tried to persuade him to behave. She was usually unsuccessful and admitted that she was unable to control him.

Brian's father, a big, aggressive-looking man, is still a steady provider for the family, even though he hasn't lived with them for eight years. According to Mrs. Brown, he is not dependable in other ways: he acts on impulse, and once served a four-year prison term.

In Brian's presence, Mr. Brown seemed awkward and tense, unable to talk to his son. When Brian accused him of treating his mother "mean," his father walked out and did not return to see his son in hospital for several days. Brian resents his father for having left his mother to live with another woman, whom Brian dislikes.

Brian has a 14-year-old sister, of whom he seems jealous, possibly because she does not have cystic fibrosis. He speaks highly of his little brother, aged four, and seems to miss his company.

Miss Chapman is a third-year student at The Hospital for Sick Children in Toronto.

Brian had not attended school for several months before his admission to hospital, because he had been suspended for running away and for swearing, screaming, and spitting at his classmates.

Thus, the absence of a father, the presence of a disorganized mother, the lack of routine in the home, and a serious medical problem all contributed to Brian's behavior. We hoped that his habits would gradually improve if we consistently ignored inappropriate behavior and rewarded that which was appropriate.

Medical background

For some reason, Mrs. Brown would not admit that Brian had cystic fibrosis. When the boy was four years old, she suspected that he had a serious illness and took him to several doctors, who told her she had nothing to worry about. Finally, when his disease was diagnosed, she was upset and clung to the belief that he was "normal." She never did tell Brian that he had cystic fibrosis. She avoided doctors and postponed asking them about her son's condition, not realizing that his lungs would deteriorate without treatment. Because he appeared well, she believed he was well.

Cystic fibrosis is a disease that cannot be ignored by either the child or his parents. In this condition thick secretions block the ducts of the pancreas, preventing important digestive juices from entering the intestine. The stools contain undigested fat and are foul smelling. Gradually the infant becomes malnourished. Small air ducts in the lungs are also blocked by thick mucous, predisposing the lungs to chronic infection and fibrotic change.

There is no cure for cystic fibrosis. Treatment is life-long and is aimed at removing the excess mucous in the lungs and supplying the missing pancreatic enzymes. If these are not accomplished the child dies, usually of pulmonary disease.

Problems with treatment

On admission, Brian was treated with antibiotics, vitamins, and pancreatic enzymes. Inhalations by mask, lasting

from 10 to 15 minutes, had to be given three times daily. The inhalations were unpleasant, since the solution used was foul-smelling.

Postural drainage then removed from the lungs the excess secretions that had been loosened by the inhaled solution. There are several drainage positions that help to clear the five lobes of the lungs. These positions are uncomfortable and the treatments can be painful, especially if the secretions are profuse. But each position must be assumed every day if the patient is to survive. The patient lies in each position for 10 minutes while the physiotherapist claps the chest over the particular lobe to loosen the secretions. Throughout the procedure he coughs up as much sputum as he can.

At first, Brian refused the postural drainage treatment, although he took his inhalations and medication without fuss. He decided he did not like the physiotherapist. This may have been because she had to emphasize the importance of the clapping of his chest. The physiotherapist was very patient with him and often let him choose his favorite position. After a week he still would not assume several of the positions and would hold none of them for the required 10 minutes. He kicked, screamed, and swore when she tried to teach him a new position.

At night Brian was to sleep in a tent, which provided moisture. This too was uncomfortable, as he became wet in a few hours from the condensation in the tent. He then refused to sleep in his tent, and even refused to stay in bed. Some nurses, in an attempt to calm him, gave him a prescribed sedative, which he did not like. Other nurses would let him stay up until he fell asleep on the floor outside the nursing station.

To get attention, Brian refused his meals. I would sit with him and we would list the foods he liked and disliked. When the cafeteria sent him a menu, he could no longer say he did not like the food offered since he had chosen it. He enjoyed this special privilege.

At the weekly team conference, those of us caring for Brian discussed the limits we should place on his behavior and planned how we would deal with his problems. Somehow we had to convince him of the importance of the various treatments, which he will have to carry out daily for the rest of his life.

The psychiatrist advised us to approach Brian in a matter-of-fact manner and to tell him simply it was now time to

do his postural drainage, or time for his inhalations. In this way Brian would know exactly what had to be done and when. The psychiatrist decided to see Brian regularly three times a week for half an hour, to give the child a chance to share his feelings with someone who was not directly involved in his medical treatment.

Mrs. Brown was counseled by the same psychiatrist. He told her that it would be necessary for the boy to have regular treatments for the rest of his life, which might be 10 to 20 years or longer. He also told her that she would have to talk to her son about his illness, although he knew it would be difficult for her to do so. Brian had to learn to accept his disease if he were to survive.

The new plan

As part of the new plan, Brian was expected to get up and have his breakfast at 8:00 a.m. When he refused, saying that at home he always slept in, I told him that while he was in hospital he would have to get up for his breakfast. When he still refused, or threw his food on the floor, I left the room. Usually he would then calm down and eat at least part of his meal.

Brian behaved similarly at the time of his tub bath or inhalations. As long as I entertained him while he took his inhalations, he behaved well; but if I had to leave the room, he would pour the solution on the floor.

Three times a day Brian was to have postural drainage. When the physiotherapist entered the room, he fought so violently that for several days it was necessary to restrain him during the treatments.

Brian enjoyed the remainder of the day, which he spent at school, at play, or in occupational therapy; in the evenings he went to the play room or to Cubs. At these times he behaved as normally as any 10-year-old boy.

When Brian had violent tantrums because he had to go to bed at 9:00 p.m., his door was locked. Eventually he would fall asleep. After he was asleep we would turn on his tent. He knew we did this and accepted it since his objection to the tent was that the noise kept him awake.

Several weeks after admission Brian asked some revealing questions: "What is the worst disease you can have?" "Will I have to have the clapping done when I'm grown up?" "Do they have tents big enough for a grown man?" Brian was beginning to accept his illness. It was important for him to be able to relate to us how he felt.

Occasionally he would have a good day, when nothing upset him, and he would take his treatments without needing restraint.

Brian still became upset if his mother did not say definitely when she was coming to visit; if the doctor mentioned that he would have to stay in the hospital for a long time; or if his mother told him he was not going home after his hospitalization, but instead was going to a children's rehabilitation center. At such times the physiotherapist needed extra help with his postural drainage. Enforcing his treatments was necessary at this time, as other approaches had failed.

New problems now developed. He would lock himself in the bathroom or run off the ward when his inhalations were to begin. At another conference, which included the physiotherapist, the occupational therapist, the pediatricians, the psychiatrist and the nurses, the psychiatrist advised us not to run after Brian when he was merely seeking attention, but to bring him back when he was running away from his treatments. When Brian said "Give me a knife, I'd rather kill myself than have to do my treatments for the rest of my life," the psychiatrist explained that the boy was going through a depression period and that we should let him talk freely, reassure, and comfort him. He urged us to observe Brian closely, since he was serious about harming himself. In addition, it was decided that since he was an active boy who needed exercise, we should allow him to go to the gym as frequently as possible.

A male psychiatric nurse was assigned to the ward because the regular evening nursing staff had difficulty coping with Brian. The first evening Brian was hostile and rebellious. He ran away; when confined to his room, he became destructive. The psychiatric nurse was strict, but kind, and disciplined him in a fatherly way. Brian's hostile feelings gradually disappeared.

Though I was no longer his regular nurse, I continued to visit Brian. I was available when he wanted someone to talk to, to read him a story before he went to sleep, to kiss him goodnight, if he wished. As a reward for his good behavior, I often took him to the cafeteria for a snack in the evenings.

He looked forward to this and knew that he had to behave well to merit this privilege. In this privacy he would tell me what, if anything, had upset him during the day, for example, when his mother had called or failed to come when she said she would. He even admitted that he should not have misbehaved.

Brian faces reality

During my final week on the ward, it was important to tell Brian exactly when I was leaving. He asked where I was going, and what I would be doing. He had begun to face reality.

When the psychiatrist decided that Brian's mother was still unable to care for him at home, we discussed what other temporary, institutional care he required and how we should prepare him for it. We showed him pictures of his new temporary home, and we arranged for him to speak to other children who had stayed there.

With help, Brian will be able to handle the inevitable problems and disappointments that lie ahead of him, just as he has come to accept the fact that he is ill and that his treatments are necessary if he is to grow up. Because he accepts his illness, his behavior has improved. No longer the aggressive or destructive child he was when he first entered the hospital, he has begun to trust the adults around him.

Since Brian must invest many hours of his life in treatments, he cannot live as rich a life as any other child. If he lives by the necessary regimen, however, he will continue to adjust to this *disability* and will, therefore, be better equipped to use his *ability*. □

No time for fear

A nurse remembers how one teen-age boy reacted to a fatal illness, and how he affected the lives of those around him.

Elvie Follett

I first saw Bob the morning after his admission to hospital. As I walked through the ward to the head nurse's station, I noticed a boy with reddish blond hair and skin so fair it looked almost transparent as it stretched taut over the fine bony structure of his face. He looked young to be in a ward for adults but, although slight, was a good height for 15 years.

A few evenings previously, Bob had noticed a large bruise on each thigh as he was getting ready for bed. Next morning he saw his doctor. At 2:00 p.m. the same day, the doctor told Bob's parents that the boy had leukemia.

Steps were taken immediately for Bob to be seen by a specialist, and within a few days he was in hospital.

In hospital, both staff and patients took a keen interest in this boy who, in the weeks to follow would do nothing of a dramatic nature, but who would show nobleness of spirit, quiet courage and other qualities of character – the stuff of which real heroes are made. Bob was to have an effect on a number of people – an effect that has been enhanced rather than diminished by time.

As instructor in science and medical nursing at the time, I helped student nurses with nursing procedures, conducted patient-centered clinics, and held discussions on all aspects of patient care. It was necessary for me to be familiar with the conditions of all patients and the doctors' orders for them.

I remember my first conversation with Bob. I was impressed with his mature outlook as he discussed his plans for school in September. He had been reluctant to enter hospital for it meant missing the June examinations at school. He was jubilant later when he was granted his year on the basis of his past work.

Making friends

Bob made friends with everyone, and, when he could, went from bed to bed sharing his treats. He talked to a 70-year-old patient with the same ease as he talked to the younger patients and classmates when they visited. He would often say to his father, "Dad, Mr. – doesn't have any visitors. Go over and talk to him."

Little incidents, such as his mother's birthday, stand out in retrospect. I saw no reason why Bob could not celebrate with his parents and sister, as he requested. I arranged a corner of the sunroom off the ward. A covered table, with a bouquet of fresh flowers contributed by a patient, was laid out with the necessities and a few chairs were drawn up. We wheeled in Bob's bed, along with the intravenous standard.

A family friend had made a cake. At

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Bob's request it was a whopping big one, for he insisted that everyone on the ward should have a piece. His mother, hiding her feelings behind a gay smile, served cake to all who could have it.

Dave and Pat, two straightforward Scotsmen, took a real interest in Bob, whose bed was next to theirs. Dave had a great sense of humor and an endless fund of stories. Their laughter was contagious. Never have I seen so much fun among a group of sick men. Both men tried to protect Bob and to keep from him any information that might disturb him. One evening they drew a screen around him and engaged in some quiet horseplay so he would not see Bert, another young lad with leukemia, being moved to a single room because of severe gastrointestinal pains and muscular spasms.

There were many other parties with goodies supplied by Bob's neighbors and friends from home. No skimpy tid-bits were found at these parties; instead, the fare usually consisted of whole roasted chickens, Dagwood sandwiches, and extra large cakes. Bob's reputation for sharing was well known.

Returning home

Bob's treatment, palliative only, resulted in considerable improvement. Drugs, blood transfusions, rest, and diet all contributed toward a feeling of well-being. There was every indication he would be returning home. As his hometown was small, we thought he should be told of his condition rather than learn it from one of his friends or by chance.

The doctor told Bob there were several types of leukemia, which varied in severity. Bob was not surprised at this diagnosis, but believed he had a mild type. He had discussed his blood and sternal bone marrow tests, compared his treatment with that of Bert, and had drawn his own conclusions. He confided to Dave that he thought he had leukemia but cautioned him not to let his parents know, as he did not want them to be worried. The day the doctor told him his diagnosis, he said to his parents: "It's not anemia I've got, but leukemia." He thought it would be easier if they knew he was aware of it. He asked his father to get him a hot dog and, alone with his mother, told her he was not afraid to die. She said later that she had no words to answer.

He began to ask his doctor questions. He learned why he was taking certain drugs and why he was on a low sodium diet. He knew that his nosebleeds and subscutaneous bruising were in part due to his low platelet count. He read an article on Strontium-90 and its possible effect on white blood cells. He was aware that the prognosis was not encouraging. "Well, I've had a good life," he told one patient.

Bob went home to enjoy his summer. More mail than usual was delivered. One morning he received an envelope containing a bank draft for $300. When his father called the bank manager for an explanation, he was told it was a gift for Bob from a friend who wished to remain anonymous, and was for him to spend in whatever way he wished. Bob, who loved music, chose a record player, records, and a small transistor radio, which he and his friends enjoyed that summer.

He swam, played ball, and went on a few weekend trips with his parents. A highlight was having Dave and his family visit. The men went fishing, and Bob caught the only fish. The day was topped by a barbecue supper in the garden.

There were a few snags, a few reminders, but Bob seemed capable of coping with them. A child asked, "Is it true you only have one year to live?" "And how did you hear that?" Bob countered, as he raced off on his bicycle. One day an acquaintance, visiting his home, asked: "What are you taking the tablets for?" "Just in the interest of research," was the quick reply as he swallowed the medication and bolted through the door.

Reentering hospital

In September Bob returned to school – for two weeks. An attack of influenza hastened a relapse, which made readmission to hospital necessary. He did not want to go, but was reassured on seeing familiar faces as he entered the same ward.

He kept a daily diary, and with a little returning strength wrote home that he intended studying French and mathematics. He made arrangements with his mother to do his Christmas shopping. In 30 envelopes, each marked with the recipient's name, he placed money and instructions for his mother concerning the gifts. He asked her to buy presents for three doctors who saw him daily, and a student nurse who had become a good friend. He wanted to keep these gifts until the last moment on Christmas Eve so the staff would not feel they had to give him something in return.

Three weeks before Christmas Bob was transferred to a private room where he could have his tree, gifts, television, and visitors. He was worried about the expense of his hospitalization and was relieved only when his father showed him an insurance policy that included coverage for leukemia.

Bob's parents heard from others of his nosebleeds, discomfort, and abdominal cramps. If he had to tell them anything he tossed it off lightly, almost gaily. One day, as he glanced at his swollen, discolored legs, which he could not bear to have covered, he said to his father: "Never mind, Dad, perhaps they'll be better tomorrow." A week before the end he said: "This has been a great day. So many of my good friends have been to see me."

The following day he told his mother that as they had been rushing Christmas and cheating a bit, he thought he would give the doctors their gifts. Though his strength was waning, he smiled his pleasure when the cuff links, cigarette lighter, and tie reappeared in use the next day.

Dave, still a patient, got up to visit Bob, "because I had to see that boy again. There were so many wonderful little things about him, and yet they were all big things. He was great in every way," he said.

A staff worker told me, "Everything about Bob was outstanding. I will never forget his courage, or the way I felt strengthened after visiting him. For him death was nothing to fear. It was like walking through a door to another room."

It is not easy to describe this boy and his affect on others. There was something about him that defies description. Some faces become blurred with time, but not his. I deem it a privilege to have known him. In him we saw a magnificent blending of the finest in human qualities, a boy who could lift others to a higher level. □

research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Sellers, Betty Louise. *A study to compare the nursing care given by professionally and technically prepared nurses on a medical unit.* Seattle, Washington, 1968. Thesis (M.N.) University of Washington.

Nursing literature was relatively devoid of support for the thesis that quality nursing care exists when there is maximum utilization of general staff nurses according to their knowledge, skills, and abilities. This descriptive study was designed to assess nursing roles of professionally and technically prepared nurses, to redefine them as necessary to provide for maximum utilization, and to assess quality of nursing care given before and after role redefinition. An activity study was employed to assess how that nurse was spending her time, while a quality study was employed to assess to what extent the nursing care was satisfactory. Each study consisted of three phases which extended over one year.

Data for the activity study was collected using a modified version of Arnstein's tool. Data for the quality study was collected using a modified version of the Pardee standards for nursing care, which employed patient interviews, nurse observations, and examination of the patient record.

Findings revealed that the quality of nursing care as given by all registered nurses on the ward did improve by 11 percent over the three phases. However, the professionally prepared nurses did not appear to be performing specifically in the redefined roles which provided for increased planning for directing and assessing of patients' nursing care needs.

Griffith, J. Kirstine (Buckland). *An institute as an educational experience in the continuing education of a selected population of nurses.* Vancouver, 1969. Thesis (M.A.) U. of British Columbia.

This study was an effort to evaluate the effectiveness of a two-day institute on "Evaluation of Personnel" as an educational experience in the continuing education of nurses, to submit a method of evaluation to critical analysis, and to examine the relationship of educational and experiential backgrounds of the participants to the learning that took place subsequent to an observational analysis of the institute. An unstructured interview technique was used three months after completion of the institute to elicit subjectively what respondents thought they had learned at the institute. The information was later arranged in a structured format for compilation, tabulation, and analysis, both by punch card and computer. The socioeconomic background data were gathered through the use of a structured questionnaire at the time of the interview. A behavioral concept of learning was used throughout.

The results revealed that 91 percent of the sample indicated that learning had occurred, as the nurses perceived a change in their behavior because they had attended the institute. Furthermore, 76 percent perceived a change in knowledge, 62 percent in attitude, and 76 percent in practice; and more than half perceived a change in all three areas. The greatest change was perceived by those who were younger, married, had less education (academic and post basic nursing), less experience in nursing, and were employed in the larger agencies. The perception of little or no change was indicated by those who had more education (academic and post basic nursing), more experience in nursing, and were employed in the smaller agencies.

The comparisons of change to background factors revealed that although none of the comparisons were consistently significant, there was a positive relationship of learning with age, basic academic education, post basic nursing education, years of nursing experience, and size of employing agency. Marital status, husband's occupation, parental status, income, social participation, years of head nurse experience, size and type of nursing unit, and size of staff showed some interesting comparisons by observation, but the sample proved too small for accurate inferences to be drawn.

The conclusions of the study were that the institute was effective as an educational experience for continuing education in the three aspects of behavioral learning examined, provided that the credibility of the respondents was acceptable. The instrument used was adequate for the purpose of indicating change of behavior with the above proviso, but not adequate for revealing whether change was relevant to certain socioeconomic data. No claim can therefore be made concerning the relationship between this data and learning in a situation such as this institute.

MacLeod, Catherine Shirley. *An exploratory study to determine if the stated objectives of a maternity nursing program provide senior diploma student nurses with a family-centered philosophy.* Boston, 1969. Thesis (M.S.N.)

The purpose of this study was to determine if the stated objectives of a maternity nursing program provided senior diploma nursing students with a family-centered philosophy.

Ten students from a three-year diploma school were interviewed following the completion of their maternity nursing experience. With the use of an interview schedule, data were collected and summarized under four major topics: students' attitudes and feelings prior to their nursing education; the maternity nursing experiences that had an impact on the students' philosophy of maternity nursing; what a family-centered philosophy means to students and how it can be achieved by nurses; and the relationship of students' former attitudes and feelings to their present philosophy of family-centered maternity nursing.

The interviews from this study revealed that students had a limited knowledge of human reproduction prior to their nursing education. The students maintained that much of this information had been gained through reading and peer relationships. From their maternity nursing experience, students became aware of parents' physical, psychological, emotional, and educational needs during the entire maternity cycle. The students recognized many areas in which nurses could assist parents to meet these needs effectively during the period of childbearing. All students interviewed subscribed to a family-centered philosophy of maternity nursing. The students readily verbalized this concept of family-centered philosophy; however, they felt they were unable to practice this type of nursing within their present nursing situation. □

books

Diseases That Plague Modern Man by Richard Gallagher. 230 pages. New York, Oceana Publications, Inc., 1969.

Reviewed by Justine Delmotte, Supervisor, Ottawa-Carleton Regional Area Health Unit, Ottawa.

The subtitle of the book, "A History of Ten Communicable Diseases," clearly describes its content. The author focuses particular attention on tracing historically 10 communicable diseases that are vital world forces.

The book is timely, with today's swift travel, expansion of tourism, migrant labor, and nomad movements. The author emphasizes that the principle of surveillance is an important factor. A global effort is being made to cope with these diseases by replacing epidemic control by epidemic prevention. What happens to their growth depends largely on what will be done in the future to cure, control, and possibly eradicate these diseases.

The author presents a brief overview of the history of these diseases in the introduction, and treats each disease in a separate chapter. Major difficulties, principles of control, and recommended measures to implement these principles are clearly presented. A profile of the disease is presented at the end of each chapter.

The annexes are particularly valuable in giving basic references for state and local agencies by listing members and associate members of the World Health Organization; important non-governmental organizations in official relations with WHO; and references relative to each of the 10 communicable diseases. The book contains a glossary of some important communicable disease terms.

Readers searching for new direction in the problems of communicable disease control will find that the book systematically presents background material and practical assistance. The book may well serve as a companion to *The Control of Communicable Diseases in Man* – the basic primer of community management of disease.

Orthopedic Nursing Procedures 2nd ed., by Avice Kerr. 414 pages. Springer Publishing Co. Inc., New York, 1969.

Reviewed by Marjorie Beckwith, Clinical Supervisor, Sherbrooke Hospital, Sherbrooke, Quebec.

This is not an exhaustive textbook on orthopedic nursing, but it is much more than a procedure book. It is a brief, clear, reference book presenting a wealth of material in a form that the busy nurse could use with much profit.

The author covers in outline form the first aid, emergency room, and hospital nursing care of patients with injuries to the spine, chest, pelvis, and extremities, and with other conditions producing musculoskeletal deformities. She deals with numerous types of mechanical devices used in treatment, such as frames, slings, casts, traction, crutches, splints, and bandages. Other procedures used in treatment of complications and special problems related to orthopedics are covered, including tidal drainage for bladder complications, restraint for irrational patients, and heat treatments (old and new) used for relief of muscle spasm and pain. The mental and emotional needs of the patient are not forgotten.

The book carries a good presentation of body alignment from the point of view of prevention as well as correction of deformities. The nurse is made aware of her own need to apply this knowledge to herself in prevention and correction of posture problems and back strain. The material on optimum positions, support, and exercise could be put to good use in every area of nursing practice.

One addition that I would like to see is a good alphabetical index for quick reference.

This comprehensive orthopedic procedure manual could be recommended as a guide on any orthopedic unit, general surgical, or medical ward.

Popular Hospital Misconceptions by Anthea Cohen. 90 pages. London, IPC Business Press Ltd., 1969.

This delightful book contains 31 humorous selections reprinted from *Nursing Mirror and Midwives Journal.* Each story briefly outlines a popular hospital misconception, many illustrated by Philip Meigh who has the ability to bring out the best in each of the author's selections.

The titles of the selections add to the humor. "I will let you know when the doctor can see you," will strike a familiar note with anyone who gets to see her doctor, after reporting for her appointment on time and is reprimanded with "Why didn't you tell somebody you were waiting?"

Any nurse married to a doctor will chuckle at Miss Cohen's "It's Wonderful being married to a doctor." When a child in a doctor's family becomes ill, the author suggests the doctor will probably say to his wife: "Well, you look after him, dear. I'm sure you can handle it. I'll have a look at him tomorrow."

Nursing is almost universally thought of as an underpaid profession. "Nurses are not in it for the money," is a priceless example of Miss Cohen's ability to capture the spirit of an issue. The accompanying illustration for this selection is delightful.

Any nurse who can laugh at the "facts of life" in her profession will be delighted with Anthea Cohen's book.

New Guinea Nurses by Elizabeth Burchill. 151 pages. Adelaide, Australia, Rigby Ltd., 1967. Canadian Agent: Ryerson Press, Toronto.

Reviewed by Valerie Fournier, Public Relations Officer, Canadian Nurses' Association, Ottawa.

Any nurse who has thought of using her skills "away from it all" will be fascinated by the experiences of Elizabeth Burchill, who worked as an infant welfare nurse in a remote area of New Guinea.

Sister Burchill's surroundings were strange and exotic. The natives she treated had not forgotten witchdoctors. The author shows that the island medical service is devoted to bringing the best possible medical care to all inhabitants of New Guinea, including those in the deep jungles.

The author describes the government's health plan for the island, including its scheme to train native girls in infant, child, and maternal care. She then treats in more detail the working of the outpost hospital where she was stationed and the mobile clinics that visited the jungle villages.

Perhaps the most interesting chapters describe what happened when Sister Burchill was temporarily put in charge of one of the mobile clinics. This gave her "a priceless opportunity to study the intricacies of native life." During her periodic examinations of mothers and infants, she came in close contact with the primitive tribesmen, in an area where health has been bound up with superstition for centuries. She found that not only their way of life, but even some of their ailments were unique!

This book is by no means confined to nursing topics. The author takes pleasure in describing the lush, tropical land-

scape and many of the individual flowers, trees, and animals she came across. She also talks of the natives she worked with and their customs. As an appealing extra, her book is laced with photographs of the scenes and people she describes.

Sister Burchill is no stranger to nursing in remote areas. She trained as a nurse in Melbourne, Australia, and worked in the Australian Outback, New Zealand, Thursday Island, and Labrador.

The author has a flowing style and a gift for making the scenes she describes come alive. This travel story with a difference – especially for nurses – may well give others in the profession the call of the wild!

Introduction to Clinical Nursing by Myra Estrin Levine. 468 pages. Philadelphia, F.A. Davis Company, 1969. Canadian Agent: The Ryerson Press, Toronto.
Reviewed by Arlene Aish, Assistant Professor, School of Nursing, Queen's University, Kingston, Ontario.

Myra Levine interprets her book as a beginning course in nursing. She has analyzed the content usually found in introductory nursing courses and has organized this content within a structure of scientific principles from which nursing processes are derived.

The theoretical framework from which the author views nursing activities is the concept of nursing as a conservation activity. Each chapter develops a particular patient problem utilizing her four principles of conservation of energy, conservation of structural integrity, conservation of personal integrity, and conservation of social integrity. Conservation is interpreted as a "keeping together." The patient is seen as an individual whose response to environmental stimuli results from the integrated and unified nature of the human organism.

Miss Levine's concept of nursing offers an excellent framework on which to base nursing content. It is unfortunate that her concept of the patient appears to be limited to the person in hospital. Little or no emphasis is placed on the fact that nurses are also concerned with people in the community.

Each chapter involves a model that provides a framework for a variety of related nursing processes; for example, "body movement and positioning" and "ministration of personal hygiene needs." Each model includes a statement of objectives, a long list of essential science concepts, and a long list of principles related to the associated nursing activities.

The author believes it is important to use a generalized approach rather than one that adheres to the policies of a particular hospital. This aim is not always followed, however. For instance, the nursing process related to vital signs includes several statements that appear to be dependent on particular hospital routines rather than on the nurse's judgment.

Although the text is referred to as a first level course, a student would need a fairly extensive background in physical and social science to use it. The development of particular patient problems in the text moves into the area of medical-surgical nursing and pathophysiology.

It is doubtful that many instructors would want to organize their content in a beginning course in precisely the way suggested in the book. However, it is highly recommended for examination by instructors and practitioners of nursing because many concepts are well developed by the author and should not be missed. Of particular interest is the last chapter, which deals with the concepts of territoriality (personal space requirements, the establishment of personal boundaries, and their defense) and of circadian rhythms.

Perceptual-Motor Efficiency in Children by Bryant J. Cratty and Sister Margaret Mary Martin. 223 pages. Philadelphia, Lea & Febiger, 1969. Canadian Agent: Macmillan Company of Canada.
Reviewed by Dr. G. J. Jarvis, Ophthamologist, Toronto.

This well-organized monograph deals principally with techniques to improve perceptual-motor efficiency in children diagnosed as having a dysfunction in this area. Remedial therapy is controversial and the authors must be congratulated for tackling this subject in such an honest and open-minded manner. In doing this, the book accomplishes more than its specific title suggests.

The foreword, preface, and first two chapters provide an objective, critical review and background of the most pertinent aspects of perceptual dysfunction. This is supported by a well-selected and up-to-date bibliography.

Although the authors are actively engaged in the training and remedial therapy of perceptual-motor dysfunction and believe that such motor training is beneficial for children, they do not overemphasize its value. In simple style they stress that correlation does not prove causality.

Unlike some disciples of unproven theories concerning the causation of perceptual dysfunction and its motor correlates, the authors question that efficient movement is the basis from which all cognitive perceptual attributes spring. The Doman-Delacato method of remedial therapeutic creeping, crawling, and lateral limb manipulation is criticized for unproven theoretical tenets and lack of objective and valid supporting data and controls.

Using a psychophysiological approach, perceptual-motor activities are analyzed and discussed as component parts of gross and fine motor activities. Movement attributes, performance capacities, and the principles of perceptual-motor education are presented in a concise and practical manner. Twenty-three performance charts for graded motor skills are given. These are particularly useful as they give normative values and thus serve as a guide to teachers and parents not to exceed certain levels of performance.

With the help of excellent drawings, the remainder of the book serves as an easy-to-follow manual. Despite the manual-type categorical style, the book never becomes purely motor-oriented, but retains a psychosomatic integrated approach when discussing self-confidence, body image, and the components of games with ideas.

The book concludes with three appendices that contain normative tables, test procedures for gross and fine motor control, games-choice tests, self-opinion tests, and physical fitness tests.

A controversial aspect of perceptual dysfunction is presented in a simple and practical form by two authors who seem qualified to discuss this specific subject. Although the book addresses itself to parents and educators, it can be recommended to everyone who has to deal with the diagnosis and treatment of perceptual dysfunction.

Personal and Vocational Relationships in Practical Nursing, 3rd ed. by Carmen F. Ross. 266 pages. Toronto, J.B. Lippincott Co., 1969.
Reviewed by Helen D. Taylor, Director of Nursing, Jewish General Hospital, Montreal, P.Q.

This book illustrates that relationships are an integral part of nursing, and that good relationships are formed when there is an understanding and control of one's own attitude and behavior. It also offers guidance to the practical nurse in developing nurse-patient relationships and vocational relationships with other people in the hospital. The roles of the individual hospital team members have been defined in this edition and nursing care patterns discussed in an attempt to give the practical nurse a better understanding of her place in the health team.

This book is designed for use as a primary text for a course covering personal and vocational relationships in practical nursing, or as a supplementary text when the subject is integrated with other basic nursing courses. Sections of the book, notably the chapters entitled "Ethical and Legal Responsibilities" and "Organizations," specifically describe the American situation. Much of the material in other chapters, however, can be generally

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books

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applied; therefore the book should be a valuable addition to the library of a school for nursing assistants. It is more comprehensive and has greater depth than some other available texts with similar titles and content.

Textbook of Pediatrics, 9th ed., edited by Waldo E. Nelson, Victor C. Vaughan, III, and R. James McKay. 1,589 pages. Toronto, W.B. Saunders Company, 1969.
Reviewed by Dr. Helen Evans Reid, Director, Dept. of Medical Publications, The Hospital for Sick Children, Toronto, Ont.

This revised edition of one of the best standard textbooks in pediatrics should be in the library of every nursing school.

The authors are distinguished scientists and pediatricians; the material they present is well organized and indexed.

The last 100 pages of the book are packed with valuable, specific information on poisoning, including its recognition and the appropriate emergency and long-term treatment; diets for the treatment of particular disorders; normal blood values, with cerebrospinal fluid values clearly tabulated; conversion tables for measures, weights, and temperatures, and charts indicating normal developmental sequences. This up-to-date information would be of immense help to nurses serving in isolated areas.

The section on maternal medications, which may adversely affect the fetus and newborn infant, and the sections on high-risk pregnancy and high-risk infants should be required reading for all those interested in reducing Canada's high neonatal mortality rate. □

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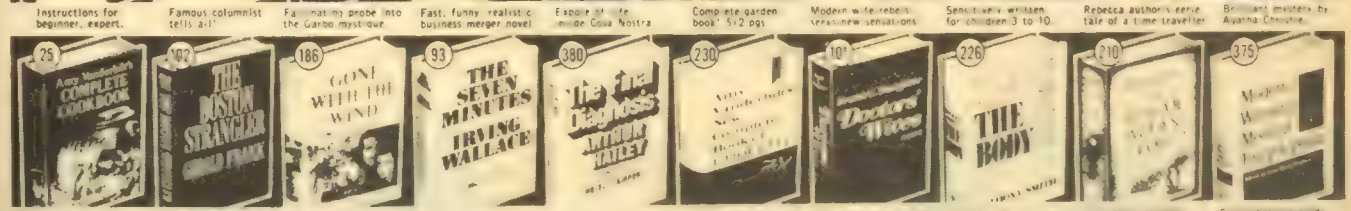

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The
Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 66, Number 2 February 1970

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The recommendations of the seven task forces that recently investigated the cost of health services in Canada ("Special Report," page 23) warrant the nursing profession's scrutiny and comment. If implemented, these recommendations would radically change the present pattern of health care and might or might not improve the care our patients now receive. Moreover, the implementation of certain of these recommendations would undoubtedly affect the nurse's role and her relationships with patients and co-workers.

The Canadian Nurses' Association will issue a short general statement on the task forces report in March. In the coming months the association will study in depth many of the 348 recommendations.

Here are a few capsule comments on the report. As with all signed editorials, these comments represent the editor's views.

There's a lot of meat in this massive report, although much of it is hidden by the verbiage that invariably follows a committee's deliberations. Certain basic recommendations, which we find easy to support, emerge: the regionalization of health services; the expansion of home care programs; the need for better prepared administrators at all levels; and the need for better utilization of health personnel.

We also support the recommendations that accreditation be mandatory for *all* hospitals and that the scope of the accreditation survey be expanded. But why did the task force stop here? Why did it not state that a hospital should be accredited only if its nursing services are up to par? Could the reason for this omission be that this particular task force (and most others) was composed entirely of physicians and hospital administrators?

We disagree with the idea of introducing another category of health worker, the "practitioner associate," to bridge the gap between nursing and medicine. Advocates of this medical assistant role use the *feldsher* system in Russia as a model when arguing that such a category should be created. Nowhere in the report, however, could we find an admission that Russia is planning to phase out her *feldshers*, because the system is no longer useful.

— V.A.L.

letters

Letters to the editor are welcome.
Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Likes November issue

Your November issue is one of the best yet. I enjoyed the short editorial on the World War I nurses, and also the article "The Bluebirds Who Went Over" by Carlotta Hacker. This is a most interesting and well-written article.

The story of "Two-Year-Old Michael – Ill and In Hospital" was also well presented. It should be instructive to many mothers as well as to nurses. – Jean Bell, Newmarket, Ont.

Nurses check their image

I have been asked by our supervisory group to congratulate you and your staff on the publication in *The Canadian Nurse* of the article by Glennis Zilm on the appearance of nurses (Oct. 1969). It is an excellent adjunct to our campaign to have our staff spruce up their appearance. This humorous vein helps and the article helps people to see themselves.

There was some concern expressed, however, that in the same issue of the journal there were ads for extremely short uniforms. This seemed a bit of a contradiction.

May I take this opportunity to congratulate you and the staff on the generally high calibre of the articles in the journal. – Mary L. Richmond, Director of Nursing, The Vancouver General Hospital, Vancouver, B.C.

We are impressed with the article by G. Zilm, "Check Your Image – It's Slipping! " in the October issue of *The Canadian Nurse.* We would like to order 12 reprints of this article. – Mary A. Rothrock, Librarian, Albert Einstein Medical Center, School of Nursing Library, Philadelphia, Pennsylvania.

We want to order 100 reprints of the article "Check Your Image – It's Slipping! " by Glennis Zilm. Gertrude Haussler, Associate Director of Nursing Service, The University Hospital, Loma Linda University, Loma Linda, California.

Our faculty has keenly appreciated the article by Glennis Zilm in your October issue. "Check Your Image – It's Slipping! " illustrates and emphasizes a problem hospitals everywhere are facing today. The situation was discussed in detail at the September faculty meeting here. It is satisfying to find each item about which we felt serious concern dealt with so succinctly in your article.

We congratulate the author and the publisher for this timely piece of work, and are ordering reprints of the article. – Mrs. Eileen Nutting, Librarian, Holy Cross School of Nursing, South Bend, Indiana.

I believe that the article "Check Your Image – It's Slipping! " would be of interest to the nursing units in our hospital. I wish to obtain reprints of it. Please send me a price list for 100 reprints of this article. – Rita C. Ostwalt, Instructor, St. Joseph Infirmary, Louisville, Kentucky.

I agree with the letter from Rosalind Paris (Dec. 1969) regarding the article "Check Your Image – It's Slipping! "

Tidiness or untidiness are not criteria for measuring professionalism. Also, many nurses do not wear a uniform, especially in public health units and psychiatric settings. Does their attire make them less professional?

Neatness and uniformity too often have symbolized submissiveness and conformity – qualities which, in my opinion, have retarded the growth of nursing. If a nurse is proud of her work, she will be proud of her appearance. It is not necessary to chastise her in her professional journal. – William Fulton, Reg.N., Toronto.

I am on the side of Mrs. Rosalind Paris (Letters, Dec. 1969). It saddened me to find on my return to part-time nursing, after 10 years in the business world, that the customer is made to feel at least tacitly right, whereas the patient rarely is. Nurses are still not listening to the patient, but are being pressured into believing that their image can make the patient acquiesce to the structured way of caring for him. This obedience from staff and patients makes things easier for administration of any large organization. At the same time we pay only lip service to the need for individual patient care.

So much talk about non-essential things, such as hemlines and appearance, appalls me. If we encourage the nurse to keep in mind what her goal is, hemlines will take care of themselves! In a climate of increased self-respect, the nurse will emulate the colleagues she respects. Such a climate will achieve more rapidly what silent manipulation from petty tyrants will never achieve.

The onus is on each individual nurse to pull up her own socks without complaining and not diminish herself or her colleagues by requiring external policing.

Let us resolve to seek honesty and meaningful caring in all our relationships. – Pam Fairchild, RN, British Columbia.

We wish to order 25 copies of the article "Check Your Image – It's Slipping! " – Mrs. A. Cox, Nursing Office, St. Anges Hospital, Baltimore, Maryland.

We are interested in ordering reprints of your splendid article in the October 1969 issue "Check Your Image – It's Slipping! " – Mrs. Sylvia Bookman, School of Nursing Library, East Orange General Hospital, East Orange, New Jersey.

Reprints of the article "Check Your Image – It's Slipping! " by Glennis Zilm (October 1969) are available from The Canadian Nurse, 50 The Driveway, Ottawa 4, Ontario. Cost: 25 cents per copy or $20 per 100. – Editor. ☐

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news

Members Appointed To CNA Ad Hoc Committee On Legislation

Ottawa. – Six members have been appointed to the Canadian Nurses' Association ad hoc committee on legislation by the association's board of directors.

Members of the ad hoc committee to consider CNA bylaws are: chairman, Jeanie S. Tronningsdal, British Columbia; Eileen C. Flanagan, Quebec; E. Marie Sewell, Ontario; Marcelle Dumont, New Brunswick; Sister Mary Felicitas, CNA president; and CNA's legal advisor, George Hynna.

The decision to set up the ad hoc committee on legislation was made by the CNA general membership at the 34th general meeting in Saskatoon in July 1968.

The committee will meet at CNA House February 26-28, 1970.

CNA Committee To Prepare Brief On Poverty And Health

Ottawa. – A special task committee has been appointed by the executive committee of the Canadian Nurses' Association to prepare a brief on poverty and health for submission to the special senate committee on poverty later this year.

Trenna Hunter, formerly director of public health nursing, Metropolitan Health Service, Vancouver, B.C., and a past president of CNA, will write the brief. Other members of the special task committee are: Catherine Keith, Department of National Health and Welfare, Ottawa; Doris Small, Victorian Order of Nurses, Montreal; Constance Grey, Toronto City Health Department; and Phyllis Kenny, Bruce County Health Unit.

The committee will meet at CNA House February 12-14, 1970.

No Canadian Candidate For 3 M Award in 1970

Ottawa. – The Canadian Nurses' Association will not nominate a candidate for this year's International Council of Nurses 3M Nursing Fellowship. This decision was made by the CNA board of directors at its meeting in November because there was too little time to prepare selection policies, make announcements to CNA members, and choose a candidate before the deadline. However, a candidate will be chosen for the 1971 ICN 3M award.

Criteria for the 3M fellowship were established at the board meeting and are the same as those required for a CNF scholarship. To be eligible an applicant must be a member of CNA, accepted into a graduate program, have intellectual and leadership ability, and experience in nursing. One CNF candidate will be chosen as Canada's entry for the ICN 3M award.

The $6,000 fellowship was recently established by the International Division of Medical Products Group of 3M Company under the auspices of ICN. It was announced at the 14th quadrennial congress of ICN last June. Nurses from more than 60 countries are eligible for the fellowship.

NWT. – This circular symbol has been chosen to commemorate the Northwest Territories "Centennial 70," which is being celebrated this year. It features three figures in black with linked hands, which are intended to express the unity of all the people in the North and the spirit of celebration. The figures represent the Franklin, Mackenzie, and Keewatin geographic areas that form the Northwest Territories. The parka hood of one of the figures has been rounded to represent the pattern worn by the people of the Mackenzie. The three figures are encircled by blue lettering on a white background. NWT permission required to reproduce symbol.

CNA Librarian Visits Libraries In Manitoba Schools of Nursing

Ottawa. – Margaret L. Parkin, librarian at the Canadian Nurses' Association, visited libraries in six Manitoba schools of nursing in December at the request of the accreditation committee of the Manitoba Association of Registered Nurses. Included were libraries at Brandon General Hospital, St. Boniface General Hospital, The Grace Hospital, The Winnipeg General Hospital, Misericordia General Hospital, and The Victoria General Hospital.

Miss Parkin told *The Canadian Nurse* that staffing was a problem common to all libraries. "Each library should be administered by a qualified librarian," she said. "However, there has been a shortage in the past, and for economic reasons it has not been possible for any of these

libraries to have a full-time librarian."

Miss Parkin believes that a health sciences library in each hospital would be more economical than employing a professional librarian for each school. The library would combine resources for all health professions.

"This could apply to any province in Canada," she said. "As nursing education gradually moves out of the hospital schools into the general education system, library facilities to support the educational programs will cease to exist as autonomous nursing libraries, and will become a collection of nursing literature within the library of the educational institution. If the institution is primarily for education in the health sciences, this library will be a health sciences library," she added.

Some libraries lack basic reference tools, such as the *International Nursing Index*, hospital and medical directories, and professional journals. However, the majority of schools were interested in developing their library resources, Miss Parkin said.

Processing audiovisual materials was one of the topics discussed at length during the workshop. "Many possibilities exist here," Miss Parkin said, "but audiovisual materials can be handled with slight modification by standard library methods."

Other topics included in the workshop were the general philosophy of library science, the content of technical services and reader services, the membership and function of the library committee, teaching functions of the library, and processing of periodicals and documents.

Ontario RNs To Carry Out Some Medical Procedures

Toronto, Ont. – Registered nurses in hospitals in Ontario will soon be authorized to carry out some procedures previously done only by medical practitioners. The decision was made last December by the Registered Nurses' Association of Ontario, the Ontario Hospital Association, and the College of Physicians and Surgeons of Ontario.

The *Policy on Special Procedures by Registered Nurses and Technical Personnel* outlines the procedures that authorized registered nurses and technicians may perform. According to the policy, under circumstances where medical personnel are not available, registered nurses may be taught to start intravenous infusions of saline, glucose, blood, plasma, or other electrolytic solutions. "The list of solutions which may be given by the designated registered nurse shall be prepared by the medical advisory committee or its delegate and who from time to time may make additions to the list," the policy states.

Other activities an authorized registered nurse may carry out include: administration of intravenous medications, external cardiac massage, chronic hemodialysis, epidural analgesia, gastric tubes, immunization procedures, intracutaneous tuberculin tests, uterine stimulating drugs, and rectal and vaginal examinations on antepartum patients during labor. During surgery, assistance may be provided by a suitably instructed registered nurse or technician, if only technical assistance is required.

A new procedure for registered nurses involves electrical defibrillation. The policy states that competent and instructed registered nurses may be authorized by a hospital's medical advisory committee to perform electrical defibrillation. The circumstances are to be specified by the committee and prepared in writing by the chief of the department concerned.

Although the College of Physicians and Surgeons of Ontario has agreed to permit registered nurses and technicians to carry out the procedures described above, a hospital must make provision for this in its rules and regulations. The policy states: "Where this provision is made the College of Physicians and Surgeons of Ontario expects the responsible medical authority in the hospital to take proper steps to assure that the registered nurses and technicians have been adequately instructed and designated for the procedures they are to be permitted to perform."

Doris Gibney, assistant executive director of the RNAO, said the new policy will have implications for nursing education because nurses are doing more today than they did 20 or 30 years ago. The policy will protect both the patient and the nurse, Miss Gibney said.

NBARN Project To Assist CNF

Fredericton, N.B. – The New Brunswick Association of Registered Nurses launched a concentrated CNF project called "Campaign 70" in January. It will continue through March. Canadian Nurses' Foundation representative Shirley MacLeod reported that the aim of the campaign is to boost the membership of New Brunswick nurses in the CNF.

Miss MacLeod said that membership application forms were issued to each member with her receipt of 1970 NBARN membership. "This personal contact will be for the convenience of association members and will serve as a reminder to join or rejoin CNF," she said. "Chapters will assist with mini-campaigns at the chapter level."

CNF has adopted the calendar year, but nurses may join at any time.

CNF Membership Still Low

Ottawa. – The year-end membership of the Canadian Nurses' Foundation indicates a total of 1,311. Provincial membership is shown below.

Canadian Nurses' Foundation Membership as of 31 December 1969

Province	*Membership*
British Columbia	170
Alberta	126
Saskatchewan	153
Manitoba	128
Ontario	319
Quebec	74
New Brunswick	211
Nova Scotia	70
Prince Edward Island	6
Newfoundland	9
Outside Canada	28
Total	1,294
Sustaining	16
	1,310
Patron	1
Grand Total	1,311

Any registered nurse can become a regular member of CNF by paying an annual fee of $2. Cheques or money orders should be sent to: CNF, 50 The Driveway, Ottawa 4, Ontario. Business firms, corporations, and associations can also be sustaining members or patrons of CNF by paying the required fee for these categories. Individuals or groups can contribute. All donations are tax deductible. The form for membership or donations is on page 51.

Students Need Counselors To Interpret Information

Toronto, Ont. – Information on adult education courses must be distributed adequately and interpreted to the potential student, according to a panel discussing the topic "Exchanging Information" at the Canadian Education Showplace held in Toronto December 4 to 6, 1969.

Diana J. Ironside, of the Ontario Institute for Studies in Education in Toronto, described the project she has been directing in which courses available for adults have been compiled into a directory for sale or reference in Toronto area libraries.

"But this information is basically a tool for counselors," she said. "There should be some guidance available to the potential student to interpret it to him." She also pointed out that the 5,300 courses listed may not constitute the total number available. However, they were all that they were able to locate during the four months in which the book was produced.

Bertrand Schwartz, director of L'Institut National pour la Formation des Adultes in Nancy, France, suggested that students must also be informed of the

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(Continued from page 8)

economic possibilities of further education. "And they must be given a choice," he added. "They should not merely be pushed into an area, they must be shown all the possibilities and then make their own selection."

Another panelist, Bob Russell of Orbafilms of Montreal, said that in future it was possible that industry may take over part of what is now government responsibility in education. He said that industry in some northern American cities has successfully experimented with hiring ghetto unemployed to train on the job.

The seminar was one of a series of six that formed the international conference on continuous learning held during the Education Showplace.

The first male nurse in Quebec history to receive his license to practice nursing. From left, Eileen Flanagan, co-chairman, ANPQ Committee on Legislation; Jean Robitaille, the first fully licensed male nurse in Quebec, and president of the Male Nurses Committee of Quebec; Jacques Maynard, treasurer of the Male Nurses' Committee; and Helen D. Taylor, ANPQ president, who made the presentation.
Miss Flanagan, who was president of ANPQ in 1946 when the Nurses Act was passed, said that ANPQ endeavored in 1946 to have men legally admitted to the profession. The move was blocked in the Quebec Upper House, and one senator commented that it was "immoral" to have men working under female nurses in hospitals. In 1962, ANPQ resumed efforts to have men legally admitted into the profession.

First Male Nurse Licensed To Practice In Quebec

Montreal, P.Q. – The first man to become a fully licensed nurse in Quebec was accepted into membership in the Association of Nurses of the Province of Quebec in December. Jean Robitaille, a graduate of Hôtel Dieu de Montréal with a baccalaureate degree from Université de Montréal, was formally presented with a license by Helen D. Taylor, ANPQ President. Mr. Robitaille becomes the first male nurse in the province's history to carry the initials "R.N." after his name.

Bill 89 – Legislation to permit men to enter the nursing profession – was passed December 12 by the National Assembly of Quebec. Previously, the profession was restricted to female nurses by the Quebec Nurses' Act. Although the prior legislation had precluded licensing of male nurses, some nursing schools have been admitting men for several years. Six hundred male graduates of nursing schools are eligible for licensing immediately by ANPQ.

In presenting the license to Mr. Robitaille, Miss Taylor said that ANPQ has been striving for many years for the admission of men to the profession. "It is particularly fitting that the legal machinery to permit male nurses to be licensed by ANPQ should occur at this time," she said, "because we are at the eve of our 50th anniversary as an association. We are, therefore, at this time celebrating two important milestones in nursing history in Quebec." With membership in ANPQ, male nurses also become members of the Canadian Nurses' Association.

Another provision of Bill 89 amends the French version of the association's title to reflect the admission of male nurses. The new name of ANPQ in French is "l'Association des infirmières et infirmiers de la province de Québec."

Bill 89 also lowers from 21 to 18 the minimum age required by law for the practice of nursing. This enables all qualifying graduates from nursing schools to be admitted to practice without waiting until they are 21 years of age.

NBARN Members Approve Fee Increase

Fredericton, N.B. – At a special general meeting, members of the New Brunswick Association of Registered Nurses approved a fee increase from $30 annually to $40 annually, effective January 1, 1970. The increase was made to overcome a deficit budget and to improve NBARN services presently offered to the members and the community.

NBARN president, Irene Leckie, chaired the meeting.

Labour Relations Act Proclaimed in NB

Fredericton, N.B. – After two years of planning, the New Brunswick Public Service Labour Relations Act was proclaimed law on December 1, 1969. The new legislation gives 30,000 public servants, including at least 2,000 nurses, collective bargaining rights.

Nurses' staff associations have been organized in local hospitals and agencies throughout the province in preparation for the new Act. Nurses have chosen the New Brunswick Association of Registered Nurses as their bargaining agent.

The Treasury Board, designated as the employer for public servants, will specify and define the groups within each occupational category. This will be done on the basis of job descriptions. After groups are named and within 90 days after proclamation, NBARN can apply for certification as bargaining agent.

The collective bargaining structured to be used by NBARN under the new Act underwent a trial run during the 1969 voluntary bargaining sessions with the New Brunswick Hospital Association.

Quota Remains The Same For Male Nurses In Canada's Forces

Ottawa. – No change has been made in the quota of four positions allotted for the enrolment of male nurses into the Canadian Forces since the first male nursing officer was commissioned as a lieutenant in November 1967.

According to Brigadier General L.A. Bourgeois, director of general information, Department of National Defence, neither male nor female nurses are being recruited for the fiscal year 1969-70 as all available positions are presently filled.

Most Canadian Forces Recruiting Centers have waiting lists of applicants, General Bourgeois said. Normally all applications from registered nurses who meet the requirements for enrolment as officers in the Canadian Forces are considered in competition when vacant positions exist.

Male nurses may be selected for any type of nursing duties for which they have been professionally trained. Currently, two of the four male nurses are serving at the Canadian Forces Hospital, Halifax, and one is at the Canadian Forces Hospital, Esquimalt, British Columbia. The other nurse serves with 1 Air Division Medical Center at Lahr, Germany where, as a trained flight nurse, he takes his turn with other flight nurses on medical evacuation flights.

The commissioning of male nurses in the Armed Services came after 26 years of attempts by the Canadian Nurses' Association and the Registered Nurses' Association of Ontario to persuade the government to change its policy of commissioning only female nurses.

RNAO Publishes Statement About TGH Senior Nurses

Toronto, Ont. – The Registered Nurses' Association of Ontario has published a detailed account of its knowledge of the suspensions of the three senior members of the nursing staff of the Toronto General Hospital in October. The statement, which appears in the current issue of *RNAO News,* is printed below in its entirety.

On Thursday, October 23, the two associate directors of nursing were asked to resign by the executive director of the Toronto General Hospital – the resignations to be effective immediately. In their view this request was not justified. They asked for a period of time for consideration prior to making a decision. The next word they had was that the director of nursing and the 2 associates were on "suspension" pending a report from consultants. The hospital had previously asked for a study of the nursing department to be conducted by the Ontario Hospital Services Commission, but the report had not yet been released by the OHSC.

During this time, RNAO staff met not only with the 3 nurses involved, but with a delegation representing the head nurses as well.

The incident was picked up in the press Wednesday, October 28. By Thursday it became evident that the situation was rapidly deteriorating, basically because no useful information supporting the action taken was forthcoming from the hospital. On Friday, a letter was sent from the RNAO to the chairman of the board of trustees of the hospital. The following release was made to the press by RNAO:

"The Registered Nurses' Association of Ontario announces today its full support of the three senior members of the nursing staff of the Toronto General Hospital who have been suspended from their positions while still remaining on full salary. The RNAO has asked the board of trustees of the hospital to disclose the basis of the unusual action taken by the executive director so that the three nurses involved may know what complaints have been made and will have the opportunity of answering them.

"The association made it quite emphatic that it has no knowledge whatever which could justify the suspension of these nurses.

"In response to numerous inquiries from nurses of all position levels throughout the province, the association announces that the three nurses involved are already receiving active assistance from their association. They have seen RNAO's lawyer and are in close contact with executive director, Laura W. Barr, and the employment relations staff."

On Monday, November 3rd, the association received a reply to its letter stating that the board of trustees of the Toronto General Hospital had rescinded the suspension of the 3 senior nurses in the department of nursing. The nurses had been reinstated in their positions. RNAO made the following release to the press:

"In reply to the Registered Nurses' Association of Ontario's request of October 31st to the board of trustees of the Toronto General Hospital that they disclose the reasons for action taken by the executive director in suspending the 3 senior nurses, the RNAO received a letter today from Mr. T.J. Bell, the chairman of the board of trustees of the Toronto General Hospital, stating:

> "The Board of Trustees of the Toronto General Hospital has rescinded the suspension of the three senior nurses in the department of nursing.
>
> "The nurses have been asked to consider appointment to the Task Force on Nursing which is investigating the problems related to budget, staffing, and organization of the nursing department. The nurses are considering this proposal, namely, that they be seconded to the Task Force as special assistants. This force will be studying the report just concluded by a consulting team from the Ontario Hospital Services Commission and should be reporting to the board of trustees of the hospital as quickly as possible."

Subsequently, a final release was made to press: "The RNAO has been notified by the chairman of the board of trustees, Toronto General Hospital, that the director of nursing and the two associate directors of nursing service have agreed to the proposal of the board of trustees that they be on loan from their present responsibilities to the Task Force on Nursing.

"As special assistants to the Task Force, they will be devoting full time to it. During this full-time involvement, we have been advised that Miss Viola Aboud will continue to function as acting director of nursing service."

Red Cross Booklet Available On Rights And Duties Of Nurses Under The Geneva Conventions

Geneva, Switzerland. – The International Committee of the Red Cross published in May 1969 a 45-page booklet entitled *Rights and duties of nurses, military and civilian medical personnel under The Geneva Conventions of August 12, 1949.* Also included are the seven Red Cross principles of humanity, impartiality, neutrality, independence, voluntary service, unity, and universality.

The section on The Geneva Conventions includes a definition, information on diplomatic conferences, signature, ratification and accession by governments, and detailed information on the Four Geneva Conventions.

The Red Cross on a white background is the universally respected international symbol adopted in October 1863. Under the section on Humane Treatment, the booklet states: "Persons taking no part in the hostilities . . . shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria."

The protective Red Cross sign is worn on the left arm and the person carries an identity card. Under the direction of military authority the emblem is displayed on flags and all equipment in the medical service.

Under terms of the Second Geneva Convention, hospital ships and lifeboats are painted white with one or more dark red crosses displayed on each side. The hospital ship hoists its national flag as well as the Red Cross flag. These markings can be used to protect only the ships mentioned.

The Fourth Geneva Convention stipulates that designated civilian hospitals have the right to display the protective emblem. Civilian casualties are transported in convoys of two or more ambulances whose drivers are under the orders of a responsible commander. The distinctive emblem does not confer protection.

The remainder of the booklet contains information on the International Red Cross and the International Committee of the Red Cross.

Copies of the booklet can be obtained for 40 cents from: The International Committee of the Red Cross, 7, avenue de la Paix, CH-1211 Geneva 1, Switzerland.

news

New Pattern Developing In Collective Bargaining For Ontario Nurses

Toronto, Ont. – Five arbitration awards settling contract disputes between Ontario hospitals and nurses' associations organized for collective bargaining under the wing of the Registered Nurses' Association of Ontario show that a new pattern seems to be developing. In each case negotiations, conciliation, and arbitration took so long that the awards gave the nurses increases retroactive to January 1, 1969, in four cases, and to April 11, 1969, in one.

Nurses' salaries have consistently been set by hospitals on the basis of the amounts the Ontario Hospital Services Commission has indicated would be approved in hospital budgets. For 1968 the basic starting figure for a registered nurse was $445 per month; for 1969, $470. In negotiations, hospitals have tended to offer only the OHSC salary rate.

Four recent arbitration awards set the 1969 basic figure at $490. Three hospitals received increases retroactive to January 1, 1969: Clarke Institute of Psychiatry in Toronto, Hamilton Health Association (a group of hospitals), and Queensway General Hospital in Etobicoke. At Peel Memorial Hospital in Brampton the increase was retroactive to April 11th. For nurses who left the hospitals in the interim, the period for which they received a bonus varied. These dates were determined by the end of the last contract, or in the case of the Clarke Institute, the long period of negotiation for a first contract.

All four contracts are for two years and therefore include an increase for 1970: nurses at Hamilton Health Association now start at $525 per month, and 1970 rates for the other four start at $535.

St. Joseph's General Hospital in Guelph, could be a pacesetter. The arbitration board award gave the nurses $525 per month, retroactive to January 1, for 1969, and a one-year contract. A 1970 contract is now under negotiation.

The OHSC has indicated no definite approved figure for starting salaries for nurses for 1970. The Commission has stated that hospital costs may rise eight and one-half percent.

Insulin Storage Important Food & Drug Directorate Warns

Ottawa. – According to a release from the Food & Drug Directorate, Department of National Health and Welfare, unsatisfactory patient response to treatment with NPH Insulin, reported by certain practitioners, may have resulted in part from the drug being subjected to improper storage conditions.

The Directorate warns that all insulin preparations must be stored under the conditions indicated in the Food and Drug Regulations. It is imperative that the provisions of this regulation be strictly observed. "No person shall sell or dispense an Insulin preparation that has not been stored by him continuously at a temperature between 35 and 50 degrees F (2 and 10 degrees C)."

Because critical reactions might be suffered by diabetics if an unsatisfactory insulin preparation were used, suitable precautions should be taken by distributors and dispensers both when they receive the preparations and when they deliver them to the patient. Examine the label for identification and expiration date, the Directorate advises. If the contents of the vial are frozen or if any discoloration, deposit, foreign matter, lumping, granulation, or any change from the normal appearance is observed, the insulin must not be sold or dispensed. The abnormality should be reported immediately to the manufacturer.

Only Insulin Injection (Regular) and Globin Insulin with Zinc are clear solutions; all other insulin preparations sold in Canada are cloudy.

UWO To Offer New Nursing Program

London, Ont. – Beginning September 1970, the University of Western Ontario faculty of nursing will offer a revised master's degree program to prepare teachers of nursing.

The course arrangement for this new master's program is designed to introduce basic concepts and theories of learning and education and to demonstrate their application in nursing education. Student participation in course work with laboratories and practice will be stressed throughout the year.

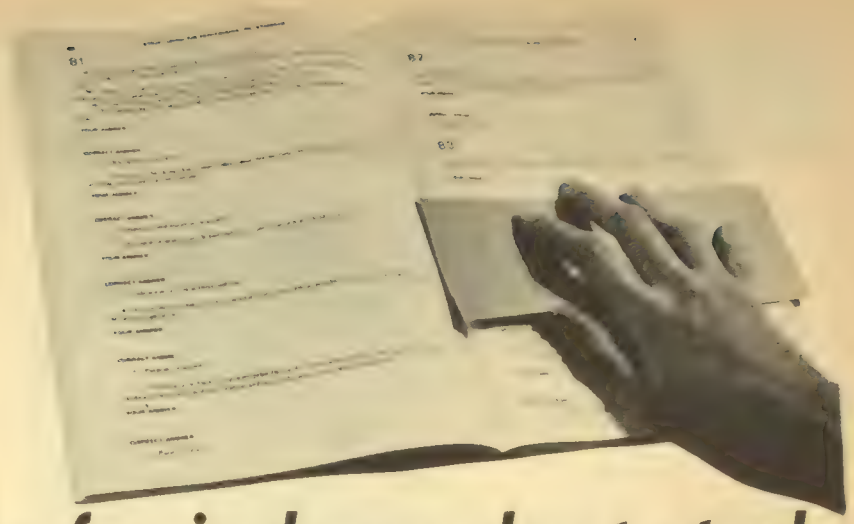
Courses with concurrent laboratory sessions will include: measurement and evaluation in nursing education; human learning and planning for teaching; student personnel services in nursing education; research and methodology with clinical investigation in nursing; education and the role of the teacher; and current issues in nursing.

Five of these courses are offered throughout the full academic year. The last is for one term only. Written into the program are opportunities for students to do case research under supervision, to experiment with various teaching methods and media, and to investigate a clinical nursing problem as a group project.

Students entering this program must have a baccalaureate degree in nursing with a minimum B average. Students with a B average from either of Western's two

(Continued on page 14)

Self-teaching texts



and workbooks for independent study

Mercer & O'Connor: FUNDAMENTAL SKILLS IN THE NURSE-PATIENT RELATIONSHIP

By Lianne S. Mercer, R.N., M.S., formerly of University of Michigan School of Nursing, and Patricia O'Connor, Ph.D., University of Michigan.

A nurse educator and a psychologist collaborated to develop this teaching program for the vitally important but often neglected skills of interpersonal relations. It requires about seven hours of independent study and answers such questions as: What should you say if a patient refuses a treatment? How should you respond when a patient asks about his diagnosis or prognosis? How can you get more information from records or from the patient himself when you need it? The principles of effective nurse-patient interaction become clear as you work through the program.

192 pages, illustrated. $4.05. May 1969.

Anderson: A PROGRAMMED INTRODUCTION TO NURSING FUNDAMENTALS

By Maja C. Anderson, B.A., M.N., SUNY Upstate Medical Center

Part I: Basic Patient Care
Part II: Basic Nursing Techniques

These volumes cover the first and second halves of the basic nursing course, from bed making and bathing to administration of medications and care of patients with communicable diseases. They teach, reinforce, and evaluate learning while the student works independently at her own pace.

Part I: 234 pages, illustrated, soft cover. $4.05. February 1965.
Part II: 305 pages, illustrated, soft cover. $5.15. March 1968.

Gillies & Alyn: SAUNDERS TESTS FOR SELF-EVALUATION OF NURSING COMPETENCE

By Dee Ann Gillies, R.N., M.A., Cook County School of Nursing, and Irene Barrett Alyn, R.N., M.S.N., University of Illinois.

This self-teaching and self-evaluating review of clinical nursing describes typical case histories and presenting situations in each specialty area and asks perceptive questions about them. As the case develops, more information is introduced and more questions asked. Perforated answer sheets (and correct answers) are provided.

426 pages. $7.30. April 1968.

Hymovich: NURSING OF CHILDREN A Guide for Study

By Debra Hymovich, R.N., M.A., University of Florida.

This workbook presents realistic cases and asks questions that review your knowledge of anatomy, physiology, pharmacology, and all the natural and social sciences. You are asked to formulate objectives, interpret tests, and make plans for nursing care — in short, to think creatively as in actual nursing practice.

389 pages, illustrated, soft cover. $5.95. May 1969.

W. B. SAUNDERS COMPANY CANADA Ltd., 1835 Yonge Street, Toronto 7

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news

(Continued from page 12)

new baccalaureate programs may enter directly into the new program. Graduates from earlier programs or from other universities must have their credentials assessed and a qualifying year, or part thereof, may be required.

As well as depth of knowledge in nursing practice, advanced work in psychology or sociology and in health science will be required. Selected students may complete the program in one academic year. Upon successful completion of the program, the degree of master of science in nursing will be granted.

For further information write to the Dean, Faculty of Nursing, The University of Western Ontario, London, Ontario.

University Of Montreal Receives Health Resources Contribution

Ottawa. – An $874,052 contribution from the federal government's health resources fund has been approved for the School of Nursing Sciences and School of Hygiene of the University of Montreal, Quebec.

The federal contribution will be used to purchase a building on Côte St. Catherine Road that previously housed the school of nursing of the Marguerite d'Youville Institute.

Three floors of the building formerly used as the students' residence will have offices for the school of hygiene and the institute of hospital administration. New laboratories will be set up on the ground floor. Other rooms will be converted into lecture and seminar rooms. The new location for the school of hygiene and the hospital administration institute provides additional space in university buildings for the faculty of medicine.

The new quarters have facilities for 540 students.

First Live Mumps Vaccine Now Available

Montreal, P.Q. – Merck Sharp & Dohme Canada Limited has developed the first live mumps vaccine, known as Lyovac or Mumpsvax. The vaccine is prepared from the Jeryl Lynn (B Level) strain, named after the patient from whom the virus was first obtained.

Mumpsvax, a live attenuated strain, is grown in cell cultures of chick embryos free of Avian leukosis.

Studies in susceptible children and adults have assessed the safety and effectiveness of the vaccine. A single subcutaneous injection induced an antibody response in approximately 97 percent of susceptible children and 93 percent of susceptible adults.

There were no significant differences in the incidence of fever in clinical trials when children vaccinated with mumps vaccine were compared with unvaccinated subjects studied concurrently. Adequate antibody levels with continuing protection of vaccinated children exposed to mumps have persisted for three years without substantial decline.

Usually mumps is a mild disease, although it may occasionally be severe and produce serious complications. Now mumps can be prevented in most cases.

Among contraindications for use of the vaccine are pregnancy, and allergic reactions to eggs, chicken, or chicken feathers. It should not be administered with other vaccines.

Additional information is available from the manufacturer at: Box 899, Pointe-Claire-Dorval 700, Quebec.

CARE/MEDICO Sponsors Project In Surakarta, Indonesia

Toronto, Ont. – CARE/MEDICO of Canada is sponsoring an all Canadian project in Surakarta, Indonesia over the next six years. A team of three Canadian doctors, three nurses, and a lab technician will work in an Indonesian hospital to upgrade the level of training of physicians and nurses in that country.

Contracts for two years, including a salary, cost-of-living allowance, and transportation both ways are available. Anyone interested in this project is asked to write C.M. Godfrey, B.A., M.D., Chairman, CARE/MEDICO of Canada, 484 Church Street, Suite 109, Toronto 5, Ontario.

Female Graduates Spurned

Ottawa. – Women graduates are denied the opportunity of competing, even on their own university campuses, for two-thirds of the jobs for which graduates are recruited.

In a paper entitled Highly Qualified Manpower Policies and the Canadian Woman Graduate: What Price Discrimination?, Sylva M. Gelber, director of the Women's Bureau, Canada Department of Labour, referred to recruiting material that showed that many of the biggest firms in Canada refused even to interview women graduates for 2,024 out of 3,268 vacancies offered.

Speaking at a luncheon meeting of the Beth Tzedec Sisterhood in Toronto, Miss Gelber suggested that industry should reexamine the grounds on which it bases its policy of limiting to male graduates recruitment for executive positions. She challenged the grounds on which industry justifies this discrimination, mentioning particularly allegations of high turnover rates of women executives as compared to those of men. She discussed the implications for national and international manpower policies of such discriminatory practices in recruitment.

Survey Shows More Schools Employ Full-Time Nurses

Toronto, Ont. – A survey conducted by the Ontario Teachers' Federation reveals a sharp upsurge in the number of schools employing full-time staff nurses.

More than 4,000 Ontario elementary schools were included in the study, which compared the number of schools employing full-time nurses between 1967 and 1969. Only 235 schools had full-time nurses in 1967, compared to 383 schools in 1968, and 629 schools in 1969. W.A. Jones, OTF deputy secretary treasurer, said the figures indicate a change from the old "mass innoculation role of school health services" to a more modern preventive medicine approach geared to the individual student.

The survey also showed that 2,695 schools had part-time nurses in 1969. However, 850 schools are still without any nurses on staff, even on a part-time basis, Mr. Jones said. "Even the smallest school in the province should have the services of a nurse for at least a half-day a week," he said. "That is the basic minimum." □

names

A number of new staff members have joined the faculty of The University of Alberta School of Nursing in Edmonton.

Devamma Purushotham (R.N., Midwife, dipl. teaching and superv., Vellore, India; B.N.Sc., Queen's U., Kingston; M.Sc.N., McGill U.) is assistant professor at The University of Alberta School of Nursing.

Miss Purushotham was formerly instructor and clinical nurse specialist at the Kingston General Hospital, Kingston, Ontario. Her experience in Canada also includes general duty at the Toronto General Hospital. Miss Purushotham has worked as a staff nurse and head nurse in Vellore, India.

Stella L. Hazlett (R.N., St. Paul's H., Saskatoon; B.Sc.N., U. of Alberta, Edmonton) is a lecturer in the community health and home visiting areas of the basic degree program at U of A.

Mrs. Hazlett worked as a general duty nurse at Union Hospital, Lucky Lake, Saskatchewan, and at Inuvik General Hospital, Inuvik, Northwest Territories. She also did general duty nursing at District Hospital, Bombola, New South Wales, Australia. As a public health nurse, Mrs. Hazlett worked in Outlook, Saskatchewan, and at Watson Lake, Yukon.

Frances M. McAdoo (R.N., Royal Columbian H., New Westminster, B.C.; B.Sc.N., Dipl. P.H.N., U. of Saskatchewan, Saskatoon; M.Ed., Colorado State U.) is assistant professor at The University of Alberta School of Nursing. Miss McAdoo is working in the postbasic degree program's public health and family health areas.

Miss McAdoo was previously nursing supervisor of public health in northern Saskatchewan. She also worked as a public health nurse in northern British Columbia, as well as an operating room nurse at the Royal Columbian Hospital in New Westminster and the Vernon Jubilee Hospital.

Patricia Hayes (S.R.N., Royal Free H., London, England; S.C.M., England; B.N., McGill U.) is lecturer in the advanced practical obstetrics program at U of A.

Miss Hayes was a clinical instructor in obstetrics at Plummer Memorial Public Hospital in Sault Ste Marie, Ontario, and at the Royal Victoria Hospital, Montreal, as well as a nurse midwife in England.

Karen R. Stevens (R.N., The Montreal General H.; B.Sc.N., U. of Western Ontario) is a lecturer in the junior medical-surgical and pediatric nursing areas of the basic degree program at The University of Alberta School of Nursing.

Mrs. Stevens was previously a staff nurse and assistant head nurse at the Victoria Hospital in London, Ontario.

Jeanette T. Funke (R.N., Regina Grey Nuns' H., Regina; postgraduate clinical course in psychiatric nursing, Allan Memorial Institute, Montreal; B.N. and Dipl. P.H.N., McGill U.) is a lecturer in the junior medical-surgical nursing and maternal and child health courses of the basic degree program at U of A.

Eileen Patricia Wallace (R.N., The Montreal General H.; B.N., Dipl. Nursing Service Admin., Dipl. P.H.N., Dalhousie U., Halifax) has been appointed lecturer at U of A.

Mrs. Wallace was previously with the emergency department of the Victoria General Hospital in Halifax, Nova Scotia. Her experience includes medical nursing at The Montreal General Hospital; nursing in the intensive care unit of The Hospital for Sick Children, Toronto; private duty nursing in Vancouver; and public health nursing with the New Brunswick department of health.

Donna E. Cooley (R.N., Calgary General H.; postbasic course in psychiatric nursing, Alberta H., Ponoka; B.N., McGill U.) is a lecturer in mental health in the basic degree program at U of A.

Prior to her appointment, Miss Cooley worked at the Royal Alexandra Hospital in Edmonton as a general duty nurse, an instructor in medical and psychiatric nursing, and for one year worked in the nursing inservice department.

Joanne M. Boyd (R.N., U. of Alberta H., Edmonton; B.Sc.N., U. of Alberta) has been appointed a lecturer at the University of Alberta.

Mrs. Boyd has had general duty and nursing office supervisory experience at the University of Alberta Hospital. As a public health staff nurse, she worked in the South Okanagan health unit in Kelowna, British Columbia; the Sturgeon health unit, St. Albert, Alberta; and the department of national health and welfare in Cambridge Bay, Northwest Territories.

The University of Alberta, School of Nursing has also appointed **Joan S. Ford** (R.N., Epsom District H., Surrey, England; Midwifery, Simpson's Memorial Maternity Pavilion, Edinburgh, and Royal Maternity H., Glasgow, Scotland; B.N., McGill U.) lecturer in the junior medical-surgical area of the basic degree program.

Miss Ford was a nursing instructor at Foothills Provincial General Hospital in Calgary before her appointment. She has had general duty experience at the Bristol Royal Hospital, England, and The Montreal General Hospital.

Lucy D. Willis (Reg.N., Atkinson School of Nursing, Toronto Western H.; Cert. in teaching and supervision, U. of British Columbia; B.S. and M.A., Teachers College, Columbia U., New York; Ed.D., U. of California, Berkeley) has been appointed director of the School of Nursing at the University of Saskatchewan in Saskatoon.

Dr. Willis first joined the faculty of the University of Saskatchewan in 1954 where she has since been an assistant professor of nursing and director of clinical education. She had previously been director of the Centralized Teaching Program in Regina; head nurse, instructor, and educational director at the Saskatoon City Hospital School of Nursing; and an instructor at the Moose Jaw Union Hospital School of Nursing.

Dr. Willis is a former president of the Saskatchewan Registered Nurses' Association. She was a Kellogg Foundation International Fellow in 1950-52, and a Canadian Nurses' Foundation Fellow in 1966-67.

Marion W. Sheahan, retired deputy general director of the National League for Nursing, was the 1969 recipient of the Sedgwick Memorial Medal, awarded annually by the American Public Health Association to the nation's outstanding public health leaders.

From 1949 to 1952, Miss Sheahan was director of programs for the national committee for improvement of nursing services. In 1952 this committee joined with several other committees and organizations to become the NLN. From 1963, when she retired from her NLN position, to 1967, she was secretary to the task force on organizational structure of NLN.

Miss Sheahan, a former APHA president, is presently chairman of the committee on equal health opportunity of the APHA. She has served on the President's Commission on the Health Needs of the Nation, the Surgeon General's Consultant Group on Nursing, the National Commission on Community Health Services.

In 1967 Miss Sheahan was one of the first two persons to receive the NLN distinguished service award, given biennially to two persons who have contributed, through nursing, to the improvement of patient care. She has also received the APHA Lasker award, the Herman M. Biggs Award of the New York State Public Health Association, and the Florence Nightingale Medal of the International Conference of Red Cross Societies. In addition, Miss Sheahan has been awarded honorary doctor of humanities and doctor of laws degrees. □

dates

March 2-6, 1970
Conference for directors of schools of nursing, Westbury Hotel, Toronto. Sponsored by the Registered Nurses' Association of Ontario, 33 Price Street, Toronto 289, Ontario.

March 16-18, 1970
Conference for staff nurses on their leadership role, Geneva Park, Lake Couchiching. Sponsored by the Registered Nurses' Association of Ontario, 33 Price Street, Toronto 289, Ontario.

March 20, 1970
Operating Room Nurses of Greater Toronto, seminar, Royal York Hotel, Toronto. For more information, write to: Mrs. Jean Hooper, Chairman, Public Relations, Operating Room Nurses of Greater Toronto, 43 Beaverbrook Ave., Islington, Ontario.

April 22-24, 1970
Conference for faculty of university schools of nursing, Twin Seasons Motor Hotel, Jackson's Point, Ontario. Sponsored by the Registered Nurses' Association of Ontario, 33 Price Street, Toronto 289, Ontario.

April 10-11, 1970
Conference for public health nurses, Geneva Park, Lake Couchiching. Follow-up from conference last March at Geneva Park, sponsored by the Registered Nurses' Association of Ontario, 33 Price Street, Toronto 289, Ontario.

April 30-May 2, 1970
Registered Nurses' Association of Ontario, Annual Meeting, Royal York Hotel, Toronto. Write to the RNAO, 33 Price Street, Toronto 289, Ontario.

May 4-7, 1970
First National Operating Room Nurses' Convention, Queen Elizabeth Hotel, Montreal. For further information write to: Mrs. I. Adams, 165 Riverview Drive, Arnprior, Ontario.

May 4-28, 1970
Developing leadership in supervision of nursing services, a continuing education course, University of Toronto. Designed for nursing staff of hospitals and community health agencies who take responsibility for the work of others. Write to: Continuing Education Program for Nurses, University of Toronto, Division of Extension, Room 104, 84 Queen's Park, Toronto 5, Ontario.

May 12-15, 1970
Alberta Association of Registered Nurses Convention, Calgary Inn, Calgary. For further information write to: AARN 10256 - 112 Street, Edmonton, Alberta

May 19-22, 1970
Canadian Public Health Association annual meeting, Marlborough Hotel, Winnipeg. For further information write to the CPHA, 1255 Yonge Street, Toronto 7, Ontario.

May 31-June 12, 1970
Ninth annual residential summer course on Alcohol and Problems of Addiction, Brock University, St. Catharines, Ontario. Co-sponsored by Brock University and the Addiction Research Foundation of Ontario. Enrollment is limited to 80. Basic information and findings of current research relating to the misuse of alcohol and other drugs will be presented. Provision will be made for discussion of prevention and treatment aspects of addiction problems. Address enquiries to: Summer Course Director, Education Division, Addiction Research Foundation, 344 Bloor Street West, Toronto 181, Ontario.

June 1-3, 1970
70th annual meeting of the Canadian Tuberculosis and Respiratory Disease Association and the 12th annual meeting of The Canadian Thoracic Society, will be held at the Fort Garry Hotel, Winnipeg. Further details are available from Dr. C.W.L. Jeanes, Executive Secretary, CTRDA, 343 O'Connor Street, Ottawa 4, Ontario.

June 9-12, 1970
Catholic Hospital Association Annual Convention, Cincinnati, Ohio. For more information, write to: CHA, 1438 South Grand Boulevard, Saint Louis, Missouri, 63104.

June 15-18, 1970
Canadian Conference on Social Welfare Skyline Hotel, Toronto. Tours and talk-ins at innovative agencies and services are planned. For information write to: The Canadian Welfare Council, 55 Parkdale Ave., Ottawa 3, Ontario.

June 15-19, 1970
Canadian Nurses' Association General Meeting, The Playhouse, Fredericton, New Brunswick. □

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.

Patient Security Suit

A new type of security garment for use in hospitals and nursing homes, called the Posey Houdini, provides patient safety and security with comfort. The suit is designed to prevent removal by the patient. The vest and lower portion of the garment are interlocked by the waist belt, which is tied under the bed, out of the patient's reach. If desired, the vest can be worn separately.

This suit, manufactured by the J.T. Posey Company, can be purchased from Enns & Gilmore Limited, 1033 Rangeview Rd., Port Credit, Ontario.

Memory tape system

A new memory tape system capable of monitoring, recording, and storing cardiac events on a closed loop magnetic tape is available from The Birtcher Corporation. Designated the Model 410 Memory Tape System, the unit provides an electrocardiogram by monitoring one to six patients simultaneously, recording their cardiac history prior to abnormal events or distress.

The system consists of six plug-in tape modules plus a strip chart recorder. It is also available in singular configurations, adding tape modules as needed to serve up to six patients. Each tape-loop is connected to the patient at the bedside through the Birtcher Sentinel Alert, Model 402. When cardiac events become hazardous, the alert signal immediately stops the recording. The tape cartridge provides a patient's full ECG history; when played back, the stored data is automatically transferred to ECG chart paper for permanent record reference. Each standard tape cartridge stores up to 70 seconds of data. Data storage capability for 3, 5, 10, and 15 minutes is available on special order.

The Model 410 Memory Tape System is an addition to the Birtcher 400 Series of Central Nursing Station patient monitoring instruments. This product is available in Canada from the Stevens Company in Vancouver, Calgary, Winnipeg, and Toronto, and from Millet, Roux & Cie in Laval (Chomedy), Quebec.

Packaging system

The new Bard Steril-Peel Packaging System is designed to meet all sterilization packaging needs. Small and large instruments and even odd-shaped items can be neatly, easily, and securely heat-sealed for either steam or gas sterilization.

The packaging material is available in 100-foot rolls in three, six, and nine-inch widths. A convenient dispenser carton makes removal of the desired length easy and at the same time protects the remaining supply. The material is transparent on one side for ready identification of the contents; an autoclave indicator stripe indicates that the contents have been sterilized.

Complete details are available from C.R. Bard (Canada) Ltd., 22 Torlake Crescent, Toronto 530, Ontario.

Walking aid

This aid is especially recommended for patients suffering from polio, rheumatism, arthritis, cerebral palsy, etc. It is also indicated as a means of obtaining early postoperative, supported ambulation.

The walking aid is strongly constructed of steel tubing, triple chrome-plated for lasting appearance. The large front caster permits easy steering, with stability achieved by the direct-action brakes. Brake pressure is adjusted by loosening or tightening the brake adjustment knobs. The handle grip height is adjusted to suit the user, assuring correct posture. Other features include an overall width of 26 inches, adjustable height 29 to 36 inches, and folding for easy storage.

For complete information, write to Everest & Jennings Canadian Limited, P.O. Box 9200, Downsview, Ontario.

Surgical tape

Drenison Tape, a new concept in topical corticosteroid therapy, has been introduced by Eli Lilly and Company (Canada) Limited. This is a transparent plastic surgical tape impervious to moisture. The tape is made of a thin, matte-finish polyethylene film which is slightly elastic and highly flexible.

The pressure-sensitive, adhesive surface is covered with a protective paper liner to permit handling and trimming before application. Because of the even distribution of steroid throughout the tape, it is particularly effective in controlling those types of dermatoses where occlusive dressing corticosteroid therapy is preferred.

Control of dosage by the physician, ease of application, and virtual invisibility when applied to the skin are some advantages offered. The area treated is protected from scratching and external irritants. It cannot be washed off and will not rub off on clothing.

This product is available from: Eli Lilly and Company (Canada) Limited, P.O. Box 4037, Terminal A. Toronto 1, Ontario.

Dressing Cutter

This new dressing cutter quickly cuts through all cast padding materials, including felt.

A curved handle, which conforms to the user's hand, provides a firm, comfortable grip. Lightweight and easy to use, the dressing cutter features disposable blades to assure a sharp cutting edge every time the instrument is used.

This cutter is narrow and thin so that it slips under the padding easily. The smooth lower edge of the instrument protects the patient from the blade's cutting surface.

For additional information, write to Depuy Manufacturing Company (Canada) Ltd.: Quebec and Maritime provinces – Guy Bernier, 862 Charles-Guimowd, Boucherville, Quebec; Ontario and Western Canada – John Kennedy, 2750 Slough Street, Malton, Ontario.

Literature available

A new catalog describing the complete line of more than 200 products manufactured by the Posey Company is available free of charge. *(Continued on page 20)*

Next Month
in

The
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- Fredericton, New Brunswick – Something for Everyone
- Something to Say – and How!
- CNA Ad Hoc Committee Repo on Functions, Relationships, and Fee Structure

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Drummond Photos, Montreal, pp. 41,42

The Hospital for Sick Children, Toronto, pp. 45,46,47

new products

The products are divided into sections, which include safety belts, limb holders, safety vests, wheelchair safety products, pediatric control products, rehabilitation, and orthopedic products.

Write to: Enns & Gilmore Limited. 1033 Rangeview Road, Port Credit, Ont.

A new brochure on the Medi-Scan 660 Hospital Staff Register System is available from Motorola Communications and Electronics, Inc.

The brochure explains how this unique electronic system provides rapid, low-cost distribution of registration data to emergency and surgical areas, nursing floors, administration areas, information centers, or anywhere in a hospital. It also points out the flexibility of the system which makes it possible to expand economically readout points to key areas throughout a hospital simply by adding low-cost status display units. Also designed to facilitate staff expansion or changes, the system requires no costly rewiring, complex rearranging of names, or reassignement of code numbers.

For a copy of the brochure, No. 92-112, write to: Motorola Communications and Electronics, Inc., 4501 West Augusta Boulevard, Chicago, Illinois 60651, U.S.A.

A filtration method for analyzing amniotic fluid as a means of estimating fetal maturity is described in "Amniotic Fluid Filtration and Cytology" by William S. Floyd, Paul A. Goodman, and Arlene Wilson. The article was originally published in the *Journal of Obstetrics and Gynecology*.

In the study, cellular contents of amniotic fluid samples were collected on a Metricel membrane filter using a Cytosieve, product of the Gelman Instrument Company. This filtration method of concentrating cells eliminates need to centrifuge sample. Cells are easily and accurately observed, and specimen can be preserved.

For free copies of this reprint, write to the Information Department, Gelman Instrument Company, P.O. Box 1448, Ann Arbor, Michigan 48106.

The Angostura-Wuppermann Corporation has produced a set of recipe, color cards that illustrate how Angostura bitters can be used to improve the taste of low-sodium dishes.

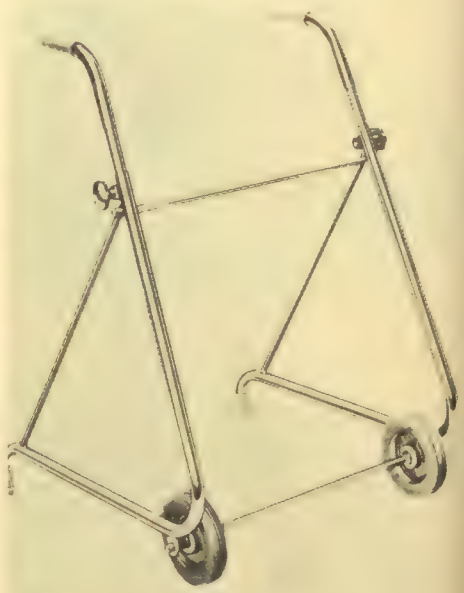
The bitters are particularly useful in restricted diets as they contain virtually no sodium and are a totally natural food product. They can be used in chicken, fish, and meat dishes, and in sauces and vegetables.

Recipes for 12 low-sodium dishes include beef liver stroganoff, meat loaf, chicken fricassee, rice stuffed fish rolls, and duchesse potatoes. The blend of Angostura is not identifiable in the finished dish. The dieter knows only that the food has more tang and flavor.

Low-sodium angostura recipe cards are available free to institutional users by writing to the Angostura-Wuppermann Corporation, P.O. Box 123, Elmhurst, N.Y. 11373.

A colorful, illustrated leaflet on prevention and treatment of decubitis ulcers is available from Everest & Jennings Canadian Limited. Preventative nursing care covers the use of alternating pressure pads and high power pump units. Major subjects are under the headings of etiology, incidence, location, prevention, and summary.

For a copy of this leaflet, write to: Everest & Jennings Canadian Limited, P.O. Box 9200, Downsview, Ontario.



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The Everest & Jennings Rollator features simplicity of design, stability, and ease of movement. Because it eliminates side motion, it gives patients the confidence of full control of their locomotion.

The Rollator, though light in weight, safely bears the weight of the heaviest patient, and the smallest size can be used successfully by children. It provides a new approach to retraining bed-ridden legs to walk, and is especially valuable in solving gait-training problems of polio, cerebral palsy, multiple sclerosis, and similar disabilities.

The unit, available in three sizes, is made of tubular steel and chrome-plated for lasting beauty. For complete information write to: Everest & Jennings Canadian Limited, P.O. Box 9200, Downsview, Ontario. □

in a capsule

Watch those writing rules

Editors may not have invented the golden rules of grammar, but they strive to live by them. Anyone who writes for publication should chuckle at the following do's and don'ts, taken from the November 8 issue of *Editor & Publisher.* Tom Watts of *Chicago Today* uncovered these rules of newspaper writing.

1. Don't use no double negatives.
2. Make each pronoun agree with their antecedants.
3. Join clauses good, like a conjunction should.
4. About them sentence fragments.
5. When dangling, watch your participles.
6. Verbs has got to agree with their subjects.
7. Just between you and I, case is important to.
8. Don't write run-on sentences they are hard to read.
9. Don't use commas, which aren't necessary.
10. Try to not ever split infinitives.

Unemployment insurance for nurses?

Hunters, trappers, and nurses take note. The federal government has promised to present a white paper outlining changes in the Unemployment Insurance Commission Act.

The Minister of Labour, Bryce Mackasey, said in the House of Commons in December that the proposed white paper, which was mentioned in the Speech from the Throne in October, might be introduced in early Spring.

The Act now excludes several groups from unemployment insurance coverage, including private duty nurses, nurses who work in non-profit hospitals, teachers, members of police forces and the Canadian Forces, and persons employed in agriculture, forestry, fishing, hunting, and trapping. The idea is that such persons can always hunt successfully for employment.

According to a news item by Murray Goldblatt in *The Globe and Mail* October 24, the government is planning to expand unemployment insurance into a more broadly based income-maintenance program. This program would drop the above categories and would treat all employees, except those considered as self-employed, on an equal basis.

Officials in the Unemployment Insurance Commission told *The Canadian Nurse* that predictions about changes in the Unemployment Insurance Commission Act, which might affect nurses, are only speculation. Also referred to as "speculation" was the rumor that the present $7,800 ceiling might be raised to $10,000, that is, employees earning up to $10,000 would pay unemployment insurance to the ever-growing fund.

Nurses who don't want to get caught in an unemployment insurance trap should let their members of parliament know how they feel! Remember that well-worn expression: An ounce of prevention is worth a pound of cure. □

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SPECIAL REPORT

Task Force on the Cost of Health Services in Canada

November 1969

In November 1968 a special committee was set up by the ministers of health in Canada to study ways to curtail the spiralling costs of health care. This committee, consisting of representatives of federal and provincial governments, then appointed seven task forces to examine costs in specific areas of hospital and health services.

When examining hospital services, the task forces looked at utilization, operational efficiency, salaries and wages, beds and facilities; when examining health services, they looked at the methods of delivery of medical care, price of medical care, and cost of public health services.

Late last November, the task forces' report was presented to the provincial ministers of health. A three-volume document of nearly 1,000 pages, the report contains 348 recommendations on ways to improve this country's health services and to curb the rising costs.

The task forces' report is now to be studied by a joint federal-provincial committee. It will undoubtedly be scrutinized carefully by health organizations and laymen as well. The minister of national health and welfare, John Munro, has proposed that the report "be regarded as a progress report and that the study group be retained to make further recommendations on implementation."

Here are some comments from the report, along with a few of the 348 recommendations.

General comments from report

The task forces obviously agreed on at least one major fact as they started their assignment: the country faces a real dilemma in its health services, mainly because of the skyrocketing costs. The report puts it this way:

"The cost of health services has risen so rapidly in Canada in recent years that three alternatives are now imminent: the standards of health care now available can be reduced; or, taxes, premiums, or deterrent fees can be raised even higher; or, ways must be found to restrain the growth of cost increases through better operation of the health service structure now in existence, and serious consideration must be given to a future major revamping of the entire system."

The task forces found the first alternative, reduction in health services, unacceptable; the second alternative, increased taxes, unpalatable, both to the people and to government. The third alternative, cost restraint, was accepted by the seven task forces, and they then proceeded to look for ways to achieve economies without diminishing the quality of care.

The task forces were apparently disturbed by much of what they found. They report that in many instances the introduction of modern cost efficiency techniques might well produce better service at less cost.

For example, more than one of the task forces reports says that acute treatment beds – by far the most expensive to build and operate – are being misused. Persons are admitted to these elaborate facilities when their real medical condition requires a less sophisticated, and therefore less expensive, level of care. Or, patients are sometimes kept in an acute bed longer than necessary, the report says.

Other comments, which are more fully developed in the task force reports, are:

- There is competition and duplication between public and private interests in the health field.
- At some point in the health system there is need for those concerned to arrive at a philosophical balance between highly expensive services of limited general application and facilities that can be used by greater numbers of people. Heart transplants in a major city versus the lack of any doctor at all in a rural town, for instance.
- Mass immunization should be undertaken by public health agencies, not private doctors.
- Regional organization of all health services, involving central coordination of

many facilities and agencies, is needed.

Recommendations re hospital services

The recommendations listed here, which represent only a fraction of the large number submitted by the task forces, have been shortened and paraphrased in some instances.

- Accreditation should be mandatory for all hospitals. A national, non-governmental body should operate the accreditation program, but the provincial health authority should be responsible for examining in depth those hospitals that failed to obtain accreditation.
- Nursing service administrators should be prepared through educational programs and experience to manage their departments.

Rationale: Many nursing service administrators lack skills in modern methods of business and personnel administration. This results in ineffective management and ultimately a decrease in operational efficiency and an increase in the cost of the delivery of nursing care to patients.

- Objective standards for nursing care should be established, and a method of measuring the quality of nursing care should be developed. Criteria for measuring the productivity of individual nursing personnel should be established. Job standards for each position in the nursing service department should be clearly outlined, and an evaluation of the quality of nursing care and performance of individual personnel should be done at regular intervals. The numbers and categories of personnel required to meet the needs of patients should be determined systematically.

Rationale: The nursing service department is responsible for the expenditure of about 50 percent of the hospital personnel budget, yet there are no acceptable objective standards for evaluating the quality of nursing care or for measuring the productivity of nursing personnel. There is no adequate system for determining the numbers and categories of nursing personnel required to deliver nursing care to patients. This is not conducive to cost saving efforts.

- The nursing service department should be reorganized to reduce the number of categories and the levels of supervisory or administrative personnel. Orderlies should be prepared to the level of registered nursing assistants. The clinical nursing specialist should be introduced.
- Registered nurses are not needed in the central sterile supply department, admitting office, pharmacy, etc. Should a hospital continue to employ nurses in these areas, these nurses should be regarded as staff of that department, not of the nursing service department. The number of registered nurses in operating rooms should be reduced and operating room technicians employed.
- Nursing care should be planned on the basis of an analysis of the individual patient's needs, not on "routine" or traditional practices. This would tend to eliminate activities done on a ritualistic basis, save nursing care time, and probably lead to more equitable staffing on days and evenings.
- Nursing units should not be staffed for the maximum nursing care load. Personnel should be employed as required to take care of an increased nursing care load.
- There should be a greater effort made to reduce turnover rates by giving general duty nurses an opportunity to use their knowledge and judgment; by granting salary increments according to standards of performance, not by years of service only; and by providing better personnel policies.
- The principle of progressive patient care within an individual hospital, a hospital system, and a health region should be adopted as a basic requirement for the efficient operation of a regional health system.
- Priority should be given to the development of graduate educational programs for clinical specialists in nursing and for postbasic speciality programs in clinical nursing.
- The authority for decisions concerning the provision of "necessary nursing care" for each patient should be clearly designated as a nursing responsibility.
- The annual salary increment programs for health service workers based solely on time in employment should be phased out.
- Nursing stations or outposts having adequate arrangements for communication with and transportation to a hospital should be used to provide service to small and remote communities.

Recommendations re health services

- A pilot project, funded by the National Health Grants, should be set up to train (and later evaluate) a class of "practioner-associates", i.e., medical assistants, in a university teaching unit under medical direction.
- Expansion of home care programs should be encouraged. The services offered should include: nursing; physician's care; occupational, physical, and speech therapy; dietary counseling; certain drugs, appliances, and laboratory services; homemaker and housekeeper services; and ancillary services, such as transportation, meals-on-wheels, social work, etc. The provision of home care programs is a responsibility of the public health agency; the coordination of services, including hospital liaison, should also be the responsibility of the agency staff.
- University educational programs in public health should be strengthened through increased financial support.
- The public health nurse should be trained to give routine immunizations and to recognize and be able to treat any sensitivity reactions that might occur.
- The public health agency, in conjunction with the family physician, should ensure that selective family planning services are made available to all people.
- The proportion of public health nursing time spent giving service in the school is too great and should be reduced.
- Since "single disease" oriented agencies tend to create duplication and fragmentation of service, their development should be discouraged.

Editor's Note: Orders for the three-volume report (cost: approximately $10.) will be accepted and filled as soon as copies are available. Write to the Health Insurance and Resources Branch, Department of National Health and Welfare, Tunney's Pasture, Ottawa. Copies are also available on loan from the Canadian Nurses' Association Library, 50 The Driveway, Ottawa 4.

Readers wishing to comment on any of the task forces' recommendations should write to the Honourable John Munro, Minister of National Health and Welfare, Ottawa. Readers are also invited to send their comments to the Editor, The Canadian Nurse, 50 The Driveway, Ottawa 4, Ontario. □

Nurse, please show me that you care!

Until nurses learn to set priorities and to base their nursing care on an assessment of each patient's needs, we will continue to hear the cry "I haven't enough time!"

Pamela E. Poole, R.N., M.S.

What is written on the next few pages is either going to make you angry or pleased: angry because you disagree and think it unjust, or pleased because you are as concerned as I am about nursing care and believe it can be improved.

Nurses in hospitals all over the country say they do not have time to give the kind of care they want to give. They are always rushing to get routine things done and consequently have little time left for individualized nursing care.

Well, what is individualized nursing care and what prevents us from giving it? To me, individualized care is that nursing care which is provided to a patient based on an assessment of his need for the care. It is not care that is automatically provided to every patient either because we have always done it or because it is a hospital routine.

For instance, when a patient is admitted, do we make any real attempt to learn his pattern of personal hygiene care at home? Do we then plan his care so that we follow his pattern as closely as possible within his medical limitations? Or do we, in most instances, have him fit into the ward routine of daily personal cleanliness activities between 8 and 10 each morning?

Rigid routine

It seems to me that we make things difficult for both the patient and ourselves by our morning bath routine. First, we have somehow decided that everyone needs or should have some kind of bath each day. On what physiological theory is this founded?

I suspect that instead of having any scientific basis, this practice derives from the late 1800s, when the need to wash patients was very appropriate. At that time hospitals, which were developed from hostels and soup kitchens, cared mainly for the needy and the derelict, who were sick. Infections were rife and nurses and doctors had to protect themselves and other patients from infectious diseases and lice.

Today, the Judeo-Christian ethic of cleanliness has become almost a religion in itself in regard to personal hygiene. Television advertising for soap, deodorants, and shampoos perpetuates the need to be clean to be acceptable. Although we may deny that we are consciously influenced by such product promotion, we do have evidence in hospitals that personal cleanliness rates a high priority in nursing care.

Contrary to such practices there is evidence that soap can be harmful to the skin.[1] What may be even more important is that by ignoring the patient's pre- and probably post-hospitalization pattern of living, we are disrupting his circadian rhythm.[2] This is an individual's physiological clock or timetable. It relates to the time he usually rises, eats, bathes, works or is otherwise occupied, and the time of retiring. We each have our own and they differ.

To the extent that the hospital routine conflicts with the patient's physiological timetable, he has to establish a new one to conform. This takes five days. If, on discharge, he chooses to reestablish his former timetable, it takes five more days. What we have done to him then is to put another physical demand on him, namely change, at a time when our goal should be to support his physiological resources and help him muster them for reparative purposes. Of course this assumes our overall goal is to assist people to get well.

We do not know to what extent we have increased the patient's hospital stay and the nursing care load by interfering with the patient's circadian rhythm. However, we should be able to see that we are providing unnecessary care to some patients by having them bathe every day. We have made ourselves very "busy" by having most patients meet what *we* have decided are their personal hygiene needs during the morning.

The morning is also the time of the hospital day when service departments other than nursing literally bombard the patient. X-ray, physiotherapy, occupa-

The author, Pamela E. Poole, is Nursing Consultant, Hospital Services Study Unit, Hospital Insurance and Diagnostic Services Directorate, Dept. of National Health and Welfare, Ottawa.

tional therapy, and other services all make their demands. Although we cannot control the scheduling of these services, we can prevent the patient from becoming exhausted by not adding all our services to an already crowded few hours. As a doctor said to me not long ago, "You have to be in pretty good shape to be a patient these days."

If a patient has not slept well and if, in fact, we believe that sleep is therapeutic, do we have to waken him to take a routine T.P.R. [3] or a routine specimen before the night nurse goes off duty? Does the patient have to wash his hands and face because the breakfast tray has arrived? Is there no priority setting for his needs? If sleep is important, why can't he have his breakfast when he wakens naturally?

Whether we have discovered it or not, there *are* dietitians in Canadian hospitals who believe and have shown that they are there because of the patient. These dietitians are aware that they, too, have a therapeutic role and will help nurses help the patient if given half a chance. It may require more flexibility in meal delivery, but this is not only possible, it is already in practice.

Hospitals now have a system of "hold" for meal trays. We have accepted this need prior to x-rays and certain lab tests, why not for the patient's need for sleep? Couldn't the night nurse notify the diet kitchen to hold a breakfast and then make sure through change-of-shift report that the day staff will not awaken the patient for an 8:00 a.m. tray? Wouldn't your dietitian be willing to discuss such a plan? Why not try her?

Scheduling of care

But what about the scheduling of nursing care itself? It seems to me as I read medical orders that there is much more flexibility in many of them than is taken advantage of by nurses. If there is no time tied to a b.i.d. or t.i.d. order, do we carry out the order at the most appropriate time for the patient?

For instance, if a patient is allowed up in the chair for 10 minutes b.i.d., what information goes into the decision to get him up at a particular time? Do we get

him up in the morning so we can make his bed while he is in the chair? If so, is it because we have decided this will best meet *his* needs – or *ours?* Or do we even think about it?

Are we aware that a patient has become fatigued by other activities and his need for rest is a priority? Do we have to make his bed first thing in the morning, or would it be better if he were left to rest until 11:00 a.m.? Couldn't he sit in the chair in the afternoon and again in the evening if it better suited his needs?

Why are t.i.d. treatments or clinical monitoring activities such as blood pressure scheduled at 10 – 2 – 6 or 8 – 12 – 4, and once-daily activities at 10:00 a.m.? Are the times of t.i.d. activities varied from one patient to another? Or are all t.i.d.s the same for everyone? If they are the same, this is not rational organization. And it certainly isn't individualized care.

In practice, probably only one or two patients actually receive the treatment at 10:00 a.m.; the rest receive it sometime before 10:00 and up to 11:00 a.m., with the same occurring at 2:00 p.m. and at 6:00 p.m. This is a fact of life because a nurse can usually do only one treatment at a time.

And do the doctors' orders specify that a t.i.d. order will be carried out three times a day with four hours between each time? If they do not, can the the nurse not use her judgment to create a wider spread if that better meets the patient's needs?

I have learned that if a medical practitioner has confidence in a nurse, he will permit much flexibility for nursing judgment. Have we really tested this professional colleague relationship or have we developed rigid routines in the name of efficiency, perhaps because some individuals in the organization have strong needs to control the behavior of others? Only the secure supervisor, head nurse, or director of nursing service can permit flexibility in decision-making on the part of her staff. But even the secure one must have evidence of behavior that demonstrates reasoned judgment before rigid controls can be lifted. After all, the director of nursing service is ultimately responsible for the nursing care of all the patients in the hospital.

Ritualism vs. judgment

The need for security has resulted in the creation and perpetuation of many hospital policies and routines. Some of these have become highly ritualistic, that is, they have meaning for the people carrying them out, but are not necessarily oriented to meet the goals of the organization.[4] We are all committed to do the patient no harm while he is within our walls. But are we also committed not to things that will do him no good?

For instance, I believe we are all concerned with the costs of the operation of our hospitals. The patient is paying these expenses, but others who are not patients are also paying through hospital insurance plans. This is so because our insurance scheme is based on actual costs of operating our hospitals. As these costs rise, the tax dollars will rise to meet them. As taxpayers we need to look carefully at practices that may not do the

patient any harm, but also may do him no good.

Twenty years ago patients who underwent surgery for an inflamed appendix or inguinal hernia were kept in bed for ten days to two weeks. They were discharged after a few days of being up and around, hence they were physically weak from being in bed. To protect the patient from falling, or perhaps more correctly the hospital from lawsuit, we took the patient to the front door of the hospital in a wheelchair and accompanied him to a waiting vehicle. Since surgery and anesthesia have changed so dramatically and with them post-surgical convalescence, what is the rationale for continuing this practice for a patient who has probably not been bedridden continously for even 24 hours? Have we thought about it at all? If we have and have retained the practice, are we hiding behind the threat of an accident and lawsuit?

What about our nurses' notes? Do they meet the goals of the organization if, in fact, the goal is for relevant, accurate information? The patient record serves many purposes. Two of its reasons for being are the provision of a medium of communication for hospital personnel and the production of a document describing the patient's care, which may find itself in a court of law.

If these are justifiable functions of the patient's record, it is imperative that the contents contain relevant, accurate information. Both treatment decisions and legal decisions are based on the information contained in these notes.

How relevant and how accurate is "slept well" or "good day"? It seems to me that it would be more useful to know how the patient slept last night relative to the night before; at least then a decision to act or not to act would be based on descriptive information. If patients are in hospital because they are ill, how "good" are their days anyway, and good in relation to what – the kind of day the nurse usually has?

If we are nursing the patient, we should know enough about him to describe not the day as a whole, but those things in the day that are relevant to his progress or maintenance of his optimum state of health. If we don't know these things, then "good day" or similar clichés add nothing worthwhile to a record that is to serve the purposes previously described. The amount of time consumed in such documentation might better be spent in learning what the patient's needs are.

It is unrealistic to claim that a nurse meets the physiological, psychological, social, spiritual, and, you name them, needs of her patients. If a nurse can accurately assess what some of these needs are, she can meet some and assist the patient to meet others, through use of self and the climate she creates. But she cannot assess a patient's needs unless she spends time with him. If he perceives that she cares about him as a person, he will help her to determine his needs.

For instance, most patients have the need for some information about what is and will be happening to them, even though the amount of information and the words used to convey it differ. Fear of the unknown is an eternal truth, but we must learn what is appropriate to discuss with this patient.

Until we examine ourselves and our practices, with the object of providing care based on an assessment of the individual patient's needs, and until we learn how to set priorities, we will continue to hear the cry "I haven't enough time." Patients can help themselves to a much greater degree than they are now generally allowed. To what extent do we involve them in their care? To what extent do they contribute to their care plan? If there is a care plan, do they even know it exists? And is it an appropriate plan?

Every nurse who has 35 to 40 hours a week to give to patients might well ask herself, "how do I use this time? " The answer could be quite revealing; the result might be that *together* the nurse and the patient could put caring back into nursing care.

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Night safety — a problem for nurses

In September 1969 a registered nurse in British Columbia was fatally stabbed as she walked home from work after midnight. Following this tragedy, The Canadian Nurse telephoned at least one hospital in each province to find out if any provisions are made for the night safety of nurses.

Eleanor Mitchell, B.N.

If you are a nurse who works afternoon or night shifts, you have probably never given a second thought to the method or route you take to get to and from the hospital.

What precautions do you take to ensure your own safety? Do you use a well-lighted route as you walk three blocks to the bus? Do you walk with another nurse? Or do you rely on the assumption that "I've gone this way many times, and nothing has ever happened," as you proceed alone along a dark but familiar route.

The laws

The Canadian Nurse investigated the laws in each province to see what provisions are made for women who work at night. According to the *Labour Standards in Canada, December 1968,* five provinces include regulations concerning night work for women.

In Quebec, under the Industrial and Commercial Establishments Act, as amended in 1968, women are permitted to work on the night shift under certain conditions. The eight-hour shift must not begin before 11:00 p.m. or after midnight. The employer must ensure the safety of women who leave work before 7:00 a.m. by providing them with convenient and safe transportation to their homes at his expense. Unfortunately, hospitals do not qualify under this act; nurses and other female employees are exempt from the provision.

In January 1969, the Ontario legislature amended its Night Work Policy. According to this Policy, "If a woman works on a shift that begins or ends between midnight and 6:00 a.m. she must be provided with private transportation from or to her home by her employer. Nurses, dietitians and most paramedical workers are now covered by this provision."

An order under the Alberta Labour Act prohibits the employment of women on shifts that begin between midnight and 6:00 a.m. unless the employer provides free transportation for the employee to or from her place of residence. Any period during which the employee is required to wait on the employer's premises for transportation is considered to be part of the working time. The order applies to women employees who work within a five-mile radius of home in cities that have a population of over 2,000. Unfortunately, the order exempts those who are employed in hospitals and nursing homes.

Manitoba regulations are similar to those in Alberta.

In Saskatchewan, female employees in hotels, restaurants, educational institu-

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Miss Mitchell is Assistant Editor of *The Canadian Nurse.* She expresses her appreciation to the hospital personnel who participated in the telephone survey.

tions, hospitals, and nursing homes who finish work between 12:30 a.m. and 7:00 a.m. must be provided with free transportation to their homes by the employer. Once again, nurses, nursing assistants, and student technicians are not covered by this provision.

None of the other provinces have laws or regulations regarding transportation for female workers at night.

The telephone survey

Responses to our inquiries on what hospitals do to ensure the safety of nurses traveling to and from work varied considerably from province to province.

The director of nursing service at St. Paul's Hospital in British Columbia told *The Canadian Nurse* that all unusual incidents observed by anyone are to be reported to the hospital security officer and to the police. Nurses are encouraged to use the "buddy system" coming to and going from work.

Seven sessions on self-protection have been arranged with the Pinkerton Protection Agency. The hospital plans to videotape a session so that it can be repeated at frequent intervals as part of the inservice education program at St. Paul's. Personnel from other nearby hospitals have been invited to attend.

At another hospital in British Columbia the assistant director of nursing said that no special provision is made for the transportation of nurses coming on and going off duty at night.

When this nurse was asked if she thought nurses should receive transportation home at night, she said: "If anything, all female employees should be included." She explained, however, that it is difficult to ensure a nurse's safety. "Even if a nurse is taken home, there is no guarantee that she will not go to the corner store at the last minute," she said.

Early in October, two hospitals in British Columbia gave their nurses the opportunity to learn the art of self-defence. Twice-weekly classes are conducted on the hospitals' premises by members of a local karate association. The nurses, who pay a nominal charge for this instruction, concentrate on the basics of kicking an attacker in the groin and jabbing him in the eyes.

According to British Columbia Attorney-General Leslie Peterson, the province once had legislation that required employers to provide female night employees with transportation to their homes. It was cancelled after women's groups claimed it was discriminatory and affected their chances for employment.

In Alberta, the director of nursing said that for the past two years her hospital has made transportation available for nurses who are changing shifts at midnight. "They can pick up a taxi chit from the hospital if they wish," she said. Nurses living close to the hospital may ask a security guard to call a taxi for them, but this is their choice, the director explained. She believes the present system is working satisfactorily.

At a large teaching hospital in Saskatchewan the director of nursing service said if a nurse comes off shift too late to take public transportation home, the hospital is responsible for providing her with free transportation. She emphasized there must be a legitimate need for a taxi, since taxi tickets are not handed out automatically. Few nurses require them because they use public transportation or their own cars. The hospital pays for taxis if nurses are called back to work at night.

A director of nursing at a large teaching hospital in Manitoba said her hospital tries to have nurses finish duty before public transportation stops. If this is not possible, the night supervisor can authorize taxi fares for nurses. She explained that nursing supervisors listened to the concerns expressed by the nurses and gave them consideration. This director thought the provision for transportation home at night was written into nurses' contracts in some hospitals in Canada.

Because the afternoon shift ends at 11:30 p.m. and public transportation is still in operation, the director of nursing service at another hospital in Manitoba said the hospital did not legally have to provide transportation home for nurses.

In Ontario, several different practices are used since the new regulation became effective in January 1969. At a military hospital, the director of nursing said no special provision is made for nurses changing shifts. It is left up to the employee, whether military or civilian, to make her own way home at whatever hour she leaves work. Night transportation is not a major problem since many military nurses live on the base.

The directors of two other hospitals in Ontario said they provided taxis for their nurses because it is now a requirement of law. Prior to this law, one of the hospitals had provided taxis for nurses on Saturday and Sunday nights.

A large teaching hospital in Ontario provides taxis between 11:30 p.m. and 6:00 a.m. for approximately 100 female nurses. Those requiring transportation obtain a ticket from the nursing office. This policy was in effect before the law was amended.

The spokesman for another hospital in Ontario said that the hospital is in no financial position to provide free transportation for the many nurses coming off afternoon shift or going on night duty. Since the shifts end or begin before midnight, the hospital does not legally have to provide transportation home for nurses. Public transportation is nearby

and continues until 2:00 a.m. However, any female worker called back to work during the night is provided with transportation paid by the hospital.

Because of the new Ontario law, this hospital changed its hours of duty. The employees resisted the change as it meant the day shift had to report for work at a very early hour. The spokesman suggested it was the individual's responsibility to travel with another nurse, rather than alone.

At another Ontario hospital the afternoon shift also ends before midnight. Nurses who must work past this time are provided with free transportation. The spokesman expressed the opinion that if nurses demanded free transportation, the hospital would be forced to employ fewer nurses, because of budget problems.

The Canadian Nurse found one hospital nurses' association contract in Ontario that requires the employer to provide transportation for nurses to their place of residence when the shift ends at midnight or later. This contract stipulates that the nurse must live within a 10-mile radius of the hospital.

At a large teaching hospital in the province of Quebec, the evening shift ends at 11:30 p.m. Public transportation is still available at this hour. The director of nursing explained that if nurses are detained until after midnight a few of them are sent home by taxi, especially if they live in a "rough" or poorly-lighted area. The only other nurses who are given taxi tickets are those on call for the operating room who may be called in at any hour of the night.

As far as this director knows, there has been no discussion of the night transportation problem in Quebec by any nurses' groups or hospitals. There have been no difficulties at her hospital and the director is satisfied with current arrangements. She believes, however, that the provincial law should include transportation home for nurses after midnight.

The assistant to the director of nursing at another teaching hospital in Quebec said that female nursing students benefit from the services of a protection agency. From midnight to 1:00 a.m. a guard stands by as students cross the street to the nurses' residence. Most of the registered nurses have cars in the parking lot, which is under surveillance day and night. Some nurses share their cars or travel in groups on a bus, she said.

At another large hospital in Quebec, the director of nursing said that most female nurses on night duty travel to work by car. At this hospital nurses on the afternoon and night shifts receive additional pay to provide for transportation. The afternoon shift receives an additional $40 per month and the night shift, $24. This additional salary is provided to pay for taxis, the director explained. This supplement was negotiated by the union for this purpose, and is a clause typical of most hospitals in Quebec, she said.

In New Brunswick, a director of nursing service said her hospital makes no special provision for transportation of nurses changing shifts at night. However, the hospital will pay for a taxi for any nurse on call after 4:00 p.m. If this nurse provides her own transportation, the hospital will reimburse her $2.00. Female x-ray technicians and laboratory technicians are also included in these arrangements. As far as this director knows, there have been no problems concerning night transportation.

In Nova Scotia, the director of nursing at one hospital said that no provisions are made for nurses' transportation at night. Since the afternoon shift ends at 11:30 p.m., nurses can use public transportation. Only those nurses on call are entitled to taxis paid by the hospital. Many nurses arrange car pools. There have been no problems with transportation as far as this director knows. For more than 10 years a commissionaire has patrolled the area between the main hospital and an affiliating hospital where student nurses live.

In Prince Edward Island, the director of nursing service at one hospital reiterated what most of the other hospitals surveyed had said: that no special provisions are made for the safety of nurses changing shift at night. However, the nurse is advised to be careful, she said. She explained that there is no real problem as most nurses travel in groups rather than alone.

Nurses in Newfoundland are not provided with free transportation at night, although one hospital does pay for the transportation of female laboratory technicians who are called back at night.

Summary

From this brief survey it appears that most nurses are expected to ensure their own safety when traveling to and from work. Five provinces in Canada have laws concerning women who work at night, but only in Ontario is the employer required to provide nurses with transportation home after midnight. Other provinces do not have laws concerning night work for women.

Some hospitals provide taxis for nurses changing shifts at night, although legally they are not required to do so. In other hospitals, shifts end or begin before midnight when the law does not require the employer to provide nurses with transportation. □

Examining student nurses' problems by the case method

The skills needed by the nurse educator to identify and analyze student nurses' problems can best be developed by the "case" method, the author says. This method presents the prospective teacher with actual problems that have confronted school of nursing faculties, and gives her an opportunity to resolve real, rather than hypothetical, issues.

Vivian Wood, R.N., M. Ed.

One of the teacher's most important responsibilities concerns student guidance. Often the teacher is the only source of help available to the student who has a personal, social, or academic problem. Thus her understanding of student behavior and her ability to react helpfully are fundamental to her success as teacher.

Teachers in nursing education need a high degree of skill in identifying and reacting to student nurse problems. Inadequate performance in this counseling role affects the individual student as well as the total environment in which the school functions. The reactions to poor situations, as recent events in other educational settings have shown, can even threaten the existence of the school. Obviously, the development of counseling skills is an integral part of any teacher preparation program.

Types of courses

Courses in student personnel services tend to fall into two categories. The first, and probably the most popular, emphasizes concepts of counseling and guidance with particular stress on interaction theories, review of vocational opportunities, and the use of standardized measures of aptitude, interest, and intelligence in career planing.[1]

The second type of course concentrates on behavioral change by developing the prospective teacher's skill in recognizing and helping to resolve student academic, social, and personal problems. The basic teaching approaches used require the student-teacher to practice the above processes in various contexts. This approach, through the case method, exposes the prospective teacher to the frustrations and difficulties in sensing a student's problems and enabling her to cope successfully with them.*

This second type of course is the one recently developed in the master's program at the University of Western Ontario.

When the use of cases was first considered, teaching materials and appropriate texts were scarce or nonexistent; therefore, the course of necessity assumed an experimental approach. From the beginning of the experiment, the use of cases as a basic teaching tool was planned. No other approach combined effectiveness in expanding student values and boundaries

Mrs. Wood, Associate Professor, Faculty of Nursing, University of Western Ontario, has been instructing in the teacher-preparation programs. She has been responsible for the following courses: "Student Personnel Services in Nursing Education," "Measurement and Evaluation in Nursing Education," and "The Diploma School Program." During the past two years Professor Wood has been conducting seminars for teachers in schools of nursing.

*A similar concept about teaching can be found in *Case Analysis and Business Problem Solving* by Kenneth Schnelle, New York, McGraw-Hill Company, 1967.

with economy – although initial development cost is not small. Before describing the experiment, however, more background on each approach is desirable.

The course in the past

Prior to the development of the nursing education option for teachers in the master's program at UWO, a course in student personnel services was offered to student-teachers in the diploma program in nursing education. This course started with an overview of student personnel services in nursing and education. Counseling theories were studied, followed by exercises to provide experience. The course then gave the student-teachers an opportunity to study institutional problems of nursing education, such as recruitment, admissions, and the setting of educational policy. The final sessions were devoted to group activity mechanisms.

One year, as part of this section, the class observed a group of graduate business students at UWO discussing a case assignment. Our students later analyzed the group using concepts previously raised in class. The class showed ingenuity and enthusiasm in carrying out this particular assignment.

Although the course in student personnel services was well received and showed reasonable results, there were some obvious shortcomings. First, the interaction process was already being taught in several courses offered by the nursing faculty. The benefit of providing another point of view was marginal at best. The unit on problems in nursing education tended to drift into a discussion of problems encountered by class members when they received their basic nursing education.

Also, few of the teaching materials were oriented to Canadian problems. Since student problems are heavily influenced by environment, some problems unique to Canada do exist. Finally, although awareness of student nurse problems may have been heightened, there seemed to be little development of skills to deal with those problems. The move to the master's program provided an opportunity to remedy these shortcomings.

The experiment

The major change in the course has been the introduction of cases as major teaching tools. Since appropriate cases did not exist, part of the course was dedicated to their development through class projects. Students visited diploma schools of nursing and investigated particular student nurse problems. They then described in a written case the problems facing the faculty and director of nursing education. After release from the agency these cases were subsequently discussed in a disguised form in class.

The course changed in other ways. Although we still begin with an overview of student personnel services, we now put more emphasis on their value in teaching and learning. A discussion of student nurse needs leads into a study of related concepts, and a major part is devoted to analysis of student nurse problems. Here the cases are used and class members develop skills in utilizing concepts and developing sensitivity to student problems.

Sufficient course time is allocated to ensure that each member of the class gets sufficient practice to improve her skills in student guidance and in structuring appropriate school policies and procedures. The course ends with consideration of the educational, occupational, and placement services that a school of nursing might implement.

The case method

What is a case? How can it be used within the context of a course?

A case in nursing education is a description of an issue that has been faced by the faculty or the director of nursing education. Specifically, in our course, the case is a descriptive account of some problems encountered by student nurses during their educational experience. Included are surrounding facts and opinions upon which faculty decision is to be or has been reached.

Cases may be categorized into two types: The "issue case" poses a problem for the student-teacher to analyze and help to resolve.[2] The "appraisal case" describes a decision already made and asks the student to assess and evaluate it.

A case describes real problems that require solutions; within the limits of the written word, it puts the student and the class in the position of the decision-maker. These real cases are presented to students for analysis, open discussion, and final decision as to the action that should be taken.

The use of actual situations involves the student in real problem solving, and provides a basis for concept generation and evaluation. For example, when discussing withdrawal and dropout of students in a diploma program, "live" case material illustrates by demonstration the infinite variety of goals, facts, conditions, conflicts, and personalities that occur in our daily lives. From the situations described, generalizations of psychological and sociological concepts can be drawn. At the same time the inadequacy of theoretical analysis of oversimplified examples can be appreciated.

Readings from nursing and research journals are used in conjunction with and following related case discussions, de-

pending on the teaching strategy. The aim is to graduate professionals, not theoreticians.

The cases developed to date treat problems of recruitment, admission, assessment, and personal problems. Several cases describe problems of student withdrawal. One, for example, concerns a bright young student nurse who became pregnant and left nursing. Should she be encouraged to return to the program? What student policies were in existence at the time of her marriage? Were these policies relevant and current? What was the cost of the student's education to the province?

These are only a few of the kinds of questions raised and discussed by the class. Without the case as a vehicle, student discussion tends to be intellectual but uncommitted, interested but lacking in depth, and, above all, decisive but unrealistic.

Teaching by the case method assists the graduate student to develop independent thinking and at the same time to gain experience in discussing and defending her analysis and position.[3] As in the actual situation, the problem may or may not be clearly defined. Similarly, the facts presented may or may not be complete.

The case may present complex problems that are not apparent. From the same set of facts, students define totally different problems. Each fact may be related to a different possible course of action. Often the obvious problem is only a symptom of a more important one. Thus, the case projects the student-teacher into the realm of practical experience and gives her a preview of the concerns she will face as a practitioner.

Evaluation

The learning that takes place with the case method differs from that in the previous course. Briefly, the graduates seem better prepared to take action when confronted by student problems in their future positions.

The advantages of the case method are many. The student-teachers learn, by personal involvement and by an exchange of ideas with their classmates, the "how" and "why" of the current problems of student nurses in diploma programs.[4] Careful guidance from the faculty leader helps the students to acquire confidence in their abilities in situations where the consequence of error is relatively innocuous. Thus, student-teachers learn quickly, easily, and naturally as they are constantly required to apply the knowledge they have gained to new problem situations. They learn the importance of research in nursing, of independent thinking, and cooperative work relationships.

The instructor may take a passive or active role.[5] She must be thoroughly at home with the content of her course. She must keep the class moving – get the discussion started and help the participants to stay involved with the issues.

Naturally, the discussion depends on the quantity and quality of students, as well as on their previous nursing experience. A student-teacher may tend to dominate the discussion or to polarize arguments about herself. In such cases she may find herself, rather than the case, the subject of discussion.

It takes time for students to develop skills in analyzing and decision-making. This is not achieved by using one case. In our course seven or eight cases are used and more will be used as new ones are written. Even here we fall short of our objective because of insufficient time. The new cases under preparation should help to remedy the problem.

Conclusions

Examination of student nurses' problems in an evolving, dynamic society is a crucial aspect of the prospective teachers' graduate program. Identifying these problems, reacting sensitively and effectively, requires a high degree of skill. Such skills can be developed by analyzing cases that describe student nurses' problems.

At the University of Western Ontario School of Nursing, data collected from Ontario schools of nursing are used for case discussion. Future plans include the writing of cases collected from schools of nursing in other provinces to expand the coverage of problems to a national level.

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□

An invitation to a checkup

"Walk in" was the invitation displayed on footprint-shaped signs outside a particularly crowded room at the Ontario Hospital Association convention last October. The author did, and discovered five screening clinics doing a brisk business on convention participants.

Tara Dier

The author holds her breath while a technician from the Ontario Department of Health takes a chest x-ray at the OHA "Walk in" clinic.

In an estimated crowd of 7,500 there are sure to be some undetected cases of glaucoma, tuberculosis, heart disease, cancer of the cervix, or diabetes. When a crowd that size is attending a convention of the Ontario Hospital Association in Toronto, uncovering a few of these conditions could be an effective way of promoting a new method of screening the public.

Early in 1969, representatives from the OHA and Dr. B.T. Dale, medical officer of health and director of the Wellington-Dufferin-Guelph Health Unit, got together to discuss the feasibility of setting up such a mass screening program at the OHA convention in October. The result was a highly successful "prevention package" for hospital personnel attending the convention. Based on the clinics Dr. Dale has been running in the Guelph area for six years, the five OHA clinics were designed to demonstrate the advantages of mass screening clinics by using the convention participants as patients.

"Walk in," the large, footprint-shaped signs in the lobby invited. I did.

The signs directed me to a room where tests were conducted for glaucoma, tuberculosis, and diabetes. One of the hospital auxiliary workers who helped with the

Miss Dier, an editorial assistant at *The Canadian Nurse* for the past three summers, is a second-year student in arts at the University of Toronto, Ontario.

paperwork at the clinics explained that these three tests were the combined efforts of many agencies: The glaucoma test was conducted by the Canadian National Institute for the Blind, with staff from the University of Toronto and the Toronto General Hospital. The Ontario Department of Health contributed one of its mobile chest x-ray units and a technician, and the Canadian Diabetic Association ran the test for diabetes.

Industry also made a contribution. Equipment and assistance were received from the Imperial Surgical Company, Kimberly-Clark of Canada Limited, the Stevens Companies, and Allan Crawford Associates Limited.

The volunteer shepherded me to the beginning of an assembly-line that led to the chest x-ray, on to the glaucoma test, and ended at the blood test. I emerged at the end in less than an hour.

The last two tests of the convention screening clinics, the electrocardiogram and the Papanicolaou test for cancer, were given in two hotel rooms upstairs. I decided to rely on the usual good health of youth and skip them, but I went up to investigate.

The ECG, I discovered, was a team effort in itself. Student nurses from St. Michael's Hospital in Toronto connected the electrodes to the patient under supervision of staff from the Toronto Western Hospital. The signals were transmitted by telephone to a computer at The Hospital for Sick Children, where cardiologists from Toronto Western interpreted the results and returned them to the hotel clinic.

"Eventually we hope to perfect the system," said research associate H. Tegelaar of Toronto Western Hospital, "so that doctors in remote parts of the country, for instance Northern Ontario, can connect their patients to a computer in Toronto by telephone. The signals would be received and interpreted in Toronto, and the results returned immediately. What we are doing here is only an indication of what could be done."

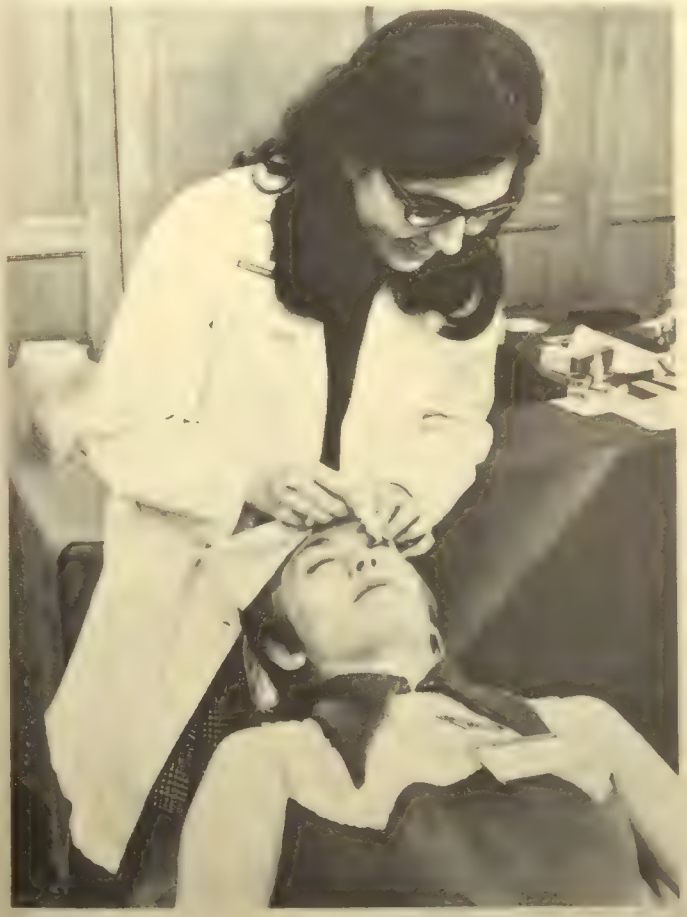
Then I crossed the hall to talk to Dr. Margaret Braund, who gave Pap tests to 116 women during the three-day clinic. Dr. Braund is associate medical officer of health at the Wellington-Dufferin-Guelph Health Unit, and she and Dr. Dale explained the clinics they have been running in the Guelph area, which were the models for the OHA clinics.

"We move into a new area around Guelph every 7 to 10 days," explained Dr. Braund, "conducting tests similar to the ones here, plus a test for hearing. The only exception is the Pap test, which we don't have the facilities to give. We recommend that women go to their family doctors for it." She added that many of the women who had the test at the OHA clinic had never had it before, although they were associated with hospitals.

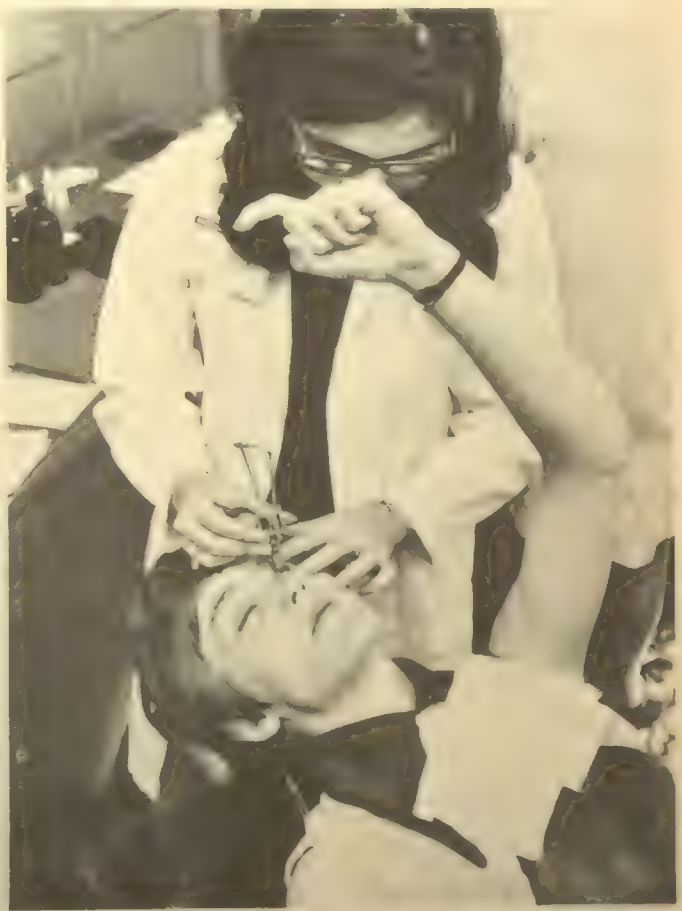
"We conduct six or seven thousand individual tests in each area," continued Dr Dale. "Ten to fifteen percent of them indicate that further examination is required. Again, we send them to their family doctors. Our purpose is to screen the patients for symptoms, not diagnose and treat them.

"We don't want to replace the family doctor, only help him," he said. "Less than half the doctors in Ontario are general practitioners, and screening clinics such as ours can help to reduce the resulting strain on doctors and community hospitals."

At the OHA convention screening clinics, a total of 1,722 tests were



Before the test for glaucoma, anesthetic drops are instilled into the author's eyes.



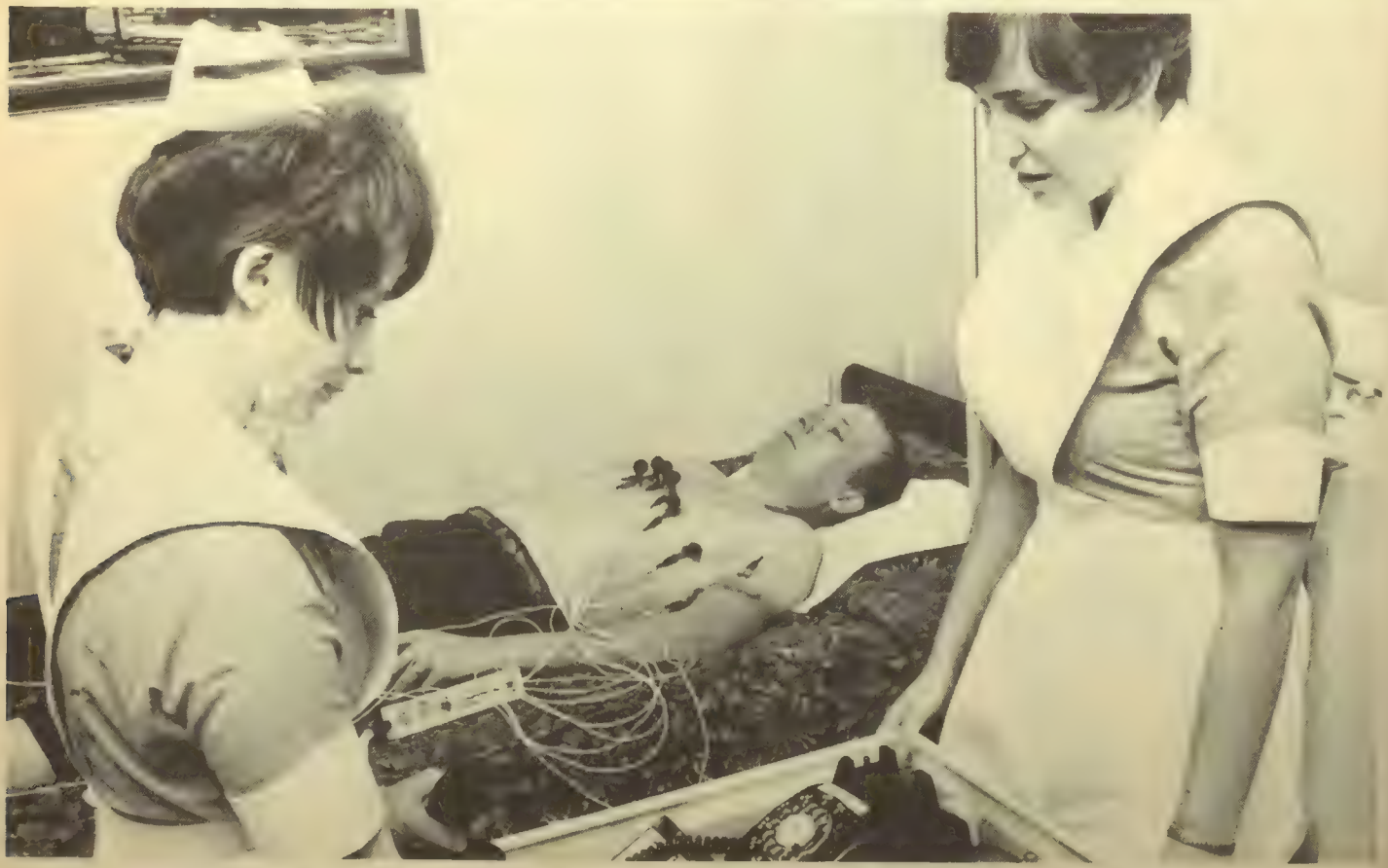
The author did her best to stare at her hand while the tonometer tested her eyeball for high pressure, an indication of glaucoma.

conducted in three days. The patient's own doctor will be notified if he needs further examination, and Dr. Braund estimates that 10 percent of the patients screened will hear from their doctors.

Despite fairly steady business in all five clinics, it was possible to go through all of them in less than two hours.

Perhaps this saving in time will eventually make a trip through the assembly line of the screening clinics an annual event for Canadian families. Personally, I still prefer the more human approach of my own family physician. □

One drop of blood was enough for the Canadian Diabetic Association's test for hyperglycemia and possible diabetes.



A patient waits while student nurses from St Michael's Hospital in Toronto dial his heartbeat into a computer at The Hospital for Sick Children for the results of his electrocardiagram taken at the OHA "Walk in" clinic.

Sleep

So far, we know remarkably little about the third of our lives that we spend in sleep — or, at least, we know little about how to regulate it. We do know that there are different stages of sleep, that each of us has his own sleep cycle and circadian rhythm, that there are different kinds of insomnia, and that sedatives sometimes have strange effects. This author illustrates how the current knowledge about sleep may be used to better understand and predict the needs of hospitalized patients.

Barbara Long

We know that patients in hospitals, away from their usual sleeping environments and beset by the problems created by illness, frequently have difficulty meeting one of their most basic physiologic needs – the need for sleep – at a time when they require it most. But how can the nurse, who every evening passes out the sedatives, assess an *individual* patient's need for sleep or for sedation? What is going on when a patient says, "I didn't sleep a wink last night," and the night nurse's report reads, "Slept well"?

In the past 10 to 15 years, research into the phenomenon of sleep has given us some data to use in assessment. It is only a beginning, however, because most research has concentrated so far on identification of the intrasleep pattern. Little is known so far about the real reason for sleep, or how sleep behavior can be controlled.[1]

The sleep phenomenon

Electroencephalograms have given researchers a better picture of what is occurring during sleep. When a person is wide awake and alert, his EEG recordings show rapid, irregular waves. But as he settles down to rest, there emerges the first of two wave patterns that occur during sleep. This is the *alpha rhythm* and consists of a regular wave pattern of low voltage, with frequencies of about 8 to 12 cycles per second.

The other EEG pattern is the *delta rhythm*, present during deep sleep. Delta waves occur at a slow 1 to 2 cycles per second and are of high voltage. *Sleep spindles*, which occur during certain stages, are sudden, short bursts of sharply pointed alpha waves of about 14 to 16 cycles per second.

Four different *stages of sleep* have been identified by researchers using EEG readings.

In *Stage I*, alpha rhythm is present although the waves are more uneven and of lower voltage than when the individual is at rest with his eyes closed. The person will have fleeting thoughts and can be awakened easily. If he is awakened, he may say that he has not been sleeping.

In *Stage II*, sleep spindles appear at intervals. The person is more relaxed; however, he may still be awakened as in Stage I, and report that he had been "thinking or indulging in reverie."[2]

In *Stage III*, delta waves begin to occur. Sleep spindles are still present. The person's muscles become more relaxed and vital signs decrease, and he is more difficult to awaken.

Stage IV is a deep sleep, and delta waves are the dominant EEG pattern. The person is very relaxed and rarely moves. If awakened, he will respond very slowly. It is during Stage IV that most sleepwalking and enuresis occurs.

In the general pattern of cycles of sleep over a seven- to eight-hour period, the individual will descend from Stage I to Stage IV and then back to *Stage I REM* sleep in about 60 to 90 minutes.

Stage I REM sleep is a stage that the person enters when ascending from Stage II. The EEG readings are similar to those in Stage I, but there are physiologic differences. Rapid eye movements (REM) occur, respiration and pulse rates increase and are irregular, and the blood pressure fluctuates widely. This is something to remember if a patient must have his vital signs checked frequently during the night. One might look closely at a patient who shows wide variations in his vital signs, yet seems to be asleep. It is during this stage, too, that most dreaming occurs.

After about 10 to 15 minutes in Stage I REM sleep, the person will descend again to Stage IV. The cycle will repeat itself three to five times during the night, but each time the individual returns to Stage I REM sleep, he spends a correspondingly longer time in that stage. Thus, in the first third of the night, more time will be spent in Stage IV, but in the last third of the night, Stage I REM sleep will predominate.[3] In the early part of the night, dreams in Stage I REM sleep are shorter, more likely to be on the dull side, and contain aspects of activities of the preceding day. As the night progresses, the dreams become longer, more

Mrs. Long (B.A., Ohio Wesleyan University, Delaware, Ohio; M.N. and M.S. in nursing, Case Western Reserve University, Cleveland, Ohio) is assistant professor of nursing at Case Western Reserve.

vivid, and less concerned with daily life.[4] The time spent in each stage is highly individual, but normally it is consistent for the same person on different nights.

Physiologic changes

The sleep-wakefulness cycle appears to revolve around the biologic circadian rhythms of the body. The point at which the basal metabolic rate is low (as illustrated by the person's body-temperature cycle) occurs at approximately the same time every 24 hours for a person on a regular sleep-wakefulness schedule. But, if the person suddenly reverses his schedule – if he starts a night job, or jets halfway around the world – it will take several days for his body to readjust to the new pattern. He will feel more tired and may make more errors at the time when his basal metabolic rate has been accustomed to being at the low point.

Likewise, a patient who usually works night shifts may feel more tired during the early afternoon for a few days after his admission to the hospital while his body adjusts to the different circadian rhythm.

Those who schedule shifts for nurses and other hospital workers should be aware that a person who suddenly changes from working the day shift to the night shift is more likely to commit errors during the low point in his circadian rhythm.

Physiologically, the vital signs, peristalsis, urine production, and possibly some of the blood constituents undergo identifiable changes during sleep.

Vital signs and oxygen consumption decrease, with the exception of the variability that occurs during Stage I REM sleep.

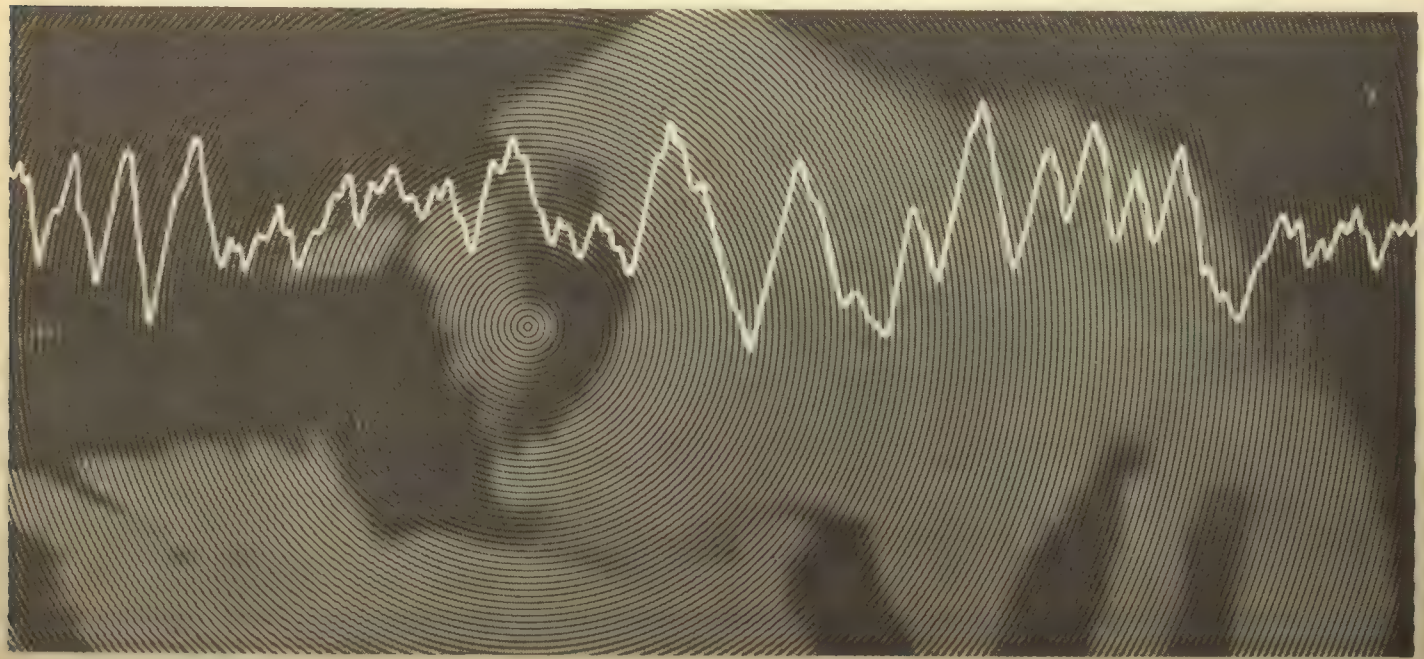
The digestive tract is not affected by sleep, except that peristalsis slows in the sigmoid colon. In patients with gastric ulcers, gastric acidity increases during Stage I REM sleep.

Urine production decreases. Pituitary and adrenocortical activity appear to be on a 24-hour cycle that influences reabsorption of water in the kidney tubules during the night.

Researchers have found that the percentages of some of the blood constituents decrease during the night. Kleitman states, however, that this is due to the increased blood volume that occurs when a person is in a horizontal position (as a result of decreased capillary filtration pressure) rather than an actual decrease in the blood constituents.[5]

The biochemistry of sleep is a new field of research, and little is known so far. Certain endogenous compounds appear to have some effect on sleep and are being studied, including serotonin, dopa, and the sex hormones – primarily progesterone. As more is known about the biochemistry of sleep, methods to control sleep may become more specific and effective.

The percentage of time a person spends in the different stages of sleep differs with age. Stage I REM time remains fairly constant throughout life, but the percentage of time spent in Stage IV sleep decreases with age.[6] The elderly patient spends less time in Stage IV due to a shorter total sleep time and more frequent awakenings during the night. An elderly person's adjustment to sleep seems to depend on the degree of his arteriosclerotic changes. The alert patient



who has little memory loss seems to sleep about the same as the young adult. The patient who shows senile changes awakens often, especially during Stage I REM, sleeps 20 percent less than the young adult, and tends to wander around at night.[7]

Medical crises are thought to occur during Stage I REM sleep. Nocturnal angina pectoris has occurred in the laboratory mostly during REM periods, raising the question of whether there is a relationship between the occurrence of myocardial infarction and the latter part of the sleep cycle when the REM periods are most prolonged. Persons who have duodenal ulcers typically have more pain at night, related to the increase of gastric acidity during Stage I REM sleep. Asthmatic episodes have shown no pattern of occurrence.[8]

Thus, one might expect patients with angina or peptic ulcers to have an increase in pain during the latter part of the night. Since a person usually perceives any pain as being worse at night, due to the fewer distracting external stimuli, the nurse's reassuring explanation, along with the ordered p.r.n. medication, may help decrease his perception of the pain.

Control of sleep

Although we know better what to expect in a sleep pattern, we still know relatively little about how to control sleep. The important variable in controlling sensory input to promote sleep appears to be quality rather than quantity. Volunteer subjects placed in a completely silent room had more difficulty going to sleep than those subjected to monotonous light or sound.[9]

Early research in factors promoting the induction of sleep indicated that immobility with muscle relaxation were effective mechanisms. Little research has been done in this area in recent years.

Most sedatives significantly decrease REM sleep. However, if the person continues to take the sedative, there is a gradual return to the baseline amount of REM sleep. But then when the drug is withdrawn there is a marked *increase* in REM sleep, associated with frequent nightmares, insomnia, and a feeling of having slept poorly. These uncomfortable changes have persisted for up to five weeks.[10]

Behavioral changes can occur, depending on the dose of the drug and on the individual characteristics of the patient. The same drug that causes sleep in one person may cause wakefulness in another. Obviously, good judgment is necessary in carrying out the order for sedatives to be given h.s., p.r.n., for not giving any sedatives at all could be as detrimental as giving them to every patient. If the patient has been taking a sedative routinely at home, omitting it in the hospital might lead to withdrawal symptoms. On the other hand, if the patient has not been taking sedatives at home, the nurse will want to consider the patient's need each night and give sedatives as necessary, but only along with other nursing measures.

Increased irritability, fatigue, and sensitivity to pain may be exhibited by newly admitted patients suffering from REM sleep deprivation due to the unaccustomed use of sedatives. If a sedative is given, its effectiveness should be noted to assist the physician in his prescription.

Amphetamines, tranquilizers, and alcohol also reduce the amount of REM sleep when taken in the usual dosage range. Behavioral changes in a person on these drugs may be due to REM sleep deprivation.

Loss of sleep

With total deprivation of sleep, normal volunteer subjects have shown changes in both personality and performance. Withdrawal, depression, and apathy occur as well as periods of irritability and aggressiveness. As total deprivation continues, confusion and hallucinations appear. In performance, the person's reaction time is not necessarily slowed down, but periods of inattention occur. Thus, when a subject could work at his own pace, performance was good, although he worked fewer problems. However, more errors occurred when subjects had to maintain a steady pace.[11]

After 48 hours of sleep loss, the body produces a stress chemical belonging to the indole group and related in structure to lysergic acid diethylamide – LSD-25. This may account for the behavioral changes.[12]

Also, the body does not produce adenosine triphosphate, the catalyst for energy release, after four days of sleep deprivation. This may be a factor causing fatigue.

Of more pertinence to nursing is the effect on a person whose total normal sleeping time is reduced. Reduced sleep is *not* a miniature of a full night's sleep: the person's EEG pattern shows that he is mostly in Stage IV sleep, and has little Stage I REM sleep. In persons whose REM sleep only is deprived, irritability, fatigue, increased sensitivity to pain, a feeling of pressure around the head, and momentary illusions have been noted.

On recovery nights, a person who has been deprived of REM sleep spends a greater than normal amount of time in Stage I REM sleep. The need to dream (during REM sleep) thus seems apparent; the reason for this need has not yet been established. Vogel suggests that REM sleep and antidepressant activity may be controlled by closely related biochemical mechanisms.[13]

In a situation where the patient is awakened frequently throughout the night, as in the intensive care unit, the nurse should be alert to the above signs of sleep restriction. Perhaps especially important is her awareness that the patient will have an increased sensitivity to pain if he has not had enough sleep. When at all possible, care should be planned so that the patient has blocs of uninterrupted sleep.

Insomnia

Insomnia is essentially a subjective feeling, meaning different things to different people. According to Kleitman, whether "insomnia" occurs depends, in

some persons, on the value the person attaches to getting enough sleep, and to deviations from his normal pattern.[14] Kleitman divides insomnia into three types: initial, intermittent, and terminal, depending on whether the person has difficulty getting to sleep initially, awakens frequently during the night, or awakens early in the morning and cannot return to sleep. Initial insomnia is the most common. Terminal insomnia is more likely to occur in elderly persons.

There are many causes of insomnia. Wheatley lists the following five general causes:

Physicial – pain, cough, pruritus, bronchospasm, diarrhea, enuresis, frequency.

Physiologic – changes due to interference with circadian rhythms; coffee and tea.

Psychologic – strong emotion, anxiety, depression.

Iatrogenic – amphetamines, antidepressants, bronchodilators, and oral diuretics (if the diuretics cause nocturnal diuresis).

Idiopathic – no cause; some persons seem to require only small amounts of sleep.[15]

If the patient complains of insomnia, the nurse can try to determine the possible cause. Are there any apparent physical causes? If so, measures to relieve these symptoms may be all that are needed. Is the patient anxious or upset about something? Psychogenic factors are the most common cause of insomnia. An interested listener or, if necessary, a tranquilizer, may be more effective than a sedative. Has the patient been receiving central nervous system stimulants? If he has repeated difficulty with sleeping, his problem should be discussed with the physician.

The nurse will, of course, vary her approach depending on the type of insomnia that is occurring.

Measures to relieve initial insomnia may include elimination of sudden or diverse stimuli and promotion of physical and mental relaxation. A good backrub is still one of the best tools for promoting sleep. Not only does it effect muscle relaxation but also, through its rhythm, it provides a monotonous stimulus conducive to sleep. A fresh smooth bed helps decrease irritating stimuli.

The patient who has intermittent insomnia awakens easily from Stage I or II sleep. Are there sudden noises (such as clanging bedpans, slamming doors, or loud voices) that cause the patient to awaken easily? Are there physical symptoms that are awakening him?

The patient with terminal insomnia may be wide awake at 4:00 A.M., but at what time did he go to sleep? If he was asleep by 9:00 P.M., he has already had a good night's sleep. Pointing this out to him and encouraging him to read or listen to the radio may settle the problem. If he has not had sufficient sleep, there may be psychologic reasons for his insomnia.

Patients tend to sleep lightly when first admitted to the hospital. During Stages I and II sleep, as mentioned earlier, if the patient awakens he may not be aware that he has been sleeping. The nurse can explore with the patient his concern about his apparent inability to sleep. If the concern is about the insomnia itself and its effect on his illness, he can be reassured that he is "resting," and that transient insomnia will not create any permanent problems. However, a patient who is having severe problems with insomnia should be watched for signs of behavioral changes indicating depression, and his behavior brought to the attention of his physician.

Recent research has given us a beginning insight into the complexities of sleep. As more is learned about factors affecting sleep, there may emerge more specific answers about how to help a patient who is having trouble sleeping. There may come a time when people can be taught how to enter Stage I of sleep at will. The role of the nurse then may include being a teacher and promoter of this ability.

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A day hospital for elderly persons

Description of a day program that is specially geared to help the aged person who is lonely and perhaps isolated from society.

Shirley Cooper

Various clinics and clubs in an urban community provide the older citizen with the medical, social, and recreational resources he requires. What happens to the individual who is not motivated or who is physically unable to take advantage of these facilities? Must he spend his remaining years in forced isolation from society?

The day hospital at Maimonides Hospital and Home for the Aged in Montreal was set up to help these lonely individuals. Its facilities are available to the aged person who is facing a crisis and who feels isolated and depressed. The person's crisis may follow the loss of a friend or family member, retirement from a job, physical deterioration, or a change in living accommodation.

The day hospital began as a pilot project in March 1966 with 10 patients. At that time the program was unique; a survey in 1964 had shown that there were no day facilities anywhere in North America that provided medical and psychiatric care specifically for the aged.*

A growing project

The day hospital, situated on the ground floor of Maimonides Hospital and Home for the Aged, has five main areas: a large activity room with a lounge and music section; a sitting room where some of the group meetings are held; a two-bed room used for treatments and emergencies; a fully equipped kitchen, used for retraining and remotivating some patients; and a cafeteria for noon meals. The staff offices are near the patient areas.

The day hospital accommodates 60 patients. This number is increasing gradually as the program expands. Since most of the patients attend two or three days per week, the average daily census is 35. A fee for attending the program is determined on a sliding scale, ranging from fifty cents to five dollars per day.

The individual is referred to the day hospital by a professional health worker or by his family. Sometimes he comes on his own. An assessment of each applicant is presented to the team by the nurse and the social worker. To be eligible for admission, an applicant must be ambulatory.

Some persons attending the day hospital use canes or walkers to give them additional support. A bus service provides transportation between home and hospital for those whose physical or mental condition prevents them from using public vehicles.

Promoting independence

The goals for each patient vary with his capacity for independence in all aspects of daily living. Prevention of regression on all levels is a common goal for patients.

To determine and evaluate an individual's potential, the staff use examinations, interviews, and observation. The goals for each patient are reviewed by the day hospital team throughout the patient's participation in the program and are discussed with the individual. His own feelings about them are explored. Basically, the goals are achieved by remotivating the patient – first through his relationship with staff members, then through recreational and occupational activities, and ultimately through relationships with his peers.

Some patients are encouraged to participate in community activities, such as "Golden Age" clubs, while maintaining some association with the day hospital. To prevent a patient from becoming dependent on the day hospital, the number of days per week that he may attend the program is gradually decreased. Other patients are discharged from the program when they can function adequately in the community. They are encouraged to work as volunteers or visitors or to join local organizations.

The team approach

The staff members include a psychiatrist who is team leader, a resident psychiatrist from a nearby general hospital, a

*R.L. Epps, and L.D. Hanes, eds., *Day care of psychiatric patients from the National Day Hospital Workshop, Kansas City, Mo., 1963*, Springfield, Ill., C. Thomas, Publisher, 1964.

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The physiotherapist leads the patients in the biweekly exercise group held at Maimonides Hospital.

medical doctor available for clinics and emergencies, two registered nurses, a certified nursing assistant, an occupational therapist, an arts and crafts worker, and a dietitian. Team meetings are held twice a week to discuss the patients' progress and their short and long-range plans.

The nurse is involved with all aspects of patient care and coordinates the activities of the members of the team. For example, she may channel communication from the physiotherapist to the bus driver who transports the patients daily, about a plan for a certain patient who is being taught to climb stairs.

Structure of the program

The day hospital operates on weekdays from 9:00 a.m. to 5:00 p.m. Group therapy sessions, occupational therapy, and medical services are provided.

Group therapy sessions help the elderly to relate better to one another. Through sessions led by staff members, the patients are encouraged to express their feelings and to interact. Five group sessions, limited to 10 patients each, are held weekly. One large group session is conducted weekly so that all patients can attend at least one therapy group.

Through crafts, patients are encouraged to express their feelings and to develop their creative talents. When their articles are sold they receive a small fee. This helps to promote a sense of worth as a productive person. One group of patients publishes a newspaper every two months; another group has formed a choir, which is directed by a volunteer.

Medical services are provided by a physician and a group of specialists who see patients on referral. All medications are distributed by the hospital pharmacy; specific instructions for any medication or treatment are explained to the patient by the nurse. If the patient suffers from memory loss, the nurse gives the instructions to his family.

To help maintain body functioning at an optimum level, exercise groups are conducted for all patients twice weekly by the physiotherapist. Only a few patients require individual physiotherapy.

A changing program

The program at the day hospital is frequently reevaluated and changed to meet the needs of the people it serves. For example, the discharge program was

A group of patients gathers for a weekly therapy session led by the author (back, right). Patients attend at least one session.

revamped to make it more effective.

Previously, patients were reluctant to be discharged; many of those who were discharged had to be readmitted after a short time. However, by preparing the patients for discharge soon after their admission and by discussing long-range plans with them over a longer period, their eventual discharge was less traumatic.

This approach was used with a 75-year-old woman, who became withdrawn soon after moving to Canada from her native England. She was admitted to the day hospital knowing that after a specific time she would be discharged. Soon after her admission she started to work as a hospital volunteer, a job she continued after her discharge.

The occupational therapist's assistant gives instruction to a group of patients hooking rugs. Later these articles will be sold at the Open House, held annually at the Maimonides Hospital and Home for the Aged.

Patient histories

Throughout most of their 10-year marriage, Mr. and Mrs. S. experienced conflict, mainly about the division of responsibilities in the home and financial matters. This conflict increased after Mr. S. retired from his small business. Mrs. S., who is 70 years old, became depressed and was no longer able to function in the home. She became totally dependent on her husband and her behavior continued to regress. Although he had always interfered with his wife's household tasks, Mr. S. resented having to cope with them on his own. He brought his wife to the geriatric clinic at a general hospital where a psychiatrist referred her to the day hospital.

The team established treatment goals for Mrs. S.: to remotivate her to care for herself, her husband, and their home; and to help her cope with her marital situation.

Mrs. S. began attending the day hospital three days a week. At first she found it difficult to relate to her peers and felt guilty about expressing any anger toward her husband. Most of the other women in the group were widowed and resented Mrs. S. because she had a husband.

Despite these difficulties, Mrs. S. soon was able to express her problems and feelings in a small therapy group. She became interested in group projects in the occupational therapy program and enjoyed teaching her skills to new members in the group. Both she and her husband had regular interviews with the staff social worker. In addition, Mrs. S. received an antidepressant medication.

After eight months Mrs. S. was discharged from the day hospital. By this time she was attending the program only one day per week and had returned to the monthly meeting of an organization she belonged to prior to her admission. She was referred back to the geriatric clinic at the general hospital, and our day hospital team continued to follow her progress.

Although Mrs. S. did not gain much insight into her relationship with her husband, the day hospital provided a milieu where she could express her feelings and find new diversions.

Mr. R., a 72-year-old widower, lived alone in his own home and had plans of remarrying. Then he had a cerebrovasular accident, which left him with aphasia and one-sided weakness. He started receiving speech and physiotherapy immediately.

Mr. R. soon became dependent on his son and daughter. He moved to his daughter's home where there was continual conflict between him and the rest of the family. His periodic visits to his son's home resulted in many disagreements as well. The resulting tension led Mr. R.'s daughter to seek help from her family physician, who referred her to the day hospital.

After he was accepted for the day hospital program, Mr. R. continued to receive speech and physiotherapy. He soon became the editor of the group newspaper (his former occupation was in journalism). As well, he discovered that he had a talent for painting.

Meetings were held with Mr. R., his children, and the staff social worker. Both Mr. R. and his children expressed a need to live independently. Mr. R. was helped to find accommodation in a senior citizen's apartment. Here he was able to be independent and to develop new relationships among his peers. His relationship with his family improved considerably. Mr. R. began attending the day hospital less frequently and a discharge plan was discussed.

The day hospital program at Maimonides Hospital and Home for the Aged has proved to be of value in remotivating and reintegrating into the community elderly persons who might otherwise have remained isolated and depressed. Perhaps this day hospital will serve as a model and as a stimulus for the creation of similar facilities for the elderly in other towns and cities in Canada. □

Tracheotomy suctioning technique

A description of some of the childhood conditions that may require tracheotomy and of the methods used at The Hospital for Sick Children to suction a tracheotomy.

Barbara Kearns

The day-to-day care that a nurse gives to a child with a tracheotomy is no small responsibility. In fact, the child's life depends on the skilful, safe, and effective nursing care that he receives. For in airway maintenance there are no half-way measures.

The purpose of this paper is to explain the method used at The Hospital for Sick Children to ensure safe tracheal-bronchial aspiration of a tracheotomy tube.

A tracheotomy may be performed either as an elective procedure when the cough reflex is inadequate, as in the unconscious patient with pneumonia, or as an emergency procedure to relieve increasing respiratory distress and hypoxia. The emergency procedure is generally required for the following common conditions.

Inflammatory diseases

Acute laryngotracheobronchitis (tracheitis, croup): This is a specific viral inflammatory swelling with a superimposed bacterial infection that causes swelling in the larynx and accumulation of tenacious secretions in the tracheo-bronchial tree. These result in stridorous, difficult respirations. The patient assumes a prone position and is usually restless and irritable. Prolonged dyspnea and tachycardia of 160 or over produce extreme fatigue, and the child succumbs unless tracheotomy is performed. The age group most commonly affected is from one to three years.

Supraglottitis (epiglottitis): Inflammation and swelling of the epiglottis and soft tissue of the supraglottic space (above the vocal cords and below the epiglottis) not only impede respirations but make swallowing difficult as well. The patient assumes a "bolt upright" sitting position; his lower jaw hangs open and pooled saliva drools from it. Death from obstruction can occur within two hours after onset of symptoms. This is therefore more of a potential surgical emergency than any other inflammatory condition of the respiratory tract. The age group commonly affected is from four to nine years.

Congenital anomalies

Subglottic Stenosis: This is a condition that results in airway obstruction from a congenital narrowing of the space just below the vocal cords at the level of the cricoid cartilage. The severity of air flow impediment depends upon the degree of obstruction. Some children, however, may not display respiratory distress despite the abnormality until a superimposed infection adds more swelling to the already narrow airway.

Vascular Compression: The most common form of vascular anomaly is the compression of the trachea by the innominate artery. As the vessel branches off the aorta it "leans on" the trachea externally, pushing the tracheal wall inward, thus narrowing the internal lumen. To relieve the distress, the innominate artery is suspended by suture to the sternum. Soon after the tracheotomy tube can be removed.

Laryngomalacia (laryngeal stridor): In this condition the epiglottis, laryngeal, and tracheal cartilages are immature and lack the strength to support the airway. As the child breathes in, the floppy epiglottis is sucked down into the supraglottic space, occluding the air passage. On expiration the passage is forced open again. Ordinarily a tracheotomy is required only in severe cases.

Congential Hemangioma: This vascular growth, which can be as small as a pea or as large as a fist, invades the laryngeal or tracheal lumen and impedes air flow in and out of the lungs. Radiation therapy has been successful in reducing the size of the mass and improving the airway.

Pierre-Robin Syndrome: This includes a congenitally small lower jaw and associated cleft palate. When hypoplasia is marked, the tongue may be displaced backward and partially obstruct respiration. In extreme cases tracheotomy is usually necessary. Around age two, enough development of the jaw has taken place to support the epiglottis adequately and relieve the distress.

New growths

Juvenile Papillomas: Mostly male toddlers are affected. Wart-like growths of viral origin begin to sprout on the vocal cords and, as the child grows, spread down into the trachea and bronchi. Its rapid growth occludes the airway and necessitates frequent removal if the patient is to survive. Since this growth extends into the bronchi, the patient's airway may still become obstructed below the tracheotomy tube. This condition normally resolves itself at puberty.

Other causes

Presence of a foreign body may obstruct respiration. Usually a foreign body can be removed without too much difficulty. The child may not require a tracheotomy, if the object that impedes respiration is not large.

Trauma, too, can obstruct the airway. Occasionally, after a diagnostic procedure such as laryngoscopy or bronchoscopy, the swelling caused by the friction of the scope in the airway is enough to occlude the airway. Also, recent research has indicated that the friction of an endotracheal tube left in the airway for a prolonged period causes tissue breakdown, scarring, and stenosis of the lumen. This does not occur in all cases,

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but in a large enough number to be a significant finding.

Some of these children require short-term care only until the immediate crisis is over and the tracheotomy tube is removed. Others spend as long as one to five or more years in hospital, undergoing repeated surgical correction.

The suctioning procedure outlined here will be based on six basic facts that must be recognized as relevant guides to safe and effective tracheotomy care.

Six basic facts

[1] To live, the human organism must have an airway free of obstruction to allow for adequate exchange of O_2 and CO_2 with its environment. Partial or total occlusion may le d to hypoxia, coma and death.

[2] The artificial opening into the trachea allows for easier access of infective agents into the lungs, as the better part of the body's natural defense mechanism – nasal mucosa, cilia, and lymph glands – has been bypassed.

[3] Air entering the lungs via the tracheotomy does so without being adequately moistened by the mucous membrane of the upper respiratory tract. Unmoistened air irritates the tracheal mucosa and dries secretions, making them difficult to raise.

[4] Any foreigh body in the airway (e.g., tracheotomy tube, suction catheter, endotracheal tube) irritates the tracheal lining. *Repeated* contact irritation of a prolonged or rough nature can cause tissue breakdown and eventually the formation of granulation tissue that will obstruct the airway.

[5] Suctioning produces a cough that helps clear the airway of secretions and initiates deep breathing.

[6] Because of its anatomical structure, the shape of the trachea and right and left bronchi can be altered slightly by the extension or flexion of the head and neck.

Using these facts as the core of the suctioning technique, the nurse should be able to maintain a patent airway and, at the same time, minimize tissue trauma, reduce the possibility of infection, assess and provide adequate humidification of air to prevent mucus plugging, and promote good lung function by stimulating the patient to cough and deep breathe.

The actual steps in the suctioning procedure are outlined in detail on the following pages. Beside each step is marked [1] [2] [3] [4] [5] or [6] to indicate which basic fact (as previously listed) is being considered as the maneuver is carried out.

THE SUCTIONING PROCEDURE

Step 1. Establish the *need* for suctioning.
See Fact [1]

1. The signs of increasing respiratory distress are: increased pulse and respiration; stridor; indrawing (subcostal, supracostal, etc.); restlessness, anxiety; pallor with circumoral cyanosis, generalized cyanosis.

Step 2. If the child requires suctioning, place him flat in bed or on some firm surface. [4]

Step 3. Wash hands thoroughly. [2]

Step 4. Unlock and remove the inner cannula, keeping a steadying finger on the outer cannula. [4]

Step 4: Removal of inner cannula.

ANTICIPATED PROBLEMS AND COMMENTS

Usually if a patient needs suctioning, a rattling, bubbling, or whistling sound can be heard coming from the airway. Whistling usually means there are drying secretions in the cannula that require liquefication and suctioning.
Frothy, loose secretions *might* be coughed up with no suctioning at all required. [4]

Children normally fidget or wiggle more than an adult. However, if the child is fully cooperative, he can sit up to be suctioned. Secretions may be harder to raise however, because of the effect of gravity on secretions in the upright position.

If the need is urgent, skip hand-washing. [1]

If the inner cannula should stick to the outer because of dried secretions, squirt about one-half cc. of normal saline between the two for lubrication, then try again.
Hold the outer cannula firmly in position and pull hard on the inner one using a steady, controlled force.

THE SUCTIONING PROCEDURE

Step 5. Place dirty inner cannula on a Kleenex on the bedside table.

Step 6. Open tray covers.

Step 7. Put on clean plastic glove.
[2]

Step 8. Pick up one catheter from dish of aqueous Zephiran 1:1000, using gloved hand. Always use a rubber catheter for a long-term patient as it is less traumatic to the tissue.
[2] [4]

Step 9. Connect catheter to "Y" connector (or straight connector if no "Y" available). You may touch the catheter at the connector end with ungloved hand to pull it securely on to ensure good suction.

Step 10. Immerse the catheter completely in dish of sterile H_2O and flush it through.
[4]

Step 11. With ungloved hand, position the child's head. Turn head acutely to the opposite side of the bronchus that requires clearing.
[4] [6]

Step 12. With the gloved hand, introduce the catheter into the outer cannula. *Suction is not applied on insertion.* Feed it through your fingers quickly but gently.
[4] [1]

ANTICIPATED PROBLEMS AND COMMENTS

Once this glove is on, it should touch nothing else but the catheter during the procedure.

When not in use, the catheters are left soaking continuously in this solution and are boiled at the end of 24 hours (i.e., rubber catheters are boiled and returned to the dish; plastic catheters are discarded).

If the catheter collapses where it connects to the "Y", try pulling it on further by folding it up on itself (much like shoving up a sweater sleeve).

Step 9: Catheter is attached to Y connector.

All aqueous Zephiran must be rinsed from the catheter, otherwise it may cause tissue irritation.

Because of the structural difference between the right and left bronchi, the left is harder to enter with the catheter. Tilting the chin up slightly more toward the right might help. If the child will not keep his head turned, maintain the position for him with the ungloved hand. If the child has a fat chin, which hides his airway, try putting a small rolled diaper or towel under his shoulders to help in neck extension.

Step 11: Head is held to left before catheter is introduced to clear right bonchus.

Does the catheter fill the entire hole of the outer cannula? It should not exceed 2/3 the diameter of the airway. Is it a straight catheter (one-holed) or French catheter (3-holed, whistle-tipped)? The more secretions you suction out with

Step 12: Catheter being inserted without suction. Note that thumb is removed from Y connector.

Step 4 13. Insert the catheter so that it extends beyond the end of the outer cannula and down into the mouth of the right or left bronchus. Because children vary in size, no specific number of inches can be stated as exact depth of insertion. Using the length of the inner cannula plus one-and one-half to two inches extra, should ensure that the catheter passes deeply enough.

It is important to get only a *good* cough started – not a strangling, red-faced purple-lips cough. If a child starts to cough like this, remove the catheter immediately. Do not use deep bronchial suctioning technique unless the patient is unconscious or unable to cough adequately, or in the immediate postoperative stage. [4]

Step 5 14. As the patient begins to cough, create suction by placing thumb over the open end of the "Y".

As the patient coughs reflexly, encourage him by saying "cough, good boy, cough" – even to an infant. A child can learn to cough on command, thereby clearing his own airway. The more secretions that are coughed up, the less amount of suctioning required. [4]

Step 14: After catheter is fully inserted, suction is produced by closing end of Y connector with thumb.

Step 4 15. Withdraw the catheter slowly, creating on-off suctioning by thumbing the open "Y". This helps prevent grabbing of the tracheal wall by the catheter tip. The catheter must be rotated on withdrawal, giving the three lumens a better chance to cover a larger surface area. To do this, roll catheter between your fingers.

Insertion and withdrawal should take a maximum of 10 seconds. Any more time leads to hypoxia and cardiac irregularities. Remember, suctioning removes air as well as secretions from the lungs. [1]

N.B. If a catheter becomes stuck in the outer cannula and resists withdrawal, do not yank forcefully. The probable result will be accidental extubation. If you have to tug, do so gently, holding the outer cannula firmly in place with your other hand. If the catheter is stuck firmly, cut it with scissors well above the tracheotomy opening or disconnect the catheter from the suction tubing. Air can be blown into this, i.e., mouth to tube, or 0_2 administered through it if necessary until a doctor is summoned.

On some wall suction outlets, there are no pressure gauges. An open tap can create as much as 260 mm. Hg. pressure which is too strong for a child. The most effective way to regulate suction pressure is by using the "Y" connector in the manner described and by keeping within the 10-second time limit. Appropriate suction pressure for a child is 80-120 mm. Hg.

THE SUCTIONING PROCEDURE	ANTICIPATED PROBLEMS AND COMMENTS
Step 16. After the first suctioning is completed, insert sterile normal saline into the outer cannula using a plastic pipette in the ungloved hand: infants – one-half cc.; toddlers – one cc.; older aged – two cc. [4] [3]	The air in hospital is dry, particularly in winter, and because the tracheotomy removes the normal humidifying action of the nasal mucosa, tracheal secretions tend to be tenacious. By using saline with each suctioning, the chances of consolidation and plugging of secretions are reduced. Also, the thinner the secretions, the more easily they are coughed out and the less suctioning is required. With some older children, and with those who, for specific reasons, cannot be suctioned, inner cannula removal and saline instillation that produces a cough, are the only steps necessary to maintain a patent airway.
	*Step 15: Repetitive thumbing. Note that thumb opens and occludes Y connector over and over again to produce intermittent suction.*
Step 17. Allow 10 seconds or so for the saline to loosen the secretions before repeating the suctioning procedure. [1]	
Step 18. Repeat suctionings until patency is reestablished, clearing both right and left bronchi. [2]	Good exchange of air in and out of the tube, little or no dyspnea, good color, and good air entry to both lungs indicate patent airway.
Step 19. Flush the suction catheter through with a small amount of aqueous Zephiran 1:1000.	
Step 20. Disconnect the catheter from the connector and replace it in the aqueous solution.	The catheter must be totally immersed if disinfection is to be effective.
Step 21. Remove dirty plastic glove.	
Step 22. With a Kleenex, wipe the outer cannula clean. Include the skin around the tracheotomy tube. Pay special attention to the area under the chin. Secretions left in the chin crease can cause tissue breakdown and infection. [2] [4]	If accumulated secretions are left, the inner cannula can adhere to the outer, making removal difficult, time-consuming, and dangerous, particularly if the child's need for suctioning is urgent.
Step 23. Pick up alternate clean inner cannula, insert and lock in place, keeping a finger on the outer cannula as you do so. [4]	

General considerations

In the overall consideration of the procedure, two areas in particular may cause concern. The first is the frequency of suctioning. As a rule, suctioning is done at the nurse's discretion, or p.r.n., based on her assessment of the adequacy of the patient's airway. Learning the significance of the different sounds that the patient makes as air passes in and out of the tube takes practice. If in doubt about the quality of air entry, look closely at the characteristics of the respirations and check with a stethoscope the air entry to both lungs.

It is a wise practice to listen to a child's chest at the beginning and end of each tour of duty as a matter of routine. It not only helps the nurse to assess her effectiveness in suctioning, but also gives an idea of the general status of the child's lung function.

In the immediate postoperative stage, the newly tracheotomized patient must be suctioned at regular, specified intervals.

The other area of concern involves the use of restraints during the procedure. Repeated practice makes the nurse quite adept at coping with little fists and grasping fingers, but "why put up with it? " The reason is that binding the child with a tight restraint impedes active coughing. It is preferable to have a second person restrain the child's hands. "Bunnying" is used only as a last resort.

Above all, consider that the child's airway is markedly reduced during suctioning and the fear of asphyxia in the patient is a real one. Try to be quick, gentle, and calm, even if anxious yourself. This approach helps to make the procedure less traumatic for your young patient.

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books

Practical Paediatrics: A Guide For Nurses, 3rd ed. by James Michael Watt. 213 pages. Christchurch, New Zealand, N.M. Peryer Ltd., 1969.
Reviewed by Mrs. E. Fitzgerald, Instructor, Sydney City Hospital, Sydney, Nova Scotia.

The author mentions many of the important needs of infants and children, as well as the most common diseases of childhood. To read this textbook with understanding, a solid background in medical sciences is a prerequisite.

The content is well organized under age groups, although most emphasis seems to be placed on the infant. Photographs and diagrams are, for the most part, excellent and are arranged close to the related subject matter. The short chapter at the end of the book on the Maori child is not of much significance to those of us on this continent.

This book would be useful as a reference text in any pediatric unit. This reviewer would not, however, recommend the book as a text for student nurses, mainly because there is only bare mention of many of the most important diseases and problems of childhood.

Psychology As Applied To Nursing, 5th ed., by Andrew McGhie. 340 pages. Edinburgh and London, E. & S. Livingstone Ltd., 1969. Canadian Agent: The Macmillan Company of Canada, Ltd., Toronto.
Reviewed by Margaret Lounds, Instructor in Psychiatric Nursing, Calgary General Hospital, Calgary, Alta.

This book is primarily for nursing students. It would also be an excellent review for graduates, as the newer theories are explained in a straightforward manner.

The book is divided into five parts, which are subdivided into chapters. At the end of each chapter questions help the reader evaluate how much has been retained.

Part I deals with the development of the personality. The section on childhood warns that we cannot be sure that specific traumatic experiences will effect a particular form of personality disturbance in later life. Unfortunately, the chapter on adolescence contains detail on psychological disorders that are common in adulthood.

Part II deals with intelligence and personality testing. The purposes, strengths, and weaknesses of these various types of tests are clearly outlined. Part III is concerned with human motivation. More detail on unconscious motivation would be helpful. The chapter dealing with environmental stimulation is particularly interesting.

Part IV presents human interaction with the environment. Learning theories are simply and effectively explained. Part V briefly describes the ways in which social groups function. Group processes, leadership, and morale are the primary focus.

The major strengths of this book are many references made to the direct application of pscyhology to nursing, theories presented in understandable language, many references for further reading, and a sincere and usually successful attempt to avoid being dogmatic.

This book would be a valuable edition for a school of nursing library.

Pharmacology in Nursing, 11th ed., by Betty S. Bergersen and Elsie E. Krug. 695 pages. Saint Louis, C.V. Mosby Company, 1969. Canadian Agent: C.V. Mosby Company, Toronto.
Reviewed by J. Louise Gillman, Lecturer, The University of Manitoba School of Nursing, Winnipeg.

In this new edition of their well-known text, the authors state that their purpose is to provide information "to enable the nurse to make intelligent decisions about the administration of drugs and their effects."

The usual introductory chapters on history, legal aspects, measurements, administration of medicines, drug action, and toxicology are included, as well as an interesting chapter on symbolic meanings of drugs and self-medication. Also included is a useful section on Canadian drug legislation.

In looking to the future, the authors indicate the advantages of changes now taking place in hospital drug administration; unit dose packaging; prefilled disposable syringes (although they omit mention of safe disposal methods); and clinical pharmacists. The increasing role of computers in ordering, distributing, and monitoring the administration of drugs is omitted.

The remaining chapters provide an overview of specific categories of drugs, illustrated by a good selection of drugs in each category. A new chapter on psychotropic drugs is included.

There are helpful reference readings and study questions at the end of each chapter. The questions would have been more useful, however, if answers were supplied, giving the student the opportunity to evaluate her own knowledge in her independent study.

The value of this book could have been enhanced by expanding several areas: teaching patients to take prescription medicines at home safely; identifying the increasingly frequent adverse interactions of drugs; and the chapter on vitamins and minerals.

In some instances, the amount of detail offered might lead the reader to assume that all important points have been covered when, in reality, they have not. For example, in describing the intramuscular route of administration, the book describes the exact sites, positions of the patient, types of needles and solutions, but omits discussion of asepsis.

This book would be a useful introductory text for nursing students, provided they have some background in biology, chemistry, and physiology, as it sometimes assumes knowledge beyond the introductory level. The book contains general information and demonstrates a pattern for the study of drugs. The professional nurse will require other sources of information to broaden her capacity for assessing the nursing implications of the drugs she gives.

This book could serve as a competent, up-to-date guide and introduction to pharmacology for beginning nursing students.

Fundamentals of Nursing, 4th ed., by Elinor V. Fuerst and LuVerne Wolff. 446 pages. Toronto, J.B. Lippincott Company, 1969.

The fourth edition of *Fundamentals of Nursing* continues to reflect the authors' attempts to meet nursing's changing needs. Teachers of introductory courses in nursing and their students will find the arrangement of the material more flexible, easier to locate, and easier to read in this new format.

The focus on principles is the same as in the previous edition. Principles that guide nursing action are explained effectively with good illustrations and photographs, up-to-date examples, and tables valid to 1965 and many to 1967. Details of procedures are not given because, in the authors' words, "It is possible that details of certain activity can be stressed to such a degree that they cloud the principles."

Of the book's seven units, unit four, Nursing Implementation – Man as an Organism, makes up the largest section. It considers man's basic needs. Two chapters in this unit are of special interest. The chapter on maintaining fluid and electrolyte balance is one of the best examples of the effective use of figures, tables, cross references, and implications for nursing. In this chapter, the table shows at a glance some of the more characteristic symptoms of fluid and electrolyte imbalance.

Implications for nursing include specific signs for which the nurse should be alert, the importance of the patient's history, and ways to prevent fluid and electrolyte imbalance. References to earlier chapters in the text help the reader integrate knowledge. The chapter ends with a study situation and reference to books and journal articles published in the 1960s. The other chapter of special interest in this unit, care of the body after death, includes a brief reference to tissue and organ transplantation.

Also new in this edition is the last unit – a patient study dealing with nursing in a home situation. The team approach of home care is well illustrated both pictorially and in writing.

Teachers and students should find this text a valuable asset to the learning experience. □

AV aids

EVR communications system

The latest addition to audiovisual materials, Electronic Video Recording, will be available in July, 1970.

EVR, a new communications system for storing audiovisual material, has been developed by the Columbia Broadcasting System's Electronic Video Recording Division. The system operates with a regular television set, the EVR cartridge, film, and player. The cartridge holds the dual-tracked film. Each track can carry a different series of frames, with a maximum program running time of 25 minutes. One track may carry questions and the other, answers. The seven-inch cartridge, sealed when in position, automatically takes up, plays, and rewinds the film.

One external connection clamps the EVR player to the external antenna terminals of a television set. The operator can switch from one track to the other without disturbing the cartridge or disconnecting the player.

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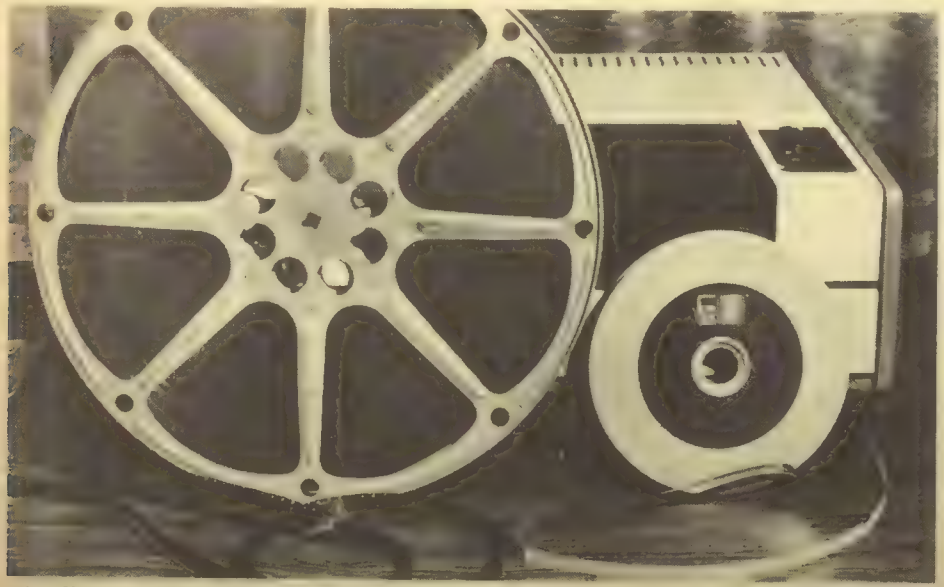
EVR will be available only from the United States at a cost of approximately $795 plus duty and handling charges. Cartridges will be made from 16 mm., 35 mm., and one- or two-track video tapes sent by a school to the CBS processing plant in Rockleigh, New Jersey.

The EVR system offers a unique new approach to teaching. Schools of nursing would find it a valuable asset. However, the initial cost of EVR, and the minimum 50-print requirement for a 5- or 50-minute program will make EVR too costly unless several schools are willing to use the same programs. Cost ranges from six dollars for a five-minute print to $47 for a 50-minute print.

Additional information on EVR can be obtained from CBS Electronic Video Recording, 51 West 52 Street, New York, N.Y. 10019.



The EVR cartridge (right) and the 16 mm. film reel (left) each stores 50 minutes of audiovisual information. The cartridge drops on a spindle on the EVR player (background). The EVR film has no sprocket holes.

The stroke patient comes home

A series of six 28-minute, 16 mm. black and white films probe the world of the stroke patient. Available from Educational Film Distributors Ltd., 191 Eglinton Ave. East, Toronto 315, Ontario.

The films describe the nature of stroke and early hospital rehabilitation; the training of the family to assist the patient; changes in treatment as the patient progresses; speech therapy; the use of graded exercises and devices for arm and leg motion; reemployment training; the activities outside the home for recreation and social living; and home care services.

The series includes: Understanding His Illness; Understanding His Problems; His Physical Well Being; Getting Around; He Learns Self-reliance; and His Return to the Community.

These films would be of special interest to nurses working with stroke patients. □

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3. *Classification internationale type des professions.* Ed. rev. 1968, Genève, Bureau international du travail, 1969. 415p.

4. *Community health* by Carl Leonard Anderson, St. Louis, Mosby, c1969. 343p.

5. *Community health test manual* by Carl Leonard Anderson. St. Louis, Mosby, 1969. 47p.

(Continued on page 52)

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70. *The effects on the registered nurse of the increasing use of non-nursing personnel in the hospital* by Frank Thomas Hughes. Toronto, 1968. 126p. Thesis (Diploma in Hosp. Admin.) – Toronto.R

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HEAD NURSE required for Labor and Delivery Suite in 242-bed hospital expanding to 669 beds. Diploma or degree in nursing administration plus post graduate obstetrical course desirable. Apply to: Director of Nursing, Burnaby General Hospital, 3800 Ingleton Avenue, Burnaby B.C.

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GRADUATE NURSES for 24-bed hospital, 35-mi. from Vancouver, on coast, salary and personnel practices in accord with RNABC. Accommodation available. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

GRADUATE NURSES for active 21-bed hospital, preferably with obstetrical experience. Friendly atmosphere, beautiful beaches, local curling club. Single room and board $40 a month. Salary $508 for Gen. Duty Registered Nurses; Salary $483 for non-registered nurses plus recognition for postgraduate experience. Shift differential. Apply to: Matron, Tofino General Hospital, Tofino, Vancouver Island, B.C.

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NEW BRUNSWICK

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NOVA SCOTIA

GENERAL DUTY NURSES: Positions available for Registered Qualified General Duty Nurses for 138-bed active treatment hospital. Residence accommodation available. Applications and enquiries will be received by: Director of Nursing, Blanchard-Fraser Memorial Hospital, Kentville, Nova Scotia.

ONTARIO

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March 1970

The Canadian Nurse

the face of Biafra:
what one nurse remembers
and the world can't forget

something to say
– and how!

are we getting to you?

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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 66, Number 3 March 1970

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The eyes tell the story. They tell of a father's anguish as he holds his child who is dying of starvation and lack of medical care; they tell of his bitterness as he asks himself why this had to happen to *his* child, why war came to *his* homeland; and, finally, they tell of his inabilty to understand why governments of other countries were unable — or unwilling — to overcome the diplomatic barriers that prevented food and medical supplies from reaching his child.

Our cover photo was taken in the former state of Biafra before hostilities officially ceased. It ties in with a staff-written article based on an interview with a Canadian RN who was working in the area when the war ended.

Recent photos in the news media confirm observers' reports that the suffering continues in Eastern Nigeria, that thousands more will die if food does not reach them immediately. Perhaps it was with this in mind that Dr. Edward H. Johnson, moderator of the Presbyterian Church, said at a national ecumenical service for world development in Ottawa February 13: There are two time bombs about to go off — the underprivileged who won't sit there indefinitely, and the affluent peoples who will suffer "a loss of human integrity that will explode inside us."

Being professional health workers in an affluent society, we have a special obligation to help de-fuse these bombs, whether they be on the national or international scene. Our strategy will, of course, take time.

For the people of Eastern Nigeria, however, there is no time. *Immediate* help is needed to save lives. Donations for food and medical supplies can be sent to UNICEF, 737 Church Street, Toronto 5, Ontario. All contributions to this organization will be forwarded without deduction of administrative expenses.

— V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Checking image

I would like to express my gratitude for the excellent article, "Check Your Image – It's Slipping! " (Oct. 1969).

The topic, photos, and writeup were to the point. I just hope that it hits those persons who really need it! We are making good use of this article at our university as a stimulus for all in the nursing profession to be on guard in looking our best at all times.

Thank you for keeping such pertinent items before us. – *Marilyn J. Christian, Dean, School of Nursing, Loma Linda University, Loma Linda, California.*

I was struck by the effectiveness of the article "Check Your Image – It's Slipping! " in getting a clear message across, and by its applicability to the current New Zealand scene. The same reactions have come from my colleagues regarding the photos, captions, and short discussion that together have such a striking effect.

As it appears that many of our journal readers would appreciate this article, I am requesting your permission to publish the article and photographs in *The New Zealand Nursing Journal.* – *Mrs. Murna C. Thomson, acting editor, The New Zealand Nursing Journal, Wellington, N.Z.*

Trying to find alumnae

The Alumnae of Misericordia General Hospital in Winnipeg would like to hear from members with whom they have lost contact. Please drop us a note and let us know where you are and what you are doing. Those wishing to renew their alumnae membership at this time can do so by enclosing $2.00.

Please send information to Miss Ethel Morris, Apt.8 – 430 Stradbrook Ave., Winnipeg 13, Manitoba, or to Miss Diane Litwin, 219 Greene Ave., Winnipeg 15, Manitoba. – Ethel Morris, Membership Committee.

Responsibility in education

I read with interest and enthusiasm the article "On the Delegation of Resposibility" (November, 1969). As a senior nursing student in a degree program, I am personally interested in the issue of teacher vs. student responsibility in education. Rigidity and external controls are not unique to nursing. They permeate our entire educational system, killing initiative and creativity. Though nursing may not be able to undo the damage, it certainly should not add to the injury. We need more experiments such as Miss Nance's to foster the development of independent, intrinsically-motivated nurses.

Although nursing is one of the more rigid disciplines, partially due to the standardized knowledge necessary for licensure, this reason is a poor excuse for making nursing school a drudgery. There is evidence that the rat-race pace and the strangulation of initiative and creativity contribute significantly to the low morale and high attrition rate in schools of nursing.

A method that would provide both standardization of knowledge and opportunity for self-direction is programmed instruction. This method at least allows the learner to proceed at his own pace. I find this generally a more efficient and enjoyable method of learning than a large lecture class. To supplement the programmed instruction, students should be given opportunity to identify areas in which they need and want additional knowledge and experience and to choose appropriate methods of acquiring it. The material learned could be shared with other students in seminars, and evaluation could be by self or by peers. There should also be opportunity for learning experiences in which students are free to practice and explore without being evaluated, as evaluation that becomes part of one's academic record inhibits creativity.

Nursing schools cannot afford to spoon-feed their students if they expect to produce nurses who will provide optimum quality nursing care, will accept responsibility for their professional growth after nursing school, and will be creative leaders in the health field and in the community. – *Elaine Zuck, University of Virginia School of Nursing, Charlottesville, Virginia.*

Metric conversion kits

I noticed in the December issue that there was a news item about Metric Conversion Kits for Hospitals. This item indicated that the kits are now being distributed exclusively by the Canadian Hospital Association.

This is not correct. The OHA continues to be responsible for supplying the kits to hospitals in Ontario at a cost of 50 cents each, not $1.00. Our arrangement with the CHA is that they will distribute the kits to hospitals outside Ontario only. – *Peter Wood, Director, Public Relations Division, Ontario Hospital Association.*

Minister of Health questioned

As I indicated in a letter to the Honorable John Munro, minister of national health and welfare, I was disturbed that the Canadian Nurses' Association was given no reasons for the rejection of its application for a research project to study factors preventing registered nurses from achieving their educational goals. (News, January 1970, page 5.)

There seem to be only two logical reasons for rejecting the application: an unfavorable appraisal by peers, or a lack of funds that necessitated rejection of some worthy submissions, including CNA's.

If the application was rejected because some qualified appraisers considered it to be unworthy of support, their reasons should be communicated to the CNA. If it was rejected because of lack of funds to support all worthy applications, this too should be communicated. As a member of CNA, I asked the minister to let the

association know why its application was rejected.

My letter to the minister also pointed out that an illogical reason for refusal of funds, which should be untenable in a democratic society, was that CNA had less political influence than other health-related organizations. Certain organizations, such as the Canadian Hospital Association, seem to have been more successful in getting applications approved.

To help prepare for future applications for research project funds, the CNA should appoint an advisory committee to its research and advisory unit. It is reasonable for members who have had experience developing research projects or evaluating submitted proposals to use their experience to assist CNA in carrying out its responsibilities with respect to studies of nursing. – *Dorothy J. Kergin, Reg. N., Ph.D., Member, RNAO Research Committee.*

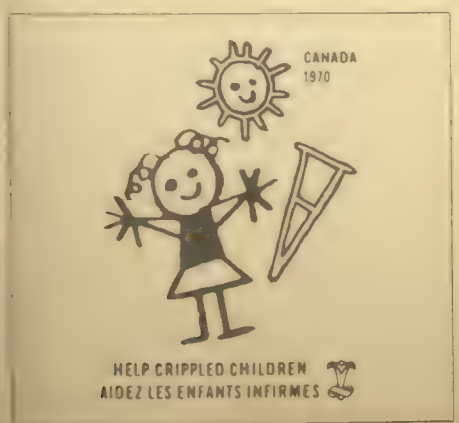
The traveling nurse

I always felt it was unjust that registered nurses could not travel from place to place outside their own country and still hope to practice their profession. Now I have had the misfortune to discover that this also applies to Canadians within Canada. It is most frustrating to experience!

I spent three long years learning to be a good nurse. I passed my registration exams in Ontario in August 1969 and five months later I discovered that I was not qualified to be an RN in Nova Scotia.

At one time nursing was something special, something to be proud of. But now it is beginning to lose its appeal. How long will it be before nursing becomes something I do because I can't do anything else? Never, I hope. But how many nurses has Canada lost for this reason?

It is a sad situation when a Canadian nurse who is educated in Canada cannot travel within the boundaries of Canada and still hope to practice as a registered nurse. Is it fair to the individual nurse? – *Mrs. Roberta Parker, RN, Antigonish, Nova Scotia.* □



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By JESSIE BERNARD, Ph.D., Research Professor Honoris Causa, Department of Sociology, Pennsylvania State University, University Park, Pa.; and LIDA F. THOMPSON, R.N., M.S., Associate Professor in Nursing, Idaho State University, Pocatello, Idaho. June, 1970. Approx. 328 pages, 82 illustrations.

Today's emphasis on nursing care of the "whole man" makes this newly revised text a significant addition to your curriculum! It explores the sociological effects of the dramatic changes of recent years, both in the world situation and in educational patterns. Well-written new discussions present the many roles a nurse must play, and examine health implications of community life. This study can give your students new insight into their identity as nurses and the changing world in which they live.

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By LOUIS P. GEBHARDT, M.D., Ph.D., Professor and Chairman, Department of Microbiology, University of Utah College of Medicine, Salt Lake City. March, 1970. Approx. 448 pages, 133 illustrations. About $10.75.

A New Book! Gebhardt

MICROBIOLOGY LABORATORY MANUAL

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This new manual, correlated with the text above, presents basic principles of microbiology in 26 flexible experiments. It includes work on sanitary microbiology, and problems involving pathogenic organisms.

By LOUIS P. GEBHARDT, M.D., Ph.D. March, 1970. Approx. 112 pages, 5 illustrations.

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MATERNITY NURSING

This new text is planned for concurrent classroom and clinical learning. It presents the entire maternity cycle as a normal physiological process, with sections on the preparatory phase, pregnancy, labor and parturition, the postpartum period, and the neonate. Its stimulating discussions stress the nurse's role as a counsellor. Practical teaching features include a complete glossary, study questions after each chapter, and blank pages for student's notes.

By CONSTANCE LERCH, R.N., B.S. (Ed.), Instructor in Maternity Nursing, Helene Fuld School-West Jersey Hospital, Camden, N.J. May, 1970. Approx. 480 pages, 7" x 10", 112 illustrations.

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This meaningful workbook, the most widely adopted in its area, now gains added significance as an adjunct to the correlated text described above. Case examples, situation questions for discussion, self-examinations, and carefully selected references help students learn theory and applications.

By CONSTANCE LERCH, R.N., B.S. (Ed.) April, 1969. 311 pages, 33 illustrations. $5.40.

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news

Alberta Nurse To Represent CNA At ICN Seminar

Ottawa. – Helen Sabin, executive secretary of the Alberta Association of Registered Nurses for the past 10 years, has been selected as the Canadian Nurses' Association delegate to the international seminar on nursing legislation. This decision was made at the CNA board of directors meeting January 26-27.

The 10-day seminar, sponsored by the International Council of Nurses, will be held in Warsaw, Poland, in April.

Mrs. Sabin was chosen because of her wide experience with nursing legislation. Recently she helped to prepare an AARN brief to the Alberta government to request that the association be represented when decisions concerning health needs were made. She also helped to revise the AARN bylaws.

In an interview with *The Canadian Nurse,* Mrs. Sabin said that Canadian nursing could bring experience to the international seminar. In particular, she referred to the nurse's favorable public image in Canada. This, she said, is important when nursing seeks to change legislation in the health field. Mrs. Sabin also mentioned that meetings between provincial nurses' associations and the government help to keep the latter informed of nursing's accomplishments and problems. "This method is employed by many provincial nurses' associations in Canada and could be employed effectively elsewhere," she said.

This international seminar is the second stage of a project initiated in 1967 with funds from the Florence Nightingale International Foundation and administered by the ICN. The first stage, completed in 1968, resulted in the publication of *Principles of Legislation for Nursing Education and Practice – A Guide to Assist National Nurses Associations,* prepared by a five-member group. The seminar in 1970 will use this publication as a basis for its deliberations.

CNA Board Approves Policy To Ensure High Standards Of Nursing Care

Ottawa. – The board of directors of the Canadian Nurses' Association has recommended that all provincial associations or nurses' bargaining agents establish professional practice committees within collective agreements to interpret nursing needs and ensure high standards of nursing care. This decision, based on a recommendation from the committee on social and economic welfare, was made at the board meeting January 26 and 27 at CNA House.

"We want nurses more involved in interpreting nursing needs and ensuring high standards of nursing care," Louise Tod, chairman of the committee on social and economic welfare, told *The Canadian Nurse.* She said that although it may not always be possible to establish professional practice committees within collective agreements, committees formed independently have been helpful in Alberta.

The board also approved the following motions made by the committee on social and economic welfare:

- That the nursing service and nursing education committees develop well-defined standards of excellence in nursing practice and seek ways to promote programs that would upgrade nursing service personnel by improving their skills in staff motivation and development and in personnel evaluation.
- That each provincial nurses' association establish an assessment board to set criteria for evaluating the post-basic (degree) preparation of nurses from foreign countries. The evaluation would help to determine salaries.
- That provincial nurses' associations review the provisions of the Unemployment Insurance Act and the Adult Occupational Training Act and report their findings at the next meeting of the committee on social and economic welfare.
- That CNA rescind its policy on strike action by nurses. The committee pointed out that the original 1946 policy statement that opposes strike action is in conflict with the provisions of certain provincial labor legislation.

The policies approved by the Canadian Nurses' Association board of directors will be presented to membership for ratification at the association's 35th general meeting in Fredericton in June.

Official Notice of General Meeting of Canadian Nurses' Association

The 35th General Meeting of the Canadian Nurses' Association will be held June 14-19, 1970, in the Playhouse Theatre, Fredericton, New Brunswick. The opening ceremony will be held on Sunday evening, June 14 at 20:30 hours, followed by daily sessions commencing Monday, June 15 at 09:00 hours and concluding Friday, June 19 at 16:00 hours. Only member of CNA are eligible to attend general meetings of the association. Students enrolled in schools of nursing in Canada are invited as guests to observe the proceedings of the general meeting. In addition, a program will be arranged especially for students who attend the meeting.

Ad Hoc Committee Set Up To Study Health Cost Reports

Ottawa. – An ad hoc committee will be set up to study the reports of the federal government's task force on health care costs. This was decided at the meeting of the Canadian Nurses' Association board of directors January 26-27.

Committee members will include the chairmen of the three CNA standing committees: Kathleen Arpin, nursing education committee; Margaret D. McLean, nursing service committee; and Louise Tod, social and economic welfare committee.

Each provincial association will also appoint a member to this committee. Chairman is Lois Graham-Cumming, head of CNA's research and advisory department.

The board commented briefly on the reports, and commended the minister of national health and welfare for the federal government's efforts to restrain the rate of increase in health service costs, while maintaining and improving the quality of care. The board agreed that CNA would welcome dialogue and collaboration with other health professions and groups in efforts to contain costs.

CNA Represented On Health Care Committee

Ottawa. – Lois Graham-Cumming, director of research and advisory services for the Canadian Nurses' Association, represented CNA at the first meeting of the nucleus committee on the delivery of medical care in Canada, held at Canadian Medical Association headquarters January 29, 1970.

This committee was formed by the CMA to study and recommend ways in which the efficiency of the health care

system can be improved.

The committee is composed of three members representing the CMA and one member from each of the CNA, Association of Canadian Medical Colleges, Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, and the Federation of Medical Licensing Authorities.

CNA To Withdraw Application For Letters Patent

Ottawa. – The Canadian Nurses' Association is requesting the minister of consumer and corporate affairs to withdraw its application for Letters Patent under the Canada Corporations Act until the matter of individual and corporate membership in the association can be resolved by the provincial nurses' associations.

This was decided at the CNA board of directors meeting January 26-27. Two provinces voted against the resolution and others abstained.

The board was notified that two provincial associations, the Registered Nurses' Association of British Columbia and the Registered Nurses' Association of Ontario, have sent letters to the department of consumer and corporate affairs, requesting withdrawal of their consent to the Letters Patent. This consent was given at a special meeting held November 5, 1969 in Ottawa to adopt several bylaws required to allow CNA to comply with the requirements of the Canada Corporations Act.

All 10 provincial associations agreed to the amended bylaws at the meeting, including one that would allow individual members of CNA to withdraw from the association.

RNABC mentioned a technicality by which it hopes the department will call the special meeting null and void. RNAO has told the department it is concerned about the bylaw on individual membership and believes that once CNA became incorporated under the Canada Corporations Act it would be hard to amend this bylaw.

If CNA became so incorporated, any amendment to the bylaws would have to be approved by the federal minister of consumer and corporate affairs.

Three Health Groups Study Transfer Of Duties

Toronto, Ont. – Canada's three major health groups – the hospital, nursing, and medical associations, have initiated Phase 1 of a four-phase, two-year study on the transfer on medical-nursing functions and responsibilities within the hospital.

The Canadian Hospital Association, the Canadian Medical Association, and the Canadian Nurses' Association, met to discuss three major topics and obtain a joint consensus on the federal-provincial task force report on cost of health services in Canada, the classification of health workers, and proposed medical assistants. They met in January at CHA headquarters in Toronto.

Representatives from the Canadian Hospital Association, the Canadian Medical Association, and the Canadian Nurses' Association met in Toronto in January to initiate a study on the transfer of medical-nursing functions within the hospital. *Standing, left to right:* Dr. A.F.W. Peart, general secretary, CMA; Dr. A. Mercer, CMA; E. Louise Miner, president-elect, CNA; Dr. B.L.P. Brosseau, executive director, CHA; Dr. Gaston Rodrigue, president-elect, CHA; Margaret D. McLean, 2nd vice-president, CNA; Chaiker Abbis, executive committee member, CHA; and Dr. D.L. Kippen, president-elect, CMA. *Front row left to right:* Dr. Helen K. Mussallem, executive director, CNA; L.R. Adshead, president, CHA; Sister Mary Felicitas, president, CNA; and Dr. R. M. Matthews, president, CMA.

A joint statement issued by the presidents of the three organizations, L.R. Adshead, CHA president, Dr. R.M. Matthews, CMA president, and Sister Mary Felicitas, CNA president, said: "Our three bodies are endeavoring to meet regularly because we are continually examining the quality of our contribution to health care in Canada. Jointly, we can achieve the highest quality of patient care through communication with each other and cooperation in programs, policies, and objectives."

Mr. Adshead said that the three associations have initiated a joint research project into the transfer of functions and responsibilities of the various health professions in the hospital. The purpose, he said, is to determine which procedures and responsibilities could be transferred from the more highly skilled and trained professions to other groups requiring less preparation.

The total project is expected to take three years at a total cost of $100,000. The federal government has given a partial grant for phase one, an in-depth survey of existing practices to establish the possibility of transferring certain responsibilities between the medical and nursing professions in the hospital.

Phase two will be an implementation of the first phase affecting recommended transfer of functions, with due recommendation for the ramifications such changes would create. Phase three will deal with the transfer of functions among other health professionals, and phase four will implement the findings of phase three.

The CHA, CMA, and CNA held a preliminary discussion on the importance of the task force report and decided to set up a working party to examine it in depth. Each association will do its own analysis, and joint meetings will be held to discuss the findings and to develop a consensus. The associations will then submit their recommendations to the minister of health.

NBARN's Biennial Plans Progress

Fredericton, N.B. – Nurses attending the 35th biennial meeting of the Canadian Nurses' Association here June 14 to 19 will also have the opportunity to become acquainted with New Brunswick and its people. This is the promise of the planning committee of the New Brunswick Association of Registered

(Continued on page 10)

Come to New Brunswick

the picture province of Canada, for your holiday this year and attend the 35th Biennial Convention of the Canadian Nurses' Association

June 14 to 19 in Fredericton

Fredericton and New Brunswick... so much to enjoy!

The capital of New Brunswick, Fredericton is one of the most picturesque cities in Canada. You will be delighted with its elm-shaded streets, its parks and the scenic river winding through the city.

Visit the art gallery, where paintings by Turner and Gainsborough, Krieghoff and Dali are displayed; or the York-Sunbury Museum with its outstanding collection of military equipment and rooms furnished in period style. Fredericton's cathedral is one of the best examples of Gothic architecture in North America. Tour the campus of the University of New Brunswick, where new and old buildings combine.

While you are here, don't miss the picture province itself. Enjoy the miles of inland waterways, the boating, the many picnic and camp sites. Or head for the sunny, sandy beaches of the coast. Whether in bustling cities, quiet towns or charming fishing villages, you will find friendly hospitality in this province of two cultures - 40 per cent of New Brunswickers are French-speaking. There is much here for the historically minded, including the oldest museum in Canada, at Saint John; the French-built Fort Beauséjour; and the Auld Kirk at St. Andrews.

Not to be missed is Fundy National Park, 80 square miles of spectacular vacationland stretching from beaches and towering cliffs to deep forests and quiet lakes. Visit the Fundy Isles, including Campobello, long the summer home of the Roosevelts.

Unique natural phenomena in the province include Magnetic Hill, the Reversing Falls, the tidal bore of the Petitcodiac River and the magnificent rock formations at Hopewell Cape. New Brunswick has 180 covered bridges, including the longest one in the world. Skilled craftsmen make shopping for silver, pottery, woven, wooden and leather goods a delight. There is comfortable accommodation everywhere, and you can savor the famous Atlantic cuisine, including lobsters, salmon, oysters, fiddleheads, and dulse!

(Continued from page 8)

Nurses, the hostess association.

A major objective of the committee is to give visitors an appreciation of New Brunswick's culture and heritage. Entertainment, welcome, social activities, and tours have all been planned to illustrate the unique personality of the province. Nurses will be presented with a special souvenir of New Brunswick.

The government of New Brunswick will sponsor and host a banquet for registrants, the menu to feature provincial dishes and products. The city of Fredericton is also making special plans to welcome nurses from across Canada.

New Brunswick nurses at the meeting will act as hostesses; they will wear swatches of New Brunswick tartan for identification.

Tours of Fredericton and other points of interest in the province are being arranged for the meeting's "hospitality day," Wednesday June 17. Tourist and general information services will be provided throughout the week.

Arrangements for alumnae meetings and other reunions during the general meeting are being coordinated by a special committee. Groups requesting information and bookings should contact Elizabeth Foran, 492 Parkside Drive, Apt. 2, Bathurst, N.B., before April 30.

Activities planned for nursing students include a special tour on June 17 and other social activities.

Members of NBARN's planning committee for the 1970 biennial meeting represent every chapter in the province. They are: *(seated, left to right)* Elizabeth Foran; Nancy Rideout, NBARN Liaison Officer (secretary); Catherine Bannister, (chairman); Diane Flower, (vice-chairman); Lois Smith. *(Standing, left to right)* Margaret McGee, Raymonde Hanson, Elizabeth Kelly, Jennifer Sherwood, Carolyn MacFarlane, Aulda Yerxa, Evelyn Patterson, Odette LeBlanc. Absent is Nicole Lajoie.

Board Approves Biennial Meeting Program

Ottawa. – The program for the Canadian Nurses' Association 35th biennial convention was approved by the CNA board of directors January 26-27. The general meeting runs June 14 to 19 in Fredericton, New Brunswick.

The official opening on Sunday June 14 will feature an address on health and welfare services for the '70s. Later in the week another guest speaker will discuss the role of the professional association in the new decade.

Special interest sessions proved so popular at the last biennial meeting in Saskatoon in 1968 that they will again be featured. Six sessions are planned covering the topics: legal aspects of nursing; psychodrama; planning of patient care; delivery of nursing care; the expanded role of the nurse; and a research symposium.

Business sessions feature largely in the program. Items for discussion include the report of the CNA ad hoc committee on functions, relationships, and fee structure; proposals of the ad hoc Committee on legislation; and the budget for the 1970-72 biennial.

Entertainment on the program includes a banquet, a whole day left free for sightseeing and hospitality, and a presidents' reception to end the meeting.

CNA Membership Now More Than 80,000

Ottawa. – All 10 provincial associations have reported an increase in active members for 1969, compared with 1968 figures. Total active membership in each association, which together makes up the Canadian Nurses' Association membership, is given below for both years.

	1968	*1969*
Alberta	8,326	8,726
British Columbia	10,441	11,120
Manitoba	4,779	5,094
New Brunswick	3,535	3,649
Newfoundland	1,824	1,830
Nova Scotia	3,956	4,353
Ontario	12,241	12,961
Prince Edward Island	618	634
Quebec	26,796	28,353
Saskatchewan	5,900	6,106
Total	78,416	82,826

Test Service Board To Set Up And Operate CNA Testing Service

Ottawa. – The board of directors of the Canadian Nurses' Association will appoint a special committee to establish and operate the CNA Testing Service. Transfer of the Registered Nurses' Association of Ontario Testing Service to CNA takes place May 1, 1970.

The special committee, to be known as the test service board, will be set up under the present CNA bylaws, as recommended by the ad hoc committee on CNA Testing Service. The first meeting of

(Continued on page 12)

Off Press Early 1970

Falconer, Norman, Patterson & Gustafson:
THE DRUG, THE NURSE, THE PATIENT **4th Edition**

By Mary W. Falconer, R.N., M.A., formerly of O'Connor Hospital School of Nursing; Mabelclaire R. Norman, R.N., M.S., University of Guam; H. Robert Patterson, Pharm.D., San Jose State College; and Edward A. Gustafson, Pharm.D., Valley Medical Center.

This well-known pharmacology text for student nurses has been thoroughly revised and updated for this new edition. New drugs have been included and information added on the chemical and physical characteristics of the drugs and their action and fate in the body. Drugs are grouped according to the "concept approach" into such chapters as **Drugs Used for Patients with Restricted Motion, Drugs Used for Patients with Guarded Prognosis,** and so on. The book is ideal for courses in which pharmacology is integrated throughout the curriculum. The text includes the entire **Current Drug Handbook** described below.

About 750 pages, illustrated. About $10.50. Just ready.

Falconer, Patterson & Gustafson:
CURRENT DRUG HANDBOOK 1970-72

By Mary W. Falconer, H. Robert Patterson, and Edward A. Gustafson.

Revised every two years, this convenient handbook lists 1500 drugs in current use, giving names, source, preparations, dosage, uses, contraindications, etc. in convenient tabular form.

About 224 pages. About $5.00. Just ready.

Jacob & Francone:
STRUCTURE AND FUNCTION IN MAN **2nd Edition**

By Stanley W. Jacob, M.D., University of Oregon Medical School, and Clarice Ashworth Francone.

This superbly illustrated text has been made even more valuable by the addition of a new set of audiovisual teaching aids. The text has been revised and brought up to date, with new tables of muscles; new sections on genetic biology, cancer, carbohydrate and fat digestion, and contraceptives; and many new references and drawings. A Teacher's Guide includes references and an annotated list of films.

About 600 pages with about 470 illustrations. About $9.50. Second edition just ready.

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presents 85 experiments keyed to the text, all of them tested in actual use.

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Jodais: PERSONAL CARE OF PATIENTS

By Janet Jodais, R.N., M.S., Colorado Associated Nursing Homes.

This new text for nurse's aides describes techniques of personal care, including simple treatments. Such important concepts as observation, interpersonal relationships, communication, safety, and rehabilitation are stressed.

About 350 pages with about 275 illustrations. About $5.50. Just ready.

news

(Continued from page 10)

the test service board will be held no later than March 7, 1970.

The test service board will be composed of registered nurse representatives recommended by nurse registering or licensing authorities. Each authority will be allowed at least one representative, with a maximum of five possible, depending on the number of nurse candidates tested by the authority. There will also be one representative from a separate nursing assistant authority, to be rotated biennially. Provincial representatives will be appointed for two-year terms.

The functions of the test service board will include: establishing policies for the CNA Testing Service; approving the content of basic contracts; recommending the nature of data to be compiled; appointing committees and subcommittees; preparing the budget and recommending the appointment of the director of the testing service, subject to the approval of the CNA board of directors.

Among the committees appointed by the test service board will be a blueprint committee for the registered nurse examination and one for the nursing assistant examination. These blueprint committees will be chosen to represent the different types of RN programs, specialities, nursing service, French and English languages, and regions of Canada. The first set of examinations must be ready for the provinces by August, 1970.

A joint committee of the test service board and the CNA board will meet within five years to review initial action and look at the possibility of the testing service being formed as a separate corporation.

AARN Presents Views On Bill 119 To Health Minister

Edmonton, Alta. – A coordinating council, compulsory licensure for all who nurse, and retention of nursing's professional prerogatives were recommendations made by the provincial council of the Alberta Association of Registered Nurses to the province's health minister last fall. The meeting between the AARN and the minister, James D. Henderson, followed the task committee's composite report of AARN members' views on Bill 119, an Act to incorporate a council on nursing.

The minister gave initial approval to AARN recommendations, and agreed that the AARN should retain disciplinary responsibility for the registered nurse, set the standards for licensure through registration, and have increased representation on the 16-member coordinating council.

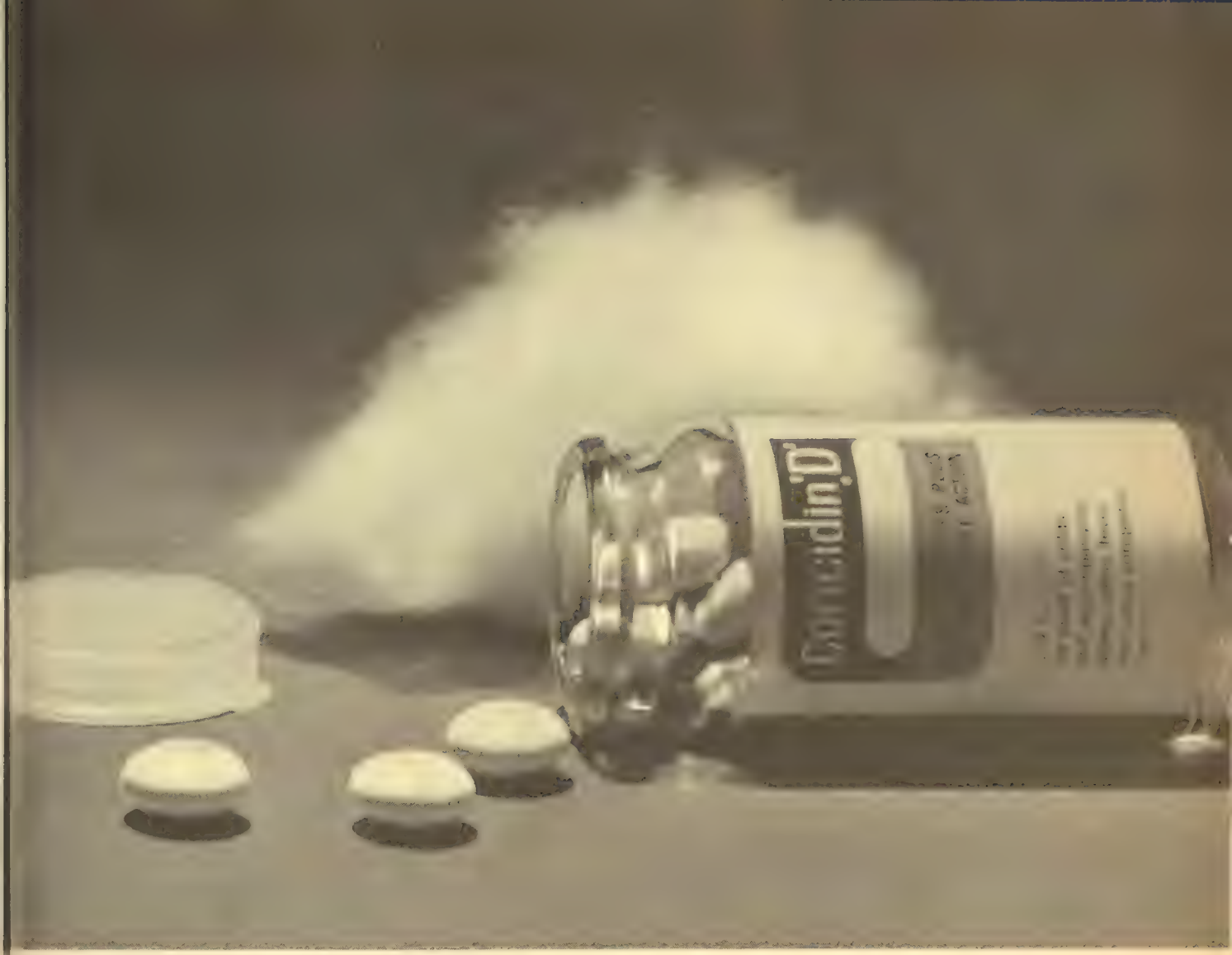
Helen Sabin, AARN executive secretary, told *The Canadian Nurse* the association believes the coordinating function of the council must be maintained throughout the Bill to be of value to nursing. Planning for nursing service cannot be done in isolation – services must be coordinated to cover total health needs and trends in education, she explained.

Currently, over 90 percent of the employed nurses in Alberta are voluntary members of the association. Mrs. Sabin said the association has recommended that registration in the AARN be a prerequisite for licensure as a professional nurse.

"We anticipate that new legislation will be introduced at the next session of the legislative assembly, provided there is general agreement on our recommendations," Mrs. Sabin said.

(Continued on page 15)

Alberta minister of health, James D. Henderson (center, arms folded), meets with the provincial council of the Alberta Association of Registered Nurses to discuss proposed legislation to establish a council on nursing. Helen Sabin, AARN executive secretary, is at the extreme right, and next to her is M. Geneva Purcell, AARN president.



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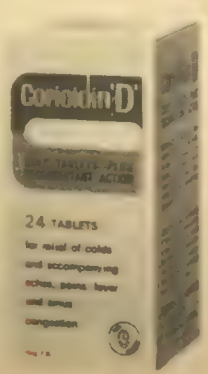

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news

(Continued from page 12)

ANPQ Donates $15,000 To CNF

Ottawa. – The Canadian Nurses' Foundation received a welcome boost from a provincial nurses' association in January. The $15,000 cheque from the Association of Nurses of the Province of Quebec will help the Foundation to make awards to all applicants whom the selections committee recommends. The donation resulted from a resolution passed by the ANPQ membership.

In 1969-70, more than $41,000 was awarded to CNF scholars. The ANPQ donation brings to approximately $35,000 the amount of funds available on February 1, for CNF scholars in 1970-71.

Symbol For Disabled

Ottawa. – An international symbol to indicate building services available for the handicapped was selected by the International Society for the Rehabilitation of the Disabled in December.

The winning entry in the world-wide competition, representing a figure seated in a wheelchair, was submitted by Susanne Kofoed, a Danish student. It was selected because it is easily identifiable from a reasonable distance, can be understood with or without text, is simple and aesthetic, and can be produced in metal, glass, and other materials.

The winning design is copyright free and available for use by anyone. It has been adopted by the standing committee on building standards for the handicapped of the associate committee on the national building code of Canada

Public Threatened, RNABC Warns

Vancouver, B.C. – The Registered Nurses' Association of British Columbia has expressed concern about a decrease in services of the provincial hospital insurance and health departments.

In a January news release the RNABC said that the published statement attributed to B.C. Health Minister Ralph Loffmark was a warning to the public that it will be unsafe to become ill. "The nursing profession cannot guarantee the safety of patients under these circumstances," said the RNABC.

According to the news release, the RNABC board of directors believes that provincial government cutbacks in extended care already are compounding problems in these facilities. Space and staffing ratios allowed for extended care facilities in B.C. do not provide for adequate nursing care or room for patients to do more than lie in bed and wait. Such a policy, the release added, tells the public not to bother with its old people.

The public must decide whether to shortchange itself or prepare to pay for adequate services, the association said. It explained that the public is threatened by the health minister's statement that decreases in health services will follow further demands on wages or staff enrolment.

(Continued on page 17)

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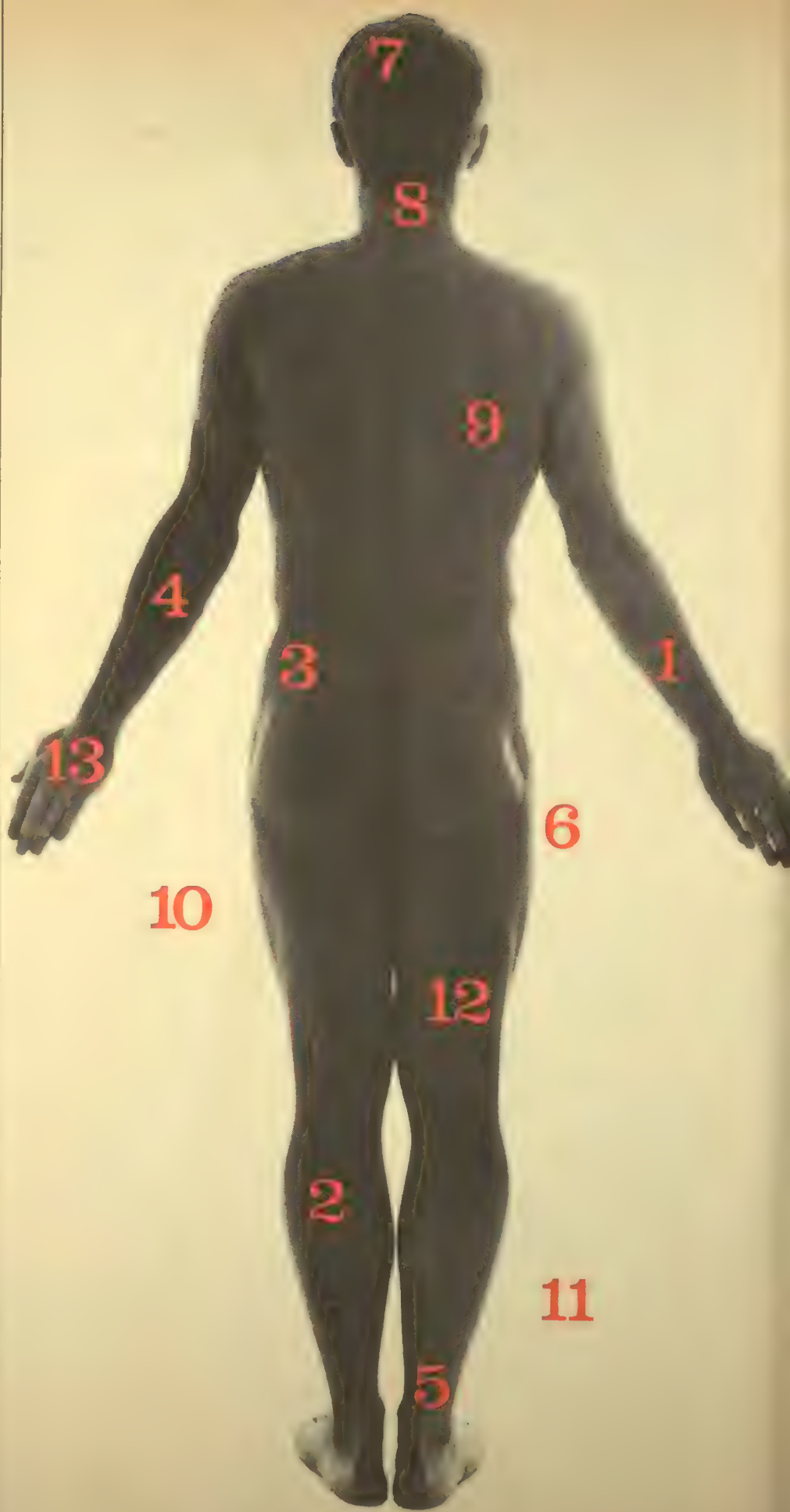

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(Continued from page 15)

The news release also criticized the provincial government policy, as stated by the health minister, for forcing nurses to spread themselves thinner in delivery of service in all areas, including intensive care, extended care, and public health. This policy does not explain how a depleted nursing staff can provide safe care at the present population level, let alone cope with a rapidly increasing population in the province, the RNABC said.

BC Nurses To Study Night Travel Problems

Vancouver, B.C. – A joint study of the "journey-home" travel problems of hospital employees who work night shifts has been undertaken by the Registered Nurses' Association of British Columbia, the Psychiatric Nurses' Association of British Columbia, and Local 180 of the Hospital Employees' Union. The study, announced by the RNABC, began in January.

Dr. Nirmala d. Cherukupalle, assistant professor at the school of community and regional planning, University of British Columbia, is conducting the study. Twenty hospitals in the Greater Vancouver and New Westminster areas are involved in the project, which aims to explore the feasibility and costs of alternative solutions to the problems of returning home from work after dark.

Travel problems in B.C. became a particular concern to nurses and their employers after the fatal stabbing last fall of a nurse on her way home from work after midnight.

"Million Letter Write-in" Helps Nurses' Campaign

London, England. – Nurses in Britain can thank the public for the support they received during their November campaign to "Raise the Roof" for better pay.

One million printed letters were distributed throughout the country by members of the 67,000-member Royal College of Nursing. Each letter contained a simple message: "I, a member of the general public, recognizing the importance to the community of the service given by nurses, support wholeheartedly their fight for a substantial increase in pay. I call upon the government to see that nurses get justice now so that we, the people of this country, can rely on their services for the future."

During the first few weeks of the campaign, Richard Crossman, secretary of state for health and social services, received 126,000 signed letters. Other individuals signed petitions with thousands of signatures and sent them to either the prime minister or the secretary of state. The British Medical Association pledged official support to the nurses' cause. The aim of the campaign was to keep pressure on the government and the Whitly Council, which looks after nurses' pay, while the latest wage claims were being discussed.

In January, the nurses received a pay offer from the government. Effective April 1, 1970, nurses in certain grades in general and psychiatric hospitals and in "Salmon" posts (supervisory positions), will receive a 15 percent pay increase. An additional 7 percent increase will take effect April 1, 1971. The present salary for a staff nurse is 785 pounds per year ($2,009.60) The Royal College of Nursing requested 1,000 pounds ($2,560).

According to an *Rcn* release, the council met in special session on January 14 to consider the offer. The council agreed that the offer "formed a reasonable beginning for further negotiations." However, the council prefers an immediate large pay increase rather than one spread over two years. Negotiations resumed on January 27. No further details were available at press time.

news

Centennial Stamp

Ottawa. – The formation of the Northwest Territories will be commemorated this year on a Canada Post Office Stamp, Postmaster General Eric Kierans has announced. The Northwest Territories is celebrating its official Centennial year.

The inhabitants of this region – more than one-third of Canada's total area – are emphasizing unity, not only with respect to all Canada, but among the Eskimoes, Indians, and other Canadians who work together in developing the Territories' component areas of Franklin, Mackenzie, and Keewatin.

The Postmaster General's announcement also said that Louis Riel, one of the most prominent figures in the events of Western Canada 100 years ago, will be commemorated on another Canada Post Office stamp in 1970. It was in 1870 that the Manitoba Act brought the Red River area into confederation as Canada's fifth province.

Red Cross Bursary Available

Toronto, Ont. – A bursary of $1,000 is being offered by the Volunteer Nursing Committee of The Canadian Red Cross Society to graduate nurses registered in Ontario. The announcement was made in January by Mrs. M. Mathieson, chairman of the committee.

The award will enable a nurse in Ontario to undertake further studies in nursing at the degree level. The successful candidate will be selected on the basis of training, nursing experience, and leadership qualities, with consideration being given to the applicant's anticipated contribution to nursing in Ontario.

Interested nurses can write to Miss C.M. Sarginson, The Canadian Red Cross Society, 460 Jarvis Street, Toronto 5, Ontario, for application forms and further information. Applications must be submitted before April 1, 1970.

The 1969 Bursary Award was made to Frances M. Howard, formerly consultant in nursing service with the Canadian Nurses' Association, who is presently studying for a master's degree in nursing service administration at the University of Western Ontario, London, Ontario.

ICN Seeks New Executive Director

Geneva, Switzerland. – The International Council of Nurses is seeking applicants for the position of executive director. The post will fall vacant this summer when present director Sheila Quinn takes up a new position. The successful candidate will work at ICN Headquarters, Geneva, starting in September 1970.

Applicants must be members of their own national association, must be fluent in English and have a good working knowledge of French. They should also have up-to-date knowledge of developments in nursing and nursing education on a wide basis; give evidence of proven managerial ability in their present position; and be capable of working as a leader of a small professional team.

Further details may be obtained by writing to ICN Headquarters, P.O. Box 42, CH-1211 Geneva 20, Switzerland.

Study Shows Hospitals Retain Involvement In Education

New York. – Hospitals that have closed their diploma nursing schools continue to be involved in nursing education, according to a report issue in October 1969 by the National League for Nursing.

The League recently surveyed 221 diploma nursing programs that closed between 1959 and 1968. It found that 63 percent now offer clinical facilities for practical nursing programs, 49 percent for associate degree programs (usually in junior and community colleges), 31 percent for baccalaureate degree programs in senior colleges and universities,

(Continued on page 21)

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(Continued from page 18)

and 11 percent for other diploma programs.

The study points out that in 1959 there were 918 diploma programs graduating 59 percent of the basic nursing students. By 1968 the number of programs had dropped to 728 with a commensurate decline in graduations to 39 percent.

The study reflects the fact that, although hospitals continue to supply the essential ingredient of nursing education – that is, clinical contact with patients – the control of nursing education is gradually shifting away from them to institutions of higher education.

Hospitals also reported that they engaged in educational activities for paramedical and ancillary personnel and for students in other disciplines, such as nursing aides, ward clerks, inhalation therapists, and technicians for operating room and obstetric departments.

The report, entitled *Present Involvement in Nursing Education of Institutions Whose Diploma Programs Closed, 1959-1968*, is available from the National League for Nursing, 10 Columbus Circle, New York, N.Y. 10019 for 75 cents a copy, U.S. Funds. (Publication No.19-1374).

UBC Family Practice Unit Involves Nurses

Vancouver, B.C. – Two Vancouver nurses are involved in a major experiment to educate members of the health professions. The experiment is being conducted at the family practice unit (FPU) recently established by the University of British Columbia's faculty of medicine.

Employed as public health nurses by the new unit are Pat Ohashi and Elinor Joensen, both graduates of UBC's school of nursing. They are participating in an experimental service, teaching, and learning situation that may broaden the scope of nursing at the primary health care level.

"At the family practice unit, we hope to demonstrate the potential for assuming a greater share of responsibility for the provision of improved health care for families that we know exists in nursing," said Elizabeth McCann, acting director of UBC's school of nursing. "In this situation nurses can be challenged to practice nursing to the maximum level of their knowledge," she said.

One of the major objectives of the FPU is to train student doctors, nurses, social workers, and other members of the health professions to cope with the many problems encountered in a family practice by actually training within a functioning family practice.

Dr. J.F. McCreary, dean of UBC's faculty of medicine, explained that the

Discussing the events of another busy day at the University of British Columbia's new Family Practice Unit are its two public health nurses, Pat Ohashi, left, and Elinor Joensen, right, and social worker, Lucille Cregheur, center.

need for a reorientation in the training of health care professionals to provide primary health care stems from the trend away from general practice in Canada. In 1945, he said, 22 percent of Canada's physicians were specialist-qualified. By 1960, more than 50 percent were specialists.

Dr. McCreary said the FPU will attempt to attract more medical graduates into family practice by creating a situation where the student can become involved in a functioning family practice and learn something of the rewards of this type of activity. To increase efficiency and decrease costs, the FPU will train doctors through the team approach to health care to delegate some health care duties to appropriate members of other health professions whose training and whose services are less costly than are the doctor's, he added.

The role of the nurse within the team approach to health care will be one of the areas where the most innovation will take place. By working side by side with nurses at the FPU, doctors will be encouraged to delegate duties that nurses are able to perform. Nurses in turn will be encouraged to think and act more independently, negating to some extent the nurse's traditional role as the doctor's alter ego.

Miss McCann explained that the nurse will be defining, developing, and interpreting her professional role within a new setting and will communicate it to her fellow professionals at the FPU and to the student doctors, nurses, social workers, and other members of the health professions who will train there. The nurse at the FPU will move freely between patients' homes and the unit, said Miss McCann. In some cases she may be able to make house calls, report on the patient's condition, and inform the doctor if it is necessary for him to make a visit.

The nurse will make her special contribution to the analysis of individual and family health problems through a nursing diagnosis and will share in the planning and provision of services for care and rehabilitation.

"ICN Calling" Gets New Format

Geneva, Switzerland. — *ICN Calling*, the news bulletin of the International Council of Nurses, now has a new format. The bulletin, produced six times a year in Geneva, is now 16 pages per issue.

Each issue contains 10 pages of English text and photographs, and selected news items in French, Spanish, and German. This format has been adapted from that of the daily multilingual bulletin distributed during the 14th quadrennial congress of ICN in Montreal in June 1969.

Persons wishing to subscribe to *ICN Calling* should write to: S. Karger AG, Arnold-Böcklin-Strasse 25, 400 Basel 11, Switzerland. Subscription price for one year is $2.15. □

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names

Hildegard Peplau (R.N., Pottstown H., Pottstown, Pa.; B.A., Bennington College, Vermont; M.A. and Ed.D., Teachers College, Columbia U., New York) has been appointed interim executive director of the American Nurses' Association. She succeeds Judith Whitaker, ANA executive director from 1958 to 1969.

Dr. Peplau is on leave of absence from Rutgers, the state university of New Jersey, where she is professor and director of the graduate program in psychiatric nursing.

Dr. Peplau has served on many committees and advisory groups of the ANA and the National League for Nursing. She is currently chairman of the ANA's division of psychiatric-mental health practice, is a member of the congress on nursing practice, and is ANA consultant to the advisory council of the National Institute of Mental Health. She is a member of the board of directors of the New Jersey State Nurses' Association and a member of the nursing education advisory committee to the New Jersey board of higher education.

From 1950 to 1960, Dr. Peplau was a member of the expert advisory panel on nursing of the World Health Organization. She also served as consultant to the U.S. Public Health Service, the Veterans Administration, and the surgeon general of the U.S. Air Force.

Dr. Peplau has lectured widely and has had many articles published in health and education journals. She is author of two books: *Interpersonal Relations in Nursing* and *Professional Experience Record.*

Margaret Neylan (B.Sc.N., McGill U.; Dipl. Superv. Psych. Nursing, McGill U.; M.A., U. of British Columbia) has been appointed associate professor and director of continuing nursing education in the school of nursing, University of British Columbia, Vancouver.

Mrs. Neylan was previously assistant professor in the school of nursing at UBC. Her experience includes teaching and supervision in psychiatric nursing at The Montreal General Hospital.

A member on various committees of the Registered Nurses' Association of British Columbia, Mrs. Neyland has also been a member of the Canadian Conference of University Schools of Nursing.

Hagen *Picard* *Houle*

Dr. Edna L. Moore Scholarships were recently awarded for the second time. The recipients were from the Laurentian University School of Nursing in Sudbury, Ontario. Mary Hagen received the Dr. E.L. Moore award for general proficiency and excellence in the practice of nursing in first-year nursing. Louise Picard received her award for general proficiency and excellence in the practice of nursing in second-year nursing. Margaret Houle was awarded the entrance scholarship.
Donations to the Dr. Edna L. Moore Scholarship Fund of Laurentian University School of Nursing may be sent by cheque or money order to Miss F.M. Tomlinson, c/o Sudbury and District Health Unit, Cedar St., Sudbury, Ontario.

Evelyn Pepper retired in January after a distinguished nursing career that brought her recognition throughout Canada, the United States, and overseas. For the past 19 years Miss Pepper has been nursing consultant in the emergency health services division of the department of national health and welfare.

Born and educated in Ottawa, Miss Pepper is a graduate of the Ottawa Civic Hospital. After becoming a registered nurse, she registered in a course in radiography and x-ray therapy given at The Montreal General Hospital. Later she received a certificate in hospital administration from McGill University School for Graduate Nurses.

Early in her career Miss Pepper worked as senior technician and nurse supervisor of the department of radiography and x-ray therapy at the Ottawa Civic Hospital. During this period she was awarded a fellowship in the Ontario Society of Radiographers.

As a nursing sister, captain (matron), and major (principal matron) in the Canadian Army during World War II, Miss Pepper served in Canada and overseas. Her war decorations include the Royal Red Cross, first class; 1939-45 Star; France-Germany Star; Italy Star; and CVSM war medal.

After the war, Miss Pepper worked in Ottawa as hospital matron with the department of veterans' affairs, where she became assistant to the director of nursing services.

In 1961 the United States civil defense council presented this internationally known nurse with the Pfizer Award of Merit for her contributions to medical-health and disaster preparedness. She has also been honored by the Order of St. John of Jerusalem, being named a commander sister in 1968.

An active member of numerous nursing associations in Canada, including the CNA, Miss Pepper is a past president of the Ottawa unit of the Nursing Sisters Association of Canada and has served on national committees of the St. John Ambulance, the Canadian Red Cross, and the Victorian Order of Nurses for Canada. She is a member of the board of the Ottawa Civic Hospital.

Sarah A. Wallace, (Reg.N., Hamilton General H.; Cert. P.H.N., U. of Western Ontario) has retired as senior nursing consultant in occupational health service with the environmental health services branch of the Ontario Department of Health, following 26 years of service with the branch.

Miss Wallace was the first full-time occupational health (industrial) nursing consultant appointed at a provincial level in Canada. She is known throughout the country for her counsel, guidance, and leadership in the field of occupational health nursing, for her contribution to nursing education, and her participation in nursing organizations at the provincial and national levels.

For the past nine years Miss Wallace was one of the few nurses on the Permanent Commission and International Association on Occupational Health. She was a member of its new subcommittee on nursing during the last triennium.

Four public health nurses from Saskatchewan, Manitoba, Ontario, and New Brunswick have been awarded $500 scholarships by G.D. Searle Co. of Canada Limited. The scholarships cover two weeks' training at the United States Planned Parenthood Association's Chicago clinic, plus living and travel expenses.

The nurses are **Sheila M. Paul**, B.S.N., Meadow Lake, Saskatchewan; **Betty Louise Flecknor**, R.N., Neepawa, Manitoba; **Ruth Linton**, R.N., P.H.N., Kirkland Lake, Ontario; and **Bella LeBlanc**, P.H.N., Shediac, New Brunswick.

The scholarship will enable the nurses to qualify for senior positions in clinics and instruct public health nurses taking up duties related to family planning.

Joanne Dolores Oss of Edmonton (R.N., City H., Saskatoon; B.Sc., U. of Saskatchewan; M.Sc., U. of Washington, Seattle) has been awarded the Abe Miller Memorial Scholarship by the Alberta Association of Registered Nurses.

The $1,500 scholarship is awarded annually to a registered nurse who is enrolled in a master's or doctoral program.

Miss Oss is on leave of absence from the University of Alberta, where she is coordinator of the bachelor of nursing science program, to receive her doctorate in education from the University of Washington.

Margaret Jean Bayer (R.N., Nova Scotia H., Dartmouth, N.S.; Dipl. Teaching in Schools of Nursing, Dalhousie U., Halifax, N.S.; B.N., Dalhousie U.) is the recently appointed director of nursing education at Nova Scotia Hospital in Dartmouth.

Mrs. Bayer has worked as a head nurse and instructor at Nova Scotia Hospital. She has been an active member in the Halifax branch of the Registered Nurses' Association of Nova Scotia.

Patricia Stanojevic (Reg.N., The Hospital for Sick Children, Toronto; B.Sc.N., U. of British Columbia; M.Sc. (App.), McGill U.) has been named assistant research and planning officer (nursing) with the research and planning branch of the Ontario Department of Health.

Mrs. Stanojevic began her nursing career as a staff nurse at The Hospital for Sick Children, where she later joined the school of nursing teaching staff. She was the first full-time nurse appointed at the hospital to organize an inservice education program for graduate nurses.

Mrs. Stanojevic's experience also includes working as an inspector of schools of nursing with the nursing branch of the Ontario Department of Health, and assistant director, professional standards, with the College of Nurses of Ontario.

J. Maurice LeClair has been appointed deputy minister of the department of national health. He succeeds Dr. John Crawford who retired in August 1969.

Dr. LeClair comes to the department from the University of Sherbrooke in Quebec, where he has been dean of the faculty of medicine since 1968. As dean, he continued to work on the staff of the University Hospital in Sherbrooke. He joined the medical faculty at the University of Sherbrooke in 1965, after serving as associate professor of medicine at the University of Montreal.

A native of Quebec, Dr. LeClair attended Collège Notre-Dame in Montreal and McGill University. A Fellow of the American College of Physicians and the Royal College of Physicians of Canada, he studied at the Mayo Clinic in Rochester, Minnesota, and practiced internal medicine in Montreal. The new deputy minister has specialist qualifications in internal medicine and hematology.

Dr. LeClair is vice-president of the Medical Research Council of Canada and the Association of Canadian Medical Colleges. He has also been active in the National Cancer Institute.

Mary E. Barrett (Reg.N., Victoria H., London, Ont.; B.N., McGill U.; B.A., Sir George Williams U., Montreal; M.S.N., Case Western Reserve U., Cleveland, Ohio) has been appointed chairman of the nursing education division of Dawson College in Montreal.

In her new position, Miss Barrett is responsible for setting up the College's nursing program. Dawson College is Montreal's only English-language CEGEP. CEGEP colleges have replaced all English hospital schools of nursing in Quebec. All English-language student nurses in the province enter CEGEPs for their nursing and pre-university schooling.

Miss Barrett has had broad nursing experience at Montreal's Jewish General Hospital, where she has worked as an operating room staff nurse and head nurse, clinical instructor, assistant director, and director of nursing education.

A former member of the curriculum committee and member of the Board of Examiners of the Association of Nurses of the Province of Quebec, Miss Barrett is now co-chairman of the ANPQ school of nursing committee. She was a 1967-68 Canadian Nurses' Foundation Fellow.

Marvelle McPherson (R.N., St. Boniface School of Nursing; B.N., U. of Manitoba) has been appointed assistant director of nursing service, planning and development, at St. Boniface General Hospital, St. Boniface, Manitoba.

Mrs. McPherson, a native of Manitoba, worked as a general duty nurse and head nurse in pediatrics at St. Boniface General Hospital prior to her new appointment.

Irene E. Biddington (R.N., Hôpital Hôtel-Dieu de l'Assomption, Moncton, N.B.; Dipl. Nurs. Serv. Admin., Dalhousie U., Halifax, N.S.) is the new director of nursing services at Hôpital Dr. Georges L. Dumont in Moncton, N.B.

Miss Biddington was assistant director of nursing service at this hospital from 1964 to 1969. She has also worked as a general duty nurse, operating room nurse, and head nurse in the outpatient department at the hospital. Her experience includes work as an office nurse in Moncton.

An active member of the New Brunswick Association of Registered Nurses, Miss Biddington is currently a vice-president of the Moncton chapter.

E. Oudot

Edna L. Oudot has been appointed coordinator, and **Nora R. Stearns** teacher, of the Team Nursing Project, Registered Nurses' Association of Ontario.

Miss Oudot (B.Sc.N., School of Nursing, U. of Toronto; M.A., Nursing Education and P.H. Superv., Teachers College, Columbia U.) has worked as a staff nurse, assistant supervisor and supervisor, and assistant director with the Metropolitan Toronto

branch of the Victorian Order of Nurses. Before her RNAO appointment, Miss Oudot was a teacher at the Nightingale School of Nursing in Toronto.

Miss Stearns (B.Sc.N., and B.A., U. of Toronto; Alliance Française diplôme de language Française, Sorbonne U., Paris, France) has had experience in Toronto as a general duty nurse at New Mount Sinai Hospital, clinical instructor and part-time lecturer at the University of Toronto School of Nursing, and team leader on the nursing research unit of Sunnybrook Hospital.

Catherine Bartleman (R.N., Royal Jubilee H., Victoria, B.C.; Dipl. Teaching and Superv., McGill U.; Dipl. in Advanced Obstetrics, U. of Alberta, Edmonton; Midwifery, Bristol Maternity H., England) has been named director of nursing at Vernon Jubilee Hospital, Vernon, British Columbia.

Miss Bartleman has worked as a staff nurse at Davidson-Hay Hospital in Port Angeles, Washington; an instructor at Archer Memorial Hospital in Lamont, Alberta, and at Queens Hospital in Honolulu, Hawaii; supervisor of obstetrics at Swedish Hospital in Seattle, Washington; and director of pediatric nursing at University Hospital in Saskatoon, Saskatchewan.

Susan D. Taylor (R.N., Cornell U. – New York H. school of nursing; M.S., Hunter College) has been appointed acting executive director of the American Nurses' Foundation. Mrs. Taylor has worked for the ANF since 1965, most recently as assistant executive director.

Before joining the Foundation, Mrs. Taylor worked as assistant head nurse, New York Hospital; Public Health Nurse, New York City Health Department; and PHN at the Greenwich House Counseling Center. Mrs. Taylor has published several articles about her employment experience at Greenwich House, where personnel from a variety of disciplines counsel drug abusers.

Marguerite Hornby (R.N., Halifax Infirmary; B.Sc.N., Mount Saint Vincent U., Halifax, N.S.; M.S., Boston U., Mass.) is the new director of nursing at Mount Saint Vincent University in Halifax, Nova Scotia.

The new director has been a staff nurse at the Halifax Infirmary and at Beth Israel Hospital in Boston, Massachusetts, and a lecturer in nursing at Mount Saint Vincent University.

Miss Hornby has served as chairman of the nursing education committee of the Halifax branch of the Registered Nurses' Association of Nova Scotia. □

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PAMOVIN Tablets of 50 mg. (red, film-coated), boxes of 6, and bottles of 24 and 100. Suspension (red), 50 mg. per 5 cc. teaspoonful, bottles of 30 cc., 4 and 16 fl. oz.

References: 1. Beck, J.W., Saavedra, D., Antell, G.J., and Tejeiro, B.: Am. J. Trop. Med. **8**:349, 1959. 2. Sanders, A.I., and Hall, W.H.: J. Lab. & Clin. Med. **56**:413, 1960.

Full information on request.

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dates

March 13-14, 1970
The British Columbia Operating Room Nurses' Group Biennial Institute, Hotel Vancouver, Vancouver. Information is available from Mrs. E. McLean, 135 Isleview Place, Lion's Bay, West Vancouver, B.C.

The University of British Columbia School of Nursing is sponsoring a number of non-credit courses: March 19-20, 1970 — maternal health nursing; April 2-3, 1970 — psychiatric nursing "behavior therapy"; April 22-24, 1970 — implementation of change in nursing services, for nurses with administrative responsibilities in nursing services. Registrations from other health professions are welcomed; May 7-8, 1970 — nursing care of adult with acute illness, for nurses providing care for surgical patients.

Information about these courses is available from: Division of Continuing Education in the Health Sciences, UBC, Task Force Building, Vancouver 8, B.C.

April 1-2, 1970
Conference on the team approach to the emergency department, sponsored by the Registered Nurses' Association of Ontario, the Ontario Medical Association, and Ontario Hospital Association, Geneva Park, Lake Couchiching, Ontario. Conference fee: $55. Write to: Professional Development Department, RNAO, 33 Price Street, Toronto 289, Ontario.

April 17-18, 1970
First assembly of the Canadian Rehabilitation Council for the Disabled, Winnipeg. Write to CRCD, Suite 303, 165 Bloor St. E., Toronto 285, Ont.

April 30-May 2, 1970
Registered Nurses' Association of Ontario, Annual Meeting, Royal York Hotel, Toronto. Write to the RNAO, 33 Price Street, Toronto 289, Ontario.

May 4-7, 1970
First National Operating Room Nurses' Convention, Queen Elizabeth Hotel, Montreal. For further information write to: Mrs. I. Adams, 165 Riverview Drive, Arnprior, Ontario.

May 4-28, 1970
Developing Leadership in Supervision of Nursing Services, a continuing education course designed for nursing staff of hospitals and community health agencies who take responsibility for the work of others. For information write to: Continuing Education Program for Nurses, Division of Extension, University of Toronto, 84 Queen's Park, Toronto 5.

May 11-June 5, 1970
Rehabilitation Nursing Workshop, an intensive four-week course offered annually to registered nurses working in acute general and chronic illness hospitals, nursing homes, public health agencies, and schools of nursing. For information write to: Continuing Education Program for Nurses, Division of Extension, University of Toronto, 84 Queen's Park, Toronto 5, Ont.

May 12-15, 1970
Alberta Association of Registered Nurses Convention, Calgary Inn, Calgary. For further information write to: AARN 10256 - 112 Street, Edmonton, Alberta.

May 18-22, 1970
Workshop on tests and measurements for teachers in schools of nursing, sponsored by the Registered Nurses' Association of Nova Scotia. Jean Church, assistant director, Dalhousie University School of Nursing, will be leader of the workshop. For further details write to the RNANS, 6035 Coburg Rd., Halifax, N.S.

May 19-22, 1970
Canadian Public Health Association annual meeting, Marlborough Hotel, Winnipeg. For further information write to the CPHA, 1255 Yonge Street, Toronto 7, Ontario.

May 25-June 12, 1970
Annual training workshop for rehabilitation workers, sponsored by The Canadian Rehabilitation Council for the Disabled in cooperation with The University of Manitoba Extension Division. Emphasis in this course is on the interdisciplinary nature of rehabilitation. Brochures and application forms are available from the Extension Division, The University of Manitoba, Winnipeg 19, Manitoba.

May 26-28, 1970
Annual meeting of the Registered Nurses' Association of Nova Scotia, Acadia University, Wolfville, N.S. For more information, write to: RNANS, 6035 Coburg Rd., Halifax, N.S.

May 27-29, 1970
Jeffery Hale's Hospital nurses' reunion, Quebec City. Nurses are requested to send their addresses, and write for more information to: Mrs. D. Firth, 1304 Allard Ave., Ste Foy 10, Quebec.

May 27-29, 1970
Registered Nurses' Association of British Columbia Annual Meeting, Bayshore Inn, Vancouver. Write to the RNABC, 2130 West 12th Ave., Vancouver 9, B.C.

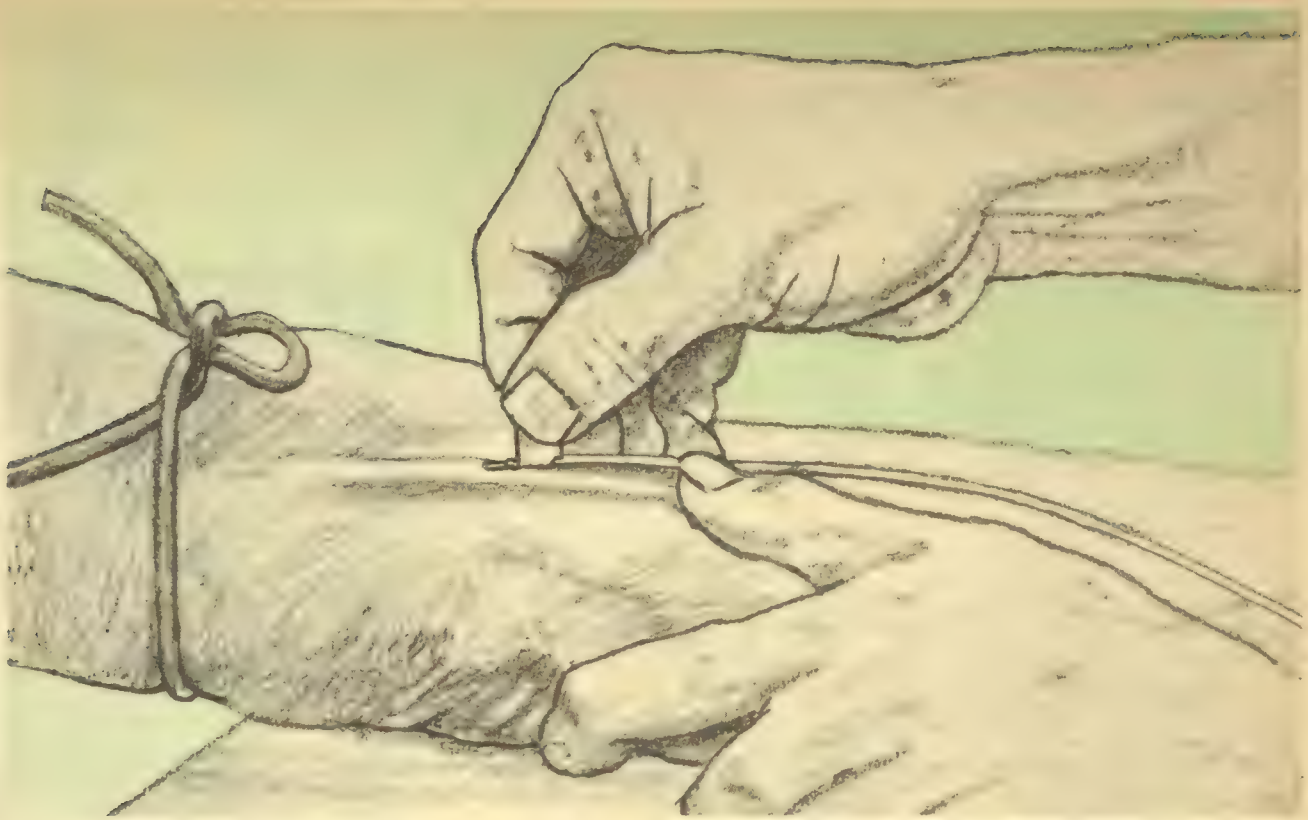
May 31-June 12, 1970
Ninth annual residential summer course on Alcohol and Problems of Addiction, Brock University, St. Catharines, Ontario. Co-sponsored by Brock University and the Addiction Research Foundation of Ontario. Enrollment is limited to 80. Basic information and findings of current research relating to the misuse of alcohol and other drugs will be presented. Provision will be made for discussion of prevention and treatment aspects of addiction problems. Address enquiries to: Summer Course Director, Education Division, Addiction Research Foundation, 344 Bloor Street West, Toronto 181, Ontario.

June 1-3, 1970
70th annual meeting of the Canadian Tuberculosis and Respiratory Disease Association and the 12th annual meeting of The Canadian Thoracic Society, will be held at the Fort Garry Hotel, Winnipeg. Further details are available from Dr. C.W.L. Jeanes, Executive Secretary, CTRDA, 343 O'Connor Street, Ottawa 4, Ontario.

June 1-3, 1970
Annual meeting of the Canadian Conference of University Schools of Nursing with the Learned Society at the University of Manitoba, Winnipeg. For further information, write to Margaret G. McPhedran, President, CCUSN, The University of New Brunswick, Faculty of Nursing, Fredericton, N.B.

June 15-19, 1970
Canadian Nurses' Association General Meeting, The Playhouse, Fredericton, New Brunswick.

June 22-July 3, 1970
Two-week conference for hospital personnel, Memorial University of Newfoundland, St. John's. Theme: Administration. Further information is available from the Association of Registered Nurses' of Newfoundland, 67 LeMarchant Rd., St. John's, Nfld. □



Use Abbott's Butterfly Infusion Set in an adult arm?

Certainly. The fact is, today more Abbott "Butterfly Infusion Sets" are used in adult arms and hands, etc., than in infant scalps.

Good reason.

Abbott's Butterfly Infusion Set simplifies venipuncture in difficult patients. It has proved fine in squirming infants. But it has proved equally helpful in restless adults, and in oldsters with fragile, rolling veins. And, once in place, the small needle, ultraflexible tubing, and stabilizing wings tend to prevent needle movement, and to avoid vascular damage.

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The Butterfly wings are flexible. Like a butterfly. They fold upward for easy grasping. They let you manoeuver the needle with great accuracy, even when the needle shaft is held flat against the skin.

Then, once the needle is inserted, the wings spread flat. They conform to the skin. They provide a stable anchorage for taping. The needle can be immobilized so securely and so flat to the skin that there is little hazard of a fretful patient dislodging or moving it.

Five Peel-Pack Sets

To accommodate patients of various ages, Abbott supplies Butterfly Infusion Sets in 5 sizes. Four provide thinwall (extra-capacity) needles. The Butterfly-25, -23, -21 and -19 come with a small-lumen vinyl tubing. The 16-gauge size, however, provides tubing of proportionately enlarged capacity, and thus is particularly suited to mass blood or solution infusions in surgery.

The sets are supplied in sterile "peel-pack" envelopes. Just peel the envelope apart. Drop the set onto a sterile tray—it's ready for use in any sterile area. Your Abbott Man will gladly give you material for evaluation. Or write to Abbott Laboratories, Box 6150, Montreal, Quebec.

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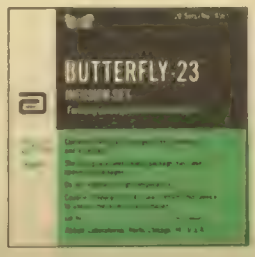

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Stelabid Forte

Stelabid Forte, an addition to the Stelabid line, is now available from Smith Kline & French Canada Ltd.

Stelabid Forte contains 50 percent more of the anticholinergic Darbid than its companion products (Stelabid No. 1, Stelabid No.2, and Stelabid Elixir). It is indicated for use in patients who require additional therapy to control hypersecretion or spasm. Stelabid Forte also contains 2 mg. of Stelazine in combination with its 7.5 mg. of Darbid.

Since both components of Stelabid Forte are long-acting, the product can be administered b.i.d. for convenience and economy. Like the other Stelabid products, it is indicated in a wide variety of gastrointestinal disorders.

Stelabid Forte is available on prescription only, in bottles of 100 maize-colored, monogrammed tablets.

Enema Kit

The unique foil closure on this disposable enema bag can be shaped into a rigid funnel for filling, then folded over to form a secure closure. The one-piece bag is dielectrically sealed for strength and eliminates the nuisance of assembly or leakage. The positive action shut-off clamp can be operated with one hand.

The kit is compactly boxed and complete with all items needed for procedure: 1,500 ml; 60 inches of 24 Fr. tubing with clamp; castile soap packet; lubricant; and waterproof underpad.

This MacBick product is available from the Stevens Companies in Toronto, Calgary, Winnipeg, and Vancouver, and from Compagnie Medicale & Scientifique Ltée. and Quebec Surgical Company in Montreal.

Leather Cuff

This new padded leather cuff, introduced by the Posey Company, is for the most active patients. The Kodel polyester padding is held in place by Velcro and can be removed for easy laundering. This cuff can be worn without padding if desired.

Each cuff comes with a 36-inch strap with a new friction type keylock buckle that allows desired arm movement. The leather cuff, lined, is Cat. No. 5163-2205, and the unlined leather cuff is Cat. No. 5163-2204.

For further information, write to Enns & Gilmore Ltd., 1033 Rangeview Road, Port Credit, Ontario.

Ear Drops

Burroughs Wellcome & Co. (Canada) Ltd. has announced a new product. Lidosporin ear drops 7.5 cc. come in a new plastic dropper packing and are being promoted for over-the-counter sales. Indication: earache. For more information, write to: Burroughs Wellcome & Co. (Canada) Ltd., P.O. Box 500, Lachine, Quebec.

Literature Available

Extracorporeal Medical Specialties, Inc., has published a four-page illustrated brochure describing the use of SAF-T-Shunt Series S-300 silicone cannulas and Series T-400 Teflon tips for customizing arteriovenous shunts at the operating table. The cannulas and tips find wide application in terminal renal disease, where patients must be connected to external dialyzers for chronic hemodialysis.

Brochures are available free of charge from: Extracorporeal Medical Specialties, Inc., Church Road, Mount Laurel Township, New Jersey 08057, U.S.A.

Ultrasound Diagnostic Instrument

A new ultrasound diagnostic instrument called the Vidoson, developed in Germany, is proving popular among gynecologists and doctors of internal medicine, according to a report from *German Features.*

The instrument sends out low frequencies that reflect off organs, tissue, and bone with varied impulses, depending on the intensity and composition of the reflector. Tumors reflect a different impulse than adjacent healthy tissue. The impulses are recorded on a screen and can be evaluated there by diagnosticians.

Menotrol Tablets

E.R. Squibb & Sons Ltd. has introduced Menotrol for control of the menopausal syndrome.

Menotrol tablets are available as small, sugar-coated tablets in potencies of 0.3 mg, 0.625 mg, 1.25 mg, and 2.5 mg. The potency is expressed in terms of sodium estrone sulfate content.

Advantages of Menotrol are: standardized potency for uniform activity; tablets that are easy to take; attractive, compact 21-day regimen package; and flexibility of dosage.

Further information can be obtained from E.R. Squibb & Sons Ltd., 2365 Côte de Liesse Road, Ville St. Laurent, Montreal 9, P.Q. □

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Now in 3 disposable forms:

- **Adult** (green protective cap)
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Fleet — the 40-second Enema* — is pre-lubricated, pre-mixed, pre-measured, individually-packed, ready-to-use, and disposable. Ordeal by enema-can is over!

Quick, clean, modern, FLEET ENEMA will save you an average of 27 minutes per patient — and a world of trouble.

WARNING: Not to be used when nausea, vomiting or abdominal pain is present. Frequent or prolonged use may result in dependence.
CAUTION: DO NOT ADMINISTER TO CHILDREN UNDER TWO YEARS OF AGE EXCEPT ON THE ADVICE OF A PHYSICIAN.

In dehydrated or debilitated patients, the volume must be carefully determined since the solution is hypertonic and may lead to further dehydration. Care should also be taken to ensure that the contents of the bowel are expelled after administration. Repeated administration at short intervals should be avoided.

Full information on request.

*Kehlmann, W. H.: Mod. Hosp. 84:104, 1955

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Quote of the month

Our monthly award of a wreath of poison ivy goes to a senior medical student at the University of Western Ontario. When asked by a reporter from *The Medical Post* if he thought the doctor has to be master and the other members of the health team the sevants, he came up with this erudite answer:

"I do not think the master-servant relationship exists in most of the supportive staff, the psychologists and sociologists with which we work. These people are really the doers and we are the onlookers. *But when you get into the field of internal medicine you run into staff conflicts with nurses and they are sometimes hard to overcome unless you are the boss."* (Italic ours.)

This boy will go far. We hope.

Cure for wandering nurse

How do you keep enough nurses working in intensive care units?

The problem of a nursing shortage in ICUs was discussed in a news item that appeared in the October 4 edition of the *Kitchener Waterloo Record.*

According to Dr. Frank Walker, coordinator of the intensive care unit at St. Joseph's Hospital in London, Ontario, the biggest single stabilizing factor in the supply of ICU nurses is marriage. "Married nurses seem to stay with us longer than single types," he said.

Many nurses might prefer the ICU prescription of Dr. Gordon Sellery, coordinator of the ICU at London's Victoria Hospital: "If there's any way to keep them, it's to keep them happy. This means that their environment should be pleasant and stimulating." Last, but not least, Dr. Sellery thinks that a younger doctor should be in charge of the unit.

Convention key

It's not too soon to be planning your strategy for CNA's biennial meeting in Fredericton in June. Planning how you can get the most out of attending a convention is an important step toward effective participation.

Here are some helpful suggestions from the September-October issue of *HospitAlta,* published by the Alberta Hospital Association.

• *Evaluate the program:* Study all sessions, speakers, social functions, etc., well in advance, to get them fixed in your mind. Underscore those that interest you the most. Then some last-minute distraction is less likely to divert you.

• *Summarize your needs:* One of the main reasons for holding a convention is to bring members together so that they can exchange ideas and solve each other's problems. Jot down your concerns and dilemmas and bring your notes to the meeting. Use it as your shopping list for first-hand advice and suggestions.

• *Command attention:* Speak up at the convention. Don't wait to be called upon. Take advantage of discussion periods and answer as many questions as you can. There is a way to do this without dominating. First, hold back to see if others have an answer; second, accumulate three or four unanswered points and tie them together when you speak.

• *Keep on the go:* Circulate – don't hide. Breakfasts, luncheons, and impromptu "bull sessions" sometimes yield better returns than formal sessions. You can absorb a good deal by mingling with people and talking shop. Eat with someone different at every meal. "Float" at parties and receptions. The person you have not spoken to yet may help you most.

• *Get directions:* If you don't know who can help you with a problem, speak to an officer or staff member. They will steer you to the experts.

Does Jane Cowell know the facts about dandruff?

Probably not!

The facts are dandruff is a medical problem and requires medical treatment. Ordinary shampoos cannot control dandruff.

New formula Selsun can!

The doctors you know are undoubtedly familiar with Selsun. And they prescribe it because it's medically recommended. And proven effective in 9 out of 10 severe dandruff cases.

Our new formula Selsun is as effective as the old. We use the same efficient anti-seborrheic — selenium sulfide. We've simply improved the carrier. A more active detergent produces foamier lather — a finer suspension gives smoother consistency.

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To top off new formula Selsun we added a fresh clean fragrance and put it in an attractive unbreakable white plastic bottle.

If you know someone with a dandruff problem tell them to ask their doctor about Selsun. And if dandruff worries you — ask your own doctor.

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SPECIAL REPORT

Ad Hoc Committee of the Canadian Nurses' Association on Functions, Relationships, and Fee Structure

Completed December 1969

CHAPTER 1
The Committee and its Assignment

At the 34th General Meeting of the Canadian Nurses' Association held in Saskatoon, Saskatchewan, July 1968, the following resolutions were passed:

1. "That an ad hoc committee be appointed by the board of directors of the Canadian Nurses' Association with the addition of consultants as required and that this committee be empowered to study:
   a) The national and provincial associations' functions and relationships;
   b) The question of membership and fee structure and that the report of this study, with recommendations, be available to the provincial associations six months prior to the 1970 General Meeting."
2. "Whereas difficulties have been encountered with respect to the amendments to the Act of Incorporation and this has resulted in uncertainty with respect to the bylaws of the Canadian Nurses' Association;
   Now be it resolved that the board of directors of the Canadian Nurses' Association immediately establish an ad hoc committee on legislation to study over the coming months the incorporation documents and bylaws of CNA to determine what, if any, amendments appear to be required, and that this committee report on these matters to the next general meeting of the association and that the Canadian Nurses' Association operate under its present bylaws until this report is accepted."

These resolutions formed the terms of reference for the ad hoc committee on functions, relationships, and fee structure appointed by the board of directors in meeting on July 12, 1968. The members of the committee are as follows: Miss K. Marion Smith, representing British Columbia; Miss Madge McKillop, representing the Prairie Provinces; Miss E. Marie Sewell, Ontario; Mlle Madeleine Jalbert, Quebec; Mrs. Marilyn Brewer, New Brunswick; Miss Dorothy Wiswall, Nova Scotia; Miss Elizabeth Summers, later replaced by Miss Janet Story, representing Newfoundland; Reverend Sister Mary Irene, Prince Edward Island; Reverend Sister Mary Felicitas, president, CNA, ex-officio; Mrs. Jeanie S. Tronningsdal, chairman.

In setting up the committee, the board of directors received the recommendation of each of the provincial associations regarding its representation. The three Prairie Provinces, because of distances, agreed to have one representative.

CHAPTER 2
An Outline of Committee Activities

The chairman of the committee met with the president in Ottawa October 10, 1968, to obtain background information regarding the committee's assignment.

The committee held three meetings at CNA House. At the first meeting, January 9 and 10, 1969, it was agreed that a member of the committee would serve as secretary, on a rotating basis. Accordingly, Madge McKillop, E. Marie Sewell, and K. Marion Smith have served in this capacity.

At this meeting the committee identified the functions and activities of the CNA and related these to its objectives as stated in the Act of Incorporation. It was decided that these functions and activities should serve as the basis of a questionnaire along with items on national-provincial relationships and fee structure. The questionnaires were distributed to provincial associations and to the board of directors and the professional staff of the CNA, with the request that they be completed and returned by March 31, 1969.

At the second meeting, held May 8 and 9, 1969, the completed questionnaires were reviewed in detail. A summary of the replies is included in Chapter 4. The committee scheduled interviews during this meeting with CNA editors, consultants, general manager, associate executive director, and executive director. This gave the committee the opportunity to clarify items in the questionnaire, and allowed the staff to express personal views.

At this meeting the president informed the committee that the board of directors, at its meeting February 11-14, had met with the legal counsel of the CNA and his associate to consider the changes in the bylaws and any new bylaws that are necessary in order that the CNA bylaws conform with Part II of the Canada Corporations Act. Since it appeared that the board of directors was considering the necessary changes to bring the CNA under the Canada Corporations Act, Part II, this committee agreed that at this time it was not feasible to take action regarding bylaws.

A draft report was prepared by the chairman, using material from the minutes, completed questionnaires, and comments from committee members. At the third meeting, held September 25, 26, and 27, 1969, the draft report that had been circulated to the committee members was reviewed in detail and revised to formulate a report for presentation to the board of directors at its meeting in November, 1969.

In the light of discussion at the meeting of the board of directors, three members of the committee revised sections of the report immediately following this meeting. The report was again circulated to the committee members for approval prior to its final release.

CHAPTER 3
Pertinent Information Regarding CNA

The Canadian Nurses' Association, founded in 1908, was incorporated in 1947 and the Act of Incorporation was revised in 1954. In keeping with a federal government trend that it is preferable for professional associations to operate under the Canada Corporations Act Part II, rather than private bills, the CNA currently is considering steps to accomplish this.

The objects of the association are stated in the present Act of Incorporation as follows:

1. to dignify the profession of nursing by maintaining and improving the ethical and professional standards of nursing education and service;
2. to encourage its members to participate in affairs promoting the public welfare;
3. to promote the best interests of the nurses of Canada and to maintain national unity among them;
4. to encourage an attitude of mutual understanding with the nurses of other countries; and
5. such other lawful acts and things as are incidental or conducive to the attainment of the above subjects.

In the present Act of Incorporation, the membership of the association is divided into the following classes: 1. honorary member; 2. association members; 3. ordinary members; and 4. any other class or classes of members which the association may establish by bylaw from time to time.

The affairs of the association are managed by a board of directors. The board is composed of the elected officers, the appointed chairmen of the three standing committees, the president of each of the 10 provincial associations, and elected representatives from the nursing sisterhoods. The board reports at each general meeting upon the business transacted since the last general meeting and is expected to make decisions and take all such appropriate action as is necessary to further the objects of the association. It carries out the legislative functions of the association. The number of voting delegates for general meetings is determined by the number of members in each provincial association.

The executive committee of the board of directors has the power to administer the affairs of the association between meetings of the board of directors. It is composed of the elected officers and the appointed chairmen of the three standing committees. It carries out the cabinet functions of the association.

The board of directors has the responsibility and authority to appoint the executive director and to delegate the implementation of association policies to this position. The executive director is the senior administrative officer of the association and acts as secretary to the board of directors and to the executive committee. All members of staff of the CNA are ultimately responsible to the executive director and through her to the board of directors.

The income of the CNA is provided through an annual membership fee paid on behalf of each ordinary member. The amount of the fee is fixed by resolution of the general meeting of the association, is collected by the provincial association to which each member belongs, and is remitted to the CNA semi-annually.

A number of the functions and activities of the CNA are mandatory to meet the requirements of the Act of Incorporation. The programs that are carried out by the association are established in accordance with the wishes of the membership and in light of the available financial support.

Relationships with other organizations are determined in accordance with criteria established by the board of directors. Every relationship reflects one or more of the objects of the association. At present, the CNA has relationships with 22 national and international organizations.

CHAPTER 4
Responses to the Questionnaire

The completed questionnaires from the executive committee of the CNA, on behalf of the board of directors, from the 10 provincial associations and from the staff of the CNA proved extremely helpful to the committee in its deliberations. Information that emerged from the questionnaires and from interviews with the staff is dealt with here under the main groupings as identified in the questionnaire.

Part I — Objectives, Functions, And Activities

The functions identified by the committee consist of the secretariat services, the representative services, and the research and advisory services. These functions and resulting activities are based on the needs of the membership who develop objectives, formulate policies, and provide the finances for the services. Administrative, public relations, and communication roles are woven through all activities and form an integral part of each function. It is recognized that some of the functions and activities of the CNA are mandatory and others are voluntary.

The responses to the questionnaire indicated that the functions identified by the committee were acceptable. The comments helped the committee to identify the following common factors.

1. There is a strong support in all the provinces for the CNA, although there is some difference of opinion on its functions.
2. The administrative structure of the CNA is questioned. It is recognized that there are certain basic business functions required, regardless of the programs undertaken. There appears to be a lack of understanding, however, of the administrative function and concern that this function is given more emphasis than the professional functions.
3. There is a need for more complete services in all aspects

of the association's activities for the French-speaking members of the CNA.

4. There is support for *The Canadian Nurse and L'infirmière canadienne* journals, with suggestions that more emphasis be placed on reporting research.
5. It is suggested that special services, such as the Canadian Nurses' Foundation and the National Testing Services, should be set up to be self-supporting.
6. The membership expects the CNA to act as its official spokesman to government, to allied organizations, to the public, and to its own members and suggests that this function should increase.
7. It is suggested that the role of the consultant requires examination. When this service is requested, the responses are emphatic that a charge should be made. It is recognized that this might work a hardship on some provinces.
8. It is recognized that the library provides a valuable national service which is not available from other sources. It is suggested that the library could be called upon to provide advisory services in the audiovisual field in view of the rapid changes and developments that are taking place.
9. The consensus is that the CNA should not be engaged in the running of workshops and conferences.

Part II — National-Provincial Relationships

It was stated in the questionnaire that functions and activities of the national and provincial associations may complement, overlap, or be in conflict.

There are some areas of difficulty in the relationships between the CNA and the provincial associations. The following common factors were elicited from the responses.

1. There would appear to be a lack of understanding of the unique role of each association.
2. There would appear to be duplication of services in some of the consultant and educational activities.
3. The interpretation of activities to members has presented problems, but indication was given that communications are improving.
4. The role of the standing committee member is not understood. She is appointed to represent her provincial association in a particular field, but at national committee meetings she is not considered as a representative from her association but rather a "national" nurse. It is suggested that the number of national committee meetings should be reviewed and the possibility of including provincial counterparts at these meetings should be considered.

Part III — Fee Structure

The types of fee structures used in financing organizations, i.e., a fixed per capita fee and a variable fee, were explained in the questionnaire. Each association was asked to react to the possible adoption of a sliding scale for the payment of fees to the CNA.

The majority of replies favored the retention of a fixed per capita fee structure. Six were not in favor of adopting a sliding scale, three would accept it with reservations in time of crisis, two were in favor, and one association withheld comment until receiving more information. It was pointed out that any kind of a sliding scale would be more expensive to administer. Any fee scale would need to be designed to produce the funds required to cover the cost of approved programs.

CHAPTER 5
Recommendations and Summary

Recommendations

In the light of replies to questionnaires, discussions with staff, and committee deliberations, the following recommendations are presented for consideration.

Objects

The functions and activities of the CNA are carried out to fulfill its objectives.

Recommendation 1

It is recommended that the objects of the association be restated as follows:

1.1 To promote high standards of nursing practice in order to provide quality nursing care for the people of Canada.

1.2 To promote educational programs required to achieve high standards of practice.

1.3 To encourage an attitude of mutual understanding and to promote unity among nurses.

1.4 To speak for Canadian nursing and to represent Canadian nursing to other organizations on national and international levels.

1.5 To foster and participate in affairs contributing to community services.

1.6 To promote the social and economic welfare of the nurse in the practice of her profession.

Membership

The CNA is a federation of provincial nurses' associations. The nurses of Canada participate in the national association only by virtue of membership in a provincial association.

Recommendation 2

It is recommended that the membership of the CNA consist of the nurses' associations of the provinces as listed in the Act of Incorporation, or territory or any division of any territory in Canada or the respective successors and assigns of such associations, and such other classes of members as the association may establish by bylaw from time to time.

Fee Structure

Careful consideration was given to the types of fee structures commonly used for financing organizations. A sliding scale was considered, but presented several adverse implications.

Recommendation 3

It is recommended that the Association be financed on a per capita fee basis with the amount to be determined according to the bylaws.

Role of the National Association

There appears to be a necessity to clarify the role of the national association in relation to the provincial associations.

Recommendation 4

It is recommended that the role of the CNA be:

4.1 To lead, to coordinate, and to advise.

4.2 To be the voice for nursing on national and international levels.

4.3 To act as a catalyst for change by identifying trends and helping to implement new programs in the health, social, and welfare fields.

4.4 To develop statements of policy on matters of national jurisdiction or of national interest and to prepare position papers on other matters.

4.5 To initiate workshops and conferences in relation to the biennial meetings or in areas of particular national interest.
4.6 To explore with the provincial associations methods to improve the exchange of information.
4.7 To provide assistance and advice to provincial associations on request.

Role of the Provincial Association

Certain functions are the prerogative of the provincial associations.

Recommendation 5

It is recommended that the role of the provincial associations be:

5.1 To fulfill the legal requirements relating to membership in the association.
5.2 To recommend standards for schools of nursing.
5.3 To implement programs for the continuing education of its members.
5.4 To formulate policies for the social and economic welfare of its members.
5.5 Where applicable, to act as the bargaining agent for the membership.
5.6 To be the voice for nursing in provincial matters.
5.7 To explore with the national association methods to improve the exchange of information.

Board of Directors

The board of directors is a policy-making body acting as the representative of the total membership of the national association. It is responsible for setting priorities and establishing programs to meet the objectives of the association. At present, the board is made up of the elected officers, the appointed chairmen, the elected representatives from the nursing sisterhoods, and the presidents of the provincial associations. The executive director acts as secretary at all meetings. It would seem that national needs could be met more satisfactorily if a different method were used in providing for membership on the board, and if all members served for a two-year term.

Recommendation 6

It is recommended that the following changes be instituted in determining the membership of the board of directors:

6.1 The chairmen of the standing committees be elected rather than appointed.
6.2 There be no specific representatives elected from the nursing sisterhoods.
6.3 A member, not necessarily the president, be elected by and from each provincial association.

National Committees

The importance of the three national standing committees is recognized. Since the chairman of the provincial committee is also the provincial representative on the national committee, with consequent dual responsibility, her two roles may be frequently in conflict. Therefore, the national needs might be more satisfactorily met by a representative from the province other than the chairman.

Recommendation 7

It is recommended that the provincial representative on the national standing committees be selected by and from each provincial association for a two-year term.

Research and Advisory Services

The board of directors approves projects and ascertains the direction the CNA is to take in the future, in the light of the financial capabilities of the association.

Activities related to professional advancement objectives need to be examined on two planes:

i. a general examination, such as gathering statistics, acquiring library holdings, conducting library research, and attending meetings;
ii. specific examination in each of the three fields of nursing education, nursing service, and social and economic welfare.

The program emphasis at any one time will depend upon current needs. Thus, the role of the nursing consultants will change also in relation to the implementation of new programs.

Recommendation 8

It is recommended that there be well-qualified nursing personnel in the research and advisory services to undertake approved programs.

French Services

There is need for the services provided by the CNA to be available in the two official languages.

Recommendation 9

It is recommended that the CNA appoint a senior member of staff, whose mother tongue is French, to provide French-speaking members with services comparable to those presently available to English-speaking members.

Special Services

The committee received comments about the Canadian Nurses' Foundation and the National Testing Service. The majority supported both these activities, providing they did not necessitate a financial outlay by the CNA.

Recommendation 10

It is recommended that as soon as feasible the Canadian Nurses' Foundation and the National Testing Service be self-supporting financially.

Administrative Review

It has been a number of years since a comprehensive review of the administrative structure of the CNA was undertaken. It is realized that ongoing review of the organization and functions of the association is part of the role of both the board of directors and the staff of the association.

Recommendation 11

It is recommended that the board of directors, in consultation with the staff, undertake a review of the administrative structure.

Summary

The ad hoc committee recognizes that the acceptance of its recommendations would necessitate changes in the bylaws of the CNA.

The committee has tried to formulate recommendations to provide for a viable association in a changing society. It is recognized that any such guidelines must be sufficiently flexible to permit easy adaptation to new situations. It is also recognized that because of the difficulty of carrying out an in-depth review of the work of the association by those most intimately involved in its activities, it may be well to consider periodic establishment of an ad hoc committee to carry out an assignment similar to this committee's. This type of review should help to set the direction for the association and to make planned adjustments as required. □

From Canada to Biafra

In October 1969, Dianne North, a Canadian RN on her way back to war-torn Biafra after a five-month absence, was interviewed at CNA House. Shortly after this article was prepared for publication, the war between Nigeria and Biafra ended, and Dianne was evacuated to Saô Tomé. Even so, the editorial staff believe this article will be of interest to nurses. The war is over, but the suffering continues.

Carol Kotlarsky

The nurse is Canadian, but the setting is African. Dianne North is shown here on the grounds of the Queen Elizabeth Hospital in Umuahia, Eastern Nigeria. She was the only Canadian nurse working in this region throughout its 31-month fight for independence as Biafra.

Dianne North is the only Canadian nurse working in Biafra, the Eastern region of Nigeria.*

A graduate of the Toronto Western Hospital and Queen's University in Kingston, Ontario, Dianne began working at the Queen Elizabeth Hospital in Umuahia, Eastern Nigeria, as a nurse with Canadian University Service Overseas. She enjoyed her work at this hospital so much that in 1966, when her contract with CUSO was completed, she signed a two-year contract with the hospital.

When Dianne first arrived at the Queen Elizabeth Hospital, she found a modern, well-equipped complex that could accommodate some 180 patients, had 150 student nurses from Eastern Nigeria, and a busy outpatient department. There were two medical and two surgical wards, one pediatric ward, two large buildings for maternity, and two operating rooms. The hospital was run by Anglican, Presbyterian, and Methodist churches from Scotland, Ireland, and Canada and was subsidized by the Nigerian government.

A sister tutor from England was in charge of the school of nursing, which was based on the British system. After four years, students became Nigerian registered nurses (NRN). Dianne explained to us that the NRN is not equivalent to the state registered nurse in Britain or to the registered nurse in Canada.

Instruction begins on wards

Dianne, who had been a clinical instructor on the surgical ward at the University of Alberta before she left Canada, was the only clinical teacher at Nigeria's Queen Elizabeth Hospital. Soon after she began teaching surgery in the classroom, she decided to introduce clinical instruction on the wards. The custom in African study, Dianne explained, is for the students to read a book, memorize it, know the material perfectly, yet have no idea how to relate the theory to the practice of the subject. Clinical instruction was an ideal way to break this down, she added.

It was exciting and challenging, Dianne said, to do her surgical teaching in the classroom and then relate this to patients with special ward assignments. For example, a student nurse would be assign-

*At the end of May 1967, the Eastern region of Nigeria declared itself an independent state – Biafra. Federal Nigerian forces moved quickly to end the secession, and the fighting ceased January 1970.

Miss Kotlarsky, a graduate of Carleton University's School of Journalism, is presently Editorial Assistant, *The Canadian Nurse*.

The Canadian UNICEF Committee is launching a national appeal for funds to support UNICEF's specialized work with mothers and children in Nigeria. Donations would be gratefully accepted at UNICEF, 737 Church Street, Toronto 5, Ontario.

This Biafran mother and her child mirror the plight of the thousands of victims who crowded the medical and surgical wards at the Biafran refugee camps during and after the war.

A nurse tube-feeds a Biafran child in a refugee camp in the Eastern Region of Nigeria.

ed three or four patients, would have to go to them and assess their condition, decide what she had to do for them, discuss this with the teacher and, in Dianne's words, "get on with the business."

In another type of ward assignment, students prepared nursing care studies by talking with patients and observing them carefully. The students then gathered in a circle on the verandas to talk about their patients, the care they were getting, should have been getting, and so on. Dianne found that this was a good learning experience as these ward clinics were popular with the students. One problem, however, was that there were not enough nurses to give this complete care.

War means change

The war, which began in 1967, disrupted the hospital's teaching program. Classes were forced to stop temporarily, but resumed when the number of casualties admitted to the hospital decreased. Fourth-year students were prepared for their final examinations twice and both times military uncertainty made the administration of the tests impossible.

"By this time the girls were so demoralized and disappointed that we felt it was too hard on them to keep them in class," Dianne said. She explained that it was better for the students to work in the hospital than to go to class and wait tensely for the inevitable air raid. About a year ago, March 1969, classes stopped completely.

Before the war there were 150 nurses on staff at the Queen Elizabeth and six doctors, mainly European. The majority of Biafran doctors, Dianne said, preferred to go to larger cities such as Port Harcourt, Enugu, or Lagos, the Nigerian capital.

With more and more of the larger hospitals occupied during the war, the Queen Elizabeth became the biggest and busiest hospital in Biafra. Its staff increased to 35 doctors – mostly Biafran – and over 250 nurses.

Dianne spoke enthusiastically of the skill of the Biafran doctors. Many had come to the Queen Elizabeth from the best hospitals in West Africa and had received much of their training in Britain and America.

So much accomplished

The doctors organized themselves into two teams. Each night one team did all the admitting, whether there were four casualties or sixty. This team, Dianne recalled, would perform up to 10 laparotomies, apply 15 to 20 plaster of paris casts, and suture countless numbers of wounds.

The nurses, too, were well organized and continued to work eight-hour shifts, overlapping an hour at the most, six days a week. "But we were working at a much greater pace and with the stress we got more done," Dianne said. At the same time the nurses finished a day's work more exhausted mentally and physically because of the strain.

Dianne vividly described the overcrowded conditions at the hospital: "On the busiest day I can remember, there were 135 men on a ward that normally held 35. They were on the beds, under the beds, and were forced out of the ward onto the verandas outside. When we came on duty in the morning we *had* to cope with these 135 patients, of whom more than 30 had undergone surgery during the night.

"Miraculously enough," Dianne continued, "we would go on that ward the next morning and find that all the patients had been accommodated, had had their surgery, and had been bathed and cared for. She credited the student nurses with the extraordinary amount of work done. "First-year students did things that third-year students wouldn't

have known how to do in normal times," she said.

Hospital relocates

In April 1969 the Queen Elizabeth Hospital had to be evacuated. The Nigerians entered two nearby towns and, as Dianne described it, "for the first time we began to hear shooting and the sound of tanks."

At that time the hospital had 900 patients. With the help of the International Red Cross and the World Council of Churches, hospital personnel transferred all the patients to other mission and military hospitals during a three- to four-day period. Queen Elizabeth staff later started up small clinic work in a bush medical station about 10 miles from Owerri, which was the acting capital of Biafra.

Dying all around

Dianne quickly learned that in wartime death was an everyday occurrence. For example, she described what she saw on her way to the market.

"I would walk by adults and sometimes even children just lying in the ditches. I didn't know if they were dead or half dead and I didn't bother to stop. I could tell by their appearance that they were so far gone that even if I brought them into the hospital, no resuscitation would help. Also, we had no more room." She added that patients often died in wheelchairs waiting in the outpatient department.

Protein deficiency was initially the worst problem created by the food shortage, but starvation itself has become worse, Dianne said. And it is now reaching the adults, not just the children. She pointed out that two million Biafrans are estimated to have died since the war began, about one and one-half million from starvation. "From what I saw in the hospital, in the town of Umuahia, and in the refugee camps I went to see," she added, "these catastrophic numbers have not been overestimated."

Conditions at the Queen Elizabeth have deteriorated since last May, Dianne said. Until that time relief flights had operated effectively, bringing in dried milk, dried fish, powdered eggs, and drugs that were sufficient to keep all the hospital, sick bay, and refugee populations healthy. However, since the Nigerians destroyed an International Red Cross airplane bringing relief supplies into Biafra in June 1969, the Red Cross has stopped its relief flights into Biafran territory, which is only accessible by air.

At least two hospitals have suffered from the bombing, Diane said. The Mary Slessor Hospital in Itu, 30 miles south of Umuahia, was almost completely destroyed by a systematic bombing raid that struck four times, and the Itigidi Hospital was completely flattened.

Returning to Biafra

When Dianne left Biafra last May, she was not sure if she would return. "There was no special job for me and there is no use going to that country unless there is something specific to do – it's a soul-destroying business," she explained.

During the summer, however, Dianne was invited to work at a neurological clinic at Ekwereazu. She explained that she would still be an employee of the Queen Elizabeth Hospital, on loan to the

There was not room for these wounded soldiers at the Queen Elizabeth Hospital in Umuahia, Eastern Nigeria. In April 1969 the 900 patients in the 185-bed hospital had to be evacuated because of nearby fighting.

clinic. Patients with gunshot wounds to the head and the spine are brought to this clinic from different parts of Biafra. The clinic also cares for patients with hemiplegia, paraplegia, and speech defects, and has a separate building for many of the amputees. Dianne said there is an excellent physiotherapist in charge.

There is a great need for morale-boosting at the clinic, Dianne told us. As well as helping the patients, she hopes to make things easier for the understaffed and war-weary clinic personnel.

Postscript

Dianne was able to spend a short time with her parents in Aurora, Ontario, before returning to Biafra at the end of October. In November she sent a letter to her friends in Canada telling of her return to Biafra and the conditions she found there. Here are some excerpts from her letter:

"Essentially, things haven't changed since I left 5 months ago: food and drugs are still scarce, people continue to die (but at an increased rate) and the military situation has remained relatively stagnant so that hospitals are full of the chronically ill or those needing rehabilitation. One cup of salt costs $21.00; a battery, $21.00; a pen, $3.00; an egg, 75 cents, etc.

"Driving to Mbaitoli, Owerri, on Sunday, I saw the matchstick legs and bony ribs of the children rather than the puffy faces and tummies characteristic of the protein deficiency disease, kwashiorkor, which was rampant here about a year ago. I don't know which is worse." □

Progressive stages of kwashiorkor, caused by severe protein deficiency. The suffering of the children in the region known as Biafra was the most tragic outcome of the Nigerian war.

Adapting instruction to individual differences

Grouping students by ability gives the teacher a better opportunity to meet their individual needs.

Betty McInnes, B.Sc.N., M.Sc. (Ed.)

In September 1968 our biology team at St. Joseph's School of Nursing in Hamilton, Ontario, adopted a relatively new method of class division: we grouped students according to their ability, rather than by random. Called "ability grouping" or "homogeneous grouping," this method places students in work groups that are alike, so that ranges in differences within a class are reduced to some extent. Nursing biology was considered the ideal course for such an approach as our students all had a varied background in science.

As simple as the ability grouping approach appears, much confusion often exists because different educators use different bases for deciding how students are alike. Our reference source is James B. Conant, an educator in the United States.[1,2] Although Conant admits that ability grouping is highly controversial, he endorses ability grouping in one subject-matter area, but not across-the-board grouping in all subjects, as this tends to segregate students.

This type of grouping is necessary only if the teacher is dealing with large numbers of students. If the class consists of no more than 32 students, such grouping is unnecessary and impractical as the teacher can organize the work within the classroom to meet each student's needs and abilities. We found that grouping for instruction in nursing biology has substantial value since groups proceed at different rates and cover different amounts of material, according to their past experience with biology.

Teacher responsibility

Once we had chosen ability grouping as our method of approach, we then had to consider teacher selection. We looked for the following qualities: particular skills and preferences for working with pupils of one ability level; ability to make adjustments to suit the particular needs of the group; and wide experience in the classroom and clinical teaching areas, as appropriate correlation must be made between theory and practice.

How the students' interest, talents, and past experiences are used by the teacher will vary with the particular problem presented by each group. Common teaching elements must be differentiated in terms of particular students and particular situations or much of the instructional material is wasted.

We have found no educational magic in grouping itself. Little is gained by grouping if each group is taught the usual material in the usual way. With a select group, the teacher takes full responsibility for adapting content, method, and pace. She interprets the data comprising a particular course according to its meaning to the students.

The teacher's recognition of differences is seen in the way the group sessions are conducted, in the types of assignments given, in the materials selected for discussions, and in the degree to which the students participate in the course.

Initial student grouping

Heterogeneous grouping in past years led the biology teacher to direct her teaching to the "average" student, ignoring the other students. Most of these groups consisted of students of various levels of preparation in biology: high school students with a grade 12 diploma who had never studied biology; students from provinces other than Ontario who had studied different subjects; grade 13 students who had not selected biology as an elective; grade 13 students who chose biology as an elective, but obtained varying degrees of success; mature students who may or may not have studied biology at some point in their education, but who had been away from school for several years; and, finally, students with varying levels of interest in biology.

This diversification was further magnified by the size of the group, which ranged from 110 to 135. All factors considered, we felt justified in implementing ability grouping as an approach to our problem.

As the personal qualities of the new students were unknown at the time of the original grouping, our initial decision was based on the one common, familiar element – high school grades. Our reason for making this decision was based on an extensive analysis of the high school biology and science grades for the

Miss McInnes, a graduate of St. Joseph's School of Nursing, Hamilton, The University of Toronto, and Niagara University, New York, is Biology Team Leader at St. Joseph's School of Nursing in Hamilton, Ontario.

students admitted to our school during the past three years. This analysis provided the criteria for the four initial ability groupings in the biology course.

Group One was composed of all students who had taken grade 13 biology as an elective and had received a final average of 50 to 59 percent. *Group Two* was composed of students who had studied biology in high school and had obtained an average of 60 to 70 percent. *Group Three* remained the most heterogeneous in nature, consisting of six categories of students: grade 12 students with no biology instruction; grade 13 students who had taken biology as an elective but had obtained a final average of less than 50 percent; students who had been away from school for a number of years and who may or may not have studied biology; grade 13 students who did not choose biology as a high school elective; students from other provinces or countries who had not studied biology; and students from other provinces or countries who had studied biology, but the course content could not be evaluated in relation to the nursing biology course. *Group Four* was composed of grade 13 students who had obtained an average of 71 percent or more in high school biology.

Variables to consider when regrouping

Since most educators suggest that relocation and shifting of students among groups throughout the school year is necessary to avoid segregation, we decided that regrouping should take place at three set intervals in our 160-hour course. The first regrouping was carried out at the end of October following a biology examination; the second, following the Christmas examination; and the third, at the beginning of February, again following an examination. The course was completed in April.

The time of regrouping was decided by the team of teachers and was based primarily on examination schedules. The first relocation was considered the most important for two reasons: 1. When students are grouped according to test scores only – the basis of our original grouping – they still vary significantly in many other areas; 2. The decisions made at this stage might affect the student's adjustment and outlook on the entire course. Other factors considered were the student's motivation level, work habits, interest in subject matter, emotional background, and the number of extracurricular activities that competed with her studies.

The criteria evolved for regrouping students were: 1. interest in biology as demonstrated by class participation; 2. special ability for learning the sciences; 3. maturity to accept group placement and handle course content with its particular approach and stress level; 4. grades obtained on biology examinations; 5. initiative for self-learning versus directed learning; 6. judgment concerning degree of study necessary for success; 7. past experience with biological concepts in high school, or college; 8. personal problems creating stress that might inhibit learning.

To avoid segregation, the biology team also used the heterogeneous or large group approach at specific intervals in the course. At these times the entire group of 120 or more students met as a unit to participate in certain aspects of the course content. In this way all students were allowed equal participation and were able to see for themselves that they were all receiving the same basic content, although the approach was different.

Approach to each group

The basic assumption of the teacher assigned to *Group One* was that although these students had previously studied biology, their level of knowledge was minimal. All teaching methods chosen encouraged these students to become actively involved in their own learning; few lectures were given.

For *Group Two* the basic assumption was that this group already possessed an average knowledge of biology. These students were encouraged to find out for themselves more about the subject. The teacher and students agreed that most of the basic knowledge would be the responsibility of the students, and that group discussions would be used to clarify and enlarge on the subject matter.

In *Group Three,* the most heterogeneous of the groups, the teacher worked on the assumption that these students had little biological knowledge. The emphasis was placed on the presentation of basic, factual material. To enhance the factual knowledge and to make the ideas more concrete, as much correlation as possible was carried out between the theory and the actual nursing care. The lecture method was used, as well as discussion groups to clarify material. This group required guidelines, as the time element of the course caused too much stress if self-directed learning was required for too long.

In *Group Four* the basic assumption was that these students had an above average grasp of biological concepts. The emphasis was placed on a presentation to maintain the students' high degree of interest in self-directed study and research. Knowledge of basic principles was considered to be almost entirely the students' responsibility, and was reviewed only through short daily question and answer periods of approximately 10 to 15 minutes. The teacher's role was one of guidance and reference.

In each of the four groups students were required to evaluate their own progress as well as the teaching approach. In turn the teacher evaluated the students, either in a group process or in a private interview, as the situation warranted. All students were required to write the same basic examinations, but tests were used in the groups as the teachers deemed necessary. In this way students could be shifted between groups and not fear the examinations.

Summary

Our biology team has noticed that the students seem less inhibited, have greater self-esteem, and fewer feelings of insignificance than they had when placed in the traditional group setting. They are no longer afraid to comment, and they are able to determine for themselves what the biology course means to them.

Ability grouping does not entirely solve the problem of meeting individual differences. However, the possibility of adapting instruction to meet each student's needs is improved by reducing the range of differences. After using the method for one year most teachers and students at St. Joseph's School of Nursing have found this method effective and satisfying – so much so that we are continuing this year.

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Fredericton — something for everyone

History, culture, and beauty combine to make New Brunswick's capital, Fredericton, a delightful place for nurses to visit during the biennial convention of the Canadian Nurses' Association, to be held here June 14-19, 1970.

Valerie Fournier, B.J., B.A.

A bronze statue of Lord Beaverbrook dominates historic Officer's Square in central Fredericton. The beaver sculpture was an 80th birthday present to Lord Beaverbrook.

Known as the city of stately elms and as "the poets' corner of Canada," Fredericton is also fast becoming the hub of central New Brunswick's economic expansion. It is a city of pleasing contrasts, combining old world charm with a bright, modern face.

Fredericton's origins lie deep in the early history of Canada. The city owes much to its river, the Saint John, which was a natural highway for the Maliseet Indians who first camped at the site of Fredericton. Next came Acadian settlers, who established a thriving village known as St. Anne's Point as early as 1731.

Later, United Empire Loyalists made their way from the United States. Some settled in St. Anne, renaming it Frederick's Town in honor of the Duke of York, second son of England's George III. The earliest records show a total population of 40 persons.

Because of its location in the center of the province and at the head of deep water navigation, Fredericton was chosen as the seat of provincial government and also as the center of education in New Brunswick. In 1788 provincial legislators gathered for the first time in the new capital.

After early years of hardship, the settlement received a large influx of

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British immigrants, who helped open up the countryside in the early 1800s. Land was cleared and a lumber industry was established.

In 1845 the city's first bishop – John Medley – began construction of Christ Church Cathedral, which remains today as one of the most perfect examples of Gothic architecture in North America. It is the first Anglican cathedral built on British soil outside the United Kingdom since the Norman conquest of England in 1066. This cathedral brought a special honor to the town of Fredericton. Because a cathedral must be erected in a city, Queen Victoria decreed that Fredericton should be so named: in 1848 she proclaimed it a city.

From that time until the present the growth of the city was rapid. Today the population within a 15-mile radius is about 70,000. This includes the town of Oromocto, permanent headquarters of Camp Gagetown, Canada's newest and most modern military installation. This camp has had great impact on Fredericton's economic growth.

Rapidly increasing population is spreading residential construction in new areas both within and outside the city. Fredericton has the greatest population increase of any comparable city in Canada, and if the trend continues it will more than double its population in the next 20 years.

Points of interest

Today Fredericton has 72 miles of elm-shaded streets, several parks, and a parkway along both sides of the river. It is a particularly green and pleasant place in June. In addition, many historical and cultural attractions await the visitor.

Officers' Square is a colonial gem in the midtown section of Fredericton. It is a beautiful park, centered by a bronze statue of Lord Beaverbrook, New Brunswick's greatest benefactor. The statue was raised by public subscription, much of it by school children, and was officially dedicated during his lifetime. A stone sculpture of two beavers, an 80th birthday gift to Lord Beaverbrook, stands by the adjacent pool. More recently an attractive triangular shelter has been raised in the Square to house a memorial plaque to the late John F. Kennedy.

The Square also contains the Officers' Barracks, one of the oldest buildings in the city, whose stone arches and iron balustrades once echoed the brisk step of British "redcoats" when Fredericton was an imperial garrison town. The building now houses the York-Sunbury museum, which holds much to interest either the serious student of history or the more casual enthusiast. The extensive military collection is impressive, but perhaps of more interest to female visitors are the parlor, bedroom, and kitchen completely furnished in period style.

Lord Beaverbrook's influence

The gifts of the late Lord Beaverbrook elevated Fredericton from a provincial capital to a major cultural center. Born Max Aitken, New Brunswick's famous benefactor was brought up in a Presbyterian manse in Newcastle, N.B., and became the peer of London's Fleet Street. But he maintained an enduring loyalty to the province of his youth.

Lord Beaverbrook realized a dream of nearly half a century when he presented the Beaverbrook Art Gallery to Fredericton in particular and to the province in general. Some of the world's most famous artists have pictures on display here, including an impressive British section containing works by Reynolds, Constable, Turner, Gainsborough, Hogarth, and Sir Winston Churchill.

Among the Canadian holdings is the largest single collection of works of Cornelius Krieghoff held by an institution of art. The main gallery is dominated by a magnificent painting by the Spanish surrealist, Salvador Dali. Companion piece to the art gallery and last of the Beaverbrook gifts to Fredericton and the province is The Playhouse, opened in 1964. The theater seats about 1,000 and there is plenty of room for exhibitions or conventions. The Playhouse is now the major center of the performing arts in the Maritimes.

Stretching from the art gallery along the river is The Green, a fine park of lawns and trees. Here you will find a statue of the Scottish poet Robert Burns. This was erected in 1906 by the Fredericton Society of St. Andrew; other Scottish societies in the province contributed to the cost. There is also a beautiful marble fountain given by Lord Beaverbrook in memory of his friend Sir James Dunn. This fountain originally stood in the gardens of Stowe House in Buckinghamshire, England.

Oldest provincial university

The University of New Brunswick, on a hill overlooking the city and the Saint John River, is important historically as well as educationally. The United Empire Loyalists brought the standards of Harvard and of Columbia University, (then King's College) to the New Brunswick wilderness. In 1785 they petitioned the provincial governor for a provincial academy of arts and sciences.

In response, a "draft charter" was drawn up and 6,000 acres of land in the parish of Fredericton was reserved for the use of the proposed institution. As a result UNB shares with the University of Georgia the distinction of being the first provincial or state institution of higher learning in North America.

The academy became a college in 1800, and until it was made a university in 1859 it was predominately devoted to the arts. UNB is non-denominational and coeducational. Facilities for 6,000 students "up the hill" include more than 30 permanent buildings.

The picturesque arts building, completed in 1828 in the center of the campus, is the oldest college building still in use in Canada. The initials of the university's pioneer students can be found carved in the antique desks and benches of one of the classrooms. Close

The arts building on the campus at the University of New Brunswick is the oldest college building in Canada. Close by is the first observatory built in Canada.

A statue of Robbie Burns faces the impressive Legislative Assembly building.

by is the famous observatory built in 1851, the first structure in Canada to be used for that purpose.

The new Memorial Student Centre and the Bonar Law-Bennett Library, given to UNB by Lord Beaverbrook, show a fine contrast with the old buildings. The library contains many priceless historical and literary treasures from his personal collection. The position of chancellor of UNB was specially created for Lord Beaverbrook, who was a former student of the law faculty. He was succeeded as chancellor by his son, Sir Max Aitken.

Distinctive programs in addition to the traditional arts and sciences include the faculties of law, forestry, and engineering. Nursing education was begun in 1959, and the faculty is now one of the best in Canada.

Poets' corner of Canada

A monument on the campus of UNB, erected by the Historic Sites and Monuments Board of Canada in 1947, gives the stamp of officialdom to Fredericton's title as the poets' corner of Canada. The earliest English speaking poet in Canada, the Loyalist Jonathan Odell, came from Fredericton. Other famous poets include Joseph Sherman, Bliss Carman, and Sir Charles G.D. Roberts; these three are commemorated by the UNB memorial.

Bliss Carman's house is still standing and is on view. Fredericton also contains several homes that once sheltered historical heroes and villains from the United States. Perhaps the most famous is Benedict Arnold, one of history's most controversial figures, who lived for two years in Fredericton's Rose Hall. History books record that Arnold was unpopular because of his bad manners and bad reputation; once the enraged citizens made an effigy of him, which they burned in his front yard, calling him a traitor.

No visit to Fredericton would be complete without a visit to Christ Church Cathedral. Numerous massive buttresses and the pinnacles surmounting the gables make its exterior striking. The stone for the walls was quarried in the immediate neighborhood, and the weatherings of the buttresses, string courses, and cornices are from the shores of the Bay of Fundy. All the dressings of the doorways and windows are of Caen stone and done in England. The nave is an exact copy of an English church in Snettisham, Norfolk.

Some items of interest on view in the cathedral are: the cloth of gold altar frontal used at the coronation of William IV in Westminster Abbey; the Royal Bible presented by the Prince of Wales, afterward King Edward VII, in memory of his visit to the cathedral in 1860; the letters patent given to the cathedral by Queen Victoria; and a pulpit antependium made from part of her coronation robe.

Nurses visiting Fredericton might wish to view Victoria Public Hospital, which has enjoyed a long history of service to the needs of a growing community. Building began in 1888, and the hospital first accommodated 14 patients. Eight operations were performed during the hospital's first year, when surgery was still in its infancy. The first operation was performed only after two board meetings and the written consent of all the physicians then on the medical staff!

A training school for nurses was established at the Victoria Public Hospital in 1896; students had to complete a two-year course. Two years after x-rays were discovered in 1895, a unit was brought to the hospital, the first such equipment to be installed in the Maritimes.

Provincial capital

In Fredericton, seat of the New Brunswick government, the increased activities and responsibilities at the provincial level are most noticeable. Proof of this growth is the new Centennial Building – the province's centennial year project – which brings most government departments under one roof, thus promoting efficiency of operation. The $5 million building is practically designed, with clean, modern lines.

Another source of pride to the capital is the province's legislative building erected in 1880. The library, housed in an annex at the rear, has a copy of the original Domesday Book (1087) printed

in 1783; one of the two sets of the Audubon bird paintings in existence; and a set of Hogarth prints made from the original steel engravings.

Built in 1828, Fredericton's old government house displays a dignified Georgian facade. After Confederation in 1867, New Brunswick's lieutenant-governors occupied the residence until 1893. In recent years it has served as a barracks for the Royal Canadian Mounted Police. It has lately been designated as a historical monument.

The city can boast of several special attractions for the convention visitor; indeed, Fredericton is becoming a major convention center of the Atlantic provinces. Accommodations range from the Lord Beaverbrook Hotel – the focal point of community life – to the university residences.

Avid shoppers will be specially interested in the top quality products of area handicraft studios. Potters, jewelry makers, weavers, and wood turners design their own work and hand-finish their products. Visits to their studios can be arranged through the tourist bureau.

The city's industrial progress has been rapid. Printing and publishing are important industries in the area; others include shoes, bricks and concrete articles, mobile homes, paper bags and containers, and steel fabrication. Canoes made in Fredericton are used in the Arctic and in many other regions.

District sights

The surrounding countryside is ideally suited for mixed farming. The federal government has taken advantage of this by establishing a research station of the Canada Department of Agriculture at the east end of the city. Visitors are welcome to come and enjoy the spacious lawns, shrubs, and trees, the colorful flowers with names clearly indicated, all located around inviting picnic grounds.

Another major tourist attraction in the Fredericton area is the new Mactaquac hydro dam, the largest single construction project ever undertaken in New Brunswick. The dam, a massive rock-filled structure, towers 180 feet above its base and stretches 700 feet across the channel of the river in a slight curve. It has created a large headpond or lake stretching 59 miles up river.

The Fredericton district provides many recreational facilities. Fishing in the area is a sportsman's delight, and local guides and boats are easily obtained. There is a large public swimming pool and admission is free; trailer and tenting facilities are available; and you will find many areas set aside for picnics. A golf course is five minutes drive from the center of town. One of the big sport attractions in Fredericton during the summer months is the twice-weekly night harness racing.

The great development of boating has made the Saint John River at Fredericton a scene of vast activity. The river itself is a famous and historic international waterway, starting in Maine and traveling the length of New Brunswick; it is known as "the Rhine of America." Talking of water, one of the best attractions of Fredericton is the availability of all the fresh seafood you can eat!

Fredericton – the capital of New Brunswick – really lives up to the old cliché: "a city that has something for everyone." □

Christ Church Cathedral, a good example of Gothic architecture in North America.

Changing horizons in psychiatric nursing

The author examines the problems of social position, role conflict, and lack of professional identity that affect nurses working in mental hospitals. She stresses the need for a clinical specialist as a role model in psychiatric nursing.

Naida Hyde, B.Sc.N.

The provincial psychiatric hospital system is an anachronism in today's society. Although rapid changes are occurring all around us, we still find psychiatric patients in antiquated buildings that are located in overcrowded cities or in the country, isolated from the community.

These buildings, which house almost half of Canada's hospitalized patients, exist to treat and rehabilitate the emotionally ill. However, the walls and the land that separate the psychiatric patient from the community symbolize the hospital's function of protecting the community from social deviants who are labeled mentally ill. Thus the hospital and its staff are required to function both as custodian and therapist.

The mental hospital as a social system and as a total institution has been studied and researched extensively. Although much useful data have been accumulated about such things as the hierarchical system, social positions, and interaction systems within the mental hospital, these findings have not always reached the staff who could benefit the most from them.

For instance, for many years the nursing department in the mental hospital accepted almost total responsibility for providing patient care. No other staff was available or interested in doing the job. In recent years, however, other professions, such as social work, psychology, and sociology, have become progressively more involved in patient care and have used available knowledge to help them deal more effectively with the psychiatric patient. Unfortunately, there is little evidence to suggest that nurses in psychiatric hospitals are using research data to improve their care and to examine their role.

Bottom of totem pole

The hospital's organizational structure can be seen as a pyramid with psychiatrists at the apex, as the medical model still holds sway in psychiatric treatment, despite efforts of non-medical personnel to dislodge it. Social workers and psychologists share the second position and status, followed by nurses at the broad base.

Nursing staff have little status compared to other members of the health team. Yet they are expected to assume a great deal of responsibility for the care and treatment of patients.

Mrs. Hyde, a graduate of the University of Toronto School of Nursing, has worked as an instructor in psychiatric nursing and as assistant director of nursing education at the Ontario Hospital Toronto, and as a staff nurse at the Clarke Institute of Psychiatry. She has observed patient care in mental hospitals in Whitby, New Toronto, and Boston, Massachusetts. She is now doing graduate work in psychiatric nursing at Boston College, Massachusetts, U.S.A.

Underlining the low-man-on-the-totem-pole syndrome is the lack of clarity that nurses have regarding their professional identity and competence. They often feel that their role consists merely of the sum total of others' expectations of them. This difficulty generates problems throughout the psychiatric team in relation to professional roles and expectations; this, in turn, influences patients and their treatment.

The multiple subordination that nurses are subject to compounds the problem. The nurse is expected to take orders from various persons, including the psychiatrist, psychologist, and social worker; at the same time, she is urged by them to assume her rightful role on the team. She is also subject to the authority of the nursing service department, which expects her to carry out a host of non-nursing duties. An example of conflict occurred when a nursing supervisor reprimanded a head nurse for not having someone available to answer the ward telephone during the patients' ward meeting; the psychiatrist, on the other hand, had strongly urged the nurses to participate at these meetings.

Nursing office directives often are more custodial than therapeutic. Supervisors want patients to receive the best care possible, but are uncertain how nurses can give this in any but a custodial way. Since each staff nurse is dependent

on nursing office personnel for job security and working conditions, the latter's power over each nurse's functioning is considerable.

In interviews with one researcher, nurses said that when they had a choice of a high visibility task, such as charting, or a low visibility task, such as talking to patients, they invariably chose the high visibility task, although they prefered association with patients.*

Educational conflicts

The majority of RNs working in psychiatry, including head nurses, are graduates of diploma schools of nursing where they received a maximum of 12 weeks of theory and clinical experience in psychiatric nursing. Today, many of these courses are only eight weeks in length. Their ability to prepare a beginning practitioner in psychiatric nursing, let alone a psychiatric head nurse, is questionable.

Today's head nurse is expected to understand psychotherapeutic procedures, such as individual psychotherapy and group therapy techniques; to know how to develop and utilize meaningful relationships with patients; and to be able to guide her staff in the same direction. Too often nursing service leaders are chosen because of seniority in the institution rather than because of suitable educational or personal qualifications. These persons' views of psychiatric nursing and treatment are completely outdated.

The head nurse occupies a crucial position in the social structure and functioning of the ward. In many situations the psychiatrist in charge of the ward is a busy resident just learning his profession. This leaves the head nurse in a power position with a great deal of responsibility. She is expected to be administrator, intermediary among staff members and between staff and patients, and an example of good mental health. In practice, however, this person often feels the weakest and least prepared to cope effectively with all her responsibilities.

Lack of sufficient and relevant educational preparation heightens the nurse's difficulties, whatever her position. In Ontario, for example, nurse aides and attendants are required to complete a course to prepare them to work with the mentally ill. Until two years ago, however, the course was abysmally outdated, geared more to prepare these assistants to work with chronic geriatric patients than with the acutely or chronically ill mental patient. These persons often developed skill in working with the mentally ill in spite of their poor preparation. Even so, many aides are in the paradoxical position of having long tenure and considerable intuitive skill and sensitivity, but at the same time feel left out and inadequate because of the team's more sophisticated discussions about patients.

On the other hand, aides and attendants in Ontario who graduate from the new, nine-month registered nursing assistant course that prepares them to work with the mentally ill find themselves in an equally untenable position. Their course contains six months of theoretical material relating to mental health and psychiatric nursing, with supervised clinical experience. After graduation, these RNAs often find that they are more knowledgeable and more clinically proficient than many RNs they are assigned to work under.

The RNs may say they are glad to have such able assistants, but the RNAs experience a great deal of subtle pressure to return to their former, custodial, subservient role. The pressure increases as the psychiatrists and social workers recognize the therapeutic potential of these nursing assistants and try to increase their involvement in patient care.

These role conflicts, status problems, and educational deficiencies severely affect the nurse's functioning within the ward setting. Thus regardless of how much nurses care about patients and want to help them, they are ill equipped to do so. Feelings of frustration, helplessness, and inadequacy produce defensive reactions. The ward nursing station or medicine room becomes a sanctuary where the staff gain some security by reinforcing each other's right to withdraw from the patients, whom they feel emotionally and intellectually unprepared to help.

Problems and solutions

Strict adherence to institutional rules and policy may also be used as a defense mechanism by nursing staff. For example, one of my patients showed regression and depression following an epileptic seizure. He was unable to communicate much during one session except to ask me for his breakfast. This was important to him not only for the food's sake, but also in a symbolic sense as I would be functioning in a mothering role. However, the head nurse and senior aide refused to let me in the kitchen in the middle of the morning.

Their insecurity, fear of criticism from above and of me as an outsider, and uncertainty about seeing a nurse function in a therapist role prevented them from considering the therapeutic value of my request. This placed me in a conflict situation of wanting to meet the patient's need, but at the same time understanding the importance of maintaining good relations with the staff – for my sake and the patient's.

Are nurses inextricably bound by the difficulties outlined, or are there solutions?

Psychiatric nursing *has* a contribution of great value to make in the care and treatment of psychiatric patients. Solutions must be found and implemented.

Three areas of change should be considered if patient care is to be improved: change in administrative structure; improved educational preparation for nursing personnel; and the implementation of a suitable role model in psychiatric nursing. The nature of both the social

*A. Wesson, *The Psychiatric Hospital as a Social System*, Springfield, Illinois, Charles C. Thomas Press, 1964.

system of the mental hospital and the solutions proposed indicate that the changes will be evolutionary, rather than revolutionary, in nature.

Decentralization needed

Problems of role conflict and multiple subordination would decrease if nursing became decentralized and functioned within each ward setting under the supervision of the team leader and the clinical specialist assigned to that ward. Decentralization would help the nurse focus her interest and attention on her ward and its milieu, rather than on the demands and expectations of the nursing department.

Decentralization calls into question the role and function of the ward's team leader, who is usually a psychiatrist. If the psychiatrist's influence is positive, that is, if he sees each nurse as a therapist, decentralization is advantageous. However, if the psychiatrist's frame of reference is more reactionary and traditional, the nursing staff and clinical specialist have to assume a much more active role, interpreting to him the need for nursing involvement with patients. Nurses who believe in their own therapeutic potential and who are willing to say that they do, can exert a powerful influence on a ward program.

Education and role model needed

Diploma schools of nursing are moving away from specialty areas and concentrating on preparing a better quality of generalist in nursing. Psychiatric nursing as a clinical specialty is taught on a postbasic level within a university, either as part of a masters program or in a program of continuing education. Thus, the diploma school graduates, who are the main source of recruitment for staffing psychiatric hospitals, have had only 8 or 12 weeks of psychiatric nursing in a two- or three-year program geared to general nursing.

Inservice education as it now exists cannot meet the needs of this group of nurses. What is needed is a suitable role model for psychiatric nurses.

Until now, the ward psychiatrist, usually by default, has assumed responsibility for helping nurses understand how they can help patients. Often, however, his efforts have been unsuccessful as nurses and many doctors are unaccustomed to treating each other as equals. In addition, nurses often lack adequate theoretical knowledge to understand what the psychiatrist is trying to teach them. This situation results in the nurse feeling inadequate, which can lead to a poor doctor-nurse relationship.

Nurses *will* learn, but only when there is supervision of their clinical work with patients. The clinical specialist in psychiatric nursing can best give this supervision and serve as a role model for nurses as a therapist and as an agent of change. In an ideal situation, she is assigned to one ward where she becomes an integral part of the ward team, working with patients, teaching the nursing staff on a day-to-day experiential basis, and collaborating with other disciplines on the therapeutic role of nursing.

This clinical specialist is a person with whom the nursing staff can identify. The nurses see the clinical specialist as a therapist who enjoys working intensively with patients. They also see her as a nurse who is secure enough to work on a person-to-person basis with patients, rather than in a traditional and structured nurse-patient framework. Such a framework has been called "professional" in nursing circles; in most instances it amounts to stereotyped, uninvolved, and non-creative behavior.

The clinical specialist understands and reacts to socially unacceptable behavior in patients as symptomatic of intrapersonal and/or interpersonal problems. She remains objective in her work with patients, aware that her behavior and feelings about a patient affect him, and that his behavior affects her.

This example illustrates the value of a clinical specialist. A young 22-year-old girl was admitted to hospital, having threatened suicide. She was frightened and felt alone in the new environment, but did not show these feelings. Her life had been a series of disappointing experiences with people, so she was now adept at keeping people at a distance.

Her method was simple, effective, and was aimed primarily at the nursing staff who threatened her because of their attempts to get close to her. She kept up constant demands for medication, interspersed with hostile, sarcastic complaints about the nursing staff, hospital policies, and her treatment. Soon the nurses became angry and defensive toward her. Because of guilt feelings, they avoided her or were cool to her, which only intensified her underlying fear, helplessness, and anger.

A clinical specialist could have helped the nurses understand their part in perpetuating this girl's unhealthy behavior and their responsibility in helping her find more appropriate ways of relating to people. This could be done only by learning to understand the patient, rather than by reacting blindly to her behavior. What this patient desperately needed was someone to accept her and give her the security she needed.

The clinical specialist can also give help and support to the head nurse. Recently I heard a head nurse say, "I communicate very well with my staff, but they don't communicate with me." This statement illustrated her faulty understanding of the mutual nature of communication and relationships. The clinical specialist would have the time, skill, and understanding to guide the head nurse's understanding of the dynamics of staff communication and group functioning.

Fear of mental illness may hinder a nurse's ability to care for the patient. Again, the clinical specialist can help staff learn to understand their own feelings and reactions to patients. As understanding develops, the staff are less likely to use distancing defenses or to act out their anxiety. □

Something to say... and how!

Though mastery of the mechanics of writing will never make you a literary giant, it may prevent you from becoming a boring scribe, the author says.

Helen Evans Reid, M.D.

As a professional you have knowledge and skills you must communicate, if you are to fulfill your complete role. Your concern for all patients is the imperative, the reason you must write.

What you have to say may vary from a simple description of a more efficient way to collect a sample or make a patient comfortable, to the detailed account of a carefully organized research project. How well your message is delivered is a compound of many things, including your enthusiasm for your subject and your knowledge of it, your ability to write, and the time you spend polishing your article before you consider it finished.

Know your reader

Obviously you must know your reader before you begin to write an article. The form of your communication depends on his identity.

The following appeared in a scientific journal:

> **The Effects of Continous Compression on Living Articular Cartilage**
>
> *The problem that prompted the present investigation arose from clinical observations of the sequelae of immobilization of joints in patients who were receiving various forms of orthopaedic treatment, etc.* [1]

Suppose the same item had been written to appear in the local newspaper. It might have read like this:

> **Surgeon Claims Casts Damage Joints**
>
> *Dr. A.C. Jones, surgeon-in-chief at Smithtown Children's Hospital said, in a paper delivered before the American College of Surgeons meeting this week in Atlantic City, that immobilization of a joint by the application of a plaster cast to a limb can cause deterioration of the cartilage lining the joint, and this damage can be permanent.*

Or, written as a magazine article, it would go something like this:

> **The Cure That is Worse Than the Disease**
>
> *Jimmy Doyle was just like any other boy of nine, racing with his playmates, playing baseball on the corner lot, climbing trees and riding his bicycle "no hands," until that February day disaster struck.*

The writer would then go on to describe the accident in detail, and include the weary hospitalization, the permanent cripple from long immobilization, and then the punch line.

> *Dr. A.C. Jones of the Smithtown Children's Hospital estimates that at least 200 Canadian children suffer some permanent disability, etc.*

Dr. Reid is Director, Department of Medical Publications, The Hospital for Sick Children, Toronto, Ontario.

The story in all three versions is the same. The *reader* made the difference. In the first case he was a scientist; in the second, probably a business man or housewife who wanted news in a quick package; and in the last, a parent.

Capture the reader

You have identified the reader, now you must capture his interest. The title is the bait. For the lay press, a catchy title, strong and positive, is needed; for the scientific press, a precise title, complete enough that the communication can be readily retrieved from the stored medical literature, is often used, particularly for technical material.

The reader is captured. Now how do you hold his interest? There is a sign on my bulletin board that reads "*All* subject matter is boring if no ideas show through. – Thomas Mann." If you are not enthusiastic about what you want to say, don't say it. And don't bother to write it, for no one sells anything he does not care about, least of all an idea.

How well your message is delivered also depends on what it is you want to say. Write down in simple words – your words – what has been said in the past and what you have to add. This exercise will eliminate those things that are irrelevant. What you write is *your* theme, *your* message.

Choose the journal by examining its general quality and prestige and the subjects it has published in the past year. As competition for editorial space is brisk, it is wise to select a topic that has not been covered during the previous year. A journal is unlikely to accept an article on a particular subject more than once in a single year unless the submission is remarkable for its novelty or timeliness.

Then read the "Instructions to Authors" column that appears in all journals, although not in every issue, to learn the journal's preference for the length of the article, the number of copies to be submitted, the form of the references, and the acceptable number of illustrations, charts, and tables. Professional writers usually send an outline of their topic to the editor for approval before writing the article.

When you have chosen the form for your article, decide on the headings and write each on a separate sheet of paper. Read over the material you have collected. Ask yourself if the item is really necessary and where it belongs.

With your material now logically arranged, construct a sentence outline for each section. The skeleton of your article, the shape to come, will be apparent. You are ready, at last, to write the first draft. Write it continuously from beginning to end, always keeping your message clear.

At this point construct any tables or graphs you may wish to submit with your article, making them as complete as possible with headings, footnotes, and labels. Tables and graphs should be a synopsis of the entire work, complete in themselves without reference to the text. They obviate the tedious repetition of data in the "results" section of a technical or research paper, where only the unusual, the unexpected, the highlights, should be mentioned.

Polish your article

No author, not even the most experienced, produces a perfect manuscript at the first writing. Your article should be revised several times and polished before it is submitted for publication.

Usually a paper can be shortened considerably by careful, conscientious revision. This does not mean that you leave out relevant material as you revise; rather, you ruthlessly eliminate unnecessary words by dropping "wind-up phrases" – those expressions that indicate your difficulty in getting a paragraph or sentence started. For example, "It has been our observation that many consider measles a benign condition," would be better expressed by, "Many consider measles benign." Writing, rewriting, choosing the precise word, the perfect word, the apt expression – these are the tools of the competent communicator.

There are other ways of improving a text's quality. Avoid monotony, a literary sin guaranteed to bore your reader and make him turn to the next article. When all ideas are equal, none is important. The product is like food without spice, a nice cold porridge of thoughts. For interest, vary the structure and the length of the sentences. Since few readers can tolerate more than an occasional sentence over 25 words, try a short, sharp sentence to dramatize a point.

Master the mechanics of writing

Style in writing is a function of the writer, as personal and as characteristic of him as the clothes he wears. The sentences you build and the words you choose clothe your thoughts and identify them as yours. A good style makes dull prose literature, makes words and ideas sparkle and flow, and delivers your message accurately and effortlessly.

To achieve a good style you must master the mechanical details of writing. These are well set out in *The Elements of Style,* by William Strunk Jr. and E.B. White.[2]

Though mastery of the mechanics of writing will never make you a literary giant, it may prevent you from becoming a boring scribe.

Here are a few reminders of how to achieve a good style in writing.

The verb you use may be in either the active voice (the subject is acting) or the passive voice (the subject is being acted upon). For example, *John caught the ball* (active). *The ball was caught by John* (passive).

Use the active voice when possible to make your writing more concise and forceful. Consider this sentence: *The course of action will always be determined by the physician.* Very wordy. Change this so that the person taking the action is the subject. *The physician will always determine the course of action.* This is concise, precise, and straightforward.

You may wish to use the passive voice for variety, but remember it can confuse your reader and dull the lustre of your style.

Put statements in a positive form. "Not" is the warning word. *He did not remember that enlarged glands in the groin are not unusual,* would be better as: *He forgot that enlarged glands in the groin are common.*

Strive to use definite, simple words, choosing the concrete over the abstract. *The position with regard to food consumption exhibits a maximum of non-availability.* Why not just say, *Food is scarce?*

Many people who speak well bury their ideas in unnecessary words when they write. Consider: *Let me call your attention to the fact that,* would be better as: *I remind you.* If it is *of interest to note,* then say what you have to say without this venerable preface. If what you have to say is uninteresting, you shouldn't be saying it.

Strong verbs make good writing. Unfortunately many authors hide good verbs in abstract nouns. For example, *Man has an appreciation of beauty.* The word "appreciation" is an abstract noun, so why not make it a verb? *Beauty is appreciated by man.* That's better. "Appreciation" has become a verb, but it is in the passive voice. Try, *Man appreciates beauty.* A vigorous verb, a vigorous sentence. From this example you can see that brevity is a by-product of vigor.

Avoid jargon. Whole vacabularies have been built up by the professionals of a particular discipline to facilitate communication among themselves. The danger is that these words become overworked, and "abuse may turn them into mere plugs for the holes in one's thoughts."[3] Originally specific, such words lose their meaning and become jargon. Nouns, such as *evaluation, motivation, breakdown* (analysis); verbs, such as *structure, trigger, update;* and modifiers, such as *basic, key,* and *overall,* are weary words that should be laid to rest.

Submit your article

Naturally the things you write and the ideas you express are distilled from what you have experienced and what you have read. But to quote someone without due acknowledgement, or to repeat his words as though they were your own, is plagiarism and inexcusable. So indicate what you have borrowed and from whom by numbering and listing all the references in the manner approved by the journal.

Of course the manuscript you submit will be well typed, the illustrations apt, clear, and precisely labeled. Enclose a covering letter to the editor of the journal and a self-addressed, stamped card on which the editor can indicate that the manuscript has arrived safely.

Then wait. Allow six weeks to two months to elapse before sending a courteous letter to the editor to find out if a decision to publish has been reached.

Don't be too discouraged if your manuscript is rejected. Few persons who write for publication have escaped the experience of having at least one paper turned down by a publisher. Try to determine why the paper was rejected, and resolve to avoid this particular pitfall in the future.

The writing and eventual publication of an article is satisfying experience for you, the author. As you transmit your personal experiences or research to others, you are truly fullfilling your role as a professional.

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1. Salter, R.B. and Field, Paul. The effects of continuous compression on living articular cartilage: an experimental investigation. *J. Bone Joint Surg.* 42-A: 31-49, Jan. 1960.
2. Strunk, William Jr. and White, E.B. *The Elements of Style.* New York, The Macmillan Co., 1959.
3. Follett, Wilson. *Modern American Usage. A. Guide* New York, Hill and Wang, 1967. □

Are we getting to you?

The Canadian Nurse travels a busy road, sometimes with unexpected detours, before it arrives at your door each month. The circulation department of the Canadian Nurses' Association, with your help, makes the road smoother.

Beryl Darling

The author, left, discusses the details of a subscriber's enquiry with Pierrette Hotte, a member of the circulation staff, Canadian Nurses' Association.

Are we getting to you?

If you are an active member of a provincial nurses' association, a personal subscriber to *The Canadian Nurse* or *L'infirmière canadienne*, or a nursing student who subscribes, you are probably nodding your head in the affirmative and thinking this question is a silly one!

Perhaps, but as one of more than 90,000 persons in 104 countries to whom the Canadian Nurses' Association's magazine is mailed each month, we thought you might like to have a glimpse behind the scenes in our circulation department and see how you can make sure your copy arrives regularly.

Members in Canada

Registered nurses form the greatest percentage of readers, as *The Canadian Nurse* is automatically provided with active membership in a provincial nurses' association. Within six weeks after the provincial nurses' association has sent a list of its members to the CNA, the new member receives her journal and continues to receive it until six weeks after CNA is notified that her membership has terminated. The journal is available in either the English or the French language and is directed to the member on the basis of information provided to CNA by the

Mrs. Darling is Circulation Manager, Canadian Nurses' Association, 50 The Driveway, Ottawa.

Françoise Charbonneau prepares an addressograph plate for a personal subscriber in Africa.

provincial nurses' association, unless an individual request is received from the member.

Processing

Journal labels for members in Canada are produced by computer at a local data center, which keeps member listings on magnetic tape. A matching master card file is maintained at CNA, filed numerically by registration number.

An addition of a new member, change of name or address of a current member, or deletion of a non-member can be made only when CNA submits the appropriate member card to the data center, indicating the action requested for transfer to the magnetic tape. This is done on approximately the twelfth of each month and is referred to as the monthly "up-date."

Four girls are engaged in processing this "up-date." During the first 10 months of 1969, a total of 111,903 cards were processed – an average of 11,190 per month. During peak periods at the beginning of a calendar year, when registration renewal takes place, as many as 19,000 cards have been processed in one month. Obviously additional help is required at these times and work continues at night and on weekends.

This "up-date" provides the final information that will be printed on the labels for the next month's issue. The labels are then sorted by town and postal zone, arranged in numerical order by registration number, and forwarded to the printer where they are cut, glued, and affixed by machine to each member's copy of *The Canadian Nurse* before being mailed from Montreal.

Any change in a listing that arrives at CNA after the tenth of any month is already too late for inclusion in the "up-date" for the next month's issue. For example, February 10 is the last date on which a change or adjustment can be made to labels for the March issue. This is why six weeks are required for processing. Any change received after February 10 will be effective for the April issue.

You might ask: What happened to the eleventh and twelfth of the month if the "up-date" is delivered to the data center on the twelfth? These two days are necessary to put the 7,000 to 19,000 cards (average 11,190) in numerical sequence by registration number, sort them by language code and province of registration, and complete a transmittal record count to accompany the delivery to the data center.

Other subscribers

Another section of the circulation department deals with a total of 15,048 listings for other subscribers. These include members living outside Canada to whom the same benefits and privileges apply regardless of their address; personal subscribers; and exchange arrangements with affiliated professional journals. These are processed on an addressograph system by one staff member. Among our subscribers are 9,239 nursing students in Canada who receive the journal each month (7,416 English-speaking students and 1,823 French-speaking students) through a bulk arrangement with their schools of nursing. Hospitals, school of nursing libraries, public libraries and health agencies, and individuals all over the world are listed among our personal subscribers.

Gloria Wilcox checks CNA's copy of February labels to confirm that an issue was sent to a member.

Brenda Moore refers to the master directory to identify a member who omitted her registration number when requesting a change of address.

Postal regulations

New postal regulations brought other changes in addition to the overwhelming increases in postage costs. Prior to April 1, 1969, hundreds of undelivered copies of *The Canadian Nurse* were returned to CNA. As the journal is now classified as third-class mail, undelivered copies are no longer returned to us. Assuming the same rate of mobility still exists within the profession, we suspect that hundreds of copies are currently being sent to the dead-letter office for disposal each month.

Joann Knight checks the CNA's master IBM card file with 1970 renewals from a provincial association.

In addition, members tell us that their journals are not reaching them. In some cases an incorrect city zone has been given, in other cases no zone has been given. The post office routinely provides directory assistance for first- and second-class mail. However, third-class mail does not receive the same service as first-class or even second-class mail. Frequently members have mentioned that their *Life* magazine and *Reader's Digest* have reached them without difficulty and without the new mail zone number included. This is probably true as these publications are still classified as second-class mail.

In effect, the priority rating of *The Canadian Nurse* has been lowered, even though the postage rates have been increased by approximately $135,000 annually. The proper city zone must be included in all addresses where zones exist to ensure proper and regular delivery.

Your label

To the five girls in the circulation department, you are known by your label.

Miss B.A. Nurse
10 Skyway Drive
Montreal 352, P.Q.
BO66-3295

For a CNA member living in Canada, the number at the lower right of the label is most important. This is your practicing license or registration certificate number, prefixed by the provincial code. We need this number to check an enquiry or make an adjustment in your listing. Please quote it on all correspondence if you are unable to attach a recent label. If you are actively registered in more than one provincial association, quote both numbers and provincial associations.

Librarian
School of Nursing
University of the Watusi
Watusiland, AFRICA
12-70 BHH 10-69

A personal subscriber or a member outside Canada, such as the subscriber listed on the label above, is identified primarily by location, since postal regulations require us to maintain listings by a geographical sort. For this reason the previous address is most important when requesting a change. The code letters at the bottom indicate the registration number for members, and, for personal subscribers, the expiration date, the agency through which the subscription was placed, and whether the subscription was a gift.

Moving?

We invite our readers to use the *"Moving?"* form that appears in each issue. If you are a member in Canada and are unable to provide a recent label, please send us your registration or permanent certificate number and the name of your provincial nurses' association. If you are a personal subscriber or member outside Canada, please give us your former name or address, registration number if a member, and the name of the agency or donor where applicable.

Please notify us personally of any change in name or address, since change of address cards provided by post offices have proven unreliable. We will change your listing only on notification from individual members, subscribers, or provincial nurses' associations.

Are we getting to you – and to your colleagues? We hope so. But if not, be sure to let us know! □

research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Kerr, Janet C. *The formulation of an instrument to evaluate performance of nursing students in clinical nursing based on correlated behavioral objectives.* Madison, 1967. Thesis (M.S.) U. of Wisconsin.

The evaluation of student performance in clinical nursing is of concern to nursing educators because of the necessity to determine the quality and effectiveness of teaching and learning and to ensure patient safety through the rendering of competent nursing services. It is important that this evaluation be as objective as possible.

Traditionally there has been a tendency to appraise personality characteristics rather than progress. It is the contention of the writer that the classification of objectives and the close relation of objectives and evaluation advocated by Benjamin S. Bloom are both applicable and helpful in making the process of evaluation in the school of nursing as objective as possible. An evaluative instrument, accordingly developed to measure clinical performance in medical-surgical nursing at two selected levels, is based on course objectives expressed in behavioral terms.

These objectives and tools for clinical evaluation were developed specifically for two clinical nursing courses at a particular diploma nursing school in the midwestern United States, and are presented to provide an example of how clinical evaluation may be carried out in terms of behavioral objectives.

Stinson, Shirley M. *Deprofessionalization in nursing?* New York, 1969. Thesis (Ed.D.) Teachers College, Columbia U.

Most major works in the nursing literature seem to be based on the assumption that the occupation of nursing is gradually becoming more and more professionalized. The reverse of that assumption, that nursing is "deprofessionalizing," is the thesis that is tested in this study. The research approach employed was that of a comparative social analysis of nursing in 1920 and in 1960. The study was restricted to nursing in the United States.

Because the concept of "deprofessionalization" is a poorly developed one, the author constructed a paradigm and a typology of "deprofessionalization." The concept of professionalization was examined in detail, and the impact of bureaucratization on professionalization was assessed.

It was concluded that within the social contexts of the times, nursing in the 1920s exemplified the characteristics of professionalization to a greater degree than it does today. Some of the major reasons for this were: 1. the relative integrity of the substantive knowledge-skill component (e.g., nurses may have more factual knowledge?); 2. the existence of a well-knit occupational culture; 3. the substantial harmony of nursing roles in the 1920s with roles of other health personnel; 4. the high degree of autonomy of the nursing practitioner in the 1920s; and 5. advancement in nursing was largely coterminal with increased clinical nursing expertise, a characteristic not typical of nursing in the 60s.

Two primary recommendations arising from the study were: First, that the American Nurses' Association reconsider its position with respect to the category of technical nurse. It was submitted that however "underprofessionalized" the status of the registered nurse is at present, her *role* is professional in its character. There was no criticism of the intent of the ANA position, but considering the relatively slow rate of professionalization of female occupations, it was considered that the ANA position was premature, and is a disintegrating factor rather than a professionalizing mechanism. Second, that the techniques of this study be applied to nursing in other countries, e.g., Canada, to establish similarities and dissimilarities in trends in nursing.

Middleton, George. *A study of the relationship between patient involvement and patient attitude in transfers occurring in a selected unit of a general hospital.* Montreal, 1969. Thesis (M.Sc. (App.)) McGill University.

This study inquires into the reasons for in-unit transfers of patients in a public medical unit of a general hospital, the degree of involvement of patients in these transfers, and their subsequent attitudes toward them. The data were obtained by head nurses completing an information sheet covering the reasons for the transfers, and by unstructured interviews with patients 48 hours after they were moved.

It was found that there were two categories of transfer: nursing, those transfers made in the interest of the patient being moved, and accommodative, those made to accommodate other patients. A greater degree of patient involvement in the nursing category was demonstrated than in the accommodative category. Patients' attitudes were more favorable to nursing than to accommodative transfers.

The findings suggest a functional relationship between the degree of patient involvement in transfers and the patient's subsequent attitude toward them. It would thus seem that regardless of the reasons for in-unit transfers, as the degree of patient involvement increases, the patients' subsequent attitude is more favorable toward these transfers.

Deas, Sister Miriam Anne. *Opinions of graduate nurses from diploma programs in British Columbia concerning their preparation to function as team leaders.* Washington, D.C., 1969. Thesis (M.Sc.N.) The Catholic University of America.

This study was undertaken to determine the opinions of selected graduate nurses from diploma programs in nursing concerning their preparation to function as team leaders.

The criteria for the selection of the participants in the study were: 1. graduation from a diploma school of nursing in British Columbia; 2. graduation within the past year; 3. employment in a general hospital in British Columbia that has approximately 100 beds or more; and 4. a minimum of six months' experience as a team leader.

The sample consisted of 26 graduate nurses who were employed in 10 hospitals; five conducted a school of nursing and five did not. The interview guide was used as the data-collecting instrument.

The findings showed that as student nurses, the majority of the participants had received five or more hours of formal instruction in team nursing and all had functioned as a team leader. The time spent as a team leader ranged from two weeks to eighteen months. Eighteen participants believed that they had received sufficient preparation, theory, and practice to function as a team member and as a team leader during the time they were nursing students in the basic nursing program.

As graduate nurses, 17 of the partici-

pants stated that they had not been oriented to team nursing during their orientation period. Only four of the nine participants, who were oriented to team nursing, recalled having the philosophy and objectives of team nursing discussed during the orientation period.

Problems that the participants believed the team leader encountered in her functioning were lack of personnel, lack of communications among nursing personnel, and a lack of self-confidence. They believed that more experience as a team leader in the basic nursing program during the early period of employment, as well as orientation and inservice education, would prevent some of these problems.

It was concluded that nursing students in British Columbia have sufficient preparation, both in theory and practice, to prepare them for team nursing, and that graduate nurses in British Columbia do not receive sufficient orientation in their first positions to enable them to function as team leaders.

Ritchie, Judith Anne. *Fantasy in the communication of concerns of one five-year-old hospitalized girl.* Pittsburgh, 1969. Thesis (M.N.) University of Pittsburgh.

The purpose of this study was to describe the concerns of one five-year-old hospitalized girl and her predominant means of communication of those concerns. The method used was the descriptive case study. The nurse-writer functioned as participant-observer, giving nursing care to the subject throughout her hospitalization. The data were obtained from process recordings, daily descriptive narratives of the subject's behavior, and interaction with those in her environment; from descriptions of the subject's spontaneous drawings; and from recordings of two types of play interviews conducted: 1. with a toy kit containing family dolls, a doctor and a nurse doll, and household equipment, and 2. with puppets.

Three major areas of concern related to hospitalization and illness were revealed. Of these, separation comprised 52 percent, followed by body integrity, 31 percent, and intrusion, 17 percent. The subject communicated her concerns by verbal communication, non-verbal communication, and fantasy. Verbal communication constituted 17 percent of the total, and consisted of verbalization, ability to listen, and refusal to verbalize. Non-verbal communication also constituted 17 percent of the total, and consisted of body language and regressive behavior.

Fantasy made up 66 percent of all communication. The concerns revealed through fantasy were more specific and more varied in each of the three areas. Fantasy also indicated the subject's needs more effectively. The major agents (46 percent) through which the subject communicated in fantasy were the stuffed toys she brought from home. These toys served as transitional objects and as imaginary companions. The other agents of communication were puppets (24 percent), drawings (18 percent), and play interviews with the toy kit (11 percent).

The study revealed how the child interprets and feels about illness and hospitalization; that fantasy may open the avenue to communication in areas which, when approached in reality terms, the child finds frightening and must deny or avoid; and that fantasy helps in the gradual mastery of the child's feelings surrounding hospitalization.

Shepherd, Audrey Elizabeth. *A study of the attitudes of public health nurses in a selected agency toward direct patient care.* Seattle, 1969. Thesis (M.A.), U. of Washington.

The purpose of this study was to measure the attitudes of full-time public health nurses in a selected agency toward direct nursing care. More specifically, it was to determine if there were differences in the attitudes toward direct patient care in relation to the age of the public health nurse, to the length of time employed in public health nursing, and to the original professional educational preparation of the public health nurse.

A modification of Vaughan's Attitude Scale on Direct Patient Care was the instrument used to collect the data. A personal questionnaire accompanied the modified attitude scale. The t-test was used for computation of the data.

The findings of the study for the 83 full-time public health nurses were that these nurses had an extremely favorable attitude toward direct patient care. Those in the 37-plus year group were more favorable in their attitude toward others than the 21-24 year group, but were less positive in their attitude toward self and aspects of nursing than the other age groups. Nurses with 0-2 years of experience in the field of public health nursing had a more favorable attitude toward the patient than nurses with more experience, but nurses with five-plus years experience were more positive in their attitude toward others than the 0-2 year experience group.

Graduates of diploma programs had a more favorable attitude toward others than those graduated from collegiate programs; however, the latter were more favorable in their attitude toward self and aspects of nursing. Finally, nurses employed at the public health nurse I level evidenced a more positive attitude toward the patient than nurses employed at the public health nurse II level. □

Next Month in

The Canadian Nurse

- Cancer Detection Clinic
- Counseling Nursing Students
- Nurse on James Bay

Photo credits for March 1970

Canadian Hospital Association, Toronto, p. 8

Joe Stone & Son Ltd., Fredericton, N.B., p. 10

AARN Newsletter, p. 12

University of British Columbia, Vancouver, p. 21

Canadian Press, pp. 39, 41

Church World Service, New York, R.G. Shaffer, p. 40

Church World Service, New York, p. 42, cover

N.B. Travel Bureau, Fredericton, N.B., pp. 45, 46, 47

The Harvey Studios, Fredericton, N.B., p. 48

Photo Features, Ottawa, pp. 55, 56, 57

books

Concepts and Practices of Intensive Care for Nurse Specialists by Lawrence E. Meltzer, Faye G. Abdellah, and J. Roderick Kitchell. 469 pages. Philadelphia, The Charles Press Publishers Inc., 1969.
Reviewed by Mrs. Eileen Clarke, Head Nurse, I.C.U., Sherbrooke Hospital, Sherbrooke, Quebec.

The introduction to this book defines the clinical nurse specialist and the nurse specialist, and outlines their respective duties within a well-organized intensive care unit. Teamwork with the physician is stressed for efficient patient care. Methods of training physician-nurse teams are suggested.

The book has 15 chapters, each dealing with a condition that requires constant nursing care. It is a comprehensive and informative book for nurses working in such a unit. Usually many reference books are needed in an intensive care unit, each dealing with a different condition. This book covers the many and varied conditions of critically ill patients.

All conditions (e.g., respiratory failure, shock, chest surgery, renal dialysis) are well described and illustrated by charts and diagrams for quick reference. There is also an excellent bibliography at the end of each chapter. The book covers modern treatments and describes up-to-date equipment. A short chapter is included on organ transplantation. Although the care of patients with myocardial infarctions has become a specialty now handled in many hospitals by coronary care units, there is a good description of this care, and the complications and treatment.

This book is clear and concise and would be an asset in any library. It could also provide valuable reading for classroom use. It leaves no stones unturned in the most challanging area of nursing today.

Current Concepts in Clinical Nursing, vol. 2, edited by Betty S. Bergersen, Edith H. Anderson, Margery Duffey, Mary Lohr, and Marion H. Rose. 361 pages. Saint Louis, C.V. Mosby Co.
Reviewed by Marie T. Mellon, Clinical Coordinator, School of Nursing, University of Ottawa, Ottawa, Ont.

This is a collection of papers by 42 nurses. The book is divided into four sections: medical-surgical nursing, psychiatric nursing, pediatric nursing, and maternity nursing. It is encouraging that the chapters in each section dealing with widely varying aspects of current nursing also deal with nursing actions, nursing interventions, nursing skills, and nursing decisions.

Medical-surgical nursing includes clinical decision-making; a new role for the nurse who is primarily responsible for care of the ambulatory, chronically ill person; trauma nursing; problems and life-style of severely burned patients; patient perceptions of nurses; and patient teaching for home hemodialysis.

Psychiatric nursing includes papers on therapeutic intervention with adolescents, use of psychodelics in adolescence, and community health care.

Pediatric nursing covers nursing assessment of sick children, brief episodes of pain in children, restraint and the hospitalized child, nursing assessment and intervention through play, and uniforms for pediatric nurses.

Maternity nursing discusses rooming-in, eating non-food substances during pregnancy, adapting postpartum teaching to mothers' low-income life-styles, indices of fetal welfare, and nursing care of the premature newborn.

There are references at the end of each chapter and there is a good index at the back of the book.

Basic Nutrition and Diet Therapy for Nurses, 4th ed., by Lillian Mowry and Sue Rodwell Williams. 226 pages. Saint Louis, Mosby, 1969.
Reviewed by M. McCloy, Assistant Dietitian, South Peel Hospital, Mississauga, Cooksville, Ont.

This book is divided into two parts. The first, on nutrition, discusses the requirements of normal nutrition, including situations with specialized needs. The second, on diet therapy, discusses how food becomes a tool of therapy.

Section one begins with a discussion of the importance of a balanced diet, based on the recommended daily dietary allowances set by the Food and Nutrition Board of the United States government. Of particular interest is the generous nature of these allowances in comparison with the dietary standard for Canadians. The Canadian standards are floor levels, whereas the American are optimum. Clinical signs of nutritional status, clearly charted in table form, compare good and poor signs.

The succeeding chapters in this section review the basic food groups, energy requirements, and digestion. One chapter outlines the changes that occur in food as it passes through the digestive system. The satiety value of different foods mentioned here is worthy of note. Chapter 10 deals with the importance of tailoring eating habits to age groups and special stress situations. The needs of the geriatric patient are considered at length. The last chapter deserves special attention as it reviews American laws that directly affect the food industry. The discussion of food-borne diseases is worthy of expanding.

Section two on diet therapy begins with a discussion of routine hospital diets. These vary from institution to institution but are basically alike. The special nature of each individual patient is included here, as well as the importance of meals that appeal to the eye.

The chapter on diabetes is handled well. It must be noted, however, that this text is American and the exchange system for American use is given. As the Canadian dietary system differs in some major respects, the introduction of the American system would be confusing.

In general, I found the book concise and well written, although the format of presenting therapeutic diets could be improved. Questions at the end of each chapter provide a vehicle for further study and review. My chief objection to this book as a text for nursing students in Canada is that it was prepared for the United States and uses American examples. Since food patterns and requirements differ in the two countries, I believe it is best to use Canadian nutrition and diet therapy texts whenever possible.

Man Modified: An Exploration of the Man Machine Relationship by David Fishlock. 215 pages. London, Jonathan Cape, 1969. Canadian Agent: Clarke, Irwin and Company Ltd., Toronto.
Reviewed by E.J. MacDonald, Science Instructor, The Moncton Hospital, Moncton, New Brunswick.

This is a fascinating, interesting book of how man's parts are being modified with the help of machines.

Man is now being measured with more precision than ever before and physiologists and surgeons need the help of engineers to make the measurements and to help with the replacement of body

parts. The author compares man to a machine with several flow systems and subsystems that are automatic, self-regulating, and self-repairing. With the central nervous system as the computer, man-made organs would have to be microminiaturized and made of substances that would not be affected by the elements of man's internal environment.

Machines can be run by computer and remote control, but as yet they have not been made as versatile as man.

Surgeons will soon be able to do microsurgery by remote control from outside the sterile capsule where the patient is placed. Space travel has helped to perfect this procedure.

There has been great improvement in prostheses. By moving remote muscles not affected by an amputation, the prosthesis moves smoothly and the person knows the position of the part involved without looking.

Engineers have several new ideas of making hearts work without removing them by adding auxiliary ventricles or using electro-hydraulic artificial hearts – separate or over existing hearts. Small artificial kidneys that can be worn around the waist and work continuously are being improved.

In the future, glands that release daily doses of drugs into the general system over a period of one or two years will be implanted under the skin. This could take the place of "the Pill."

When tissue typing is as improved as blood typing is now, it may be possible to replace more organs. However, will the demand for hearts and kidneys ever be met, considering that the demand for the cornea is still not met?

This book gives us an idea of what will happen in the years to come. When engineers and surgeons finally solve the problem of the body's rejection of foreign substances, the possibilities of replacing body parts will be unlimited.

This book would be interesting reading for any instructor or student.

Illustrated Dictionary of Eponymic Syndromes and Diseases and Their Synonyms by Stanley Jablonski. 335 pages. Toronto, W.B. Saunders Company, 1969.

The author's purpose in compiling this dictionary is "to gather together in one volume the profusion of eponyms and descriptive synonyms used to designate syndromes and diseases." An eponym is a name or phrase formed from or including the name of a person, such as Huntington's chorea.

Included in this illustrated dictionary are eponymic names of pathological conditions named after the discoverers, literary and mythological characters, and patients. Eponyms used in naming clinical entities, animal diseases, experimental diseases, important diagnostic signs, and pathological conditions are entered, along with their non-eponymic synonyms.

This dictionary would be of considerable value in a school of nursing library and for quick reference on a hospital medical unit. Its use to the individual nurse practitioner would be limited. □

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

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No more than *three* titles should be requested at any one time.

Stamps to cover payment of postage from library to borrower should be included when material is returned to CNA library.

Books and Documents

1. *Les complications en chirurgie et leur traitements,* par Curtis P. Artz et James D. Hardy. Paris, Maloine, 1968. 1005p. (Traduit de la 2. édition Americain par Ch. Alamowitch et J. Bezier)

2. *Coordinate index reference guide to community mental health,* by Stuart E. Golann, New York, Behavioral Publicatons, 1969. 237p.

3. *Correspondence education and the hospital: a summary report of a study conducted at Pennsylvania State University.* Chicago Hospital Research and Educational Trust, c1969. 50p.

4. *Facts about nursing, 1969.* New York, American Nurses Association, 1969. 250p.

5. *International standard classification of occupations.* rev. ed. 1968. Geneva, International Labour Office, 1969. 355p.

6. *Introduction to work study,* 2d ed. Geneva, International Labour Office, 1969. 436p.

7. *Manuel de géronto-psychiatrie,* par Christian Müller. Paris, Masson, c1969. 275p.

8. *Les médicaments.* Paris, Editions du Seuil, 1969, par Jean-Marie Peltz. 190p. (Collections microcosme. Le rayone de la science, 29)

9. *Nursing en obstetrique,* par Françoise Piquette. 3.éd. Montréal, Renouveau Pédagogique, c1969. 254p.

10. *Nutrition and diet therapy; 1500 multiple choice questions and referenced answers,* edited by Mirenda Rose et al. Flushing, N.Y., Medical Examination Publishing, 1969. 211p.

(Nursing examination review book no.8)

11. *Pédiatrie* par Marie-Claude Turcotte-Daoust. Montréal, Renouveau Pedagogique, 1969. 424p.

12. *Popular hospital misconceptions* by Anthea Cohen. Reprinted from Nursing Mirror and Midwives Journal. London, IPC Business Press, 1969. 90p.

13. *RN's 1966; an inventory of registered nurses.* Prepared by Eleanor D. Marshall and Evelyn B. Moses. New York, American Nurses Association, 1969. 50p.

14. *Research contributions from psychology to community mental health,* edited by Jerry W. Carter. New York, Behavioral Publications, c1968. 110p.

15. *Scientific writing,* by Lester Snow King and Charles G. Roland. Chicago, 1968. 133p. (Based on a series of articles previously published in the Journal of the American Medical Association.)

16. *Standards for psychiatric facilities: a revision of the standards for hospitals and clinics.* Washington, American Psychiatric Association, c1969. 115p.

17. *Threshold to nursing: a review of the literature on recruitment to and withdrawal from nurse training programmes in the United Kingdom,* by Jillian MacGuire, London, G. Bell & Sons, c1969. 271p. (Occasional papers on social administration no.30)

18. *Writing for professional and technical journals,* by John H. Mitchell. New York, Wiley, 1968. 405p. (Wiley series on human communication)

Pamphlets

19. *Declaration of principles and code of professional standards for the practice of public relations with interpretations.* New York, Public Relations Society of America, 1963? 10p.

20. *Improving delivery of comprehensive nursing services.* New York, National League for Nursing, 1969. 36p.

21. *Present involvement in nursing education of institutions whose diploma programs, closed 1959-1968,* by Sylvia Lande. New York, National League for Nursing, 1969. 8p.

22. *Report, 1968. Toronto, Canadian Mental Health Association,* 1969. 16p.

23. *Special procedures by registered nurses and technical personnel* Toronto, Registered Nurses' Association of Ontario, 1969. 4p.

24. *Tell me where to turn: the growth of information and referral services,* by Elizabeth Ogg. Public Affairs Committee, 1969. 38p. (Public affairs pamphlet no. 428)

25. *What happens when you go to the hospital,* by Arthur Shay. Chicago, Reilly & Lee, 1969. 30p.

26. *The world health organization in Africa, 1970.* Brazzaville, Congo. World Health Organization, Regional Office for Africa, 1969. 44p.

Government Documents

Canada

27. Dept. of National Health and Welfare. Occupational Health Division. *Guide for the development of a provincial occupational health nurse consultant program.* Ottawa, 1969.

28. Dept. of Regional Economic Expansion. *Inventory of research on adult human resource development in Canada. 1963-68,* by Garnet Page and George Caldwell. Ottawa, Queen's Printer, 1969. 215p.

29. The Science Council of Canada. International Subgroup. *Scientific and technical information in Canada. pt. 2 ch. 4* International organizations and foreign countries. Ottawa, Queen's Printer, 1969. 63p. (Science Council of Canada special study no.8)

United States

30. Post Office Department. *National zip code directory.* Washington, U.S. Gov't. Print. Off., 1969, 1695p.

31. Dept. Health, Education and Welfare. Public Health Service. National Institutes of Health. *Source book for community planning for nursing in South Dakota.* Prepared by the Division of Nursing. Washington, U.S. Govt. Print. Off., 1969. 232p.

Studies deposited in CNA repository collection

32. *Effets thérapeutiques de la fonction "expressive" de l'infirmière dans l'accomplissement d'une de ses activités autonomes.* Montréal, 1969. 76p. (Thesis (M.Nurse)-Montréal)R

33. *Jeanne Mance; infirmière missionnaire laique, 1606-1673,* par Soeur Allard, Montréal, Centre Jeanne-Mance Hôtel-Dieu, 1960. R

34. *One hospitalized preschool girl's way of dealing with separation anxiety,* by June F. Kikuchi. Pittsburgh, 1969. 72p. (Thesis (M.N.)-Pittsburgh)R □

April 1970

The Canadian Nurse

university schools of nursing in Canada

a split in the family

cancer can be beaten

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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

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For Smokers Only

Having read that the Great Man Himself — Dr. Sigmund Freud — tried all his life without success to give up smoking (he apparently averaged 20 cigars a day, clenching them with some difficulty as his jaw had become cancerous and had been replaced by an artificial one), we wondered what chance *we* would have to kick the habit. After all, we lacked his obvious motivation for wanting to quit, to say nothing of his rare gift of introspection.

And our past efforts to abstain from cigarette smoking didn't offer much encouragement. As Mark Twain said many years ago, "It is easy to give up smoking. I have done it thousands of times." Nevertheless we decided to give it another try.

Admittedly, much of the impetus for our decision to stop smoking came from the non-smokers in the building — a disgustingly healthy, cough-free group who cleared their throats and rubbed their eyes complainingly whenever they were forced to enter our polluted corner. Not the least of these was a *reformed* smoker — the librarian — who continually brought to our attention magazine and newspaper items that did little for the morale. Sample headlines: Smoking Beagles Get Cancer; Female Mouth Cancer Rate Up; Smokers Responsible For More Fires; Smoker's Bad Breath Knocks Over Non-Smoker At Twenty Paces, etcetera.

If there's anything worse than a reformed smoker, particularly if she happens to be a librarian . . . . But on with the story.

It's now over 15 weeks since we had a puff. That's 15 *LONG* weeks. But we're living proof that it *can* be done. Furthermore, we've given heart a physician friend who had doubts that a heavy smoker really could quit. "If *you* can do it, *anyone* can do it," this physician exclaimed. (After an icy silence, we decided to accept the remark as a compliment.)

Has it been worth the effort? Absolutely. And we'd be delighted to pass on our method to anyone interested in trying to stop.

It's now April — "cancer month" — a good time for any smoker to quit. With pleasant weather and more outdoor activities ahead, a smoker's chance of staying off the weed is better. Now we don't want to sound like a reformed smoker, but let us draw certain facts to your attention . . .

V.A.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Show me that you care

The article, "Nurse, Please Show Me That You Care! " (Feb. 1970) by Pamela Poole seems ideal in theory, but could be practicable only in a dream hospital with one nurse to three patients. To my knowledge, no such place exists.

Until nursing conditions and salaries improve, the profession will not be attractive to young high school graduates. With a chronic nursing shortage, putting individualized care back in nursing – as explained by Miss Poole – is a far-off goal. – *J. Comeau, RN, Halifax, Nova Scotia.*

I must admit that the article, "Nurse, Please Show Me That You Care! " (Feb. 1970) made me angry. However, this does not mean I am unconcerned about nursing care. I certainly hope to see it improved, but I don't think this can be accomplished by attacking staff nurses and telling them to spend less time with routine chores and more time with patients.

How many nurses have greeted a supervisor with a comment such as: "I had a long talk with Mr. Smith tonight about his finding a place to live," and received a reply such as: "That's fine – are your wheelchairs washed? "

Staff nurses have always cared for their patients. I presume this is why most of us entered nursing. If that care has been smothered or extinguished by routine business, I suggest looking at higher levels for the cause and the cure. – *M. Hepburn, RN, Halifax, Nova Scotia.*

After reading Pamela Poole's article, "Nurse, Please Show Me That You Care! " (February 1970), I was in no way angered, but I was somewhat confused. As the new trend in nursing is toward specialization and automation – one not more than the other – Miss Poole is either putting the cart before the horse or does not believe that absence makes the heart grow fonder.

I agree with Miss Poole that a nurse is not a nurse if she does not care. I would even say that a person who does not care for others is not a whole person. Although I sympathize with the author's anxieties, this article contains no solution. Maybe, as yet, there is none.

Under the heading "ritualism vs. judgment," Miss Poole states that 20 years ago the patient was weakened by remaining in bed postoperatively. On discharge, to prevent him for falling or perhaps to prevent the hospital from a lawsuit, the nurse took the patient to the front door and accompanied him to the waiting vehicle. So, for 20 years I have been tricked into thinking that this was tender, loving care!

When progress was needed, we should have asked: progress of what, and for whose betterment? – *Dorothy M. Dent, Ottawa.*

Hurrah for Pamela Poole on her article about slavery to routine!

If nurses would stop taking the time to say, "I haven't enough time," and would take the time to give the kind of nursing care they say they want to give, they might be surprised at what they get done.

It is up to each nurse to try to get rid of routine. Unfortunately, the staff nurse can get very discouraged using her initiative and talents to help her patients, when she must continually answer to head nurses and supervisors who are hung up on routine. All supervisory staff are not like this, but a good many still are and do a great deal to interfere with individualized care. – *Rhoda L. Brooke, RN, Vancouver, B.C.*

The pregnant student nurse

I have spent seven years nursing in obstetrics – six in the case room and one as head nurse of a postpartum unit, before retiring to the new role of motherhood. During these years, I gained insight into the trauma resulting from pregnancy out of wedlock.

One patient, in particular, made me wonder about the policies of our nursing institutions. She was a student nurse with three months of training to complete when she was forced to give it up because of pregnancy. Without job training and an adequate income, she eventually had to give up her baby for adoption.

As the age of permissiveness is here to stay, all we can do is contribute a positive example to young women.

My plea is to eliminate the nursing drain that results from undesired pregnancy in the student nurse. In many cases, pregnancy forces the student nurse to leave the educational institution and go into society as just another dropout, untrained to fill any role. Few places of higher learning, apart from schools of nursing, force a student to give up her education completely because of pregnancy. Schools of nursing should examine their policies and decide whether their rules need updating. This may be hard to accept, but undesired pregnancy is here to stay.

Would we sooner have the student obtain an abortion, legal or otherwise, so that on the surface everything is rosy? Will the presence of a pregnant student taint the moral outlook of her fellow students? We would be naive, indeed, to believe so. Most young women have concluded for themselves the course of action they wish to follow in most situations, and there is not much that parents and educators can do to alter this. We can, however, alter the outcome by making available information on how to prevent pregnancy. Not all schools of nursing apply an outdated moral, ethical code to its students. But for every progressive school, there are probably five that need a change in policy.

We need to accept the fact that a number of students will be lost to the profession if forced to leave because of pregnancy. The profession needs every trained and skilled individual. We must not be guilty of old-fashioned concepts in an ever-changing world. – *Francene (McCarthy) Cosman, RN, Dartmouth, Nova Scotia.*

Change "midwife" to "matrician"

About a month ago, an article written by Sidney Katz in the *Toronto Star* was drawn to my attention. In this article, Dr. Helen K. Mussallem, executive director of the Canadian Nurses' Association, described the term "midwife" as follows: "It has a stigma attached to it. It conjures up a picture of an old, unhygienic, unscientific granny delivering babies in the backwoods, relying heavily on superstition and magic elixirs. We need a new term to reflect the scientific training of the modern nurse-midwife."

This is precisely the way in which I have thought of this word, and this has worried me as it is an obstacle to modern obstetrical developments. I would like to suggest a solution to this problem. The word I suggest is "matrician."

The first part of the word refers to maternity, motherhood, etc., and the

Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

second part refers to the scientific training necessary for the management of the mother. It compares with technician, obstetrician, etc., and has a direct relationship to maternity work. I think parents would be proud to be able to say: "Our RN daughter is now studying to be a matrician," whereas they probably would not even mention that their daughter was a midwife. Similarly, the appeal to the youngster would be far greater with this term than with anything else I have been able to come up with. The term "maternity nurse" is bulky, awkward, and difficult to apply.

I hope that publication in your journal will at least bring this matter to the attention of a large number of people who are interested and concerned about this matter. – *Michael Bruser, MD, Mall Medical Group, Winnipeg, Manitoba.*

Health Services

I would like to comment on the recommendation of the task force on health services regarding time spent by public health nurses in school service. (Task Force on the Cost of Health Services in Canada, February 1970, page 23.) The recommendation was that this time should be reduced. Since I have read only this condensed report, I do not know how the task force reached its decision. I know, however, that I do not agree with this recommendation.

I speak from experience in a generalized public health program and in a specialized full-time school health service program. It is necessary to spend enough time in the school to be part of the staff so that teachers and students feel free to seek counseling. It is possible to do a routine, superficial job in less time, but this does not fulfill a school nurse's function of preventing and detecting problems that arise.

Our society is producing more disturbed children who must be accommodated as far as possible in the ordinary school program. Due to her unique training, the public health nurse is able to help both pupil and teacher in this problem area – but this takes time.

If public health agencies find it necessary to reduce service to schools, perhaps more school boards will be forced to hire full-time nurses. On page 15 of the February issue, *The Canadian Nurse* reports that this appears to be happening, according to a survey of Ontario schools. – *Dorothy Fulford, Ottawa, Ontario.*

Up-to-date publication

After reading the February issue of *The Canadian Nurse*, I would like to say what a marvelous magazine it is and how much I appreciate the articles.

Thank you for an instructive and up-to-date publication. – *Mrs. Betty Kwiatkowski, RN, Ontario.* □

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news

CNA Legislation Committee Recommends Bylaw Changes

Ottawa. – The ad hoc committee on legislation of the Canadian Nurses' Association met February 26-28 to revise the bylaws of the Association.

In preparing the draft, members considered the bylaws recommended by the CNA ad hoc committee on functions, relationships and fee structure as well as comments and recommendations made by the provincial nurses' associations.

A copy of the revised bylaws will soon be sent to the provincial associations for study. The bylaws will be put to the vote at the general meeting of CNA in Fredericton, June 14-19.

The committee was chaired by Jeanie S. Tronningsdal, British Columbia. Members included Eileen Flanagan, Quebec; Marie Sewell, Ontario; Marcelle Dumont, New Brunswick; CNA President, Sister Mary Felicitas; and George Hynna, CNA legal counsel.

Few Jobs Available, RNABC Warns Nurses

Vancouver, B.C. – The Registered Nurses' Association of British Columbia is advising out-of-province nurses who make enquiries about registration that employment opportunities are very limited in B.C. at present. Most vacancies occur during the spring or summer months.

Nurses from out-of-the-province are being urged by RNABC to be assured of a position in B.C. before leaving their present employment. Registration in B.C. is required before a nurse can be employed in any hospital where the clinical facilities are used by a school of nursing.

However, at present nurses with post-basic preparation and experience have a wide choice of positions in B.C. above the general staff level both in teaching and in administration. For this reason RNABC is advising its members to take further study to prepare themselves for supervisory or administrative positions in such fields as psychiatric nursing, extended care, and operating room nursing.

McGill Hosts Conference

Montreal, Quebec. – Some 200 nursing students from 15 Canadian universities met in Montreal the weekend of February 13-15 for the annual Inter-University Nursing Conference.

The Conference, hosted by the students and faculty for the School For Graduate Nurses, McGill University, included both basic and postbasic baccalaureate nursing students. Universities represented were: Lakehead, Windsor, Laurentian, Queen's, Western, McMaster, Toronto, Ottawa, Montreal, New Brunswick, Moncton, Dalhousie, St. Francis Xavier, and Mount Saint Vincent College. Among those attending were several faculty members and master's students.

The first meeting of the Inter-University Nursing Conference was held in Toronto in 1968. The original purpose was to get nursing students in universities together to compare programs. A similar idea was behind the 1969 conference held at McMaster University in Hamilton, Ontario. This year, the objective was to exchange ideas and opinions about the nurse's perception of her role as defined by her education.

To meet this objective, an inter-disciplinary panel discussion was held, followed by small group workshops. Panel members were Reverend Howard Christie, chaplain at The Montreal General Hospital; Olive Goulet, associate professor of nursing, Laval University; Dr. J. Lella, assistant professor, department of sociology, McGill University; and Dr. N. Steinmetz, department of epidemiology, McGill University. Dorothy Rowles, assistant to vice-president – academic, at Ryerson Polytechnical Institute, Toronto, Ontario, was guest speaker at the banquet for official delegates on Saturday evening.

At the concluding meeting, delegates decided to form an Inter-University Nursing Association. Ground work for this will be laid during the coming months, and final plans will probably be made at next year's conference in Ottawa.

Test Service Board Holds First Meeting

Three members of the Test Service Board take time for coffee. The board met at CNA House March 4-7 and chose Helen Grice (left), as permanent secretary, Jean Dalziel (center), chairman, and Anna Christie (right), vice-chairman. Mrs. Grice is a representative of the Registered Nurses' Association of British Columbia; Mrs. Dalziel, a representative of the College of Nurses of Ontario; and Miss Christie, a representative of the New Brunswick Association of Registered Nurses. There are 18 members on the board, which was appointed by the board of directors of the Canadian Nurses' Association to establish and operate the CNA Testing Service.

Post-Convention Tour Of Maritimes Offered Nurses

Fredericton, N.B. – A week-long post-convention tour of the Maritime provinces is being offered to nurses attending the 35th biennial convention of the Canadian Nurses' Association here June 14 to 19.

The tour, running June 20 to 27, will explore the natural beauty and historic sites of New Brunswick, Nova Scotia, and Prince Edward Island. The tour package

will cost about $150, which includes transportation, accommodation, breakfast and some other meals.

Among other places, nurses will visit:

- New Brunswick – Saint John, including the New Brunswick Museum and the Reversing Falls, Hopewell Cape, Fundy National Park, Moncton, the Magnetic Hill, Fort Beausejour.
- Prince Edward Island – Summerside, Charlottetown, and the island's sandy beaches.
- Nova Scotia – Cape Breton, Ingonish, the Cabot Trail, Halifax, the south shore, Annapolis Valley, Digby, and back to Saint John, N.B., where the tour ends..

The tour has been arranged for nurses by the New Brunswick Association of Registered Nurses. Arrangements may be made directly through: R.V. Lenihan, president, Moncton Travel Agency, 735 Main Street, Moncton, N.B.

Federal Government Nurses Meet

Some 30 federal government nurses from across Canada attended a senior nurses' conference in Ottawa March 2-6. The conference was conducted as a workshop on orientation and continuing inservice education, sponsored by the medical services branch of the Department of National Health and Welfare. Enjoying Wednesday night's banquet are (left to right) Alice Smith, Adviser, Nursing Services; Catherine Keith, Adviser, Nursing Education; and Ethel Martens, Adviser, Health Education, medical services branch, Dept. of National Health and Welfare, Ottawa.

Many PEI Nursing Students Must Study In Other Provinces

Charlottetown, P.E.I. – The Association of Nurses of Prince Edward Island expects that many prospective nursing students from PEI will have to seek entrance to schools of nursing in other provinces this year.

The PEI School of Nursing, which opened in September 1969 and is the only nursing school in the province, could accept only 60 nursing students in September 1969. The same number will be accepted this year. Last year there were some 200 qualified applicants for these 60 positions.

Applicants for the school of nursing will no longer be required to pass the Atlantic Provinces Examining Board examinations as a prerequisite for admission. This is because the University of Prince Edward Island has established new admission criteria in lieu of passing the examinations, and the school is following suit.

TV's Marcus Welby, MD, Honored

Ina L. Williams, president of the Association of Operating Room Nurses, presents a plaque of appreciation to Robert Young, star of Marcus Welby, M.D., at the opening session of the 17th Annual AORN Congress held in California in February. Mr. Young welcomed the 6,000 operating room nurses and other health industry leaders to the Los Angeles area. Other participants in the opening ceremonies shown here are Betty Thomas of Denver, who was installed as the new president; and Dr. Denton Cooley, of Houston, Texas, famous heart transplant surgeon.

Hospital Budget Restrictions Put Damper On Bargaining

Amherst, N.S. – Negotiations between the board of commissioners of Highland View Hospital and the registered nurses' staff association of the hospital broke down in late February when the board said it could not offer any wage increase or additional fringe benefits for 1970.

The board said this was a direct result of budget restriction placed on the hospital for 1970 by the Nova Scotia Hospital Insurance Commission. Provincial hospitals' operating budgets will not increase this year over 1969 despite requests for an overall 10 percent increase.

The Registered Nurses' Association of Nova Scotia believes this situation will hamper all collective bargaining by nurses in 1970. To date 12 nurses' staff associations have been formed in the province.

New Two-Year Contract For RNABC

Vancouver, B.C. – The terms of a new two-year contract for some 5,000 registered nurses in 69 British Columbia hospitals have been announced by the Registered Nurses' Association of British Columbia.

The agreement worked out between the RNABC and the British Columbia Hospitals' Association is effective from January 1, 1970 to December 31, 1971. It provides for an eight percent salary increase during the first year and a seven and one-half percent increase the second year.

The 1970 base rate for a registered general staff nurse will be $549 to a

maximum of $684. The base rate for that level in 1971 will be $590 to a maximum of $740. The base rate in 1969 was $508 to $633.

The contract also provides for a shorter work week of thirty-eight and three-quarter hours in the first year and thirty-seven and one-half hours in the second year. The portability clause provides for transferable salary increments, sick leave benefits, and service credits toward extended vacations if not more than 60 calendar days elapse after a nurse's last employment in another British Columbia hospital. Benefits also include a shift differential of $1.20 for each afternoon and night shift worked.

3-M Nursing Fellowship Awarded

Geneva, Switzerland. – Berenice King of New Zealand is the first nurse to receive the 3-M Nursing Fellowship. The $6,000 award, sponsored by the Minnesota Mining and Manufacturing Company and administered by the International Council of Nurses, is for postbasic nursing studies in the institution of her choice.

Miss King, who was one of 28 applicants, is a member of the national economic welfare committee in New Zealand. As nurse adviser (nursing education) to the division of nursing of the Ministry of Health in Wellington, New Zealand, she is involved in reviewing schools of nursing. She previously held posts as ward sister, tutor sister, public health nurse in a rural area, and temporary nurse instructor in public health.

Berenice King took her basic nursing training at the Christchurch School of Nursing, New Zealand. A registered maternity nurse and registered midwife, she is also the holder of the Plunket Nursing Certificate and a certificate in psychiatric nursing. She holds a diploma of nursing from the New Zealand Post-Graduate School for Nurses and has BA and MA degrees in education from the University of Canterbury in Christchurch.

Miss King plans to use the fellowship for studies in nursing research at the Ohio State University School of Nursing in the United States. On completion of the program she hopes to return to the nursing division in New Zealand. She believes that New Zealand has a commitment to aid developing countries in the South Pacific and Southeast Asian region, and "would consider it a privilege to contribute to this aid in the field of nursing."

All 74 national nurses' associations in membership with ICN will agin be invited to submit applications for the second 3-M Nursing Fellowship, which will be awarded in January 1971.

Editor Needed For ICN Nursing Review

Geneva, Switzerland. – The International Council of Nurses is seeking applications for the post of editor of the *International Nursing Review.* The successful candidate must take up the position by October 1970 and will reside in Geneva.

Applicants must have previous experience in the editorial aspects of magazine production and must speak English, with a good working knowledge of French. It would be an advantage to be a nurse.

Further details may be obtained from: ICN Headquarters, P.O. Box 42, CH-1211 Geneva 20, Switzerland.

NBARN Sets Up Management Nurses' Association

Fredericton, N.B. – A new organization formed within the New Brunswick Association of Registered Nurses, the Management Nurses' Association, will assume an active role in nursing affairs that relate to the management nurse group. Its first meeting was held here March 16.

The association was developed in response to an expressed need for opportunity to discuss mutual goals and problems. Membership is open to all registered nurses employed full-or part-time in a management position. The constitution defines a management nurse as an RN who is responsible for administering the nursing program in a hospital or agency.

The MNA lists five objectives: to promote highest possible health standards for the people of New Brunswick; to establish lines of communication with employers and with other appropriate groups; to promote and sponsor educa-

(Continued on page 14)

ospitals' operating budgets will not in-ease this year over 1969 despite quests for an overall 10 percent in-ease.

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Velvet smooth aspiration and injection. Stable, multi-vaned plungers, extra wide comfortable wings, contoured and grooved thumb pieces combine to create a comfortable grip, perfect balance and flawless action which makes positive control a reality. Other features include easy-to-read vertical calibrations which will not rub off or fade, airtight leak-resistant connection between needle hub and syringe luer tip, and extra mixing ranges in popular syringe sizes. Wide choice of syringe sizes and needle/syringe combinations are standardized for hospital convenience and economy.

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Handy Peel Paks assure sterility of needles and syringes.** Separate easily to fully expose contents. Permit sterile aseptic introduction onto sterile field. Serve as patient charge records.

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(Continued from page 11)

tional programs and/or workshops; to regulate relations between management nurses and their employer and to negotiate a written contract; to establish and promote salaries and conditions of employment for management nurses that reflect the value of their services to society and their worth in relation to other occupations and professions.

The provincial committee of the MNA has representatives from each of five regions as determined by the provincial health district boundaries. Membership in the committee consists of regional committee chairmen and secretaries.

Officers of the MNA provincial committee are: president, Constance Morrison; vice-president, Anne Thorne; secretary, Virginia Levesque; treasurer, Ruth Dennison. Education, finance, and negotiating committees have been set up to help achieve the MNA's objectives.

"Miss Hope 1970"

Toronto, Ont. – Judy Sharpe, nurse intern at St. Joseph's School of Nursing in Peterborough, Ontario, has been chosen "Miss Hope 1970" in the competition sponsored by the Ontario Division of the Canadian Cancer Society.

TV personality Fred Davis congratulates Judy Sharpe of Peterborough, Ontario, who was chosen "Miss Hope 1970" by the Ontario Division, Canadian Cancer Society.

Miss Sharpe competed with 12 other contestants in Toronto on January 25th, each of whom gave a three-minute talk on some phase of cancer nursing, the cancer problem, and the Canadian Cancer Society. In addition to receiving a cash prize of $200, Miss Sharpe will represent the Cancer Society on special occasions at public meetings, on radio, and on television appearances. Her travels will be underwritten by the Cancer Society.

Judy Sharpe is a native of Picton, Ontario. She has her gold cord in Girl Guides and has been a Red Cross swimming instructor. When she graduates this year she plans to specialize in pediatric and intensive care nursing.

St. Lawrence College Teams With Regional School of Nursing

Brockville, Ont. – St. Lawrence College, Brockville Campus, has entered a cooperative program with the Brockville General Hospital Regional School of Nursing for the teaching of non-nursing science subjects to first- and second-year students.

A sociology course is now given to 60 first-year nursing students at the school by a St. Lawrence College teacher. In September the program will expand to eight non-nursing science courses for first- and second-year students, to be given by college staff rather than nurse-teachers, as is currently the practice.

Courses will include such subjects as developmental psychology, philosophy, and English and will result in St. Lawrence College credits on successful completion.

Elaine McClintock, director of the regional school of nursing, said the use of St. Lawrence College teaching staff to instruct non-clinical subjects will enrich the overall nursing program. She said the broader academic background of college teachers will benefit nursing students by providing a more rounded education in purely academic subjects. Mrs. McClintock pointed out that nurse-teachers will be relieved of non-clinical teaching loads, permitting them to devote full-time to nursing science instruction.

The cooperative program is patterned after similar ones developed between community colleges and their local schools of nursing throughout Ontario.

RNABC Asks Government To Adjust PH Budget

Vancouver. – The Registered Nurses' Association of British Columbia has asked the B.C. government to adjust the budget for public health services. The recommendation was made in a brief submitted in February to the provincial cabinet.

The association is concerned that in recent years the numbers of public health personnel employed in B.C. have failed to keep pace with the increase in population or with the increased utilization of services, such as home nursing and follow-up of patients being treated for psychiatric disorders.

(Continued on page 17)

The "Saneen" disposable diaper concept.

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June 14 to 19 in Fredericton

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The capital of New Brunswick, Fredericton is one of the most picturesque cities in Canada. You will be delighted with its elm-shaded streets, its parks and the scenic river winding through the city.

Visit the art gallery, where paintings by Turner and Gainsborough, Krieghoff and Dali are displayed; or the York-Sunbury Museum with its outstanding collection of military equipment and rooms furnished in period style. Fredericton's cathedral is one of the best examples of Gothic architecture in North America. Tour the campus of the University of New Brunswick, where new and old buildings combine.

While you are here, don't miss the picture province itself. Enjoy the miles of inland waterways, the boating, the many picnic and camp sites. Or head for the sunny, sandy beaches of the coast. Whether in bustling cities, quiet towns or charming fishing villages, you will find friendly hospitality in this province of two cultures - 40 per cent of New Brunswickers are French-speaking. There is much here for the historically minded, including the oldest museum in Canada, at Saint John; the French-built Fort Beauséjour; and the Auld Kirk at St. Andrews.

Not to be missed is Fundy National Park, 80 square miles of spectacular vacationland stretching from beaches and towering cliffs to deep forests and quiet lakes. Visit the Fundy Isles, including Campobello, long the summer home of the Roosevelts.

Unique natural phenomena in the province include Magnetic Hill, the Reversing Falls, the tidal bore of the Petitcodiac River and the magnificent rock formations at Hopewell Cape. New Brunswick has 180 covered bridges, including the longest one in the world. Skilled craftsmen make shopping for silver, pottery, woven, wooden and leather goods a delight. There is comfortable accommodation everywhere, and you can savor the famous Atlantic cuisine, including lobsters, salmon, oysters, fiddleheads, and dulse!

news

(Continued from page 14)

The situation has become even more critical this year because the government has allowed no increase in nursing personnel, says RNABC.

CMHA Council Discusses Mental Health Problems

Toronto, Ont. – Drug abuse and proper use of sensitivity training were among the problems discussed by some 45 menbers of the national scientific planning council of the Canadian Mental Health Association during its 22nd annual meeting in February 1970.

Among the decisions of the council were the following:

- A study group is being set up to gather information on all public health programs across Canada that have a mental health aspect. The Canadian Nurses' Association will suggest a public health nurse to be a member.
- CMHA will set up consumer guidelines for potential participants in the new sensitivity training groups run by commercial enterprises. It is hoped these guidelines will enable people to measure the value to them of such a group before taking part.
- CMHA will approve a demonstration and training project for mental health personnel concerned with the care and management of patients in a drug crisis.
- CMHA will prepare a brief to the LeDain committee on the non-medical use of drugs, concentrating on the problems of drug abuse in society.
- CMHA has established a draft of guidelines for volunteers who work in schools with a focus on emotionally disturbed children. The association believes such volunteers can be most useful.

CNA representative at the annual meeting was A. Isobel MacLeod, director of nursing at The Montreal General Hospital.

and are most abundant along the rivers and their valleys. The fiddlehead can be found in mamy areas of North America. But only in a few areas – including New Brunswick – have they become a delicacy and the basis of a business.

WHO Bans Smoking At Its Meeting

Geneva, Switzerland. – The executive board of the World Health Organization has requested that those attending its meetings refrain from smoking. The board welcomed similar action taken on cigarette smoking by WHO's regional committees for the Americas and Europe.

The board's resolution recognizes "that the individual must decide for himself whether he will risk endangering his health by smoking cigarettes, but should also have regard to the influence on others of his example." The board also stated its belief that no organization devoted to the promotion of health can be neutral in this matter.

In discussion, board members called smoking "the principal avoidable cause of premature death."

As pointed out in the resolution previously adopted by the WHO regional committee for Europe, this decision was

(Continued on page 20)

New 2nd Edition! **PROGRAMMED INSTRUCTION IN ARITHMETIC, DOSAGES, AND SOLUTIONS** *By Dolores F. Saxton, R.N., B.S., M.A.; and John F. Walter, Sc.B., M.A., Ph.D.* This carefully structured presentation, proven effective in four years of actual use, allows students to proceed in short, logical steps, at their own speed, from basic to more complex material. This new edition has been revised to include a review of basic concepts of arithmetic, presented in terms of both "old" and "new" math. It introduces the metric and apothecaries' systems, and the problems encountered in moving from one system to the other. Students then move on to mathematical problems encountered in actual nursing situations. July, 1970. Approx. 64 pages, 2 illustrations.

New 6th Edition! **SCIENTIFIC PRINCIPLES IN NURSING** *By Shirley H. Gragg, R.N., B.S.N., B.A., M.A.; and Olive M. Rees, R.N., M.A.* This extensively revised new edition uses a modern multidisciplinary approach to emphasize problem-solving by use of known principles. In effect a new book in both content and appearance, it offers a fresh new view of this basic material. Relevant material on concepts of homeostasis is correlated throughout, as is much more information from the physical, biological, social, and behavioral sciences. A meaningful section uses sample plans to demonstrate the importance of effective nursing plans, and an entirely rewritten section on rehabilitation reflects current emphasis on this area. April, 1970. Approx. 424 pages, 165 illustrations. About $8.55.

easier to teach, easier to learn!

New 4th Edition! **MICROBIOLOGY** *By Louis P. Gebhardt, M.D., Ph.D.* An ideal text for nursing students without an extensive scientific background, this well-balanced survey of fundamental microbiology carefully examines general principles, industrial and sanitary applications, and pathogenic microorganisms. This carefully revised new edition incorporates updated terminology and revised classification of microorganisms, as well as an outstanding new discussion of molecular biology and microbial genetics. A short section on rejection immunity indicates problems encountered in organ transplantation. New illustrations and an expanded glossary highlight this edition. March, 1970. Approx. 364 pages, 133 illustrations. About $10.75.

New 2nd Edition! **BASIC CONCEPTS IN ANATOMY AND PHYSIOLOGY — A Programmed Presentation** *By Catherine Parker Anthony, R.N., M.A., M.S.* This self-teaching manual can help your students develop a clear, functional understanding of the human body. In a format proven by the success of the first edition, it presents important, up-to-date material on each body system, and requires the student to respond to the information. Two new chapters in this timely revision depict the circulatory system and kidney function. Many new frames in other sections add recent developments and enhance learning. New illustrations clarify important points. July, 1970. Approx. 180 pages, 52 illustrations. About $5.25.

A New Book! **MICROBIOLOGY LABORATORY MANUAL — A Sequence of Experiments** *By Louis P. Gebhardt, M.D., Ph.D.* In this flexible manual, correlated with the new edition of Dr. Gebhardt's text, students learn basic microbiology laboratory principles and procedures, and explore soil and sanitary microbiology, microbial genetics, and pathogenic microorganisms. The 26 relatively simple experiments include sub-units which may be assigned for added depth. Their realistic design makes use of naturally occurring microorganisms and materials whenever possible. Searching questions which follow each unit guide effective review. March, 1970. Approx. 112 pages, 5 illustrations. About $5.25.

New 3rd Edition! **INTEGRATED BASIC SCIENCE** *By Stewart M. Brooks, M.S.* This compact fusion of basic physics, chemistry, microbiology, anatomy and physiology can help you eliminate time-consuming duplication of material in your curriculum. Proven effective through two previous editions, this timely revision is a logical, sequential presentation of essential laws and theories, and the application of these principles to the appropriate body system. It incorporates carefully selected new material, including a new chapter on genetics. A Teacher's Guide is furnished without charge to instructors adopting this text. April, 1970. 522 pages, 316 illustrations. $11.00.

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(Continued from page 17)

motivated by the fact "that cigarette smoking is an important cause of, or a substantial factor contributing to, premature death from bronchopulmonary cancer, coronary disease, chronic bronchitis, and other chronic lung diseases."

Nurses Discuss Communication And Evaluation

Ottawa. – Some 270 registered nurses and nursing students attended a nursing service symposium on communication and evaluation presented by the University of Ottawa School of Nursing in January 1970.

The symposium brought together scholars, specialists, and practitioners from nursing, medicine, psychology, and education to share knowledge and discuss issues. It was open to graduate nurses employed in hospitals and public health agencies in the Ottawa Valley.

First day of the symposium was devoted to communications, and included discussion on: the need for communication in health care facilities; how communications affect nursing service and the distribution of care; the nature of leadership and the need for leadership behavior. During the second day topics included: the need for evaluation in nursing service; interviewing and rating scales; developing an evaluation program for nursing care.

ICN Committee Members Outline Basic Issues For 1969-73 Quadrennium

Geneva, Switzerland. – The professional services committee of the International Countil of Nurses will recommend that a special ICN committee be set up "to study development and utilization of library resources, facilities and services for nursing."

The committee, meeting in January at ICN Headquarters, felt the need to develop the use of library resources in nursing was urgent at this time.

The committee also discussed the need for a definition of one or more groups of auxiliary nursing personnel in existence. A questionnaire will be sent to all national nurses' associations in 1970, asking if they wish to suggest new names for a second and third category of nursing personnel and to state to what extent these two categories are organized in their countries.

The committee believes the difference between the registered nurse and the categories of auxiliary nurse should be identified in terms of practice of nursing, preparation for nursing, and formal recognition awarded.

Panel members during the first day of the Ottawa University School of Nursing's symposium on communication and evaluation are, from left: Roy Laberge, editor of Canadian Labour; Geneva Lewis, director of public health nursing at the Ottawa-Carleton Public Health Unit; Roberta Rivett, of Ottawa Civic Hospital; and J. Brown, director of nursing service at Ottawa General Hospital.

ICN headquarters has prepared a "historical background to the preparation of a special international instrument on the status of nurses." The committee will in future decide on the points that nurses would wish to see included in this document when it is published. The document will deal with all nursing personnel.

The committee reviewed the ICN code of ethics and will recommend that a sub-committee be set up to consider its revision.

Chairman of the committee is Ingrid Hamelin, Finland. Members include: Laura Barr, Canada; Rebecca Bergman, Israel; Adele Herwitz, USA; Renée de Roulet, Switzerland; Gertrude Swaby, Jamaica; and Margery Westbrook, United Kingdom. This was the first meeting of the committee for the 1969-73 quadrennium.

Canadian Nurses Give Volunteer Service In West Indies

Montreal, Quebec. – Three young nurses from The Hospital for Sick Children in Toronto are working in St. Lucia, West Indies, as volunteers with Canadian Executive Service Overseas. The CESO undertaking began in 1968.

Kerry Pincombe, Susan Webb, and Anita Miller have been working at St. Judes Hospital in Fort Vieux, St. Lucia, since October 1969. They are expected to remain on the island, where they are working mainly with children, until May 1970.

Under a combined plan of CESO and the Canadian Medical Association, physicians, surgeons, nurses, and technicians take time out from their practices and positions in Canada to relieve overworked medical personnel in the Caribbean and to direct improvements in medical services in the developing islands.

The work is hard, often complicated by shortages of essential drugs and equipment, the unaccustomed heat is trying, and the queues of patients long. Yet in a recent report, the three Toronto nurses said: "So far our work at St. Judes has been very challenging and rewarding . . . the opportunities we've had really make our three years of training worth while."

The CMA selects the Canadian personnel who serve without remuneration. The host government or institution furnishes living accommodation and incidental expenses, and CESO provides travel costs.

Enquiries can be directed to Dr. John Bennett, CMA House, 1867 Alta Vista Drive, Ottawa 8, Ontario. □

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So if you're looking for a pair of Oxfords that will stand up for you, buy White Uniform by Savage.

names

James H. Wiebe is the new director general of the medical services branch of the Department of National Health and Welfare. Dr. Wiebe will direct the branch's activities, which include health and treatment programs for Indians and Eskimos, administration of quarantine regulations, and immigration medical work overseas.

Dr. Wiebe, a native of Saskatchewan, received a bachelor of arts degree from the University of Saskatchewan in 1939. While he was a medical student at the University of Manitoba during World War II, he joined the Royal Canadian Army Medical Corps. In 1946, he was seconded by the army to conduct a health program on the Caradoc Indian reserve in Ontario. After discharge with the rank of captain, he joined the newly-formed Indian Health Service of the Department of National Health and Welfare.

Dr. Wiebe has worked as medical superintendent for the Lady Willingdon Hospital on the Six Nations Reserve near Brantford, Ontario, and as director of the eastern region of the Indian and Northern Health Service, an area that included most of Ontario, Quebec, the Maritimes, and the eastern Arctic.

Margaret Phillips (Reg.N., The Hospital for Sick Children, Toronto; Cert. in Teaching, McGill U.; B.S. in Nurs., and M. Litt., U. of Pittsburgh Nursing School; Ph.D., U. of Pittsburgh School of Education) has become associate professor at the University of Toronto School of Nursing.

Dr. Phillips has worked in Toronto as a staff nurse at Sunnybrook Hospital and as an instructor in psychiatric nursing at Wellesley Hospital; in London, England, as a staff nurse at Maudsley Hospital; and in Pittsburgh, Pennsylvania, as a head nurse and supervisor at Western Psychiatric Institute, and as assistant professor at the University of Pittsburgh School of Nursing.

The School of Nursing, Memorial University of Newfoundland, St. John's, has announced four faculty appointments.

B. Coady

Shirley A. Campbell

Barbara Coady (R.N., Salvation Army Grace Hospital, Halifax, N.S.) has been appointed clinical instructor in psychiatric nursing at Memorial University of Newfoundland. Mrs. Coady previously worked as a staff nurse at the Salvation Army Grace Hospital in Halifax, an instructor at the Hospital for Mental and Nervous Diseases in St. John's, Newfoundland, and an instructor at the Salvation Army General Hospital in St. John's.

Active in the Association of Registered Nurses of Newfoundland, Mrs. Coady was public relations chairman for four years and was a member of ARNN's education committee.

Shirley A. Campbell (R.N., Akron City H., Akron, Ohio; B.Sc.N., U. of Akron) is a lecturer at Memorial School of Nursing. Mrs. Campbell held the positions of staff nurse, head nurse, supervisor, and assistant director of nursing at Children's Hospital in Akron, Ohio.

Joyti Mukerjee

Marilyn Marsh

Joyti Mukerjee (B.Sc.N., M.N., College of Nursing, Delhi U., India; B.Ed., Calcutta U., India) is a lecturer at Memorial School of Nursing.

Miss Mukerjee held a number of nursing positions in India. She was a staff nurse, instructor, nurse educator, and administrator with the West Bengal Government Service at Medical College Hospital in Calcutta and Presidency General Hospital. She also worked as an instructor with the Lien Service in Rangoon, Burma.

Marilyn Marsh (R.N., St. John's General H., Nfld.; Dipl. Nursing Education, U. of Western Ontario; Dipl. Rehabilitation Nursing New York U.; B.N., Memorial U. of Newfoundland) is a lecturer at Memorial School of Nursing. Mrs. Marsh worked as a clinical instructor at St. John's General Hospital and director of nursing at the Children's Rehabilitation Center in St. John's, Newfoundland. She has served on various committees of the Association of Registered Nurses of Newfoundland.

Philip E.T. Gower (R.N., Nova Scotia H., Dartmouth, N.S.; B.Sc.N., U. of Western Ontario, London) has been appointed assistant director of nursing service at Queen Street Mental Health Centre in Toronto.

Mr. Gower has been supervisor of eastern service at Queen Street Mental Health Centre. He previously worked at London Psychiatric Hospital and was a staff nurse in the operating room of the Toronto Western Hospital. As a member of the Registered Nurses' Association of Ontario, he was active in the creation of the Middlesex North chapter, and was chairman of the socio-economic committee while attending university.

The Winnipeg General Hospital in Winnipeg, Manitoba, has announced two appointments to the department of nursing service.

E. Margaret Nugent

Alma McKone

E. Margaret Nugent (B.A., Dipl. Education, U. of Manitoba; R.N., The Winnipeg General H.; M.A., Teachers College, Columbia U., N.Y.) has been named director of nursing service at The Winnipeg General.

A native of Winnipeg, Miss Nugent has worked as a staff nurse, clinical instructor in surgical nursing, and clinical coordinator at The Winnipeg General Hospital; evening charge nurse, instructor, and surgical nursing supervisor at Cornell University – New York Hospital; and

administrator at Shriners Hospital for Crippled Children in Winnipeg. Before her new appointment, Miss Nugent was administrative assistant in intensive care nursing at The Winnipeg General Hospital.

Miss Nugent is president-elect of the Manitoba Association of Registered Nurses. She served as first vice-president of MARN, as a board member, as chairman of MARN's board of examiners, and as a member of its education committee.

Alma McKone (R.N., Saskatoon City H.; B.Sc.N., U. of Western Ontario) has been named director of inservice education at The Winnipeg General Hospital.

Mrs. McKone has held positions in Nipawin, Prince Albert, and Saskatoon, Saskatchewan. She is currently the representative of the Manitoba Association of Registered Nurses on the Licensed Practical Nurse Advisory Council, and is chairman of the committee of inservice education directors in Manitoba.

Patricia M. Wadsworth (R.N., Vancouver General H.; B.Sc.N., U. of British Columbia) has assumed the position of staff training coordinator at The Vancouver General Hospital.

Mrs. Wadsworth has held a number of positions at The Vancouver General Hospital. After working as a staff nurse and head nurse, she was appointed assistant building supervisor and then supervisor of the outpatient department.

An active member of the Registered Nurses' Association of British Columbia, Mrs. Wadsworth has served as president of the Greater Vancouver District. She was the first chairman of the RNABC committee on economic and social welfare in 1965, and has served on a number of other committees.

Mrs. Wadsworth is completing work for a master's degree in adult education at the University of British Columbia.

Gertrude Robertson (S.R.N., Royal Infirmary, Dundee, Scotland; Dipl. Teaching & Superv., B.N., McGill U.) has been appointed associate director of nursing service at the Royal Columbian Hospital in New Westminster, British Columbia. Miss Robertson has been a staff member at the hospital since January 1969.

Before coming to Canada in 1955, Miss Robertson served with the British Army Nursing Service for three years. She has worked as a staff nurse, head nurse, and supervisor in Britain, the United States, and Canada. From 1960 until she joined the staff at the Royal Columbian Hospital, she was maternity supervisor at the Jewish General Hospital in Montreal.

Jeanne S. Martin (R.N., B.Sc., U. of Alberta, Edmonton) has joined the teaching staff of the nursing education department at Mount Royal Junior College in Calgary, Alberta, as instructor in medical-surgical nursing.

Mrs. Martin has held a variety of positions in Alberta and Ontario. She was a clinical instructor at Holy Cross Hospital in Calgary; a general public health nurse with the City of Toronto Health Department and the Victorian Order of Nurses in Ottawa; and classroom instructor at the Ottawa Civic Hospital.

A number of appointments have been made to the faculty of nursing at The University of Western Ontario.

Jessie Mantle (R.N., Royal Jubilee H., Victoria, B.C.; B.N., McGill U.; M.Sc., U. of California, San Francisco Medical Center) is assistant professor at The University of Western Ontario.

Miss Mantle has worked as a head nurse and instructor in anatomy and physiology at St. Paul's Hospital school of nursing in Vancouver. She was a Canadian Nurses' Foundation Fellow in 1968-69.

Mary Buzzell (R.N., The Montreal General H.; B.N., McGill U.; M.S., Boston U.) is assistant professor at The University of Western Ontario.

Miss Buzzell taught at The Montreal General Hospital, at St. Paul's Hospital in Vancouver, and at the University of British Columbia, and was assistant director of nursing in charge of inservice education at The Montreal General Hospital.

Jocelyn A. Hezekiah (S.R.N., Royal-Sussex County H., England; S.C.M., Oxford, England; B.N., McGill U.; M.Ed., Ontario Institute for Studies in Education) is also a new assistant professor at The University of Western Ontario.

Originally from Trinidad, West Indies, Miss Hezekiah has worked at The Montreal General Hospital in a variety of positions in nursing service and nursing education, most recently as clinical coordinator in the school of nursing.

Sheila Kelton (B.Sc.N., The University of Western Ontario) and **Sandra Fisher** (B.Sc.N., Syracuse U.) are new instructors in the faculty of nursing at The University of Western Ontario. Mrs. Fisher was formerly a staff nurse in pediatrics at St. Joseph's Hospital in London, Ontario. □

dates

April 16-17, 1970
First Assembly of the Canadian Rehabilitation Council for the Disabled, Fort Garry Hotel, Winnipeg. Theme: The voluntary agency in crisis. For further details, write to: The Canadian Rehabilitation Council for the Disabled, Suite 303, 165 Bloor St., E., Toronto 285, Ontario.

April 17-18, 1970
First assembly of the Canadian Rehabilitation Council for the Disabled, Winnipeg. Write to CRCD, Suite 303, 165 Bloor St. E., Toronto 285, Ont.

April 30-May 2, 1970
Registered Nurses' Association of Ontario, Annual Meeting, Royal York Hotel, Toronto. Write to the RNAO, 33 Price Street, Toronto 289, Ontario.

May 1970
Workshop on pediatric nursing, The Hospital for Sick Children, Toronto. For further information, write to The Hospital for Sick Children, 555 University Avenue, Toronto 2, Ontario.

May 4-7, 1970
First National Operating Room Nurses' Convention, Queen Elizabeth Hotel, Montreal. For further information write to: Mrs. I. Adams, 165 Riverview Drive, Arnprior, Ontario.

May 4-28, 1970
Developing Leadership in Supervision of Nursing Services, a continuing education course designed for nursing staff of hospitals and community health agencies who take responsibility for the work of others. For information write to: Continuing Education Program for Nurses, Division of Extension, University of Toronto, 84 Queen's Park, Toronto 5.

May 11-June 5, 1970
Rehabilitation Nursing Workshop, an intensive four-week course offered annually to registered nurses working in acute general and chronic illness hospitals, nursing homes, public health agencies, and schools of nursing. For information write to: Continuing Education Program for Nurses, Division of Extension, University of Toronto, 84 Queen's Park, Toronto 5, Ont.

May 12-15, 1970
Alberta Association of Registered Nurses Convention, Calgary Inn, Calgary. For further information write to: AARN 10256 - 112 Street, Edmonton, Alberta.

May 14-15, 1970
National workshop on increased educational opportunities for the deaf of Canada, Don Valley Holiday Inn, Toronto. Information is available from Mr. E. Marshall Wick, President, Canadian Association for the Deaf, 210-200 Gateway Blvd., Don Mills 402, Ontario.

May 19-22, 1970
61st annual meeting of the Canadian Public Health Association, Marlborough Hotel, Winnipeg, Manitoba. Write to: CPHA annual meeting, Norquay Building, Room 316, 401 York Avenue, Winnipeg, Manitoba.

May 18-22, 1970
Workshop on tests and measurements for teachers in schools of nursing, sponsored by the Registered Nurses' Association of Nova Scotia. Jean Church, assistant director, Dalhousie University School of Nursing, will be leader of the workshop. For further details write to the RNANS, 6035 Coburg Rd., Halifax, N.S.

May 26-28, 1970
Annual meeting of the Registered Nurses' Association of Nova Scotia, Acadia University, Wolfville, N.S. For more information, write to: RNANS, 6035 Coburg Rd., Halifax, N.S.

May 27-29, 1970
Registered Nurses' Association of British Columbia Annual Meeting, Bayshore Inn, Vancouver. Write to the RNABC, 2130 West 12th Ave., Vancouver 9, B.C.

May 28-29, 1970
Workshop for community nurses, sponsored by the faculty of nursing, The University of Western Ontario. Professionals from family practice education, medical sociology, and nursing research will address the group. A one-day follow-up session will be held in late fall. Address inquiries to: Ethel Horn, Associate Professor and Director, workshop for expanding role of the community nurse, faculty of nursing, The University of Western Ontario, London 72, Ont.

May 28-29, 1970
Annual meeting of the Manitoba Association of Registered Nurses, International Inn, Winnipeg. For further information, write to MARN, 647 Broadway Avenue, Winnipeg, Manitoba.

June 1-3, 1970
Annual meeting of the Canadian Conference of University Schools of Nursing with the Learned Society at the University of Manitoba, Winnipeg. For further information, write to Margaret G. McPhedran, President, CCUSN, The University of New Brunswick, Faculty of Nursing, Fredericton, N.B.

June 1-3, 1970
70th annual meeting of the Canadian Tuberculosis and Respiratory Disease Association and the 12th annual meeting of The Canadian Thoracic Society will be held at the Fort Garry Hotel, Winnipeg. Further details are available from Dr. C.W.L. Jeanes, Executive Secretary, CTRDA, 343 O'Connor Street, Ottawa 4, Ontario.

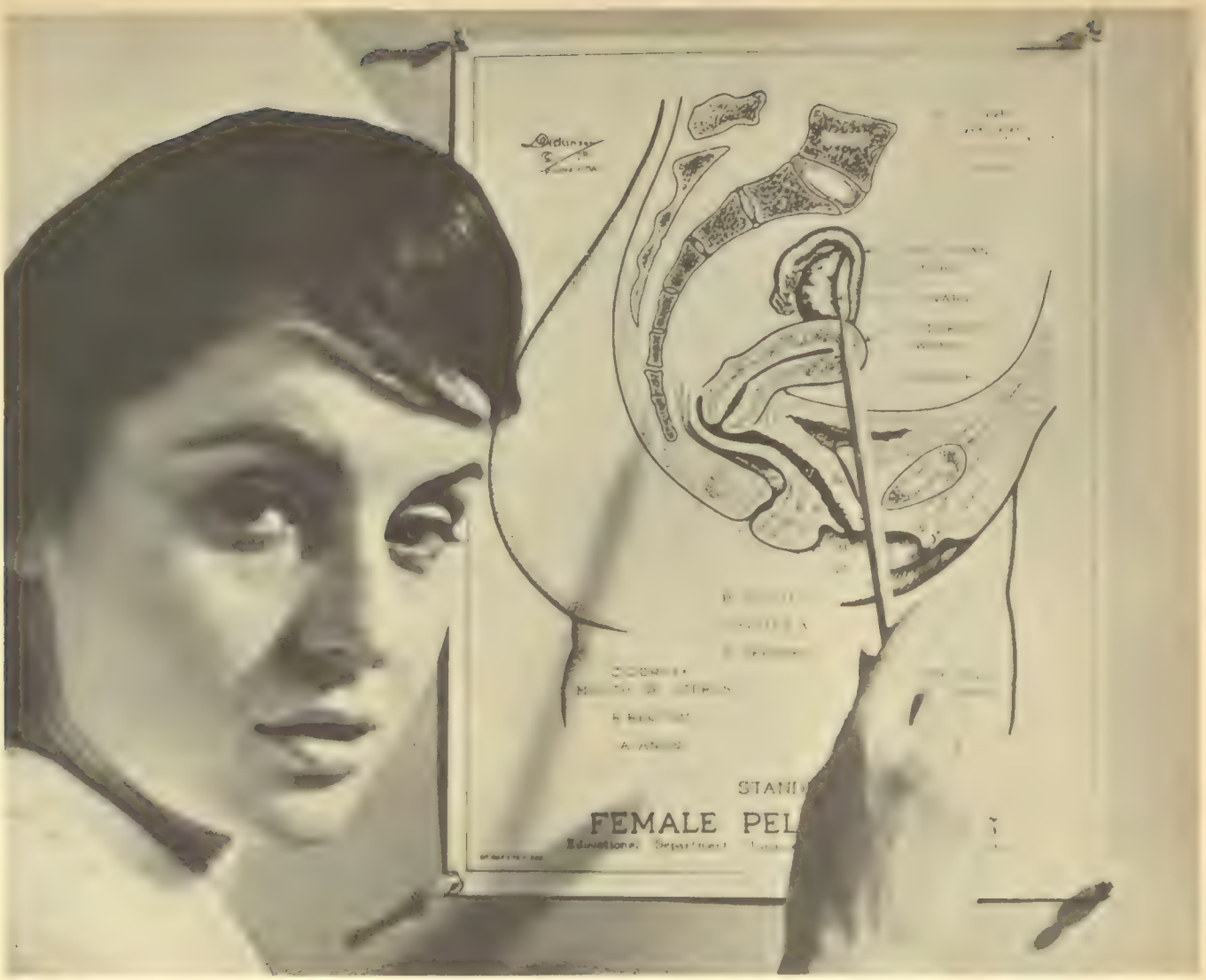
June 3-5, 1970
Canadian Hospital Association national convention and assembly meeting, Jubilee Auditorium, Edmonton, Alberta. Focus will be on the hospital and community health. Tours of the Rocky Mountains will be available at the end of the convention but must be paid for by April 30. Reservation deadline for the convention is May 1. Write to the CHA, 25 Imperial Street, Toronto 7, Ontario.

June 10-13, 1970
First annual meeting of the Canadian Association of Neurological and Neurosurgical Nurses in conjunction with the Canadian Congress of Neurological Sciences, Royal York Hotel, Toronto. For further information write to: Miss M. Maki, Apt. 306, 161 Wilson Avenue, Toronto 380, Ontario.

June 15-19, 1970
Canadian Nurses' Association General Meeting, The Playhouse, Fredericton, New Brunswick.

June 17-20, 1970
20th annual meeting of the Canadian Psychiatric Association, Winnipeg. For information, write to: The secretary, Canadian Psychiatric Association, 225 Lisgar St., Suite 103, Ottawa 4, Ontario.

July 18-22, 1970
Annual meeting of the Canadian Pediatric Society, Fort Garry Hotel, Winnipeg. Write to: Dr. V. Marchessault, executive secretary, Canadian Pediatric Society, Department of Pediatrics, University Hospital Centre, University of Sherbrooke, Sherbrooke, Quebec. □



when teen-agers want to know about menstruation one picture may be worth a thousand words

Never are youngsters more aware of their own anatomy than when they begin to notice the changes of adolescence. And never are they more susceptible to misinformation from their friends and schoolmates.

To negate half-truths, give teen-agers the facts — using illustrations from charts like the one pictured above. They'll help answer teen-agers' questions about anatomy and physiology. These 8½" x 11" colored charts of the female reproductive system were prepared by R. L. Dickinson, M.D. and are supplied free by Canadian Tampax Corporation Ltd. Laminated in plastic for permanence, they are suitable for grease pencil marking. And to answer their social questions on menstruation, we also offer two booklets — one for beginning menstruants and one for older girls — that you may order in quantities for distribution.

Tampax tampons are a convenient — and hygienic — answer to the problem of menstrual protection. They're convenient to carry, to insert, to wear, and to dispose of. By preventing menstrual discharge from exposure to air, Tampax tampons prevent the embarrassment due to menstrual odor. Worn internally, they cause none of the irritation and chafing associated with perineal pads.

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new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.

Transistorized Monitoring Instrument

A new monitoring instrument permits a doctor or nurse to keep track of fetal hearbeats of 10 patients at a time from one central listening post location.

Designated the MM-1000, this transistorized instrument was developed by the medical division of Magnaflux Corporation, Chicago, for use with its MD-501 ultrasonic Doppler shift instrument that provides an easily interpreted audible signal of fetal heart rate.

The central station unit extends monitoring to patients in separate, preselected rooms. Instant selection of any patient is available by adjustment of a station selector dial. A trained operator can listen for abnormalities in as many as 10 patients, even while performing other duties.

The ultrasonic monitoring is valuable in evaluating fetal conditions during pregnancy and labor, and in positively identifying certain conditions associated with grave prognosis in time for corrective action.

The transducer probe of the central station unit is quickly and easily affixed to the exterior of the patient's abdomen. It sends signals that are monitored through a high-fidelity, built-in speaker, or through headphones. Slight adjustment of the transducer position and of volume and tone controls on the MM-1000 panel provides fine tuning of signals.

Since the Doppler output represents motion of the fetal heart rather than sound, there is little or no interference from background noise associated with maternal motion.

This system requires no invasion of the birth canal or rupturing of membranes, which may be necessary in fetal electrocardiology.

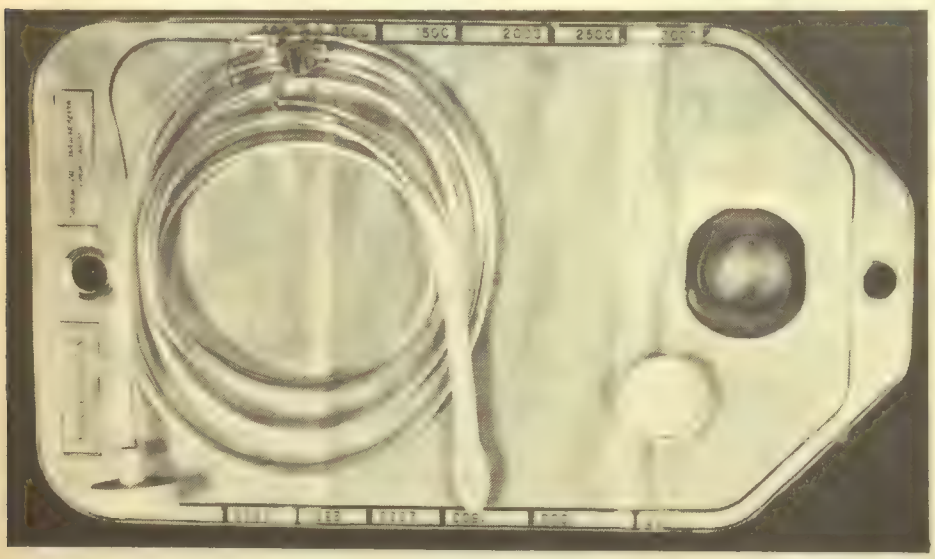
The MM-1000 unit features solid state circuitry with instant warm-up. It is finished in gray vinyl and weighs about 20 pounds. This Doppler instrument is available from Electronic Instruments Laboratory, 1565 Louvain Street West, Montreal 355, Quebec.

Safety Lap Robe

This lap robe keeps the patient covered, his legs and feet warm, and protects his clothing. The waist belt holds the patient against the back of the chair and keeps

the robe in place. The strap across the knees prevents any forward sliding movement and holds the feet in position on the footrest. The shoulder Y-strap prevents the patient from slumping forward. The item may be easily laundered. The robe comes in one size and is adjustable to all patients.

The Posey safety lap robe with shoulder strap, Cat. No. 5163-4532, is available from Enns & Gilmore Limited, 1033 Rangeview Road, Port Credit, Ontario.



Barium Enema Units

This system offers a wide choice of barium enema administration units. Advantages of the system are a rigid, wide-mouthed spout for filling; screw-on, administration sets that are attached after filling; large bore tubing with retention balloons, air contrast, and a wide range of insertion tips; one-piece, dielectrically sealed bag with built-in sediment trap and a large 3,000 cc. capacity; and finger loops at both ends of the bag for easier mixing, carrying, and hanging.

Barium enema units, pre-charged with Barimex, Baraloid, or Baracoat, or empty, are individually packaged with the widest choice of media and administration sets available. Any of the 18 variations may be ordered by catalog number.

This Macbick product is distributed in Canada through the Stevens Companies in Toronto, Calgary, Winnipeg, and Vancouver. In Montreal, Compagnie Medicale & Scientifique Ltée, and Quebec Surgical Company are the distributors.

Automatic Dialysis

A dialysis apparatus, which cleans the blood directly inside the abdominal cavity, has been developed by LKB Medical, Stockholm, Sweden. The treatment is claimed to be safer and less expensive than previously applied dialytic equipment.

Conventional artificial kidneys feature a permeable membrane through which the blood is kept in contact with the dialysis fluid. The new apparatus, PD 700, utilizes the permeability of the abdominal membrane itself. The dialysis fluid – a glucose solution – can work inside the abdominal cavity for 10 to 60 minutes. The liquid is then changed and the cycle repeated for some 10 hours until the treatment is complete.

The entire process is automatic. The apparatus measures temperature, volume of dialysis fluid pumped in and out, as well as computing the difference between durations of treatment. If the pre-set values are not followed, the treatment is automatically interrupted.

The PD 700 is especially suitable for acute dialysis and for treatment of patients at home, LKB Medical says. □

Coming Up This Spring

Freeman: COMMUNITY HEALTH NURSING PRACTICE

By Ruth B. Freeman, R.N., Ed.D., The Johns Hopkins University School of Hygiene and Public Health.

Designed for advanced nursing students and for teachers of LPN's and health aides, this new text introduces modern concepts of community health nursing as a dynamic and societally-oriented discipline. Dr. Freeman bases her presentation on two fundamental concepts: the family as the unit of service and "community diagnosis" (assessment of community health needs) as the keystone of public health practice. She devotes special attention to problems of current importance, such as poverty, family planning, and mental health. Recent research is incorporated throughout the book, and extensive lists of up-to-date recommended readings are provided.

About 500 pages. About $9.75. Ready May, 1970.

Thompson: PEDIATRICS FOR PRACTICAL NURSES
Second Edition

By Eleanor Dumont Thompson, R.N., formerly of Mary Hitchcock Memorial Hospital and Hanover (N.H.) School of Practical Nursing.

A new edition of this established text is now in press. In clear, easily understood language it tells the practical nursing student what she needs to know to care for children. The arrangement follows a developmental sequence; for each of seven age groups there is a chapter on normal growth and development followed by a chapter on disorders characteristic of the period. Learning thus proceeds from the known to the unknown. Among the topics to which Mrs. Thompson has given special attention in this new edition are emotional growth and development, the value of play, drug abuse, and newer programs for child care on the local, national, and international levels. A glossary has been added and an Instructor's Manual will be available.

About 380 pages, illustrated. Soft cover. About $5.25. Just ready.

Falconer, Norman, Patterson & Gustafson:
THE DRUG, THE NURSE, THE PATIENT **4th Edition**

By Mary W. Falconer, R.N., M.A., formerly of O'Connor Hospital School of Nursing; Mabelclaire R. Norman, R.N., M.S., University of Guam; H. Robert Patterson, Pharm.D., San Jose State College; and Edward A. Gustafson, Pharm.D., Valley Medical Center.

This well-known pharmacology text for student nurses has been thoroughly revised and updated for this new edition. New drugs have been included and information added on the chemical and physical characteristics of the drugs and their action and fate in the body. The text includes the entire **Current Drug Handbook** described below.

About 750 pages, illustrated. About $10.50. Ready May, 1970.

Falconer, Patterson & Gustafson:
CURRENT DRUG HANDBOOK 1970-72

By Mary W. Falconer, H. Robert Patterson, and Edward A. Gustafson.

Revised every two years, this convenient handbook lists 1500 drugs in current use, giving names, source, preparations, dosage, uses, contraindications, etc. in convenient tabular form.

About 224 pages. About $5.00. Just ready.

Jodais: PERSONAL CARE OF PATIENTS

By Janet Jodais, R.N., M.S., Colorado Associated Nursing Homes.

This new text for nurse's aides describes techniques of personal care, including simple treatments. Such important concepts as observation, interpersonal relationships, communication, safety, and rehabilitation are stressed.

About 350 pages with about 275 illustrations. About $5.50. Just ready.

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in a capsule

Now here's Max...

The Canadian Nurse on radio? It doesn't happen every day, so we have to tell those who missed the early-morning Max Ferguson show on CBO radio February 11 just what they missed!

Every morning around 8:25, Max takes a light look at one story in the news. On that particular day, the news was Pamela Poole's article, "Nurse, Please Show Me That You Care," featured in our February issue and carried in Toronto's *Globe and Mail.* And Max even mentioned the journal twice in his introduction.

Miss Poole, Max explained, was advocating Christian charity in nurses so that they don't wake up patients at odd hours for their own convenience.

In his skit, Max portrayed two characters – an old lady who was hospitalized, and her nurse. The nurse came to wake up the patient, who said she wasn't sleeping; she had phoned down to accounting to find out her bill and had received such a shock, she had been out cold for the last two hours.

The patient was being allowed to go home and had to get ready to leave. She thanked her nurse profusely for not waking her up at 2:00 a.m. for a bath, at 4:00 a.m. for a thermometer, etc. Each time the nurse replied, "Well, it's just an instance of our new attitude of Christian charity to our patients. We're not inconveniencing them for our own sakes."

Finally, the old lady asked for a wheelchair to take her to the front door of the hospital. "Oh, but we don't have wheelchairs anymore," the nurse replied. "They're no longer necessary. Remember – Christian charity! "

"Well, but . . . how do I manage to get to the front door then? "

"How? How do you think? Take up your bed and walk! "

Depression follows colostomy

Depression is the initial reaction of most patients after colectomy and permanent colostomy because of carcinoma. And this response seems worse in those who claim they were not prepared adequately for the operation.

The first year or so after surgery is the crucial period for determining eventual adaptation. The surgeon or nurses should help patients gain a certain degree of mastery over the colostomy before they leave hospital. This is an essential factor in the eventual adjustment of most patients.

The attitude of the family – especially the spouse – often determines the patient's self-concept when he returns home. It may be useful to include key family members in initial plans for the patient's recovery. The patient should be made aware of colostomy mutual aid clubs.

These facts were included in an abstract in the November 1969 issue of *Modern Medicine of Canada.* The original article, "Psychologic response to colectomy," by Richard G. Druss, John F. O'Connor, and Lenore O. Stern, Columbia University and Presbyterian Hospital, New York City, appeared in a recent issue of the *Archives of General Psychiatry.*

The authors reported the emotional adjustments of 22 men and 14 women to colostomies following surgery for carcinoma. A questionnaire and other follow-up data were used in evaluating adjustments. Most patients were in good physical health a year after surgery; it was mainly psychological factors that kept some incapacitated.

The first sight of the colostomy was always upsetting. It was impossible to predict eventual adjustment from overt hospital behavior, however. Some patients revealed their true feelings only at a later date. Others, often younger patients, who were most distressed immediately after surgery, had adapted well a year later.

Many patients said that confidence in their doctor or nurse, as well as their training in mastering their colostomy, was decisive in helping them through the postoperative period. A number of patients said they were glad to be alive and that the colostomy was a small price to pay for a longer life.

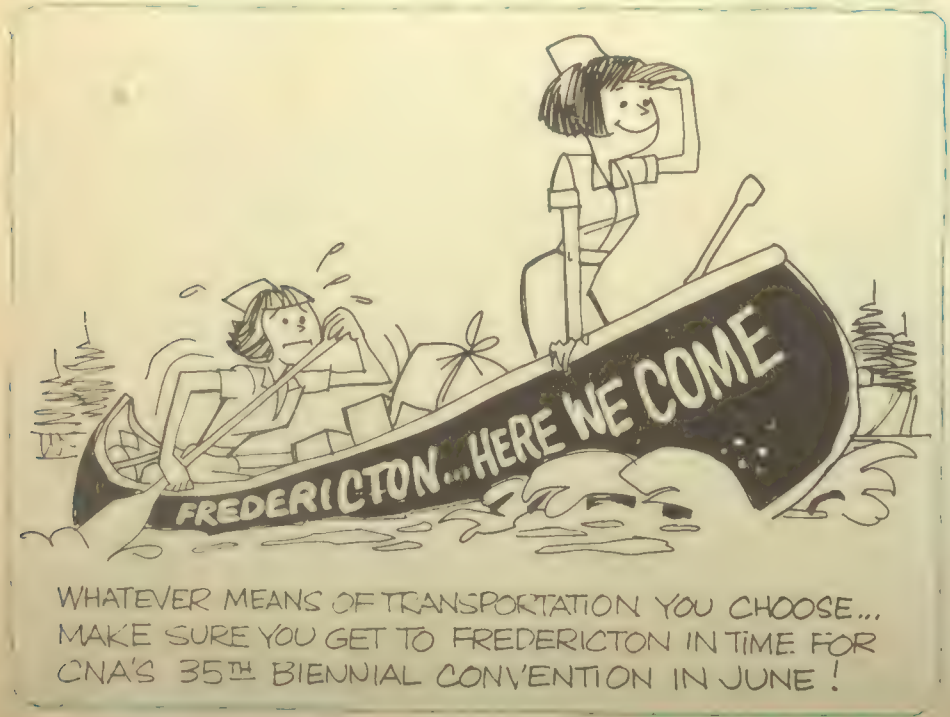
There was a definite deterioration of social relationships in nearly three-fourths of the group, the most common reason being fear of producing an odor.

J. M. M. is not dead

A correction in a recent issue of *The Journal of The American Medical Association* brought back a few memories – memories we could do without. The *JAMA* correction read: "John Montague Murphy is not dead."

It seems that the editorial gremlins, which plague all magazines and newspapers, had been at it again. They had mixed up the names of the living and the deceased. And presumably John Montague Murphy was a little perturbed to find himself listed with the latter.

These rascals played a similar trick on us a few years ago. A nurse who was included in what was then known as the "In Memoriam" column, turned out to be very much alive and very angry. The experience was as shattering for us as it was for her; it was one of the reasons why we decided to discontinue the "In Memoriam" column. □

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A split in the family

This "beds-eye-view" of nursing by a non-nurse may not heal any breaches among nursing groups, but the author asks: Why does one branch of nursing treat patients as intelligent, independent, whole persons, while the other treats the same patients as mindless, dependent bodies?

Shelagh Rose

I had plans for the last trimester of my pregnancy. Having left my job as a social worker two months before the expected arrival of my baby, I had little time to make preparations. Tasks like reading for my university course, painting nursery furniture, and going to prenatal classes I had purposely saved for this period.

It was therefore a shock to discover, on a routine visit to my doctor in my seventh month, that I had to go to hospital for the remainder of my pregnancy.

A good place to learn

Perhaps things would have worked out differently if I had been feeling really sick, but at first I was not. Once the routine of medication, laboratory tests, diet, and bed rest had been established, I wanted to go on with my postponed tasks within the limits of the maternity ward.

I reasoned this was an ideal place to continue the prenatal instruction that I had begun at the local public health center.

Nothing could have surprised me more than the reluctance of hospital nurses to answer my questions. I was not asking for information about my own condition; my doctor, on his daily rounds, was always willing to discuss this. My questions to nurses were more general:

"What caused the childbed fever that people used to die from? "

"If the doctor delivers the baby, what does the nurse do in the case room? "

I quickly learned that my questions about labor and caserooms were regarded with suspicion. I was put off with various suggestions that it was better not to know, or that I wouldn't be myself when my turn came, or that it didn't help to worry about these things.

However, I kept trying. This baby was one of the most important things to have happened in my life, and, naturally, I was interested.

After about two weeks, I managed to convince one young nurse that I should have a tour of the case room, arguing that I had missed going with my prenatal class. She gave me the "grand tour" and I had a chance to ask all sorts of questions:

"Why is the box for the baby elevated at one end? "

"At what stage of labor does one move from the labor room to the case room? "

"How much would I be able to see in the overhead mirror? "

"Would I be allowed to see the placenta? "

There was only one thing in the case room that worried me, and because I saw it I had a chance to discuss my fear with my doctor and have his reassurance. The

The author has degrees in arts and social work and is presently working toward her master's degree in adult education at the University of British Columbia, Vancouver, B.C.

nurse who had taken me on the tour, however, confessed she was sorry she had.

Ignorance is not bliss

Finally, the attitude of the nursing staff so annoyed me that, bursting with frustration, I tackled my doctor on the subject of hospital nurses. Why were they so different from the public health nurses who had been willing to answer my questions? I asked. Why did hospital nurses greet my questions with indifference, suspicion, anxiety, or even hostility?

What was the matter with these nurses? I stormed. They seemed to believe that ignorance is bliss – and surely that idea went out with the nineteenth century!

My doctor calmed me and I shall never know if he discussed this with the nurses. I only know that my relationships with the nurses began to improve. Perhaps they just grew accustomed to me, like the pert redhead who asked, "Once you get an answer you don't worry any more, do you?"

There were also nurses who responded to my private campaign of brainwashing, which consisted largely of letting them know how much easier it is to cooperate in treatment if you know what to expect.

Only hospital nurses

During my convalescence, I continued to be disturbed by my inability to reconcile the attitude of hospital nurses with that of nurses I had known in college classes and as colleagues in schools and social agencies.

Why was it that public health nurses tried to help the "whole person," but hospital nurses did not? Public health nurses encourage patients to participate in their treatment and try to teach them to accept responsibility for continuing good health. In general, public health nurses make demands appropriate to intelligent, independent adults.

Hospital nurses seem content to deal with patients as physical beings and to encourage dependency, sometimes beyond the needs of the medical situation.

Do nurses not receive the same emphasis in their professional training as I did in social work – that people must be viewed as physical, social, and emotional beings? This doctrine must by now have been adopted by all the service professions.

Yet, when I asked one nurse how she would feel if a teacher treated her children as little bundles of intellect, without regard for their physical comfort or personality needs, she seemed not to understand me.

Another example

I was not the only one. A lovely Spanish girl on the ward was about to have her second child, this time by Caesarean section because of an Rh complication. She had many fears about what she would be facing.

Although I was a stranger, she expressed her doubts to me when she discovered that I was recovering from a similar operation.

Despite her problem with English, there was no mistaking that three things worried her: that this was not a "natural" way to have a baby; that operations are dangerous; and that she would have great pain.

Not being a nurse, I could only reassure her that for some, nature's way is not the best way, and people like us should be glad doctors have alternatives. I agreed that there is a risk with surgery, but added that a doctor weighs this against the other risks when making a decision. Finally, I admitted there was pain, but assured her that the nurses would do all possible to make her comfortable, and that she would not be able to recall the feeling of pain once it was gone.

Although she squeezed my hand and repeated her thanks, I am quite certain that it would have meant more to her to have had this reassurance from people who understood her medical condition and were actively involved in her care.

Epilogue

It is entirely possible my expectations of hospital nurses are quite unreasonable, and that I experienced conflict because I was expecting something that is not in keeping with the nurses' role as they define it.

If, on the other hand, the present trend toward automation in nursing care necessitates a redefinition of the nurses' role, then a worthy objective may yet be found in caring for the "whole patient."

A preview of this paper was sent to the administrative staff of the hospital and they accepted the inherent challenge. A high standard of patient care makes it possible for this hospital to explore the teaching function of the nurse without detriment to other tasks, and it may be that the results of their program will provide a sequel to this story. □

Welcome to the picture province

New Brunswick, with its picturesque countryside and 600 miles of sea shore, its quiet villages and bustling cities, will be the extra attraction for nurses who attend the 35th general meeting of the Canadian Nurses' Association in June.

Valerie Fournier, B.A., B.J.

A scenic wonderland surrounded on three sides by the sea, New Brunswick deserves its description as the picture province of Canada. It is a giant rectangle, some 28,000 square miles in area, bounded by the Bay of Fundy and the Gulf of St. Lawrence on the seaward sides and by Quebec, Nova Scotia, and Maine on the land frontiers.

Inviting roads lead you through vast forests, rivers, and hills and along 600 miles of seacoast. New Brunswick offers the summer visitor clean, uncrowded beaches, warm sunny days and cool nights, the quiet charm of the rural countryside.

New Brunswick is a busy, progressive province. It has vast pulp and paper mills; commercial fisheries on a large scale; large mineral resources now being developed; and a thriving agriculture of potatoes, poultry, livestock, and apples.

But New Brunswick is also steeped in history. Nearly 45 percent of its people are French speaking and the influence of their Acadian background has blended with that of the modern-day descendents of the United Empire Loyalists who emigrated north during the American Revolution. The population of 626,000 lives in fishing villages or bustling cities, in quiet towns and snug rural communities.

You would naturally think of a holiday by the ocean in New Brunswick. Along the coast are dozens of sweeping beaches, safe for children and a delight to adults. At night the moonlit beaches become ideal settings for the famous lobsterbakes.

But the province also has more inland waters for its size than any other area on the continent, which is one reason why it is host to thousands of sportsmen every year. In rivers such as the Restigouche and the Miramichi you can do battle with the Atlantic silver salmon, the "king of the game fish." Or you can enjoy the beauty of rivers like the St. Croix, the "sentinel river," which makes part of the border with the United States, or the Saint John, known as the "Rhine of America" – though most New Brunswickers call it "The River."

These inland waterways invite you to go sailing, power-boating or canoeing while you enjoy the rolling farmlands and pleasant landscapes. But the real sailing enthusiast will prefer to brave the ocean: sailing about the Fundy Isles is an unforgettable experience, and throughout the summer Shediac Bay on the east coast is bright with sails.

For those who prefer to travel on firm land with tent or trailer, New Brunswick offers some 60 parks, including five beach parks and two wildlife parks, all conveniently situated along the province's main highways. Facilities range from basic, near-wilderness sites to fully-serviced campgrounds, and many parks are located near one of the beauty spots of the picture province.

Mrs. Fournier, a graduate of Carleton University's School of Journalism, is Public Relations Officer at the Canadian Nurses' Association, Ottawa.

Past and present

The flavor of its colorful history exerts a strong influence on life in New Brunswick, which abounds in historic buildings and monuments. Since 1534, when French explorer Jacques Cartier recorded his delight in the area, New Brunswick has played its part in the history of North America. Local museums dot the countryside, inviting you to look at the past. Pioneer days come to life in Canada's first public museum, the New Brunswick Museum at Saint John. Here, the story of the province is told through visual presentations that evoke the Indian, French, and English periods of the past. One section of this museum is devoted to antiques and toys of yester-year.

Other historic sites include: Fort Beauséjour, built in 1751 by the French as a protection against the British when New Brunswick was a pawn in the power struggle between the two nations; the Auld Kirk at St. Andrews, built in 1822 by the early Loyalists, where congregations still worship; or Dochet Island, where Samuel Champlain and the Sieur de Monts wintered with their men in 1604-5.

Many towns and cities across the province have a fascinating past. St. Andrews is known far and wide as a summer resort, and many distinguished Americans and Canadians have built beautiful homes here. It was founded in 1784 and is one of the oldest towns in New Brunswick; it is also noted as a commercial fishing center. From St. Andrews you can drive on the sandy floor of the ocean across to Minister's Island – at low tide, that is. At high tide the road is under 10 feet of water.

Saint John, largest city in New Brunswick, is the oldest incorporated city in Canada. The Saint John River mouth was discovered by Champlain in 1604, and the area was controlled by the French until 1758, when it was captured by a British expedition. In 1785 the Loyalist settlements at Saint John were made into a city by royal charter. You can visit the Martello Tower, an unusual form of fortification constructed in 1812, Loyalist House, unchanged since 1817, and many other historic sites. In contrast, Saint John is one of Canada's principal ports, with dry dock and shipyards built to handle the largest ocean-going vessels. It is also a busy industrial city.

North, south, east and west

Other towns in New Brunswick offer everything from a waterfall to wildlife sculptures to a lobster festival. First stop on the Trans Canada Highway after the Quebec border is Edmunston, where you see part of the province's great pulp and paper industry at work. The channel of the Saint John River and other tributary streams sometimes look like solid rivers of pulp logs.

Forty miles down the highway is Grand Falls, named after its waterfall, which drops directly 75 feet. Twelve miles from Fredericton* is Oromocto, which has developed from a village of 675 inhabitants in 1956 to an up-to-date town of more than 14,000. This extraordinary growth was brought about by the establishment of Canadian Forces Base Gagetown, the largest military training area in Canada.

A couple of miles from Sussex, known as the dairy center of the Maritimes, is "Animaland", an unusual exhibition of sculpture. Here Winston Bronnum, one of the best-known sculptors of wildlife, has set up a hundred of his carved animals in natural woodland settings; the visitor walks along paths among the trees and discovers animals from moose to bobcat.

Moncton is known as the hub of the Maritime provinces because of its geographical location; it has become the travel and distribution center of the three provinces. The Miramichi district is a history-steeped area, and the history of the two main communities, Chatham and Newcastle, is bound up with the days of long lumber and wooden sailing ships. Today the economy of these cities is still largely dependent on extensive lumbering and allied operations. The late Lord Beaverbrook, famous British press lord, spent his boyhood days at the Presbyterian manse in Newcastle.

Situated on the Northumberland Strait section of New Brunswick, Shediac is known chiefly for its splendid views and bathing beaches, which have made it one of the most popular summer resorts on the Atlantic coast – particularly since the water temperature there is unusually high. One of the highlights of any New Brunswick vacation should be the annual Shediac lobster festival, with its parades, carnival, and games.

North shore

New Brunswick's main highway of commerce and recreation – Highway 11 – hugs the north shore and gradually sweeps along the east coast, offering the visitor the picturesque charm of a section inhabited mainly by Acadian-French.

The first city, Campbellton, an ocean port and rail center, is landmarked by a bald, 999-foot mass known as Sugar Loaf Mountain, one of the province's tallest peaks. Fifteen miles down the coast is Dalhousie, home of a large newsprint mill and a popular summer resort, with a sandy beach noted for its strange fossils and myriad colorful stones.

Skirting the 55 miles of Bai des Chaleurs (which means bay of warm waters) from Dalhousie to Bathurst, another prominent lumbering and paper port, is a succession of summer resorts. Sandy beaches are found all along this stretch,

Would you believe a hill where cars coast uphill without power? That's what happens at New Brunswick's famous Magnetic Hill!

The bustling docks at Saint John contrast with a lamppost that evokes the historic past of New Brunswick's largest city.

and the tourist armed with a shovel can dig clams for added fun – and a delicious meal.

From Bathurst, the shore route leads to Caraquet, a picturesque Acadian fishing community said to be the longest village in the world. This colorful spot is the home port for the largest fishing fleet in the province and is also a busy port of call for steamers and tankers. A new marine museum is open to visitors. Farther on is Shippegan, which rivals Caraquet in popularity, and Shippegan Island, famous for its peat moss industry.

One of the most colorful events along the north shore is the blessing of the fleet, an annual ritual that takes place on a Sunday in July at one of the main fishing villages. Fishing draggers representing the various districts form a procession and travel up the bay vying with one another in the gaiety of their decorations.

This area of the province is believed to have been a pirate sanctuary. According to local gossip one family lived it up for quite a while after discovering gold coins in an iron pot at Caron Point.

Fundy park and isles

A must for any visitor to New Brunswick is Fundy National Park – 80 square miles of spectacular vacationland sweeping in a wide panorama from the coast. Along the park's eight-mile shorefront are sheltered coves with sandy beaches and towering cliffs buffeted by the strong Fundy tides. Facilities include an outdoor, warmed, salt-water swimming pool, and a nine-hole golf course with its first tee some 200 feet above the green.

There are deep forests, quiet lakes, and tumbling streams for the angler. Wildlife is plentiful and is protected. You can hike or ride horseback along the many trails, paint or take photographs of the magnificent scenery. Every kind of accommodation is available, and there are many camp and picnic sites. The New Brunswick School of Arts and Crafts operates in the park during most of July and August each year, offering visitors an opportunity to learn simple craft work through courses ranging from a single day to six weeks.

Leave the mainland behind for a visit to the Fundy Isles – Grand Manan, Campobello, and Deer. They form a maritime world of their own, but you can reach each island by ferry.

Largest island is Grand Manan, center of the commercial fishing activity of the islands and of the unique dulse-gathering operation as well. Dulse is a seaweed that grows on tidal rocks and is picked at low water to be brought ashore and dried on the beach. Dulse is a health food, and you either love it or hate it! The towering cliffs of the island's western edge contrast with the gentle slope of its eastern beaches.

Campobello, long-time summer home of the Roosevelt family, is the site of the first memorial erected to the late U.S. President, and the property has now been dedicated as a joint Canada-U.S. park. Deer island is also a center of commercial fishing, and the island's lobster pounds – the largest in the world – ensure a year-round supply to gourmets around the world.

Unique natural phenomena

New Brunswick boasts several free shows not to be found anywhere else in the world, such as the Reversing Falls, where the Saint John River meets the sea at the head of Saint John harbor. The freak action of the Bay of Fundy tides, the highest in the world, causes the ocean

The strange-shaped rocks at Hopewell Cape are one of New Brunswick's unique natural phenomena.

water to push the river water upstream for a while; later, when the tide is at low ebb, the river tumbles over the deep gorge, pursuing a normal course to the ocean. Only when the water level is at slack can boats navigate through the Reversing Falls rapids. At other times it is a boiling caldron of treacherous rapids and tricky whirlpools, a delight for camera enthusiasts and those interested in the unusual.

Another display is put on by the Petitcodiac River, where a broad wall of water known as a tidal bore surges upriver at certain times each day. One minute the river is almost a dry bed of mud; the next it is a roaring tide of water. Again it is the Bay of Fundy tides that force the water into the mouth of the river under tremendous pressure twice a day.

Audience participation is needed to appreciate Magnetic Hill, located seven miles from Moncton. You drive your car to the bottom of the hill, shut off the

Camping amid the scenic beauty of Fundy National Park is one of the joys of a New Brunswick vacation. This park has an eight-mile shorefront.

engine, and it coasts uphill backwards without help! Some say it is an optical illusion, but most visitors to the hill simply say they don't know how it happens. While at the hill you can also visit the nearby provincial game farm and observe at close range deer, moose, bear, and beaver in their natural habitat.

The curious rock formations at Hopewell Cape on the upper reaches of the Bay of Fundy are well worth a visit. Known as the Sentinels and the Caves, these giant columns of rock that guard the entrances to huge caves have been quarried from the soft red sandstone by the erosive action of the Fundy tides. Atop one of the columns grows a good-sized tree, billed as "the largest flower pot on earth."

Perhaps the greatest oddity of them all has been seen by only a few: the mysterious fire-ship that sometimes haunts the Northumberland Strait. It is a large full-rigged four-masted ship, with her masts and sails ablaze, and she only appears when a rainstorm is lashing the area. Nobody knows her origin, and to date she is simply known as "the phantom ship of Northumberland Strait."

Bridges & bargains

A delightful feature of New Brunswick is the abundance of covered wooden bridges — about 180 in all. They include the longest covered bridge in the world, 1,282 feet long, at Hartland. Most of these old bridges are off the beaten paths; on many you can still find ornate hand-lettered signs promoting horse blankets, liniments, and buggy whips. There are even reminders to "walk your horse and save the fine." The provincial government has instituted a long-range plan to save some of these covered bridges and restore them to their original condition.

Another way to get across New Brunswick's many waterways is by ferry; the province has a fleet of car ferries that ply the main rivers. All are free.

Shopping, or just browsing, can be a treasure hunt in New Brunswick; the contemporary crafts have a sophistication of design that makes them valued souvenirs. Meticulous craftmanship distinguishes the hand-wrought silver, the graceful pottery and the famous woven, wooden, and leather goods. You can buy beautiful handwoven tweeds at St. Andrews, silver jewelry set with native stones at a studio in Sussex; or visit the Loomcrofters at Gagetown and the Madawaska Weavers in St. Leonard.

All over the province craftsmen produce attractive leather goods, wood carvings, basketry, needlework, metal-craft, and allied arts. You should also visit the Indian and Eskimo craft center at Nashwaak, which offers the largest selection of native crafts in the Maritimes.

Leading Canadian artists have studios in New Brunswick, where tourists are welcome and advice is dispensed to all who ask. Collectors who wish to buy paintings to take home will find them in abundance and variety and at reasonable prices.

One other treat the visitor to New Brunswick will not want to miss is the Atlantic cuisine. You can enjoy fresh lobster, salmon, oysters, delicious berries of every kind with thick country cream, and fresh vegetables. You can make up your own mind about dulse, and savor the delicious fiddlehead greens. Wherever you go New Brunswickers will give you a warm and friendly welcome. And you can be sure of a unique stay in the picture province — after all, where else can you find a reversing falls, the world's longest covered bridge, and a phantom ship? □

Cancer detection clinic

More than 20 years ago, a few women took advantage of the facilities offered in this clinic at Women's College Hospital in Toronto. Since then, many more have attended the clinic and found the hope of cure through early detection.

Fanny H. Cracknell

More than 20 years ago, a group of doctors at the Women's College Hospital in Toronto, Ontario, decided to establish a cancer detection clinic for women. Recognizing the importance of detecting cancer in its symptomless early stage, these doctors organized a physical screening program whereby women could be examined at regular intervals.

The first clinic opened in 1948 in a corner of the outpatient's department at this hospital. The screening included examination of the breasts, cervix, rectum, skin, chest, and blood.

Obviously, these examinations could have been done by the patient's family doctor; and in many cases they were. However, a large group of women did not have an annual examination and many had never had a Papanicolaou smear of the cervix taken. To avoid duplication by the family doctor and the clinic, a potential patient was asked to get her doctor's cooperation. This meant he would examine the patient annually and include a Pap smear, or encourage her to attend the WCH clinic, and accept responsibility where treatment or referral was indicated.

The first clinics

The clinic opened in 1948 with a staff of seven: five doctors, including the director, Dr. Florence McConney, one nurse, and two volunteers.

We were fortunate to have the financial support of The Ontario Cancer Treatment and Research Foundation, whose subsidy has supported us through the years. The Soroptimist Club furnished the clinic and has helped to maintain the equipment.

The original charge of five dollars soon became unrealistic. Today, for holders of the Ontario Hospital Services Insurance Plan, the charge is eight dollars. Others pay twelve dollars. Fees are reduced accordingly if a patient is unable to pay the usual charge.

Publicity was no problem since it was almost as if women had been waiting for a clinic such as this. Before long there was a waiting list one year in advance. During the first two years 1,502 patients had been to the clinic. It required two mornings to examine 12 patients. To examine more patients we needed larger facilities.

Eventually we acquired an old house at 61 Grosvenor Street, added another nurse to our staff, and opened a larger clinic in 1950, where we could examine 12 patients a day, five days a week. To our surprise the number of persons on the waiting list continued to increase. For one month we suspended new applications. When calls were resumed, 52 applications were made in one day. Attendance in 1950 rose to 1,878.

Fanny (Posno) Cracknell, a graduate of Brantford General Hospital, is nurse-in-charge at the Women's College Hospital Cancer Detection Clinic, 901 Bay Street, Toronto, Ontario.

Common cancer sites

From an analysis of the data compiled over 20 years at the clinic, cancer of the uterus was most common, followed by skin, breast, rectum, gastrointestinal tract, ovary, and lungs.

To examine the cervix, we use the Papanicolaou smear, recognized during the 1940s as a safe, reliable, surface biopsy. If the Pap smear reveals cell changes, the patient is seen every two to six months, depending on the severity of dyskaryosis. These findings may remain static for months or years; not infrequently the Pap may eventually show a negative reading.

If the Pap smear indicates increasing dyskaryosis, Class IV or V, a cone biopsy is indicated and this is brought to the attention of the patient's family doctor. If he wishes to have further diagnostic procedures carried out at the Women's College Hospital, the patient is admitted.

In early stage cancer, the cone biopsy may be sufficient treatment. This patient is reexamined after six months and then annually. Several of our patients are in this category.

When the disease reaches the invasive stage, the cone biopsy is only a diagnostic measure and must be followed by further surgery or sometimes radiation. If this does not constitute a cure, further surgery, with or sometimes without radiation, does. Today, uterine cancer is almost 100 percent curable if diagnosed and treated in the pre-invasive stage.

During examination for breast malignancy, the patient is taught how to examine her own breasts. In several instances patients who have attended our clinic have discovered lumps during their monthly breast self-examination. Some of these lumps proved malignant on biopsy. The possibility of cure was much greater because of early detection.

In some cases, however, breast self-examination makes a woman more anxious. Then she is encouraged to see her doctor or come to the clinic for an examination.

The use of soft tissue x-ray technique, known as mammography, provides an additional method of detecting small lesions in the breast. When a suspicious mass is found by palpation, the diagnosis can be confirmed by x-ray.

In addition to the digital examination, which is part of the routine screening, a protosigmoidoscopy is carried out for patients who require it or wish it.

When the clinic opened, a chest x-ray was included in the examination. Today, patients are referred to their local chest clinic. Although a detailed history is taken, examinations at the clinic are limited to accessible organs. If further examination is indicated, we recommend this to the patient's doctor.

The nurse's role

How does the nurse fit into this program? Basic clinical experience in assisting physicians and guiding patients is a necessity; as well, the nurse must be able to perform certain procedures, such as obtaining blood specimens.

TABLE 1

Total patients seen	31,814
Total examinations conducted	58,732
Malignancies detected	346
Sites	
Uterus	131
Skin	102
Breast	75
Rectum	12
Ovary	6
Gastrointestinal tract	6
Blood (leukemia)	6
Mouth, neck, and thyroid	4
Lung	3
Fibrous sarcoma	1

However, the main challenge is psychological. We face a constant barrage of questions by telephone and letter. Some express a great fear of cancer, others are not even related to the cancer problem. The nurse must be well-informed and able to communicate easily with those who ask for help. Often she directs patients to other sources of medical help.

As nurses, we have a responsibility to avoid creating a false sense of security. We stress the value of regular examinations, listen to the "quiet worrier" express her concerns, answer her questions, and direct many to family doctors and medical centers for problems unrelated to cancer.

How well-informed is the average woman about cancer and its treatment? Literature from the Canadian Cancer Society has helped her to be much better informed than women were in the past. However, the rather sensational and, at times, premature news stories in the press often cause confusion and fear. After the appearance of such an article or news item, we invariably receive an increase in telephone calls and letters.

The clinic grows

Attendance at the clinic continues to grow. In 1958, when Dr. Henrietta Banting succeeded Dr. McConney as director, the staff consisted of three doctors, two nurses, a full-time typist with bookkeeping experience, and a part-time filing clerk. Approximately 2,846 visited the clinic that year.

By 1964, attendance reached 3,703 and the waiting list was long. Since 1965, when 4,836 women were examined, the number has remained relatively stable. We see an average of 24 women daily. Many arrange an annual appointment. The physical screening at the clinic does not take the place of the annual physical examination by the family doctor.

When Women's College Hospital expanded its facilities in 1966, we moved to our present location at 901 Bay Street. The move did not create any great change, although more people are attracted and wander in for information. Men are directed to outpatient departments at nearby hospitals.

Women frequently are referred to the clinic by their family doctor. Those referred by doctors in the smaller cities and towns often attend in groups of five or more. The atmosphere in the waiting-room almost resembles a social gathering, which helps lessen tension for the apprehensive individual. During the Easter or Christmas recess, the clinic becomes a gathering place for teachers.

Statistics

As attendance at the cancer detection clinic grew, our statistics took on more meaning. From a large group of apparently well women, we compiled statistics between 1948 and 1968, shown in Table 1.

Statistics are incomplete – not so much in what they express, but in what they leave unexpressed. For the one patient in 92 who had cancer during this period, there were 91 who did not.

Conclusion

Our work never becomes monotonous. Every day brings surprises and challenges. We never know who our next patient will be. It could be a doctor's wife, a young student, a famous author or artist, a charwoman, a teacher, a nurse, or a housewife. They all come. □

Cancer can be beaten

The nurse's fight against cancer is not limited to care of patients who have the disease. Equally important is her responsibility to help reduce the number of persons who fall victim to the disease and to overcome the attitudes of defeat and fear that surround the word cancer. Knowledge of the agencies involved in cancer research, education, and treatment will help her fulfill her role.

Kell Antoft

Although in terms of mortality statistics cancer is the second cause of death in Canada, only about 40,000 new cases are discovered each year. If each Canadian doctor were to see an equal proportion of these cases, the average would be less than two cases per doctor per year.

Since cancer therefore is not an everyday experience for the doctor, he needs the support of all health and educational resources to detect the disease early. Furthermore, since many cases of cancer can be prevented, an all-out effort is needed to teach the public about signs and symptoms of cancer and early detection.

How to keep informed

In what way can the nurse keep herself informed so that she can speak intelligently about cancer? To help her, the Canadian Cancer Society and its sister organization, the National Cancer Institute of Canada, carry on extensive professional education through literature, films, and lectures. Because these efforts are carried out largely by volunteers, nurses can help by making their interest known to the local unit of the Society.

Frequently nurses are bewildered by the different organizations involved in cancer treatment, research, and education. In many provinces, for example, there are provincial cancer control foundations operating under government sponsorship. The primary concern of these foundations is to provide diagnostic and treatment services.

Then there is the National Cancer Institute of Canada, which is primarily responsible for the support of research on the causes and nature of cancer. The Institute is a professional body with membership drawn from Canadian medical schools, professional societies of doctors and government agencies, as well as from the Canadian Cancer Society. The Society considers the Institute to be its research arm and provides most of the funds required to finance its program.

The Institute provides the major financial support for cancer research units at a number of Canadian universities. These units consist of small groups of scientists working on a particular aspect of the cancer process. The Institute also has responsibility for professional education about cancer, and provides professional groups with films and literature for teaching purposes. To doctors already in practice, the Institute makes available *Ca*, a quarterly journal devoted to discussions of diagnostic and treatment problems and to reports of new developments resulting from research. The Institute serves a somewhat similar function for the dental profession, since dentists are in a position to detect early or precancerous changes in the oral cavity.

The Canadian Cancer Society, a volunteer organization of both laymen and professionals, operates through a system of units and branches with activities coordinated by provincial divisions. Since its founding in 1938, the Society has put its main emphasis on education about cancer.

New demands have been made as knowledge of cancer has increased. The cervical cytology technique, for example, raised the prospect that cancer of the cervix could be eliminated if the female population became convinced of the need to seek this test every year or so. Research that eventually led to the understanding of cigarette smoking as the primary cause of lung cancer created the need to present factual material and involved the Cancer Society in a study of all the complex problems of seemingly irrational human behavior.

The Canadian Cancer Society also has an important role in providing services to patients. The need varies from province to province, since in some areas provincial health insurance schemes do not cover the specialized needs of patients with cancer. The Society's services include such things as transportation of patients to treatment centers; provision of dressings, drugs, and colostomy appliances; operation of lodges and hostels for out-

Mr. Antoft, now with the Institute of Public Affairs, Dalhousie University, was formerly assistant executive director of the Canadian Cancer Society and the National Cancer Institute of Canada.

Student nurse finalists in the "Miss Hope" contest, staged by the Ontario division of the Canadian Cancer Society, participate in the 1968 Grey Cup Parade in Toronto. A photo of this year's "Miss Hope" is on page 14.

of-town patients; and, above all, the warmth and understanding of thousands of volunteers who do all they can to alleviate patients' fears and suffering.

Cancer can be beaten

The nursing profession has taken a prominent part in the development and the carrying out of the Society's educational program. In addition, nurses have provided outstanding leadership at all levels. For example, they were the first to sound a note of caution about the Society's former educational program, which emphasized the importance of the danger signals of cancer.

Nurses were concerned about this negative approach because they recognized that fear was already an alarming feature of the public's awareness of cancer. When polls of public attitudes confirmed this fear, the Canadian Cancer Society realized that warnings about danger signals were largely self-defeating. This led to the new "Cancer Can Be Beaten" approach, with "Hope" as the key word in the campaign to instill in the minds of Canadians a rational attitude toward cancer.

The change in emphasis led to replacement of the danger signals with these seven safeguards: *For everybody* – have a regular medical checkup; don't smoke cigarettes; have your dentist check for unusual conditions; arrange with your doctor for a bowel examination; avoid excessive exposure to sunlight. *For women* – practice regular breast self-examination; have a regular Pap test.

The nursing profession can play a leading part in the success of this campaign. The public looks to the nurse not only as a member of a hospital staff, but as a member of the community to whom the individual can turn for advice and for interpretation of medical news. This places a heavy responsibility on the nurse to keep herself informed, to avoid dealing in speculative conversation about health matters, and to use the techniques of persuasion and reassurance in combatting fear of cancer.

In the Canadian Cancer Society, therefore, the nurse has an organization to which she can turn for support, assistance, and information when her professional life brings her into contact with some aspect of the cancer problem. More than that, the Society presents the nurse with the opportunity to take a positive role in the fight against cancer. As a professional she is in a unique position to bring reason where there is ignorance. As a human being she is in a unique position to bring hope where there is despair. □

University schools of nursing in Canada

A brief, up-to-date account of the programs offered by university schools of nursing.

University of Alberta

The school of nursing of the University of Alberta, located in Edmonton within the university's health sciences complex, is on a 154-acre site on the bank of the North Saskatchewan River.

The school offers a four-year, integrated baccalaureate program for high school graduates, leading to the bachelor of science in nursing degree. A new integrated degree program for registered nurses is planned for September 1970. Details of this program will be in the new calendar of the school of nursing.

Admission requirements for the degree programs include Alberta senior matriculation or equivalent, with a 60 percent average in five required subjects. RNs must be graduates of approved diploma schools of nursing and eligible for registration in Alberta. Because of the need to limit enrollment in the degree programs, preference will be given to Alberta high school graduates and RNs working in the province. Applications for admission should be made early in the year.

The certificate program in advanced practical obstetrics, equivalent to Part I Midwifery, is designed to give advanced preparation to RNs who work in obstetrical units of hospitals or in outlying areas where medical services are limited.

A two-year program leading to the degree of master of health sciences administration, with a major in nursing service administration, is offered by the division of health services administration in conjunction with the school of nursing. This program is designed to prepare nurses for senior administrative positions. Academic admission requirements are a baccalaureate degree in nursing with at least a 65 percent average in the academic work of the last two years. Details of this program can be obtained from the director, division of health services administration, department of community medicine.

For complete information about nursing programs, individuals should write to Miss Ruth McClure, Director, School of Nursing, University of Alberta, Edmonton, Alberta.

University of British Columbia

The school of nursing of the University of British Columbia is situated on beautiful Point Grey Peninsula, a part of Greater Vancouver. It offers an integrated, basic degree program for qualified high school graduates, a postbasic program for registered nurses qualified for admission to the university, and a master's program for qualified baccalaureate nurses.

The programs leading to a bachelor's degree prepare students for professional practice in all areas of nursing and include study of the fundamentals of teaching and administration. The master's program is designed to help the student develop greater knowledge and understanding in a clinical nursing area, as well as an

opportunity to explore a functional role, such as administration in nursing services or teaching.

The school also offers two diploma programs of approximately nine months, designed to help individuals function more effectively in a particular and more circumscribed area of nursing: public health nursing and administration of hospital nursing units. The latter program will be discontinued within two years.

Admission to the university requires a minimum of British Columbia secondary school graduation – academic technical program or equivalent, with a 65 percent average. Admission to the basic baccalaureate program requires completion of first-year university, and for the master's program, completion of a generic nursing program baccalaureate with good academic standing. Registered nurses require registration in their own province.

The school of nursing is involved in the plans of the evolving health sciences center. The faculty anticipates an increasing emphasis on the interprofessional approach to the delivery of health services. For information, write to Miss Elizabeth K. McCann, Acting Director, School of Nursing, University of British Columbia. A $10 assessment fee is required for evaluation of educational transcripts from outside British Columbia.

University of Calgary

The University of Calgary had its origins in 1945 and since then has grown rapidly to accommodate a current student population of about 8,000. Situated in the northwest section of the city, it is surrounded by a Rocky Mountain panorama. The university gained full autonomy in 1966.

The school of nursing was established on an independent basis within the university administrative framework in 1969, and will offer a four-year basic baccalaureate course, commencing September 1970. After completing this program, the student will be awarded a bachelor of nursing degree (BN), and will be eligible to write licensure examinations to practice nursing in Canada.

The student will be enrolled in the university in each of the four years and will pursue simultaneous study in the humanities, sciences, and nursing in each of these years. Clinical experience is obtained in conjunction with several hospitals and community health agencies and is associated with courses in nursing content throughout each academic year.

Significant features of the program include emphasis on the Canadian cultural milieu and on flexibility to allow for individual differences. Each term allows for at least one elective area of study, and in the final year there will be an opportunity for independent study in nursing. Intersessional periods of continuous clinical practice will be held in the spring; however, a minimum of two summer months will be free of classes and clinical experience. Admission of postbasic students to the baccalaureate program is under consideration for 1972.

The purpose of the school is to prepare nurses who are qualified to assume first-level positions in professional nursing. The curriculum is designed to prepare a generalist in professional nursing, rather than one who has received specialized preparation in functional areas, a philosophy compatible with national professional standards.

Students from high schools in Alberta are admitted on presentation of Alberta Grade XII senior matriculation with an overall average of at least 65 percent and with 50 percent or equivalent letter grade standing in the required courses. Students from outside the province will be evaluated on an individual basis. In the first years of operation, enrollment in the school of nursing is limited to 60. Further information may be obtained from the registrar's office.

The Director of the School is Dr. Shirley R. Good.

Dalhousie University

Dalhousie University in Halifax, Nova Scotia, was founded in 1818. The Forrest campus, where the faculty of health professions – nursing, pharmacy, and physiotherapy – and the faculties of medicine and dentistry are situated, is in the southwestern section of Halifax. Nearby are many of the city's health agencies and hospitals.

The school of nursing was organized in 1949 and has developed according to the needs of the province. Candidates for the basic baccalaureate program enter with senior matriculation – Nova Scotia Grade 12 – for a four-year program, which combines academic and professional nursing subjects. Clinical experience is obtained in the local hospitals and health agencies. Students receive a bachelor of nursing (BN) degree.

Graduate nurses may obtain the bachelor's degree by completing three years of university work. This program provides depth and continuity in the professional nursing courses, and offers a wide choice of general academic subjects. In addition to the degree programs, the

school offers diplomas in public health nursing, teaching in schools of nursing, and nursing service administration.

A unique feature offered by the school of nursing is a two-year program for registered nurses leading to a diploma in outpost nursing. Variations in the program have been developed for nurses with diplomas in midwifery or public health nursing. E.A. Electa MacLennan, Director of the School, says, "This course was designed to prepare Canadian nurses for responsible nursing positions in remote areas. The first year is spent on the Dalhousie campus and the second year is spent in field situations, such as Labrador or Northwest Territories' hospitals.

Persons interested in more information should write to the Director, School of Nursing, Dalhousie University, Halifax, Nova Scotia. Men and married women may apply. Applicants for some courses are limited; for example, 50 are accepted in the basic baccalaureate program and only 10 in the outpost nursing course.

Lakehead University

Lakehead University in Thunder Bay, Ontario, has evolved from a technical institute to college to university. The first degrees in arts and science were granted in 1965. The university admitted the first students to its school of nursing in September 1966.

The campus comprises 300 acres and is situated centrally in the city. An active building program, including student residences, is in progress; the modern buildings will conform to a long-range plan to ensure well laid-out and beautiful surroundings.

Two programs that lead to a bachelor of science degree in nursing are offered: one for registered nurses who wish to further their education and improve their clinical competence, and one for students who have senior matriculation standing, including Grade 13 chemistry. This four-year integrated program includes general and professional education within the university, hospitals, and other related health agencies.

For information about these programs, write to Miss Christena Winning White, Director, School of Nursing, Lakehead University, Thunder Bay, Ontario.

Laurentian University

Laurentian University is situated on a beautiful campus in Sudbury, northern Ontario. The school of nursing, one of six professional schools of the university, admitted its first students September 1967.

Entrance requirements for French- and English-speaking students are given in detail in the university calendar. An English-speaking student from Ontario is normally expected to present a minimum of four subjects, seven credits of Ontario Grade 13 arts and science, with a minimum overall average of 60 percent. The seven credits must be as follows: English or French (2); chemistry (1); biology (1); and three additional credits.

Students study for the BScN degree; after passing the Ontario nurse registration examination, they are qualified to practice nursing in hospitals or public health agencies and are prepared to advance professionally, without further formal preparation in all nursing positions for which a bachelor's degree is preferred. Graduates of the program who wish to study at the master's or doctoral level have a sound basis for advanced study.

Approximately 50 percent of the curriculum consists of liberal arts and sciences, which are open to all students in the university. All nursing courses are under the control of the faculty of the school of nursing and are taught on campus and in local hospitals and health agencies. Expanding hospital, medical, and public health facilities ensure that a good variety of clinical experience is available.

Faculty and students are completely accepted as members of the university community and participate fully in the life of the university and its varied activities.

The university senate has given approval in principle for a postbasic BScN degree, but this will probably not be

implemented for about another two years. Entrance requirements for it will include Ontario Grade 13 English or French and Grade 13 biology and chemistry, with a minimum overall average of 60 percent. Equivalent academic standing will be required for students from other provinces or countries.

The Acting Director of the School of Nursing is Dr. Margaret N. Lee.

Laval University

The Laval University school of nursing, established in Quebec City in 1967, is affiliated with the faculty of medicine. Its French-language program leads to a degree in nursing science. The school is closely associated with the health sciences complex of the university, and two of its staff have seats on the permanent committee of the health sciences.

Since September 1968, nursing students have been enrolled in the same courses offered to all other students in the health sciences. As a result, all students should have a greater appreciation of the scientific and professional interests of their colleagues in other health disciplines. They are also learning to work as a team from the beginning of their university experience.

The program of studies in nursing science is organized to permit the student to attain first-level objectives in university learning. Specifically, students learn to work independently and to adjust to scientific progress as well as to developments in professional practice.

Basic information is given in the biological sciences and in the sciences of human behavior and professional learning related to clinical nursing care. The course requires three academic years or six trimesters, plus six weeks of clinical experience at the end of the second year. At the end of three years the student is granted a degree in health sciences, nursing science division.

All candidates must be high school graduates or have equivalent qualification. They should also have completed the biological sciences option offered at the CEGEP level. Those holding a nursing diploma should direct their enquiries about admission to the Service d'admission or to the Secretariat of the school of nursing. At present, there is a total student body of 68, but in future 60 students will be admitted annually to the school. The Director of the School of Nursing is Mlle Claire Gagnon.

Applicants to the school should apply to: Service d'admission, Sécretariat général, Université Laval, Québec, 10, Québec.

University of Manitoba

The University of Manitoba, established in 1877, is situated on the banks of the Red River about seven miles from downtown Winnipeg. In 1929 the 663-acre site in Fort Garry, occupied by the Manitoba Agricultural College since 1913, was chosen as the permanent site of the university. Courses in nursing were first offered in 1943.

The present nursing program offers a four-year, integrated program leading to a bachelor of nursing (BN) degree. In the first three years of the program, the academic year in nursing is from September through June. In the final year, it is from September to early May.

The bachelor's program for registered nurses approximates the four-year curriculum, requiring about three years to complete. At least two full years at the University of Manitoba are required, although exception may be made for candidates with credits from another university.

As well, programs leading to a certificate in either public health nursing or teaching and supervision are offered to RNs. These programs are designed so that the student who later chooses to proceed into the baccalaureate program may apply the courses already completed in the certificate program.

Several institutes are also offered each year to meet special needs of nursing groups, such as supervisors and instructors.

Minimum requirements for entrance include Manitoba Grade 12 – senior matriculation – and the prerequisite high school subjects.

Those interested in applying should write for complete information on admission requirements and courses offered to Dr. Margaret Hart, Director, School of Nursing, University of Manitoba, Winnipeg, Manitoba.

McGill University

The School for Graduate Nurses at McGill University is in downtown Montreal. Next October the school celebrates its 50th anniversary.

Programs at the baccalaureate and master's level are offered; the most recent leads to a master's degree with emphasis on the teaching of nursing.

The basic baccalaureate degree program prepares high school graduates for a nursing career and takes five years after Quebec Grade 11. In 1971, students will enter the three-year university portion from the biological stream of Quebec CEGEP or university equivalent. Applicants with senior matriculation from other provinces are considered for entrance to the second year of the CEGEP program, with four years to the BSc(N) degree.

The total course consists of academic and professional subjects with field experience in teaching hospitals and health agencies. Graduates are prepared to accept responsibility to practice nursing

within the new patterns of health service.

For graduate nurses with senior matriculation, nursing is a two-year program leading to a BN degree. Academic and professional courses are integrated with a focus on the study of nursing, how it is organized and taught.

The two-year program leading to the degree of master of science (applied) prepares the specialist in nursing who is equipped to promote the development of nursing through research, education, or service. The core of the program focuses on the study of nursing: examination and analysis of experience, and intensive investigation of more specific phenomena and problems. Students may also explore the process of learning to nurse and the implications for teaching and curriculum, or may be concerned more directly with change and development in nursing service and the health field.

A one-year program leading to a master of nursing prepares teachers of nursing for the new educational programs in Canada. Throughout the course and in the two-month internship, beginning specialists in nursing, i.e., highly qualified graduates of four-or five-year basic nursing university programs, participate in teaching nursing in many clinical settings. Courses in psychology, anthropology, sociology, and education assist in exploring how students learn to nurse and in testing related teaching practices.

The Director of the School for Graduate Nurses is Miss Elizabeth Logan.

McMaster University

The school of nursing is an integral part of McMaster University in Hamilton, Ontario. Nursing students share the academic and educational resources, as well as the social and recreational facilities, with other students.

Since the first course for nurses was offered at McMaster, yearly enrollment of students has increased. In 1964, due to restricted resources, it became necessary to limit enrollment to a maximum of 30. In 1969, however, enrollment was doubled because of the near completion of the new health sciences center. Ultimately, first-year enrollment is expected to reach 75.

The health sciences center will house a university hospital, biomedical library, medical learning resource center, and will provide facilities for research. The school of nursing will share these resources with the faculty of medicine and eventually with other schools that educate health workers.

The present four-year basic course leads to the bachelor of science in nursing degree and qualifies students for first-level positions in hospital and public health fields. It prepares students for nurse registration under the College of Nurses of Ontario and grants approved public health nursing qualifications. The broad background of professional education offered in the course provides the necessary foundation for graduate study in nursing.

The study of nursing spans the four years of the program. From an introduction to health needs of individuals and families, the student is helped to evaluate the basic nursing needs of patients, and in the first year has the opportunity to plan and give nursing care in the hospital. In subsequent years, nursing study prepares the student to provide increasingly complex nursing care to patients and their families.

Admission requirements are Ontario Grade 13 or its equivalent, with certain prerequisite subjects. Applications from students from all provinces and from other countries are welcomed.

As the number of applicants for admission is always greater than the number of vacancies, prospective students should apply before May for admission the following September. Further information may be obtained from Miss Alma E. Reid, Director, School of Nursing, McMaster University, Hamilton, Ontario.

Memorial University of Newfoundland

Memorial University is situated in the lovely old city of St. John's. It is surrounded by hills and valleys overlooking famous Signal Hill, with Cabot Tower standing high on a rock at the entrance to the harbor.

The university school of nursing admitted its first students to a basic, integrated baccalaureate program in September 1966. These students will graduate in May 1970.

Registered nurses who are residents of Newfoundland and entered hospital schools of nursing before 1966 can enrol as mature students in the degree program.

The program extends over four years. Students are admitted after successful completion of the first year at Memorial. Students from other provinces are admitted from Grades 12 and 13. Biology and chemistry are required and physics is advantageous.

Each year the students gain nursing experience in hospitals and agencies. The academic year of the university has been organized on a semester basis, and all curricula have been redesigned. In future, there should be more time for nursing laboratory practice during the academic year, enabling the faculty to eliminate or reduce the extended clinical practice period in May and June.

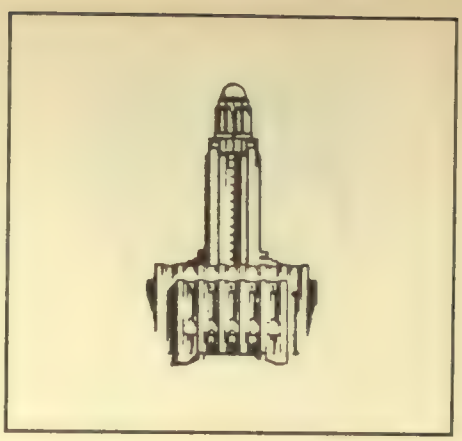
Over one-half of the faculty members

are prepared at the master's level in their area of specialization. With their assistants, they are responsible for the content and supervision of clinical practice.

Enrollment is limited to 20 students in the first year to permit a workable student-teacher ratio and to keep within the limits of available clinical practice facilities. Male students are welcomed.

Students from the school are elected as representatives to various administrative, faculty, and student committees and organizations of the university.

Applications should be made to the registrar of the university. Further information about the school can be obtained from Miss Joyce Nevitt, Director, School of Nursing, Memorial University of Newfoundland, St. John's, Newfoundland.



University of Moncton

When the University of Moncton in New Brunswick received its charter of incorporation, other French-language institutions for higher learning in the province became affiliates of the university. These included Collège Saint-Joseph, Collège Saint-Louis, and the Collège Sacre-Coeur. Degrees are granted by the university.

As early as 1964, the University of Moncton recognized the needs of New Brunswick's French-speaking nurses in nursing education. With the encouragement of the New Brunswick Association of Registered Nurses, Sister Jacqueline Bouchard was appointed to organize and direct the university's Ecole des sciences hospitalières. This school has the same academic status as other faculties and schools within the institution. The director is a member of the academic senate.

In 1965, a four-year program of studies leading to a degree in nursing science was inaugurated. Applicants must have completed Grade 12 or equivalent from another province, and must have a 60 percent average in examinations set by the New Brunswick department of education. Students receive intensive clinical experience during the summer months of the first three years. The school maintains complete control over the program. Agreements have been reached between the university and certain institutions and hospitals in the area to provide facilities for clinical practice.

In 1966, a three-year program that provides for completion of studies at the baccalaureate level was begun. Applicants must be registered nurses. Courses in psychiatry and public health are requisites for the degree. However, they must be completed outside the regular academic program, which combines general and professional learning. There will be no further admissions to this program after 1975.

University of Montreal

The University of Montreal is the only French-language institution in the world that offers a master's degree in nursing. The faculty of nursing offers three majors in its master's program: hospital nursing administration, nursing education, and psychiatric and mental health nursing.

In 1967, Institut Marguerite d'Youville became part of the faculty of nursing at the University of Montreal. Founded in 1934, this institution was an affiliate of the university and offered advanced preparation in nursing education.

As well as the master's program, the university has offered graduate nurses baccalaureate studies in nursing science and basic preparation for those wishing to study nursing under university direction. Clinical specialization in psychiatric and mental health nursing was added to the master's program in September 1968.

Admission to the baccalaureate program requires a high school diploma and an option in biological sciences. This will be enforced for graduate nurses as of September 1972. Until then, diplomas from secondary schools and from C.P.E.S. (courses that prepare students for higher education) will be accepted. The baccalaureate program is three years in length. Graduate nurses are allowed credits for past preparation and can complete their studies in about two years. Each year 40 are admitted to the basic course and 100 to the nursing division. Applicants to the master's program must hold a degree in nursing science or its equivalent. The program covers two academic years and requires a thesis. Six students are admitted to each section of the program.

The faculty of nursing, in cooperation with the Canadian Nurses' Association and the Canadian Hospital Association, administers the French-language section of the course in nursing unit administration. A certificate from the two spon-

soring bodies is awarded when studies are completed. The faculty also assists in preparing nursing personnel for service in countries that adhere to the Columbo Plan, a program sponsored by the Canadian International Development Agency.

Dr. Alice Girard is Dean of the Faculty of Nursing.

Mount Saint Vincent University

Mount Saint Vincent University in Nova Scotia is the only independent women's university in Canada. It is a Catholic institution for higher education, conducted by the Sisters of Charity. Located in Rockingham, about a 20-minute drive from downtown Halifax, the campus overlooks Bedford Basin. The university is growing rapidly, with a new tower residence on campus and a student union building completed recently. A new academic building and adjacent professional buildings are under construction.

Marguerite Hornby, director of the school of nursing, is responsible to the academic dean who reports directly to the university president.

The basic nursing program is a four-year, integrated program leading to a bachelor of science in nursing degree. Under a new agreement with Dalhousie University, nursing courses are centralized at Dalhousie, with students taking arts and science courses at Mount Saint Vincent. The course includes three summer sessions. Hospital practice is given in Halifax hospitals and health agencies under direct supervision of the university nursing faculty.

A degree program is also open to registered nurses who have completed one-year university certificate courses in a nursing specialty. Nurses in this program must complete 10 courses in science and liberal arts subjects. This program, instituted to meet a pressing need for nurses with degrees in administrative and teaching positions in Nova Scotia, will be offered for a limited time. No certificate courses are available.

Admission to the basic four-year, integrated program requires a Nova Scotia Grade 12 high school pass certificate in the university preparatory program, or its equivalent. Married women may apply, and although the university is primarily for women, men may apply. About 20 students are admitted to each new class. Interested candidates should write to the Director, School of Nursing, Mount Saint Vincent University, Halifax, N.S.

University of New Brunswick

The University of New Brunswick, one of Canada's oldest universities, is situated on a hillside overlooking the Saint John River. The school of nursing was established in 1958 and the first students enrolled a year later. In 1969 the school became the faculty of nursing and now occupies a new building – Katherine MacLaggan Hall.

Two programs are offered: a four-year basic degree program and a three-year program for registered nurses. Both programs, which lead to a bachelor of nursing degree, are generic, without specialization, both include public health nursing integrated within the professional content and courses in general education in the faculties of arts and science.

The basic degree program extends from mid-September until approximately the end of June. Concurrent nursing theory and practice are arranged sequentially throughout the four years. During the academic year, clinical experience is provided in hospitals and community agencies in the Fredericton area, and during May and June a period of concentrated practice is arranged in several centers in the province.

The program for RNs is given during the academic year. Summer school and extension courses may be taken, but at least the final year must be spent in full-time study. Public health nursing practice is arranged during the academic year, supplemented by additional experience at the end of the third year. Psychiatric nursing experience is arranged for students who have not previously had it.

Entrance requirements for applicants to the basic degree program include a 70 percent average on New Brunswick departmental examinations in seven subjects, and for RNs, a 60 percent average. SACU tests will be required after 1970. Male and female, married, and single applicants are given equal consideration.

Further information may be obtained by writing to Miss Margaret G. McPhedran, Dean, Faculty of Nursing, University of New Brunswick, Fredericton, N.B.

University of Ottawa

The University of Ottawa school of nursing, founded in 1933, originally offered a three-year diploma course. Since 1943, the school has offered programs leading to a certificate and to a baccalaureate in nursing education or public health nursing for registered nurses. Originally a privately-owned, sectarian institution, the university became a public educational enterprise in 1965.

In 1961 the school established a basic four-year program leading to a degree of bachelor of science in nursing.

Entrance requirements for high school graduates are Ontario Grade 13 or equivalent standing in English or French, chemistry, biology, and three other credits, with an average of at least 60 percent. There are 125 full-time students enrolled in this program. Students in the school of nursing may take general arts and science subjects in French or English, although not all sections offer identical courses in both languages. Nursing classes are given in English, with options for written work in French.

One-year, postbasic certificate courses in public health nursing and nursing education and supervision will be offered for the last time in the fall of 1970. Students in the 1970-71 academic year who wish to proceed to a baccalaureate degree must complete requirements for the degree by the fall of 1973.

The new program, now under revision, will lead to a BScN degree and will start in the fall of 1971. The BScN program will provide generalized preparation for professional nursing practice, including public health nursing. Information about entrance requirements, length of program, and curriculum will be available at a later date.

Future plans for the school include office and classroom space in the science building, now under construction, until the health science complex is built. There are also plans to develop a master's program in nursing.

Sister Yolande Proulx is Director of the School of Nursing.

Queen's University

Queen's University school of nursing in Kingston, Ontario, has replaced its five-year program with a new integrated curriculum for basic and graduate nurse students studying for a bachelor of nursing science degree. Graduate nurses probably will complete the requirements in three years, rather than the four years needed by basic students.

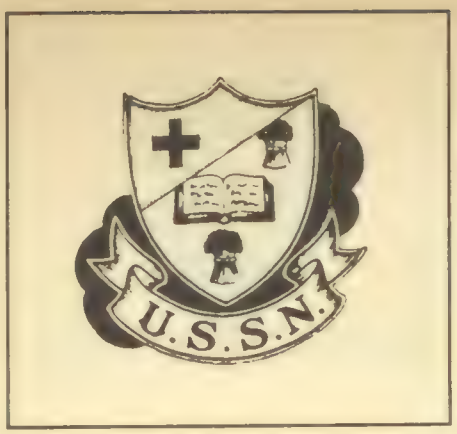
The purposes of Queen's nursing program are: the education of competent professional nurse practitioners for the future, advancement of nursing knowledge, and improvement of current practice.

The school of nursing, utilizing the resources of the university and community, offers learning experiences and guidance to enable students to design, implement, and evaluate nursing action based on a scientific rationale; to become active participants in the health team; and to become involved citizens in a democratic society. The nursing courses focus on nursing needs of people in the community, as well as in an agency setting; provide a flexible approach to learning that enables students to observe and participate in the health care of an individual or family.

Graduates should be capable of designing, implementing, and evaluating nursing action based on knowledge of the dynamics of human behavior, biological, physical, and medical science; establishing collaborative relationships with other members of the health team; developing relationships with patients and families to enable them to achieve their maximum health potential and retain their right to self-determination and independence; and developing skill in assessing the capacity of technical and vocational nursing colleagues and in providing appropriate guidance to aid them in achieving their maximum potential for nursing care.

Admission requirements are a minimum of 60 percent in seven units of Grade 13 or equivalent, including chemistry, mathematics A, and physics, Beginning courses in mathematics and physics, if studied during the first year at Queen's, may lengthen the program. Graduate nurses must submit a diploma from an approved school of nursing and be eligible for registration in Ontario. Personal interviews are highly desirable. The current enrollment of 90 includes 27 in the new program.

Dr. Jean Hill is Dean of the School of Nursing.



University of Saskatchewan

The University of Saskatchewan has two campuses, one in Saskatoon and one in Regina. The school of nursing is on the Saskatoon campus, a 3,200-acre site on the bank of the South Saskatchewan River.

The baccalaureate program (BSN) for high school graduates is a four-year, integrated course. Clinical experience is provided in University Hospital and in various branches of public health agencies in the province. Graduates are prepared for first-level positions in hospitals and public health agencies.

The baccalaureate program for graduate nurses requires the equivalent of three academic years. At least one year must be spent in full-time study on campus, but part-time study, summer sessions, night classes, and correspondence courses permit graduates to plan according to their own work and personal requirements. To date, the programs available provide for specialization in teaching, public health, nursing service administration, and advanced psychiatric nursing. Changes that might affect specialization are anticipated in this program within two years.

One-year diploma courses are available for experienced graduate nurses in public health nursing, nursing service administration, and advanced psychiatric nursing.

Entrance requirements are based on Saskatchewan Grade 12 — senior matriculation — or its equivalent. Specific high school subjects are also required. The school admits about 100 students to the degree courses and about 10 to 15 to each diploma course. Men and married women are admitted. Mature students are also considered under adult admission standards, if requested. Students in the school of nursing participate actively in campus life and may live in university residences.

Students should enquire about admission as early as possible in the year. Completed applications for admission to baccalaureate programs must be received by mid-August. Because of quotas and field experience planning, applications for diploma courses should be completed by early summer.

Complete information concerning these programs can be obtained by writing to Dr. Lucy Willis, Director, School of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan.

St. Francis Xavier University

Founded in 1853, St. Francis Xavier University in Nova Scotia received its charter in 1866. The 27 university buildings are situated on a 200-acre campus near the town of Antigonish.

Through an agreement with St. Martha's Hospital, the university has awarded degrees to nurses since 1926. However, the department of nursing at the university was officially established in 1966 and is part of the faculty of sciences. Sister Marie Simone Roach, presently completing doctoral studies at Catholic University, will become chairman of the nursing department in the spring of 1970.

The school offers two courses leading to a bachelor of science in nursing degree. High school students are admitted directly to a four-year, basic, integrated program. Clinical experience in medical, surgical, obstetrical, and pediatric nursing is taken at St. Martha's Hospital in Antigonish, psychiatric nursing at the Nova Scotia Hospital at Dartmouth.

Community health nursing is available through agreements with the public health department of Nova Scotia. Other health agencies in surrounding communities are also used extensively. Part of the summer months in the first two years are utilized for clinical experience. The degree program for graduate nurses has been two years, with some additional summer school classes. Beginning in September 1970, the course will be increased to three years, with expanded nursing content.

For admission, a Nova Scotia Grade 12 certificate is required. Candidates must have at least a 50 percent average in the required subjects and an overall average of 60 percent. Graduate nurses must have a license to practice. On the successful completion of either course, the bachelor of science in nursing degree is granted.

The school admits 10 to 15 high

school students to each class. Registered nurse enrollment is usually about 15. For more information concerning the courses, write to: The Registrar, St. Francis Xavier University, Antigonish, Nova Scotia.

University of Toronto

Founded in 1920, the University of Toronto School of nursing was first to offer a basic integrated course in which humanities and sciences were related to nursing throughout the course. In 1946 the university first granted its degree to nurses.

In the basic degree course, content in the humanities, social, and biological sciences is given throughout the course, concurrently with the nursing subjects. Nursing is taught around a central core with concurrent clinical applications in hospitals and health agencies. The program is four years, or 34 months in length, and leads to a bachelor of science in nursing degree.

Graduate nurses can also enroll for a degree course. The same academic principles are applied in a program that consists of three academic years for graduates of the diploma schools of nursing. In this course, content in the humanities, social, and biological sciences is integrated with nursing subjects. Nursing is taught by the faculty of the school in the classroom and clinical areas.

Graduate nurses can take the first year of the degree course either full-time in the school or part-time in evening and/or summer sessions through the division of university extension. The third year is taken on a full-time basis. There is opportunity in the summer for the student to secure employment.

All degree candidates are prepared for public health nursing, teaching, and supervision.

Ontario Grade 13, with certain prerequisite subjects, is required for admission. However, the admission standards are continually under revision and applicants should write directly to the university for information. Special consideration is given to mature applicants – over 25 years – who may not have had Grade 13 or who have not taken the required high school subjects.

The school offers a one-year certificate course in public health nursing. The program covers one academic year and includes five weeks of field work.

Dr. Helen M. Carpenter is the Director of the School.

University of Western Ontario

The University of Western Ontario is in London, a city of just over 200,000, situated midway between Toronto and Windsor. The Health Sciences Center at the north end of the 500-acre campus includes nursing, medical, and dental faculties, a cancer research center, and a university hospital under construction. A well-qualified and expanding faculty of nursing is an integral part of the coordinated health sciences division.

Both undergraduate and graduate education in nursing is offered at Western. A four-year basic degree program is given for high school graduates, and a three-year degree program is offered to registered nurses who have graduated from diploma programs. Each leads to a BScN degree, with the common purpose of preparing professional nurse practitioners who can assume beginning professional responsibilities in hospitals and other health agencies; are capable of using further experience to enable them to take responsibility in nursing practice; and have a sound educational foundation for graduate studies.

Both BScN programs require Grade 13 standing for entrance, with specific prerequisite courses. There are special provisions for mature applicants – those who are at least 23 years of age – whose academic qualifications do not fully meet the admission requirements.

Graduate education leading to the MScN degree offers preparation in administration or teaching. The two-year program in administration may be in hospital nursing service, public health nursing service, or administration of schools of nursing. The two-year program in education is intended for beginning and experienced teachers of nursing.

Entrance requirements for graduate education are a bachelor's degree in nursing or in arts or science, in addition to

graduation from an approved diploma program in nursing; an academic year of post-basic study with a diploma in a nursing specialty from a university school of nursing; and an overall B average in undergraduate courses.

Graduate education is designed to prepare personnel for leadership positions in nursing. New graduate programs now under consideration for the future are those with a major in a clinical nursing specialty and a major in nursing research.

Total enrollment in all programs is currently 195. Inquiries for further information about programs and requests for application should be directed to Dean R. Catherine Aikin, Faculty of Nursing, The University of Western Ontario, London, Ontario.

University of Windsor

The University of Windsor is situated in Windsor on a large campus bordering the Detroit River. Residences are available for students who want to live on campus.

In 1955 the department of nursing was created within the faculty of arts and science and in 1962 it became a separate school. From 1957 to 1967, the school offered a non-integrated program leading to a baccalaureate degree in which the first and final years were taken at the university. This has now been replaced with a four-year, integrated, basic baccalaureate program that began in September 1968.

The school of nursing presently has three different types of programs. First, it offers a four-year basic program for high school graduates, leading to the bachelor of science in nursing degree. This program includes science and arts, as well as nursing courses. Concurrent clinical teaching and experience are provided. This program prepares the graduate for the practice of individualized, scientific nursing in the hospital or home; public health nursing team leadership positions; and graduate level studies. On successful conclusion of the program, the student qualifies to write the provincial nurse registration examinations.

Second, the school offers a baccalaureate degree program for registered nurses who meet university admission requirements of two academic years and a summer session. This includes preparation for the general practice of public health nursing and introduces the student to the basic principles of teaching or administration. Students may take the non-professional courses through the division of extension.

The school also offers a diploma program of one academic year in public health nursing for RNs.

Admission requirements for all programs are Ontario Grade 13 or the University of Windsor preliminary year or equivalent, and must include among other credits English, biology, and chemistry. Registered nurses must be currently registered in a province of Canada. RNs seeking admission under the maturity clause must have completed at least biology, chemistry, and English of Ontario Grade 13 level.

Complete information on each program is contained in the school brochure and the university calendar. As the academic year begins in mid-September, candidates are advised to submit their applications several months in advance and to seek a personal interview. The Director of the School of Nursing is Miss Florence M. Roach. □

Counseling students in a hospital school of nursing

The authors, both registered psychologists, describe the functions, success, and future of the counseling service for student nurses at the Calgary General Hospital in Alberta.

Donald G. Ogston, B.Ed., M.Ed., and Karen M. Ogston, B.A., M.A.

Interest in the psychological development and counseling of nursing students is shown in nursing education literature to be directed largely toward university-affiliated nursing schools.[1,2] These schools have access to the university or junior college counseling service.

Hospital-affiliated schools do not usually provide or have access to a formalized counseling service, although their students have the same needs and concerns as university students. Most nurse educators in these settings realize that counseling should be an integral part of a total nursing education program, but do not always know how to provide it.

Counseling service started

Recognizing to need for a counseling service, the Calgary General Hospital school of nursing set up one in the fall of 1967. Since then this service has been available to the student body of about 300 students a year.

This counseling service consists of three functions: counseling the students, consulting with the faculty, and conducting research.

The counselor is a member of the hospital's psychology department. This affiliation has three advantages: the counselor is a professional psychologist registered under the provincial psychologists' act, ensuring competence in counseling, consulting, and research; he is independent of the administration of the school of nursing, assuring the student freedom of access and strict confidentiality; and he can give priority to the needs of the school of nursing.

Counselor's time divided

Table 1 shows the development and growth of the counseling service. The number of formal hours the counselor spent per month on each of the three functions is given for each year. During the 1967-68 session, the counselor spent 115 hours on the three functions. In 1968-69 this time was increased to 197 hours, even though there were two changes in personnel. It is generally assumed that an amount of time almost equal to the time spent counseling is devoted to preparation and administration.[3] On the basis of this assumption, the actual amount of time the counselor spent would be roughly twice the above totals.

The majority of counseling time was spent in one-to-one relationships, working through study, educational-vocational, and social-personal problems. Study problems were primarily in reading or study strategy. Educational-vocational difficulties concerned decisions about continuing studies in nursing, adjustment to the nurs-

Mr. and Mrs. Ogston have both held the position of counselor at the Calgary General Hospital. Both authors are working toward a Ph.D. in psychology at the University of Calgary, Calgary, Alberta.

MONTH	1967 - 1968			1968 - 1969		
	COUNSELLING	CONSULTATION	RESEARCH	COUNSELLING	CONSULTATION	RESEARCH
OCTOBER	3	0	1	11	8	3
NOVEMBER	5	1	2	10	6	1
DECEMBER	5	2	2	10	8	4
JANUARY	8	3	1	15	9	3
FEBRUARY	6	3	2	7	3	2
MARCH	5	3	2	15	2	4
APRIL	3	4	1	2	6	3*
MAY	2	2	3	5	4	1
JUNE	10	6	4	13	4	2
JULY	5	3	3	13	8	4
AUGUST	3	2	0	2	2	2*
SEPTEMBER	4	4	2	2	3	0
TOTAL	59	33	23	105	63	29

* new counsellor

Table 1. Time spent by counselor in each of the three functions.

ing program, and the choice of nursing area in which to practice. Social-personal problems involved self-adjustment, interpersonal relationships, family, and heterosexual orientation.

Group counseling constituted the remainder of the time spent. Communication skills and special problems were dealt with most effectively in a group setting.

Problems unique to nursing

Nursing students present additional problems that are unique to their situation. One common complaint is that residence living inhibits the pursuit and development of extracurricular activities; in short, many students feel cloistered. Another problem is that nursing education is unusual because it requires professional responsibility of its students before their program is completed. Many students find such responsibility stressful. This stress may be intensified by the sometimes rapid adjustment required as the student changes from one study area to another.

Currently a more preventative approach is being established to provide students with ways to handle concerns as they arise, rather than trying to remedy existing problems. For example, a "study skills" program can introduce rapid reading and study strategies, thus minimizing the number of problems that occur at crucial times, such as during examination periods. Groups directed toward developing nursing skills can provide a setting in which stress-preventing techniques are discussed and practiced. Study groups and other group situations have the additional value of familiarizing the student with the existence and function of the counselor.

Klemer found that high school counselors have a somewhat inadequate stereotype of nursing students.[4] If high school counselors are counseling girls toward nursing on the basis of a faulty stereotype, problems can be expected. A form of preventative service could be a yearly workshop for high school counselors held by the school of nursing and coordinated by the counselor.

Consultation and research

The professional counselor has been particularly useful as a consultant for the faculty of the school of nursing. Because of their positions, faculty members are often the first to be aware of a student's problem. The counselor can frequently offer the faculty guidance to assist them in their work with students. Moreover, the counselor's independence from the administration permits him to approach problems differently than the faculty. Presenting faculty with alternative approaches has been useful in rethinking policy that governs student evaluation and assessment.

Two areas in which a counselor has much to contribute are student evaluation methods and the routine and special psychometric assessment of students. A registered psychologist has competence in developing and using achievement measures. On occasion, a promising applicant does not have all the requirements necessary for admittance to the school. In such a case the counselor might be able to provide auxiliary data, through testing, on which a decision, fair both to the applicant and the school, can be made.

The counselor's research role has important potential. Early studies, directed toward securing student norms on personality and achievement tests, might eventually be used in admission procedures. To this end, preliminary analyses of personality scales have been conducted to differentiate successful students from unsuccessful ones. The development of computerized accumulative student records and instruction methods is an extremely exciting area of study. These projects, although still in the discussion stage, are possible in the near future.

Conclusion

The school of nursing's counseling program has experienced an increased demand for its services. Although much has been achieved in two years, there is much more to be done. Preventative activities, such as group work, should eventually benefit all students, not just those headed for problems. Basic research, complementary to preventative programs, should be undertaken. Student satisfaction with nursing, the role of the residence in group development and harmony, and the effects of teaching methods are examples of research areas that merit attention and perhaps consequent change.

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research abstracts

Kikuchi, June F. *One hospitalized preschool girl's way of dealing with separation anxiety.* Pittsburgh, Pa., 1969. Thesis (M.N.) University of Pittsburgh.

A study of one preschool girl who experienced separation anxiety during her long hospitalization was carried out using the descriptive method, case study technique. The child of this study was admitted to hospital, comatose and moribund, with the diagnoses of multiple staphylococcal abscesses and generalized sepsis.

Initial contact with this child was made on the 67th day of her 91-day hospitalization. While giving care to this child for 19 days during the third month of hospitalization, the nurse-writer made direct observations. Process recordings, records of projective play interviews, the child's clinical records, and discussions with the child's parents and health workers were the sources of data. The data were validated by a clinical nurse specialist.

An analysis of the data to determine the behavioral patterns of this child revealed a theme of separation anxiety. Her behavior related to this theme was further analyzed to determine how she dealt with her feelings about separation from her parents through the medium of play, through the interaction with the nurse, and through the use of the defense mechanism of regression.

This child appeared to be particularly vulnerable to separation anxiety for many reasons: her sudden separation, her traumatic illness, the length of hospital stay, her parents' infrequent visits, lack of one nurse giving consistent care, and her developmental stage. By the time the nurse observer started to care for her, this child was defending herself by using defense mechanisms of denial and repression. As she began to form a close relationship with the nurse, her use of denial and regression started to lift. Much of the pent-up anger that she felt toward her family for having left her was then released.

Unstructured play seemed to give her the opportunity to work on her anger by taking on the active role and doing to her family in play what she had to experience passively. Such play also enabled her to satisfy her desire to reunite her family, to use oral aggression, and to be the *real* baby. During her contact with the nurse, she gradually transferred her positive feelings for her mother to the nurse. As this transference increased, the anger this child felt toward her mother for the separation was directed increasingly toward the nurse.

In conclusion, it was found that as this hospitalized, preschool girl was permitted to express and deal with her fear of abandonment and her anger about her separation in her own way and at her own pace, she was able to deal more effectively with her feelings about separation from her family. A positive, consistent relationship with a need-fulfilling person appeared to be essential for such development to take place.

Gauthier, Sister Cecile Marie. *Organization of the elements of a selected nursing curriculum as revealed in course outlines.* Washington, D.C., 1966. Thesis (M.S.N.) The Catholic University of America.

The purpose of this study was to identify and describe the organization of elements of a preservice nursing curriculum as revealed in course outlines. A literature survey was conducted to identify types of curriculum elements and patterns of curriculum organization in relation to the purpose of the study.

Analysis of documentary materials, a form of descriptive research, was the method used for the study. The data consisted of curriculum elements, expressed as words or phrases, or in short sentences that could be identified as a knowledge or a skill item, extracted from the course outlines.

Elements were classified according to the three broad divisions of general education, nursing-related areas, and nursing, in terms of subject matter, structure of subject matter, and educational focus within units of courses. Vertical and horizontal organization of elements, according to these broad areas, was studied by courses, semesters, and years.

Some of the findings were that the curriculum was constructed from 24 subject matter areas. Subject matter components were distributed approximately as follows: 5 percent of the total curriculum components were general education components, 64 percent were nursing-related, and 31 percent, nursing components.

The construction of course units from subject matter components seemed to vary in the three types of courses identified. Organization of components appeared to vary from year to year and by semesters. General education components appeared in the general education courses only. Nursing-related components were identified in the nursing-related courses and in 14 of the 16 nursing courses. Nursing components were present in all nursing courses and in four nursing-related courses.

Brkich, Rita M. *A study to determine how patients view their digoxin therapy.* Montreal, 1969. Thesis (M.Sc.App.) McGill U.

This descriptive study was conducted to determine how patients view their digoxin therapy. A sample of 40 patients was interviewed to collect the patients' thoughts, feelings, and practices of digoxin therapy. Categories were derived from each of the questions. Content analysis was carried out to determine the nature and frequency of responses.

It was found that patients could generally explain the purpose and effects of digoxin; that they had positive feelings toward the therapy; and that they generally carried on reasonably safe practices in self-administration.

Withmore, Mary Anne. *A study of communicative behavior in young hospitalized children.* Montreal, 1969. Thesis (M.Sc.App.) McGill U.

A descriptive, exploratory research study was carried out to investigate communicative behavior among young hospitalized children. The researcher sought to discover any patterns or regularities in communicative behavior.

The sample under study consisted of 29 children from eight months to thirty-four months of age. The research setting was a medical-surgical unit in a large pediatric hospital. Data were collected in a running narrative form by the methods of observation and participant-observation. The data were subjected to a content analysis.

Three patterns or groups of communicative behavior clearly emerged from the observations. These groups showed certain regularities and consistencies, which were described. A possible interpretation of the patterns of communicative behavior was discussed, and recommendations for additional research were suggested. □

books

A History of the General Nursing Council for England and Wales 1919-1969 by Eve R.D. Bendall and Elizabeth Raybould. 312 pages. London, H.K. Lewis & Co. Ltd., 1969. Canadian Distributor: McAinsh Ltd., Toronto.
Reviewed by Glenna Rowsell, Employment Relations Officer, New Brunswick Association of Registered Nurses, Fredericton, N.B.

The authors have succeeded in capturing the important and exciting events that led to the inception of the General Nursing Council for England and Wales and the governing legislation. It is a timely publication, released during the 50th anniversary of the General Nursing Council.

The chapters are in chronological order; recurring events are only described in detail the first time they happen.

Readers who are unfamiliar with the United Kingdom governmental process and the societies and committees referred to in the book might miss the historical implications for the General Nursing Council. Although the book is well documented and includes an index of names and subjects, the reader is inclined to get lost in the masses of names, dates, titles, and figures. For example, is it important for the reader to know how many votes each member of the council received?

This book may have a limited reading audience in Canada, but would provide an excellent reference text for students and graduates interested in the history of nurse registration and the struggle for legislation.

Human Anatomy and Physiology, 6th ed., by Barry G. King and Mary Jane Showers. 432 pages. Toronto, W.B. Saunders Company, 1969.
Reviewed by H.J. Alderson, Associate Professor, School of Nursing, McMaster University, Hamilton, Ontario.

This book is concerned with the introduction of much new material in keeping with the advances in cellular biology. More emphasis in this edition is placed on biology at both the cellular and molecular level; many microscope photographs should help the student grasp these concepts. Selected aspects of genetics are included in the section on reproduction.

Much of the material throughout this book has been rearranged in a more meaningful sequence. The information on endocrine mechanisms follows the nervous system and is included under "integration and control of the body."

The sections on bones, muscles, and articulations are well illustrated, with the written material printed in smaller type close to the diagrams. The vascular system deserves special mention; the information is correlated so that arterial supply and venous return are now considered together. The cranial nerves and special senses have been combined in a functional manner and the information concerning each condensed in table form close to the descriptive diagrams.

Many new illustrations have been included and others made clearer by pastel shading. The major sections of the book are organized under five main headings on the basis of functional activity and have been set apart by colored title plates. The authors should be commended for their effort in producing the sixth edition of this excellent text.

Community Health by Carl Leonard Anderson. 343 pages. Toronto, C.V. Mosby Company, 1969.
Reviewed by Ethel Horn, Associate Professor, Community Nursing, Faculty of Nursing, The University of Western Ontario.

Within the many broad areas of community health, this book is concerned with the polluted environment, the aged in the population, drug abuse, and the mental health of the population – a concern in an already over-crowded, technological society.

This text brings readers of differing backgrounds and disciplines to a broad awareness of community health. The overview of the book gives a background of the rise of concern for health over the ages. The other four areas are: promoting community health, preventing disorders and disabilities, environmental health, and health services. Community health has taken on many new aspects, and new approaches and programs are explored in this text. Consideration of the worker's role and the citizen's participation is discussed when feasible.

The format of the text is attractively set in each section. Interesting to the instructor and the student will be the questions about the community and health and the up-to-date additional references that conclude each chapter. Both student and teacher can find many uses for this material in the student-centered classes of today.

The author combines areas that were previously seen in parts, but not as the whole community and its health. This holistic approach enhances and lends emphasis to the ecological approach.

Thus, the author brings the reader a new framework as a basis for viewing health problems of man in his environment. This text will be useful to a wide range of health workers in today's health team.

The Elderly Patient by Bernard A. Stotsky. 160 pages. New York, Grune & Stratton Inc., 1968. Canadian Agent: The Ryerson Press, Toronto.
Reviewed by Viola Allan, Administrator, Island Lodge and Carleton Lodge, Homes for the Aged, Regional Municipality of Ottawa-Carleton, Ontario.

This book deals comprehensively with a broad range of conditions associated with aging and programs of service to the aged. Several critical areas are discussed: economic security, housing, recreation, self-care and physical hygiene, family relations, community resources, institutional care, home care, medical and nursing care, psychiatric problems, mental health, and death and bereavement. From this wealth of material the author could have been more selective and treated fewer topics in depth.

The author criticizes current institutional and community services, offers suggestions for improvements, and dispels some past misconceptions. He concludes that the degree of social organization of the community is crucial in determining whether aged persons interact socially and relate to younger persons.

The chapter on general hygiene of aging focuses on self-care practices that are advocated for good health. The suggested measures could be incorporated into teaching programs for personnel engaged in caring for the aged. The suggested activity schedule for a nursing home seems skimpy and lacks imagination; however, it may be directed toward nursing home directors who consider any activity program too complicated or expensive to undertake. In the chapter on nursing homes, the author is critical of custodial attitudes that still exist. He describes the fears and anxieties of elderly people entering institutions, and suggests six rules for "successful transplantation" that could be used as primary objectives by nursing homes.

The author recommends that institu-

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tional physicians give more attention to the social, psychological, and financial factors in their patients' lives. A fuller use of caseworkers is also advocated to obtain complete histories and to utilize all community services for the patients' benefit. As well, administrative ingenuity must be exercised to break down bureaucratic hurdles of many community agencies in limiting their spheres of responsibilities. Community services should be organized around the patient rather than around the needs and skills of independent agencies.

This is a valuable book that should interest all those concerned in the care or social planning of the aged.

AV aids

Nursing as a career

A new Canadian filmstrip and record unit gives a good insight into the choice of nursing as a career. The unit costs $14.75.

This unit is designed for use under the direction of a teacher in class-room situations or by individual students. Although maximum results are achieved by using the recording in conjunction with the filmstrip, each can be used independently.

One side of the recording contains a 20-minute panel discussion in which two teachers of nursing answer questions asked by a group of girls interested in a nursing career. The other side of the recording contains commentary for the filmstrip. It is easy to synchronize sound with pictures when a manually-operated projector is used with a separate record player.

A detailed brochure outlining the contents of the unit can be obtained by writing to McGraw-Hill Company of Canada Limited, 330 Progress Avenue, Scarborough, Ontario.

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A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

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After the last CNA board of directors' meeting, we talked to the association's executive about some of the questions to be discussed at the general meeting in Fredericton next month. The six members of the executive spoke frankly about the major issues facing CNA, their reactions to the report of the ad hoc committee on functions, relationships, and fee structure, and their belief about the association's role in the future. Their comments are published on page 33 of this month's issue.

In the interview, CNA President Sister Mary Felicitas listed as the most vital issue the relationship between the individual member and the national association. "I believe the average nurse lacks involvement with CNA, sees it as something remote, and is unaware of its goals and functions," she said.

We agree with Sister Felicitas and with her remark that members will have an opportunity to improve this relationship at the general meeting in June. At this meeting CNA members will debate the recommendations of the ad hoc committee on functions, relationships, and fee structure, and decide whether to accept or reject them.

Somehow, in some way, the national association must be restructured so that more members will recognize it as a dynamic organization demanding their participation. This will not be an easy task, as we all tend to be somewhat provincial — in every sense of the word — in our thinking and in our loyalties. Somehow, too, we must involve more of our younger members. Although their apparent disinterest in CNA could come from their lack of knowledge about it, part may result from a feeling that their contribution is not really welcome.

Ultimately, CNA's ability to involve its members, young or old, rests with the relevance of its goals. These goals must not be restricted to member needs alone. They must encompass the health needs of society, and range from the quality of nursing care being provided in Canada to the problems of environmental pollution and the population explosion. Obviously, we can't hope to solve all these problems. But with more involvement and enthusiasm of membership, we can at least make an intelligent contribution.

V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Heavy smoker

I enjoyed your tongue-in-cheek editorial on the difficulties involved in trying to break the smoking habit (April 1970). I was surprised to learn that Dr. Freud had been unable to stop his cigar smoking.

There's one thing you didn't mention, however: Dr. Freud reached the ripe age of 83. That's not bad for a heavy smoker! — *NBJ, RN, Ottawa.*

Questions nerve deafness

In the article "Aging and learning" (Nov. 1969) the author, Monica D. Angus, writes: "High levels of noise have relatively little effect on hearing by people with nerve deafness; therefore older people may work better than persons with normal hearing in situations where the noise level is high." I believe this is an error that is misleading to readers of *The Canadian Nurse.*

Persons who have not experienced nerve deafness or have not had much to do with those who have this defect would find it hard to understand how confusing it is in a noisy environment. Those with nerve deafness could be misunderstood in such a setting, could misinterpret instructions, and be more fatigued than the average person, just by being exposed to noise during the working day.

I am pleased to see nursing research being done on the subject of aging and learning. I am convinced that a person is never too old to learn, given the right circumstances and the correct frame of mind. — *Elizabeth Egener, RN, London, Ontario.*

The author replies: The point you raise about nerve deafness and the problems for persons working in areas where there is a high level of noise is interesting. There are two problems related to nerve deafness and work in "high levels of noise": one is physiological and the other involves communication. Perhaps if we consider these separately, we will see that both our statements are correct.

With respect to physiology, persons with normal hearing who work in areas where there is a high level of noise usually suffer damage to their ears. This is not the same for persons with nerve deafness. That is, the latter are not going to damage their ears to a greater extent by working in conditions where high levels of noise prevail.

With respect to communication, persons with nerve deafness do have a problem in that they do not hear as clearly in the presence of background noise. Therefore, communication or conversation for them is, as you suggest, confusing, tiring, and frustrating. However, in situations where conversation is unnecessary, for example, in many types of factories or assembly-line work, persons with nerve deafness may function extremely well.

About 20 percent of persons with nerve deafness experience the phenomenon of "recruitment." In these cases the inner ear is sensitive to increases in sound in spite of nerve deafness. The other 80 percent who do not experience "recruitment" should, as I suggested, function extremely well in the kinds of work I outlined above. — Monica D. Angus, B.C.

Concerned about pollution

Your March editorial contains a sentence that prompts me to write. I completely agree with your statement, "Being professional health workers in an affluent society, we have a special obligation to help de-fuse these bombs, whether they be on the national or international scene."

One national bomb that must be defused if we are to survive to help others as well as ourselves, is that horrifying, sometimes invisible bomb that has been named "pollution."

Would it be possible for *The Canadian Nurse* to publish the official policies of the Canadian Nurses' Association, the 10 provincial nurses' associations, and the National Victorian Order of Nurses as they pertain to pollution? And could there be presented an article on the organized activities of registered nurses' groups in this country-wide fight against pollution?

"Being professional health workers . . . we have a special obligation . . . ." Is there an unanswered challenge here? — *Catherine Allan, R.N., B.C.*

Show me that you care

I was pleased with Pamela Poole's article "Nurse, please show me that you care! "

What patients need are nurses who think of them rather than of dogmatic hospital policies and antiquated traditions. Patients are individuals with specific problems, and nurses are individuals with education and training that should be put to use for the patient's comfort and cure.

Unfortunately, a nurse comes up against the various idiosyncracies of a head nurse and often non-liberal hospital policies that encroach on her free-thinking processes. Such is the dilemma of today's general duty nurse! — *Anne Luke, RN, Montrose, British Columbia.*

I did not fully agree with the article by Pamela Poole, "Nurse, please show me that you care! "

The patient has to be treated as an individual. However, his daily routine has changed so much when he is in hospital that it is irrelevant to consider his usual times of work. Although a patient who is used to a night shift requires some extra understanding and cups of tea, he does not usually have the energy to join in the planning of his day.

I am all for morning baths, and believe that each nurse can decide on the extent of washing, after assessing the patient's condition and wishes. A person who has been in bed for a number of days, especially one with a fever, certainly appreciates his sponge bath. Surely the person who exclaims, "Nurse, that feels

much better," is more ready to face the morning activities.

Routine observations often can be safely omitted at the nurse's discretion, but I wonder if the doctor's orders would cover such omissions.

I believe that a nurse or a nurse's aide should still accompany the discharged patient to the waiting relative, car, or taxi – not for fear of a lawsuit, but to carry through the nurse's personal interest and contact.

I agree with much of the article, and admit that more emphasis is needed to consider the patient first as an individual. – *Elizabeth A. Watt, RCN, SCM, Fort St. John, British Columbia.*

Must study task force report

It was reassuring to see in your March issue that the Canadian Nurses' Association has established an ad hoc committee to study reports of the federal government's task force on health care costs.

Because nurses play such an important role in the delivery of health care, they should be aware of the many issues and recommendations put forth by the task force. We agree there are numerous worthwhile recommendations; however, we believe nurses should be aware of those recommendations that are not favorable to our situation. As an example, note recommendations 35 to 37 under salaries and wages.

On the one hand, the task force has suggested many limitations to nursing personnel and, on the other hand, it has suggested many areas of subsidization for the medical profession. What other independent contractors have such a utopia? Consider the physical plant in which they have to operate and carry out their services; for example, the fantastic amount of equipment and personnel utilized in one operation at no cost to the doctor. Now they want a guaranteed income; note recommendations 7 to 12 and 15 to 21 under the price of medical care.

The medical profession has been clever in controlling its supply over the years in order to put itself in this enviable position. However, it seems unfair and unjust for it to attempt to administer the nursing situation, just when nurses are rising out of the mire of the minimum wage bracket.

It is time for nurses to speak out, instead of smiling sweetly under the guise of professionalism, and to look at the favorable recommendations. Nurses, as a group or individually, must take time to analyze this report. We have been placated far too long by the medical profession. If we do not make our stand now, quality patient care and determination of it will slip out of our hands. "Too soon old we get and too late smart." – *M.L. Annable, President, Nurses' Association, Ottawa Civic Hospital, Ottawa.* □

news

CNA Research Committee Meets

Ottawa. – The ad hoc committee on research of the Canadian Nurses' Association held its first meeting at CNA House April 6-8. It met to formulate a possible policy on research for CNA.

The committee worked out a general policy as well as details regarding the functions and activities CNA should engage in as a professional association, according to Dorothy J. Kergin, committee chairman and associate director of the School of Nursing, McMaster University, Hamilton.

Members of the ad hoc committee pointed out the need to establish a special CNA committee on research to fulfill the responsibility inherent in this general policy, said Dr. Kergin in an interview with *The Canadian Nurse.* This committee would indicate a structure or framework through which policies could be implemented.

The committee believes that CNA should initiate discussion with other groups that have responsibilities for research in the field of nursing, such as the Canadian Council of University Schools of Nursing and the Department of National Health and Welfare. This would ensure that the whole field of research in nursing is covered, and that there are no gaps or overlaps, said Dr. Kergin.

The committee report will be presented at the next meeting of the CNA Board of Directors, June 13 in Fredericton, N.B.

Members of the committee are: Moyra Allen, associate professor of nursing, School for Graduate Nurses, McGill University; Shirley Stinson, assistant professor, School of Nursing, University of Alberta; Lucy Willis, director, School of Nursing, University of Saskatchewan; and Margaret McPhedran, dean, faculty of nursing, University of New Brunswick.

The ad hoc committee was set up by a motion of the CNA Board at its January 1970 meeting.

CNA Meeting Won't be "All Work And No Play"

Fredericton, N.B. – The New Brunswick Association of Registered Nurses, hostess to the 35th biennial convention of the Canadian Nurses' Association, is preparing a packed program of pleasure activities for registrants. The meeting runs June 14 to 19 in Fredericton.

These activities will begin on Sunday June 14 with an unusual musical treat for

Lady With Lamp Born 150 Years Ago

May 12, 1970 is the 150th anniversary of Florence Nightingale's birth. To mark this occasion *The Canadian Nurse* scoured the archives section of the Canadian Nurses' Association library for relics of the great lady of nursing. This photo from the archives collection was taken at the request of Queen Victoria after Miss Nightingale's return from the Crimea in 1856.

The most solid relic in the CNA archives collection is a yellow brick from Miss Nightingale's last home at 10 South Street, London, where she lived from 1865 till her death in 1910. It was presented to CNA on its 25th anniversary in 1934 by the National Council of Nurses of Great Britain.

The CNA archives also contain a number of letters from Miss Nightingale. Several are replicas of original letters sent to the Florence Nightingale International Foundation, but at least two letters are originals.

Perhaps the most delightful is an undated note reproduced here in full: "From Miss Nightingale to her Patient. Dear Sir, Send me the latest Bulletin of your State – don't eat too many Oysters – There is a Ward in the Pickenham Hospital awaiting you where we have much experience in *mending* broken hearts as well as sprained Ankles."

Another authentic letter mentions a new patient, a gardener. "Some days ago, apice [sic] of grit entered his eye; and the means taken to get it out made him sick physically (as they did me figuratively) . . . I often think what 'robust' creatures we must be to bear not only the Water cure but other means of (ignorance)? cure."

The CNA library is collecting a listing of all Miss Nightingale's mementos, letters, etc., in Canada and their whereabouts. The librarian would be pleased to hear from anyone who can add to this listing. Write to CNA, 50 Driveway, Ottawa.

(Continued from page 7)

those attending the interfaith service at the beautiful and historic Christ Church Cathedral.

Monday evening will feature a "down-east" picnic barbecue hosted by the city of Fredericton. This outdoors event (weather permitting) will be informal, and registrants should pack their most relaxing garb to enjoy the picnic spirit to the fullest. Tentative entertainment plans for the picnic include the Elm Tree Square Dance Club. Pool facilities will be available nearby for those who wish to swim after the picnic.

Wednesday is hospitality day, a complete day to concentrate on the beauty and entertainment that New Brunswick has to offer its guests. Tours are being organized. For example, you can drive to St. Andrews, a beautiful coastal town that is popular with summer visitors. Here you can take a boat cruise, visit a lobster plant, tour the town's historical landmarks and magnificent mansions, or shop.

If you choose to tour the Loyalist port of Saint John, Canada's oldest incorporated city, you will visit many of its scenic and historic highlights. The trip includes a visit to one of the city's breweries.

There is also much to see and do in and around Fredericton. Tours to Oromocto, billed as Canada's model town, and Base Gagetown, the largest military training base in the British Commonwealth, have been organized.

Registrants can also drive to the Mactaquac fish hatchery, which boasts the largest salmon hatchery in the world; the Mactaquac hydro-electric power project; Mactaquac Park; the historical settlement of King's Landing at Prince William; and the newly-created town of Nackawic with its St. Anne-Nackawic pulp and paper mill.

For those spending Wednesday evening in Fredricton, tentative plans are being made for a coffee house with entertainment and bar facilities.

Thursday evening will be free for shopping, local sightseeing, and private get-togethers. Later in the evening, the nationally known pipes and drums band of the Black Watch (Royal Highland Regiment) of Canada will give an outdoor concert, their final performance before disbanding.

An exhibition of NB arts and crafts will be on display throughout the week at the Beaverbrook art gallery. The exhibition will mark the first showing of this provincial art collection.

There will be no charge for many of these activities. Tickets for the Monday barbecue and Wednesday tours will be on sale at an information center in the Lord Beaverbrook Hotel. The NB Travel Bureau will also have a tourist information and display center at the hotel.

In addition to information center services, NBARN will publish an information handbook for each registrant.

A first aid and survival station will operate at The Playhouse, site of the business sessions.

A Cake For Street Haven's Fifth Birthday

Toronto, Ont. – One of Toronto's most warm-hearted institutions celebrated its fifth birthday in March with a party and a cake. Peggy Ann Walpole, the registered nurse who founded Street Haven at the Crossroads, a drop-in center for female offenders, cuts the cake while Linda Sutherland waits to serve it.

Street Haven began with a $20 investment in a former beverage room in downtown Toronto, and is now located in a large, pleasant house nearby. Operating on an annual budget of $60,000, it provides a refuge for alcoholics, drug addicts, lesbians, prostitutes, even thieves. The 4 staff members and 70 volunteers who run the center make home and hospital visits to girls, contact and assist them in court, and refer them to community and welfare agencies, as well as providing "open house" 6 days a week and a 24-hour emergency answering service.

"But no one is ever pushed into more assistance than she wants," emphasized administrative secretary Maureen Marquardt. "We don't ask questions and there are no forms to fill in. We simply provide a bed and a meal if necessary, and a place to meet and talk to people. We do give such assistance as finding a permanent place to live and a job, but only if the girl asks for it. Basically, Street Haven is somewhere a girl can come to get off the street."

Finances for the center are provided by a fund-raising drive each September. About $20,000 is donated by the Drug Addiction and Research, the United Church of Canada, and city and provincial governments; another $40,000 comes from private funds. This money, plus the time, effort, and concern of the staff and volunteers, provides help for 100 to 120 girls per week. In five years of operation, a total of some 1,200 girls have been helped by Street Haven.

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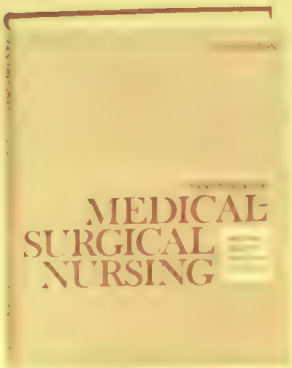

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CNA Librarian Attends Interagency Council Meeting

Ottawa – Margaret Parkin, the Canadian Nurses' Association representative on the Interagency Council on Library Tools for Nursing, was pro tem secretary of the Council's meeting in New York March 6.

A revised list of reference tools for nursing, prepared by the Interagency Council, received final approval at the meeting. This list, published in the April issue of *Nursing Outlook*, incorporates a Canadian supplement that substitutes Canadian publications for American references.

Agencies represented on this council include the American Journal of Nursing Company, American Nurses' Association, American Nurses' Foundation, American Hospital Association, American Medical Association, and CNA.

Council members meet twice a year to exchange ideas, plans, and experiences; explore the library needs of nursing; and make suggestions to appropriate executive bodies on the development and use of library tools and services. At the next meeting in the fall, CNA's representative will serve as chairman.

Three Senior Nurses Leave Toronto General Hospital

In October 1969, the two associate directors of nursing at Toronto General Hospital were asked to resign immediately by the executive director of TGH, Dr. J.D. Wallace. Shortly after, the director of nursing and the two associate directors were told they had been suspended, pending a report from consultants. In November, after the Registered Nurses' Association of Ontario had announced its complete support of the three nurses, the TGH board of trustees rescinded the suspension. (For further details see "RNAO Publishes Statement About TGH Senior Nurses" on page 11 of the February 1970 issue.)

The Canadian Nurse received word recently that the three senior nurses had left Toronto General Hospital on March 15, 1970. The editor wrote immediately to the chairman of the TGH board of trustees, asking for further details. In reply, the editor received a noncomittal letter from TGH's executive director, Dr. Wallace, suggesting that The Canadian Nurse obtain its information from the RNAO.

The letter sent to the executive director of the RNAO by the chairman of the TGH board of trustees is printed below with the permission of that Association.

Dear Miss Barr:

On November 4, 1969, I wrote to you concerning the re-assignment, on a full-time basis, of Miss M.J. Dodds, Miss I. Hagan and Mrs. M. Decker to the Hospital's Task Force on Nursing as Special Assistants. Since that time, they have contributed to special studies that are resulting in beneficial changes in the organization of our Nursing Services, which changed considerably the positions held by the three nurses.

During the past few weeks, proposals for continuing education programmes and for a further re-assignment to other positions in the new organization have been discussed with the three nurses. After much thought and consideration, they have decided that they would prefer to amicably leave their positions with our hospital. Mutually acceptable conditions that will protect their future security have been agreed to and they will leave on March 15, 1970.

Within the period of their employment at Toronto General Hospital, there was never any question of the professional competence or personal integrity of Miss M.J. Dodds, Miss I. Hagan or Mrs. M. Decker – Yours sincerely, Thomas J. Bell, Chairman, Board of Trustees.

RNAO Lifts Greylisting Of Milton District Hospital

Toronto, Ont. – The Registered Nurses' Association of Ontario lifted its greylisting of the Milton District Hospital April 9, after the hospital's director of nursing and assistant director had been reinstated.

The greylisting of the Milton Hospital was imposed by RNAO March 24 following the written resignations of 61 registered nurses employed by the hospital. The nurses' resignations were to take effect April 24. Their action was taken in

(Continued on page 12)

Hazardous Product Symbols

Ottawa. – New regulations that will require warning labels on poisonous, flammable, explosive, and corrosive products in everyday household use were announced in March 1970 by Consumer and Corporate Affairs Minister Ron Basford.

Under the new requirements, a uniform set of symbols will show both the type and degree of hazard; warning statements and basic first aid information will also appear on labels in both English and French. The new regulations, the first issued under the Hazardous Products Act of June 1969, deal specifically with consumer chemical products such as bleaches, polishes, sanitizers, glues and cleansers.

The symbols developed by the Consumer Affairs Bureau represent four hazards: a skull and crossbones mean poison; a flame means flammable; an exploding ball means explosive; and a skeletal hand in a container of liquid means corrosive. Each symbol is placed inside an outline that shows the degree of severity of the hazard. An octagon, like a traffic stop sign, means danger; a diamond, like a traffic warning sign, means warning; and a triangle, like a traffic yield sign, means caution. There are 12 symbols in the full series, which may be used in various combinations. The new symbols were pretested in Ottawa area schools, Mr. Basford said, and a high percentage of children grasped their meaning. The rules apply to all regulated products whether manufactured in Canada or imported. Since all prescribed consumer chemical products sold in Canada must first be relabelled, the regulations will not come into force until June 1, 1971.

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(Continued from page 9)

support of the former director of nursing, Lucille Verrall, who was fired on January 27. Assistant director, Phyllis Walker, was demoted on the same day and then resigned. Mrs. Verrall and Mrs. Walker were both removed from the hospital by security guards.

On March 12 the Ontario Hospital Services Commission recommended that a new director of nursing be appointed, after the Commission had obtained the views of the hospital administrator involved but not those of Mrs. Verrall.

RNAO informed the Milton hospital on March 16 that the resignations entrusted to it by 61 nurses of the hospital would be submitted unless Mrs. Verrall was reinstated as director of nursing, or a justifiable reason as to why she should not continue was given Mrs. Verrall and the RNAO. A second condition was the reinstatement of Mrs. Walker. When no action had been taken by the hospital board of directors by March 24, the nurses' resignations were forwarded to the Milton District Hospital Administrator.

The hospital board's decision to reinstate the two senior nurses followed a series of meetings of hospital directors, nurses, doctors, citizens, and RNAO staff. Anne Gribben, director of RNAO's employment relations department, told *The Canadian Nurse* that the final outcome was very satisfactory to both the nurses at Milton District Hospital and the RNAO. "Any differences of opinion that existed between the nurses and the hospital board are now a matter of the past," she said.

Nurse Should Develop A "Colleagueship of Equals," Sociologist Tells Conference

Toronto, Ont. – To give good patient care, nurses must have the dignity of knowing that their colleagues and "the system" care for them, according to sociologist Hans O. Mauksch, director of health care studies at the University of Missouri. Dr. Mauksch was speaking at a conference on nursing education for the beginning practitioner, sponsored by the Registered Nurses' Association of Ontario in March.

"Many nurses don't want to work with nurses," he said. "They want to work with patients or doctors. Nursing must develop a 'colleagueship of equals' if it is to provide its best service." Dr. Mauksch warned that the "aura of patient care" was so strong in nursing education that it threatens to interfere with education itself. "The patient and the doctor are often put on a pedestal, and perhaps they are sometimes put there to be forgotten," he added. "Most nurses are deeply committed, but they are inhibited by this system."

Dr. Mauksch also had criticism for nursing service. "It is bureaucratic and serves only the institution, not the patient," he claimed. It is part of the institution's tendency to serve units rather than patients, he added. He also questioned the role the student is prepared for and the one she eventually accepts as a practicing nurse, suggesting that much of the student's time is wasted learning something she will never use.

"But we cannot change this overnight," he admitted, "since social behavior does not change simply with a change in the environment." He cited as an example a study he had conducted at a hospital that had tried to change the role of its nurses. New nurses coming into the hospital had continued in their old patterns rather than adapting to the new ones, Dr. Mauksch said.

"We must inculcate the obligation to question and learn," he said, "so that the idealism of the student does not simply change to competence, but modifies it to include both." Dr. Mauksch said that nursing, like other professions, has absorbed all the inadequacies of the system, and that it must identify them for what they are, rather than accepting them as part of the system.

Other speakers at the conference included The Honorable Thomas Wells, minister of health for Ontario; Margaret D. McLean, nursing consultant for the hospital insurance branch of the department of national health and welfare; Dr. Norman H. High, professor of adult education at the Ontario Institute for Studies in Education; and Geneva Lewis, director of public health nursing, Ottawa-Carleton Regional area health unit, Ottawa, Ontario.

Students Debate Nursing Issues

Students in the certificate program in nursing education at the University of Ottawa held a lively debate March 13. Two questions were debated: first, that primary consideration should be given to individualizing clinical experience to meet each student's learning needs, and second, that medical-surgical nursing should be given at two levels of expertise. Participating in the two-hour program were, left to right, Maureen Hunka, affirmative speaker in the first debate; Nancy Powell, chairman; Helen K. Mussallem, executive director of the Canadian Nurses' Association and one of the debate's three judges; and Camille Wolfe, negative speaker in the second debate. The negative sides won both debates in the afternoon program.

Ryerson Offers Three Advanced Nursing Programs

Toronto, Ont. – In September 1970 the nursing department of the Ryerson Polytechnical Institute will be offering all three of its advanced nursing programs in psychiatric, pediatric, and adult intensive care nursing.

The advanced pediatric and the adult intensive care nursing programs have been offered once and have received favorable reactions from students and employers. They are each one semester (15 weeks) in length.

The advanced psychiatric nursing program has been offered three times as a one-semester program, and in September will become a two-semester (full academic year) program. The first semester of this new program will be similar to the original programs, and the second semester will go into more depth in psychiatric nursing. Nurses who have satisfactorily completed the original program will be eligible to enter directly into the new second semester in January 1971.

(Continued on page 15)

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MARN
celebrates
Manitoba
Centennial

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1. Five Manitoba registered nurses were made charter members of the Manitoba Association of Registered Nurses' new honors list at a meeting saluting the province's centennial on February 13, 1970. With Bente Cunnings, executive director of MARN, (third from left in back row), are, left to right: Myra Pearson, Fay McNaught, Lois Abbott, Marjorie Jackson, and Vi Miller.

2. Bringing greetings from the Canadian Nurses' Association to the "Salute to Manitoba" is Marguerite Schumacher, CNA first vice-president.

3. Admirers of the display of arts and crafts, the work of Manitoba nurses, featured during the evening.

4. Intermission time during the "Salute to Manitoba" night staged by MARN, and Manitoba nursing students. Some 2,000 nurses and students celebrated Manitoba's centennial year at the gala event.

5. The Winnipeg General Hospital Glee Club performs as part of a special program of entertainment.

6. MARN President Dorothy Dick (right) and Bente Cunnings, MARN executive director (second from right) chat with Rene Toupin, minister of health and social services in the Manitoba government, and Kathleen DeMarsh, assistant executive director of the Winnipeg General Hospital.

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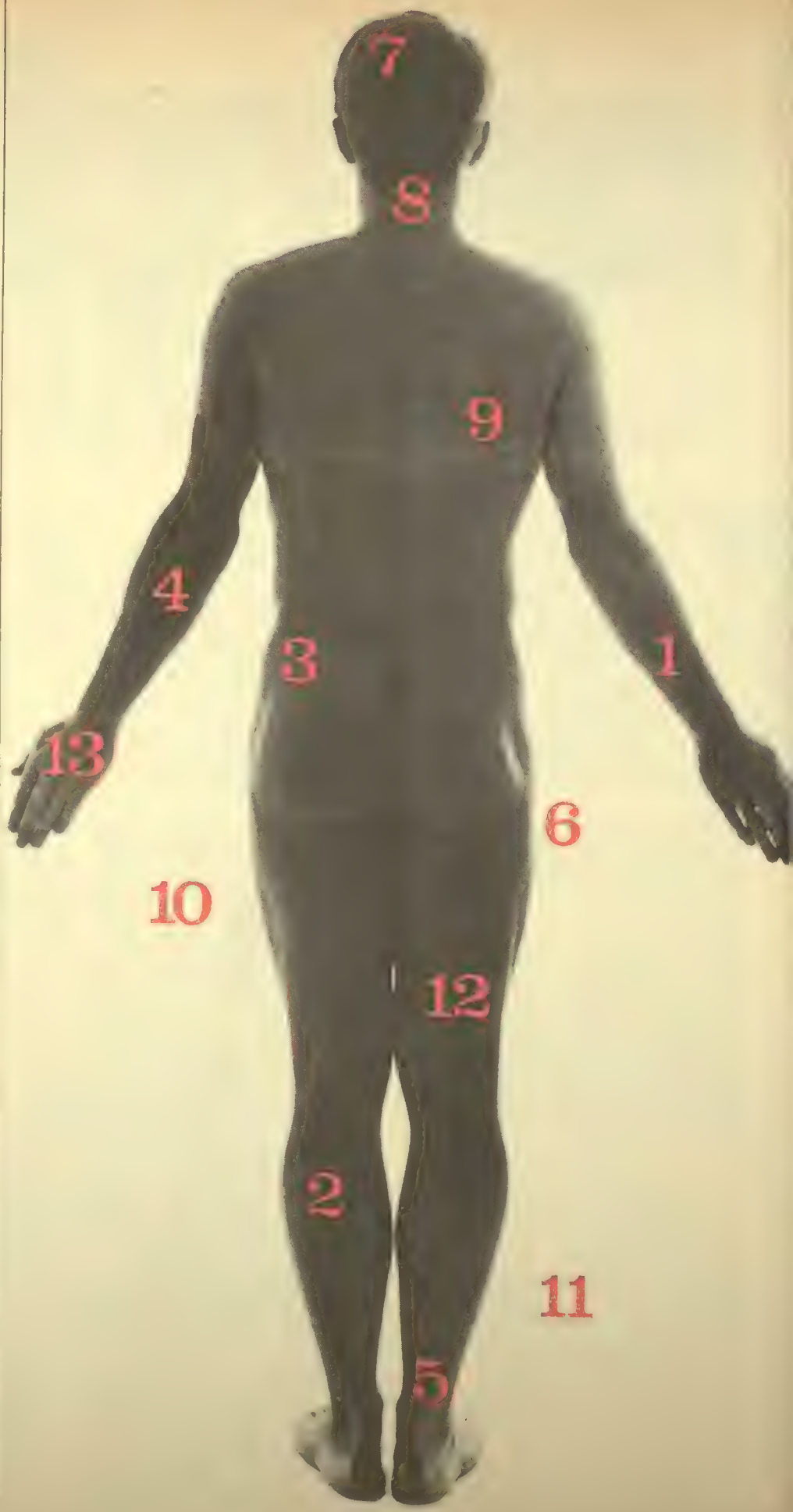

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A certificate is awarded to successful graduates of each of the three advanced nursing programs. They are available for part-time as well as full-time students.

Each program offers a course in nursing in the specific area, including classes and selected, supervised clinical experience; a course in the corresponding medical theory and practice; and a range of courses in the related social sciences and humanities.

The entrance requirements for the advanced nursing programs is registration or pending registration in Ontario. For further information contact the Registrar, Ryerson Polytechnical Institute, 50 Gould Street, Toronto 2, Ontario.

Task Force Reports Published

Ottawa. – The Department of National Health and Welfare announced in March that the task force reports on the cost of health services in Canada were ready for publication in final form.

The English edition of the reports is now available, with the French edition to follow as soon as possible. Price for the three-volume reports is $8.75 per set.

Orders for the reports may be placed through the Queen's Printer, Mail Order Division, Ottawa, Ontario, or at the Queen's Printer Bookstores in Vancouver, Winnipeg, Toronto, Ottawa, Montreal, and Halifax.

Three nurses were among the 40 members of the seven task forces appointed by Health Minister Munro in February 1969 to prepare reports on three major areas of health care costs: hospital services, medical care, and public health services.

CHA Holds Symposium On Computer Applications In The Health Field

Ottawa. – "Computers In Health" was the theme of the national symposium on computer applications in the health field, presented by the Canadian Hospital Association with the cooperation of the Department of National Health and Welfare. The symposium was held in Ottawa March 18 to 20.

Experts in this field from Sweden, France, Puerto Rico, the United States, and Canada discussed current applications, past performance, and future plans, including successes and problems encountered. Emphasis was on current working applications and reasonable expectations for future developments.

In his keynote speech, Health Minister John Munro explained how computing systems can provide better quality of services to Canadians, and better hospital

news

and medical services. "In hospitals, for example, they can provide such services as scheduling hospital activities, E.C.G. interpretations, and inventory control," he said.

Professor Blain Holmlund from the University of Saskatchewan spoke on the single use – system study group. "The basic objective is how to improve hospital systems, not how to use computers in hospital," he said.

In his talk, Professor Holmlund referred to "Conway's law" – the hypothesis that systems resemble the organizations that produce them. "Witness the hospital systems proposed by the large organizations in recent years," he said. "They tend to have unique characteristics, but all resemble corporate structures – huge, expensive, impersonal, and conforming. Give primary responsibility for the design of systems to a group of 'computer experts' and the system will invariably use a computer. Moreover," the speaker continued, "the system will tend to *computerize* people instead of *peoplize* the computer,"

Professor Holmlund told his audience that effective hospital systems improvement requires a creative problem-solving group of people with a variety of professional backgrounds. "Within such a group," he said, "there should be a sufficient number who despise and ridicule computers and who continually extol the virtue and superiority of human common sense."

Among the resolutions passed at the symposium was one calling on those responsible for education courses in the health field to include at least an introduction to computer technology, information, and communication sciences.

OR Nurses Question Panel On Medico-Legal Problems

Toronto, Ont. – Consent forms, patient identification, equipment, and drugs seemed to be the areas of most concern to nurses attending a panel discussion on medico-legal aspects of operating room nursing in Toronto March 20. The panel discussion, part of a one-day seminar sponsored by the Operating Room Nurses of Greater Toronto, was based on questions sent in by the participants.

Robert Elgie, neurosurgeon at Scarborough General Hospital, one of five panelists discussing the problems, said a nurse would not be legally liable if she assisted at an emergency operation that the surgeon considered necessary without the patient's consent, but that she has a moral obligation to question the surgeon if she believes he may be wrong. Dr. Elgie also was concerned with the question of how informed a patient should be before he is asked to sign a consent form. He said that the patient should have a specific explanation, but not one that would frighten him.

Two of the panelists at a discussion on the medico-legal aspects of operating room nursing warm up with a debate before answering questions from the audience. Dr. Robert Elgie, a neurosurgeon at Scarborough General Hospital, talks to chairman Florence Bestic, OR instructor at the Wellesley Hospital, Toronto.

Panelist Frederick A. Jaffe, director of laboratories at Queensway General Hospital, pointed out that the legal term "informed" was a grey area involving degrees of responsibility and liability. "The degree would have to be established in court," he said.

The problem of identification of patients is the surgeon's responsibility, according to Dr. Elgie. Douglas Crowell, anesthetist at St. Joseph's Hospital, Toronto, added that the anesthetist should also check identification. "I would never begin anesthesia without being sure of my patient's identification," he said.

Sponge and equipment counts are also the surgeon's responsibility, said Dr. Elgie. However, he said, the nurse would be liable if it were the hospital's policy to have the nurse count equipment, and the surgeon had not confirmed it. Sponge counts are admissible in court as evidence, he said.

When questioned about the legality of administering drugs by a person not qualified to do so, Eric R. Willcocks, administrator of Toronto East General Hospital, said that such a person would have no support in court for his actions.

"No one unqualified to administer drugs should do so, even if he has the verbal or written orders of a doctor," he said.

The panel was chaired by Florence Bestic, OR instructor at the Wellesley Hospital School of Nursing, Toronto.

RCAMC Offers Annual Bursary

Ottawa. – The Royal Canadian Army Medical Corps Fund is inviting applications for an annual bursary of $300.

Applicants must be dependents of: non-commissioned members of the RCAMC who have been accepted for career status; non-commissioned members or former members of the RCAMC, who have served a minimum of five years subsequent to 1950; or former RCAMC non-commissioned members of the Canadian Army Special Force (Korea).

The bursary will go to a dependent who has achieved satisfactory scholastic standing in the entrance, first, second, or third year of a recognized Canadian university, teachers' college, school of nursing, or institute of technology course requiring a minimum of 2,400 hours of instruction.

Further details may be obtained from the Secretary, RCAMC Bursary, Surgeon General Staff, Canadian Forces Headquarters, Ottawa 4, Ontario.

U of T Nursing School Offers New Master's Program

Toronto,Ont. – A new program leading to the degree of master of science in nursing will be offered by the University of Toronto School of Nursing, starting in the 1970-71 session. It will provide opportunity for advanced preparation for leadership roles in nursing and for specialization in community health nursing, medical-surgical nursing (cardiovascular, pulmonary and neurological), or psychiatric nursing.

The course is designed to enable students to develop depth in nursing knowledge in a selected area; ability to make discriminating use of research findings and investigate nursing problems; understanding and appreciation of leadership responsibilities.

Candidates will be required to complete successfully a minimum of four full courses and a thesis to qualify for the degree. The program may be completed in a minimum of 16 months. As well as the nursing and research subjects, which will be given in the school of nursing, supporting graduate courses will be offered in other university departments. Community health agencies and teaching hospitals will provide the field for clinical study and the investigation of nursing problems.

Applicants who have obtained a B.Sc.N. degree in the University of Toronto, or an equivalent degree, with second class standing in the final two years, will be considered for admission. All students must satisfy the university's general regulations for admission as outlined in the calendar of the School of Graduate Studies. For further information or application forms, write to: The Secretary, School of Graduate Studies, University of Toronto, Toronto 5.

Notice

of

Canadian Nurses' Foundation

Annual Meeting — June 15, 1970

Playhouse Theatre,

Fredericton, N.B.

The annual meeting of the Canadian Nurses' Foundation will be held Monday June 15, 1970, at 1600 hrs., in the Playhouse Theatre, Fredericton, N.B. Members will be seated on the main floor and will be asked to present their 1970 membership card for admission. Non-members will be welcome and will be seated in the balcony.

news

Speaker Relates Inservice Education, Job Satisfaction

Toronto, Ont. – There is a definite relationship between job satisfaction and inservice education, according to an American nurse who addressed the Operating Room Nurses of Greater Toronto March 20. Myra K. Slavens, educational director of the Association of Operating Room Nurses, Inc., of Englewood, Colorado, spoke at the morning session of the one-day seminar.

Miss Slavens said one of the main causes of poor relations between employer and employee is confusion caused by poor communication. This could be helped by an inservice education program that would provide an adequate orientation program to new staff, she said. By encouraging better rapport between employer and employee, providing enough information for the new employee to function effectively, and giving her an introduction to her co-workers, better patient care and job satisfaction is encouraged, she added.

A well-planned program in continuing education is also essential to improve communication and to ensure that the nurse has up-to-date knowledge, Miss Slavens said. She emphasized that both orientation and continuing education programs would involve change and resentment, and suggested that by involving staff in planning and ensuring adequate communication of plans, this could be reduced. "Feedback from staff is especially important," she said, "because the program should be based on their needs. It must also be flexible enough to cover the varying needs of the different participants."

Nursing must lose its rigidity, Miss Slavens continued, and learn to effect and accept change if it is to survive. Rituals, such as taking temperatures at customary rather than logical times, will have to give way to more use of the nurse's judgment, she said.

Conference Focuses On Youth Mental Health Problems

Ottawa – The mental health problems of childhood and youth were the focus of a national conference on medical action for mental health held March 11-13, 1970.

Some 185 persons attended the conference, organized by the Canadian Medical Association. Recommendations from the conference include:

- Models of community organization are needed to provide examples of the total use of all interested groups.
- A means of reaching those authorities providing funds should be found so that more funds can be allocated to prevent mental health problems.
- More regional programs to help children and youth are needed.
- Every program should be evaluated.
- Information on the experiments being conducted in Canada on these problems should be made available.

Those attending the conference agreed that real and effective implementation of the recommendations by all involved disciplines is necessary. The Canadian Nurses' Association was represented by Constance Gray, Public Health Nursing Division, Toronto Department of Public Health, who was a member of the initial planning team for the conference.

Red Cross Booklet Available In Canada

Single copies of the Red Cross booklet on "Rights and Duties of Nurses Under the Geneva Conventions" (News, Feb., page 11) can be obtained from provincial headquarters of the Canadian Red Cross Society. Larger quantities can be obtained from the National Headquarters, 95 Wellesley Street East, Toronto 5, Ontario.

ICN Publishes New Nursing Statement

Geneva, Switzerland. – The International Council of Nurses has published a statement on nursing education, nursing practice and service, and the social and economic welfare of nurses; its underlying principle is the interrelationship of these areas as inseparable parts of nursing as a whole.

The document was prepared so that national nurses' associations would know ICN's stand on these matters. ICN hopes the statement will help the associations in formulating their own policies.

The statement calls for educational requirements for entrance into nursing schools to be on a level with those of comparable professions in the country, and special preparation for nursing school faculty. It points out the need for health and nursing services in the promotion of health and elimination of disease, and calls for the participation of nursing at all levels of health service planning and administration. It states the need and right of nurses to take part in determining conditions of employment.

The English version of the statement is available now and the French, German, and Spanish translations will be ready shortly. Orders may be placed now with: International Council of Nurses, P.O. Box 42, CH-1211 Geneva 20, Switzerland.

Copies of the statement cost 25 cents each.

WHO Reports Decrease In Smallpox

Geneva, Switzerland. – Smallpox incidence declined by almost 60 percent in the first three years of a world-wide eradication campaign launched by the World Health Organization in 1967.

Smallpox dropped from 128,300 cases in 1967 to an estimated 56,000 in 1969. The number of countries reporting smallpox decreased from 43 to 29. The most marked reduction occurred in the countries of West and Central Africa, which recorded only 10 percent as many cases in 1969 as in 1968.

The WHO report stresses that the improvement is even more impressive than shown in these figures because the reporting of smallpox has steadily improved since the beginning of the campaign.

Since September 1968, no smallpox has been introduced into Europe, Australia, and North America – another sign of the overall decline of the infection. As recently as 1962, 60 countries recorded cases of smallpox, indigenous or imported, compared with 29 countries last year.

There are 17 countries in Africa, South America, and Asia where smallpox transmission continues in endemic fashion, compared with 27 in the beginning of 1969. In all but two endemic countries, intensive programs of eradication are now in progress. With three exceptions, freeze-dried vaccine of satisfactory potency, stability, and purity is now used in all endemic countries.

WHO still needs donations of vaccine. The organization distributed 21,640,000 doses of vaccine in 1969 and will need 33 million doses in 1970. Nine countries made donations to WHO in 1969.

According to the report, the next logical step is for every country to set up the machinery for immediate investigation of each smallpox case by trained investigators to trace the source of infection and to apply prompt and effective containment measures.

Nurse Instructor Needed For MEDICO In Indonesia

New York, N.Y. – A nurse instructor with a degree in nursing education is needed by MEDICO, a service of CARE, for an all-Canadian medical team stationed in Indonesia. The post is offered on a two-year contract basis.

Team headquarters is at Mangkuben Hospital in the city of Surakarta, Central Java Province. Three Canadians – a physician, an operating room nurse, and a laboratory technologist – launched this program in January 1970. The team will be expanded at a later date.

Although patient care will be part of the nurse instructor's daily responsibility, her main goal will be to help train counterparts to staff the six major regions of the province. She will be involved in a nurses' training program currently underway with 350 candidates.

In addition to the CARE-MEDICO Canadian team, two nurses who speak French fluently are needed for a joint American-Canadian team stationed at a hospital in Tunisia. These positions, also offered on a two-year contract, require an operating room nurse for immediate assignment and a general duty nurse to begin work in May 1970.

Qualified Canadian nurses interested in the Indonesian or Tunisian positions are asked to write to world headquarters for details. Address queries to: Mr. Leonard Coppold, Director of Professional Personnel, MEDICO, a service of CARE, 660 First Ave., New York, N.Y. 10016, U.S.A.

Psychiatrists Say Abortion Should Be Removed From Law

New York, N.Y. – Abortion performed by a licensed physician should be entirely removed from the domain of criminal law. This is one of the conclusions presented by the Group for the Advancement of Psychiatry, an organization consisting of nearly 300 distinguished psychiatrists, in a report it has just released entitled *The Right to Abortion: A Psychiatric View.*

In this document, formulated by the organization's committee on psychiatry and law, the authors have analyzed the question of legalized abortion from social, ethical, and legal viewpoints and

(Continued from page 19)

have concluded "that a woman should have the right to abort or not, just as she has a right to marry or not." Anything short of this "stands four square against the right of the woman to control her own reproductive life."

The authors believe that the moral questions of when life begins and what constitutes the taking of a life in this particular situation are answerable only through personal religious beliefs and should not, therefore, be directed by the state. "There can be no doubt," they assert, "that strong religious ideals contribute to sustaining the system of legal sanctions that makes abortion a source of guilt and labels it a crime."

The authors emphasize that present laws do not eliminate illegal abortion, citing studies suggesting that most abortions in the United States are illegal. The affluent do not find it difficult to obtain a therapeutic abortion, whereas others, the report says "are driven by their needs into the hands of practitioners and charlatans who may employ dangerous techniques . . . Thus decisions are made individually and personally, responsive to social, economic, moral, religious, and psychological factors, regardless of the status of the law."

Seeing the moral issue of abortion as a "seemingly insoluble" legislative problem, the authors turn to other considerations. They express repeated concern for the mental health of both the mother and the unwanted child. "There can be nothing more destructive to a child's spirit than being unwanted," the authors maintain, "and there are few things more disruptive to a woman's spirit than being forced without love or need into motherhood."

In other arguments, they criticize the American Law Institute's "liberalized" abortion law. This law provides for a legal abortion when great risk to the mother's physical or mental health is apparent, or when conditions indicate that the child would be born with grave physical or mental handicap. Such beliefs must be certified by two physicians in writing.

The authors argue that this law, in effect in some states now, does not provide any answer to the moral question. Neither does it provide specific "psychiatric criteria" for standardizing interpretation of the law in all states. Thus, decisions fall upon the psychiatrists instead of upon the individual or society.

In their conclusion, the authors suggest that many of the social, sexual, and pragmatic goals served by legal sanction against abortion have diminished in the past decades and that their continued application no longer can be sustained by a justifiable state interest. They recommend further study leading to future policy changes.

Copies of *The Right to Abortion: A Psychiatric View,* can be obtained at $1.00 each (US funds) from the Publications Office, Group for the Advancement of Psychiatry, 419 Park Avenue South, New York, N.Y. 10016. Quantity prices are available on request.

NLN Favors Open Curriculum

New York. – The National League for Nursing board of directors has adopted a statement favoring an open curriculum in nursing that would permit students to move from one type of nursing program to another or into nursing from another health discipline.

The board recognized that although each type of nursing education program gives preparation for a specific kind of nursing career, many nursing schools, colleges, and universities are experimenting with curriculum plans that permit students who change career goals to move rapidly to another type of program.

The board also approved a nationwide research study to determine and evaluate activities underway to achieve the open curriculum in nursing education, subject to funding. □

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In dehydrated or debilitated patients, the volume must be carefully determined since the solution is hypertonic and may lead to further dehydration. Care should also be taken to ensure that the contents of the bowel are expelled after administration. Repeated administration at short intervals should be avoided.

Full information on request.

*Kehlmann, W. H.: Mod. Hosp. 84:104, 1955

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names

Mona C. Ricks, of Ottawa, has joined *The Canadian Nurse* as assistant editor. Prior to this appointment, Mrs. Ricks had been an information officer in the federal civil service. In her last assignment, editor of a magazine for the Department of Indian Affairs and Northern Development, she covered stories that demonstrated the diversified programs of the Department in Ottawa and field offices across Canada. Her stories told of a young Eskimo sculptor, who, during a course at the University of Alaska, became aware of the importance of education in southern society and wrote a plaintive letter beseeching students to remain in school; the varied duties required of wardens in Canada's national parks – why they use trail horses in summer and skis in winter; and of Eskimo patients in southern hospitals and their need to communicate with friends and relatives in the North.

As an editor of school textbooks with McGraw-Hill Company of Canada Ltd., Mrs. Ricks became acquainted with guidance and counseling programs in the public schools, and the ongoing approach to educational challenges in today's changing world. In public relations her duties involved marketing books of varied subjects, meeting authors, and writing book reviews. While working as an editorial assistant on the *Canadian Medical Association Journal,* she gained insight into the vast area of medical research.

When asked why she chose to work in the news field, Mrs. Ricks replied, "I didn't really choose the work, it chose me. Soon after my arrival in Canada as a newcomer from England, I was *on the spot* when a nest of horned owls was found in a broken tree limb." The young owls made news for Mrs. Ricks. It was her published story of the owls' rescue that created her interest in journalism. A few months later she enrolled in a journalism course and graduated with a diploma. Since then her work in the news media has led to many interesting adventures. The most notable, she says, was a Toronto kidnapping case.

Her editorial duties with the journal include covering items of general interest to the nursing profession. "I've seen some of the many roles a nurse fulfills," says Mrs. Ricks. "As a Red Cross volunteer I visited veterans in hospital and played cards with the old-timers. I always remembered to *look the other way* when they forgot to play the right card."

Visitor To New Zealand

Verna M. Huffman (left), principal nursing officer with the Department of National Health and Welfare in Ottawa, visited New Zealand February 15-26 after attending the International Conference on Domiciliary Nursing in Melbourne, Australia, where she was a guest speaker. S.M. Bohm (right), director of the division of nursing, New Zealand Department of Health, arranged Miss Huffman's program of studies and comparisons.

The Canadian Nurses' Association's first executive secretary, **Jean Scantlion Wilson**, died April 8 at Almonte, Ontario.

Miss Wilson, who was known and respected nationally and internationally, was CNA executive secretary from 1923 to 1943, and served as editor and business manager of *The Canadian Nurse* from 1924 to 1932.

Brought up in Ontario and Quebec, Miss Wilson received her nursing education at the Lady Stanley Institute in Ottawa. She was graduated in 1906, and spent several years in positions at the Vernon Jubilee Hospital, B.C., and the Moose Jaw General Hospital, Saskatchewan. From 1917 to 1920 she was secretary-treasurer and registrar of the Saskatchewan Registered Nurses' Association.

In 1921 Miss Wilson entered the McGill University School for Graduate Nurses, where she obtained a certificate in administration in schools of nursing. Also in 1921 Miss Wilson became honorary secretary-treasurer of the Canadian National Association of Trained Nurses. In 1922 the CNATN general meeting decided to open a national office and employ an executive secretary. The following year Miss Wilson was appointed to the post and set up a national office in Winnipeg, Manitoba.

In 1924 the Canadian National Association of Trained Nurses changed its name to the Canadian Nurses' Association. That year, *The Canadian Nurse* was transferred to the Winnipeg office, and Miss Wilson became its editor and business manager until 1933. The national office then was moved to Montreal, Quebec, and Ethel I. Johns was appointed full-time editor and business manager of the journal.

A shrewd businesswoman, Miss Wilson was to a great extent responsible for the solid financial situation of CNA at the time of her retirement in 1943 to her farm in Almonte. In 1938 CNA awarded her the Mary Agnes Snively Memorial Medal and award for "nurses whose work exemplifies Miss Snively's ideals of nursing and service."

Miss Wilson was an honorary member of the Saskatchewan Registered Nurses' Association and the Canadian Nurses' Association.

Anne Elizabeth Blatz (R.N., Misericordia H., Edmonton; Dipl. Nursing Serv. Admin., B.Sc.N., U. of Saskatchewan, Saskatoon) has been appointed instructor in nursing education at Mount Royal Junior College in Calgary.

Miss Blatz has worked as a general duty nurse at Misericordia Hospital in Edmonton, Alberta; as a clinic nurse at Baker Clinic in Edmonton; as head nurse at the University of Denver Hospital, Colorado; and as assistant head nurse at Calgary General Hospital. □

in a capsule

What a gas!

Our New Brunswick colleagues have been telling us about the pleasures awaiting registrants to the 35th biennial convention of the Canadian Nurses' Association to be held June 14 to 19 in Fredericton.

One scheduled treat particularly caught our eye. A tour of Saint John has been laid on for the hospitality day June 17, and "one of the city's breweries will receive the touring delegates for what promises to be an interesting afternoon."

We wonder what exactly they mean by that!

TV medical hour

Since 1959, the Swiss Medical Association, in cooperation with the Swiss TV network, has provided the general public with some 129 medical programs.

The Swiss medical TV hour is a program of public medical education that deals with disease prevention and hygiene and public health. The program is intended to improve rapport between patient and physician.

These programs have included reports on progress in medicine, general aspects of practical medicine and procedures, the work of the general practitioner, suggestions for improvement of health and prevention of disease, and lectures with popular presentation of new breakthrough-type developments, such as heart transplantation, immunological problems, and cancer research developments.

The Swiss public has accepted the TV programs with enthusiasm and approval, reports the *Journal of the American Medical Association* of February 2, 1970.

We wonder how many Canadians would prefer this type of TV education to the drama that surrounds the word "doctor" on our screens.

Walking good for eyes

Jogging is acknowledged to be good for whatever ails you, but who would have guessed that plain walking was good for the eyes? This question was asked in the January *St. John News,* published by the St. John Ambulance in Canada.

Proof for this recently-found connection between walking and eyes came in the form of $40,000 – the sum raised by two Canadian "Miles for Millions" walks for the Ophthalmic Hospital in Jerusalem. The Miles for Millions organizations in Ottawa and Calgary each presented St. John Ambulance with $20,000 for the Ophthalmic Hospital.

Those of us who have been impulsive enough to volunteer for these worthwhile walks know how healthy it feels after walking 25 miles on pavement and pebbles. But you really do feel good in retrospect, when you re-walk your feat for the benefit of less health-minded friends.

New development?

The first sentence of a press release we received recently read: "A seminar on conception control for physicians will be held on April 2-3 at New York University Medical Center, 550 First Avenue, New York City."

That's one seminar we won't want to miss. □

dates

May 12-15, 1970
Alberta Association of Registered Nurses Convention, Calgary Inn, Calgary. For further information write to: AARN 10256 - 112 Street, Edmonton, Alberta.

May 19-22, 1970
61st annual meeting of the Canadian Public Health Association, Marlborough Hotel, Winnipeg, Manitoba. Write to: CPHA annual meeting, Norquay Building, Room 316, 401 York Avenue, Winnipeg, Manitoba.

May 25-June 12, 1970
Training course in rehabilitation, Winnipeg. Write to: Extension Division, The University of Manitoba, Winnipeg 19, Manitoba.

May 26-28, 1970
Annual meeting of the Registered Nurses' Association of Nova Scotia, Acadia University, Wolfville, N.S. For more information, write to: RNANS, 6035 Coburg Rd., Halifax, N.S.

May 27-29, 1970
Registered Nurses' Association of British Columbia Annual Meeting, Bayshore Inn, Vancouver. Write to the RNABC, 2130 West 12th Ave., Vancouver 9, B.C.

May 27-29, 1970
Saskatchewan Registered Nurses' Association annual meeting, Hotel Saskatchewn, Regina. More details are available from SRNA, 2066 Retallack Street, Regina, Saskatchewan.

May 28-29, 1970
Annual meeting of the Manitoba Association of Registered Nurses, International Inn, Winnipeg. For further information, write to MARN, 647 Broadway Avenue, Winnipeg, Manitoba.

June 1-3, 1970
70th annual meeting of the Canadian Tuberculosis and Respiratory Disease Association and the 12th annual meeting of The Canadian Thoracic Society will be held at the Fort Garry Hotel, Winnipeg. Further details are available from Dr. C.W.L. Jeanes, Executive Secretary, CTRDA, 343 O'Connor Street, Ottawa 4, Ontario.

June 3-4, 1970
Workshop on alcoholism and drug addiction: the feelings and attitudes of nurses to the problems of dependency and how it affects nursing care in acute and long-term cases. Sponsored by the Kent County Chapter of the Registered Nurses' Association of Ontario and the Alcoholism and Drug Addiction Research Foundation. For further information, write to: Mrs. R. Hundertmark, Alcoholism and Drug Addiction Research Foundation, 153 King St. West, Chatham, Ontario.

June 3-5, 1970
Cardiovascular Nursing in the New Decade and the Computer Age, sponsored by the American Heart Association, Council on Cardiovascular Nursing, Kansas Heart Association, Department of Postgraduate Medicine, University of Kansas Medical Center. Address inquiries to the Canadian Heart Foundation, 270 Laurier Ave. West, Ottawa, Ont., or Mr. Bill Stanley, Program Director, Kansas Heart Association, 5229 West 7th Street, Topeka, Kansas 66606, U.S.A.

June 3-5, 1970
Canadian Hospital Association national convention and assembly meeting, Jubilee Auditorium, Edmonton, Alberta. Focus will be on the hospital and community health. Tours of the Rocky Mountains will be available at the end of the convention but must be paid for by April 30. Reservation deadline for the convention is May 1. Write to the CHA, 25 Imperial Street, Toronto 7, Ontario.

June 10-13, 1970
Glace Bay General Hospital graduates' reunion, sponsored by the hospital's alumnae association, Glace Bay, Nova Scotia. Graduation of the nursing school's last class is June 11 and dance June 12. Address inquiries to: President, Alumnae Association, Glace Bay General Hospital, Glace Bay, Nova Scotia.

June 10-13, 1970
First annual meeting of the Canadian Association of Neurological and Neurosurgical Nurses in conjunction with the Canadian Congress of Neurological Sciences, Royal York Hotel, Toronto. For further information write to: Miss M. Maki, Apt. 306, 161 Wilson Avenue, Toronto 380, Ontario.

June 15-19, 1970
Canadian Nurses' Association General Meeting, The Playhouse, Fredericton, New Brunswick.

June 17-20, 1970
20th annual meeting of the Canadian Psychiatric Association, Winnipeg. For information, write to: The secretary, Canadian Psychiatric Association, 225 Lisgar St., Suite 103, Ottawa 4. □

Among the "most helpful" books of 1969

In a recent review, expert nurses in six specialties singled out, from all the books published in 1969, the ones they found most helpful to students, teachers, and nursing practitioners. We are proud that these Saunders books were selected:

Hymovich: NURSING OF CHILDREN: A Guide for Study

"Contains the core content of pediatric nursing arranged in logical sequence and enriched by exceedingly useful bibliographic entries, Here is a workbook for students of nursing that excites a teacher's imagination . . . I would expect this book to appeal to a staff nurse in search of a way to organize her thoughts about a patient as much as it does to a teacher seeking help for a student."

By Debra P. Hymovich, R.N., M.A., University of Florida.
389 pages, illustrated. Soft cover. $5.95. Published May, 1969.

Secor: PATIENT CARE IN RESPIRATORY PROBLEMS

"The major aim . . . is to present a nursing specialization as an inseparable bleeding of technical expertise and personalized patient-centered care. Technical innovation in the patient setting requires that the nurse have flexible manipulative skills and reliable interpretive skills." How to develop those skills is discussed in depth in this new monograph, the first in a new series.

By Jane Secor, R.N., M.A., Syracuse University.
299 pages, illustrated. $8.40. Published September, 1969.

Sutton: BEDSIDE NURSING TECHNIQUES IN MEDICINE AND SURGERY
Second Edition

"A reference for all those occasions when a nurse knows what to do but can't quite remember how to go about doing it. The newest concepts of hospital care, recent designs in equipment, current techniques and procedures, and latest diagnostic and therapeutic methods in medicine and surgery are included and explained in the light of a nurse's role in patient care. Numerous illustrations and diagrams enhance the explanations."

By Audrey Latshaw Sutton, R.N.
398 pages with 871 illustrations. $8.95. Published March, 1969.

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- ☐ Secor: **Patient Care in Respiratory Problems** ($8.40)
- ☐ Sutton: **Bedside Nursing Techniques** ($8.25)

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One standard — or two?

In most Canadian hospitals two standards of nursing care are offered — one for the female patient and one for the male patient. This double standard of care can be removed by upgrading the education of the orderly.

Albert W. Wedgery, Reg.N., M.A.

Is the nursing profession in Canada still too complacent about the lot of the male patient in our hospitals?

Perhaps this is an unfair question considering the attempts being made by many institutions to upgrade the preparation of auxiliary workers and to introduce the team nursing concept, which makes the best use of the skills of all nursing personnel. However, if routine bedside nursing is becoming more and more the realm of the auxiliary worker, we must make an even greater effort to see that these workers are well prepared.

I have a strong personal conviction that the male patient in most hospitals is entitled to a better grade of service from non-professional nursing personnel than he is now receiving. For example, in 1968 there were 698 registered male nursing assistants for the whole of Canada.[1] Compare this paltry total with 10,821 — the number of orderlies employed full-time or part-time in general and allied special hospitals for the same period[2] — and you begin to appreciate the realities of the situation for the male patient.

Mr. Wedgery, a graduate of the School of Nursing, Ontario Hospital, Whitby; the University of Western Ontario, London; and Teachers College, Columbia University, New York, is formerly Associate Director of the College of Nurses of Ontario.

Poor quality care

The generally poor quality of orderly care, which often results from lack of professional instruction, supervision, and guidance, demands the development of a more respected, more responsible, and more secure male auxiliary worker to meet the needs of the male patient. There is need particularly to make the orderly a more stable employee instead of regarding him as another piece of flotsam in the constant ebb and flow of personnel.

For example, it has just been reported by a joint federal-provincial committee studying ways to improve Canada's health services, that in 1967 the turnover rate of orderlies in public hospitals across Canada was 47 percent. What does this high turnover rate mean in increased costs through the time consumed in training, inefficient discharge of duties, poor use of equipment and supplies, and, even more important, the lowered standard of care that is an unavoidable concomitant?

If the seemingly indispensable orderly were given a greater opportunity to learn and advance through continued guidance and encouragement, there would be not only a conspicuous improvement in the calibre of the orderly group itself, but also a refreshing uplift in the standard of care provided by these workers. When human life and suffering are at the mercy of hospital personnel, all workers must be prepared properly for their tasks.

The orderly is not entirely at fault for

the often unhappy position in which he finds himself in most of our institutions:

> "That he has often been inefficient and has performed duties for which he was unprepared without adequate supervision is no denial of the essential place he has filled. Within a well-coordinated team, with better in-service training, his efficiency could be increased."[3]

Is there any doubt that the nursing profession should look into its corporate conscience and help the orderly climb from his usual place on the lowest rung of the nursing service ladder?

Examples of progress

A notable example of real progress in this direction was a new deal for orderlies (to say nothing of a new deal for male patients!) undertaken 10 years ago by the Winnipeg General Hospital. Taking stock of its situation, this institution discovered that only a reappraisal of the orderly's function and the organization of a course of instruction, designed to make full use of his potential, could bring about a long-needed element of efficiency and stability to this area of patient care. Consequently, a certified orderly training program paved the way for a wholesale improvement in morale and resulted in a more dependable, more satisfied, and, therefore, more valuable member of the nursing team.

Out of this move toward better nursing care through better qualifications and better preparation has developed the Manitoba Association of Certified Orderlies, incorporated in 1960. The code of ethics of this organization reflects a genuine desire on the part of its members to fit as closely as possible into the concept of quality care for all patients and to establish the orderly as a good citizen, a conscientious worker within the limit of his preparation, and a respected representative of nursing in the eyes of the public. In effect, the evolution of the certified orderly in Manitoba has given real meaning to an often despised job.

Nor have other provinces been idle. The Central Nursing Orderly School in Edmonton, operated under the Alberta Department of Education since 1967, offers training to men who want to be part of the health team. The recruitment brochure about this vocational opportunity contains the following description:

> "The Nursing Orderly must be a responsible man. He must be dedicated in his work of helping patients; in addition, he must be competent to give safe nursing care. By being all of these, the Nursing Orderly keeps the interests of the patient uppermost at all times and ensures that he is performing his part for the team."

This appraisal of the role of the orderly within nursing service and the important nature of the task he can perform clearly points to an outlet for certain abilities in a new and worthwhile career.

In the summer of 1968, the Toronto Board of Education, at the request of the Ontario Hospital Association, offered two programs of instruction for hospital orderlies: a full-time course designed to prepare new orderlies, and a part-time, upgrading course for orderlies already working in hospitals. Following these ventures, there was a major increase in the number of regionalized orderly programs around the province. The upgrading courses have been particularly successful because they have led to orderlies being better integrated into organized patient care upon their return to the hospitals.

A manual developed by the Ontario Hospital Association, *Guidelines for the Preparation of Hospital Orderlies,* has been used widely and to good purpose as a step toward the development of a uniform program of instruction in this province.

Thus, it is reasonable to expect that as other attempts are made to prepare orderlies at the level of a nursing assistant, many more men could find real satisfaction in this humanitarian work. And is it not logical to expect that some of these orderlies will become interested in professional nursing?

Fresh approach needed

As guest speaker at the International Council of Nurses' Quadrennial Congress in Montreal in June 1969, the Minister of National Health and Welfare, the Honorable John Munro, had this to say to Canadian nurses particularly:

> "...for all the money the Canadian taxpayer is spending for hospital insurance, shouldn't we be able to expect that all our citizens are more or less equal in terms of access to necessary health care? – an access that we have come to accept as a fundamental human right, after all."[4]

The minister was asking for a commitment on the part of the nurses in this country to live up to the purpose of nursing: namely, the best possible care of the patient. Therefore, anything less than this in the pursuit of patient welfare vitiates our contribution to the betterment of mankind.

Isn't it time, then, to take a fresh approach to the care of the male patient in our hospitals? The sooner we get rid of a double standard of nursing care and achieve a proper synthesis of all nursing personnel, the sooner we can say that the best interests of every patient are in the forefront of our efforts. If we fail to do this, we shall miss the opportunity to serve all members of the public with the proper degree of efficiency and concern.

References

1. *Countdown 1969.* Ottawa, Canadian Nurses' Association, Table 2, p.133.
2. *Ibid.*, Table I, p.114.
3. Pearce, Evelyn C. *Nurse and Patient.* Toronto, J.B. Lippincott Company, 1954, p.78.
4. Munro, John. A challenge that confronts us. *Canad. Nurse* Aug. 1969, pp.40-43. □

idea exchange

Five members of the head nurses' association at The Vancouver General Hospital examine the results of the questionnaire they asked graduate nurses to complete. Left to right: Sheila Petrie, D. Babcock, E. Jakubovskis, M. Shepherd, and B. Burgess.

A Head Nurses' Association Takes Action

Head nurses are directly responsible for developing a staff that can operate on a high level of effectiveness and for providing good patient care. Both responsibilities become more difficult when there is a high turnover of nursing staff.

What makes nurses leave their jobs? Why do they change jobs at frequent intervals? What are they looking for in their new jobs? The head nurses at The Vancouver General Hospital, who are organized as an autonomous association, decided to try to find some answers to these questions.

As head nurses, one of our main objectives is to improve professional and administrative knowledge. With this in mind, our association decided to conduct a study to find out how general duty nurses felt about The Vancouver General Hospital and what made them dissatisfied enough to leave it.

The first step in the investigation was the formation of a committee of eight head nurses. This committee developed a questionnaire based on some of the ideas the head nurses had regarding graduate nurse dissatisfaction. From an analysis of these ideas, a tentative questionnaire was prepared and given a trial run using the head nurse group. The subsequent criticisms and suggestions were considered when developing the final questionnaire.

A total of 660 questionnaires was distributed. Each head nurse gave one to each graduate nurse on her unit. This method of distribution allowed the head nurse to explain the purpose of the questionnaire and to emphasize that participation in the enquiry was on a voluntary and anonymous basis. To facilitate the return of the questionnaires an envelope was attached, addressed to the inservice education center. At the end of the three-week limit 303 questionnaires, or 45.5 percent, were returned.

The response to the questionnaires was enlightening. The respondents expressed their feelings freely, helping the head nurses to understand their satisfactions

and frustrations. Most comments could be grouped into three main areas: staff development, personnel policies, and interpersonal relations.

In the area of staff development, graduates indicated a need for more inservice education and a better system for attending ongoing programs; they suggested specific topics for inservice education. This information was forwarded to the inservice education department and the graduate inservice program was revised to include the nurses' suggestions. The head nurses reviewed the weekly time of the program and agreed to encourage graduate nurses to attend.

The questionnaires revealed many dissatisfactions with personnel policies. Many criticisms dealt specifically with hours of work and rotations. In response to this, the head nurses and the director of nursing took part in an intensive workshop to plan time schedules.

Many graduates commented on interpersonal relations. The analysis revealed that communication, or lack of it, was the basis for much frustration and dissatisfaction. The need for better communication between a head nurse and her graduate staff prompted the organization of a head nurse inservice program on interviewing techniques. This program helped the head nurses feel more sure of themselves when they evaluated and counseled their staff.

As a result of this inservice program the head nurses discarded the traditional system of evaluating staff. The new system gives each staff member an opportunity to evaluate herself and to explore goals and objectives with her head nurse. The head nurses now plan to interview their graduates every three months and to use this opportunity to encourage graduates to evaluate their own progress and to discuss their current problems and ideas. This method has proved effective as a means of evaluation and as a method of improving communication. The head nurses hope that some of the frustrations and dissatisfactions expressed by the graduates will be eliminated.

In answer to requests for information on the outcome of the questionnaire, the graduates each received an outline of the actions initiated as a result of their ideas and suggestions.

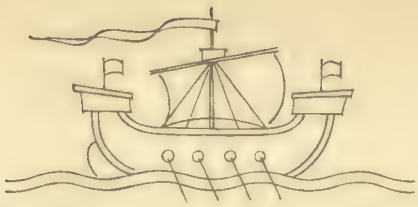
It is still too early to measure the influence of the study on the turnover rate of graduate nurses at this hospital, but the head nurses are considering resubmitting the same questionnaire to evaluate changes in graduate staff attitudes. Whatever the final outcome, the head nurses believe they have grown both professionally and personally by undertaking this study. The project has given them a direction and a sense of purpose for continued explorations into their relationships with their graduate staff. — The Head Nurses' Association, The Vancouver General Hospital, Vancouver, B.C. □

Move Equipment With Ease

An adaptation of the type of dolly used for moving cartons in a store has been a boon to nursing personnel at Prince George Regional Hospital in British Columbia. The new metal cart has two wheels, which make it easier to move awkward items such as bedside lockers from one area to another, thus reducing noise and possible damage to floors.

The upright part of the cart is approximately four feet in length with the handles at a convenient height for pushing when the cart is loaded. The flange at the bottom is made of a thin strip of metal that is eased under the edge of the locker. The locker can then be tilted slightly, with the weight supported by the long frame of the carrier, and pushed with little effort.

When not in use, the cart stands on the wheels and the flange, and takes up very little space. — Jane Layhew, Head Nurse, Medical Ward, Prince George Regional Hospital, Prince George, British Columbia. □



FREDERICTON, NEW BRUNSWICK
JUNE 14–19, 1970

CANADIAN NURSES' ASSOCIATION

THIRTY FIFTH GENERAL MEETING

TENTATIVE PROGRAM

ISSUES CNA MEMBERS FACE AT 35TH GENERAL MEETING

TICKET OF NOMINATIONS

FREDERICTON — HERE WE COME!

CNA BIENNIAL MEETING
Program Highlights

Theme:
Continuing to Care in the '70s

Sunday 14 June

19.00 Interfaith service

20.30 Official opening
Address:
"Health and welfare services for the '70s"
Miss Verna Huffman, Principal Nursing Officer, Department of National Health and Welfare

Monday 15 June

09.00 President's address
Report of Arrangements committee
Report of nominating committee

11.00 Address:
"Professional associations in the '70s"

14.00 Report of executive director
Auditor's report
Budget 1970-1972

15.30 Recess
Evening picnic - City of Fredericton, host

19.00 Symposium on the publication of nursing textbooks in French

Tuesday 16 June

09.00 Reports of standing committees on
- nursing service
- nursing education
- social and economic welfare

14.00 Report of the ad hoc committee on functions, relationships, and fee structure

16.30 Poll - election of officers

16.30 Interest sessions - concurrent

1 . Legal implications of nursing
(simultaneous translation)
Mr. L.E. Rozovsky, Departmental Solicitor, Nova Scotia Hospital Insurance Commission

2 . Psychodrama
(English only)
Mrs. Dorothy M. Burwell, Director of Nursing, Clarke Institute of Psychiatry, Toronto, and Associate Professor, Faculty of Nursing, University of Toronto

19.30 Banquet - Government of New Brunswick

Wednesday 17 June

Hospitality and sightseeing day

Thursday 18 June

09.00 Report of ad hoc committee on legislation
Revision of bylaws

14.00 - Interest sessions - concurrent

17.30 1 . Planning of patient care
English
- Miss Myrna Sherrard, Nurse Clinician, The Moncton Hospital, N.B.
French
- Mme. Huguette LaBelle, Director, Vanier School of Nursing, Ottawa

2 . Delivery of nursing care
English and French
- Miss Pamela Poole, Nursing Consultant, Hospital Services Study Unit, Hospital Insurance and Diagnostic Services, Department of National Health and Welfare

3 . Expanded role of the nurse
(simultaneous translation)
Mrs. Rosemary Coombs, Clinical Nurse Specialist, Ottawa Civic Hospital
Mrs. Monica M. Green, Director of Public Health Nursing, Health Branch, British Columbia Department of Health Services and Hospital Insurance

4 . Research Studies
(simultaneous translation)

Friday 19 June

09.00 Unfinished business
Budget 1970-1972
Report of Resolutions Committee

14.00 Report of election
Installation of officers

16.00 President's reception

Participants confirmed at press time are included

Issues CNA members face at 35th general meeting

Nursing care; CNA fees; personal or corporate memberships in CNA; salaries and working conditions; education; CNA consulting services; what the CNA can do for members; what members can do for the CNA — these are among the subjects that will be under scrutiny at the coming CNA general meeting in Fredericton. Recently the editor of The Canadian Nurse talked to the CNA executive * about some of the questions under review at the coming meeting. Here, in question and answer form, is the result.

Q. What are the major issues facing nurses at the Canadian Nurses' Association's general meeting in Fredericton in June?

SISTER M. FELICITAS: Probably the most vital issue concerns the individual member and her relationship with the national association. I believe the average nurse lacks involvement with CNA, sees it as something remote, and is unaware of its goals and functions. In June we'll have an opportunity to improve this relationship as we consider the recommendations of the ad hoc committee on functions, relationships, and fee structure. [The complete report of this ad hoc committee is in the March 1970 issue of *The Canadian Nurse.*]

LOUISE TOD: In other words we hope members will be willing to restructure CNA in such a way that the individual nurse will have a better chance to contribute, to help the national association attain its goals.

KATHLEEN E. ARPIN: I see another dimension in the ad hoc committee report. As well as providing a framework within which individual members can participate, the restructuring of the CNA should also provide an environment in which the association's board of directors and staff can best function to serve *both* nurses and nursing. There's a lot happening in nursing today, and for me, the second major issue – an overlapping one as it, too, involves structure change – concerns the delivery of nursing care. In 1970 this is more than a cliché: everything around us points out that we must provide health services and therefore nursing care in a very different way than we have in the past. Our association has to move with the times, "be with it," and try to foresee what the demands of the future will be.

MARGARET D. MCLEAN: I agree with this. And one of the reasons a nurse becomes actively involved in her professional association is because of her concern for the quality and quantity of care people receive.

E. LOUISE MINER: It seems to me that we have to do more than give nurses the opportunity to become involved. We have to help them understand that this involvement is a professional responsibility. And if the Canadian Nurses' Association is not attempting to upgrade patient care, if it isn't keeping up with the times, then it shouldn't exist.

MARGUERITE SCHUMACHER: As a profession we've matured considerably in the past few years and have channelled our energies in a more productive way. For example, the Canadian Nurses' Foundation scholarships have allowed more nurses to further their education. These scholars are coming back with considerable preparation and we're now capitalizing on their knowledge. Much more research in nursing is being carried out, particularly in clinical nursing.

KATHLEEN E. ARPIN: This emphasis on the delivery of health care will be focused in two ways at the forthcoming general meeting: first, through the ad hoc committe's recommendations on the role of the association and, second, through the theme of the meeting. "Continuing to care in the '70s," and the special interest sessions that highlight patient care.

MARGARET D. MCLEAN: Another major issue to be resolved at the general meeting concerns CNA's bylaws. Presently there

*The six members of the Canadian Nurses' Association executive are: Sister Mary Felicitas, president; E. Louise Miner, president-elect; Marguerite Schumacher, 1st vice-president; Margaret D. McLean, 2nd vice-president and chairman of committee on nursing service; Louise Tod, chairman of committee on social and economic welfare; and Kathleen E. Arpin, chairman of committee on nursing education.

The author (back to camera) interviews the CNA executive. Left to right: Sister M. Felicitas, president; Marguerite Schumacher, 1st vice-president; Kathleen E. Arpin, chairman, committee on nursing education; Margaret D. McLean, 2nd vice-president and chairman, committee on nursing service; Louise Tod, chairman, committee on social and economic welfare; and E. Louise Miner, president-elect. The six members of the executive discussed the issues facing CNA members.

is some difference of opinion among provincial nurses' associations as to whether membership should be individual and/or corporate. Obviously the decision made by CNA members will affect the future of the association, hence its contribution to society.

Q. Is there any possibility that a member association might withdraw from CNA if this bylaw on the individual and/or corporate membership is not resolved?

SISTER M. FELICITAS: It's not probable, but it's always a possibility.

Another item of great significance is the fee that member associations are willing to pay CNA. If this fee is reduced, some part of CNA's planned program will have to be chopped.

MARGARET D. MCLEAN: Perhaps the real issue is this: members have to decide what services they want from CNA and what they consider to have priority. The fees are secondary; we must look at the priorities first.

CNA'S ROLE FOR THE FUTURE

Q. The ad hoc committee on functions, relationships, and fee structure has recommended that there be well-qualified nursing personnel in CNA's research and advisory unit to undertake approved programs. In your opinion, what should the association's role be in research?

E. LOUISE MINER: CNA should help to identify the areas where research is needed. The association wouldn't necessarily be responsible for funding research, but could assist in getting money for a given project, locate persons to undertake it, and possibly assist in developing the project.

KATHLEEN E. ARPIN: I don't see this as a cut and dry issue, where we say "We will do this, we will do that . . . ." In January the CNA board of directors agreed to set up an ad hoc committee on nursing research to look at the question of CNA's role in research. And I think we *do* need some guidelines. But I don't see that we should have this role or that role. Our policy should be flexible. We have to look, think, and make our decision on what seems appropriate at a given time.

E. LOUISE MINER: The national association has a coordinating function in research. It's up to CNA to know what research is going on in the country at a given time, and who is doing it.

MARGARET D. MCLEAN: I think we have to do more than this. Our association must supply some money for research. At times we might employ a researcher who designs a project and is the principle investigator. I don't mean that this person should be on staff at all times. It's like staffing the hospital nursing service — you bring in people to meet the maximum load.

MARGUERITE SCHUMACHER: Right now the association is not "on top of it." We really don't know what research is being conducted across the country. And I think it's time that we did get on top of it. If there's a project that needs to be done and no one else is going to do it, then we've got to do it

ourselves. I agree that we may have to employ a qualified person to do it.

KATHLEEN E. ARPIN: I see the CNA research and advisory unit acting as a clearing house. The staff would have some back work to do, finding out what kind of research has gone on what is going or, and what is planned for the future. I guess I see this unit as an "on their toes" group.

MARGARET D. MCLEAN: One of the research and advisory unit's major jobs should be to get research findings implemented. I see this as a real role for the elected officers and staff of CNA and its federated members. This could be done in various ways: at meetings, workshops, conferences, and speaking engagements. We have no right to ask the principle investigator of a research project to be responsible for getting her own findings implemented. Also, it's a misuse of her time.

MARGUERITE SCHUMACHER: We have to go even further. We may want to implement some of these research findings, but our hands may be tied because, like all organizations, we do not operate in a vacuum. So there is a need for CNA to collaborate even more with other groups, such as the Canadian Hospital Association and the Canadian Medical Association. We need to interpret to these groups and others what is happening and what needs to be done so that valid research findings *can* be implemented. Also, on a governmental level there needs to be more interpretation and face to face contact.

SISTER M. FELICITAS: I see this interpretation and implementation role as the job of the research and advisory staff. I'm not sure what these employees will be called – it may be "consultant" or some other name.

LOUISE TOD: We can't leave all this interpretation to staff, though. Somehow we have to convince our members, who are knowledgeable about their particular area of nursing, to promote the association's goals and to encourage implementation of research findings.

Q. The traditional role of the CNA consultant was questioned at the 34th general meeting in Saskatoon in 1968. Do you believe that the association should continue to employ consultants in nursing service, nursing education, and social and economic welfare?

E. LOUISE MINER: We seem to get hung up on this word consultant. I believe each senior employee at national office must have a basic, generalized competency. Then he or she could be assigned at certain times to a specific area, for example, to act as a liaison officer between CNA and the federal government. This general competency is terribly important, as the needs of our association vary from time to time. We have to get away from the idea that these employees are 100 percent nursing service, or education, or social and economic welfare.

Sister Mary Felicitas: "The most vital issue concerns the individual member and her relationship with CNA. I believe the average nurse lacks involvement with her national association, sees it as something remote, and is unaware of its goals and functions."

E. Louise Miner: "In the future the Canadian Nurses' Association should probably look at the problem of pollution. This is even more important than the smoking issue. It's in areas like this where we can attempt to affect legislation at the federal government level."

Margaret D. McLean: "Members have to decide what services they want from CNA and what should have priority. The fees are secondary; we must look at the priorities first."

SISTER M. FELICITAS: We have to recognize, too, that the provincial nurses' associations have grown tremendously in the past few years. They have many more persons on staff now and the competencies of these persons vary according to the needs of the province. The CNA tries to avoid duplicating what the provinces have already done or can do, and attempts to provide leadership on a national level and supply the provinces with what they need at a particular time. The CNA can put itself out of business in certain areas and this is quite alright. I don't think we want to be in something forever.

KATHLEEN E. ARPIN: I see this as the key: CNA's role is to start things, and when things have reached a point there they are moving, we should move on to a new area. I didn't feel any negativism at the Saskatoon meeting concerning the role of consultant. Instead, I felt that members were pointing out that the time had come to move on to other projects.

LOUISE TOD: Social and economic welfare is a good example of this need for change in the consultant role. When welfare was a relatively new idea for nurses, the responsibility of CNA's consultant in this area was pretty basic: to help the provincial nurses' associations develop programs of their own. These programs are now developed at the provincial level, so CNA's role has changed and needs to be reassessed.

KATHLEEN ARPIN: The consultant CNA needs today has to be someone who can initiate a project, but give it up before every detail has been completed and move on to something new. She has to be comfortable on new and thin ground. When the ground starts to get deeper, then it's time for her to move forward.

MARGUERITE SCHUMACHER: We have to consider, too, just how much we can afford. We have to ask ourselves how we can put the money we have to its best use. When we look at the facts, such as CNA's need to be involved in research, to have bilingual staff, and so on, we will then be able to decide what consultants we need and can afford.

Q. The ad hoc committee on functions, relationships, and fee structure has recommended that CNA appoint a senior member of staff, whose mother tongue is French, to provide French-speaking members with services comparable to those presently available to English-speaking members. Would you comment on this recommendation.

SISTER M. FELICITAS: I believe all provincial nurses' associations are in favor of having a French-language department at CNA House. Personally, I am all for having a well-qualified person at the head of that department.

MARGARET D. MCLEAN: Further to that, it is one of the hopes of the present board of directors that we would be able to offer our services in French or English.

SISTER M. FELICITAS: Our biggest problem is money, as this type of service is expensive. Also, CNA has had difficulty in attracting bilingual staff.

MARGARET D. MCLEAN: This is going to be a challenge that faces the incoming board of directors. The board will have to set priorities within the financial limitations as set by membership.

Q. The ad hoc committee also recommended a fixed per capita fee structure. Do you believe that all the provincial nurses' associations will agree with this recommendation?

E. LOUISE MINER: I believe the member associations will accept a majority decision. After all, the ad hoc committee asked the provincial nurses' associations for their opinions before making this recommendation.

Q. Are there any social issues to be presented to the general membership by the board of directors? For example, will CNA be taking a stand against cigarette smoking?

LOUISE TOD: The committee on social and economic welfare will recommend to membership that nurses should become more involved in their communities. And as a professional group we should make more suggestions about issues that fall within our competency. Probably we *should* be taking a stand against smoking. We have the background professionally and should be setting an example.

SISTER M. FELICITAS: We have taken a stand on certain social issues and submitted briefs in the past biennium. For example, CNA is presently preparing a brief for the Special Senate Committee on Poverty. Also, we submitted a brief to the Commission on the Status of Women in the fall of 1968.

E. LOUISE MINER: In the future, we should probably be looking at the problem of pollution. This is even more important than the smoking issue. It's in areas like this where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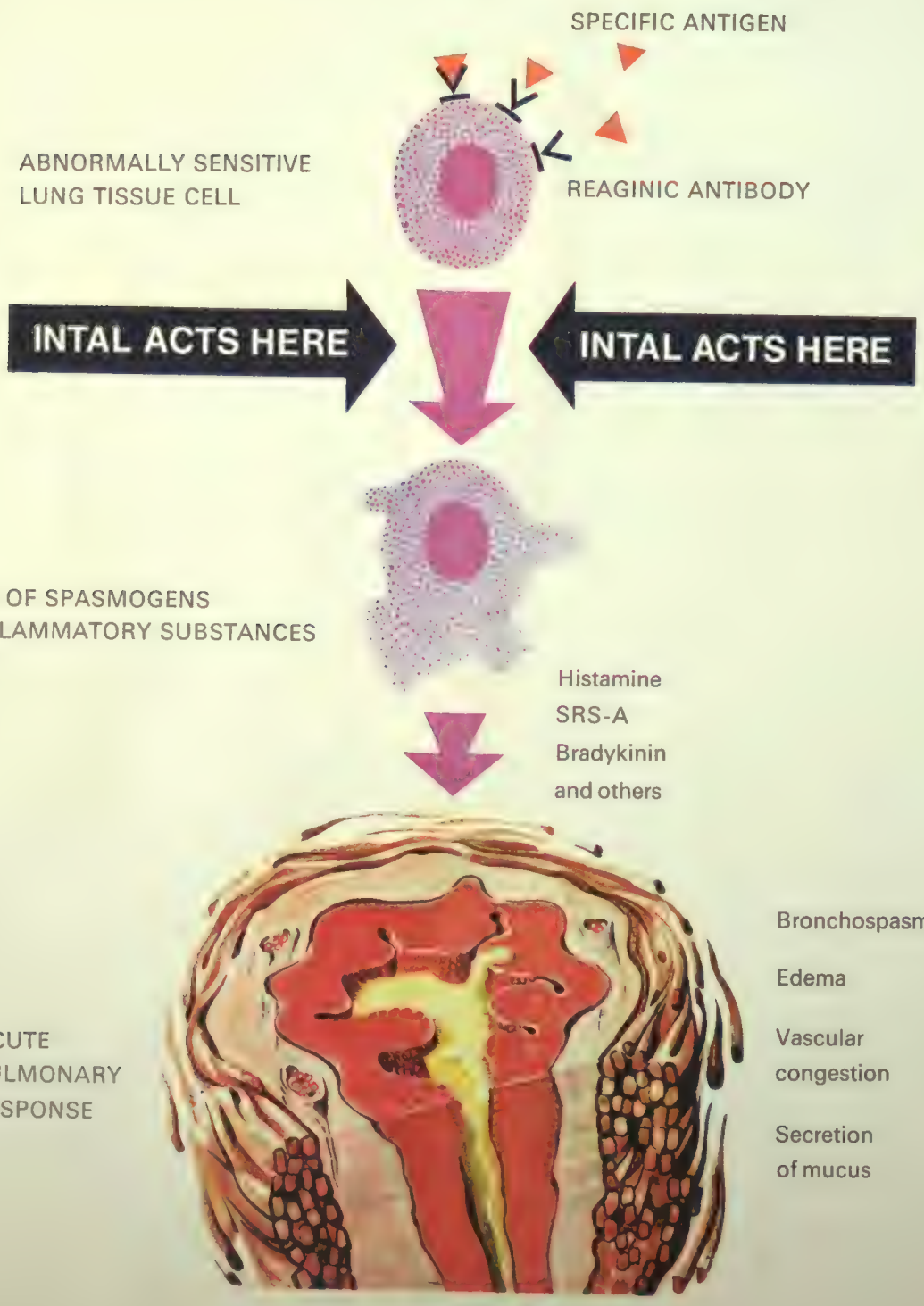

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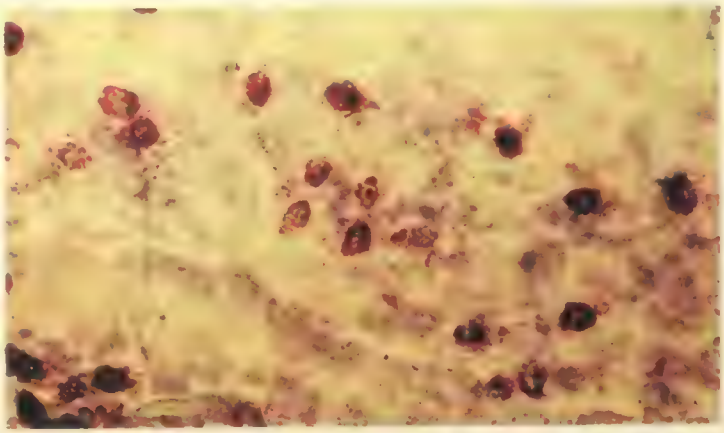
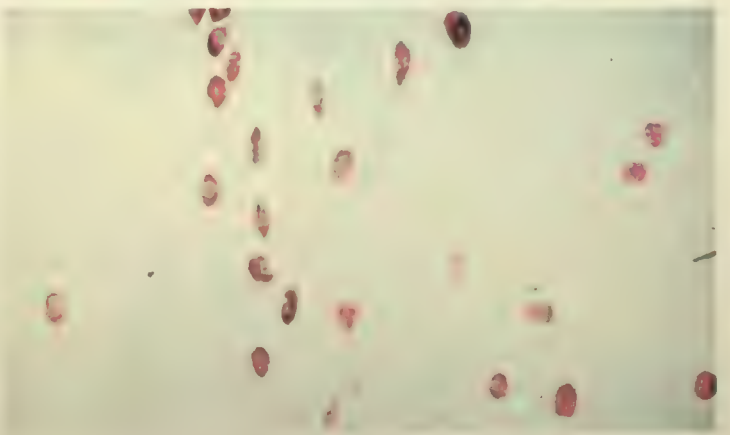
INTAL is a preventive therapy, which at last offers the asthmatic the prospect of a full, active life.

Sensitised mast cells, before antigen challenge



Sensitised mast cells, disrupted after antigen challenge



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INDICATIONS	Bronchial asthma.
ADMINISTRATION	INTAL shows significant clinical effect only when administered by inhalation. The drug is supplied in a single dose cartridge, which is administered by a specially developed insufflator, the Spinhaler. Each cartridge contains 20 mg. disodium cromoglycate (INTAL) in ultra-fine powder form, with lactose B.P. as a carrier.
DOSAGE—ADULTS AND CHILDREN	**Initial treatment**—one cartridge four times per day. In more severe cases, and during periods of high challenge, the dose may be increased to eight per day (one every three hours). It is important that the patient should appreciate that INTAL is not intended to provide symptomatic relief in acute attacks. **Maintenance therapy**—when adequate response has been obtained, the frequency of inhalations may be reduced to three or even two cartridges per day. **Patients should be warned against suddenly discontinuing therapy when symptoms have been partially or completely controlled by INTAL.**
CONCOMITANT THERAPY	Other asthma medication should be continued until clinical improvement with INTAL permits a progressive reduction in their dosage. INTAL therapy alone will often control symptoms of moderately severe asthma, especially in children and young adults. In severe asthma, particularly in older patients, INTAL therapy alone may be insufficient to control symptoms. In a proportion of such cases, significant improvement can be obtained by combining INTAL with corticosteroid therapy. In steroid-dependent patients, the addition of INTAL therapy to the regimen often permits a slow, progressive and significant reduction in the maintenance dose of steroids. *The dangers of sudden withdrawal or reduction of corticosteroids are well recognised, particularly in patients on long-term administration. For full details of steroid dosage during INTAL therapy, please see the INTAL product literature or packing leaflet.*
WITHDRAWAL OF INTAL	Continuity of therapy is important in patients whose asthma is controlled by INTAL. If for any reason INTAL is withdrawn, a suggested regimen is the progressive reduction of dosage over at least one week. It should be borne in mind that symptoms of asthma may recur when INTAL is discontinued.
SIDE EFFECTS	*No serious adverse effects attributable to INTAL therapy have been reported.* Transient irritation of the throat and trachea has been the most frequently reported reaction, particularly following local infective episodes. There has been a small number of cases of an erythema or urticaria of the face. In each case the rash disappeared within a few days of withdrawal of the drug. At the beginning of INTAL therapy, in a small proportion of cases, transient bronchospasm follows the inhalation of the dry powder into hyper-irritable airways. It has been found that this effect, should it occur, may be minimised by the prior inhalation of a bronchodilator aerosol.
CAUTION	Teratogenicity experiments in animals have indicated that the use of INTAL in humans is unlikely to carry teratogenic risks. Nevertheless, as with any new drug, it is advisable where possible, to avoid its use during the first trimester of pregnancy.
PRESENTATION	INTAL cartridges are supplied in bottles of 30. Spinhaler turbo-inhalers are supplied in individual containers.
STORAGE	Important: INTAL cartridges should be stored in a cool dry place.

Further information on INTAL is available from Fisons (Canada) Ltd,
26 Prince Andrew Place, Don Mills, Ontario, Canada. Telephone: 445-5700
INTAL is a trade mark of Fisons Ltd.—Pharmaceutical Division,
Loughborough, England
Printed in the United Kingdom

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we could attempt to affect legislation at the federal government level.

LOUISE TOD: We say CNA should be anticipating legislation that concerns us, but perhaps we should also be spending more time in suggesting alternatives for what we don't like.

COMMITTEE ON NURSING SERVICE

Q. What are this committee's most important recommendations to the general membership?

MARGARET D. MCLEAN: One of the most important is that there should be sufficient registered nurses on staff in extended care facilities to assess the nursing needs of patients, to plan their nursing care, and to give or supervise nursing care. By extended care facilities I mean rehabilitation units, geriatric centers, nursing homes, long-term care hospitals, home care programs, and foster home care for psychiatric patients. What is even more important than this recommendation, and what may have greater impact in the provinces, is the survey of extended care facilities conducted by each committee member in her home province. We all became much more knowledgeable about extended care facilities that exist in the provinces and about the nursing care needed by patients in these facilities. I think that in future we can expect greater involvement of the professional nursing associations in extended care facilities.

MARGUERITE SCHUMACHER: Doesn't this highlight again the many changes that are taking place? A few years ago we didn't have these facilities and weren't confronted with the problem of having to look at their staffing needs. Now the situation has changed; these facilities are springing up all over the country and it's timely for us to speak about them.

MARGARET D. MCLEAN: As chairman of the committee on nursing service, I consider the recommendation on nursing research to be of considerable importance. If approved by membership, CNA will make a direct financial contribution for research purposes to the Canadian Nurses' Foundation for the next five years. Our committee saw an urgent need for research in many areas of nursing practice.

COMMITTEE ON NURSING EDUCATION

Q. What do you consider as this committee's most important recommendations during this past biennium?

KATHLEEN E. ARPIN: There are two major recommendations. One is that nursing students in university programs should receive priority in the use of hospital and health agency facilities. The implication here is that we should be focusing on the baccalaureate and higher education programs at this time if we want to achieve the association's goals and make its statement of policy operational. We need to sell the baccalaureate program to students who plan to enter nursing and we need also to expand the programs presently offered. One of the limitations in the expansion of baccalaureate programs in Canada is the lack of clinical resources.

The committee's second major recommendation is that research should be carried out to determine how students learn to nurse. This is actually something we know little about. We feel we know a great deal about it, but when we get right down to it we find we have no real evidence. It gets back to the topic we were discussing a moment ago: the use of clinical resources. For example, are there other ways we can use the clinical resources? Is the student really *learning to nurse* when she is practicing in the clinical area?

The committee on nursing education believes it is essential for the profession to become more knowledgeable about this area of student learning. It therefore recommended to the board of directors that CNA stimulate, encourage, and become involved in projects in this area.

The committee also recommended that the subject of the proliferation of health workers be discussed with allied groups, so that the whole area of collaboration, of examining goals together, could be considered. The committee members believe that the unique role of the nurse in the delivery of health service could be interpreted at such meetings. The committee has taken a stand against the proliferation of health workers, but wants it understood that it does not focus only on medical assistants. The members saw this as just one dimension of a very large problem.

COMMITTEE ON SOCIAL AND ECONOMIC WELFARE

Q. What are this committee's most important recommendations to the general membership this June?

LOUISE TOD: We broadened our approach in this biennium so that our focus was not primarily on economics. More than ever before we worked closely with the committees on nursing service and nursing education, as we know the three cannot be divorced. Also, we spent considerable time on the individual nurse and the importance of her participation as a member of a profession and the community.

Probably our most important recommendation is that the nursing service and education committees seek ways and

Kathleen E. Arpin: "Our association has to move with the times, 'be with it,' and try to foresee what the demands of the future will be."

Marguerite Schumacher: "There is a need for CNA to collaborate more with other groups, such as the Canadian Hospital Association and the Canadian Medical Association. We need to interpret to these groups and others what is happening and what needs to be done so that valid research findings can be implemented.

Louise Tod: "Somehow we have to convince our members, who are knowledgeable about their particular area of nursing, to promote the association's goals and to encourage implementation of research findings."

means of promoting programs to upgrade nursing personnel. If we can provide an environment in which nurses can carry out nursing care as they feel they should, this is going to be reflected in improved patient care. Along with this we have recommended that bargaining agents for nurses attempt to establish professional practice committees within collective agreements to interpret patient care needs to administration. We believe that nurses should be making more decisions about nursing care. We can't negotiate these items into a contract, but through professional practice committees in hospitals nurses would have the means of communicating their concerns about patient care to administration.

MARGARET D. MCLEAN: In reference to the work of the three standing committees, we have, as Miss Tod said, increased our collaboration and referral. For example, during the biennium the nursing service committee discussed ways to increase the effectiveness of administrative and supervisory personnel in nursing service. We referred this item to the committee on social and economic welfare, which has now made a statement about it. Also, the committees on nursing education and nursing service worked together to polish up the statements on CNA's beliefs about continuing education and the clinical specialist. This collaboration has been very helpful.

LOUISE TOD: The social and economic welfare committee's recommendation that CNA's no-strike policy be rescinded was really just a tidying up statement. CNA has supported collective bargaining for many years and recognizes it as a provincial prerogative. It follows that the provincial nurses' associations must use the steps available to them, and in several provinces one step is the strike. A group of nurses may be faced with the decision of whether to take strike action, and this should be *their* decision. They should not be hamstrung by statements made by the national association.

Q. Should the national association set a salary goal each year?

SISTER M. FELICITAS: Some provinces say this hinders their bargaining effort, others say it helps. At least this is what they told the ad hoc committee on functions, relationships, and fee structure.

LOUISE TOD: The committee on social and economic welfare believes it is important that CNA provide leadership in this area. The national association's recommended salary is a goal toward which each province should work. Some provinces will come close to meeting this goal in the near future, but others will still be far from it.

SISTER M. FELICITAS: Let us hope that the day may soon come when we no longer need to present salary goals! □

Canadian Nurses' Association

TICKET OF NOMINATIONS

Biennium 1970-1972

President-Elect: (1 to be elected)
Margaret D. McLean, Marguerite E. Schumacher

Vice-Presidents: (2 to be elected)
Margaret L. Bradley, Jean Church,
Isabel T. Colvin, Kathleen G. DeMarsh, Shirley R. Good,
Huguette Labelle, K. Marion Smith

Representative of Nursing Sisterhoods: (1 to be elected)
Sister Marie Barbara, Sister Kathleen Cyr, Sister Cecile Gauthier,
Sister Rita Kennedy, Sister Cecile Leclerc, Sister Grace Maguire

President: E. Louise Miner

E. Louise Miner. *Royal Alexandra Hospital School of Nursing, Edmonton, Alta.; Diploma public health nursing, U. of Toronto; B.N., McGill; M.P.H., U. of Michigan.*

Present Position: Director, Division of Public Health Nursing, Saskatchewan Department of Public Health.

Association Activities: vice-president SRNA, 1957-59; president SRNA, 1959-61; executive CNA, 1959-61, 1964-66; first vice-president CNA, 1966-68; president-elect CNA, 1968-70.

All Canadians should have equal opportunity to benefit from the best nursing service available. This service should be provided to all people regardless of where they are, not only to those confined to a bed surrounded by four walls; nursing education programs should reflect this belief.

The Canadian Nurses' Association has a major responsibility to assist in ensuring that the changing nursing needs of Canadians are met. Many more nurses must become actively involved in assessing these needs and in developing and implementing plans to meet them.

Canadian nursing has a proud heritage, which we have a responsibility to maintain and strengthen. A strong national nursing association to speak in a united voice is essential. Less privileged countries are entitled to our support as they plan for provision of required nursing services.

The maximum participation of the nurses we seek to lead is vital. We are blessed with a wide variety of cultural backgrounds that form part of the fascinating Canadian mosaic. We must learn to communicate more effectively among ourselves without prejudice. We know that the whole is only as strong as the weakest part. Our task requires the utmost intellectual honesty, self-discipline, and personal integrity. We must continue to develop our inner capacity to live with truth, to know ourselves, and to practice self-adjustment.

A profession is a combination of competence and integrity. Full professional status is not reached until the profession is willing to assess and improve its practices and to determine the validity of its goals and to what extent these are being attained. Only to the degree that all members participate effectively in this continuing process will the goals of the CNA be achieved.

I look forward to your involvement and your considered support as I accept the position you have asked me to assume.

CANDIDATE FOR PRESIDENT-ELECT

Margaret D. McLean. *Royal Victoria Hospital School of Nursing, Montreal; B.Sc.N., U. of Western Ontario, London, Ontario; A.M., Columbia U., New York; special course in methods improvement.*

Present Position: Senior Nursing Consultant, Hospital Insurance and Diagnostic Services, Health Insurance and Resources Branch, Department of National Health and Welfare, Ottawa.

Association Activities: executive of AARN; Board of Examiners, AARN; committee work, RNAO; chairman, education committee, Ottawa West Chapter, RNAO; chairman, CNA nursing service committee 1966-68, and 1968-70; 2nd vice-president CNA, 1968-70; has served on many other CNA ad hoc and special committees; member, joint advisory council, Nursing Unit Administration Extension Course; member, planning committee for first conference on hospital-medical staff relationships.

I accepted the nomination for the same reasons that I did two years ago. I believe that nursing has a unique and important contribution to make to society and I believe in nurses. I believe they will increasingly make this contribution and in a more excellent way.

Many of my colleagues know that I have tried throughout my professional life to seek, encourage, and reward excellence in nursing. I believe being an officer of the Canadian Nurses' Association provides another avenue through which one can seek, encourage, and reward excellence in nursing practice, nursing services, nursing education, and nursing research. At this time I am very happy to be taking immersion courses in French so that I can make a greater contribution to nurses and nursing in Canada.

CANDIDATE FOR PRESIDENT-ELECT

Marguerite E. Schumacher. *Victoria Hospital, Winnipeg, Manitoba; B.Sc., Western Reserve U., Cleveland, Ohio; M.A. and Ed.M., Columbia U., N.Y.*

Present Position: Director, Health and Social Services, Red Deer College, Red Deer, Alberta.

Association Activities: vice-president, AARN 1961-63; president, AARN 1963-65; CNA executive 1963-65; 2nd vice-president CNA, 1966-68; 1st vice president CNA, 1968-70.

Nursing, being a personal service, is involved with relationships. In the practice of nursing the relationship may be with two people, namely, the patient and the nurse, but the relationships may become more complex as members of the patient's family are included and as the nurse collaborates with other members of the health disciplines and nursing team.

I believe that the nurse is in the unique position of being the one who serves in an expressive role. The nurse is the one who can keep the health team functioning smoothly if she recognizes her important role in this area of human relations.

Bertrand Russell once remarked that the problems in our world are less and less like those of driving in the desert, and more and more like those of driving in midtown Manhatten. The need then is for skills in working with other people. I believe we need to construct an ideology that will be responsive to new notions of man's relationship to his fellow man.

As a member of the CNA executive, I see my role as being one of "facilitator" to use the skills that I may have to assist and support the group in all of their deliberations.

CANDIDATE FOR VICE-PRESIDENT

Margaret L. Bradley. *The Montreal General Hospital School of Nursing; B.N., McGill.*

Present Position: Lecturer and Coordinator of basic degree program, School of Nursing, Dalhousie University, Halifax, Nova Scotia.

Association Activities: chairman, Board of Examiners (Montreal-English section); member and later chairman, Quebec Curriculum Committee; chairman, Montreal Instructor's Group; member and later chairman of Montreal District Education Committee; chairman, committee socio-economic welfare, RNANS; president, Atlantic Region, Canadian Conference University Schools of Nursing.

It is my belief that many new, exciting, and controversial developments are about to take place in the health services field, particularly in the area concerned with delivery of health services to the Canadian people. This is a time when nurses must speak out on behalf of nursing, and take an active part in determining their own destiny and the future of their profession. It is urgent that we interpret our nursing role and function to the people of Canada; that we lay to rest the image of nursing that portrays us as efficient administrators and organizers who leave the task of nursing to others; that we create the image of a nurse as one involved in the skills of nursing, the planning of coordinated health care, and the one who establishes sound relationships with patients and health workers.

Because I so firmly believe that nurses must speak for nursing, I therefore feel obligated to become involved in the work of the professional association and so accept the nomination for office in the Canadian Nurses' Association.

CANDIDATE FOR VICE-PRESIDENT

Jean G. Church. *Royal Victoria Hospital School of Nursing, Montreal, Que., B.Sc., Dalhousie University, Halifax, Nova Scotia; Certificate in Teaching and Supervision, McGill University, Montreal; M.A., Columbia U., N.Y.*

Present Position: Assistant Director, School of Nursing, Dalhousie University, Halifax, Nova Scotia.

Association Activities: past president RNANS; chairman of various RNANS committees; member, advisory committee on nursing education NSHIC; member, selections committee CNF; member, CNF Board; member, CCUSN.

I believe that our profession has the responsibility of providing a high quality of nursing for the people of Canada. I believe, too, that this goal can be achieved most effectively when the nurses from the 10 provinces are united in a strong national association.

I believe that the Canadian Nurses' Association is in the unique position of being able to provide the leadership that is necessary in determining the direction that nursing will take as we seek solutions to the dilemmas facing the profession.

I have been active in professional association work on the provincial level, and I am convinced that the provincial associations need the support and the stimulation that can come from a dynamic national association.

In accepting nomination for office in the CNA, I am affirming my belief in our national association, and at the same time supporting my conviction that each member has a responsibility to contribute to the professional organization.

CANDIDATE FOR VICE-PRESIDENT

Isabel T. Colvin. *Regina General Hospital School of Nursing; B.N. and M.Sc., McGill University.*

Present Position: Administrator (Patient Care), Regina General Hospital.

Association Activities: chairman, nursing service committee, ANPQ; chairman, nursing service committee, SRNA; chairman of other provincial committees.

Our professional association is a key factor in obtaining for nursing the prestige and support that we need in order to guide our own destiny and not haye our decisions made for us by more powerful voices in the health care field. It is our responsibility to assess our rightful place in the delivery of health services, and in this collective task each individual has her own part to play and a contribution to make to the best of her ability.

At this time, also, nursing associations are engaged in an appraisal of their traditional role, particularly so in relation to the more active participation of all members in the decisions that will affect their careers. We must look realistically at the demands for involvement that characterize many institutions today, and satisfy those legitimate aspirations that arise in our own association.

I would consider it a privilege to be associated with the Canadian Nurses' Association at this period of change and challenge in the field of nursing and in the health care services generally.

CANDIDATE FOR VICE-PRESIDENT

Kathleen G. DeMarsh. *Saskatoon City Hospital School of Nursing; diploma in teaching and supervision and B.A., U. of Toronto.*

Present Position: Assistant Executive Director, The Winnipeg General Hospital, Winnipeg, Manitoba.

Association Activities: member, sub-committee to study minimum curriculum standards for diploma schools of nursing, RNAO; past chairman, nursing education committee, MARN and member of other committees; member, nursing education committee, CNA.

When one stands on the threshold of a new century – as we do in Manitoba – one is apt to take liberties one would not dream of taking at any other time. The liberties I propose to take could close the door forever to me being elected to office or they could open the door so wide as to usher in a major change in the very mechanism by which we handle our affairs as an association! I am not suggesting that I am a radical, though heaven knows our profession could do with a few. What I am suggesting is that we urgently need to find a way to shake the grate of our beliefs about nursing so the cold ashes of the past may be swept away and the warm embers of worth that have survived through the ages may once again burn brightly in the hearts of all nurses everywhere.

I believe that part of the dilemma we find ourselves in as a profession stems from the credibility gap, which I would define as the difference between what is known by "the few," and what has been the experience of "the many." Can we, in the next century, generate a quality of care for each other as human beings and as professional persons of worth, such as will enable us to bridge that gap effectively? Can we create a climate of trust within our profession and within each setting where nursing is practiced, which will foster innovation and encourage the professional growth of each individual nurse? Unless we can, I am concerned about what we may give to our patients, and they, after all, are the main *raison d'être* for our existence as a profession!

If I did not care about people – nurses as well as patients – I would not have accepted this nomination. Whether elected or not, I will continue to place a high value on the worth of the individual human beings with whom I come in contact. I want to see nursing perceived as a profession that is more interested in listening and in learning than in lecturing and in "laying down the law." Albeit if we are to survive, we will undoubtedly find ourselves doing a little of both!

CANDIDATE FOR VICE-PRESIDENT

Shirley R. Good. *Women's College Hospital School of Nursing, Toronto; B.Sc.N. and M.Ed., Drury College, Springfield, Missouri; Ed.D. in nursing education, Teachers College, Columbia U., N.Y.*

Present Position: Director of Nursing, University of Calgary School of Nursing, Calgary, Alberta.

Association Activities: chairman, Middlesex chapter, RNAO nursing education committee, 1963-64; member, CNF selections committee, 1968.

My acceptance of the nomination for the office of vice-president is a reaffirmation of my belief in organized nursing – provincial, national, and international in scope.

Canadian nurses to date have traversed a long and arduous route to delineate and clarify the various roles and functions of nursing practice, to formulate two systems of nursing education, and institute economic security realistically, consistent with the times. These are formidable gains. However, we cannot afford the complacency of a plateau existence.

The decade of the '70s and beyond will find us in continued conflict of crisis of values. Nor can we deal with problems of "how to" without first posing the problems of "why." Therefore, it is my contention that the CNA members, executive and staff, through collective voice and action, *can* and *must* deal with the problems of contemporary society, which means above all else qualitative patient care, supported by education and research. Also, as nurse citizens we must further influence the bodies politic to action for improved health resources and services for the well-being of all citizens.

CANDIDATE FOR VICE-PRESIDENT

Huguette Labelle. *U. of Ottawa School of Nursing; B.Sc.N.Ed., B.Ed., and M.Ed., U. of Ottawa.*

Present Position: Director, Vanier School of Nursing, Ottawa, Ontario.

Association Activities: chairman, committee on continuing education, Ottawa East Chapter, RNAO; active in professional activities at chapter and provincial levels; planning and conducting conferences in other provinces.

It is inevitable that during the next decade a new pattern of health services will emerge with an expansion of the nurse's role as a key member of the health team. Concentrated efforts will be necessary to utilize more effectively all present health personnel and resources in an attempt to provide the best possible health care for all citizens. More creative organizational patterns will have to evolve to meet the demands for comprehensive health services. Since these services will be diversified and take place in different settings, the educational preparation of the nurse will need to undergo further modifications to permit them to cooperate fully with developing patterns, to test those against previous practices, and to serve as innovators of new designs.

Will Canadian nurses be able to meet this challenge? Nurses will be in a position to meet this challenge to the extent that individually and collectively they have been able to participate actively in planning, implementing, and evaluating plans for attainment of a higher degree of excellence in nursing and overall health care. Only through this involvement, accompanied by the freedom to explore and to experiment, will each nurse discover the outstanding challenge of being a nurse today. This active role of the nurse has been advocated in educational programs and in nursing practice, but it must become a reality instantly in order to end the present exodus of nurses to other fields.

Today, perhaps more than at any other time in history, there is a need for a powerful professional organization that will direct the efforts of its members in reaching high levels of excellence in nursing and simultaneously safeguard the welfare of its members. A professional organization will therefore be successful in its endeavors to the extent that it succeeds in involving its members in attaining set goals and in sharing the interpretation of these to government and general public.

CANDIDATE FOR VICE-PRESIDENT

K. Marion Smith. *B.S.N., U. of British Columbia; M.Sc., McGill U.*

Present Position: Assistant Director of Nursing, The Vancouver General Hospital, Vancouver, B.C.

Association Activities: active member of RNABC, having served on the executive committee and a number of other committees; member of the ad hoc committee studying the functions of the CNA.

Just as the profession has a responsibility to the community, so have the members of this profession an individual responsibility to the profession. I believe this responsibility encompasses the contemplation of new ideas, creative thinking, and the expansion of knowledge. It is necessary to continue to develop policies in accordance with the needs and wishes of the membership, then help put such policies into effect. There is continuing need to uphold efforts to match statements of public purpose with what is actually done and to provide the climate in which group action can solve problems that will permit individuals to concentrate on their work and do a better professional job.

Sister Marie Barbara

Sister Kathleen Cyr

Sister Cecile Gauthier

Sister Rita Kennedy

Sister Cecile Leclerc

Sister Grace Maguire

Candidates for Nursing Sisterhoods Representatives

Sister Marie Barbara. *New Waterford General Hospital; B.S.N., St. Francis Xavier University; M.S. in Nursing, Boston University.*

Present Position: Director, School of Nursing, St. Martha's Hospital, Antigonish, Nova Scotia; and Acting Director, Dept. of Nursing, St. Francis Xavier University.

Association Activities: secretary, curriculum council, RNANS; has held office of president, first and second vice-president, RNANS and chairman, committee on nursing education; representative of RNANS on advisory committee on nursing education to Nova Scotia Hospital Insurance Commission.

I am justly proud to belong to the Canadian Nurses' Association, and to serve in any capacity on its board of directors would indeed be a privilege and an opportunity.

As the official voice for nursing in Canada, the CNA has attained prestige and an enviable record in promoting the scholarship and welfare of its members. It has given tremendous leadership to the various provincial associations and has been successful in making its voice heard both by government and its confrères in the other health professions. Over the years, CNA has been fortunate in having some of the most outstanding Canadian nurse leaders as its officers and committee members. This in itself offers a unique learning and professional opportunity, besides ensuring the continued development and enhancement of the goals of the association.

Nursing must not be concerned *solely* with its self-image or even the welfare of its members, laudable as the latter may be. Because nursing was born of the need for care by man, the CNA is pledged to work toward the goal of expediting the delivery of optimum health care to all its citizens.

Concerned health professions, along with government officials and concerned citizens, are wrestling with this gigantic problem. The other pressing problems of our age, such as hunger, proverty, pollution, and over-population will yield to enlightened and intelligent solutions supported by cooperative efforts among all men of every race, creed, and color. Canadians can play decisive roles in helping to solve these world-wide threatening problems.

I believe that the CNA, on national and regional levels, can make significant contributions in support of citizen and government action by having an informed membership, through *The Canadian Nurse* and direct communications with the provincial associations; by encouraging its members and officers to participate in welfare and community organizations; and by engaging in articulate and persuasive dialogue with government and other influential agencies.

Sister Kathleen Cyr. *B.Sc., Seattle U.*

Present Position: Instructor in Psychology, St. Joseph's Hospital School of Nursing, Victoria, B.C.

Association Activities: active member of the RNABC, presently on the executive committee and the committee on registration.

The national association is a vital force in shaping the future of nursing in Canada. I believe I have the responsibility, as a member of a professional organization, to become personally involved and to try to contribute in a real way to the development and maintenance of a strong national association.

Sister Cecile Gauthier. *St. Boniface General Hospital School of Nursing; B.Sc.N., U. of Montreal; M.S.N., Catholic University of America, Washington, D.C.*

Present Position: Director, School of Nursing, St. Boniface General Hospital, St. Boniface, Manitoba.

Association Activities: member, board of directors, MARN; member of various MARN committees.

For the last few years it has been a challenging and rewarding experience for me to serve on committees and the board of directors of my provincial association. I have come to believe that the nursing profession can live and continue to grow only if individual members show concern and responsibility for its development. The board of the Canadian Nurses' Association has in the past given leadership and established the necessary guidelines to support and assist the provincial associations.

To serve at the national level would be an opportunity to gain knowledge and insight into a higher level of organization. It would offer the occasion to join efforts with nurses from other parts of the country who, like myself, have a desire to foster the development of nursing in our rapidly changing society.

Sister Rita Kennedy. *(formerly Sister St. Leonard). Lorrain School of Nursing, General Hospital, Pembroke; B.Sc.N.Ed., U. of Ottawa; M.Sc., Catholic University of America, Washington, D.C.*

Present Position: Director, St. Mary's School of Nursing, General Hospital, Sault Ste. Marie, Ontario.

Association Activities: member of RNAO committees, including the committee on nursing service and the planning committee for school of nursing improvement programs; past president, Catholic Hospital Conference of Ontario; formerly member, coordinating committee of the Quo Vadis Project; member, Council of the College of Nurses of Ontario 1963-66 and 1966-69; and secretary-treasurer, Algoma Regional School of Nursing.

As a nurse I am profoundly concerned about the future of nursing generally and the practitioner of nursing and her education more specifically. The increased complexity of health care offers broader avenues for the professional nurse and a great challenge for her traditional role. I believe nurses have a responsibility to promote the professional growth of the nurses of Canada and, therefore, ensure optimal nursing care to our citizens.

At no other time in the history of nursing in Canada has there been such a need for nurses to direct and control the future of nursing. We must not jeopardize our heritage by abdicating our responsibilities to other bodies; we cannot attempt to achieve our goals in isolation as individuals or in groups. Rather, we must realize that our goals can be achieved only through cooperation and commitment to the principles in which we believe. Hence I welcome the opportunity to serve and learn through the Canadian Nurses' Association if it be the wish of the electorate.

I believe that education is a process of learning that fosters growth, creativity, freedom, and unity. I believe that the primary goal of nursing education is to unlock, open doors to awareness, competence, knowledge and skill in fulfilling the nurse's role in meeting community health needs. The advent of the space age and changing social structures, with all of their implications, has modified and expanded the role of the nurse. She must keep ahead of the pace lest her unique functions in meeting health needs be usurped by others.

Change, however, to be significant and purposeful, must come through the educative process. To provide this process for the best nursing care of the Canadian community is the responsibility of the CNA. With its broad perspective on Canadian health needs and recognition of the inherent dignity and worth of every Canadian citizen, the CNA is challenged to take the initiative in bringing about fruitful change in nursing practice in Canada for today and tomorrow.

Sister Cecile Leclerc. *Notre Dame Hospital, Montreal; B.Sc.N., University of Montreal; M.A., Catholic University, Washington, D.C.*

Present Position: Director of Nursing Education, Edmonton General Hospital School of Nursing, and Director, Department of Nursing, College St. Jean, Edmonton, Alberta.

Association Activities: vice-president, chairman of committee on finance, and member of other committees for the AARN, 1956-67; representative of the nursing sisterhoods on the CNA executive, 1962-64; member of the CNA committee on constitution and bylaws, 1964-66.

My reason for accepting the nomination is that I believe personal involvement is one of the most tangible ways of giving evidence of my desire to contribute, as well as I can, to the betterment of our association.

Having had the privilege of serving on the board of the Canadian Nurses' Association as nursing sisterhoods representative a few years ago, I consider that experience as most valuable and enriching both personally and professionally.

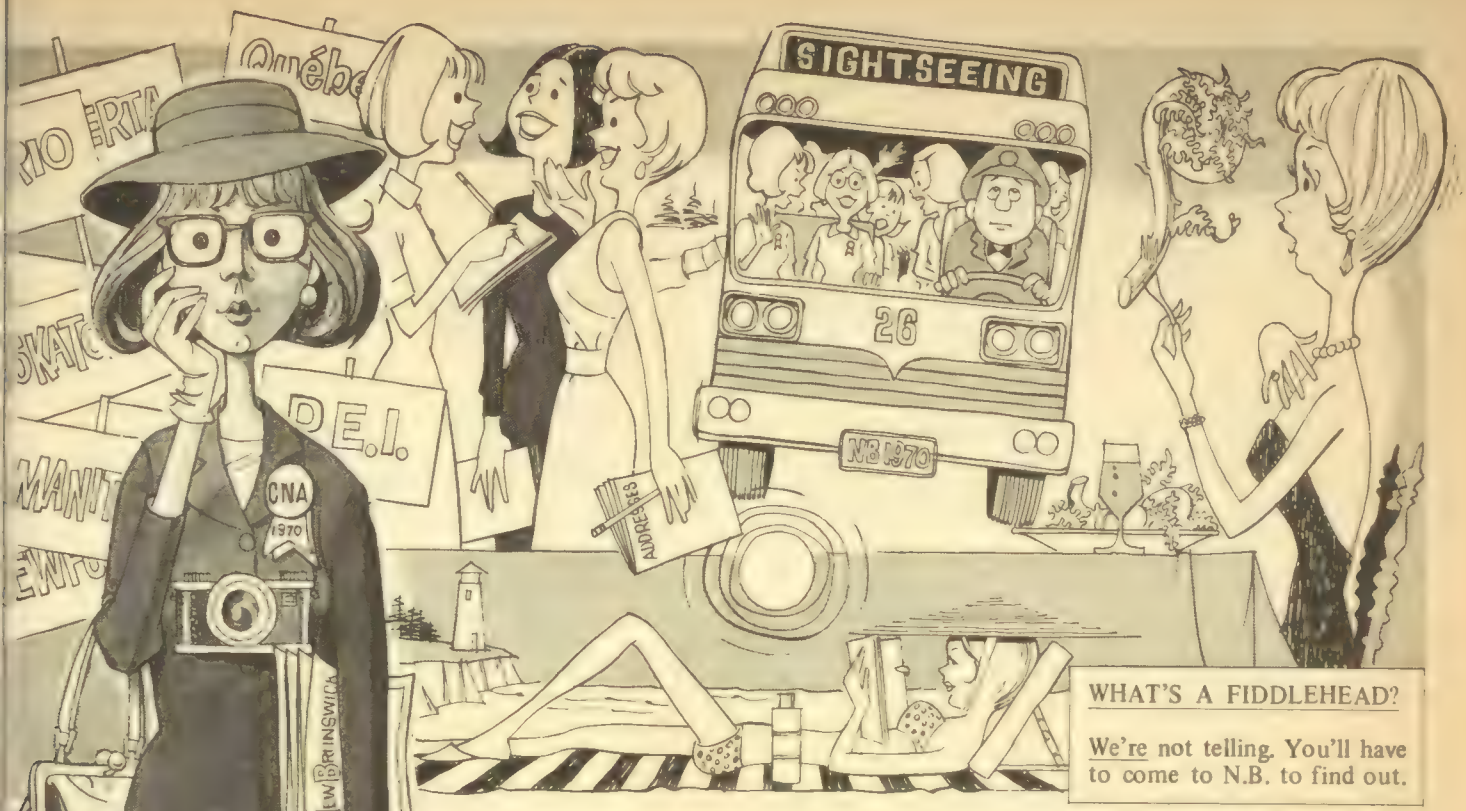
It is my belief that through active participation in the affairs of our national association I shall be a more effective member of our provincial and local nursing associations.

Sister Grace Maguire. *St. Mary's Hospital, Montreal; Diploma in Teaching and Supervision, U. of Alberta; B.S.N., U. of Ottawa; M.S.N., Catholic University of America, Washington, D.C.*

Present Position: Director of Nursing, Providence Hospital, Moose Jaw, Saskatchewan.

Association Activities: member, board of nursing education, department of education, province of Saskatchewan; member, board of examiners, SRNA.

My purpose in accepting the nomination for office in the Canadian Nurses' Association for the 1970-72 term is as follows: 1. to share some of my learning and experience with others in order to better understand the problems that face nursing in each of the provinces in Canada and other countries; 2. to gain a greater appreciation of the Canadian Nurses' Association and its many contributions; 3. to be able to bring or share the knowledge acquired through this contact to the local and provincial level to help promote a greater awareness, a desire for participation, and a need for unity on the part of the individual members and the provincial and national associations. □



WHAT'S A FIDDLEHEAD?

We're not telling. You'll have to come to N.B. to find out.

Fredericton — here we come!

A recipe to help each CNA biennial conventioneer plan her strategy for next month's meeting in Fredericton.

Carol Kotlarsky, B.J.

The 1970 biennial meeting in June has something going for it that no other CNA biennial has had: Fredericton.

For nurses who have yet to see this charming New Brunswick capital, or the province, or even the Maritimes, there is lots to look forward to. Whether your interest lies in history, photography, gastronomy, or athletic activity, this part of the country will be for you.

Whatever way you look at it, whatever road you take to get there, plenty awaits each visitor to Fredericton. The only question is: how do you make the most of one event-packed week?

Read on, and feel free to pack any of the following tips that might help somewhere along the convention route.

Miss Kotlarsky, a graduate of Carleton University's School of Journalism, is Editorial Assistant, *The Canadian Nurse*.

Planners win

Once you get to Fredericton, it will be easy to get swept off your feet in the bewilderment of scheduled business and social events that do not leave too many spare minutes. Nothing pays off more than a close examination of the program before arriving in the convention city. Once you have decided that a particular session is important to you, some last-minute distraction is less likely to prove tempting.

Make notes before and during the week. And keep them handy! Since you can't remember everything, jot down names of people you want to meet during the week, as well as new names, addresses, and ideas for future reference. This kind of organization can pay big dividends. You may also wish to compare notes with fellow convention goers.

Once the week's meeting is over, you

might want to think over all you did, what you missed, or would do differently the next time. With these thoughts in writing, you will have some good preparation for your next conference.

Social do's and don'ts

Do you think of social events as essential aspects of any convention, or simply as "fillers" if nothing more serious is in the offing?

One secret of getting the most from a large meeting is knowing how – and when – to mix social gatherings with business sessions. Whether it is over an informal cup of coffee or over a formal lobster, people are more relaxed than they are at work sessions. Committee reports, interest sessions, and speeches have their place, but they can't dominate every waking hour.

Informal get-togethers often provide those little extras that make a convention especially memorable. Don't hesitate to introduce yourself to people you haven't met, whether it is during a coffee, lunch, or dinner break. That person standing or sitting alone is probably waiting for an introduction too. If, on the other hand, you're already part of a group, you can always invite another person to join. Try to keep on the go and meet as many people as possible. Even breakfast can provide a convivial meeting time – if you're an early riser.

Taste the varied menu

Throughout the week, an assorted fare of dinners, concerts, receptions – to name only a few of the offerings – will satisfy all appetites.

Tuesday night the government of New Brunswick is giving a banquet for all registrants. This should give everyone a good preview of the hospitality planned for Wednesday.

Just because one full day in the middle of this fast-paced week has been set aside for sightseeing, doesn't mean a conventioneer can take it easy! There's so much to see in and around Fredericton, that this one day will only help you realize how long you would like to spend there.

While sightseeing, take advantage of the generously-offered hospitality. Meet the Maritimers and find time to marvel at the beautifully varied landscape and seascape. There are 600 miles of seacoast in the province, so whether you're looking for a sandy beach, sheltered cove, quiet lake, or tumbling river, you won't have far to go.

Gourmet's guide

Seafood worshippers will not be the only gastronomic connoisseurs who will find an unusual assortment of epicurean delights in this province. In addition to such delicacies as lobster à la Bretonne, devilled crab, and Kromeskies (oysters, chicken, and mushrooms), you will be able to enjoy fiddleheads.

Tuesday night's menu, says the New Brunswick Association of Registered Nurses, will include seafood, fiddleheads, and New Brunswick wine. To avoid suspense, NBARN has described the fiddlehead as a rather strange-looking, tender green vegetable that "will no doubt be a popular topic of dinner conversation."

For those who really like to know what they're eating, fiddleheads are the early growth of the ostrich fern. They have to be picked during the short delicacy stage as the leaves poke through the soil. Each spring New Brunswickers can be seen along the rivers harvesting the greens for a family treat. Also popular is the frozen variety. The province boasts the only commercial company in North America that freezes fiddleheads.

Tour Maritimes

If you have time for a week's exploration after the biennial, this one-week tour package, announced by NBARN, may be for you.

Beginning June 20, take the conducted tour from Fredericton along the Saint John River to the Bay of Fundy and the port city of Saint John. There you will see the Reversing Falls, Martello Tower, and New Brunswick Museum. Then continue to Fundy National Park, Hopewell Rocks, and on to Moncton for a visit to Magnetic Hill.

From Fort Beausejour you will go by ferry to the garden province – Prince Edward Island. Enjoy the famous sandy beaches, a tour of Summerside, and an overnight stop in the capital of Charlottetown. Take another ferry to picturesque Cape Breton and arrive at the famous Keltic Lodge at Ingonish for one night's stay. Then follow the historic Cabot Trail; see the beauty of its mountains, interspersed with glimpses of the Atlantic.

Cross the Canso Causeway to mainland Nova Scotia and Halifax. After touring the city's historic Citadel, a drive along the province's scenic south shore will take you to the Lunenburg Fisheries Museum, Peggy's Cove, and Mahone Bay. On June 26 the tour bus will leave Halifax and drive through Annapolis Valley, stopping at Grand Pré Memorial Park, then continuing to Digby to board the ferry for Saint John, N.B.

Arrangements for this $150 tour can be made through Mr. R.V. Lenihan, President, Moncton Travel Agency, 735 Main Street, Moncton, New Brunswick.

Summing up

Although the following lines by James De Mille were written about New Brunswick a century ago, they have not completely lost their meaning.

Sweet maiden of Passamaquoddy,
Shall we seek for communion of souls
Where the deep Mississippi meanders,
Or the distant Saskatchewan rolls?
Ah, no! in New Brunswick we'll find it –
A sweetly sequestered nook –
Where the swift gliding Skoodoowabskooksis
Unites with the Skoodoowabskook.*

*Robert M. Hamilton, *Canadian Quotations and Phrases*, Toronto, McClelland and Stewart Limited, 1965, p.146.

books

The Intimate Enemy: How To Fight Fair in Love and Marriage by George R. Bach and Peter Wyden. 405 pages. New York, William Morrow & Co., 1969. Canadian Agent: George J. McLeod Ltd., Toronto.

Reviewed by Dr. S.R. Laycock, Vancouver, B.C., formerly Dean of Education at the University of Saskatchewan, Saskatoon.

Dr. George R. Bach, the senior author, is a psychologist and director of the Institute for Group Therapy in Beverley Hills, California, where he developed the theory of constructive aggression in marriage counseling. His collaborator, the author of several books, is executive editor of *Ladies Home Journal.*

The authors believe that true intimacy in marriage can thrive in healthy men and women only if the partners learn how to fight and to do so by fair, clean, above-the-belt fighting and by leveling with each other. Training in doing this is given by the senior author through the use of group therapy with several couples in a group.

The authors' aim is to replace "game playing" with true intimacy. They discuss the dangers of storing up grievances; how to deal with Vesuvius temper outbursts; why winning a fight may be more costly than losing; the importance of making a fight-appointment; finding a partner's "fair-belt-line"; how drinking affects fighting; avoiding Virginia Woolf fighting; the use of warming-up exercises before fighting; how to end a good fight; dirty and sick fighters and how to stop them; exercises to improve intimate communication; using sex as a strategic weapon; and fighting before, during, and after sex; teaching aggression-control to children; how to reduce needless fights with children; making intimate living work; generation gap fights; courtship fights; and fights about extramarital sex.

The book is applied mostly to husband-wife relationships. However, most of the rules apply to any intimate relationship, such as a close friendship, where two people make themselves vulnerable to each other and must, therefore, learn the arts of leveling, honesty, and fairness in their dealings with each other.

Although not all psychologists and marriage counselors would approve of, or be able to use, Bach's technique of fighting, his method, especially when carried out in his type of group therapy, could be of real value to many couples. If the book were made available to young people in their late teens and early twenties, it would help them to discard rose-colored glasses that make them see marriage as a guarantee of living happily ever after. It might even make them realize that the goals of happiness and intimacy in marriage have to be bought by a great deal of leveling and honesty with the marriage partner.

Mosby's Comprehensive Review of Nursing, 7th ed., by Editorial Panel. 590 pages. Toronto, C.V. Mosby Co., Ltd., 1969.

Reviewed by Doris Weiler, Evening Charge Nurse, Almonte General Hospital, Almonte, Ontario.

This text is a pleasure to read. It is not heavy reading and for the most part, is easily absorbed. The presentation makes it interesting – a trait seldom found in textbooks. It would greatly assist nurses who have practiced for many years, those studying for registration, students, and nurses who have been out of nursing and plan to return.

Anatomy and physiology are easy to assimilate, but more illustrations would facilitate learning. The sciences, including social science, are well presented and the pertinent factors, especially in chemistry and microbiology, are covered. This is important, as the nurse needs an easy-to-read, overall picture, not a lot of ponderous detail that results in loss of interest.

The history of nursing is contemporary and mostly national. It creates a desire for a more detailed, international picture of the struggle of nurses for a rightful place beside and with the patient.

The section on communicable disease nursing is most interesting and, with one exception, is one of the best accounts I have read. Contact – direct or indirect – is considered at the beginning; however, one exemple of contact includes conflicting statements.

Psychiatric nursing is well presented with good case histories, although more emphasis should have been placed on the method and approach to mentally ill patients. For example, if the patient feels the nurse is timid or fearful, rapport can never be established.

The answer sheet method is good, can be processed readily, and is advocated extensively. However, this method has disadvantages. In I.Q. tests, people with game aptitude and a good memory can score high, but may lack proper knowledge of the subject.

Jensen's History and Trends of Professional Nursing, 6th ed. by Gerald Joseph Griffin and Joanne King Griffin. 339 pages. Toronto, C.V. Mosby Company, 1969.

Reviewed by Glennis Zilm, formerly an instructor in history of nursing.

This revised edition of a standard American history of nursing text has a bigger format with larger two-column pages and more illustrations.

Few changes have been made in the sections on the early history of nursing. The section on the contributions of Kaiserworth remains one of the best offered in any basic text. Changes in organization, as in the section on nursing publications, have improved the book, and new sections, such as the one on lobbying, will interest many.

This edition starts on a less preachy, student-oriented note than did the fifth edition; the opening unit, list of major trends, and a note about how to use the book, have been removed. The general concept of relating trends to movements in history – one of the strengths of this text – has been retained, however. Unit seven, on contemporary developments and trends, is considerably updated and improved. It will be of considerable value to United States nurses.

This American text has little to offer on contemporary nursing or trends for Canadians. The unit on history and present-day activities of nursing in Canada is too brief and outdated to be really useful to Canadians. Although revised somewhat, it still contains errors, such as the spelling of the name of Alice Girard, ICN president from 1965 to 1969. It concentrates far too much on using Ontario as an example, rather than considering that each province has its distinct standards.

The unit on nursing in other countries is poorly done. The chapter on nursing in the British Isles, for example, ends with the recommendations of the Lancet Commission in 1932 and fails to show modern trends and conflicts in Britain. The unit also fails to point out some of the differences in patterns of nursing education and practice around the world, such as the differences of the health worker system in the U.S.S.R. □

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, *except Reference items,* may be borrowed by CNA members, schools of nursing and other institutions. *Reference items* (theses, archive books and directories, almanacs and similar books) do not go out on loan.

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No more than *three* titles should be requested at any one time.

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2. *Aide – mémoire de pathologie à l'usage de l'infirmière.* Suivi d'un lexique médical. Préparation au diplôme d'état. Par Henri Diriart et al. Paris, Baillière et fils, 1969. 389p.

3. *Ambulatory nursing care* an annotated bibliography prepared by Vivian V. Clark assisted by Leanne P. Davidson. New York, Health and Hospital Planning Council of Southern New York, 1969. 69p.

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9. *Dictionary of Canadian biography,* General editor, George W. Brown. Toronto, University of Toronto Press, 1969. 759p.R

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12. *Educational television* by Earl Rosen. Toronto, Canadian Association for Adult Education, 1969. 95p. (Canadian Association for Adult Education. Trends)

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22. *Proceedings of Annual Conference, 1968.* Chicago, American Library Association, 1969. 199p.

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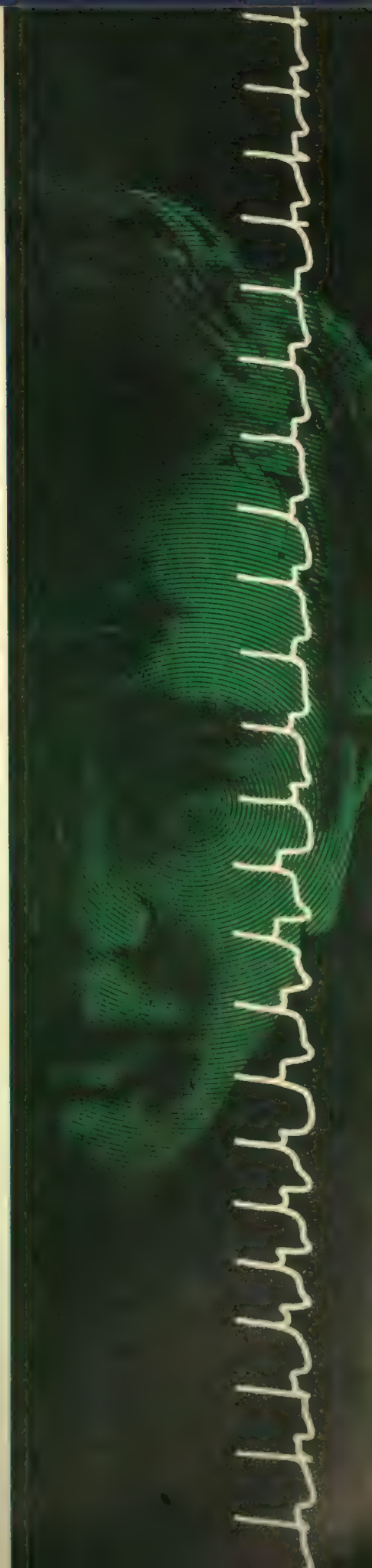
The Canadian Nurse

50 The Driveway, Ottawa 4

June 1970

The Canadian Nurse



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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 66, Number 6 June 1970

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The newspaper report that the federal government's health department plans to start a program "to train nurses as doctor-assistants" (see "At Press Time," page 14, News), came as a shock to nurses, who have been led to believe that no such unilateral decisions would be made by any group, let alone by government. The news probably shocked lay readers as well, because no one has yet bothered to find out if the public will accept "doctor-assistants."

On the verge of irreversible shock ourselves, we investigated. We were assured by government spokesmen that the main purpose of the proposed program was to give additional preparation to the federally-employed nurses in the north, to help them cope with the medical problems they are already encountering; the purpose was *not* to establish a new category of health worker.

Also, we learned that no definite plans have yet been made with any outside agency to provide this new program, although three universities have expressed interest. We were also told that the graduates of such a program would not be called "doctor-assistant." No one seemed to know just what they would be called.

On the surface, all looks well. No one can argue with the principle involved: that the nurses in the north need all the education and experience they can get to help them cope with the medical problems they have to handle.

However, despite assurances that nothing new is being started, that the issue is really an internal one concerning only the medical services branch of the government, we cannot help but feel that this may be a backdoor approach to create a new medical category.

Our main question is this: As a two-year program in outpost nursing already exists at Dalhousie University, why set up a new one?

Why, indeed, unless, as the news item says, the program will create and train "doctor-assistants."

If, as a national association, we are as concerned about patient care as we say we are, we must take a stand on this "doctor-assistant" issue and take it quickly. Otherwise, we may soon find this new category set up and in operation, while we are still trying to "initiate dialogue with appropriate groups."

V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Reply from Minister

I recently received a letter from the Honorable John Munro, Minister of National Health and Welfare, in reply to the letter I sent him earlier this year. ("Letters" page 4, March 1970".)

In his letter Mr. Munro has attempted to clarify the facts with respect to the action of the National Department of Health and Welfare in relation to the Canadian Nurses' Association's application for a grant to carry out a nursing education project. ("News," January 1970, page 5.) In his letter the Minister states:

"In my letter to the Canadian Nurses' Association I indicated that the pressures developing in connection with the recommendations of the Task Forces on the Cost of Health Services made it very difficult for me to approve this particular project at that time.

"You will be pleased to know, however, that a number of such projects are presently being re-examined by my Review Committee in the light of our better knowledge of the number of projects arising from the Task Force activities, of priorities and of available funds."

Since I had expressed my concern that the Department, as reported in the January issue of *The Canadian Nurse*, had given no reason for the lack of approval for the Canadian Nurses' Association's submission, I was interested in receiving his letter. Other *Canadian Nurse* readers may have had similar concerns. Perhaps you might like to clarify the situation by publishing this letter. — *Dorothy J. Kergin, Reg.N., Ph.D., Associate Professor, School of Nursing, McMaster University, Hamilton, Ont.*

Task force report

I appreciated the interesting report on "Task Force on the Health Services" (February 1970). However, I do not agree with the idea of reducing or not employing registered nurses in the operating room, central supply room, admitting office, etc.

I believe nurses should continue to assume responsibility in the operating room. They are more adequately trained than operating room technicians and other personnel, and academically and professionally they have more knowledge.

As nurses, one of our goals and objectives is to provide continuity of care before, during, and after operations. Don't we consider nursing in the operating room as one of our specialties?

In the other departments, are the non-nursing personnel aware of the basic and scientific principles involved? I agree that they know the how and when of cleaning and sterilizing instruments and other articles, but I doubt if they know the why and the applicability of these scientific theories. Does not nursing care, planning, and meeting the individual's needs begin as soon as the patient is admitted, or even earlier?

To remove the registered nurse from these different departments simply means a reduction in the quality of nursing care. – *Solomon M. Guerrero, RN, Winnipeg, Manitoba.*

I have worked as a registered nurse for nine years and was very pleased to read the special report on "Task Force on the Cost of Health Services in Canada" (February 1970).

If the Minister of National Health and Welfare puts a little effort toward making the task force's ideas possible, I think 100 percent of nurses and other hospital personnel will rejoice. At least he will be remembered for a long time. – *Mrs. Caliboso, RN, Prince Rupert, British Columbia.*

Need to economize

I recently attended two workshops — one on the problems and priorities of nursing, and one on continuing care of the elderly patient. These workshops were informative and covered the subject matter well; however, at the end of each, those present were acutely aware that the programs outlined could never be implemented with the present shortage of staff and funds in health institutions.

Since extra financial assistance to hospitals comes from taxes, each nurse has a responsibility to be economical. If she were made aware of hospital costs, from the price of a syringe upward, she might try harder to keep costs down.

Much could be done to economize at the administrative level. For instance, are nurses employed to nurse, or do many still function as clerks and cleaners? Are the best nurses available hired to fill vacant positions? Are nurses adequately prepared for the positions they find themselves in, particularly in specialized areas? Is any thought given to maintaining a happy working environment? Are hospital administrators qualified to make studies of staffing and work patterns, and institute change where necessary? Are all administrators in small hospitals necessary, or could some functions be shared with other small institutions in the area?

Conscientious nurses can tolerate only so much of the poor quality of nursing caused by these restrictive practices. Then they must look elsewhere for fulfillment, causing continual staff turnover and an ever greater strain on the hospital budget. — *Mrs. Phyllis McNey, Stony Plain, Alberta.*

February issue best

As a Canadian nurse away from home, I was extremely proud of the February issue. It was the best one yet. All the articles were interesting and instructive.

Our journal more than holds its own among its peers. — *Mrs. Lois MacRae, RN, Denver, Colorado.* □

a little knowledge is not enough . . . give teen-agers the facts about menstruation

Some teen-agers have heard they shouldn't bathe or wash their hair during their menstrual periods. Some think unmarried girls shouldn't use tampons. Others say exercise brings on "cramps." No wonder they call it the "curse."

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*Kehlmann, W. H.: Mod. Hosp. 84:104, 1955

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news

Committee Studies Health Cost Reports

Ottawa — Thirty-nine recommendations from the task force reports on the cost of health services in Canada, were discussed by an ad hoc committee at the Canadian Nurses' Association April 20-22. The committee reviewed those sections of the reports that applied to nursing and nurses. Commenting on the meeting, chairman Lois Graham-Cumming, head of CNA's research and advisory services, said six of the task force reports contained recommendations that related specifically to nursing: operational efficiency; salaries and wages; beds and facilities; price of medical care; cost of public health services, and utilization of hospital services and manpower. Mrs. Graham-Cumming said preparation for the meeting had been carefully set out in a questionnaire, sent out to each committee member prior to the Ottawa discussions. Members were asked to study the recommendations and state their reactions — agreeing or disagreeing, and the reasons why. A summary of the advance questionnaire was prepared by Mrs. Graham-Cumming for the April meeting. The outcome of the discussions will be submitted to the CNA board of directors for action before the general meeting of the CNA in Fredericton, New Brunswick, June 14-19. The 14 member committee included the chairman of three CNA standing committees: nursing education; nursing service; and social and economic welfare. Provincial associations were represented by an appointed member. The committee will meet again for a four-day discussion on those sections of the reports which do not specifically mention nursing, but still affect the profession.

Issues of Journal Needed

The Canadian Nurses's Association needs the following issues of *The Canadian Nurse:* 1969: January, April, September; 1967: February; 1966: January, February March, July, September; 1965: January, March, April.

Please send these issues to the CNA Circulation Department, 50 The Driveway, Ottawa 4, Ontario.

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Although discussions centered on the health costs of Canada at the April CNA ad hoc committee meeting in Ottawa, time out for reflection on what might occur at the June general meeting took over during coffee break. Five of the committee showed interest in preconvention advertising. Commenting on the artwork are *(left to right)* Dr. Rae Chittick, now retired; Joyce Bailey, director of nursing, Wellesley Hospital, Toronto; Joan Toner, director, school of nursing, Carleton Memorial Hospital, Woodstock, N.B.; Olivette Gareau, director of public health nursing, health unit division, Ministry of Health, Quebec; and Roy Harding, head nurse, Victoria General Hospital, Halifax, Nova Scotia.

CNA Awarded National Health Grant

Ottawa — A national health grant of $9,746 was awarded in May 1970 to the Canadian Nurses' Association toward a research project on "factors preventing nurses from achieving their educational goals."

National Health and Welfare Minister John Munro announced the grant for the 1970-71 fiscal year under the new national health grant program. The project was begun in May and should be completed by June 30, 1971.

The study is designed to determine what prevents registered nurses in leadership positions in Canada from obtaining the educational preparation needed for their work. A great discrepancy exists between the academic qualifications the Canadian nursing profession believes nurses should possess and the qualifications actually held.

This discrepancy was pointed out in the annual national inventory of registered nurses compiled by the CNA research unit, and was also identified by the recent federal government task forces on health care costs.

The study aims to answer the following: 1. the proportion of nurses with some university education who desire additional academic preparation; 2. the proportion of these nurses who are making satisfactory progress toward or are delayed in achieving their goal; 3. the factors that are delaying nurses in achieving their goals, and the remedial action indicated.

Questionnaires designed to reveal this information will be sent to nurses having some educational preparation in a university. Project director is Lois Graham-Cumming, director, CNA research and advisory services.

Nurses In The Future

Ottawa — What will be the role of the nurse in the future? This question was answered by the executive director of the Canadian Nurses' Association in two recent speaking engagements in the United States.

Dr. Helen K. Mussallem depicted the

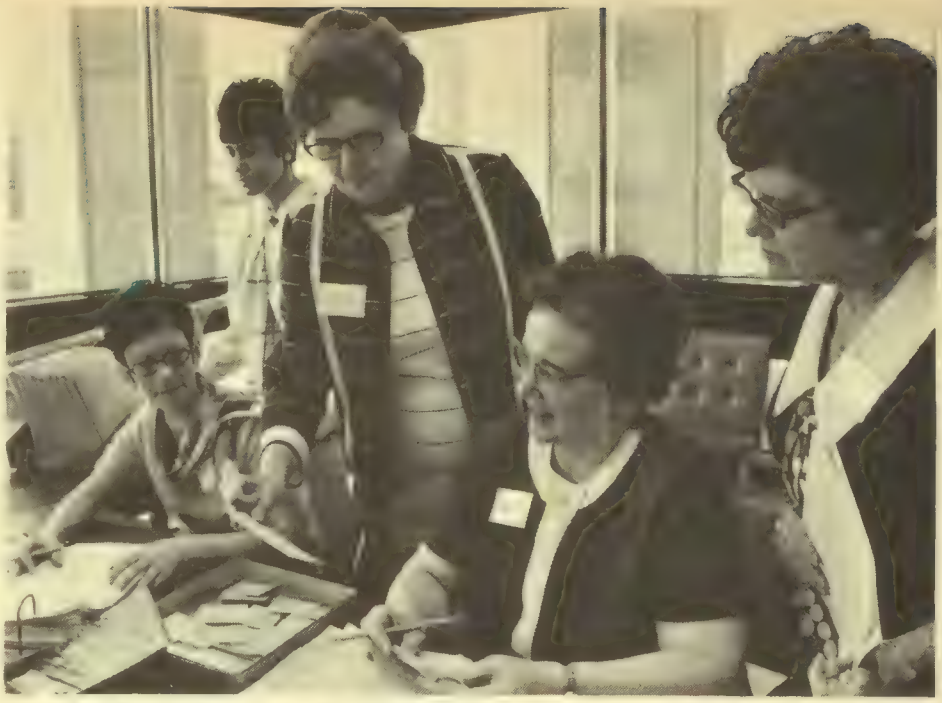
nurse of the future as one who will be the primary health professional contact in the community. The nurse, as perceived by Dr. Mussallem, will be required to take on many responsibilities of the doctor in general practice.

Speaking to audiences at Rockland Community College, Suffern, and Teachers College, Columbia University, N.Y., Dr. Mussallem said the expanded role of the nurse in health care delivery systems is not new in Canada. "In remote areas of the country, the nurse has already assumed this role," she said.

For the nurse of the future, Dr. Mussallem felt the greatest problem will be, "How to determine if nursing will be provided by nurses as we know them now."

The pattern of medical practice is changing, she told her audiences. "If the decline in the number of family doctors continues, it will inevitably lead to a new pattern for health care delivery."

The role of the nurse was also discussed at the recent Commonwealth Foundation Caribbean Seminar on Nursing, held in Barbados. Dr. Mussallem attended as a consultant.



Margaret D. McLean, (standing, center), chairman and coordinator for the national seminar for directors of nursing held by the Department of National Health and Welfare, reviews registration preparations for the four-day meeting.

Directors Of Nursing Attend Federal Seminar

Ottawa — Directors of nursing from across Canada attended a seminar held here April 7-10 by the department of national health and welfare. Its objective was to share with the directors tools that the federal and provincial nursing consultants found useful in assessing and improving nursing service and its management.

Sixty-three French-speaking and 64 English-speaking nursing directors attended the seminar, the first of its type. Chairman and coordinator was Margaret D. McLean, senior nursing consultant hospital insurance and diagnostic services branch of the federal health department.

Three major topics were discussed: organizing nursing service to meet objectives; use of level of care assessment which categorizes patients according to nursing needs; and delivery of nursing care designed to meet the individual patient's needs, rather than relying on routines.

The two language groups met separately for discussion except at the opening session and at the closing meeting, when methods of implementation were discussed. Miss McLean told *The Canadian Nurse* many directors agreed to use level of assessment as one means of implementing what they had learned during the seminar. They felt it would help to staff more realistically for patients' needs, she said.

Nursing directors who attended the seminar would try to share what they learned with other directors in their province through regional meetings, said Miss McLean. Directors also listed many aspects of care procedures that were routinized and agreed to review these on their return to determine if all patients need these routines, added Miss McLean.

The directors of nursing were chosen to attend by provincial hospital insurance groups; most from hospitals with more than 200 beds. In October an appraisal form will be sent to seminar participants to find out how implementation procedures have progressed, Miss McLean said.

These second-year nursing students from the Ottawa Civic Hospital participated in the first Miles for Millions walk held in Canada this year, on April 18. Starting off on their 40-mile walk through Ottawa are, from left, Sue Saint, Joyce Baldwin, Liz Matheson, Marg Rook, and Barb Redmond.

Nurses Serve Abroad With Miles For Millions Funds

Ottawa — This spring thousands of Canadians have been walking in Miles for Millions marches to raise money

Keynote speaker at the institute on human relations in the health services sponsored by the RNANS and the Dalhousie University School of Nursing was Dr. James Gill of Harvard University, seen here with Joan Fox (center), RNANS president, and E. Electa MacLennan, director of the Dalhousie University School of Nursing.

for 15 national agencies that work for international development. Several of these agencies send nurses abroad.

In 1969, 114 sponsored walks involved 400,000 Canadians and raised nearly $4.5 million. This year 150 walks are expected to take place. May 2-3 was declared National Walk Week-end, but some walks will be held in the fall and at other times.

One agency in which nursing students can participate is Canadian Crossroads International, which uses Miles for Millions funds to sponsor university students on summer service projects in Africa. Nursing students have been sent to help in the health programs of various African countries.

The Canadian University Service Overseas sends nurses to work in developing countries with Miles for Millions money. These nurses are working in more than 40 countries around the world to improve health standards; they are paid by their overseas employer at local rates.

Care of Canada is supporting three young Canadian nurses in Afghanistan through Medico, a service of CARE. Several other agencies aid health programs abroad, in which nurses are involved. These include the Canadian Save the Children Fund; the Canadian UNICEF committee; and Oxfam.

BC Operating Room Nurses Meet

Vancouver, B.C. — Use of drugs and their interaction with anesthetics were among the subjects discussed when the British Columbia Operating Room Nurses Group held its second biennial institute, March 13 to 14 in Vancouver.

Other subjects on the program were: future concepts in operating room nursing; recent advances in the surgical treatment of arthritis; cardiac arrest; principles and methods of sterilization.

Gloria Stephens of St. Pauls Hospital, Vancouver, was elected president of the group during the meeting.

The registration was more than 400. The majority were operating room nurses, but there was representation from emergency rooms, central supply rooms, recovery rooms, intensive care and public health.

RNANS Sponsors Institute On Human Relations In Nursing

Halifax, N.S. – "Human relations in the health services" was the topic at a two-day institute held here March 9 and 10. Some 400 registered nurses, representing all areas of nursing service in the Atlantic Provinces, attended the institute, which was co-sponsored by the Registered Nurses Association of Nova Scotia and Dalhousie University School of Nursing. Dorothy Wiswall, Dalhousie School of Nursing, and Marianne Fightlin, RNANS nursing service adviser, coordinated the program.

Dr. James Gill, a psychiatrist at Harvard University, opened the sessions. Dr. Gill stressed that in health care it was of utmost importance for all in the health team to care about those involved.

It's Finger-Lickin' Good!

Colonel Sanders, of Kentucky Fried Chicken fame, celebrated his 79th birthday recently during a stay at The Wellesley Hospital, Toronto. Here he cuts into a birthday cake appropriately decorated with a chicken. Looking on are, from left: Doreen Nakamura, Mefus Ensor, Gloria Demessa, Alfred Kiessl, all of The Wellesley. *(Photo courtesy of Wellesley World.)*

He emphasized that both nurses and patients need to know and to talk to each other since illness is a crisis and the nurse must enter into this crisis by listening, caring, and doing. Yet it is essential that, in belonging to this health group, the individual develops a sense of self-esteem and fulfillment, he added.

Also discussed at the two-day meeting were the psychological aspects of communication; how well nurses communicate; communication and the delivery of health services; health priorities and the team concept in health care; communications between health services and the public; and communications as a nursing concept.

Dr. Gill will return to Halifax on May 20, 1970 for a follow-up of the institute with directors of nursing service, their assistants, and supervisors from the Atlantic provinces.

MARN Recommends $600 A Month Starting Salary

Winnipeg, Manitoba. — The Manitoba Association of Registered Nurses has recommended a basic starting salary of $600 per month for registered nurses with a diploma, beginning September 1, 1970.

This recommendation was made in a booklet on employment standards for registered nurses distributed to members in March.

The booklet was also sent to all hospital administrators in Manitoba, the provincial health department, and the Manitoba Hospital Commission.

Basic pay in Manitoba for nurses is now $470 a month, but will increase to $500 in September under collective bargaining contracts signed between four hospitals and nurses' bargaining units two years ago. These agreements were later expanded by the province to include most nurses working in Manitoba.

The basis for the $600 a month recommendation was a membership vote at MARN's last annual meeting, which expressed agreement with the national salary goal set by the Canadian Nurses' Association for 1970; CNA recommends the $600 a month basic starting salary.

The MARN booklet recommends six yearly increments, bringing the basic pay of a registered nurse to $766 per month in the sixth year of service. The recommended salary for a beginning practitioner with a baccalaureate degree is $720 per month.

Laurel Rector, MARN employment relations officer, said the recommended starting salary "is not necessarily the figure MARN will use at contract bargaining time." Herman Crewson, executive director of the Manitoba Hospital Association, said hospital staffs now under contract will be bound by the present contract — giving $500 a month basic salary in September until the end of the year.

RNAO Supports Concept Of Expanded Role For Nurse

Toronto, Ont. — Ontario nurses are strongly in favor of an expanded role for the nurse. At the annual meeting of the Registered Nurses' Association of Ontario, April 30-May 2, delegates voted unanimously in favor of a resolution that supports the concept of an expanded role for the nurse in the delivery of health care services, "such a concept to be identified, defined, and interpreted by the nursing profession in collaboration with the medical profession."

The resolution also stated that RNAO would cooperate with other appropriate groups in the development of models for the delivery of health care.

Delegates also approved a resolution that directs RNAO to investigate the circumstances under which nurses are asked to assume standby duty, and to propose a fair standard of standby allowance. Several members explained that in many small hospitals nurses who work in areas such as the operating room and the obstetrical department are required to assume standby duty frequently, and receive little, if any, financial remuneration. They pointed out that there are too few nurses in these small hospitals to form nurses' associations for collective bargaining.

A resolution to investigate the possibility of setting up an "employment referral service" was defeated by the voting delegates, mainly because other centers in the province already provide this type of placement service.

Few changes were made in the RNAO's standards of employment for 1971. The main change involved a recommended increase in the minimum salary for a registered nurse, from $7,000 to $7,500. The Canadian Nurses'Association's 1970 salary goal for the beginning practitioner from a basic diploma nursing program is $7,200 per annum, and for the beginning practitioner from a baccalaureate program, no less than $8,640.

Delegates also approved a recommendation that there should be 10 annual increments of not less than $300. The salary proposals called for an additional increment of $600 a

Notice

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year for a nurse with a university certificate or diploma; $1,200 a year for a nurse with a bachelor's degree; and $1,800 for a nurse with a master's degree.

The RNAO's recommended 1971 fees for private duty nurses are: $36.50 for an eight-hour day; $18 for four hours or less; and $22 (for each patient) for shared nursing for eight hours.

Friendship Lounge At CNA Biennial

Fredericton, N.B. — The Nurses' Christian Fellowship of Canada will have a Fellowship Lounge in the Beaverbrook Hotel during the biennial convention of the Canadian Nurses' Association, June 14-19, where nurses can relax and meet friends. NCF plans include a breakfast and short devotional period in the lounge each day, as well as coffee served throughout the day.

After the biennial there will be a national NCF weekend June 19-21 at St. Andrews-by-the-Sea. Brochures and further information will be available at the Friendship Lounge.

Give Priority To Members, RNAO President Tells Nurses

Toronto, Ont. — "Our overwhelming concern for non-member nurses has . . . inhibited our own progress," the president of the Registered Nurses' Association of Ontario, Laura E. Butler, told an attentive audience at the association's annual meeting April 30 to May 2.

Speaking of RNAO's problems of low membership, Miss Butler said members must face the fact that compulsory membership is not possible in Ontario at this time. She suggested that RNAO members concentrate on the quality and involvement of the membership they do have, and less on non-members.

Later in the meeting, delegates defeated a resolution that would have directed the RNAO board to set up a task force to investigate the possibility of initiating compulsory membership or investigating alternatives.

Miss Butler expressed concern about RNAO's present financial situation. Admitting that the problem was a real one that could not be ignored, she made it clear that RNAO was not bankrupt.

"It is true that the services and structures which our membership has said it wants exceed considerably the fee that membership seems to be willing to pay to maintain them," Miss Butler said. "We can no longer go on," she warned, "even in our credit-oriented society, extending ourselves in services and projects to which 30,000 members committed us and which 13,000 are left to maintain."

On the second day of the meeting, RNAO members were presented with details of the association's financial difficulties by president-elect M. Josephine Flaherty, and asked to consider a "Course of Action" prepared by the RNAO board of directors, Dr. Flaherty gave these facts:

During the 1968-69 fiscal year, it cost $41.50 per member to finance the association's activities; the present membership fee is $35.

The association has had four deficit budgets in five years, even though approved expenditures have been reduced and unexpected donations received from various sources.

The association has had to eat into its investments and, as a result, the investments have decreased by 35 percent — from $404,602 to $263,975 in 1969.

To cut expenses, the RNAO's board proposed a "Course of Action," which recommended that the professional development department be made self-supporting; that income relating to publications be increased; that professional librarian services be reduced to half time; that income from

annual meeting registration fees be increased; and that an attempt be made to have the affiliation fees to the Canadian Nurses' Association reduced from $10 to $7. (The resolution recommending that the affiliation fees to CNA be reduced was later defeated.) The RNAO board also proposed that at least two task forces be set up to study and recommend modification of the corporated structure of the association and to determine the factors that influence members to remain in the association.

A board proposal that received almost complete acceptance involved an increase of the annual membership fee in RNAO from $35 to $42. Several members pointed out that membership in other organizations and unions demanded much more that the present RNAO fee. A nursing student brought laughter and applause when she said she would prefer to pay the $42 membership fee when she becomes an RN, than to join an association that is so "hung up on fees."

No vote was taken on the change in membership fees, as a bylaw must first be amended and approved at a general meeting to permit any change. A special meeting will probably be held next September, the RNAO president told *The Canadian Nurse*.

Over 2,000 nurses registered for the three-day meeting at the Royal York Hotel. Sessions were well attended, and the evening session had to be moved to a larger room to accommodate the enthusiastic audience.

E. Louise Miner, president-elect of the Canadian Nurses' Association, brought greetings to the RNAO members on behalf of the CNA.

Panelists Debate Extended Role of Nurse

Toronto, Ont. — Should the nurses' role be expanded, or should a new category of worker — the physician's associate — be introduced? This topic brought frank and sometimes heated comments from both the audience and panel members during an evening session at the annual meeting of the Registered Nurses' Association of Ontario, April 29 to May 2. The panel, chaired by Verna Huffman, principal nursing officer, Department of National Health and Welfare, included, left to right: Dawn Marshall, a nurse clinician; John Sproule, Q.C., a taxpayer representing the community; Verna Huffman; Helen Singer, representing outpost nursing hospitals; Dr. George Wodehouse, a medical practitioner; and Ethel Irwin, a public health nurse.
Replying to Mr. Sproule's comment that midwives could help relieve the apparently overburdened physician, Dr. Wodehouse said doctors would welcome such a helper, but questioned whether women would accept her. Verna Huffman, panel chairman, received loud applause when she said that midwifery is accepted in many other parts of the world, and it would probably be accepted in this country, if "we didn't have so much resistance from the medical profession." A member of the audience said that nursing has shaken the "handmaiden" role, but it appears that doctors have not. She pointed out that the nurse already sees herself as a "physician's associate" — in other words as the colleague and equal of the physician in the work setting.

Alberta Nurses Reject Bill To Set Up Nursing Council

Edmonton, Alta. — The Alberta Association of Registered Nurses has rejected Bill 80 — legislation that would have established a province-wide coordinating council on nursing. Following this April 9 decision, the Alberta government, which introduced the bill in the legislature February 27, said it will not bring the bill before the House again.

Although the AARN was originally in favor of the bill, which it helped redraft from controversial Bill 119, it claimed that amendments to Bill 80 were not acceptable to nurses in the province.

The AARN said the major issue was the setting of standards of licensure for the professional nurse. The association stressed that the control of standards of service must be vested in the organized profession and it feared that the amendments to the bill would identify two standard-setting bodies — the coordinating council and the AARN. "Bill 80 as amended would fragment the responsibility for setting standards of practice for the professional nurse," AARN said.

According to the association, Alberta nurses could not accept the concept that a coordinating council on nursing would set standards of licensure, when only five members on a 17-member council were to be appointed by the organized profession.

Ontario Report On Healing Arts Recommends Nursing Changes

Toronto, Ont. — To have more registered nurses, and more nurses with higher qualifications working in Ontario are two of the aims of the provincial report on the healing arts issued late April 1970.

A three-man committee was appointed almost four years ago by Ontario Premier John Robarts to study all aspects of the healing arts. Among the recommendations of the committee concerning nursing, are:

- Legislation to aid collective bargaining for nurses, providing for compulsory arbitration and safeguards to maintain essential services in the event of a strike. This legislation should allow the Registered Nurses' Association of Ontario to act as bargaining agent when requested by the majority of nurses in a given bargaining unit.
- Nursing specialties, including midwifery and psychiatry, with educational opportunities for personnel in each specialty.
- Improvement of salaries and working conditions for graduate nurses.

- Use of incentives, salary differentials, and other methods to bring back qualified nurses not now practicing.
- Continuation of registered nursing assistants as a separate group whose discipline and certification should be removed from the College of Nurses of Ontario.
- Better pay for nurse faculty, more space and expansion of programs to encourage enrollment in university degree programs in nursing.
- Greater freedom for nurses to determine their own role.
- Organization and financing of more nursing-oriented research, especially into professional roles and relationships.
- Financing of new schools of nursing under the Ontario department of education. The Ontario Hospital Services Commission should not finance existing hospital, regional, and special schools of nursing; budgeting should be done if possible through the department of education.

In recommending these measures the committee voiced its concern at the high rate of turnover among nurses in the province, where 4,000 or more nurses may be lost to active nursing every year.

The committee recommended that the College of Nurses of Ontario should end its control over admission requirements and curriculum standards to schools of nursing — these should be the responsibility of the nursing faculties involved (in cooperation with appropriate advisory committees). However, the committee believed the College should retain the power to be self-regulatory; it should still license nurse graduates and assess the competence of applicants for licensure who have been educated outside Canada.

The committee felt all the senior professions in the health field, including nursing, have been given too much power to govern themselves, and recommended that the provincial government take a more active role in the functioning of their regulatory bodies. These bodies should have "a sufficient number of lay representatives to make their presence felt."

Senior professions should participate in compulsory programs to ensure continuing competence, which should be made a condition for re-licensure, according to the committee report.

The committee also recommended that higher grade medical workers, such as nurses with postgraduate education, be developed to aid doctors in routine tasks.

Keep Licensing Functions Separate Lawyer Tells RNAO Members

Toronto, Ont. — A conflict of interest is bound to develop when the functions of the licensing body of a profession are not clearly distinguished from those that belong to a voluntary association, a professor of law told members of the Registered Nurses' Association of Ontario, May 2.

Speaking at a luncheon at the RNAO annual meeting, Horace Krever, Q.C., faculty of law at the University of Western Ontario and a member of the three-man Committee on the Healing Arts, said it is totally wrong for the body entrusted by the legislature with the task of protecting the public — by licensing or registration — to become entangled with the interests of the profession it governs. "Most professions now make this distinction," Professor Krever said, "but in nursing, Ontario is the only province to have seen the light and to have removed from the voluntary association the regulatory functions that are now performed by the College of Nurses of Ontario."

Professor Krever gave the nurses his opinion of why the Committee on the Healing Arts recommended that the nursing profession in Ontario be allowed to retain its self-regulatory status. "My

guess is that the recommendations with respect to nurses represent a conscious act [on the part of the Committee] of expressing confidence in the contribution nursing can make, and to enable nursing to develop a stronger and louder voice when dealing with other professions, hospital administrators, and government," he said.

Professor Krever noted that nurses are reluctant to speak up, and said this reticence is observable. He urged RNAO members to speak out frequently and loudly, and to demonstrate that they can assume more responsibility than they are now being given.

The Committee on the Healing Arts, Professor Krever explained, is no longer in existence, as its report was submitted to the Ontario government, Tuesday April 28 — four days before Professor Krever addressed the RNAO meeting. The Committee was set up nearly four years ago by the premier of the province to study all aspects of the healing arts in Ontario.

RNAO Members Support CNF

Toronto. — The Canadian Nurses' Foundation became $520 richer in May, as members of the Registered Nurses' Association of Ontario gave it their enthusiastic support. Over 180 RNAO members became new members of CNF at the association's annual meeting April 30-May 2.

Any nurse can become a regular member of CNF — the only national organization in Canada that provides nursing scholarships for higher education and grants for nursing research — by paying an annual fee of $2. Business firms, corporations, and associations can also be sustaining members or patrons of CNF by paying the required fee for these categories. All donations are tax deductible. Cheques or money orders should be sent to: The Canadian Nurses' Foundation, 50 The Driveway, Ottawa 4, Ontario.

RNABC Urges Inquiry Into Health Care Financing

Vancouver, B.C. — The Registered Nurses' Association of British Columbia urged in April that a public inquiry be made into the financing of health care in British Columbia.

This was prompted by RNABC's concern about recent developments in the province's health care program, including an announcement by Ralph Loffmark, minister of health, that the provincial government will meet only 70 percent of salary increases awarded hospital employees since January 1.

RNABC pointed out that the eight percent increase approved in contracts signed by the B.C. Hospitals' Association and RNABC for this year is in line with increases granted by the provincial governement to its employees and by other groups.

RNABC said that although it supports present efforts to increase efficiency in hospital planning and service to curb rising costs, it deplores elimination of hospital personnel or reduction in the quality of service to the public as a means of cutting costs. The B.C. Hospitals' Association has estimated that proposed cost cutting measures would lead to elimination of approximately 1,200 positions in hospitals.

Correction

An error was made on page 41 of the May issue of *The Canadian Nurse*. The information given for Miss Kathleen G. DeMarsh, a candidate for vice-president of the Canadian Nurses' Association, should have read: Kathleen G. DeMarsh — Saskatoon City Hospital School of Nursing; diploma in teaching and supervision and B.A., University of Toronto; and M.Sc.N., University of Western Ontario.

Some Women Suffer "Utter Hell" With Premenstrual Tension, MD Tells OMA Convention

Ottawa — Almost all women between 35 and 45 years suffer some premenstrual tension for two or three days, some have it for five to seven days, and others go through two weeks of "utter hell," a Montreal gynecologist told an audience of physicians at the 90th annual meeting of the Ontario Medical Association, May 4 to 8.

Speaking at the session "Women and Their Curses," Dr. Robert A. Kinch, professor, department of obstetrics and gynecology, faculty of medicine, McGill University, described the woman with premenstrual syndrome as being irritable, depressed, and unable to sleep. He said she often had bowel problems, headaches, and weight gain, but frequently did not mention these problems to her physician. "But women *do* discuss these problems with each other over the bridge table," Dr. Kinch said, and this probably does them some good as they are able to get rid of their feelings."

Dr. Kinch advised physicians to be forward in asking their female patients if they had premenstrual problems. He said that the physician should look into the patient's emotional environment to find out if anything there is making the situation worse, and should listen closely to her complaints. Suggesting that premenstrual tension can be heightened by too much social activity, Dr. Kinch said he advises his patients to cut down on the amount of formal entertaining they do in their homes at this time.

Dr. Kinch told his physician audience that the edema found in women premenstrually responds well to diuretics.

Before the session, several women demanding freer abortion laws picketed the OMA registration area in the Château Laurier. One of their placards read: "Women's Curses are Conservative Doctors."

At Press Time...

Ottawa — A Canadian Press item in the May 13 issue of *The Globe and Mail* reports that the federal government plans to set up a program to train "doctor-assistants." The aim of the program, according to CP, is to graduate nurse practitioners who will be able to do many medical procedures now reserved for doctors. The program would be for nurses who work in remote departmental nursing stations.

The story says that the first apprenticeship group, probably 20 registered nurses, is expected to receive its special medical training at one or more universities. Preliminary talks have apparently taken place with McGill University and the universities of Toronto and Manitoba. The CP item quotes Dr. J.H. Wiebe, director general of medical services, department of national health and welfare, as saying that the target date for the first class is this fall. In a telephone interview with *The Canadian Nurse*, Dr. Wiebe said that the federally-employed nurses in the north assume considerable responsibility and should be given additional preparation. "We owe it to these nurses to provide them with exposure to the type of experience they will encounter," he said.

Dr. Wiebe believes these nurses should have "credit in all ways, including financially," for the work they do. With the additional training recommended, they would receive this credit, he suggested. Dr. Wiebe denied using the term "doctor-assistants" to describe the nurses who would receive this additional preparation.

When asked if the decision to establish this special program might set a precedent and encourage other agencies to prepare physician's assistants, Dr. Wiebe said, if this happened it would be a by-product and not intentional. □

names

Australian Visitor in Ottawa

Winnifred M. Ride, right Nursing Adviser to the Minister of Health in Australia, spent May 6 at CNA House. Speaking with her is Lillian Pettigrew, associate executive director of the Canadian Nurses' Association. On her three and one-half-month professional tour, Miss Ride visited Hong Kong, Geneva, Switzerland, Denmark, Sweden, Norway, Finland, England, and Scotland before visiting Canada and the United States.

Linda R. Long (R.N., Yorkton Union H., Yorkton, Sask.; B.N., McGill U.; M.N., U. of Washington, Seattle) has been appointed associate director of nursing service and director of staff development at Moose Jaw Union Hospital, Moose Jaw, Saskatchewan.

Miss Long has held a wide variety of nursing positions: general staff nurse at Regina Grey Nuns' Hospital; general staff nurse, head nurse, and assistant director of nursing at Yorkton Union Hospital, Yorkton, Saskatchewan; general staff nurse at the Montreal Neurological Institute; supervisor of chest surgery at Saskatoon Sanatorium; night supervisor at Galt Hospital in Lethbridge, Alberta; instructor and associate director of Yorkton Hospital school of nursing; director of Saskatoon City Hospital school of nursing; and adviser to schools of nursing, Saskatchewan Registered Nurses' Association.

Active on many SRNA committees, Miss Long has also served as chairman of the board of examiners, and as a consultant in continuing education programs. She was a member of the ad hoc committee on nursing education, the committee whose report resulted in the establishment of two-year diploma programs under the department of education, rather than in hospitals.

Dorothy J. Kergin has been named director of the school of nursing at McMaster University in Hamilton. She succeeds **Alma Reid**, who retires next month after 20 years as head of nursing education at McMaster.

Dr. Kergin (B.S.N., U. British Columbia; M.P.H., Ph.D., U. Michigan) has had varied experience in nursing service and education. She worked as a public health nurse with the health branch of the British Columbia government in Princeton, Kitimat, and Port Alberni; as nursing supervisor with the Aluminum Company of Canada in Kitimat, B.C.; and as a faculty member in the school of public health at the University of Michigan.

On her appointment as associate director of the school of nursing and associate professor of nursing at McMaster in 1968, Dr. Kergin took charge of public health nursing preparation in the bachelor of science in nursing course. She has also participated in the development of new programs in nursing education and research and in the administration of the school of nursing.

Dr. Kergin was a Canadian Nurses' Foundation fellow in 1966-67 and 1967-68.

Alma Reid (Reg. N., Toronto General H.; B.A., U. of Toronto; Dipl. Teaching, McGill U.; Cert. Teach. and Superv., U. of Toronto School of Nursing) was an instructor in nursing at Cornwall General Hospital, Cornwall, Ontario, and a lecturer in nursing at the University of Toronto and Yale U. before her appointment as director of McMaster's school of nursing.

In 1954 Miss Reid was awarded a travel fellowship by the W.K. Kellogg Foundation, and in 1955 she was elected president of the Registered Nurses' Association of Ontario.

Virginia Henderson (R.N., Army School of Nursing, Washington, D.C.; B.S. and M.A., Teachers College, Columbia U., New York) has received an honorary Doctor of Laws degree from The University of Western Ontario in London.

Dr. Henderson is known internationally for her many achievements in nursing. She is the author of a number of important books and pamphlets, and has contributed numerous articles to nursing periodicals. Her *Textbook of the Principles and Practice of Nursing*, which she and a Canadian nurse — Bertha Harmer — wrote, is considered "The Bible" for schools of nursing.

Currently research associate and director of the Nursing Studies Index program in the School of Nursing at Yale University, New Haven, Connecticut, Dr. Henderson was formerly

an instructor and associate professor of nursing education at Teachers College, Columbia University; clinical director at Norfolk Protestant Hospital School of Nursing in Rochester, New York; instructor and educational director at Norfolk Protestant Hospital School of Nursing in Norfolk, Virginia; and a staff nurse with the Visiting Nurse Associations in New York City and Washington, D.C.

At the request of The University of Western Ontario 20 years ago, Dr. Henderson became involved in the development of nursing education at Western. She has since been involved in many workshops in southwestern Ontario, at Victoria and Westminster Hospitals in London and at Western.

M. Helena McMillan (B.A., McGill; R.N., Illinois Training School for Nursing, Chicago) died January 28 in Boulder, Colorado. She was 101.

A well-known nurse in both Canada and the United States, Miss McMillan was lady superintendent of the Kingston General Hospital, Kingston, Ontario, for three years. She was principal, superintendent nurse, and matron of Lakeside Hospital in Cleveland, Ohio, where she organized the hospital's school of nursing — now the Frances Payne Bolton School of Nursing at Case Western Reserve University. In 1903 she founded the Presbyterian Hospital School of Nursing in Chicago.

At the American Nurses' Association convention in 1936, Miss McMillan was awarded the Walter Burns Saunders Memorial Medal for "distinguished service in the cause of nursing." The ANA members were told: "From the beginning of her work Miss McMillan had the concept of the school of nursing as an educational institution rather than as a hospital service."

Adele Herwitz (R.N., Beth Israel H., Boston, Mass.; B.S. and M.A., Teachers College, Colombia U.) has left the position of associate executive director of the American Nurses' Association to take a six-month appointment as executive director of the International Council of Nurses in Geneva, Switzerland. She succeeds Sheila Quinn of the United Kingdom who resigned to take a position in England.

Miss Herwitz has been active in the ICN since 1958. In 1960 she served on a special ICN economic welfare committee, and has been economic correspondent to the ICN from the United States. In 1969 she was reelected to a four-year term on ICN's professional services committee.

A former director of the ANA economic security program, Miss Herwitz has held the positions of head nurse at Beth Israel Hospital in Boston; general duty nurse at Veterans Hospital and medical supervisor of Sydenham Hospital in New York City; and captain in the Army Nurse Corps, serving in the South Pacific during World War II.

Susan McCallum

Patricia Parker

Several new instructors have joined the faculty of nursing at The University of Western Ontario.

Susan McCallum (Reg.N., The Hospital for Sick Children, Toronto; B.N., McGill) has been appointed instructor in the faculty of nursing, The University of Western Ontario.

Mrs. McCallum worked as a staff nurse in emergency and in public health nursing for three years.

Patricia Parker (B.Sc.N., U. of Toronto), a new nursing instructor at The University of Western Ontario, has experience in general hospital psychiatric nursing and public health nursing in the Lambton Health Unit in Sarnia, Ontario.

Janet Pfisterer (B.Sc.N., The University of Western Ontario) is also a new instructor in The University of Western Ontario's faculty of nursing. Mrs. Pfisterer was formerly an assistant head nurse at New Mount Sinai Hospital in Toronto, and worked with the Victorian Order of Nurses in London, Ontario.

Dorothy Rowles (R.N., St. Paul's H., Saskatoon, Sask.; B.N., McGill U.; M.A., U. of Toronto) has left the position of chairman of the nursing department at Ryerson Polytechnical Institute in Toronto to become executive assistant to the vice-president, academic, at Ryerson. In her new position, Miss Rowles will devote more time to the development of educational changes throughout the institute.

Miss Rowles has worked as a matron of two community hospitals in Saskatchewan, lecturer in nursing at McGill University, and inspector of schools of nursing with the nursing branch of the Ontario Department of Health. While studying for her master of arts degree, she undertook a study, "The Ryerson Project," for the Registered Nurses' Association of Ontario. After completing her degree, she was appointed instructor-supervisor of nursing at Ryerson.

names

R. Roslyn Klaiman (R.N., Jewish General H., Montreal; B.N., McGill U.; M.A., New York U.), has been named chairman of the nursing department at Ryerson Polytechnical Institute in Toronto.

Miss Klaiman worked at the Jewish General Hospital School of Nursing in Montreal from 1959 until she joined the staff at Ryerson in 1965 as an instructor.

At the Jewish General and Ryerson she was particularly interested in programmed instruction and in new teaching techniques.

Floris E. King (Reg.N., Toronto East General H.; B.Sc.N., U. of Toronto; M.P.H., U. of Michigan; Ph.D., U. of North Carolina) has been awarded a federal health research grant of $14,870. She will use this grant to study the utilization of the nurse prepared at the postgraduate level, and relate this to the adequacy of the nurse's educational preparation.

In 1968, Dr. King joined the faculty of the University of British Columbia's School of Nursing, where she coordinated the school's master's program. Prior to this, she was program director and nursing consultant for the Canadian Tuberculosis Association.

Dorothy Dick (R.N., Royal Victoria H., Montreal; cert. P.H.N., McGill; B.Sc. and M.A., Teachers College, Columbia U.) has been appointed supervisor of the Planned Nursing Program of the Health Services at Red River Community College, St. James-Assiniboia, Manitoba.

From 1964 until her recent appointment, Miss Dick was director of nursing education at Victoria General Hospital in Winnipeg. In addition to general duty experience at the Royal Victoria Hospital in Montreal and The winnipeg General Hospital, she was a staff nurse with the Winnipeg City Health Department, an instructor in the University of Manitoba's School of Nursing, and for six years was clinical coordinator at The Winnipeg General Hospital.

Miss Dick is president of the Manitoba Association of Registered Nurses, and a member of the board of directors, Canadian Nurses' Association.

Next Month
in

The
Canadian
Nurse

- Teachers — You're Trespassing!
- The Charge — Negligence
- New Product Evaluation in Hospital

Photo Credits for June 1970

Photo Features, Ottawa, pp. 7, 8, 14

Dept. National Health & Welfare, Ottawa, p. 8

Jarvis Studios, Halifax, N.S., p. 9

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Roy P. Strable, Photographer, Ottawa, p. 21

Tom Boschler Photography, Hamilton, Ont., p. 30

Terry Pearce, pp. 26-29

dates

June 15-19, 1970
Canadian Nurses' Association General Meeting, The Playhouse, Fredericton, New Brunswick.

June 17-20, 1970
20th annual meeting of the Canadian Psychiatric Association, Winnipeg. For information, write to: The secretary, Canadian Psychiatric Association, 225 Lisgar St., Suite 103, Ottawa 4.

June 22-July 3, 1970
Conference on administration for general duty staff nurses, Memorial University of Newfoundland. Registration fee: $10. For further information write to the AARN, 67 LeMarchant Rd., St. John's, Nfld.

June 22-July 3, 1970
Seminar for senior nursing executives, sponsored by the faculty of nursing, The University of Western Ontario London. Enrollment limited to 75. Course fee: $150; with residence: $300.

July 6-10, 1970
Canadian Home Economics Association, and Canadian Dietetic Association second joint convention, King Edward Sheraton Hotel, Toronto. Pre-convention workshop at Glendon College, July 2-4. Educational tours and post-convention conference, sponsored by the College of Education, University of Toronto, are also offered. Write to Elizabeth Thompson, CHEA and CDA Convention Publicity, 154 University Avenue, Toronto 1, Ontario.

July 18-22, 1970
Annual meeting of the Canadian Pediatric Society, Fort Garry Hotel, Winnipeg. Write to: Dr. V. Marchessault, executive secretary, Canadian Pediatric Society, Department of Pediatrics, University Hospital Centre, University of Sherbrooke, Sherbrooke, Quebec.

August 2-7, 1970
Congress of the International Association for Child Psychiatry, Jerusalem, Israel. Theme: The Child in his Family. Details on group air fare and travel programs are available from Dominion Travel Office Ltd., 55 Wellington St. West, Toronto 1, Ontario.

August 24-28, 1970
Workshop for library staff in nursing, hospital, and medical libraries, sponsored by the OMA, OHA, and RNAO, Wilson Hall, New College, University of Toronto. Topics to be discussed include administration of a library, collection development, organization of library materials, and library services. Applications are available from: Miss S.C. Maxwell, Librarian, Ontario Medical Association, 244 St. George Street, Toronto 5, Ontario.

September 1970
14th annual conference on personal growth and group achievement, sponsored by the Registered Nurses' Association of Ontario. Write to: Professional Development Department, RNAO, 33 Price Street, Toronto 5, Ontario.

September 10-12, 1970
Convention of the Canadian Society of Extracorporeal Circulation Technicians and the Ontario Dialysis Association, Park Plaza Hotel, Toronto. More information can be obtained from Mrs. Nancy Reid, Chairman, Convention Committee, Ontario Dialysis Association, Sunnybrook Hospital, 2075 Bayview Ave., Toronto 12, Ontario.

September 14, 1970
American Academy of Medical Administrators, 13th annual convocation, luncheon and reception, Hotel Sonesta, Houston, Texas, U.S.A. Write to: American Academy of Medical Administrators, 6 Beacon Street, Boston, Mass., 02108.

September 28-October 9, 1970
Symposium in respiratory disease and tuberculosis nursing, Winnipeg. Organized by Miss E.L.M. Thorpe, Chairman, Ad Hoc Steering Committee, nurses' section of the Canadian Tuberculosis and Respiratory Disease Association. For further information write to Miss Thorpe, Consultant, Sanitorium Board of Manitoba, 800 Sherbrook Street, Winnipeg 2, Manitoba.

October 7-10, 1970
Annual conference, Canadian Association for the Mentally Retarded, Hotel Vancouver, Vancouver, British Columbia. Special emphasis will be on the preschool child, residential services, and occupational-vocational programs.

October 26-28, 1970
Annual meeting of the Association of Registered Nurses of Newfoundland, St. John's. Write to the AARN, 67 Le Marchant Rd., St. John's, Nfld. □

in a capsule

Catchy heads

How often have you read an article in a newspaper or magazine because of an unusual headline – one that raised a provocative question, made you chuckle, or baffled you? Your curiosity was aroused, so you had to read on.

This is the art of headline-writing. For example, the following newspaper "head" caught our attention: "Canadian Medical Brains Stay Home." *What* does that mean? It's obvious, of course – Canada is now losing less medical brainpower to the United States – but not until *after* you read the first paragraph. And once you get that far, chances are that you'll keep going. The originality for this particular head came from the *Sault Ste. Marie Star*, Sault Ste-Marie, Ontario.

Then we came across this headline: "You'll join STOP THAT after you have read this." In case you don't know what STOP THAT stands for, it's the Society to Stop Proliferating Those Horrible Acronymic Titles. According to an article in the March 7 issue of *Editor & Publisher*, a New York newspaper reader, fed up with seeing long names condensed into capsule terms, attempted to STOP THAT popular practice.

The next time you're mystified by a CNJ, CP, ETC CAP-tion, take the *Editor & Publisher*'s advice and resign yourselves to becoming ACORNS – Acronym-Oriented Nuts.

Females driven home

The problem of night safety for nurses was examined in an article in the February issue of *The Canadian Nurse*.

This question has since received attention in newspapers. The *Gazette* asked: "Ladies, do you know what you should do to walk in safety on streets at night?" This story gives young women a Montreal police sergeant's advice on safe travel at night.

One of the suggestions was "Stay on well-traveled, well-lit streets, walking near the curb..." And another: "Take a good look for loiterers before entering a poorly-lit street." Ladies were also advised not to "go to cocktail lounges alone at night, and to refuse the overtures of the over-friendly man."

Progress is being made to give women much-needed protection at night. The Alberta cabinet has passed regulations, effective June 1, that require Alberta employers to provide transportation to and from home for female employees who must leave or go to work between midnight and 6:00 a.m.

It is good to see that governments, as well as female employees, are aware of the dangers of loitering in the dark.

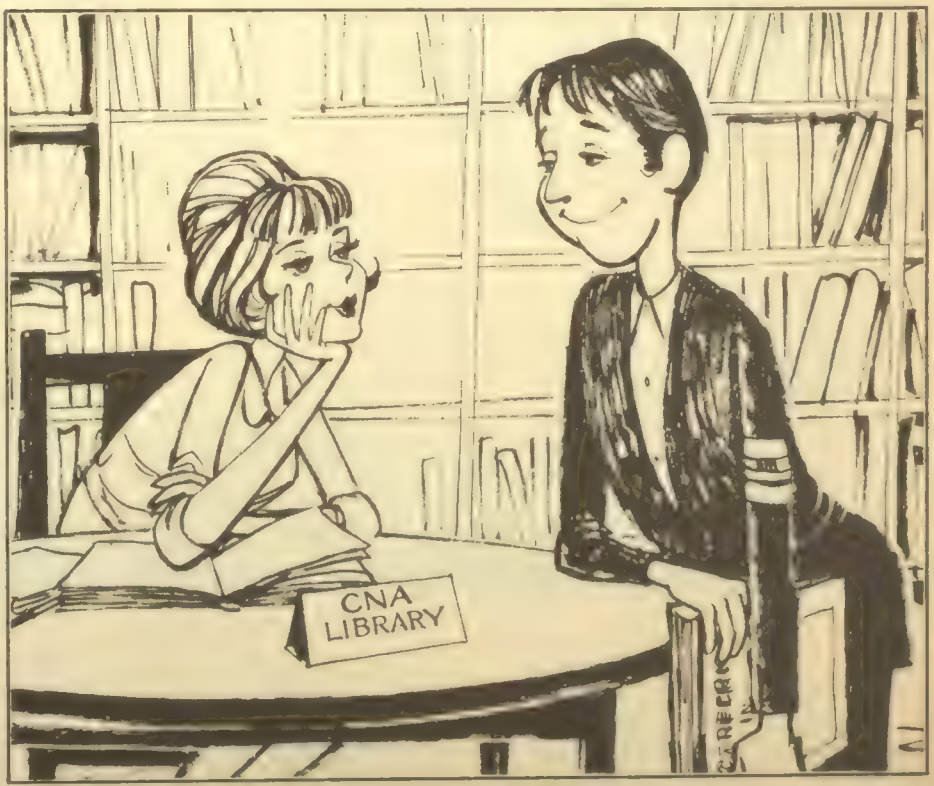
Don't overdo it

These days you don't have to look very far to find advice on how *not* to get heart disease. Of course, the chances are good that you might have to give up your favorite foods, trade in your car for a bicycle, and leave your job and head for the nearest uncivilized island — if you want to remain hearty.

Although much of this advice comes from doctors, the doctors themselves talk as though they don't necessarily want to follow it. For example, a *Globe and Mail* news item quotes Dr. R.L. MacMillan of Toronto saying that he would give "a couple of years for a good bordelaise sauce and steak."

Then there was The Canadian Press report of a talk by Dr. Richard Bates from Lansing, Michigan. He told the Canadian Club in Toronto: "It profits a man very little . . . if he has never felt the soft glow of drunkeness, the joy of an after-dinner cigaret, the pleasures of illicit love."

Even if a person drank in moderation or not at all, did not smoke, exercised 20 minutes a day, got regular medical checkups, and had normal blood pressure and low blood cholesterol, his chances of reaching 100 would only be 1 in 100,000, Dr. Bates said. And he added: "I'm not going to try it. Once you're that old all the joys are gone. After 40, half your taste buds are gone. Peanut butter tastes like library paste."



"My Area of Interest Is . . ."

Never let it be said that everyone who visits the library of the Canadian Nurses' Association is interested *only* in books. As proven by the library register, romance can rival reading in this library.

One nursing student and her boyfriend, who spent their time in the library looking at each other *over* their books, signed their "area of interest" in the register as "my boyfriend" and "my girlfriend." And we thought the only dates the librarian saw were on overdue books!

Pinworms may spread in any family, at any time. Usually a single dose of VANQUIN is effective for eradication of pinworms.

Therapy is well tolerated, economical, and convenient. VANQUIN Suspension or VANQUIN Tablets provide a convenient dosage form to administer to patients of virtually every age...from grandchild to grandmother.

Dosage: Children and adults, a single oral dose equivalent to 5 mg. per Kg. body weight. This is approximately equivalent to one 5-cc. teaspoonful of VANQUIN Suspension or one VANQUIN Tablet for each 22 pounds of body weight.

Precautions: Tablets should be swallowed whole to avoid staining teeth. Pyrvinium pamoate will stain most materials. Stools may be coloured red.

Side Effects: Infrequent nausea and vomiting and intestinal complaints have been reported.

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VANQUIN Suspension contains the pamoate equivalent of 10 mg. pyrvinium base per cc. Each VANQUIN Tablet contains the pamoate equivalent of 50 mg. pyrvinium base. Detailed prescribing information available on request.

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Let's have permanent shifts

Nursing administrators should allow nurses to work only one shift rather than having them rotate through all three shifts. The permanent shift has administrative advantages, advantages for the nurse and, most important, it has advantages for the patient.

Helen Saunders, B.A., B.A.Sc. (Nursing), M.N.

The ratio of acutely-ill patients to the less ill on each nursing unit continues to rise in general hospitals. Nursing care is becoming increasingly complex and demands more specialized skills. To provide this skilled nursing care, hospital staffing policies and practices need to be reassessed.

I submit that staff on permanent shift, as opposed to continual rotation to all shifts, is one policy that would improve the health and job satisfaction of the hospital general duty nurse, increase stability and efficiency in nursing administration, and make possible a more consistent level of patient safety and care on all shifts.

The term "permanent shift" may not convey the same meaning to all. In this article it means that a person is employed to work on the shift of her choice – steadily, without rotation to the other two shifts.

Permanency of shift should be tempered, however, with common sense. For example, a new nurse should be required to have a thorough orientation to the hospital and the nursing service unit on which she will work. This should be given on whatever shift it can be given best.

Miss Saunders, a graduate of The Vancouver General Hospital, the University of British Columbia, and the University of Washington, is presently Inservice Education Supervisor at the Royal Jubilee Hospital, Victoria, B.C.

As well, each nurse should be assigned to the other two shifts for about one week every six months. This would keep her aware of the 24-hour care given in her unit, of the differences and similarities in the pace of work, and the administrative problems of the staff on each shift.

With these two conditions realized, permanent shift offers nothing but advantages.

Advantages for the nurse

Permanent shift can have social, educational, psychological, and health advantages for the nurse.

To begin, the nurse would be able to choose the shift that best fits her personal and family life. She would be able to take part in sports groups or teams, hobby groups, community organizations, church activities, professional association work – in fact, in all social activities that require fairly constant attendance to maintain active membership. It is impossible to keep up many social activities while on a continually rotating shift.

For nurses who are also mothers, baby-sitting arrangements could be stable and would not have to be constantly rearranged every few weeks, sometimes on an irregular basis. Permanent shift would not only simplify the baby-sitting problem for parents, but also would surely benefit the children.

For nurses who wish to continue their education while working, permanent shift

makes it possible for them to take courses. The day nurse can sign up for an evening course, the evening or night nurse can take day courses. No one can take any course – and attend all classes – if she is perpetually rotating shifts.

Even on-the-job inservice education courses tend to be less effective when each class in a series is attended by different individuals because of shift rotation.

Permanent shift also offers psychological advantages by giving each nurse a feeling of belonging to an area of responsibility that is hers. Rotating shifts cannot do this, any more than assigning a nurse to "float" to all units can give her a sense of belonging.

Some nurses are psychologically suited to one shift more than to another. They are happier, feel better, and work better on a shift that suits them. And it isn't always the day shift that is preferred.

Evening and night shifts appeal to some nurses, at least for a while, for the opportunities they offer for added responsibility, exercise of initiative, and professional growth.

Research on the physiological effects of continual adaptation to different hours for sleeping, eating, and peak mental and physical activity in a 24-hour period show damage to health.

A basic rule of health is: maintain regular hours for sleeping and eating. Although working and eating by day and sleeping at night is the pattern most people follow, studies show we can adapt to other patterns, without harm, provided we are given the time needed to adapt and provided the new patterns are constant.

Advantages to administration

Supervision of nursing service and administration of the hospital on evening and night shifts would be easier with staff on permanent shift. Permanent shift staff would gain the knowledge and experience needed to ease the burden of supervision of the evening and night supervisors. A permanent evening or night nurse on a unit can gradually assume a great deal of responsibility for patient care and she will also know more of the administrative problems of her shift and how to handle them.

Because she can develop her own organizational plan, the permanent shift nurse will become the master rather than the slave of routines and thus can spend more time in patient care. The nurse on a rotating shift, on the other hand, will find herself needing time to readjust to routines and will have little authority to work out her own plan for patient care on her brief shift assignments.

Permanent shifts would obviate the need to put a new staff member on the evening or night shifts within a few days of her arrival on the unit to fill a vacancy in the shift rotation. On many units, shift rotation becomes as inexorable as death or taxes.

An objection sometimes raised to permanent shift concerns the problem that head nurses would have in trying to evaluate performance of permanent evening and night staff. The answer to this objection is that it is easier for evening and night supervisors to know the staff on their shifts as individuals and to judge the quality of care given when the nurses are on permanent, rather than rotating, shift.

Alternatively, it would be good for patient care as well as staff evaluation if the day supervisor or the head nurse of the unit occasionally worked an evening or night shift. This would give her the opportunity to assess the nursing performance and care given on these shifts.

Surely evaluation by the above two methods is more valid than that of a head nurse assessing the evening and night performance of a rotating staff based on her knowledge of how the individual functions on days!

Success of team nursing depends to some extent on how a group works together as a team. One of the greatest obstacles to team spirit and efficiency is a constant change of team members and team leaders. Mandatory rotation of staff obviously compounds this problem.

On day shift, patients on a unit usually are divided under several team leaders, and one team may not know the patients of another team. When the team member moves to another shift where she is required to know all the patients, the problem is made worse.

Advantages to the patient

Permanent shift also enhances continuity of patient care. When shifts constantly rotate, no nurse is responsible for a patient on any one shift for longer than a few days at a time. This situation confuses and upsets patients and relatives, infuriates doctors, and is most frustrating to nurses.

Patients – and their relatives – like to get to know their nurses, to have, for example, the security of knowing who will come if they wake up at 3:00 a.m.

Permanent shift would help to lessen the number of complaints that "I never know who my nurse is."

Every hospital wants to provide a safe level of care for patients on all shifts, but do we do this? To rotate all general duty nurses in turn to take charge on evening and night shifts – regardless of their experience or their own need for guidance and teaching – does not assure a safe level of care on these shifts.

Some hospitals with schools of nursing still rotate students to take charge on evening and night shifts. The time-honored nursing myth militates against changing this pattern because "this is the best way to learn how to take responsibility."

Even if there is truth in this belief, what about the safety of the patient during this supposed learning process? What about the patient's side of the question when there is continual rotation of nurses, each "learning the hard way"?

If students must go on the night shift to learn, then even one experienced, permanent shift nurse in charge would ensure greater safety to patients and still allow for increased responsibility, with guidance, for students or inexperienced graduates.

Staff on permanent shift would have to understand that in emergencies they might be called to replace another nurse on another shift. However, if this were for only one or two shifts or until regular relief could be employed, most nurses would be willing to accommodate the needs of the unit.

Any nurse wishing to change from the shift for which she was employed could ask for a transfer, just as she might ask for a transfer from one nursing unit to another.

But at least she would have the opportunity to benefit from the advantages of permanent shift. And so would her patients. □

Prinzmetal's variant angina in a coronary unit

Early recognition of this abnormality by nurses in a coronary unit can lead to appropriate treatment and a lowering of the mortality rate in acute coronary disease.

Sharon Dolman, Cynthia Paget, and Jean Walkden

In 1959 Printzmetal described a variant form of angina.[1] This consists of cardiac ischemic pain that occurs at rest and is accompanied by an elevation of the S-T segment of the electrocardiogram, rather than a depression of the S-T segment, which usually accompanies cardiac ischemic pain. Changes in the electrocardiogram that he described were frequently confused with those of acute myocardial infarction, but between the attacks the electrocardiogram returned completely to normal.

Because of the transient nature of the changes, such patients are hard to recognize. With the availability of continuous monitoring in coronary units, the disorder may be recognized more easily as shown in the following patient history. The tracing obtained on the monitor approximates Lead I.

Patient history

A 46-year-old man who had previously been well came to the emergency department of the Toronto General Hospital following three episodes of severe squeezing pain in the anterior part of the chest. The pain had radiated to the neck, jaw, and left ear. The attacks were similar in severity, each had occurred while the patient was at rest, and had subsided spontaneously after 5 to 10 minutes.

The pain was associated with sweating, but there was no shortness of breath. These attacks had occurred approximately two days apart the week preceding admission.

There was no significant family history of heart disease. The patient had smoked 15 to 20 cigarettes a day for 25 years.

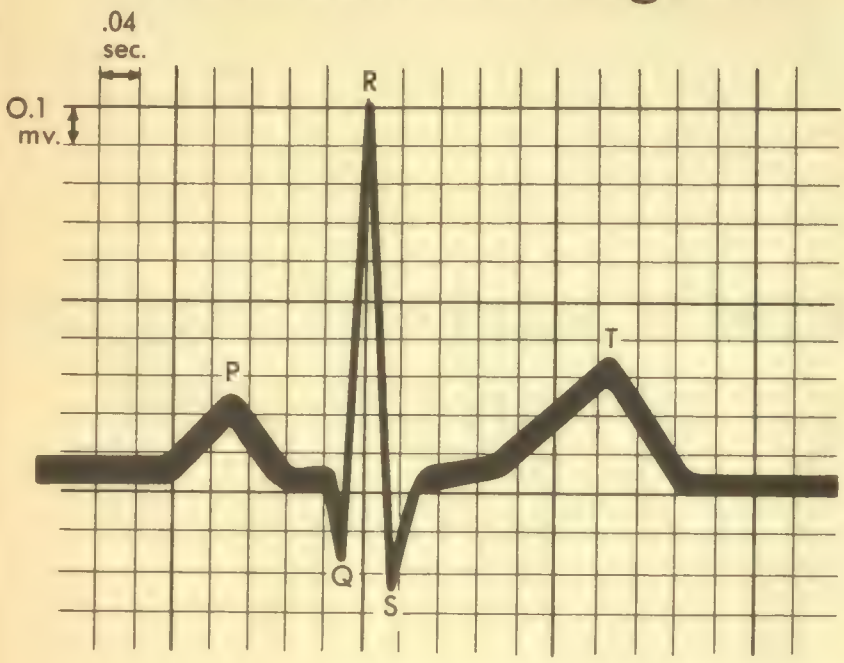
On examination, the blood pressure was 170/105 and there were no other abnormal physical findings. The first electrocardiogram, taken a few minutes after the third attack of pain had subsided, showed elevation of the S-T segments in leads II, III, and aVF.* The T wave in lead I was flat. The diagnosis was considered to be acute posterior myocardial infarction and the patient was transferred to the coronary unit.

The next electrocardiogram, taken 11 hours after admission, showed a return of the S-T segments to the baseline with a negative T wave in leads I and aVL.

Mrs. Walkden is Head Nurse of the Coronary Unit, Toronto General Hospital. Mrs. Dolman and Mrs. Paget are former staff members of the Unit. The authors express their appreciation to Dr. R.L. MacMillan and Dr. K.W.G. Brown, Directors of the Coronary Unit, for assistance in producing this article.

*The following designations are used for augmented unipolar leads: aVF – when the positive terminal of the electrocardiograph is connected to the left foot; aVR – when the positive terminal is connected to the right arm; and aVL – when the positive terminal is connected to the left arm.

The Electrocardiogram



Normal electrocardiogram tracing

During each contraction of the heart, a pattern of electrical activity, known as the electrocardiogram (ECG) can be recorded. The letters P,Q,R,S, and T are used to denote the different waves that make a single heart beat. It is the spread of the electrical impulse to different parts of the heart muscle that produces the characteristic wave form of the healthy heart.

The P wave is the first deflection in the tracing and is due to the spread of electrical activity throughout the atria. It is followed by the QRS complex caused by excitation of the ventricles. The T wave reflects recovery of the ventricular muscle following stimulation. The (R-T) or S-T segment begins at the end of the S wave and runs along the baseline until the beginning of the T wave. Characteristically this segment is depressed below the baseline if the blood supply to the heart muscle becomes temporarily inadequate, for example, in an individual during the pain of angina pectoris.

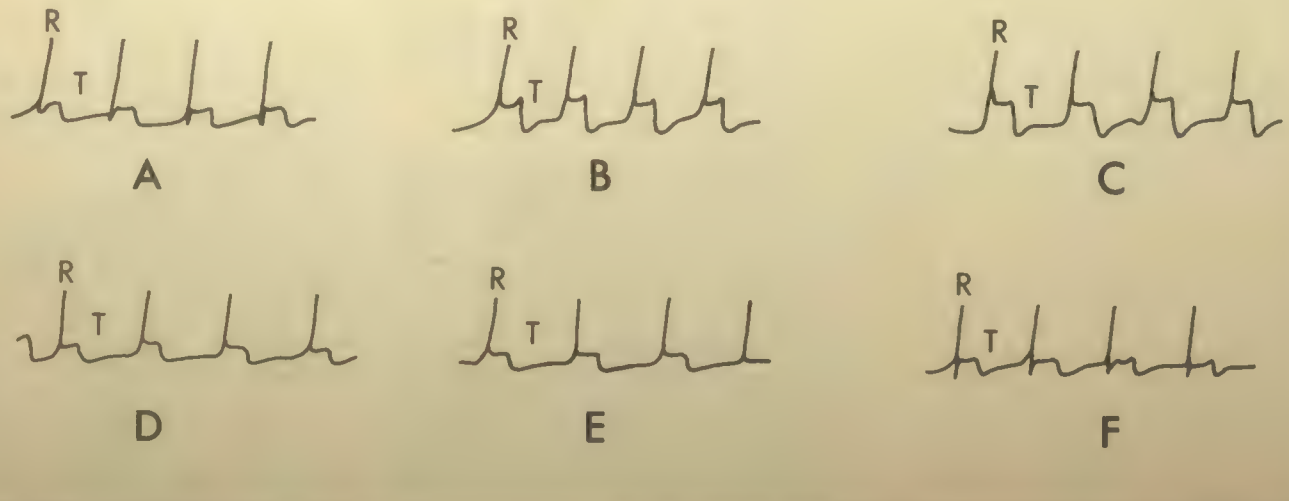


Figure 1. Segments of monitor record taken at intervals of two minutes. Elevation of R-T Segment shown in B preceded chest pain, which did not occur until C (2 minutes later). Maximum pain occurred 4 minutes after onset of ECG changes. E and F show return of R-T segments to normal, as pain subsided.

Shortly after this another attack of pain occurred, accompanied by elevation of the S-T segments on the monitor tracing. The changes subsided with the disappearance of pain.

On the monitor, three more transient elevations of the S-T segments occurred during the next 12 hours. The first occurred during sleep and lasted only three minutes. The patient did not wake up. During the second episode, the patient was awake. The S-T segments became elevated one minute before the patient experienced pain *(Figure 1)*. This time the elevation persisted for five minutes and again returned to normal.

Twenty-four hours after admission, the S-T segments again became elevated while the patient was sleeping fitfully. When he awoke, he complained of slight pressure in his chest. The discomfort persisted over the next four hours, culminating in a very severe, crushing type of pain that required morphine gr. 1/6 on two occasions for relief.

When the pain subsided, The S-T segments again returned to normal. Frequent ventricular premature beats were noted on the monitor record and an anti-arrhythmic agent, procainamide hydrochloride 500 mg., was given by intramuscular injection.

The next day, his third in hospital, the patient remained comfortable. The day following, however, a short burst of ventricular tachycardia occurred for 15 minutes, accompanied by more chest pain that again required morphine. This time the T waves were inverted in leads I, aVF, V_2-V_5.** These changes persisted and the diagnosis of anterior myocardial infarction was made.

One week later, signs of mild left ventricular failure developed with rales being heard over the lung bases. These changes disappeared following an injection of Thiomerin (a mercurial diuretic) and daily dose of Lasix (a diuretic). Q waves appeared in leads I, aVL, V_3-V_5. The remainder of the convalescence was uneventful and the patient was discharged home four weeks after admission.

**V_1 to V_6, the precordial leads, designate the six standard positions on the chest where the ECG leads are placed.

Discussion

Eleven days after the onset of transient attacks of cardiac ischemic pain, this patient developed a proven anterior myocardial infarct. Following admission to the coronary unit, continuous monitoring enabled the staff to determine that the patient was suffering from Printzmetal's variant angina. It would have been difficult to make such a diagnosis in an ordinary hospital setting.

The electrocardiogram reverted to normal shortly after each attack. As the staff realized that Prinzmetal's angina may herald the development of an established infarct, they watched the patient carefully and gave him intensive nursing care.

Transient elevation of the S-T segment occurred during sleep; the pain was not sufficient to wake the patient. On another occasion the electrocardiographic changes preceded the onset of pain. This has been previously reported.[2]

Following the development of a proven myocardial infarct, ventricular irritability was noted on the monitor record with a short burst of ventricular tachycardia. This was promptly treated with procainamide hydrochloride. Mild signs of heart failure also appeared and were recognized promptly. Diuretic therapy produced a good response.

Summary

Continuous monitoring of a patient with repeated episodes of chest pain revealed transient elevations of the S-T segments on the electrocardiogram and enabled the nursing staff to assist in the diagnosis of variant angina. The electrocardiographic changes may precede the onset of pain.

The recognition of this abnormality reflects the close nursing supervision available to patients in a coronary unit. Appropriate treatment may contribute to a lowering of the high early mortality in patients with the symptoms of acute coronary disease.

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Nurse on James Bay

Terry Pearce

Once a week, nurse Nancy Leach travels with her guide-interpreter, John Nakogee, from Port Albany on the west coast of James Bay up the Albany River to the small Indian village of Kasheshewan.
The first call is "Halfway Place," where about four Indian families live in a small clearing beside the river.

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Miss Leach gives members of a family a medical check, then talks through John Nakogee about beaver skins and the weather.

She spends time with Maggie Nishinapay, takes her temperature and blood pressure, and promises to call on the way back with pills from the clinic at Kasheshewan.

At Kasheshewan, the busy clinic is in one room of the small school. The patients are mothers, children, elderly men. She weighs and checks the babies . . .

diagnoses an ailment with the help of her interpreter . . .
writes a last-minute prescription for an ill wife. For the next six days she leaves the clinic in charge of a missionary lay dispenser.

Needed: a positive approach to the mentally retarded

Negative attitudes of hopelessness and helplessness influence the social climate and the experiential world of the retarded child. Nursing and medical personnel can help to dispel these negative attitudes and replace them with positive, constructive attitudes that will help both child and family.

Karin C. von Schilling, B.Sc.N., M.S.

In our success-oriented culture, high value is placed on intellectual achievement. Signs of mental deficiency in a child invariably elicit feelings of disappointment, hopelessness, and helplessness.

These negative feelings, likely to be most disturbing to the affected family during the initial adjustment period, are reflected in society's attitudes toward the mentally retarded; in too many instances they are also reflected in the attitudes of medical and nursing personnel.

Why this negative attitude on the part of professional health workers? Probably because present-day medical technology has no "cure" for mental deficiency and it is therefore regarded as hopeless.

Parents of a child born with a *physical* defect, such as clubbed feet or hare-lip, receive some comfort in knowing that the defect can be repaired in the future and the child will eventually be normal. But what comfort is or can be offered to parents who have a child with an "incurable" mental defect?

Medical-nursing support needed

When defects in a child are discovered, medical-nursing efforts must be directed toward improving transactions and interactions during the initial traumatic experience. This is necessary either in the maternity unit, when the child is born with a recognizable defect, or later, when a diagnosis of mental retardation is established.

During the birth process, the mother is likely to be acutely aware of verbal and non-verbal communication around her. As soon as the child is born she expects to be informed of its sex and that "the baby is all right."

If such assurance is not forthcoming immediately, the mother is often haunted by fears of gross abnormality or even death of the baby. She may seek information from the attending nurse.

Nurses feel uncomfortable when confronted with a fearful mother's questions, and in such situations often respond by avoiding contact and interactions with her. Yet the situation calls for purposeful, supportive action to help alleviate the stresses of uncertainty and to help the mother perceive and deal with reality.

The major principle for the nurse's actions is honesty – and tact – about her own feelings, about her knowledge or lack of it, and about what is done around the baby. This is not the time for elaborate explanations or speculations. Simple, honest answers are apt to be most helpful in conveying a caring attitude, a willingness to stand by, and a trust in all members of the medical team.

Miss von Schilling, a graduate of the University of Toronto and the University of California, San Francisco, is Assistant Professor at McMaster University School of Nursing in Hamilton, Ontario. She is the author of another article on the birth of a defective child, published in *Nursing Forum*, Vol. V11, no.4, in 1968.

When the mother poses the frantic question "What's wrong with my baby? " the nurse, if she does not have detailed information but is aware of a concern for the baby's condition, can reply: "Well now, I don't know, but as soon as one of the doctors is free we'll ask him over to tell us. I'll stay with you."

It is rather obvious that the frequently offered reply of "Just relax! Your baby will be fine," is one of denial and avoidance and is apt to increase, rather than alleviate, anxiety.

Parents need each other

Parents should be together when they learn about their baby's abnormality so their feelings and reactions can be shared from the beginning. Together, parents can resort to established ways of comforting and strengthening one another.

There appear to be few indications for withholding the baby from his parents. Any mother wishes to see and hold her baby as soon as possible after delivery to establish the reality of his existence and his intactness as a human being. Parents of a baby with a defect also need to see the child so they can take hold of reality and dispel some of their imagined fears.

Explaining a defect such as Down's syndrome does not mean much to parents who have a limited repertoire of medical terminology and whose minds are clouded with anxiety under the initial impact of the bad news. When they see their child they are often surprised that he looks and behaves much like any other newborn.

After seeing and holding their mongoloid offspring, some mothers decide against giving them up even if their doctor does suggest institutionalization. Nurses in the delivery room and on the maternity ward should use every opportunity to help parents view and hold their child, as this seems to be an important step in fostering a mutually rewarding parent-child relationship. Such a relationship offers the child a basis for the security and trust that is so essential for his growth and development.

Hospital nurses can help

Nurses are in an opportune position to offer meaningful support when parents cope with their initial grief, frustration, anxiety, and guilt.[1] Parents may need encouragement in expressing their sorrow about the child's condition, and nurses can encourage and support the grieving process, which may take many forms. Recognizing and accepting that the parents need to cry, express hostility, or be quiet and withdrawn, is not easy for the nurse who finds such situations stressful and uncomfortable.

But the nurse can learn to acknowledge perceived behavior and say, "It's all right to cry," or, "It is difficult when so many questions have no answer; it must make you feel frustrated and angry," or, "You have been so quiet. Is something bothering you? "

By allowing expression of feelings, nurses help parents voice their concerns and talk about the problem. They need to explore such questions as, "What did I do wrong? " or "Why did this happen to us? " A nurse cannot provide answers, but by listening she encourages parents to look at the situation and to begin to anticipate ways of coping.

After helping parents with their initial reactions, the nurse can assist them to become more comfortable in caring for the baby. They need to become acquainted with his individual characteristics and his need for comfort and love, regardless of his congenital defect.

All too often mothers tell a story of how the baby was brought in and placed on the bed, of how they were left alone to feed him, not knowing what to expect or what to do, and of how they were afraid of their own feelings of anger toward this child who was causing so much upset and confusion. Parents need to learn to care for their child under the guidance of a nurse or a knowledgeable, caring individual. This allows them to gain confidence and feel capable of offering comfort and care to the baby.

By talking to the baby or commenting on his attributes and responses, the nurse can help the parents see him as a person, not as a congenital anomaly. Her presence when the mother is feeding the baby offers opportunities for questions about the child's condition and what it might mean to the family and the child.

The type of questions asked will alert the nurse of a need to clarify or a need to consult other members of the team so that available resources can be explored and mobilized. A sense of success and satisfaction gained from the first child care experiences appear significant in helping parents gain hope and confidence in their own ability to care for the baby.

Community nurses help at home

Before mother and baby are discharged from hospital, steps can be taken to initiate referral to a district nurse, the local association for mentally retarded, or other available community services that might help. Some hospitals notify the public health agency when a discharge is planned for a child with a congenital anomaly. This assures prompt visiting by a nurse who is knowledgeable of the child's defect and who can plan and offer support and assistance.

Members of the local association for the mentally retarded are often willing to come and visit newly-afflicted parents. Parents seem to get comfort from knowing they are not alone in facing the problem of their child's mental retardation. Knowledge that other parents have managed and that there are facilities within the community may constitute a source of hope.

The first few days, weeks, and even months at home constitute a critical period for many parents. Regular visits by a nurse and a close relationship with the doctor contribute greatly to favorable adjustments at home.

Most new parents live through anxiety-provoking experiences when the baby refuses to eat, regurgitates, cries excessively, or does not sleep for several hours. Parents of a retarded or abnormal child need to hear that such occurrences are common and "normal"; this adds to their ability to provide care and comfort.

Their ability to cope and their self-esteem can be enhanced through praise and recognition of their efforts. When the public health nurse visits a family with a retarded child, she needs to center her attention on the family itself, with special emphasis on the mother. The whole family – including the baby – benefits when the nurse takes a sincere interest in the mother and makes her well-being the object of attention.

The goal is to foster a positive approach to mental retardation and to attempt to strengthen the family unit.

Not always recognized

A deficit in mental ability is not always apparent at birth. In many cases, inability to meet the demands of accelerated learning and maladaptation during the pre-school and school years first indicate a defect in cognitive ability.

These children may have been considered normal earlier and therefore received normal psychosocial stimulation during infancy and the first formative years, perhaps establishing the sense of trust and security so essential for later personality growth.

A child diagnosed at birth or shortly after as mentally retarded is more likely

to start in a social climate of hopelessness. Mothers of mongoloid babies, when asked, related to the author unhappy stories of what happened to them during their hospital stay when the child was born and diagnosed as mentally defective. The parents' own trust and confidence is built up, reinforced, or undermined by how doctors and nurses respond and react.

Parents are often told to abandon their newborn mongoloid child, to forget they ever had a baby, to apply for institutionalization of the child. Such advice, although well intended, is insensitive and hardly realistic.

Each case, each set of parents, and each family needs careful assessment and consideration. The newborn period, when parents are dealing with their shock and emotional responses, is hardly the time for long-term decisions.

Is placement in an institution in the interests of the parents and of benefit to the child?

The argument against institutionalization of mongoloids is well presented and documented by Fotheringham and Morrison.[2] These writers explore a number of questions commonly asked by parents and others who envision the mentally retarded child as a strain on parents and siblings and hazardous to family integrity.

Their studies contradict the urgency for institutionalization and lend support to the concept that the child, at least during infancy and early years, benefits from living in the family milieu. They found that the mongoloid child's needs in infancy do not differ greatly from those of normal infants and that he "generally does not require elaborate physical care, but desperately needs the . . . atmosphere of love and security possible only through maternal closeness."[3] This should lend support to efforts to promote home care for such children.

Children with Down's syndrome show wide variations in achievement and mental ability. Although the diagnosis is usually established at birth, the learning potential remains an unknown quantity until much later. Even then, arguments rage about the validity and reliability of testing devices, which seem to determine the educational experiences offered.

As well, there are questions about a limited endowment in learning ability versus environmental influences, such as the quality of human relationships, and about experiential sequelae and limitations in sensory-motor stimulation at optimal development levels.

Although the retarded child shows differences in development of mental processes when compared with other children, the differences in the organization of the world around him appear even more striking.[4]

A mentally deficient child needs added protection to ensure his safety and security. Nonetheless, much of this alteration in his experiential world can augment non-growth rather than facilitate potential development. The retarded child – as any other – needs positive feedback as fuel for his learning and for the development of his self-system. His experiences with the human and object world should provide maximum stimulation from which he can derive a sense of achievement, mastery, and self-worth. These are essential for a positive self-image and the utilization of learning potential.

All community resources

After a family has been assisted and supported during the first stages, health care and guidance should then emphasize prevention of physical and emotional isolation, which can occur in the home. A creative approach in utilizing family and community resources can provide stimulation and rewarding experiences to the child and his family.

The greatest hazard is the attitude of hopelessness. A nurse working with family members can help them develop games and activities that involve the retarded child; such activity offers him the necessary motor-sensory stimulation. I once witnessed a family's enjoyment in being creative and doing something with and for the child. Yet, in this case, the physician had asked, "What good will it do? He is retarded."

Physicians and nurses need to watch their attitudes as these will influence others. The premise "Every child can learn" must be substituted for "He is retarded; there is no hope."

The mentally retarded are all too often viewed as tainted, less-than-human, and a burden to society. Preoccupation with "problems" precludes the realization that many families and individuals have derived growth-promoting experiences from their associations with the mentally retarded.

As one mother said: "Susan has helped us all to become more sensitive and appreciative of people. We find we have more to offer to each other and to the people we meet. I feel almost sorry for some of the families in our neighborhood; they don't know what they have and they don't know what they are missing."

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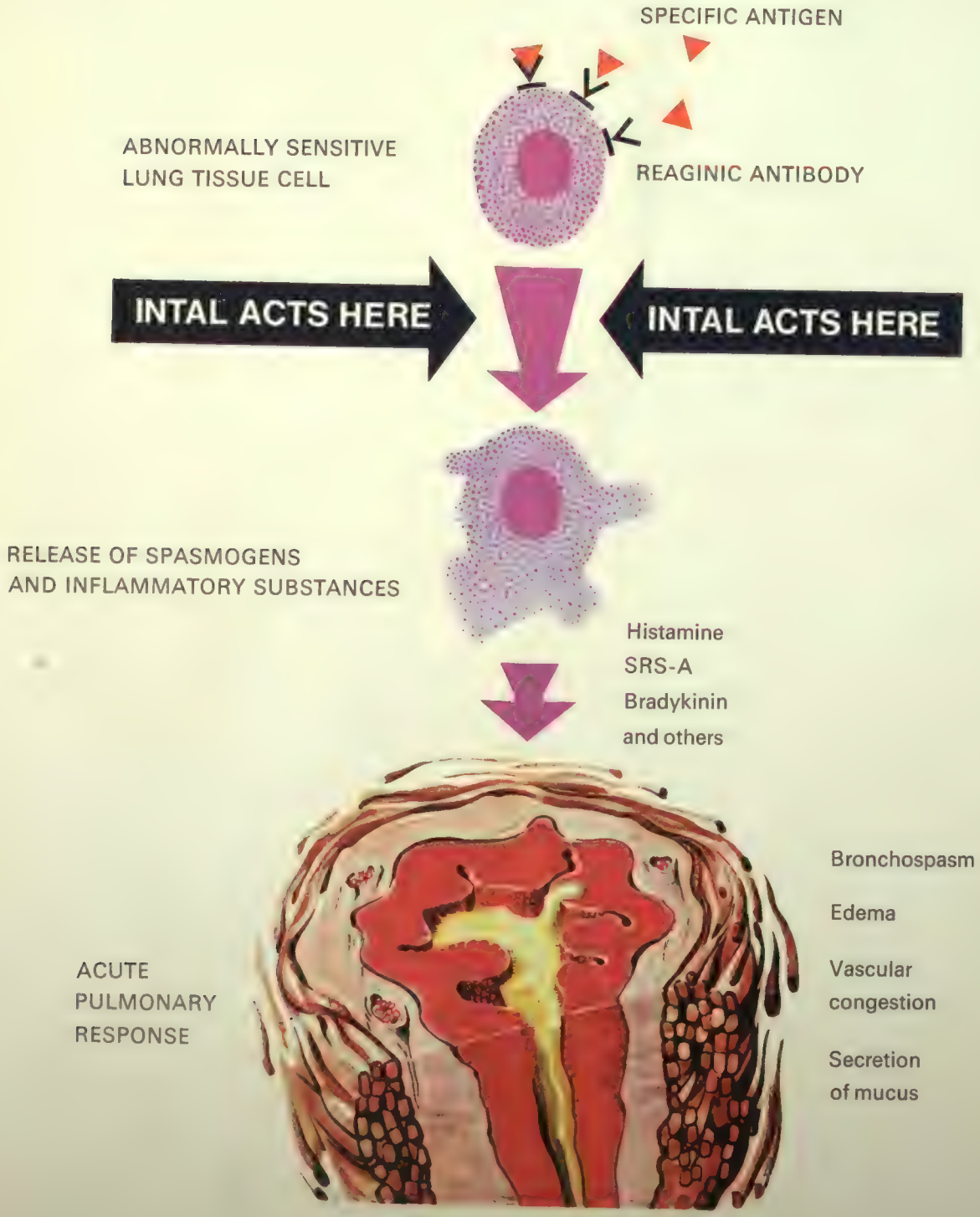
For the asthma patient...
Intal is a revolution in preventive therapy

Intal prevents asthma



before the attack begins

INTAL is new and unique. It is not a bronchodilator, not an anti-histamine, not a steroid, and acts in a different way from any previous anti-asthmatic drug. On the left is a diagram of the probable mode of action of disodium cromoglycate at the cellular level. One of the very first stages of the allergic reaction is blocked, thus preventing the release of the mediators of the asthmatic attack.

On the right are the results of one of many experiments on rat mast cells which confirm the effectiveness of INTAL. Unprotected cells rupture and release spasmogens. Protected cells do not.

The confidence which such a defence brings, especially to children, is invaluable to the doctor in subsequent management and encouragement of the patient.

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Incidence and severity of attacks.
Wheeze and chest tightness.
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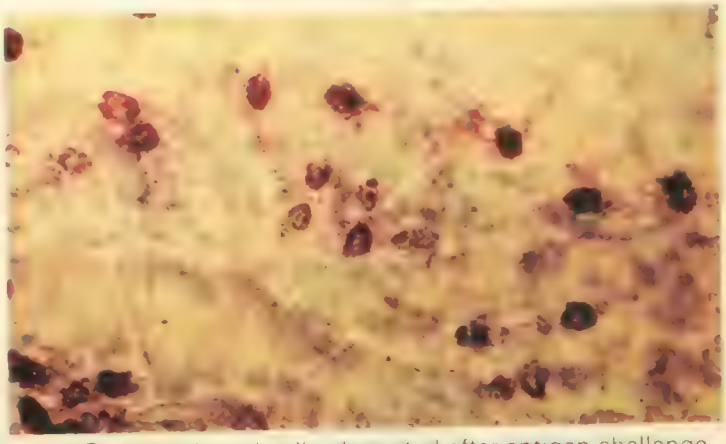
Cough.
Concomitant therapies, e.g. bronchodilators and steroids.

In thousands of patients, INTAL has already led to improvement in:

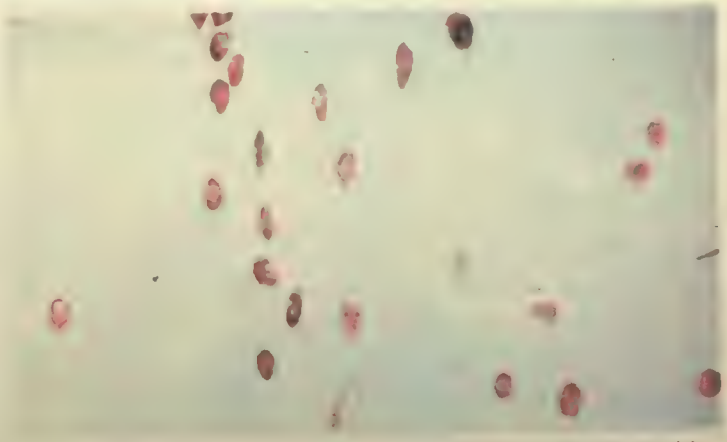
Attendance at work or school.
Exercise tolerance.
Lung function tests.

INTAL is a preventive therapy, which at last offers the asthmatic the prospect of a full, active life.

Sensitised mast cells, before antigen challenge



Sensitised mast cells, disrupted after antigen challenge



Mast cells sensitised and challenged, but protected with INTAL. They are substantially intact.

Intal defends against asthma attack

INDICATIONS	Bronchial asthma.
ADMINISTRATION	INTAL shows significant clinical effect only when administered by inhalation. The drug is supplied in a single dose cartridge, which is administered by a specially developed insufflator, the Spinhaler. Each cartridge contains 20 mg. disodium cromoglycate (INTAL) in ultra-fine powder form, with lactose B.P. as a carrier.
DOSAGE—ADULTS AND CHILDREN	**Initial treatment**—one cartridge four times per day. In more severe cases, and during periods of high challenge, the dose may be increased to eight per day (one every three hours). It is important that the patient should appreciate that INTAL is not intended to provide symptomatic relief in acute attacks. **Maintenance therapy**—when adequate response has been obtained, the frequency of inhalations may be reduced to three or even two cartridges per day. **Patients should be warned against suddenly discontinuing therapy when symptoms have been partially or completely controlled by INTAL.**
CONCOMITANT THERAPY	Other asthma medication should be continued until clinical improvement with INTAL permits a progressive reduction in their dosage. INTAL therapy alone will often control symptoms of moderately severe asthma, especially in children and young adults. In severe asthma, particularly in older patients, INTAL therapy alone may be insufficient to control symptoms. In a proportion of such cases, significant improvement can be obtained by combining INTAL with corticosteroid therapy. In steroid-dependent patients, the addition of INTAL therapy to the regimen often permits a slow, progressive and significant reduction in the maintenance dose of steroids. *The dangers of sudden withdrawal or reduction of corticosteroids are well recognised, particularly in patients on long-term administration. For full details of steroid dosage during INTAL therapy, please see the INTAL product literature or packing leaflet.*
WITHDRAWAL OF INTAL	Continuity of therapy is important in patients whose asthma is controlled by INTAL. If for any reason INTAL is withdrawn, a suggested regimen is the progressive reduction of dosage over at least one week. It should be borne in mind that symptoms of asthma may recur when INTAL is discontinued.
SIDE EFFECTS	*No serious adverse effects attributable to INTAL therapy have been reported.* Transient irritation of the throat and trachea has been the most frequently reported reaction, particularly following local infective episodes. There has been a small number of cases of an erythema or urticaria of the face. In each case the rash disappeared within a few days of withdrawal of the drug. At the beginning of INTAL therapy, in a small proportion of cases, transient bronchospasm follows the inhalation of the dry powder into hyper-irritable airways. It has been found that this effect, should it occur, may be minimised by the prior inhalation of a bronchodilator aerosol.
CAUTION	Teratogenicity experiments in animals have indicated that the use of INTAL in humans is unlikely to carry teratogenic risks. Nevertheless, as with any new drug, it is advisable where possible, to avoid its use during the first trimester of pregnancy.
PRESENTATION	INTAL cartridges are supplied in bottles of 30. Spinhaler turbo-inhalers are supplied in individual containers.
STORAGE	Important: INTAL cartridges should be stored in a cool dry place.

Further information on INTAL is available from Fisons (Canada) Ltd,
26 Prince Andrew Place, Don Mills, Ontario, Canada. Telephone: 445-5700
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Three patients with Hodgkin's disease

Each patient reacts differently when he learns he has a disease with a poor prognosis. This individual reaction must be accepted and understood by the nurse if she is to help him.

Marion Jackson, B.Sc.N.

Joseph is a 19 year-old high school graduate who works as a shoe clerk in a large department store. He has no family. Harry is a 35-year-old farmer, a father of two teenage girls. Brian is a 28-year-old accountant whose wife is pregnant with their first child. These three men have at least one thing in common: each has been diagnosed as having Hodgkin's disease. This disease is eventually fatal, yet with treatment, remissions may last from 5 to 15 years.

The nursing care required by these patients is in many ways similar; however, the needs of each patient differ. To formulate a plan for nursing care, the nurse must understand the person who has the disease, the disease process itself, and the therapeutics involved.

The disease

Hodgkin's disease, the mildest form of the lymphomas, is divided into three classifications: Hodgkin's paragranuloma, Hodgkin's granuloma, and Hodgkin's sarcoma. Four clinical stages have been defined to indicate the severity of the disease. This clinical staging can be used for any lymphoma.

Stage I – Disease limited to one anatomic region or to two continuous anatomic regions on the same side of the diaphragm.

Stage II – Disease in more than two anatomic regions or in two non-continuous regions on the same side of the diaphragm.

Stage III – Disease on both sides of the diaphragm, but not extending beyond involvement of lymph nodes, spleen, or Waldeyer's ring.

Stage IV – Involvement of bone marrow, lung parenchyma, pleura, liver, bone, skin, kidney, gastrointestinal tract, or any other tissue or organ in addition to lymph node involvement.

Hodgkin's paragranuloma has a relatively good prognosis for life expectancy and therapeutic response. Hodgkin's granuloma is less benign, but not a highly malignant disease. With early treatment, therapeutic remissions have lasted from 5 to 15 years. Hodgkin's sarcoma is highly invasive and rapid in growth.

Symptoms and findings

Often the patient seeks medical advice when he discovers enlarged lymph glands. Fever, weight loss, excessive sweating, pruritis, and fatigue are other symptoms that may persuade him to seek medical advice. Respiratory difficulty may be a complaint if mediastinal nodes are involved.

Physical examination reveals lymphatic nodes that are firm, non-tender, and of various sizes. Liver and spleen may be enlarged. Laboratory findings indicate lymphopenia and eosinophilia. Lymph node biopsy confirms the diagnosis. More sophisticated diagnostic procedures, such as inferior vena cavagraphy, lymphangiography, liver and renal function studies, lung tomograms and splenic scan, indicate the degree of involvement and further manifestations of the disease.

Late complications of the disease include hemolytic anemia, intractable itching and fever, respiratory difficulty, superior vena cava obstruction, and pleural effusion. In Hodgkin's sarcoma, the glandular enlargement may be painful and tender.

Treatment

The objectives of treatment are to halt the growth of malignant cells, to compensate for any damage caused by pressure from the growth, and to provide symptomatic relief from discomfort and pain.

The method of treatment depends on the clinical stage of the disease. Radiotherapy to the localized glandular enlargement may be used, generally over a four-week period. This treatment is usually reserved for specific symptoms or complications.

Miss Jackson, a graduate of the University of Saskatchewan School of Nursing, has been employed as a Clinical Instructor at both the Toronto Western Hospital and the Regina Grey Nuns' Hospital. She is presently Director of Medical Nursing at the University Hospital, Saskatoon, Saskatchewan.

Chemotherapy has been used with a degree of success in treating Hodgkin's disease. Although there are many chemotherapeutic agents available, only the more commonly used drugs will be discussed here.

Nitrogen Mustard: The usual dose is 0.4 mg. per kilogram of body weight, given intravenously in divided doses. Because of the nausea and vomiting caused by this drug, it is often administered late in the day after a light lunch and no supper. Antiemetics may be used to control the nausea and vomiting. The patient usually shows improvement in one to three days. If there is no bone marrow depression, the treatment may be repeated every two months.

Leukeran (chlorambucil): May be used as a maintenance drug three to six weeks following nitrogen mustard therapy. The usual oral dose is 0.2 mg./kg., given in divided doses following meals. Improvement may not occur for three to four weeks, with the maximum effect seen in two to four months. Since there is danger of bone marrow depression, weekly blood counts are taken.

Cytoxan (cyclophosphamide): The usual dose is 2-3 mg./kg., given intravenously daily for six days. This is followed by 50 to 100 mg. orally, one to three times daily as a maintenance dose. With this drug there is a high incidence of alopecia. The patient should be forewarned of this possible side effect.

Other antineoplastic agents in use include Velban, Alkeran, and Thiotepa.

Further treatment is supportive, protective, and symptomatic in nature.

Nursing care

Skin care is given frequently, using tepid water, non-irritating soaps, and soothing lotions to combat fever, excessive sweating, and pruritis. Sometimes medications are ordered to relieve these symptoms.

Nutrition is most important for the patient who is losing body fluid through excessive sweating. Since he may be fatigued and anorexic, the nurse may have to assist him with his meals. Foods should be high in caloric value.

The nurse prepares the patient for diagnostic and therapeutic procedures and in many instances stays with the patient as these are carried out. She also assists with his rehabilitation and convalescence, teaching him the importance of his follow-up care.

It is easy to indicate the physical nursing care required by the patient. Much, however, depends on how it is carried out and on how the patient, his family, and the nurse react to the disease.

The unique role of the nurse is to support the patient – to help him contend with the problems that arise because of his disease. Many of the diagnostic and therapeutic regimes are most uncomfortable, but if the patient knows that the nurse understands how he feels, he is better able to cope with the situation. The nurse's relationship can be vitally important to him. She is the one who spends the greatest amount of time with him while he is hospitalized. If she effectively uses this time by being understanding, giving good explanations, and being supportive, she can have a therapeutic effect.

It is difficult to look after any patient who has a disease with an ominous prognosis; however, the nurse must not dwell on the poor prognosis, but rather on the positive effects that can be achieved through treatment. She can do this only by accepting the realities of the disease and by finding out how the patient feels about his illness and his future. She must not decide how the patient should react.

Reaction to disease

Joseph, the 19-year-old clerk, had been found to have Hodgkin's disease during a pre-employment physical examination. The physician noted lymphatic swellings on the left side of his neck and in his left axilla. Joseph said these swellings had been present for some time but were painless and had not bothered him.

Diagnostic tests taken in the outpatient department confirmed the diagnosis of Hodgkin's disease, and the physician arranged for Joseph's admission to hospital. The nursing staff were confronted with a rather agitated lad who had no desire to be hospitalized. Joseph's doctor told him his diagnosis and what to expect. He had one of the milder forms of Hodgkin's disease and his prognosis was good with treatment.

Despite our efforts, we were unable to convince Joseph that he needed treatment and follow-up care. He discharged himself, saying he was well and not a thing was wrong with him. Two years later, he was readmitted. He was comatose and never regained consciousness.

Harry, the 35-year-old farmer, was admitted to hospital with a two-month history of extreme fatigue, weight loss, and excessive sweating, particularly at night. He had lost 30 pounds in the two weeks prior to admission. In hospital he continued to lose an average of two pounds per day for the first two weeks (total weight loss: 60 pounds). He was so weak that he required complete help with all his needs.

He had severe generalized discomfort and, after extensive diagnostic tests, it was discovered that he had Hodgkin's

sarcoma. His prognosis was extremely poor. It was doubtful that he would ever leave hospital. This was three months before Christmas.

Overtly, Harry seemed able to accept his disease and its outcome. He discussed it with his family and informed them he would have one more Christmas at home. He was extremely determined and gradually began to do more for himself. As he had predicted, he went home for Christmas. Shortly after the holiday season, he returned to the hospital with further involvement. He had pleural effusion, severe anemia, and a retroperitoneal mass. He lived only three more days.

Brian, the 28-year-old accountant, was admitted to hospital with a temperature of 104 degrees Fahrenheit, excessive sweating, and severe pruritis. His prognosis was a therapeutic remission of from 5 to 15 years.

After being informed of his disease and prognosis, he was unable to discuss his illness with anyone, even his wife. He seldom spoke, seldom asked for anything. He accepted all treatments and nursing care willingly and seemed to live each day as it came with no thought for the future.

Perhaps he was unable to look at the future. He did not look sad, bitter, or cheerful. He looked apathetic. His physical response to treatment was good, but his attitude continued to be passive.

Brian was discharged from hospital after an eight-week stay. Three years have passed since that admission. Physically, he has continued to do well. Because we have not had personal contact with him since hospitalization, his present attitude toward his illness is unknown.

These patients give only three examples of the varied reactions to an illness that is long-term, permanent, and potentially fatal. Joseph denied that he had the disease. He felt well, so therefore would not admit that he had an illness, refused treatment, and thus ended his own life, probably prematurely. How does the nurse react to this patient? How should she react?

Harry had a very positive outlook about his illness. He seemed to possess an inner strength, which gave him the ability to accept and live within the confines of his illness. He made the most of whatever was left, setting goals for himself, discussing them with his family, and being realistic about these goals. He too exhibited denial – not about the disease *per se*, but about its ability to interfere with his Christmas goals. This would seem to be healthy denial.

Brian, on the other hand, was rather passive and indifferent to his illness. He did not deny its existence, nor did he make the most of his relatively good prognosis. He appeared to have given in to the disease and involved no one in his illness, not even himself. He did not appear to have the inner strength to contend with such a disease. How does one nurse this patient? Perhaps a clergyman or social worker could give guidance to the nurse in this instance.

Of these three patients, the most seriously ill was by far the easiest to nurse. Harry accepted his illness, or at least acknowledged its presence, and became involved with it; therefore, it was easier for the nurse to accept his illness and provide his care. He was always pleasant and it was always a pleasure to visit his room. It was an easy situation for the nurse.

The most difficult patient to approach was Brian, mainly because the nurse found it difficult to become involved with him. But it is by becoming involved, by really caring on a professional basis, that a patient such as Brian can be helped. Although the nurse is tempted to avoid his room except when essential, she must realize the importance of spending as much time as possible with him. A positive attitude from those who provide his care could give Brian and patients like him hope, and possibly stimulate a positive attitude. Often the patient's attitude toward a disease seems to influence his prognosis.

The nurse must be prepared to look for and recognize individual differences. She must toss out preconceived notions about patients' behavioral patterns and not expect them to conform to a stereotyped classification of reactions.

There are as many different reactions to a disease as there are patients with a particular disease. The nurse's role is to try to understand the patient's reactions toward illness and his method of coping with problems. She can then help the patient find, in his own way, the best solution.

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Decentralized nursing service

Under this system, now in operation at the University Hospital in Saskatoon, Saskatchewan, the role of the senior nursing staff changes from one of authority to one of leadership.

Madge McKillop

Nursing has traditionally had a hierarchical type of organization with centralized authority and a long line of communication. In most hospitals the nursing organization is complex with many levels of authority. The nurse in the ward finds it difficult to make decisions about patient care, yet is responsible for it.

The staff at the University Hospital in Saskatoon believed this problem could be attacked by trying to simplify either the individual ward organization or the total nursing service structure. Since change would be possible only if authority were delegated by nursing administration, we agreed to try a decentralized form of nursing organization and, at the same time, to reduce by one the levels of authority within that organization.

Further impetus to the plan was given by other factors in the total hospital organization. For example, the former position of director of nursing had become "nursing administrator," with more involvement in general hospital administration. Also, we had found that centralization of authority in the traditional nursing office was more often a bottleneck than a channel of communication. Supervisors who were perfectly capable of making decisions relating to their own areas often developed into the best paid messengers in the organization.

Moreover, the supervisor's role in relation to department heads was an ambiguous one. Although responsible for a large group of patients and staff, her position often did not permit her to talk on equal terms with other department heads.

At the same time, other hospital functions were developing specialized departments. There was no longer just a laboratory, but several departments providing laboratory services. Meanwhile, nursing service, representing 40 to 45 percent of the total staff, was lumped together in one department. No one person could expect to be aware of the many needs of this complex group.

Plan for decentralization

To overcome some of these problems, we decided to divide the nursing service into six departments of nursing, each with its own department head, a director of clinical nursing. Each director of nursing of a clinical area would report to the executive director of the hospital through the nursing administrator in the same way as other department heads report to an administrative officer.

These department heads would then be responsible for the organization and administration of their area in accord with general hospital policies. This would include staffing, assignments, promotions, budget, and so on. The department heads would be expected to work closely with the medical chiefs in their area to provide the best possible patient care; to help meet the objectives of the educational programs of the many students who come to the wards; and to participate in or initiate research projects.

Implementation of plan

As seen on the organizational chart, a senior nurse is still assigned to evening and night duty. Although each director of clinical nursing is responsible for planning the nursing services in her area for the 24-hour period, there is a need for nursing supervision at all hours and there are also administrative duties that must be assigned to some responsible person for the evening and night shifts. At this stage it would not seem economically sound to employ additional administrative staff when the present evening and night staff are handling these responsibilities well.

The position of administrative adviser is a new one. This is an individual well qualified in nursing administration who acts as a resource person for the directors and who undertakes special studies in problem areas. She reviews policies and recommends revision as required.

The director of inservice education has a dual responsibility: She is responsible for orientation and staff education within the hospital, and acts as liaison between the university school of nursing and the hospital nursing service. A joint nursing service-nursing education committee sets policies.

Planning for this change took almost two years. The proposed plan was discussed with the hospital administrative staff and received approval in principle. Weekly seminars were arranged for the supervisors to give them help in upgrading their administrative knowledge and skills. Assistance in this program was provided by the executive director, the business administrator, the director of personnel, and members of the nursing staff. They covered topics such as hospital philosophy and policies, preparation and management of budgets, personnel policies and their application, staff development, the union contract and their role in relation to the union, and interdepartmental relationships.

Other departments were brought into the planning early. Discussions were held with the medical department chiefs who expressed interest and support. The personnel department took on more responsibility for the recruitment and screening of applicants for nursing – a responsibility that had previously been carried out

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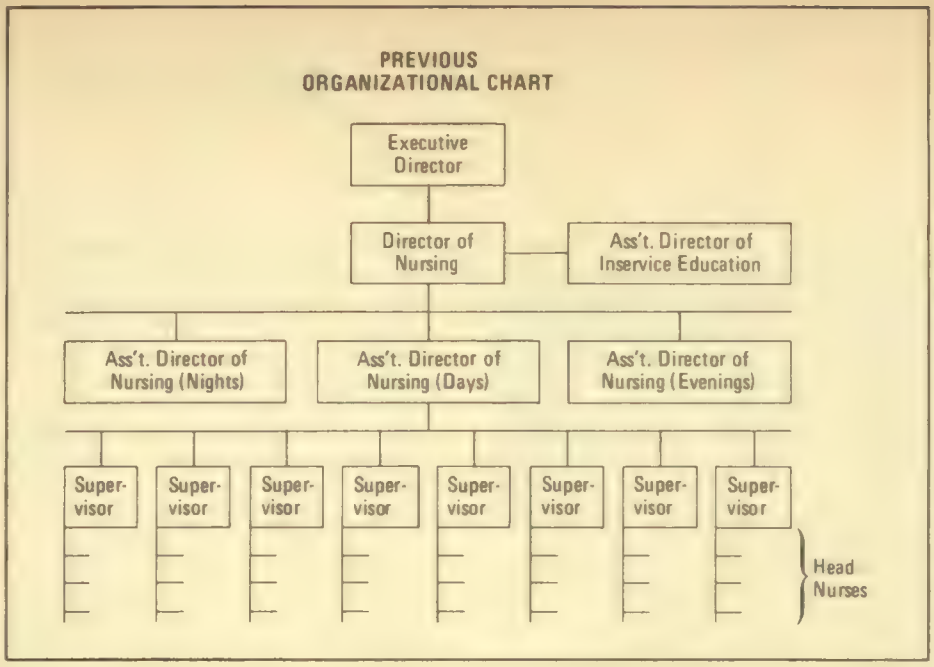

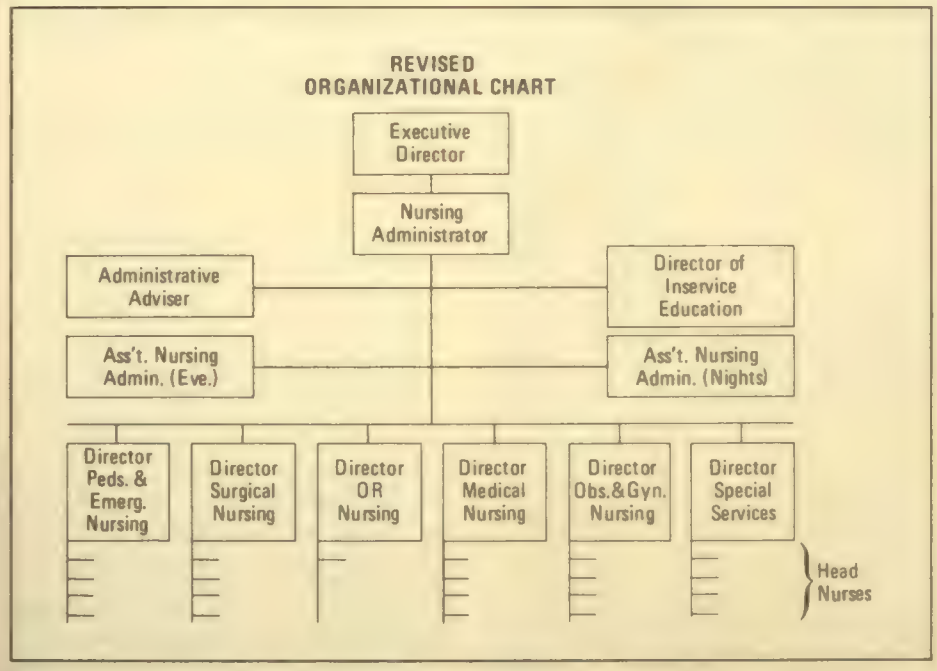

by a senior member of the nursing office staff. This change made it possible for the department head to work with personnel in hiring staff for her area.

The nursing operating budget, prepared by the supervisors in consultation with the head nurses, was broken down into clinical areas and reported monthly. Board approval for the change was sought and given wholeheartedly. Finally, job descriptions were developed for each of the positions.

Problems

Naturally, there was resistance to change. Some staff felt safer in a known setting. People had to change their attitudes. As the scope of the former supervisory position increased to that of department head, the responsibilities of each head nurse increased as well. Staff had to adjust to this and it took time.

Another problem has been that of coordination. Constant vigilance is required to make sure hospital policies are being carried out; at the same time, staff must be given enough scope to allow individual development. Priorities must be established for assignment if more than one area wants to hire the same person. If these cannot be settled at the departmental level, the nursing administrator must make the decision.

The major change – and the one that has taken longest – concerns the image of the traditional nursing office: we had to change it so that it would no longer be recognized as the sole decision-making area for nursing. The nursing administrator had to learn to work as a coordinator, a resource person who identifies trends and helps to initiate change. She now must let others make many decisions that were formerly her responsibility, and has to realize that there is more than one way to achieve a desired end. Other departments, too, have had to learn to refer questions to the director of clinical nursing in an area, rather than channel everything through the nursing office.

Results

To date, the organization seems to be working well. The directors are growing in their positions and are taking full responsibility as department heads. Head nurses have found that their role has expanded to the point that they are now writing a new job description for themselves. Service department heads say they are finding their work easier now that a decision can be made at ward level. New staff are more likely to be assigned to the clinical area of their choice because the staff in personnel refer an applicant to the director in that area.

One of the concerns expressed was that the nursing administrator would become a mere figurehead, cut off from the actual work situation. This has not happened. In fact, communications have improved and it is easier to keep abreast of what is happening. There is more time for consultation and discussion. Directors of nursing in each clinical area have made a point of keeping the nursing administrator aware of changes and developments.

Budgetary controls have improved. Because each director is responsible for her own budget and gets a monthly report of the financial picture, it is easier for her to establish controls and to take corrective action if required. The directors take pride in working within their budgets.

Final results cannot yet be assessed as this is still an evolving situation. We hope, however, that the continued delegation of authority will permit more scope for the nurse giving care at the bedside. Decisions will relate more closely to the work situation. The role of senior nursing staff will change from one of authority to one of leadership, and a more colleague-type of relationship will develop. □

books

Surgery for Students of Nursing, 5th ed. by John Cairney and J. Cairney. Edited and revised by Richard Orgias. 471 pages. N.M. Peryer Limited, Christchurch, New Zealand. 1969.

Reviewed by Leita Nemiroff, Instructor, Medical-Surgical Nursing, Misericordia General Hospital, School of Nursing, Winnipeg, Manitoba.

The objective of this book is to help nursing students understand the principles on which surgical treatment is based. The beginning student can easily understand the book.

As an introduction to various types of surgery specific to body systems, the authors have wisely discussed important topics, such as infections and asepsis, body fluids, hemorrhage and shock, wounds and skin grafting, and anesthesia. These are only a few of the topics related to surgery that are dealt with.

Each type of surgery discussed is preceded by a brief review of anatomy and physiology of that body system or specific body organ, accompanied by black and white photographs. The authors discuss preoperative management of the patient and outline the various surgical approaches. Illustrations help the nurse understand the specific surgical treatment. Discussions of postoperative management of the patient are procedure oriented.

This book can best be used as a well-illustrated dictionary of surgery and surgical techniques. It is particularly useful for the beginning and more senior student as a handbook, rather than a textbook.

Neurological and Neurosurgical Nursing, 5th ed. by Esta Carini and Guy Owens. 386 pages. Toronto, C.V. Mosby Company, 1970.

Reviewed by Marilyn Kavanagh, Head Nurse, Intensive Care Unit, Peel Memorial Hospital, Brampton, Ontario.

This book is the most recent edition of a popular neurological nursing text.

In the preface the authors stress, "In this time of elaborate monitoring devices, of intensive care units, and of specialized teams, let us not overlook the continuing importance of the personal nursing care of the patient." This concept, found throughout the book, is of foremost importance, no matter what aspect of nursing care we deal with.

The format of this book is excellent. There are 19 chapters that review in detail the care of the neurological patient, with many precise diagrams and photographs describing anatomy and reviewing diagnostic procedures.

In the chapters dealing with the surgical correction of the disease, the pre- and postoperative nursing care is clearly described, with specific observations required for the particular surgical procedure, as well as posturing and turning, nutrition, elimination, and division.

The medications used most commonly in the treatment of neurological patients are grouped according to their specific and systemic effects.

This would be an excellent reference book for any nursing library. My only objection is that there are no references to any of the great Canadian achievements in this field.

Materia Medica and Pharmacology for Nurses, 7th ed. by J.S. Peel. 209 pages. Christchurch, N.Z., N.M. Peryer Limited, 1969.

Reviewed by David M. Quinn, Pharmacy Department, Royal Inland Hospital, Kamloops, B.C.

The author is a hospital pharmacist in New Zealand who has been introducing materia medica and pharmacology to nurses for the past 20 years. This book, printed biennially, reflects a direct and experienced approach to the subject. The author knows what to teach and how to teach it.

The chapters on weights, measures, and calculations are excellent. This is traditionally a weak area for nurses. How we could all be helped by the long overdue elimination of the apothecary and "teaspoonful" system!

The section on pharmacology follows the usual textbook format, with just enough detail for the student to absorb. Doses are given, but not the route or suggested frequency of administration (except in an appendix that lists pediatric doses).

There are omissions: isoprenaline aerosols, the meaning of idiosyncrasy, Gram staining, and the idea that certain combinations of seemingly innocuous drugs, such as mineral oil and dioctyl sodium sulfosuccinate, can be dangerous. A reference list of drugs that are contraindicated with MAO inhibitors and with oral anti-coagulants would be useful.

More careful editing would have caught the odd spelling mistake and such delightful statements as: "Cephaloridine . . . is a derivative of an antibiotic obtained from a sewage outlet in Sardinia" and "its toxicity is slow."

There are occasional areas of dispute: we are told that penicillin G is effective against *Brucella* and that sodium bicarbonate causes "rebound gastric acidity."

The differences between Canadian and New Zealand practice – the legal matters, official and trade names of drugs, methods of treatment in poisoning, and drugs used – will confuse the student. The dose given for aldactone, for example, suggests that we have a different formulation here; and surely tandearil is not an antihistamine. NPH insulin and syrup of ipecacuanha are not used in New Zealand, and B.N.F. mixtures are no longer *à la mode* here.

These variations are sufficiently numerous for me to wish that we had a Canadian version of this book.

Patient Care In Respiratory Problems by Jane Secor. 229 pages. Saunders, Monographs in Clinical Nursing – 1, Toronto, W.B. Saunders Company, 1969.

Reviewed by L. MacDonald, Director of Nursing, Provincial Sanatorium, Charlottetown, Prince Edward Island.

The major aim of this book is to present a nursing specialization as an inseparable blending of technical skills and personalized patient-centered care. This is a valuable reference book and should be of particular interest to nurse clinicians, nurse educators, and nursing students.

The author points out that the expansion of knowledge of health and illness has brought about the extension of the responsibilities of the nurse. She is now becoming a skilled therapist, and is assuming more of the tasks that formerly fell in the realm of medical practice.

One part of the book deals with signs and symptoms and major complications of specific conditions in respiratory disorders; understanding these enables the nurse to adjust nursing care safely and efficiently. Special treatments are clearly defined, and equipment, such as respirators, nebulizers, and closed drainage systems are well-illustrated.

One particularly interesting chapter is on clinical studies of pulmonary emphysema, laryngectomy, cancer, pulmonary tuberculosis, pulmonary embolism, and traumatic injuries. □

AV aids

Multimedia System Launched In Canada

Nurses from a number of Montreal hospitals saw the Multimedia Instructional System demonstrated at the Queen Elizabeth Hospital early in April. So far this product of Hoffmann-LaRoche Inc. provides a program of instruction only in intensive coronary care, although the company promises additional programs.

The multimedia system incorporates different educational techniques into an integrated teaching system. The techniques include films, sound filmstrips, audio tapes, textbooks, and testing and evaluation. The system is divided into 13 instructional units, each self-contained yet interrelated to reinforce each other. If a course already exists in a hospital, any of these units can be used to supplement or replace portions of it.

A complete system contains:

- 9 films that give a broad overview of key subjects in coronary care nursing and introduce the other instructional elements in the system. Live action and animation are both used effectively. Scripts come with the films.
- 29 sound filmstrips, which present specific subjects in depth, describe procedures, develop principles of practice, and instruct in arrhythmia detection and treatment. Scripts are included.
- 12 audio tapes, which expand on material in the films through questions and answers; express differing views on management of nursing problems; and present lecture-type material. Scripts are provided.
- 11 copies of the text *Intensive Coronary Care — A Manual for Nurses,* by Lawrence E. Meltzer, Rose Pinneo, and J. Kitchell. The multimedia system expands and updates the basic course content of this manual.
- 1 copy of *Cardiopulmonary Resuscitation Conference Proceedings,* edited by Archer S. Gordon.
- 10 student workbooks, with 73 ECGs to be interpreted by the student, reading assignments, an outline of each film and filmstrip, and clinical experience record.
- An instructor's manual, which gives details on how to prepare for the course and how to conduct it, suggested schedules, outlines of films and filmstrips, and interpretation of ECGs.
- A pre-test of the student's general knowledge of cardiac nursing and a final examination of objective questions that cover the course.
- An audiovisual equipment instruction book.
- A technicolor super 8mm projector with rear screen attachment and earphones for individual learning.
- An Elco Mastermatic sound filmstrip projector, with rear screen attachment and earphones, which also plays the audio tapes. Projector loading is made easy — the films, filmstrips, and tapes are packaged in plastic cartridges. One cartridge contains both sound and picture for each filmstrip.

Advantages of this system are: it can be used in the hospital to instruct groups of nurses or individuals; a nurse can repeat any section of the course on her own; filmstrips can be stopped for explanation or discussion and easily continued; and instructors do not have to repeat lectures on the same material.

There is a suggested schedule for this course. If given in an intensive program, the course would take 20 days to complete. This is based on a 120-hour schedule of 40 sessions.

According to Hoffman-LaRoche, the Multimedia Instructional System is being tested in 10 hospitals in the United States by the U.S. Public Health Service. It will be kept up-to-date by recommendations of a board made up of current users of the system, Dr. Lawrence Meltzer, the U.S. Public Health Service, and practicing cardiologists.

Nurses questioned by *The Canadian Nurse* after the two-hour presentation in Montreal were enthusiastic about the system. The supervisor of inservice education at the Queen Elizabeth Hospital thought the audiovisual equipment could be put to excellent use in Montreal hospitals, and that the course should be a requirement for nurses in coronary care.

The head nurse of the coronary monitoring unit at The Montreal General Hospital said she would highly recommend the system. She thought some parts of it could be used for students, although it was "definitely a postgraduate course." It could be used to train key people in the hospital, she said. This nurse found the series on cardiac pacing particularly interesting.

AV aids

(Continued from page 39)

A clinical instructor at The Montreal General Hospital thought some parts of the system were good for students, but expressed doubt concerning the workbooks. "Once you understand the principles, you don't need one at hand," she explained. The effectiveness of the system, she believed, would depend on the instructor.

For complete information about the Multimedia Instructional System, write to Hoffmann-LaRoche Inc., 1956 Bourdon Street, Montreal 378, Quebec.

Film catalogue

A group of Toronto librarians and nurse educators interested in audiovisual aids have pooled all available resources in the area on 16 mm films used in nursing education. The result is an impressive film catalogue compiled by the Metropolitan Toronto Schools of Nursing Audiovisual Aids Committee.

The catalogue includes a table of contents, list of sources for obtaining films, film résumés, and a subject index. Copies, at a cost of $8.50 each, are available from Miss M. Seguin, 35 Shuter Street, Toronto 205, Ontario.

Free films directory

A brochure entitled "Free Films Directory" is available from Crawley Films Limited. This excellent guide lists 488 sources of free 16 mm sponsored films in Canada. It also provides helpful suggestions on how to borrow films, and gives projection tips. For a copy of this film directory, write to Crawley Films Limited, 19 Fairmont Ave., Ottawa 3, Ontario.

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, *except Reference items,* may be borrowed by CNA members, schools of nursing and other institutions. *Reference items* (theses, archive books and directories, almanacs and similar basic books) do not go out on loan.

Requests for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50, The Driveway, Ottawa 4, Ontario.

No more than *three* titles should be requested at any one time.

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*Kehlmann, W. H.: Mod. Hosp. **84**:104, 1955

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letters

Letters to the editor are welcome.
Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Alberta orderlies comment

The article "One standard — or two?" (May 1970) by Albert Wedgery is to the point. The author is to be commended for speaking about a problem that has existed for many years.

In some parts of the country, orderlies have tried to organize programs to prepare them for their work. Mr. Wedgery rightly states that in Manitoba the problem of inadequately prepared orderlies has been partly solved by a training program in operation for the past 10 years.

This article also states that in Alberta a school for nursing orderlies has been operating since 1967. However, as far back as 1961, orderlies in Alberta have tried to improve their preparation. Early in 1962 the Alberta Association of Nursing Orderlies was incorporated. This body, with the assistance of the Alberta Association of Registered Nurses and other associations interested in upgrading patient care, was responsible for establishing the Alberta Nursing Orderly School. Previous to this, preparation of orderlies had been on an inservice basis. Although not ideal, this was at least an attempt to improve the preparation of these members of the nursing team.

It is to be hoped that other provinces will act on the recommendation of the Task Force on the Cost of Health Services in Canada, that the nursing orderly should be prepared at the level of the registered nursing assistant. This, in effect, is what is being done in Alberta under the department of education. — *G.E. Lefebvre, president, Alberta Association of Nursing Orderlies.*

Overcoming nursing routines

One of your best and most interesting articles was Pamela Poole's "Nurse, please show me that you care!" (Feb. 1970).

I heartily agree that we are slaves to routine, but is this due to the nurse herself? She is certainly frustrated to find she cannot give all the care she wants to give her patients during her eight-hour shift.

However, beginning when she is a student, the nurse is drilled in the "accepted" daily routine — medications, meals, and treatments — according to the clock, rather than the patient's desires. The nurse comes to perform these duties in an almost robot-like way, but thankfully, usually in a friendly manner.

Many nurses would like to adapt their nursing care to each patient's needs at a certain time; for example, the nurse should have time to give more intense care pre- and postoperatively.

So often a nurse leaves a patient's bath until later in the day to allow him to rest, only to have a head nurse or supervisor find the patient resting and immediately send an S.O.S. for the nurse: "Mr. Jones is lying in bed and hasn't had his bath or even been up yet!"

The need for individualism in nursing must be accepted by clinical instructors, nursing supervisors, and directors of schools and hospitals before general duty nurses can give better, more effective nursing care, which meets patients' needs at a given time. — *Noreene R. Collins, R.N., Ottawa.*

I was pleasantly surprised to read the article by Pamela Poole, "Nurse, please show me that you care!" I have felt the same way for a long time.

At one point in my teaching experience I had to prove to myself that this concept of individualized patient care was not ivory-tower philosophizing, but was applicable to nursing situations commonly found in clinical areas.

Thus, one summer I returned to bedside nursing in a busy medical-surgical unit. I asked that I be given my patient assignment a day ahead. I arrived 20 minutes early in the morning to check for changes in the medical plan of therapy; assessed patients' needs and set priorities for individual patient care; tried to anticipate needs associated with fluid intake and elimination so that I would not have to retrace my steps in the midst of caring for another patient; capitalized on opportunities to combine a number of nursing activities while giving care; and explained to each patient that he should call me when necessary and that in the meantime I would try to see him.

Many times I was repaid for my efforts by verbal and non-verbal expressions of appreciation, a developing sense of trust in my care, and patient interest in his own care. Some days I felt more successful than others, but my spirits were never too dampened because I believed I recognized the patient as a person with a variety of needs and did the best I could.

If we each shouldered our share of responsibility for getting to know our patients as Miss Poole pointed out; worked together to cut down on ritualistic, outmoded practices; carefully planned for the optimum utilization of nurses' various levels of skill; and concerned ourselves with the positive effects of a cooperative nurse-patient relationship based on individual patient needs, would there be so many disillusioned nurses? — *Lillian Douglass, Reg.N., Ramathibodi Hospital, Bangkok, Thailand.*

Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

Scholarship available

The Regina General Hospital School of Nursing Alumnae makes available a scholarship of $500 to active members of the alumnae who are presently engaged in nursing. This scholarship may be used in any university school of nursing for postgraduate study. Completed applications must be received by June 1, 1970.

Application forms and further information may be obtained from: Mrs. Shirley Newis, Chairman, Scholarship Committee, 1016 Lorimer Place, Regina, Saskatchewan.

Award winners announced

The Faculty of Nursing, The University of Western Ontario, is pleased to announce the names of the students who have been given awards this year from the Mildred I. Walker Bursary Fund. The students are Carol A. Black, Linda N. Brown, and Jacqueline E. Lewis.

This fund was established in the Faculty of Nursing by the students and friends of Miss Walker. — *R. Catherine Aikin, Dean, Faculty of Nursing, The University of Western Ontario.*

Copies available

A limited number of copies of *Proceedings, Conference on Continuing Nursing Education* held June 24, 1969 in Wilson Hall, McGill University, under the sponsorship of the University of British Columbia School of Nursing, are available at a cost of $3. They can be obtained from the Division of Continuing Education in the Health Sciences, University of British Columbia, Task Force Building, Vancouver 8, B.C. — *Margaret Neylan, Associate Professor and Director, School of Nursing, University of British Columbia.* □

news

Poverty Is Cause Of Illness, CNA Tells Senate Committee

Ottawa. — The cause of illness among the poor is rooted in their economic conditions and is beyond the jurisdiction of nursing care, the special senate committee on poverty was told June 4 by the Canadian Nurses' Association.

"Poverty is a major, contributing cause of ill health and an impediment to the maintenance of good health," CNA said in a brief presented to the committee. The association urged treatment of the cause of illness — poverty — rather than just the symptoms.

CNA also pointed out that the total cost of health care will be decreased to the extent that poverty can be removed or lessened.

"By the sheer weight of numbers in combination with the nature of their work, the nursing profession probably has more experience with poverty and its effects than any other segment of the Canadian population," said CNA.

CNA recommendations to the committee on poverty included:

- More financial assistance to prepare the increasing numbers of nurses needed to work in community health programs. This would especially involve public health nurses, who are likely to see the most forceful impact of poverty on health. At present, only 8.3 percent of working nurses are in public health, and the need for their services has grown rapidly.
- More experimentation to seek better methods of bringing health care to the poor, such as neighborhood health programs.
- Better coordination by health departments of the knowledge and services of health and welfare agencies that aid the poor. This would result in less fragmentation, more continuity, and better quality care.
- Establishment of an economic level at which good health can be maintained by the dependent poor. Also, the independent poor should be helped to have an income at least as good as that of the dependent poor.
- A much extended program for giving suitable care to the elderly poor. This could include adequate assistance to help them remain at home, and use of day care centers, geriatric centers, or health maintenance clinics.
- More attempts to train natural leaders chosen by their peers in the poor communities to work with public health agencies and assume some responsibilities in the health program for their group.

Presenting the Canadian Nurses' Association's brief to the special senate committee on poverty in June, were: Dr. Helen K. Mussallem, *left*, CNA executive director, and Trenna Hunter, chairman of the CNA committee that prepared the brief. Here they talk with Senator David Croll, chairman of the special committee.

Members of the senate committee also asked questions at the hearing about subjects such as nurse registration, the number of male nurses, and how to attract more nurses to the profession.

The brief was presented to the committee by Dr. Helen K. Mussallem, CNA executive director, and Trenna Hunter of Vancouver, B.C., chairman of the CNA committee that prepared the brief. Other members of the committee were Constance Gray, Toronto; Catherine Keith, Ottawa; and Phyllis Kenny, Walkerton, Ont.

Let Students Do Work Of RN, BC Health Minister Tells Nurses

Vancouver, B.C. — Loud boos from members of the Registered Nurses' Association of British Columbia followed a remark by the provincial health minister, Ralph Loffmark, that student nurses should be allowed to do the work usually assigned to registered nurses.

Speaking at the 58th annual meeting of the RNABC held May 27 to 29, Mr. Loffmark said that students must be given more responsibility, if they are "to grow and develop properly." He said nursing education seems to be moving away from hospital schools into schools of technology and universities.

Health minister Loffmark brought greetings from the provincial government on the first morning of the annual meeting, and returned later, after the regular sessions, to answer questions posed by RNABC members during his morning speech.

Responding to criticism of his government's decision to meet only 70 percent of salary increases awarded hospital employees as of January 1, and the effect this decision and others will have on health care in the province, Mr. Loffmark said the provincial government has already paid $10 million more than its estimated hospital expenditure for the current fiscal year. To do this, he said, the government has had to "scrape the bottom of the

barrel." He said that hospitals are free to use their 1970 budget in any way, even on increased salaries, but they won't get any more money from the government when the till is empty.

Most of Mr. Loffmark's answers brought applause from his audience.

Over 500 attended the RNABC annual meeting. Dr. Helen K. Mussallem, executive director of the Canadian Nurses' Association, brought greetings from CNA, and later was guest speaker at an evening banquet.

VON Director Reviews Changes In Past Ten Years

Winnipeg, Man. — The 1960s have produced many changes in structure, program, and personnel of the Victorian Order of Nurses, Jean Leask, VON director in chief, said during the Order's 72nd annual meeting, May 8.

"During the 1960s a major activity within the organization was the exploration of ways and means to extend our service in response to community needs," said Miss Leask.

Solutions included initiation of visiting nursing service in new communities; extension of this service to neighboring towns, villages, and rural areas; reorganization and amalgamation of adjacent branches to form new units with a broader administrative base and, in many cases, extended boundaries.

"Our response may also have been a modification of program, the withdrawal from an area of service being met by another agency, or the initiation of a new program which was not being offered and which would contribute to the health services of the community," she added.

Between 1960 and 1969 a significant change took place in the organization of branches at the local level. In 1960 there were 119 VON branches, which mostly served an urban area. Since then services have been discontinued in eight small communities and six new branches have been opened.

Thirty-one branches were reorganized into 12 new ones and many branches extended their boundaries. The number of branches was reduced to 98, but visiting nursing service was available to many more citizens.

During the 1960s the role of the provincial branches became increasingly important, Miss Leask said. Each of the nine provinces in which VON branches are established now has a provincial branch. "Originally established to approach provincial governments for financial support for branches in their province, their activities now include interpretation and extension of service as well as functioning in a coordinating capacity at a provincial level," she said.

In 1969 patients visited numbered almost 105,000. More than 1,351,000 visits were made to these patients. In contrast to 1960, most patients had medical or surgical conditions and the service they received accounted for 90 percent of all visits.

Of every 10 patients, six were adults,

(continued on page 8)

Jean Leask, *left*, director in chief of the Victorian Order of Nurses, gave a 10-year review of VON activities at the Order's 72nd annual meeting in Winnipeg last May. She is shown with Christine MacArthur, assistant director in chief, at VON House, Ottawa. The chairs in this library at VON House are from the living room of lady Aberdeen, the founder of the Victorian Order of Nurses.

Testing Service Gets New Home

Ottawa. — The staff of the new Canadian Nurses' Association Testing Service began moving into their offices at CMA House on May 1. Looking through some new books are Dorothy Colquhoun, *left*, acting director of the Testing Service, and Nancy Wright, her assistant. The first set of registered nurse examinations will be delivered to the province of New Brunswick — where examinations are scheduled first — by August 10, 1970.

For Study Now --- for Reference Later

Law Every Nurse Should Know New Second Edition

By Helen Creighton, B.S.N., R.N., A.B., A.M., J.D., Southwestern Louisiana Institute.

The long-awaited revision of this classic book is now in press. Written by a nurse and nursing educator who is also a lawyer, this book sets forth the facts of law that every nurse — from student to superintendent — should know. It covers every aspect of the law that is important to the nurse, from her obligations as an employee to her responsibilities in witnessing a will. Tens of thousands of nurses found the first edition of this book valuable for study and for reference; the new edition is substantially larger, with added coverage of such topics as "good samaritan" laws, child abuse, telephone orders, supervision of paramedical personnel, sterilization, and organ transplantation. Canadian law is fully covered.

About 300 pages. About $8.75. Just ready.

Abdallah's Nurse's Aide Study Manual New Second Edition

By Mary E. Mayes, R.N., Supervising Nurse, Emergency Room, Ventura County General Hospital, Ventura, California.

The new Section Edition of this widely used handbook for nurse's aides has been considerably expanded, with many new topics added. Designed for use in inservice training programs, it is equally valuable for individual use as a review guide. It starts with the necessary orientation to the hospital and a summary of human anatomy; then it describes virtually every hospital procedure an aide might be called upon to perform. Each procedure is explained in specific, numbered steps, and review questions check the student's comprehension of each chapter. This edition covers advanced procedures that aides sometimes perform under supervision, such as tracheostomy care, catheterization, and oxygen therapy.

About 250 pages, illustrated. Soft cover. About $4.00. Just ready.

The Nursing Clinics of North America

The most recent issue of this famous hardbound periodical carries two symposia on topics of current importance to nurses. The first discusses in depth the care of the ambulatory patient. Hester Y. Kenneth is Guest Editor. The second symposium is on administration on the patient's behalf, with Helen W. Dunn as Guest Editor. Sixteen full articles and two special features are included in this issue — 172 pages with no advertising, bound between hard covers for permanent reference use. The Nursing Clinics brings you four such issues each year, all written specifically for nurses by famous nursing authorities.

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(continued from page 6)

one a sick child, and three expectant mothers or mothers with newborns — the reverse of the picture in 1960.

By 1969 the VON was participating in 29 coordinated home care programs in four provinces — Saskatchewan, Manitoba, Ontario, and Quebec. "Through them we have developed a closer partnership with government, with hospitals, and with other community health and welfare agencies," said Miss Leask. "Development of these programs has affected the personnel we employ, has enhanced the nursing service we can give, and has been one stimulant for the initiation of new programs."

By 1969 nursing was still the basic fundamental program of the VON, but in a few branches it had been joined by others, said Miss Leask. These include the provision of physiotherapy; five programs in home help service; and two "meals on wheels" services.

In several branches in Ontario a VON nurse is carrying out pre-employment health assessment examinations as well as reassessment on a regular basis in a part-time occupational health nursing program.

The changes in structure and program over the past decade are reflected in the type and number of personnel employed in 1969, said Miss Leask. There were 835 permanent positions in 1969, compared with 650 in 1960. Of these, 798 were nursing positions.

In addition to nurses and nursing assistants, the VON employs medical directors of coordinated home care programs, physiotherapists, a social worker, a supervisor for meals on wheels and homemaking service, and the home help staff.

"The rapidly shifting emphasis in our visiting nursing program to the care and rehabilitation of persons ill at home has brought new responsibilities and new opportunities for teaching," Miss Leask said. "It is essential that we maintain an adequate proportion of nursing staff with public health preparation," she added. Last year 61 percent of the nursing staff held this qualification, and 25 percent held baccalaureate or master's degrees in nursing.

RNAO Announces Greylisting

Toronto, Ontario.— The Registered Nurses' Association of Ontario, following a request from the Muskoka-Parry Sound Health Unit Nurses' Association, announced the greylisting of the health unit in May.

After prolonged negotiations, including the services of a conciliation officer and a mediator, the association and the employer were unable to reach agreement and the association exercised its right to strike. All public health nurses and registered nurses, with the exception of the supervisor, are on strike.

RNAO recommended that registered nurses not accept employment with the health unit until a satisfactory collective agreement has been negotiated on behalf of the present staff.

CNF Board Meets

Ottawa. – The board of directors of the Canadian Nurses' Foundation met at CNA House May 15 to ratify the choices by the CNF selections committee of recipients of 1970-1971 CNF scholarships. CNF president Hester J. Kernen, *center,* associate professor of public health nursing at the University of Saskatchewan, Saskatoon, talks with board members Sister Marie Bonin, *left,* faculty of nursing, University of Montreal, and Marion C. Woodside, associate professor, University of Toronto, Ontario.

NBARN Annual Meeting Sticks To Business Only

Fredericton, N.B. — Harriett Hayes of Moncton, N.B., was elected president of the New Brunswick Association of Registered Nurses at its 54th annual meeting May 21 and 22.

The meeting, which usually runs three days, was held in two days this year because of NBARN's involvement in hostess plans for the Canadian Nurses' Association's general meeting in Fredericton June 14 to 19. The shortened program featured business sessions only.

Highlighting the first session on May 21 was the address given by the outgoing president Irene Leckie, followed by a lunch at which life and honorary memberships in NBARN were presented.

Business sessions continued May 22 and concluded following the election of officers. Other officers elected were Apolline Robichaud, first vice-president; Lorraine Mills, second vice-president; Margaret MacLachlan, honorary secretary.

The 12th annual meeting of the New Brunswick Student Nurses' Association was held in conjunction with the NBARN meeting.

Three Staff Associations Certified In Nova Scotia

Halifax, N.S. — Three staff associations for registered nurses have been certified by the Nova Scotia Labour Relations Board. Certification includes in the bargaining unit all nurses except evening and night supervisors and those in positions above this level.

Margaret Bentley, employment relations officer for the Registered Nurses' Association of Nova Scotia, said there are now five such certified staff associations in the province. The three newly-certified associations are the New Waterford Consolidated at New Waterford, the Dawson Memorial at Bridgewater, and Colchester at Truro.

Neurosurgical Nurses Form World Federation

New York, N.Y. — The World Federation of Neurosurgical Nurses was set up at a meeting during the fourth international congress of neurological surgery, which took place in September 1969. The new federation is affiliated with the World Federation of Neurological Surgeons.

At the meeting, Agnes M. Marshall was elected president. She is course director in neurosurgical nursing at the Chicago Wesley Memorial Hospital and instructs in surgery at Northwestern University Medical School.

Elected secretary was Doris McDonald, staff nurse, department of neurosurgery, Charles Le Moyne Hospital, Greenfield Park, Montreal.

The next meeting of the Federation's executive committee will be in Prague, Czechoslovakia, in June 1971; its first international congress is scheduled for 1973 in Tokyo, Japan, in collaboration with the fifth international congress of neurological surgery.

Membership in the Federation is limited to nurses in the specialty field of neurosurgery as determined by its member societies throughout the world. Inquiries on membership should be sent to Miss McDonald.

US Nursing Students Protest Suffocating Education

Miami Beach, Fla. — Student nurses concluding their annual convention May 3 had a message for the American Nurses' Association, and it came through loud and clear: they want the opportunity to be involved with, and "to be human with," the people they are caring for.

Members of the National Student Nurses' Association presented their ideas at a joint meeting of NSNA and ANA with a demonstration, placards, and music. In a skit the students charged the nursing profession with fostering a suffocating educational system, with "murdering" ideals, and stifling involvement with patients.

Throughout the dialogue between students and experienced practitioners, students asked to be listened to and to be given a chance to demonstrate the depth of their commitment to humanity. Practitioners suggested that some of the students' "bones of contention" were not so much with the professional organization as with the system of delivery of care in health agencies.

ICN Congress Papers Published

Geneva, Switzerland – The International Council of Nurses is publishing in one volume reports and papers from its 14th quadrennial congress held in Montreal, June 1969. The book, entitled *Focus on the Future*, will contain:

- A résumé of the meeting of the Council of National Representatives in article form.
- Reports of the president, executive director, membership committee, and professional services committee.
- A résumé of the congress in article form.
- Papers presented in plenary sessions.
- A selection of papers presented in special interest sessions.

The expected publication date was April 30, 1970. The volume is available in English only. Price per copy of *Focus on the Future* is $12. (U.S. funds.)

Orders should be addressed to: International Council of Nurses, P.O. Box 42, CH-1211 Geneva 20, Switzerland.

ANA House Of Delegates Votes To Double Dues

Miami Beach, Fla. — The house of delegates of the American Nurses' Association approved a resolution to double ANA dues, effective September 1, 1970. The decision to increase the annual dues to $25 was made at the association's convention, held May 4 to 8.

Approval of the dues increase followed several efforts to resolve the ANA's financial plight by varying the amounts of the increase, and even by proposing no dues increase at all. Another suggestion was to appeal for additional voluntary contributions to pay off debts.

Many members argued that a national professional organization such as ANA cannot operate on donations, that failure to face increasing costs of a positive program would mean a weakening of the voice of nursing, and that ANA would have to "join the poverty group" as an association.

One delegate pointed out that the dues increase from $12.50 to $25.00 annually means 7 cents per day for each member. Another delegate said that most other national professional organizations have raised their dues in recent years "and we must put our money where our mouth is."

The vote for the dues increase was 816 to 249. Many of those who opposed the increase cited financial stress of their state associations and opposition to a dues increase from state association members. Several delegates expressed fear that the dues increase would mean loss in membership. Other delegates felt that without the increase, ANA could do nothing, and "an organization that does nothing will lose membership."

Delegates and members came to the

convention concerned about the serious financial difficulties of ANA. In several serious sessions they scrutinized financial reports and questioned elected officials and staff. They assessed the extent of indebtedness, the cost of maintaining minimal programs and staff, and the demands of the future. Late in the evening of the day before adjournment, they made their decision. The debts will be paid, and new and existing programs to permit nursing to make significant contributions to improve health care will be carried out.

Over 1,500 Nurses Attend First National OR Convention

Montreal. — What was a dream for operating room nurses in Quebec 12 years ago, became a reality last May 4.7.

During these four days the first National Operating Room Nurses Convention was held in Montreal. Some 1,500 nurses registered at the Queen Elizabeth Hotel. President of the Association of Nurses of the Province of Quebec, Helen Taylor, and second vice-president of the Canadian Nurses' Association, Margaret McLean, attended.

Throughout the convention interest in the agenda and the extensive range of exhibits was held at a high key. Speakers commented on a variety of subjects, including "Acute Emergencies," "Basic Hazards in OR to Patient and Staff," "Role of the OR in Kidney Transplant," and "The Professional OR Nurse and the OR Technician."

Claire Brault, operating room supervisor, Notre-Dame Hospital, Montreal, discussed the risks and dangers of the operating room. Miss Brault stated, "if the nurse is free to take a risk, she is also free not to expose herself to that risk nor to expose the patient."

"The latter," said Miss Brault, "is sufficiently handicapped without being exposed to an additional risk which could be fatal."

Explaining why she felt it was important for the role of the operating room nurse to be discussed, Miss Brault said, "The patient is always more or less anxious before surgery. He is aware surgery represents a certain amount of risk, for instance — he fears he may not wake up after the operation, that he may be deprived of his faculties, and he has other concerns.

"It is up to the nurse to give the patient the needed explanations, and make sure that this is done in a climate of calm trust," continued Miss Brault.

Risks involving the patient and the

At the first National Operating Room Convention, held in Montreal, May 4-7, the main theme was on the work of the operating room nurse and the technician. Two groups faced each other representing the doctors and the nurses. From left to right in this picture are, Dr. I. Shragovitch, chief surgeon, Jewish General Hospital, Montreal, and Dr. Shirley Stinson, associate professor, division of health services, University of Alberta, Edmonton, who defended the role of the technician in the operating room. Dr. Maurice Falardeau, surgeon, Notre-Dame Hospital, Montreal, and Thérèse Guimond, assistant director of nursing services, Maisonneuve Hospital, Montreal (not in the above picture) argued in favor of male and female nurses in the operating room of hospitals in Canada.

Cartoonist Normand Hudon did not lack models when he opened his sketchbook at the first national convention of operating room nurses, held May 4 to 7. An exhibitor at the convention guessed rightly, Mr. Hudon did prove popular.

operating room personnel were covered in Miss Brault's talk. She felt every precaution should be taken to safeguard all those concerned during surgery, and stressed that the operating room nurse must be able to assume her responsibility and so fully play her role as a member of the team responsible for the well-being of the patient.

Many of the speakers used audio-visual aids to illustrate their comments. This form of communication was well received by the audience.

Dr. R.A. Béique, physicist and chief of the medical biophysics department, Notre-Dame Hospital, Montreal, spoke on radium and radiology. He pointed out the risks of radiation for human beings, particularly somatic, genetic, and psychic effects.

The danger of explosions in the operating room was discussed by Jacques Degenais, biochemical engineer at the Cardiology Institute, Montreal. He outlined the need for good ventilation in the operating room, explaining that it also acts as a prevention against contamination.

A seminar on asepsis and sterilization was illustrated by cartoons. Bilingual legends were used throughout the discussion.

Discussing the role of the operating room technician, Dr. I. Shragovitch, chief surgeon, Jewish General Hospital, Montreal, said he was pleased to have an opportunity to, "try and further their role in our operating room milieu."

According to Dr. Shragovitch, an ORT program was started 15 years ago in the Jewish General Hospital, and was accepted by the ANPQ. He said the program had proved satisfactory, and illustrated the need for "further developing such a program."

Following a lengthy commentary on the subject, Dr. Shragovitch said, "It is not only my own and our own hospital experience that I am emphasizing, but the fact that the Canadian Task Force, our nursing bodies, and the experiences in the United States should move us all, especially the ORN, to continued efforts to develop this program."

Although the convention was packed with work sessions and discussions on subjects related to the operating room nurse and the technician, time was scheduled for relaxation each day. During these get-togethers, nurses and speakers continued their favorite topic — the operating room nurse and how best to serve the patient.

Nurses attending the three-day annual meeting of the RNANS at Acadia University, Wolfville, Nova Scotia, heard speakers discuss education and its application by the nurse. Four participants were, *left to right*, Sister Mary Felicitas, CNA president; Virginia Dunlop, inservice supervisor, Victoria General Hospital, Halifax; Isabel Brown, director of nurses, Scarborough Regional Hospital, West Hill, Ontario; and Sister Clare Marie, Glace Bay, who chaired the morning session.

CNA President Addresses RNANS Annual Meeting

Nova Scotia — Focusing attention on the word *love*, Sister Mary Felicitas, president of the Canadian Nurses' Association, told the May annual meeting of the RNANS here, that she felt love is an important factor in nursing care.

Definitions of the word, Sister said, included *nourish, preserve, and cherish*, each a vital force in itself.

Speaking to the three-day meeting at Acadia University, Wolfville, Sister Felicitas welcomed members of the RNANS before summarizing her concepts of the nurse-patient relationship, and its response to love.

Discussing an inservice program in a general hospital, Virginia Dunlop, inservice supervisor, Victoria General Hospital, Halifax, said, "industry has developed programs that assist employees to find their proper place in the organization and to develop their capabilities to the fullest." An inservice program, according to Mrs. Dunlop, "should be developed around the areas of personnel needs — orientation, skill training, development of leadership, management abilities, and continuing education."

A representative from the Halifax Youth Agency, Alistar Watt, told the nurses, "We are a drug taking society. Half the commercials on television are aimed at making you take some kind of drug."

Referring to the widespread use of non-medical drugs and the rehabilitation of the addict, Mr. Watt stressed, "Unless society can give the addict that which he needs to be able to cope without drugs, he will be back on the street."

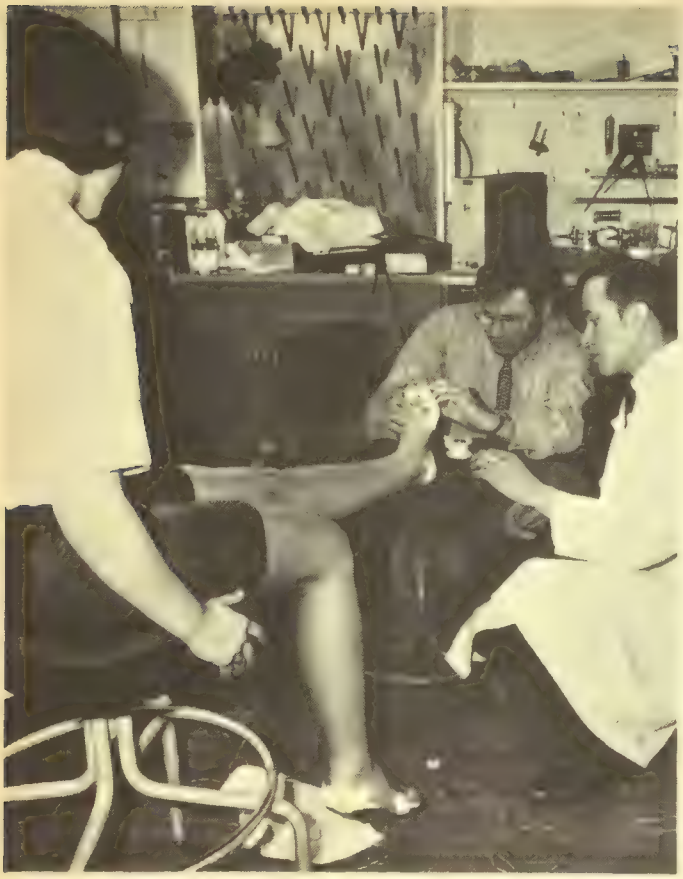
Posing a tantalizing question, barrister George Cooper asked his audience if the law should take upon itself the job of, "dictating morals to these [drug addicted] people."

Isabel Brown, director of nurses, Scarborough Regional Hospital, West Hill, Ontario, presented a synopsis of the two-year program in action. Followed by a question and answer session, the symposium detailed the various facets involved in the program.

Reports from local branches were received from committees on nursing education, nursing service, and social and economic welfare.

Membership in the RNANS was reported as 4,665 in 1969, and the enrollment in schools of nursing 500.

Other points of interest in the reports included: the repeal of the present Board of Examiners by-law, enabling broader representation to meet the needs of the CNA testing service; a two-year diploma program for five schools of nursing approved, and approval given to shorten affiliation programs in obstetrics, pediatrics, and psychiatry to eight weeks; the G.E.D. test accepted for assessing the prospective mature student; and $3,000 voted to the Canadian Nurses' Foundation Scholarship Fund.



Attaching footswitch electrodes to the foot of secretary Joan Bryan at the NRC Laboratory is a tedious but important routine before the gait study can commence. Dr. Morris Milner (center) and his work associate, Arthur O. Quanbury, are seen taping metal pads in position. A closeup of the footswitch electrodes and electromyographic electrodes, located on the outer side of both legs, is seen as the subject begins her walk along the metal strip on the sixty-foot wooden walkway.

Computerized Walking

Ottawa — "Watching the girls go by" is more than a light-hearted phrase for two bioengineers at the National Research Council in Ottawa. Their concern is the study of human locomotion and the development of programmed electrical stimuli to activate paralyzed lower limbs.

Walking on a metallic strip, down a 60 foot walkway, to the tune of a constantly beeping machine, has been a 21-year-old secretary's contribution to the study. Dr. Morris Milner and Arthur O. Quanbury, bioengineers in the Control Systems Laboratory, NRC, carefully noted her gait as they researched data on muscle stimuli.

Under conditions programmed by the engineers, the secretary's walkway preambulations were paced by a moving study-cart. Affixed to her heels and toes were metal pads. As the pads made contact with the metallic strip, an electronic beep in the study-cart recorded gait measurements in signals transmitted by wires attached to her legs, and a junction box carried at her waist.

To the watchful engineers, the constant beep alerted them to peculiarities in walking habits and muscle use.

Describing their work to *The Canadian Nurse,* Dr. Milner referred to his comments in *Nature,* August 9, 1969, where he and his associate, Arthur Quanbury, noted that the study ". . . deals with the effects of surface stimulation on normal human beings. Electrodes of various areas, and stimuli consisting of square wave voltage pulses of 50 Hz, 0-2 ms wide and going negative at the stimulus site, were used. These pulses were applied in trains lasting for one second, with an intervening rest period, also of one second. This regimen corresponds roughly to the periods of activity of the various muscle groups in an average walking cycle."

Interest in the study started a year ago, when the two bioengineers discovered little attention had been given to the evaluation of problems and development of devices, enabling totally paralyzed lower limbs to be moved.

They feel the value of their work "will depend on the ability to relate joint trajectories to specific abnormalities and deficiencies, and to extract pertinent data for electro-stimulation of useful muscles."

Full understanding of the detailed, complex process of human locomotion is the initial aim of the study. To achieve this, and to find answers to involved questions, undergraduates from Carleton University in Ottawa have experimented with a human leg formed in clear plastic. They have "explored internal electric fields produced by electrically active surface electrodes," attempting to gain greater knowledge of the "best surface stimulation arrangements." The leg is fitted inside with leg bone structure and filled with a "physiologically normal solution."

Other experiments include the use of rats in a study on "how muscles might best be used as transducers, to extract information about the forces they exert and the motions they impart to the limbs."

"If found feasible," says Dr. Milner, "our experiments will be a positive way to monitor the position and behavior of the neuromuscular system, subject to programmed electro-stimulation.

A research group in Winnipeg, with "similar, but more immediate clinically oriented interests" has been collaborating with the NRC team.

Dr. Milner, who came to Canada from South Africa to take part in the study, will be returning to his homeland this

summer. He will introduce the locomotion study in the Groote Schuur Hospital, Capetown, where he has been appointed head of medical physics in bioengineering.

Asked if the nursing profession would be involved in the hospital application of this study, Dr. Milner said, "Although nurses have not been involved in the NRC experiment, I expect the nurse to take active participation eventually.

"They will definitely be of great assistance to me and my work in South Africa," he added.

American Indian Nurse Is ANA Choice

Miami Beach, Fla. — Audra Pambrun, a member of the Montana Blackfeet Indian tribe, was named national winner of the American Nurses' Association BE-INvolved Nurse contest. The announcement came May 5 at the ANA annual convention.

All registered nurses in the United States were eligible for nomination in the ANA search for exceptional performance in improving the health, social, or economic climates of their communities. Miss Pambrun, who received a $2,000 award from Schering Laboratories, is contributing half of this award to Montana's first suicide crisis intervention center in Browning, Montana, which she opened a year ago. This center is manned by aides trained by Miss Pambrun.

As director of community health aides for the Office of Economic Opportunity's community action program in Browning, Miss Pambrun covers a territory that has a caseload of 7,000 Blackfeet Indians. Each month she drives 2,000 miles to visit at least 50 families. She has trained local people, mostly Indians, to work as community aides.

They visit almost every home on the Blackfeet reservation to help with services such as transportation to hospital, housing repair, sanitation, and counseling. Miss Pambrun has also set up an accident prevention workshop for community aides in Browning.

Student Nurses In U.S. Show They "Give A Damn"

Miami Beach, Florida. — More than 1,000 members of the National Student Nurses' Association in the United States set the stage for the 18th annual convention of the organization, held April 30 to May 3, with a one-day hunger strike.

Wearing white armbands, many fastened with "Give a Damn" buttons to indicate the day's theme, the students bought food with the amounts allotted to welfare recipients in their respective states. These amounts ranged from 3 cents per meal in Puerto Rico to 28 cents in New York State.

Sparked by a resolution introduced by the District of Columbia Student Nurses' Association, the protest diet spread throughout the convention. This meant sharing a jar of peanut butter and a loaf of bread or a meal of crackers and water.

Senator George McGovern, in his keynote speech at the convention, noted that 15 million Americans suffer daily from lack of food. He pointed out that the average taxpayer contributes $400 annually to military expenditures and $2 annually to feed the hungry.

The National Student Nurses' Association includes representatives from all states except Alaska, plus the District of Columbia and Puerto Rico. The four-day convention preceded the biennial meeting of the American Nurses' Association, May 3 to 8. □

names

Florence H.M. Emory, *second from left,* received an honorary Doctor of Laws degree from the University of Toronto, May 29. Until her retirement in 1954, she was associate director of the University of Toronto School of Nursing. Congratulating Dr. Emory are, *left to right,* Dr. Claude Bissell, president of the university; Dr. Omond Solandt, chancellor; and Dr. Helen Carpenter, director of the school of nursing. The citation read, in part: "Miss Emory influenced the development of public health nursing in Canada and throughout the world through her publications and through the students she taught." Dr. Emory is author of the well-known text *Public Health Nursing in Canada,* published in 1945.

An honorary Doctor of Laws degree has been awarded by the University of Toronto to **Florence H.M. Emory,** professor emeritus of the university's school of nursing and an internationally honored nursing leader.

Because of her early interest in preventive medicine, Dr. Emory entered the Grace Hospital School of Nursing in Toronto, graduating in 1915. She then joined the Toronto department of public health, working as a district superintendent and later supervisor of the school health service.

In 1924, after a year of studies in preventive medicine and public health at the Massachusetts Institute of Technology and Boston College, Dr. Emory joined the department of public health nursing at the University of Toronto as assistant director. This department became the school of nursing in 1933, and in 1938 Dr. Emory became associate director of the school.

She is also well known for her work as professor of nursing with particular responsibility for public health teaching, and her leadership in establishing the bachelor of science in nursing course, the first of its kind in Canada.

Dr. Emory has contributed greatly to many professional and community organizations. She was chairman of the public health nursing section of the Canadian Public Health Association from 1925 to 1927; first president of the Registered Nurses' Association of Ontario from 1927 to 1930; president of the Canadian Nurses' Association from 1930 to 1934; chairman of the membership committee of the International Council of Nurses; and national chairman of nursing services for the Canadian Red Cross Society.

In 1953, Dr. Emory was awarded the Florence Nightingale Medal by the International Committee of the Red Cross. After her retirement in 1954, she served as honorary adviser in nursing to the Red Cross Society.

Eileen M. Jacobi has been appointed executive director of the American Nurses' Association. She succeeds Hildegard E. Peplau, interim executive director since September 1969, who was elected president of the association at the ANA convention in Miami Beach.

Dr. Jacobi has served as ANA associate executive director since December 1968. She has a diploma in nursing from Cumberland Hospital School of Nursing in Brooklyn, New York; bachelor's and master's degrees from Adelphi University, Garden City, New York; and a doctoral degree from Teachers College, Columbia University.

The new executive director has a wide range of experience in clinical nursing, education, research, and administration. From 1956 to 1968 she was an assistant professor, associate professor, professor, and dean at Adelphi University. She has worked as psychiatric nursing consultant, Veterans Administration Hospital, New York City; instructor in nursing education and consultant in psychiatric nursing at Teachers College, Columbia University; and supervising research nurse at Creedmoor Institute for Psychobiologic Studies, Queens Village, New York.

Dr. Jacobi is consultant and ANA liaison to the National Institute of Mental Health Advisory Council, and is active in numerous professional, community, and educational organizations.

E. Jean Mackie (R.N., Royal Alexandra H., Edmonton; certificate in teaching and supervision, U. of Toronto; B.N., McGill; M.N., U. of Washington, Seattle) has been named director of nursing at Selkirk College, Castlegar, British Columbia. The college's new nursing program will begin in September 1971.

Miss Mackie was previously director of the Algoma Regional School of Nursing in Sault Ste. Marie, Ontario. She has been chairman of the department of nursing education at Mount Royal Junior College in Calgary; medical-surgical nursing teacher at Everett Community College in Everett, Washington; assistant director of nursing education and clinical teacher at the General Hospital

Nurse Elected President of CPHA

Geneva Lewis, director of public health nursing for the Ottawa-Carleton region, accepts the congratulations of two staff members in her office at the public health unit. Mrs. Lewis is the first nurse and the first woman to be elected president in the 61-year history of the Canadian Public Health Association. Here, she looks at press clippings of the CPHA convention, held in Winnipeg May 19 to 22, with Wilhemina Visscher, *left*, assistant director of public health nursing for the Ottawa-Carleton region, and Catherine McGregor, *right*, a supervisor at the health unit.

A graduate of Hamilton General Hospital and the University of Buffalo, Mrs. Lewis has had 20 years experience in public health. After 10 years with the Welland district health unit, she accepted her present position in 1960.

Mrs. Lewis told *The Canadian Nurse* that, as president, she hopes for increased lay involvement in the association and for a closer liaison with other health agencies. She would also like a closer relationship between associations such as the CPHA and the Canadian Nurses' Association.

in Calgary; clinical teacher at the General Hospital in Medicine Hat, Alberta; and nursing arts teacher at the Royal Alexandra Hospital School of Nursing in Edmonton.

D. Jean Passmore

Elizabeth E. Hartig

The Saskatchewan Registered Nurses' Association has announced two appointments to its professional staff: D. Jean Passmore and Elizabeth E. Hartig.

D. Jean Passmore (R.N., Royal Jubilee H., Victoria, B.C.; dipl. teaching and superv., U. of Saskatchewan, Saskatoon) is the new assistant registrar for SRNA.

Mrs. Passmore, a native of Calgary, Alberta, was an obstetrical instructor at Providence Hospital in Moose Jaw, Saskatchewan, before her appointment. She has also worked in general duty, surgery, and obstetrics at Providence Hospital.

An active member of SRNA, Mrs. Passmore has been vice-president, secretary-treasurer, and chairman of the education committee of the Moose Jaw chapter, and a member of the committee setting examinations for nursing assistant certification in Saskatchewan.

Elisabeth E. Hartig (R.N., Royal Victoria H., Montreal; B.Sc.N., U. of Western Ontario, London; M.N., U. of Washington, Seattle) is the newly-appointed nursing consultant for SRNA. In this position, Miss Hartig is responsible for providing consultative services to the general membership of SRNA, with major emphasis on continuing education programs.

Miss Hartig has worked as an operating room nurse at Victoria General Hospital and Deer Lodge Hospital in Winnipeg, Manitoba. For 10 years she served with the Lutheran Church in America's board of world missions in India, where she worked as a director of a school of nursing, in nursing service, and in hospital administration.

Since her return to Canada, Miss Hartig has been a clinical instructor at the Royal Alexandra Hospital in Edmonton, Alberta, and matron of Good Samaritan Hospital in Edmonton. From 1961 to 1963, she was director of the centralized teaching program for student nurses in Saskatoon, Saskatchewan. She has also been medical-surgical coordinator at the University of Saskatchewan school of nursing in Saskatoon; assistant professor in nursing education at The University of Western Ontario in London; and assistant superintendent of nursing education and director of the school of diploma nursing at the Saskatchewan Institute of Applied Arts and Sciences in Saskatoon.

Ruth C. MacKay (Reg.N., Hamilton General H.; B.A., McMaster U., Hamilton; M.N. and M.A., Emory U., Atlanta, Georgia; Ph.D., U. of Kentucky, Lexington) has been appointed associate professor at Queen's University School of Nursing.

Dr. Mackay was an instructor in nursing at Emory University and the University of Kentucky; coordinator of the sophomore year at the University of Kentucky College of Nursing; public health nurse in St. Petersburg, Florida, and Dalhousie, New Brunswick; and general duty nurse at Mount Hamilton Hospital in Hamilton, Ontario.

Margaret J. Brackstone (Reg.N., Public General H., Chatham, Ont.; Dipl. Nurs. Educ. and B.Sc.N., U. of Western Ontario, London) is the new assistant director, school of nursing, at Public General Hospital in Chatham.

Before this appointment, Mrs. Brackstone worked as an instructor at Hamilton Psychiatric Hospital, and at Hamilton Civic Hospitals School of Nursing in Hamilton, Ontario.

Jean Dobson (R.N., Victoria General H., Halifax; Dipl. Nursing Serv. Admin., Dalhousie U.; B.Sc.N., Mount Saint Vincent U., Halifax) is the new director of nursing at Nova Scotia Sanatorium in Kentville, Nova Scotia.

Miss Dobson has experience as a staff nurse at Victoria General Hospital in Halifax, The Montreal General Hospital, King Edward VII Memorial Hospital in Bermuda, and Blanchard-Fraser Memorial

names

Hospital in Kentville, Nova Scotia. She has also been a staff nurse, head nurse, supervisor, and director of nursing service at the Nova Scotia Sanatorium.

An active member of the Registered Nurses' Association of Nova Scotia, Miss Dobson is a past president of the Valley branch, a member of the RNANS nursing service committee, and a third vice-president of the association.

Alberta G. McColl (R.N., Regina General H.; Dipl. P.H.N., U. of Saskatchewan, Saskatoon; B.S.N., U. of British Columbia; M.S., U. of California, San Francisco) has been appointed associate director of nursing education at Royal Columbian Hospital school of nursing in New Westminster, British Columbia.

Miss McColl first joined the hospital school faculty in 1960 as surgical nursing instructor. From 1965 until her new appointment, she was psychiatric nursing instructor in the affiliate program. Her previous experience also includes work as a public health nurse with the department of public health in the Weyburn-Estevan district of Saskatchewan.

As an active member of the Registered Nurses' Association of British Columbia, Miss McColl is a past secretary and president of the New Westminster chapter. She is currently a member of the RNABC committee on nursing education and a member of the board of examiners.

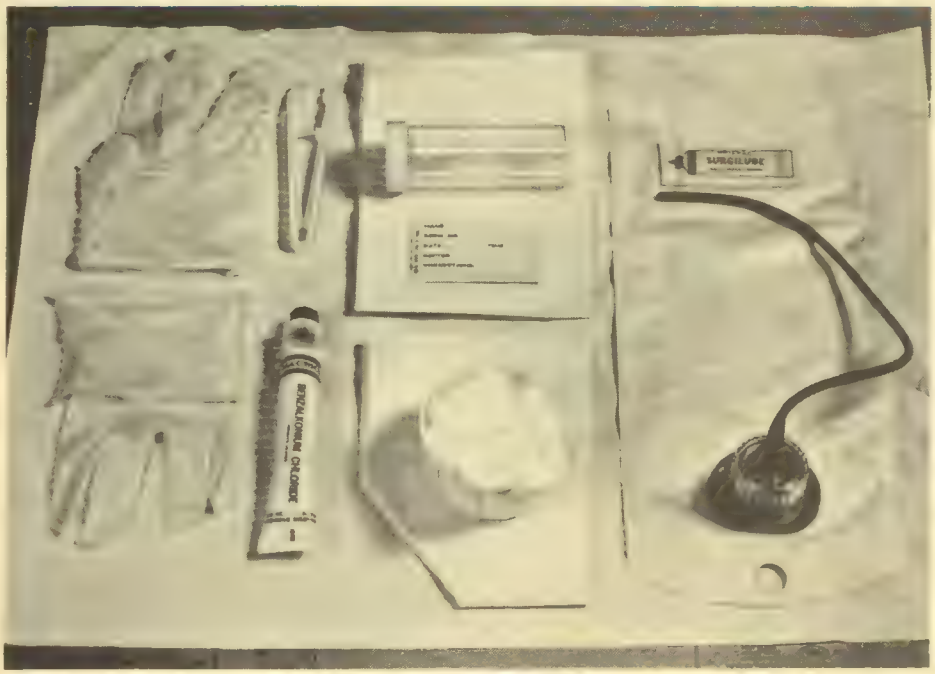
Miriam Pill (S.R.N., Kings College H., London, England; S.C.M., maternity hospitals in Cambridge and Dorset, England; Cert. Teaching and Admin. and B.Sc.N.E., U. of Ottawa) has been named director of nursing at Maimonides Hospital and Home for the Aged in Montreal.

Before coming to Canada, Miss Pill worked as an operating room staff nurse at Freedom Fields Hospital in Plymouth, England. She was a supervisor of nurses at the Ottawa Civic Hospital and was assistant administrator at New Orchard Lodge in Ottawa prior to her appointment.

Active in the Registered Nurses' Association of Ontario, Miss Pill was first vice-president of the Ottawa West Chapter in 1969. □

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.



Urethral Catheter Tray

Urethral Catheter Tray

This generously-sized, closed system collection bag can accommodate the contents of even greatly distended bladders without the need for disconnecting, emptying, and reconnecting. Because the system is completely closed, there is no danger of spilling or leakage during use.

The specially designed, screw-on connector protects the funnel end of the catheter from contamination and permits collection of sterile specimens without contamination of the catheter or specimen container. The 1,500-ml capacity collection bag features an opaque white backing that permits excellent visual monitoring of urine coloration and flow. The tray is complete with all items needed for procedure, all sterile packaged within a CSR wrap.

This MacBick product is distributed through the Stevens Companies in Toronto, Calgary, Winnipeg, and Vancouver, and from Compagnie Medicale & Scientifique Ltée. and Quebec Surgical Company in Montreal.

Safety Grip Bath Seat

This safety grip bath seat overcomes difficulties experienced in using a bathtub and aids in personal washing. The elevation of the seat permits its use as a Sitz bath in a regular bathtub.

Constructed from chrome-plated tubing, this unit is fitted with non-slip rubber tips to give extra holding power. The bath seat features an open frosted seat 6 inches high, with a wide base of 14 inches.

For complete details write to Everest & Jennings Canadian Limited, P.O. Box 9200, Downsview, Ontario.

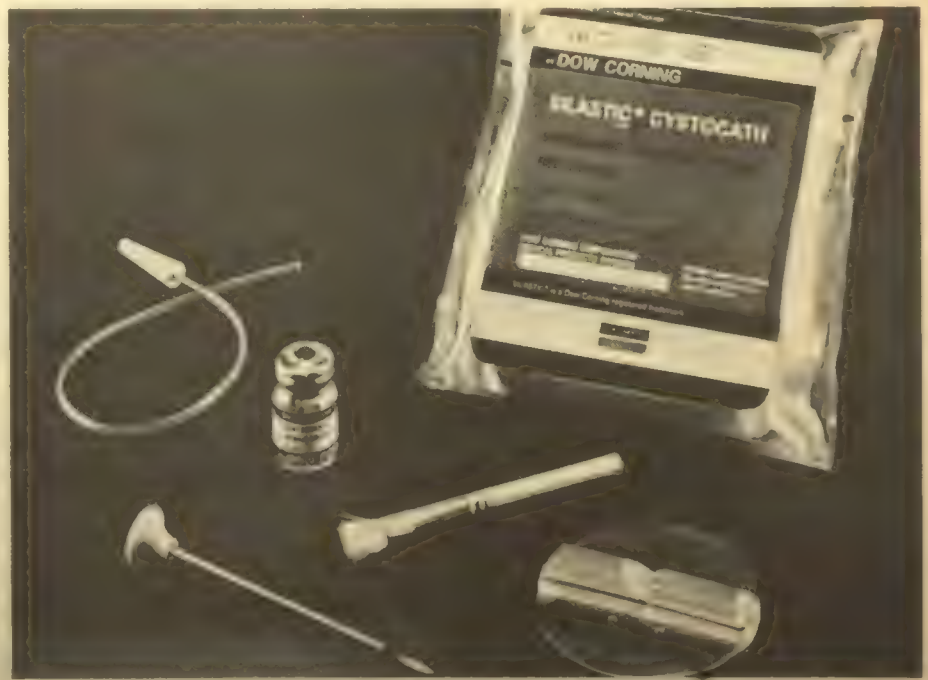
Bladder Drainage

A new self-contained suprapubic system for bladder drainage following gynecological surgery has been introduced by Dow Corning.

The Silastic Cystocath features a soft, flexible, incrustation-resistant silicone rubber catheter; an easily-applied body seal for catheter fixation and protection of catheter entry site; and a non-irritating, pressure-sensitive, silicone adhesive that affords maximum protection for the duration of use.

This system promotes early spontaneous voiding and minimizes the possibility of bladder contamination. In addition, trauma due to urethral catheterization and subsequent patient discomfort are eliminated.

Specific material and design advantages, plus the benefits of a matched components system, represent a significant advance to the postoperative management of bladder drainage. The Silastic Cystocath is packaged sterile and is disposable. More information is available from the Medical Products Division, Dow Corning Silicones, 1 Tippet Road, Downsview, Ontario. □



Bladder Drainage

dates

August 2-7, 1970
Congress of the International Association for Child Psychiatry, Jerusalem, Israel. Theme: The Child in his Family. Details on group air fare and travel programs are available from Dominion Travel Office Ltd., 55 Wellington St. West, Toronto 1, Ontario.

August 24-28, 1970
Workshop for library staff in nursing, hospital, and medical libraries, sponsored by the OMA, OHA, and RNAO, Wilson Hall, New College, University of Toronto. Topics to be discussed include administration of a library, collection development, organization of library materials, and library services. Applications are available from: Miss S.C. Maxwell, Librarian, Ontario Medical Association, 244 St. George Street, Toronto 5, Ontario.

September 1970
14th annual Registered Nurses' Association of Ontario conference on personal growth and group achievement. For further information write to: Professional Development Department, RNAO, 33 Price Street, Toronto 5, Ontario.

September 26, 1970
The Nightingale School of Nursing in Toronto is marking its 10th anniversary with an open house and reception for alumni and invited guests. For further information, write to The Nightingale School of Nursing, 2 Murray Street, Toronto 2B, Ontario.

September 28-October 9, 1970
Two-week symposium on the nurse's role in prevention and treatment of acute and chronic respiratory insufficiency, Manitoba Rehabilitation Hospital, Winnipeg. Further details are available from Miss E.L.M. Thorpe, Consultant, Sanatorium Board of Manitoba, 800 Sherbrook Street, Winnipeg 2, Manitoba.

October 5-6, 1970
Institute on operating room and central supply room procedures, auditorium, Calgary General Hospital School of Nursing. Sponsored by the Alberta Association of Registered Nurses. For further details write to the AARN, 10256 - 112 Street, Edmonton, Alberta.

Ocrober 5-30, 1970
Advanced program in health services organization and administration, The University of Toronto School of Hygiene. The second part of this program will be held March 1-26, 1971. Fee: $200 for each part. For further information, write to: Dr. R.D. Barron, Secretary, School of Hygiene, University of Toronto, Toronto 5, Ontario.

October 7-10, 1970
Annual conference, Canadian Association for the Mentally Retarded, Hotel Vancouver, Vancouver, British Columbia. Special emphasis will be on the preschool child, residential services, and occupational-vocational programs.

October 25-29, 1970
National conference on the impact of the environment, sponsored by the Canadian Council on Children and Youth and The Vanier Institute of the Family, Winnipeg. For more information, write to The Vanier Institute of the Family, 170 Metcalfe Street, Ottawa 4, Ontario.

October 26-28, 1970
Ontario Hospital Association annual convention, Royal York Hotel, Toronto. Write to the OHA, 25 Ferrand Dr., Don Mills, Ontario.

October 26-28, 1970
Annual meeting of the Association of Registered Nurses of Newfoundland, St. John's. Write to the AARN, 67 Le Marchant Rd., St. John's, Nfld.

November 30-December 4, 1970
Conference for nurses in staff education and staff development, Westbury Hotel, Toronto. Sponsored by the Registered Nurses' Association of Ontario. Write to: Professional Development Department, RNAO, 33 Price Street, Toronto 5, Ontario. □

in a capsule

Arteriosclerosis studied

Which comes first in vascular disease — arteriosclerosis or atherosclerosis? According to an article in the April 7 issue of *The Medical Post,* the terms are often used interchangeably, and both are correct, but only at a certain stage of the disease.

The author of the article, Derek Cassels, reports that a research team from New York's Cornell University believes that fibromuscular thickening of the inner arterial coat — arteriosclerosis — comes first. After this initial change a secondary phase leads to deposition of fatty tissue to transform the disease to atherosclerosis.

The researchers have been studying these disorders for many years, using rabbits in their experiments. In their report they conclude: "These results [of the various experiments] indicate that fibromuscular thickening of the inner arterial coat can be a preferential site of fat deposition. The results also suggest that in man the primary event in atherosclerosis is not necessarily deposition of fat as is widely believed but is, at least in some instances, arterial injury."

Phenacetin warning

Phenacetin has been in the news a good deal lately.

Following The Vancouver General Hospital's decision in January to replace tablets containing phenacetin with others that are free of this ingredient, a number of doctors have commented on the possible dangers of phenacetin.

According to a news item in *The Globe and Mail* January 22, Dr. William Mahon, clinical pharmacologist at the Toronto General Hospital, said he planned to recommend that TGH also change to phenacetin-free pills. Phenacetin ought to be taken off the market, he said. Dr. Mahon pointed to research in Australia that indicates this compound can be a substantial hazard if taken in large amounts.

Another Canadian authority, Dr. Jeffrey Bishop, director of the federal government's Drug Advisory Bureau, Food and Drug Directorate, listed 217s, 222s, Exedrin, Sinex, Sinutab, and Coricidin as preparations containing phenacetin that do not require prescriptions in Canada. He lists the following over-the-counter preparations that do *not* contain the compound: Contac-C, Dristan, Bufferin, Anacin, Neocitran, Instantine, and Bayer Decongestant capsules.

Dr. Bishop told *The Canadian Nurse* that phenacetin has been suspected of causing renal damage. Since 1965, the Food and Drugs Act has required that labels on preparations containing phenacetin carry a warning. The Food and Drug Directorate is now studying all reports of renal damage associated with phenacetin, and is looking at acetaminophen, another antipyretic-analgesic agent. The Directorate is considering further regulatory action, Dr. Bishop said.

In an article in *The Canadian Nurse* in December 1964, Dr. John B. Dossetor, a leading Canadian nephrologist, wrote: "Analgesic preparations can damage the kidneys when ingested in excessive amounts. Phenacetin is a common ingredient of such pills and is believed by many to be the toxic factor."

Concluding his article, Dr. Dossetor said: "It may be necessary to do no more than caution users of phenacetin-containing compounds, by means of the label on the bottle, that excessive intake might cause kidney damage."

Don't rock the boat

With water sports now in full swing, it's a good time to follow the advice of the Canadian Red Cross Society.

- If you use a power boat, see that the motor matches the boat. Attaching a large motor to a small boat can be dangerous.
- Make sure your boat is large enough for the number of passengers you intend to carry. A small metal plate on the boat gives safe load and power specifications.
- Outfit your boat with legally specified safety equipment — one lifejacket for each person on board, two oars or paddles, a bailing bucket or manual pump, and a fire extinguisher. It is also advisable to carry red distress flares, tool kit, first aid kit, and anchor on a 50-ft. line, and spare gas. □

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Teachers — you are trespassing!

The author suggests that the question of "territory" is responsible for the hostility between nurse educators and ward staff.

Daphne Walker Mesolella, R.N., B.N.

Most nurses are aware of the hostility that exists between nursing service personnel and nurse educators. What is the reason for this antagonism?

Conversations I have had with educators and ward staff in my own hospital and in others lead me to believe that the hostility between these two groups is too widespread to be written off in terms of individual personalities.

Question of territory

A key factor responsible for this hostility is "territory." As Robert Ardrey notes, "What territory promises is the high probability that if intrusion takes place, war will follow."*

In the hospital, the unit is the territory of the staff members working there. This is clearly shown by the adjectives commonly used by staff members to describe their place of work: "This is *my* ward," or "How are *your* patients today?"

Into this private territory intrude the clinical instructor and her students.

The degree of hostility directed to the instructor and her students is related to the length of time they spend on the ward. At one point when I was a student in a hospital school of nursing, I was assigned to the same ward for several weeks. My classmates and I joined the permanent nursing staff and received most of our clinical teaching from the head nurse and the registered nurses on the unit. The staff members accepted us and showed no hostility — perhaps because we worked the same hours and rotated shifts with them. Thus, we were not considered intruders.

In those days, university nursing students, accompanied by their own instructors, came to our wards periodically for clinical experience. As "hospital-trained" students, we resented these "intruders" and often interpreted their short ward visits and small patient assignments as an indication of their disregard for the needs of *our* patients.

Problem grows

Recent developments in nursing education have intensified the problem of territory. Community college programs in some provinces and the CEGEPs in Quebec have diminished the time students spend on the wards. Also, with hospital schools of nursing gaining more control over their students' time, with programs being enriched by more clinics, and with more instructors assigned to the wards with students, the students and their instructors are no longer considered members of the ward team. They come to the ward several times a day generating even more hostitility.

How can this hostility be reduced?

Few educators would want to revert to the days when student nurses worked long hours, rotating evening and night shifts, and were often too tired to absorb lectures and planned learning experiences. Nor would the solution be to eliminate the role of clinical instructor. Students have benefited from a nurse educator whose primary function is to guide their learning.

Perhaps, as Maxwell Jones suggests, hospitals should be totally decentralized, with each unit autonomous, and each area responsible for teaching its students. ** In line with this thinking, the clinical instructor would join the ward staff as a permanent member of the team. Between periods of teaching, she could become more involved in direct patient care. Such involvement would keep her up-to-date and would give her a chance to become better acquainted with the rest of the nursing staff. She might even act as a consultant for staff members if requested.

Only when such a plan is adopted, or when students' clinical experience closely approximates the ward schedule, will nurse instructors and their students be accepted by ward staff — not as trespassers, but as members of the team.

The author is a graduate of the Royal Victoria Hospital School of Nursing in Montreal, and received her Bachelor of Nursing degree from McGill University. She was a Clinical Instructor at Douglas Hospital in Verdun, Quebec, when she wrote this article for *The Canadian Nurse*.

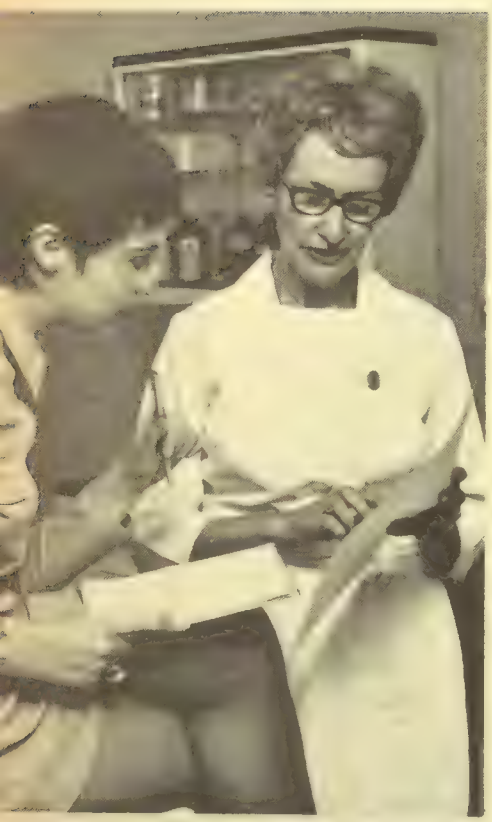
* Robert Ardrey, *The Territorial Imperative*, New York, Dell Publishing Co., Inc., 1966.

** Maxwell Jones, *Social Psychiatry in Practice*, Middlesex, England, Penguin Books, 1968, pp. 179-180. □

She's a regular at the racetrack...

... and as the registered nurse at Blue Bonnets about the only thing she hasn't done yet is look after the horses!

Valerie Fournier, B.A., B.J.



Author Valerie Fournier, left, interviews Mrs. Geoffrion in her first-aid room under the grandstand at Blue Bonnets racetrack in Montreal.

Someone you're always sure to find at the Blue Bonnets Racetrack in Montreal is Denise Geoffrion — she's been a regular for 14 years. She knows all the jockeys, sulky drivers, and staff at the huge, modern track. Yet the most she ever bets on the horses is $10 or $15 a year.

"I'd be a fool if I spent more than that," says Mrs. Geoffrion, who is the registered nurse on duty during every race at Blue Bonnets. In her years of working at the track she has seen too many people with heart attacks, anxiety, and empty wallets to feel the gambling urge herself.

Mrs. Geoffrion has many potential patients to worry about every night: 950 employees in the stands, more than 1,200 persons working in the stables, and up to 35,000 spectators in the stands — though the nightly average is between 8,000 and 10,000. "It's like a small town after 7:00 p.m.," says Mrs. Geoffrion. Last year she treated over 3,000 patients and sent 300 of them to hospital.

Present for all races

The presence of a registered nurse and a doctor at race time is specified in the contracts of the jockeys and sulky drivers at Blue Bonnets. Mrs. Geoffrion, whose first language is French, is also on hand to treat visitors and staff.

This season there are 210 days of harness racing and 63 days of flat racing at the track. "Sulky drivers and jockeys are two entirely different breeds," Mrs. Geoffrion says. "The drivers don't come

Mrs. Fournier, a graduate of Carleton University's School of Journalism, is Public Relations Officer at the Canadian Nurses' Association, Ottawa, Ontario.

On quiet nights at the racetrack Mrs. Geoffrion keeps herself busy. Here she finishes crocheting a mauve and white hat made of raffia.

As part of her job Mrs. Geoffrion checks on the health of the staff at Blue Bonnets. Here she takes the blood pressure of Harold Woolgar, an electrician at the track.

to me for first aid unless there is a bad accident on the track. Most of the time I have to run after them to treat them. They figure it's closer and easier to get treatment along with their horses from the track veterinarian!"

On the other hand, the jockeys are always coming in with minor ailments. Mrs. Geoffrion says they tend to be fussy and temperamental and keep her very busy. Flat racing is also more dangerous than harness racing.

The jockeys worry over a small scratch or a headache, and expect Mrs. Geoffrion to come over to their rooms on the other side of the stands for an examination, even though all medical equipment is kept in the first-aid room. If a jockey claims he cannot race because of some ailment, Mrs. Geoffrion must go through a complicated procedure that involves bringing in the superintendent and track judges to confirm that he is incapable of riding. If he misses a race without due cause, he is fined at least $40.

"I must know all my boys," she says of the jockeys and drivers. "I have to train them to come to me when necessary, and I am careful how I handle them." After 14 years at the track, she knows the individual problems of each jockey. One regular is a hemophiliac, and she is particularly anxious when she knows he is riding.

A full-time job

Mrs. Geoffrion started her job as track nurse when it was a part-time position. In those days the racing took place at Richelieu Park, a smaller track in Montreal, and races were held for only 100 days a year. The racing season has lengthened each year, and now her job keeps her working five evenings a week for eleven and a half months.

"I also work 50 Sunday afternoons a year," she says, "but for some reason I'm still considered a part-time employee. I don't know how much more regular I can get!" Mrs. Geoffrion starts work around 6:00 p.m. each evening and stays until after the crowds leave before midnight.

Sometimes Mrs. Geoffrion is swamped with calls, especially during special events when a large purse is at stake. The excitement is apparently too much for some people. Sunday afternoons during the summer are also busy. "Pregnant women and people with epileptic or cardiac conditions watch the races and forget they are standing in the sun for two or three hours," she said.

Heart attack is the most serious emergency the nurse encounters, and it happens frequently at the racetrack — usually once every three or four days. A police ambulance can be on hand within four minutes for visitors, and those who require hospitalization are usually taken to St. Mary's, the nearest hospital.

Mrs. Geoffrion has treated many arm and leg fractures resulting from accidents during races, and an ambulance is kept on the track at all times for emergencies that involve jockeys and drivers. She is alerted to a crisis on the track by the closed circuit television and the loudspeaker in her room.

Accidents big and small

One of the most spectacular accidents occurred this year when the lead horse in a harness race tripped and fell. Five horses, their drivers, and sulkies piled into the first team. Luckily only one driver was hurt when a horse fell on him and broke his collarbone. Four of the six drivers involved came to Mrs. Geoffrion for treatment of minor injuries.

In fact, minor problems, such as scratches, splinters, headaches, and burns, are the most common ailments Mrs. Geoffrion treats. But with so many people in the stands, these often keep her more than busy. Every night she compiles a full report on the number of patients and their treatment.

Most of these visits are quite routine, but she does have the occasional story to tell. There was the time, for instance, when a rotund man being treated for a minor burn fainted and fell right on top of her. And it is not unusual for men to bring their wives who are feeling ill to her office, asking her to keep them until the end of the night's racing so they can go back upstairs and bet!

"Fortunately, I've never had to deliver a baby during the job, though I've had two extremely close calls," says Mrs. Geoffrion. "I'm just as glad, since I'm no longer interested in obstetrics — after 16 years spent in maternity wards, who would be?"

Six stretchers are kept around the stands, and one is in the first-aid room below the stands. A room adjoining the first-aid room holds two beds, a wheelchair, and an oxygen tank; the doctor on duty also has his own office. These doctors are usually from one of the Montreal hospitals, and they change frequently. Other equipment includes a special spotlight for removing splinters, and equipment for locating foreign bodies in eyes and ears — a common problem on the track and in the stands.

A few quiet nights

Some nights are quiet, and then Mrs. Geoffrion keeps busy reading, knitting or crocheting. She makes mod hats out of raffia and knits beautiful dresses; her work has been sold to many Montreal boutiques.

The main reason Mrs. Geoffrion took the job at the racetrack and has stayed for 14 years is that she is interested in people and wants to learn as much as she can about them. An enterprising person, she once worked at the Royal Victoria Hospital in Montreal to improve her English, and she also took a job at the Santa Cabrini Hospital to learn Italian. "Some of the jockeys are Italian and are delighted to hear a few words of their own language," she says.

The nurse at Blue Bonnets is a well-known character among the staff. On quiet nights someone always drops in for a chat, and Mrs. Geoffrion is usually the first to hear the latest news. She says the staff is like one large family to her; she checks on those who have hypertension or who need a series of injections for allergies. In short, she looks after them well.

What with the staff, jockeys and drivers, and the steady stream of visitors to the track, Mrs. Geoffrion has had more than enough to keep her interested and enthusiastic about her unusual job. And although she likes horses, about the only thing she has not had to do yet is to stand in for the veterinarian! □

Negligence in the recovery room

Some months ago, an injury received by a patient in the post-anesthesia recovery room in a Canadian hospital was the basis of a lawsuit brought against several doctors and the hospital. The action was dismissed against the doctors. The hospital was found liable. Here, sharply condensed, is how the trial judge interpreted the evidence that led to the verdict.

Friday, April 22, 1966 began as a normal day in the post-anesthesia recovery room of a well-equipped western Canadian hospital. The five operating rooms were booked for that morning, two patients were in the P.A.R. room, and the two nurses on duty had things well under control. At approximately 10.25 a.m., and with the full knowledge and approval of her supervisor, one of the nurses left the room for her coffee.

In the interval between her departure and her return, events occurred in the P.A.R. room that set in motion a lengthy lawsuit in which it was alleged that the doctors involved and the hospital were negligent. In this interval a patient, a 44-year-old school teacher and mother, who had undergone a cholecystectomy, was brought to the P.A.R. room and while there, according to the trial judge, "suffered a lack of oxygen to the brain for such a length of time that this directly resulted in permanent brain damage which has reduced her to an infantile state." The patient and her husband brought suit, alleging negligence.

The task that confronted the court in this instance was to investigate the responsibility for the result and, if anyone or any organization was found to be negligent, to direct that they pay damages to the patient and her family.

As background to this kind of situation it should be recorded that not every disaster of necessity indicates that there has been a negligent act. Some years ago in a leading case, it was said that the court would be doing a disservice to the community were it to impose liability on hospitals and doctors for everything that goes wrong, and it was held that the court must have regard to conditions in which doctors and hospitals have to work and should "not condemn as negligence that which is only misadventure."

In the same case it was also said that "... in medical cases the fact that something has gone wrong is very often not in itself any evidence of negligence. In surgical operations there are inevitable risks."

The trial lasted eight days and brought out reams of evidence — vastly more than could be included in an article of this nature. Among the elements of particular significance to nurses involved was evidence of ambiguities in the recording of the time of specific events in the P.A.R. room. This of course brought into question the exact time when the nurse was absent and the relation of this time to those particular moments in history when the patient suffered the injury. Also involved was the judge's appraisal of the responsibilities devolving on the P.A.R. room and its staff.

Other elements were also examined, but in view of the conclusions of the trial judge this article will focus largely on these two aspects as seen through the eyes of the trial judge and recorded in his reasons for judgment. For the purpose of anonymity, all participants in these events are identified by initials. The patient was Mrs. L, and the two nurses most closely associated with the event are identified here as Nurse S and Nurse M.

How did this situation in this particular hospital develop in a manner that became the basis of legal action? Here in excerpted and abridged form is how the trial judge summarized it after hearing evidence from the plaintiffs and defendants.

Trial judge's comments

"Various times were given both verbally and by way of nurses' charts as to the happening of certain events. I find that these times are all approximate times, were not accurate times and cannot be relied upon.

" When I refer to any times they will be merely approximations and I do not find them to be facts.

This article was prepared in collaboration with E. Peter Newcombe, Q.C., of the firm of Gowling, MacTavish, Osborne & Henderson, Ottawa. The editors thank Mr. Newcombe for his valuable assistance.

"Around 10.25 a.m. Nurse M left the P.A.R. room to go for coffee. She had gone on duty at 9.30 a.m. This left Nurse S alone in the P.A.R. room with patient T and baby H. While Nurse M was still absent, and after her departure from the P.A.R. room, patient M arrived. This put Nurse S alone in the P.A.R. room with three patients.

"Nurse S said that she started to attend to M when he was brought in, but she had to leave M because Mrs. L was brought in. It was definite that Nurse S was alone in the P.A.R. room when Mrs. L was brought in. This placed her, Nurse S, in the P.A.R. room with T, M, Mrs. L, and possibly baby H was still there. The next event took place still in the absence of Nurse M, namely the arrival of the patient R at the P.A.R. room accompanied by his anesthetist, Dr. T, and a nurse who had been in the operating room with R. I am satisfied that patient R arrived just after Mrs. L came into the P.A.R. room and that Nurse M was still not in the P.A.R. room.

"Nurse S then left Mrs. L to go to R, because R's anesthetist, Dr. T, gave her an order...that he wanted an injection of Demerol to be forthwith given to his restless patient R. Nurse S then left Mrs. L to give this injection to patient R. It is to be noted that Nurse S had not finished her check of Mrs. L when she left Mrs. L to go to administer the Demerol to the patient R.

"At this stage of the proceedings T, M, Mrs. L, and R were all in the P.A.R. room (baby H most likely having been returned to the ward by this time) and Nurse M was still absent from the P.A.R. room.

"Various mechanical steps had to be gone through by Nurse S in order to go to the narcotics drawer in the P.A.R. room, unlock same, measure out the required amount of Demerol for the patient R, administer same, before being in a position to return to attend to Mrs. L whom she had left. Before returning to Mrs. L, however, the telephone rang and Nurse S answered same. This call was a personal call from a nurse who was away ill and who wanted to have somebody pick up her pay cheque. Mrs. L was unobserved by anyone at least during these events.

"When Nurse S returned from where she had left off in her check of Mrs. L, she noticed that the patient was not breathing or was in trouble with her breathing and thereupon moved the patient and the stretcher on which she was lying to another station where she felt the suction outlet operated better. She also stated that she called Dr. C who was in the P.A.R. room using the telephone..."

(Editor's note: There followed some observations on the movements of patients and doctors that indicated by the time Nurse M returned to the P.A.R. room, the injection had been given to R and that Nurse S called to her for assistance.)

"...Nurse S said that ordinarily there are two nurses on duty in the P.A.R. room and that they can call for extra help if needed. She said that on the arrival of Mrs. L, she checked to see if her respiration was adequate, that same was adequate and normal and that her pulse was regular. She did not have time to take her blood pressure. She said that Dr. C brought in patient M and that he, Dr. C, was in the P.A.R. room on the telephone at the time that she noticed that Mrs. L was in trouble. There is a conflict here between the evidence of Nurse S and Dr. C. The doctor states that he was assisting in an operating room as an anesthetist in another operation when he received a call that there was trouble in the P.A.R. room; that he left this operation and immediately ran to the P.A.R. room. He fixed this time at 10.50 a.m., and stated that his training in his work deals with watching the clock at all times so he knows how long a patient has been under an anesthetic. I accept his evidence in view of the inexactitude of the nurses' times as shown by the contradictions in the charts . . . .

"Nurse S claims that she was away from Mrs. L for from three to four minutes. If the time of the arrival of Mrs. L is accepted as being 10.30, then one can pinpoint the trouble as having occurred between 10.30 and 10.50. Nurse S stated that Mrs. L was in good condition when she left her in order to go to get the injection to administer to patient R. She had not, however, had time to check the blood pressure of the patient, which would be an essential part of checking her over. Nurse S put the time that the patient stopped breathing at 10.35. As stated, I do not accept this time as being accurate. She stated that there were four patients in the P.A.R. room including Mrs. L at the time she noticed that Mrs. L was not breathing. She said she took the blood pressure of Mrs. L for the first time when Dr. C arrived and at that time the blood pressure was very low. She also stated that the gastric tube had not been attached up to that time."

(Editor's note: Conflicting evidence was also heard regarding the presence of the pharyngeal tube, but as this evidence was resolved in favor of the doctor, details are omitted here.)

"I digress here to point out that it seems to be the practice of the nurses in this P.A.R. room to fill in times on charts for one another. This practice leads to inaccuracies. For example, on page 33 of Exhibit 26, a time appears as 10.40, whereas underneath same the previous figure seems to be 10.50.

"Nurse S stated quite frankly that 'we (Nurse M and herself) did not expect the patients to bunch up so quickly.' They had mutually agreed that Nurse M go for coffee when she did go. Nurse S said that she did not feel that she needed any assistance when Nurse M left for coffee. . . .

"There were five operating rooms booked for operations that day and Nurse S who was in charge of the P.A.R. room knew this fact.

"The nurses' charts show that the injection of Demerol to R and the injection of methedrine to Mrs. L were both administered at 10.40. This, of course, was not possible and illustrates the unreliability of the times recorded on these charts.

"Nurse M said it was the practice for two registered nurses to be in the P.A.R. room. She said the room was quiet, namely not much activity when she went to coffee. She said that if they in the P.A.R. room needed help they could ask for same but that she requested no help or relief when she went for coffee. She said that she was only out 10 minutes, that she left between 10.20 and 10.25, and returned from 10.30 to 10.35. She said she wrote down the time 10.40 for the administration of Demerol to R. (She was not present when this injection was given, I find, and must have obtained the time from Nurse S.) She said the narcotics sheet would be the exact time of the administration of the Demerol. There is a conflict on these two "times".

"Nurse M said that there was no time set for her coffee break and that it was up to the nurses themselves to agree on same. She said that on occasions she has been alone in the P.A.R. room with possibly four or five patients. She admitted that the nurses in the P.A.R. room should keep the patients therein under constant surveillance and the doctors rely on the nurses to do this.

"The nursing supervisor who was on duty on the day in question testified that usually there are two registered nurses in the P.A.R. room. These nurses are expected to take their coffee breaks before any patients arrive. If this is not feasible, then they could obtain relief by calling for a substitute while they went on their coffee break. In effect, the nursing supervisor left it to the discretion of the P.A.R. room nurses as to when they went for coffee.

"The director of nursing, who was also the assistant administrator of the hospital and has been such since 1965, stated that the regulation of having two registered nurses in the P.A.R. room was in effect when she took over her position as assistant administrator. She said she could have assigned extra nurses if requested, and that the matter of relief for the nurses in the P.A.R. room was a responsibility of the nursing supervisor."

(Editor's note: The trial judge then commented on the functions of the P.A.R. room in the following manner.)

"The function of this room is to provide highly specialized care, frequent and careful observation of patients who are under the influence of anesthesia. They remain in this room until they have regained consciousness and their bodies return to their normal functions. Respiratory arrest is not an uncommon occurrence in the P.A.R. room and therefore the personnel in this room must be watchful and alert at all times in order to protect the patients in this labile and vulnerable stage. The nurses in this room are there for the purpose of promptly recognizing any respiratory problem, cardiovascular problem, or hemorrhaging. They are expected to take corrective action and/or to summon help promptly.

"Many doctors gave evidence on this trial. No one challenged the principle that the patient is more prone to crises after the operation than while in the operating room where the respiration is being controlled. From this point of view it is my opinion that this is the most important room in a hospital and the one in which the patient requires the greatest attention because it is fraught with the greatest potential dangers to the patient. This known hazard carries with it in my opinion a high degree of duty owed by the hospital to the patient. As the dangers or risks are ever-present there should be no relaxing of vigilance if one is to comply with the standard of care required in this room. One well-known anesthetist, namely Dr. M, stated that this care should be 'constant and total care.' An eminent surgeon, Dr. M, who testified in a most lucid and careful manner, stated that the patient should be observed 'every minute or two.' Various terminology was used by these doctors and I conclude from the evidence that close scrutiny and ever-present watchfulness is required in this room and the patient is entitled to expect same.

"The prevailing standard of care in the P.A.R. room as far as numbers of staff personnel is a ratio of one registered nurse for each three patients in the recovery room but with always a minimum of two registered nurses present, regardless of the number of patients in the room. Some hospitals utilize nurses' aides in these rooms as assistants to the registered nurses. In either case the prevailing medical opinions point out the necessity of always having a minimum of two staff bodies in the P.A.R., regardless of the number of patients therein with the ratio of one for three.

"In my view the hospital was meeting the standard of care requirements insofar as the numbers of nurses per patient ratio was concerned — providing that the two registered nurses assigned to this room or relief substitutes were present together in this room.

"Both Nurse S and Nurse M were experienced P.A.R. room nurses.

"I find that Nurse S was negligent in failing to provide the required observation of Mrs. L; in leaving her unobserved for a period of time longer than the three to four minutes which she suggested. I accept the opinion of the director of anesthesia that Mrs. L's period of anoxia was probably longer than four minutes. I find the damage done to Mrs. L is more consistent with the period of anoxia being longer than four minutes. Nurse S in my opinion was also negligent as the nurse in charge in agreeing to the absence of Nurse M for her coffee break at a time when they expected or should have expected the arrival of other patients from the operating rooms.

"Nurse S should have arranged for relief at this time. If she failed to realize that she required relief, then she was negligent in that regard in view of her knowledge of the operations which were going on in the operating rooms. These items constitute in my view more than mere errors in judgement. I am mindful that the standard demanded by law is not that of perfection; but an anesthetized person is entitled to expect a high degree of performance, diligence and observation on the part of the nurses in the P.A.R. room because of the great risk of an obstruction or other trouble developing.

"I find that Nurse M was negligent in leaving the P.A.R. room at the time that she did without heed to the patients present at that time or the reasonably anticipated arrivals from the operating rooms. Nurse M was experienced enough to know that a respiratory obstruction can easily happen and go undetected if patients are not looked at frequently. Armed with this knowledge she nevertheless nonchalantly went for her coffee.

"Nurse M has stated that there was no set time for the coffee break. The nursing supervisor testified that she expected these nurses to take coffee before any patients arrived. It would appear to me that a lackadaisical attitude had arisen in regard to this matter of 'coffee-breaks' and that this should have been corrected by the administration of the hospital through its nursing supervisor. The control should have been more rigid ensuring that there were always two personnel in the P.A.R. room. Nurse M, as stated, testified that on occasions she herself has been alone in the P.A.R. room with four or five patients. The necessity for watchfulness had given way to carelessness.

"These negligent breaches of duty on the part of the nurses brought about the injury suffered by Mrs. L and I find that the injury, as Dr. G stated, 'could have been prevented by adequate and skillful nursing care.' The hospital is liable in damages for the negligence of these nurse employees." □

New product evaluation in hospital

Here is a step-by-step description of the methods employed by one Canadian hospital to determine "What's new?" in medical products. It also tells why team evaluation of the product is an effective tool.

Rita Dolan, B.S.N.

"What's new?" may have become a well-worn cliché, but at the University Hospital in Saskatoon it is more than a mod expression. Whenever the question is directed toward me, I am expected to come up with an answer! And that means — knowing what new product has come into the hospital for consideration. By exploring with me the methods used at the University Hospital to arrive at an answer, you may find "What's new?" is also important in your nursing area.

The introduction of a new product originates in the hospital purchasing department; but a specific product may be requested by the department requiring it. For each new product, whether unsolicited or requested, three major questions have to be answered: What is involved in selecting products which best serve patient needs? Who should be consulted? Who should make the decision?

An increasing number of new products have come on the market in recent years. Many of these have been brought to the attention of the hospital purchasing agent. But because research into and the development of new products is expanding rapidly, a product is often obsolete before its merits can be assessed. One Canadian hospital magazine recently listed over 90 new products in a single issue!

Although the purchasing agent is vitally concerned with the welfare of the patient, he cannot possibly determine alone which new product is best, especially if he recognizes that the decision should be made by the user at the *point-of-use* — the patient's bedside. For this reason, many large hospitals have set up an evaluation committee, a widely representative group whose knowledge and judgment can be utilized to assist the purchasing agent. It is this committee that forms the basis of an organized approach to the assessment of a new product's merits, before introduction into the hospital.

Committee objectives

It was in March 1968, that the University Hospital appointed a committee responsible for evaluation and standardization, and known as the medical and surgical supply committee. Chaired by the assistant purchasing agent, its representatives come from the nursing and medical staff, central supply service, and administration; other departments are represented as required. Objectives of the committee are: to ensure that the patient gets the best possible

Miss Rita Dolan, a graduate of the Regina Grey Nuns' School of Nursing, is Nursing Coordinator of new product evaluation at the University Hospital, Saskatoon, Saskatchewan. She had been operating room supervisor in the same hospital.

Discussion of a new product by the evaluating committee evolves around three main questions — patient needs, consultation, and who decides for or against the product. Chaired by the assistant purchasing agent, the committee represents most areas of the hospital. At this session, author Rita Dolan (third from right), gives her reactions to the product under discussion. Other members from left to right: Beno Enns, controller; Lottie Rea, director, O.R. Nursing; Dr. William B. MacDonald, anesthetist; Beth Bouey, central supply supervisor; Rita Dolan, nursing coordinator; Ronald Nuthrown, assistant purchasing agent; and Dr. Clarence Berg, surgical staff.

service from the product; the hospital gets the best cost value; and that standardization of products is achieved throughout the hospital.

The formation of the committee was not unique, but it did become obvious to the nursing administrator and the purchasing agent that a cohesive force was needed to coordinate the committee's duties. It seemed essential to have someone who would be responsible for planning and establishing a program for investigating, selecting, and testing products. And so a new role in the hospital's nursing service department evolved — a nurse coordinator, with responsibilities to: develop an interest in, and awareness of, new trends and new products in relation to nursing needs and improvement of patient care; maintain contact with the nursing areas by being aware of nursing needs and keeping nursing staff informed of new trends; make the initial assessment and selection of potentially useful products through discussion with the purchasing agent and sales representatives and, after consultation, set up evaluation programs in specific hospital areas; function through the evaluation committee, preparing and submitting reports with recommendations, follow-up reports at required intervals, and promote standardization in the hospital.

Philosophy and method

At the University Hospital we believe that products to be tested have to be given a *fair* evaluation. We also feel this must be done at point-of-use (the patient care area) by the nursing and medical staff, and all concerned with using the product. How do we do this? What is our approach?

When a sales representative brings a new product to the attention of the purchasing agent, the Nursing Coordinator is consulted and an appointment with her and the salesman may be made. Similarly, requests from the nursing department, for the need of or information on a new product, are channelled through one source (the nursing coordinator) to the purchasing agent, who makes the necessary enquiries. When the information is received, meetings with the sales representatives might include other nursing staff. This is decided by the nursing coordinator. If the product is considered to have potential, a sample is obtained and displayed at a weekly nursing administrative meeting (including evening and night supervisory staff). Following the meeting, directors of nursing have an opportunity to request an evaluation carried out in a specific clinical area, or they may prefer to delay decision until after discussion with the head nurses.

The responsibilities of the nursing director (in some hospitals known as supervisor) in planning total patient care are vital. Her functions also include developing patient care in harmony with the objectives and policies of the hospital. All of which point to a sound reason why the nursing director plays an important role in evaluation and standardization.

The coordinator has to consult many people before accepting a new product for evaluation; there may be implications involving several departments. It is possible the medical staff, central supply services supervisor, the laundry manager, the bacteriologist, or the building services department might have opinions on the product — foresight has proved to be better than hindsight!

After all these people have considered the product, the coordinator approaches the nursing area. She plans for evaluation with the nursing staff and all others concerned. Effective testing is accomplished by establishing specific criteria, and checking the product against it for a variable period of trial use. An evaluation record or form, which accompanies the product to the nursing unit, is completed by the user for follow-up information. Personnel are given thorough instruction in the use of the product, and close follow-up is

During evaluation of a new product, the hospital personnel are given thorough instruction in its use. Sometimes a sales representative displays the product, as in this picture. Peter Groves demonstrates the use of an elastic sheath bandage to nurses (left to right), Diane Walker, head nurse; Annie Bannon and Sylvia Swan, both certified nursing assistants; and Correlia Vanderhoeff, R.N.

kept during the trial period. Failure to do this could adversely affect acceptance of change from one product to another.

There are certain factors to be considered when making a decision on a product, and answers to many questions are sought.

- Will a disposable product fulfill the same function as the reusable one it replaces?
- Will it improve patient-care?
- Will professional personnel approve its use?
- Will other hospital departments be affected by its use?
- Is it labor-saving?
- Will its use be feasible economically?
- Does the packaging meet acceptable standards of sterility?
- Is it launderable? If so, will it withstand repeated washing?
- Is it likely to require maintenance or repair?
- Will there be storage or disposal problems?
- Will adequate supplies be available?
- Will it promote standardization?
- What are the implications for teaching many categories of staff?

If the evaluation results are favorable, the Coordinator prepares a report with recommendations to the chairman of the evaluation committee, who takes the necessary steps to obtain approval for purchase. If a product is not acceptable (for valid reasons) it is withdrawn from use. Whether recommended for purchase or not accepted, the product manufacturer and supplier are notified by a written report. If final approval to purchase is obtained, all nursing areas and departments concerned are informed of the proposed product change, and time allowed for staff instruction. The director of inservice education is also consulted, and, depending upon the magnitude of the change, a new product program is organized for the nursing staff. Sales representatives are always willing to assist, and their services may be utilized in the instruction program.

For convenient reference, records of all completed evaluations are kept by the coordinator, and a copy goes to the purchasing department. It is also essential for the follow-up report to be continued after the new product is in use throughout the hospital. Periodic check-ups are made to ensure the product continues to meet the standards set up initially. Any difficulties encountered are reported to the coordinator, and through her, the information is relayed to the purchasing agent and back to the manufacturer. It is important to emphasize that not only the nursing staff participate in the evaluation programs. When other disciplines are involved, the same evaluation procedures are followed.

In a recent evaluation of intravenous catheters, the opinions and written comments of medical staff and housestaff (the user at the point-of-use) provided the necessary product information. Staff of the departments of physiotherapy, radiology, laboratory, and outpatients have also been actively involved in testing products relating to patient care. Interdepartmental cooperation and good communication are vital to the success of the program.

Advantages

Among some of the advantages found in new product evaluation, eight points stand out: The comfort and safety of the patient is increased by elimination of the trial and error approach; nursing staff satisfaction is heightened by being involved in product selection, resulting in increased awareness and interest in new trends; the use of a product during an adequate period of time is the only way to discover its merits and limitations; a more consistent feed-back of information to the purchasing department and to the manufacturer is possible; the flow of sales representatives to various hospital areas is controlled (the

Patient cooperation at the point-of-use is another aspect of product evaluation which is essential to the decision — accept or not accept. Nurse Thelma Strihhell, assistant head nurse, and James Caister, nursing orderly, are seen with a happy and cooperative patient, Joseph Fisher, at the University Hospital, Saskatoon.

majority of salesmen have expressed satisfaction with this method); stress on the importance of greater awareness of reporting malfunctioning products or equipment noted; inter-departmental relations have improved as a result of the coordinated approach; and standardization and product control have helped to decrease hospital costs.

Limitations

There is a degree of resistance to change in most of us, and often first reactions to a new product prove unreliable. It is not always easy to give an unbiased, objective opinion, especially if use of the product means a change in procedures or techniques that have operated for years. Also, an assessment can take weeks, even months, if there are many different product brands to consider, and staff become tired of adjusting to each new change.

Obtaining recorded staff opinions is a necessary and important part of the evaluation procedure, and one of the most difficult to accomplish. Staff sometimes seem reluctant to commit themselves to written reactions, or perhaps *time* is involved. It takes time for the staff to fully appreciate that their opinion *is* important, that they *can* help to make decisions by being involved, and that to do so is part of their patient care responsibility in the hospital.

Cooperation

It would be impossible to successfully carry out the program without *willing* patient cooperation. Cooperation of the nursing and medical staff is another key to success. This refers also to all other departments involved, the active participation of the evaluation committee, and the support and encouragement of the hospital administration.

Are we completely satisfied with our program at the University Hospital in Saskatoon? No! With every completed evaluation we learn something more that improves our methods. Ideas and suggestions are always welcomed to help answer the challenging question "What's new?"

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This nurse coordinates patient services

If you have to be hospitalized, Brockville, Ontario, is a good place to be — especially if you require long-term care. In this small but progressive city, one nurse is doing a remarkable job of coordinating hospital and community services so that fewer gaps are left in a patient's rehabilitation.

Carol Kotlarsky, B.J.

Ann Cole, patient services coordinator in Brockville, spends much of her time contacting community agencies and individuals who are able to help patients after they are discharged from either of the two hospitals in the area.

Until September 1969, Ann Cole had worked as a registered nurse in various hospital positions and with the Victorian Order of Nurses. But for almost a year now she has been involved with patients in a new, far broader role.

As patient services coordinator for the 214-bed Brockville General Hospital and the 105-bed St. Vincent de Paul Hospital, Mrs. Cole is involved with the overall hospital experience of patients, particularly patients who need extended care, and their return to the community. This work requires a thorough understanding of the patient's background, medical situation, and emotional needs; hospital procedures; and the agencies that can help him when he leaves the hospital.

Mrs. Cole stresses that she is not a social worker. She explains that her past work as a general duty nurse, head nurse, instructor, coordinator of in-service education, and VON nurse in Brockville — as well as some upsetting experiences she had as a patient —

Mrs. Cole is a graduate of the Kingston General Hospital, Kingston, Ontario. She has worked as a general duty nurse in Guelph, Oakville, and Brockville, and as part-time evening supervisor in Hamilton, Ontario; as an obstetrics instructor, head nurse, and in-service education coordinator at Brockville General Hospital; and with the Victorian Order of Nurses in Brockville, Ontario.

made her aware of the need for a nurse to coordinate the many factors that contribute to a patient's successful rehabilitation. As coordinator, she works closely with the medical and nursing staff in both hospitals.

Hospital-community liaison

Mrs. Cole is well acquainted with services available in Brockville and the surrounding area. Community services she works with are varied: nursing and private homes, VON, Red Cross homemakers, Alcoholics Anonymous, Children's Aid Society, municipal and provincial government departments, local service groups, and other organizations.

One particularly complicated patient situation Mrs. Cole encountered shows how one person's problem can involve many of the community's resources.

A woman with multiple sclerosis became a paraplegic, and became almost totally blind. While she was in and out of hospital, her marriage became so shaky that it was useless to try to maintain it.

The number of agencies and individuals who helped this woman, which involved getting her and her 18-year-old son to relatives in England, was astounding, Mrs. Cole says. She lists the legal aid society, the Canadian National Institute for the Blind, a Roman Catholic priest, the Catholic Women's League, the Multiple Sclerosis Society, the Lion's Club, the Oddfellows, a travel agency, and numerous friends.

This community help involved counseling, paying room and board in town for the woman's son, buying him the clothes he needed, supplying the woman with a wheelchair, buying her shoes, getting her passport renewed and getting her son's passport and photographs, checking with the airline and British High Commission to make sure the relatives understood the circumstances, and paying both fares to England.

Finding the "right" nursing home

Soon after she began her job as coordinator, Mrs. Cole visited the area's nursing homes to assess their facilities. What she looked for in homes for chronic, long-term patients was comfort, cleanliness, good nursing care, and interest in all aspects of the patient's well-being. She also determined if volunteer groups visited the home to provide diversional therapy. One nursing home, she discovered, was so beautiful that elderly persons were reluctant to go there. Patients want to feel at home, she explains.

Mrs. Cole is a weekly visitor to the admitting departments, where she receives the names of new patients. Here she waits while a nurse and clerk check the patient admitting cards at St. Vincent de Paul Hospital.

Choosing the best nursing home for a particular patient is a decision that often faces the patient services coordinator. By listening carefully to the patient and his family and considering his medical, social, and financial situation, Mrs. Cole decides which nursing home would best suit him. She makes sure that the patient is satisfied with the choice before he leaves hospital.

Before leaving a patient who has been discharged from hospital, Mrs. Cole makes sure he has her telephone number. She tries to visit a patient in a nursing home once during his first week or two, and maintains close contact with nursing home administrators.

Extended care

Sometimes a patient can return to the community directly from active care in hospital. But when a patient requires a long period of hospitalization, Mrs. Cole finds out if he needs active treatment or if an application for transfer to the Brockville General's extended care unit can be made by the patient's doctor. A 40-patient extended care unit serves both Brockville General and St. Vincent de Paul Hospitals.

A problem with the extended care unit, Mrs. Cole says, is that hospital staff and particularly patients and their relatives think of it as the "last step before the grave." This creates a barrier to the patient's transfer to this area. As soon as she knows that a patient can be moved to the extended care unit, she visits him to talk about it and to explain why he is going there. She hopes she will soon have photographs of the unit to show her patients.

Mrs. Cole talks enthusiastically about the Brockville General's ADL unit, where an occupational therapist teaches convalescent patients "activities of daily living." These activities might include simplified techniques, such as tying shoelaces with one hand. As the patient improves, the occupational therapist assesses the number of daily activities the patient can perform for himself. This ADL unit also serves both hospitals in the Brockville area.

Discussing the progress of patients on the extended care unit at Brockville General Hospital involves all staff. Shown at a weekly staff conference are, left to right, Ann Cole, patient services coordinator; a patient, relieved to hear that her progress is encouraging; the head physiotherapist of the extended care unit; a student nurse; the hospital nursing supervisor; the head nurse of the extended care unit; a nursing assistant from this unit; and the occupational therapist.

Convalescent units, Mrs. Cole emphasizes, can make patients' lives much more meaningful. She is concerned, though, that these units are not staffed as adequately as active wards. The reason for this, in her opinion, is the misconception that convalescent patients do not require the same amount of care as patients on active treatment wards. At Brockville General, three physiotherapists work part-time on the extended care unit.

With the assistance of the head nurse and head physiotherapist of the extended care unit, Mrs. Cole has organized an inservice program for nurses working with convalescent patients. It consists of a weekly conference attended by staff nurses, the head nurse, and head physiotherapist of the extended care unit, and occupational therapist from the ADL unit. In addition, head nurses from other units are invited if patients on their wards are waiting to be admitted to the extended care unit. During the conference everyone is encouraged to contribute to the discussion of the patient's progress in the hospital.

Before each conference, Mrs. Cole reviews the background of each patient on the extended care unit — his home, financial, and medical situation. She uses this information to keep the conference participants aware of anything that might further the patient's progress. Sometimes a patient whose plan is being discussed is asked to attend the conference and help with the planning.

Member of health team

While working with a patient, Mrs. Cole keeps the doctor closely informed about what she is doing. She keeps a file for each patient, and on a card she records the basic situation; information from her interviews with the patient, including her discussions with the doctor; and notes on anything else she does.

Mrs. Cole recalls that when she first became coordinator, nurses had difficulty understanding her role on the health team and did not know which patients should be referred to her. To explain her role, she first spoke to nurses at an inservice program. Then she talked to each head nurse and to as many other nurses as possible, giving them examples of what was happening on other wards.

She has also participated in classes for nursing students, who study a social service situation and decide what agencies should be involved. In the fall she hopes to hold an inservice program for nurses to give them a chance to express their views on the effectiveness of the coordinator's role.

Time to care

Since she does not work shifts or have to follow ward routine, Mrs. Cole determines her own work schedule. She organizes her time to suit the situation. This might involve talking with a patient and his family in the evening to decide how he can best be cared for after discharge from hospital, Or it could mean being asked at any hour to find a temporary home for children of out-of-town accident victims.

For a long time, community services have not been fully utilized, Mrs. Cole says, partly because hospital staff lacked time to work with them. As soon as she sees a patient, Mrs. Cole tries to determine which agencies can help him and makes sure their services are familiar to him before he leaves hospital. By assessing a patient's overall situation and knowing the programs each agency offers, she is usually able to direct him to the most suitable agency.

From Ann Cole's obvious enthusiasm for her work as patient services coordinator, it is easy to see why she describes this position, with its limitless potential, as fascinating. □

Use of part-time teachers benefits students and faculty

How one school of nursing uses part-time instructors to supplement its regular teaching staff.

F. Joan McPhail

On December 6th, 1967, the school of nursing at the Ottawa Civic Hospital entered a new phase. On that day the school became totally responsible for the students' learning experiences during the first two years of their three-year program. No longer were the students obliged to provide nursing service during these two years.

At first, no one on the teaching staff fully realized the implications of this major decision. Later, we became aware of certain problems: Who, for example, was going to be responsible for the student in the clinical area when the teacher was ill, on leave of absence or compassionate leave, or was at a conference? It didn't take us long to decide that we needed teachers who would be willing to work on a part-time basis.

Two categories

We have two categories of part-time teachers: those who relieve on a call basis when the teacher is absent for some reason; and those who are employed on a regular part-time basis for varying periods throughout the year because of curriculum requirements. Sometimes one teacher fits into both categories.

The teachers who relieve on a call basis may be used in any clinical area in the hospital during any of the three terms or the "skills practice" periods. Naturally we try to select the teacher who is best suited for the particular clinical area in the hospital.

Since September 1968, we have employed a teacher on a regular part-time basis in the pediatric unit to help the 24 to 36 students who rotate through this unit every six or seven weeks. This teacher works three to four weeks out of six or seven, beginning at the fourth week of the students' experience. She rotates during these four weeks with the two permanent teachers through two periods of duty, 7:45 a.m. to 4:15 p.m. or 12:00 noon to 8:00 p.m.

This year we hired two regular part-time teachers in the nursing skills area. The four permanent teachers indicated they would be able to teach theory of skills to the 170 beginning students, but believed they needed help in both the classroom and hospital settings.

One of these part-time teachers works five half-days a week, usually in the mornings. She assists with classroom practice periods as required and is responsible for these beginning students on one of the hospital wards. The other part-time instructor participates in the students' hospital experience only, which involves the morning hours every second week from Tuesday to Friday inclusive.

Last year, three part-time teachers were assigned to help the first-year students with their more advanced clinical experience. One teacher worked full-time every day on a particular ward for the entire term, and the other two alternated on one ward for two-week periods. This year we will be using four of these teachers: two will alternate with each other to cover one ward, and two will cover a ward full-time.

In all, eight teachers are available for relief teaching. Some indicate inability to work certain days of the week and some limit themselves to one or two days weekly. This requires careful scheduling. In budgeting for teachers we plan for relief in case of illness, attendance at conferences or workshops, and of course for regular part-time teaching.

Responsibilities and orientation

The part-time teachers' responsibilities depend on the area in which they are working, their previous experience in that area, and their educational qualifications. Generally, those on a call basis are expected to do only incidental teaching at the bedside and to conduct pre- and post-care conferences. Those involved on a full-time basis are expected to participate more fully in the program. They assist the student in pre- and post-care conferences, mark assignments for students for whom they are responsible, help set examinations, and assist with student evaluations.

An orientation program has been set up for all part-time teachers. The

Mrs. McPhail, a graduate of the Ottawa Civic Hospital School of Nursing and the University of Western Ontario's Certificate Program in Teaching and Supervision, is Administrative Assistant to the Principal of the Ottawa Civic's School of Nursing.

Full-time and part-time teachers at their weekly planning meeting at the Ottawa Civic Hospital. Left to right: Sharon Thompson, part-time teacher; Emily Reynolds; Jo Logan, part-time teacher; Joan Babcock, Diane Shaughnessy, and Alice Keiwan.

amount of orientation needed by each teacher varies with her previous experience in the school and in the hospital. Orientation includes an explanation of the philosophy of the school, the overall objectives of the program, and the objectives of each term or practice period.

The teacher is given a brief review of the school's curriculum and learns what to expect from various levels of students for whom she will be responsible. She is oriented to her assigned ward and is introduced to the ward staff and other teachers. She is expected to attend faculty meetings when possible.

Advantages of system

Use of part-time teachers has several advantages. First, the system benefits the permanent teachers as they have time to attend conferences and workshops, to take a leave of absence if necessary, and to work on committees. For example, the school's curriculum committee recently revised the curriculum for the second term. This meant that all members of this committee had to be freed from their ward responsibilities for a number of Fridays. To do this we used other faculty members for relief purposes and obtained the assistance of three part-time teachers.

Faculty members also benefit from working with the part-time teachers, as ideas are shared. One of the regular part-time teachers is presently doing research for her master's degree. Both our students and instructors are involved in this research. Not only did this part-time teacher benefit from the use of our facilities, but our teachers found that they learned a great deal by participating in her research.

Last, but not least, the students benefit from this additional clinical supervision. Part-time teachers are generally well accepted by the students. The teacher on a call basis may be accepted with a little more reservation because of her limited time with them.

Summary

As a result of changes in educational programs for nurses, more use will undoubtedly be made of part-time teachers in the future. The Ottawa Civic Hospital School of Nursing has two categories of part-time teachers, those who are available on a call basis to relieve for illness or leave of absence, and those employed on a regular part-time basis because of curriculum requirements.

Responsibilities given to these teachers vary with their educational qualifications and their previous experience. The choice and placement of these part-time teachers is made with care. Their special areas of skill are weighed and the person called is the one who best fills the need at the time. Both the school and the faculty benefit from a system of part-time teachers.

Certain things must be considered when planning to use part-time teachers. These include careful budgeting, maintenance of records, a planned orientation program, and faculty involvement in deciding how and where these teachers may be used. □

Hospital nursing and the demand for change

Traditionally, the nursing profession has been conservative and passive when faced with the need for change. If this passivity continues, nurses will find themselves standing aside as others make decisions for them.

J. Ivan Williams, Ph.D.

The basic organizations of society are currently being questioned and there are increasing demands for change. Schools, universities, churches, governments, the family, the business world, as well as the whole health care system are being re-examined, and the question of priorities is being raised.

By looking at the place of the hospital in society, the emerging patterns of health care, and the factors that influence the growing demand for services, one can determine why the hospitals are being challenged and suggest what sort of changes will be made. Since nurses are central to the operation of hospitals, they should play some role in making decisions about these changes. To participate they must understand the basic processes involved.

Characteristics of organizations

Organizations are established so that man may collectively solve problems that individuals alone cannot manage. There are a number of organizations in our society, each designed to meet particular problems and accomplish certain goals. The key characteristics of organizations in Western societies include a highly specified division of labor, written regulations governing each position, employment of individuals according to technical competence and professional training, payment by salaries, and security and promotion based on impersonal standards of performance.[1]

The primary consideration of an organization is whom it is designed to serve. Peter Blau and W. Richard Scott have developed a typology of organizations as seen in *Figure 1*.[2]

Mutual benefit associations as described in *Figure 1* exist only as long as they meet the interests of their members. Business concerns operate as long as owners profit. If the clients do not seek the services or are driven away, the service organizations cannot render service.

The elections in a democratic society determine whether the public is served in a satisfactory manner. The implicit assumption is that organizations that serve well survive, and those that fail to serve, fail to survive.

Any organization that has "people as products" has a whole set of peculiar problems. The hospital is no exception to this general rule.

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Type of Organization	Primary Beneficiary	Examples
1. Mutual Benefit Associations	Members	CMA, CNA, CHA Private Clubs
2. Business Concerns	Owners	GM, Ford, Labatts
3. Service Organizations	Clients	Schools, Churches, Hospitals
4. Commonwealth Organizations	Public-at-large	Various governmental bodies

Figure 1 - The Cui Bono Typology

First, only a limited range of means are available as the individuals are viewed as ends in themselves. Second, it is difficult to demonstrate conclusively which treatment procedures are most effective and what constitutes good patient care. Third, people are self-initiating; they can act as well as respond. Nurses may become frustrated in their appointed rounds because of patients who refuse to conform.

Four, belief systems are important. How persons are viewed is as important as what is done; thus, mental hospitals operate differently from general hospitals because the patients are viewed differently.

Five, there is a continued surveillance of the organizations on behalf of the public. Hospitals must be accredited by duly constituted bodies before they can operate.[3]

Given these perspectives on organization, an analysis can be made of the hospital in society, the relative position of its professional workers, and the problems of the patients. Particular emphasis is given in this paper to the nurse as the person caught in the middle, between doctor and patient.

The hospital

Hospitals were once under the jurisdiction of the religious orders or were charitable institutions. Most medical care was administered outside their walls. Until the middle of this century, one-half of all births and deaths occurred outside the hospital. In this century, hospitals, as complex medical and educational centers, have become the key to medical care, particularly in the urban and large metropolitan areas and among low income groups.

The two main goals of today's hospital are to provide patient care, and to do so in such a way as to serve the professional values of the medical professions.[4] As the current hospital has emerged, one might wonder whether it exists more for the primary purpose of education, training, and practice of the physicians and secondarily for patient care.[5,6,7]

The problems

There are two basic sources of demand for change in the present organization of hospitals: the public, and the medical and nursing professions. These are interrelated, and both directly affect the role of the nurse and the nursing executive.

To understand the public demands, the shift in fundamental assumptions about health care must also be understood. Since World War II, there has been growing conviction in industrialized societies that health should be a guaranteed right and that resources should be organized and expanded to assure this. In Canada, voluntary private insurance and later universal semi-voluntary government insurance have attempted to guarantee health care.

At the same time, health costs have risen faster than the cost of living, hospital beds have become scarce, and doctors' income has increased more rapidly than most occupational groups. Even though hospitals are better equipped and nurses better educated, there are widespread complaints about the quality of hospital care. People are less willing to be treated as "cases," and want to be cared for as human beings.

Consequently, the whole medical care system is coming more under public scrutiny, from provincial to local levels. The governments and citizen groups are challenging the professions and their practices. In one city, where the board of directors of a large hospital are elected in a municipal election, candidates promise that, if elected, they will find out what is happening. Demands are made for public board meetings; newspapers report internal organizational conflicts.

These demands probably affect the nurses in three ways. First, the nursing staff will come under public scrutiny; if the doctors or patients complain about nursing procedures, external pressure for change will increase. On the other hand, as people become more aware of nursing problems they will support attempts to prepare more nurses and to provide better pay and working conditions for nurses, their assistants, and orderlies, all of whom are underpaid according to accepted wage levels for comparable positions. Third, the public will probably be less tolerant of strikes and work slowdowns as bargaining devices.

In short, hospitals are more likely to become "commonwealth organizations," serving the public-at-large. As a consequence they will also come under more public surveillance and the subsequent demands for change. If participatory democracy means the inclusion of as many people as feasible in decision-making bodies, then there probably will be more demands for participatory democracy in the operation of hospitals.

The second problem arises for demands for change *within* the hospital. Hospital personnel consist of three groups: physicians, nurses, and administrators. Rigid barriers separate these groups and each group has its own hierarchy. Cutting across these groups are the various clinical departments that sometimes become autonomous medical empires. The clinical departments involve inservice wards and outpatient clinics. The question arises, who actually benefits from this type of organization?

In reality the key to the current problems in hospitals is the physician. Patients become cases to be treated and to be used as heuristic devices for the education and training of physicians in the clinical specialty involved. Even though the "cases" receive technically competent care, the care is segmented, fragmented, with little regard for the social and emotional dimension of the patient's illness. Not infrequently one clinical department is unaware of what other departments are doing for family members and the patient himself.

A number of studies have demonstrated the effects of hospitalism, where the individual is reduced from an independent, autonomous member of society to a child dependent upon the expectations and demands of the physicians and nurse.[8] The consequences of hospitalism, particularly in chronic hospitals, may offset the treatment process.

One of the advantages of treatment in the home was that the patient was not isolated from his normal social environment and received social and emotional support from his family. He remained a person rather than a case or product. The old concept of bedside nursing implied that one of the functions of nursing was to provide similar kinds of support. Now such support appears to be missing.

The problem could be simplified if physicians and nurses agreed on what their roles should be. Clearly, the nursing profession is in the midst of change. There are three polarized continua that serve as the axis for the conflict: the professional versus the traditional models of nursing; the university versus the hospital programs; and the instrumental versus the expressive functions of nursing.

Professional and Nightingale Models

The traditional model of discipline and the religious model of service, purity, and devotion to duty. The professional view emphasizes education, leadership, research, and participation in planning therapeutic medical care. If the term bedside nursing typifies the former, the team approach signifies the professional working together with other professionals such as doctors, dentists, and social workers.[9,10]

University vs. Hospital Training

Of the 137,318 registered nurses in Canada in 1969, only 6.2 percent had baccalaureate degree or higher academic degrees.[11] The Canadian Nurses' Association has recommended that there be one university-prepared nurse for every three diploma nurses. Such statements are predicated on the assumption that there are differences between the abilities of the graduates of the two programs.

Essentially the graduates of diploma programs are viewed as technicians who work with patients under the supervision of a professional nurse. The professional nurse is viewed as the university graduate who selects appropriate nursing programs for the patient in the hospital and community, works as a member of a health team, evaluates and recommends changes in the programs, works with members of allied professions in solving community health problems, provides personal patient counseling, and engages in administration, teaching, consultation, and research.[12] Some nurse educators believe that administration, teaching, consultation, and research can be introduced in baccalaureate programs, but that adequate training for these areas should be at the master's degree level.

If such differences are defined into educational objectives for the respective programs, the differences within the ranks of nursing are more likely to widen. This is particularly true as university student nurses are more likely to be from the upper middle classes, are more likely to reflect the students' pressures for general reform, and more likely to reflect career and professional aspirations. The diploma nursing students are more often from the working classes, and probably are more concerned about job security and service; they are more likely to leave the active profession for home life.[13]

The more professionally-oriented nurses are challenging physicians. The demand for the health-team approach explicitly curtails the authority and power of the physicians. These new nurses are no longer intimidated by the physician's prestige and knowledge.

Instrumental vs. Expressive Functions

An increasing variety of positions are available to nurses in teaching, administration, research, and clinical settings. Within the clinical departments of a hospital a nurse may serve in a number of positions without being a bedside nurse.

The instrumental function involves making the organization operate and planning and implementing programs. The expressive function is more concerned with meeting the patients' psychosocial needs. The former implies patient versus product; the latter implies patient as person.[14]

The future

Generally, professional, university graduate, and instrumental are seen as one clear option in today's nursing. There is a feeling among some administrators, for example, that the talents of a university-educated nurse should not be wasted by having her engage in bedside nursing. The traditional, hospital-trained, and expressive nurse is seen as a blend of nurse/nursing assistant. She is relegated to carry out the directions of others and is left with little time for the patient.

This is not to say that such a dichotomy must arise from the three polarities. There are at least eight possible combinations, ranging from traditional, university, and expressive, to professional, hospital-trained, and instrumental.

People are demanding reforms, and they do want *quality* health care for *all*. They are no longer satisfied to be products, but demand to be treated as people with real social and emotional concerns. The health professions will have to reorganize themselves and provide this type of individualized care or the public, via the government, will delimit the areas of authority and responsibility. As Blishen stated:

> Some nurses, however, seem unwilling to accept new responsibilities since it means delegating to others old responsibilities from which they gain emotional satisfaction. This reluctance is evident in their opposition to reforms in nursing education which attempt to change traditional nursing values and socialize students into a conception of the new nursing role. For those who support the reforms, these changes not only bring nursing into touch with the realities of twentieth-century medicine, but they also mean a change of status of the nurse.[15]

Traditionally the nursing profession has been conservative and passive in the face of similar demands. The CNA and its counterpart in the U.S.A., the American Nurses' Association, have been relatively weak professional groups in terms of protecting the interest of their members and shaping the profession.

The profession is going to change. If nurses decide to be passive, the changes will be the result of external pressures. If the nurses are active, they may shape not only their own profession, but the health care delivery system as well. The challenge is now, the response is yet to come.

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research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Muldoon, Sister Marie Barbara. *The teaching role of the staff nurse.* Boston, Mass., 1963. Thesis (M.Sc.N.) Boston University.

The purpose of this study was to identify the specific occasions in which the staff nurse in a general hospital teaches and the content of the teaching. The study was conducted in a 185-bed general hospital serving a large urban population.

A checklist of teaching activities and an opinion questionnaire were used to collect data. Observation schedules were arranged to correspond with the peak load of nursing care activities on three medical-surgical units and one emergency service unit from 7:30 to 10:30 a.m., 1:00 to 2:30 p.m., and 4:00 to 6:30 p.m. for six days. The sample consisted of 11 nurses — staff nurses employed on these four units during day and evening tours of duty. A total of 42 hours was spent observing the teaching activities of the 11 nurses.

Of the 234 teaching occasions in which these nurses were observed, 150 were devoted to teaching physical care of the patient, and most of this teaching was directed to the nonprofessional nursing personnel. On 127 occasions aides and orderlies were taught nursing activities involving physical care. Activities concerned with emotional support of patients were taught considerably fewer times. Patients were taught 37 times; on 55 occasions teaching was overlooked or omitted.

The nurses agreed that teaching the nonprofessional nursing personnel and student nurses was necessary during their nursing practice, and accepted this teaching responsibility. Only one nurse, who graduated before 1950, did not accept her teaching role, claiming the teaching she did delayed her too much in her nursing duties. The nurses' answers to the situation-type questions dealing specifically with patient teaching indicated a varying understanding and recognition of their responsibilities for teaching patients.

The conclusions of the study were: the staff nurse engages in teaching activities during her nursing practice and recognizes this as she directs and instructs student nurses and nonprofessional workers; the staff nurse teaches both administrative and nursing care procedures; nursing care procedures are taught most often by the staff nurse, and physical care of the patient receives the most emphasis in this teaching; the staff nurse directs most of her teaching to the nonprofessional workers; emotional support is not given proportionally the same emphasis as physical care; and the staff nurse, although recognizing and accepting her responsibility for teaching students and nonprofessional workers, does not readily recognize her responsibilities for teaching patients.

Griffiths, Helen Frances. *Development of Likert scale to identify one nursing behavior practiced in general nursing.* London, 1969. Thesis (M.Sc.N.), The University of Western Ontario.

This study comprises an initial phase in the development of a research tool, which was intended to identify one nursing behavior in general nursing. The problem was to construct a Likert-type scale to identify this "one nursing behavior." The behavior in this study most closely approximated the concept "therapeutic use of self," found in the literature. In this study, this one nursing behavior has been called "H-behavior in nursing" and was the number that resulted from the total score on the 90-item, 7-point Likert-type scale, by any respondent.

The method was to construct a 90-item, 7-point summated attitude scale of the Likert type, composed of common sayings about nurses and nursing. Forty-five items were worded so that agreement indicated a high understanding, and 45 items were worded so that disagreement indicated a high understanding of therapeutic use of self by the nurse.

The subjects were a group of 380 nursing students, excluding first-year students, in five schools of nursing in southwestern Ontario. Methods of data analysis were frequency distributions and frequency polygons, determination of bimodal items by three different methods, correlation matrix using PM correlations, item-total correlation arranged in descending order of magnitude, inspection of a grid derived from the correlation matrix, and coefficient alpha of the original 90 items.

Criteria for selection of items were bimodality of distribution and item-total correlation of 0.3 or above. Ten items met the criteria of this study, as showing promise for use in future. □

Next Month in

The Canadian Nurse

- CNA Convention Report
- Drug Misuse in Teenagers
- Body Image in Pregnancy

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National Research Council, Ottawa, p. 12

Robert Landsdale, Etobicoke, Ont., p. 14

Miller Services Ltd., Toronto, pp. 22, 23

University Hospital, Saskatoon, Sask. pp. 30 — 32

The Recorder and Times, Brockville, Ont., pp. 33 — 35

Ottawa Civic Hospital, Ottawa, p. 37.

books

On Death and Dying by Elisabeth Kübler-Ross. 260 pages. Toronto, Collier-Macmillan Canada Ltd., 1969.
Reviewed by Jeanne Quint Benoliel, Associate Professor, School of Nursing, University of California, San Francisco, California.

Based on interviews with more than 200 hospitalized patients, this book is a valuable addition to the growing number of volumes concerned with the psychology of dying. Using a psychiatric perspective, the author proposes that dying in the psychologic sense takes place through five sequential, though overlapping, stages: denial, anger, bargaining, depression, and acceptance. Each stage and its behavioral manifestations are described in detail, and case materials from actual interviews are effectively used to illustrate the major points made. The central concern of the book is the difficulties patients have in communicating their needs during serious and fatal illnesses.

One chapter is devoted to the influence of families, emphasizing the patient's problems when his family cannot "give him up" psychologically. Another important chapter deals with hope and with the unfortunate consequences for the dying person when he and those around him differ in their reactions to his dying. According to the author, these conflicts have their origins mainly in two sources: when other individuals respond with feelings of hopelessness while the patient is still in need of hope, and when the patient is ready to die and other people continue to cling to hope, no matter how unrealistic it may be.

The interviews on which the book is based began as an effort to assist theology students in learning to talk with dying patients. The author frankly describes the resistance encountered in getting the project started. Despite many problems, the interviews eventually came to be used as the core of an interdisciplinary seminar for medical students, nurses, chaplains, and many other professional workers. The author provides persuasive argument that those in the helping occupations can learn from persons who are dying, if they allow the dying patient to be their teacher during this difficult time.

The book provides evidence that an interdisciplinary seminar on the problems of the dying can do a good deal to improve communication among the many disciplines involved. By providing a mechanism for open discussion of the conflicts and pressures posed by death, this type of seminar encourages the development of mutual respect and understanding among those participating.

The author makes no pretense that talking with dying patients is easy. Rather, the problematic aspects of death for the patient, his family, and hospital staff are described and discussed with respect and understanding. In simple and clear terminology, the book provides direction for anyone interested in improving his ability to talk meaningfully with those who are dying. Nurses interested in this aspect of their work should find it a valuable reference, as should teachers of nursing.

In Horizontal Orbit, Hospitals and the Cult of Efficiency by Carol Taylor. 203 pages. Toronto, Holt, Rinehart and Winston of Canada Ltd., 1970.
Reviewed by Madge McKillop, Nursing Administrator, University Hospital, Saskatoon, Saskatchewan.

In this book, the author attempts to show the effect of centralized administration, with its cult of efficiency, on patient care. The horizontal orbit of the title is the movement of the patient to many different areas of the hospital, frequently in the horizontal position.

The book is divided into three sections: the hospital, hospital roles and relationships, and society and the hospital. In the first section, the author examines today's hospitals and the various decision-making methods used in them. In the second section, she describes the roles of various members of the hospital, with particular reference to the doctor, patient, and nurse. She also suggests some ways in which these roles might be modified to benefit everyone, particularly the patient. In the final section, she looks at changes occurring in society and their implications for the hospital, and especially nursing. She uses some of the work done at the University of Florida Hospital as an example.

Unfortunately, the author attempts too much. Interesting topics are merely touched on, leaving the reader still questioning the basis of some statements. There is a tendency, particularly in part I, to stereotype the nurse as a slavish follower of rules. It would have been valuable to define the effect of the cult of efficiency more clearly. As usual, there are sections that have application only to the United States. For example, medicare American style is quite different from medicare Canadian style.

Despite these shortcomings, this is a valuable book, particularly for nursing administrative staff who are looking critically at present practices. The concept of the role of nursing as the "patient protector" is a valuable one. The description of the "conveyor belt approach to people centered operations" may be somewhat exaggerated, but it does emphasize that big business practices cannot be introduced into hospitals without modifying them to meet the special needs of the institution. The author describes one method of decentralization that gives more scope for decision-making by the nurse providing patient care.

The many references suggest areas for further study and more detailed examination of the topics discussed. This book would also be of value to graduate students in nursing administration or for faculty. However, junior students would find it confusing.

Symptoms of Psychopathology: A handbook, edited by Charles G. Costello. 679 pages. Toronto, John Wiley and Sons, 1970.
Reviewed by R. Barnett, Ph.D., Psychology Department, Carleton University, Ottawa, Ontario.

Thomas Kuhn, author of *The Structure of Scientific Revolutions,* suggested that textbooks play a conservative role in science, that is, they propagate the current facts and theory of the day. The present handbook is such a volume. Ostensibly it is aimed at both the clinician and researcher. It may be of some use to the clinician unversed in experimental psychopathology, but it will be of little use to the researcher who demands more than token summaries of topic areas.

The book should find its major use

books

in educational settings where the reader needs a quick review of a subject area. The average chapter length is 25 pages. The amount of technical knowledge the reader must possess for understanding varies from chapter to chapter, from a prerequisite undergraduate course in abnormal psychology to familiarity with work in learning, perception, and psychophysiology.

The book's aim is to examine a set of "symptoms" indicative of "psychopathology." Unfortunately, there is no attempt to examine analytically what constitutes a symptom or what is the referent of the term psychopathology. The major chapter concerns the problem of classification and psychopathology. Here the above problems should have been examined, but were not. This lack of foresight contributes to the wandering subject matter of the entire volume. Since the editor provided no guidance in what constitutes a "symptom," the contributing authors never confront this focal problem. Consequently, in a chapter on disorders of thinking, the author discusses the behavior of a variety of patients on perceptual and cognitive tasks and avoids the topic areas of hallucinations and delusions. Further, language disorders and the psycholinguistics of schizophrenic speech are ignored in this chapter. Instead there is frequently cited research in "overinclusion" and "concreteness."

The format of the book is designed around these topic areas: cognitive and perceptual disorders, disorders of affect, disorders of behavior, and psychosomatic disorders. The subject areas within each of these topics are sometimes theoretically and pragmatically important, e.g., chapters on disorders of memory, attention, and depression, and sometimes trivial on both counts, e.g., chapters on tics and thumbsucking. The major value of the book is the select bibliography following each chapter, which allows the reader to locate primary sources readily.

Cornerstone for Nursing Education by Teresa E. Christy. 123 pages. New York, Teachers College Press, Teachers College, Columbia University, 1969.

Reviewed by Margaret Steed, Adviser to Schools of Nursing, University of Alberta, Edmonton, Alberta.

This book is a study that traces the de-

velopment of the division of nursing education at Teachers College, Columbia University, from its inception in 1899 through the administration of its first two directors, M. Adelaide Nutting and Isabel M. Stewart. It portrays a broad movement toward better, more informed education for nurses. The belief that education is an instrument of social change permeates the book.

The book captures and holds the reader's attention, then leaves the reader overwhelmed with the vision, courage, and leadership capacity of the many nurses mentioned. At the same time, it is perplexing to think that many of the concepts that were promoted and advocated some 50 years ago are still being debated.

This study is extremely interesting in the way it demonstrates the need to construct a perspective for analysis of current activities. Through a reconstruction process, professional groups can measure, evaluate, and predict social change. The author relates current social forces that have always affected nursing, for example, changes and advances in science and technology, in the social structure, in intellectual concepts, and in economic and political establishments.

The book identifies many concerns for nursing that are still evident. These include the lack of standardization in nursing education, the lack of resemblance to education in hospital schools of nursing, the need for a sound economic basis for schools of nursing, development and growth of auxillary nursing personnel, the need for emphasis on prevention by the community nurse, courses for teacher preparation, and opportunities for night classes for postbasic study of nursing.

The concepts of pre-service and in-service education, continuing education, and the role of the clinical specialist were promoted during the years covered, and the need for research as a foundation for nursing was advocated. Comments show that the major critics of nursing education continue to be members of the medical profession and hospital administrators.

The true delight of the book is the series of achievements and goals of the issues in nursing during that time. The question that arises, and is asked, is: Are there nurses today astute enough to recognize the value and needs of nursing, and well enough prepared to pursue them, so that we may build on this cornerstone of nursing?

This book is particularly valuable for the study of history and trends in nursing and nursing education, and for those seeking reference to debate the many issues in nursing. I believe all nurses would find this book a rewarding experience.

Persuasion, 2nd ed., by Marvin Karlins and Herbert I. Abelson. 179 pages, New York, Springer Publishing Company, Inc., 1970.

Reviewed by D.G. Ogston, Faculty of Arts and Science, The University of Calgary, Calgary, Alberta.

In his 1969 presidential address to the American Psychological Association, Dr. George Miller encouraged psychologists to explain to the public exactly what they were doing in their laboratories. He predicted little future for a discipline that remained encapsulated in a mystique. *Persuasion,* though not a response to Dr. Miller's call, is a volume that does much to open social psychology to public view. The book is more than two psychologists' review of thoughts and theories on opinion and attitude. It is a comprehensive collection of the research and evidence that supports our contemporary understanding of persuasion.

The authors view persuasion as an everyday occurrence in any society or interpersonal relationship. The means of persuasion may be subtle or severe, and the consequences minor or crucial. Most of us are usually unaware of our daily persuaders until an issue is made

books

of them and images of brainwashing or subliminal advertising spring to mind. Certainly there is the extreme side of persuasion, as the authors indicate by citing some of the relevant research, but generally persuasion is a product of human interaction. As such, its study is important to our understanding of behavior and each other.

To its credit, the book presents research that has stood the test of rigor. The research cited is representative of the best conducted during the past few years. Within its nine chapters, the book covers questions, such as: What kind of people are the best persuaders? Who is most easily persuaded? Under which conditions is persuasion best achieved? How long does the persuasion effect last? One chapter is devoted to research methods and one to definitions. Their inclusion provides a depth of understanding seldom found in books of this kind.

The authors operate on the premise that persuasion can be viewed as a science, amenable to scientific methodology. In their attempt to demonstrate that this is the case, they present and review some 30 issues with dispatch. The advantage of this approach is brevity. However, the brevity results in rather choppy reading as the reader attempts his own integration of the evidence.

This book should be of particular value as a reference in schools of nursing. Instructors may find it useful in preparing their own courses. The information in it makes it a regular mini-handbook. It would be a valuable complement to psychology or sociology courses. Anyone who wonders why he is persuasion-prone or immune to persuasion, will find the book interesting and informative.

Healthier Living 3rd ed., by Justus J. Schifferes, 578 pages, Toronto, John Wiley & Sons, Inc., 1970.
Reviewed by Mona C. Ricks, assistant editor, The Canadian Nurse.

As a college course in health education, *Healthier Living* gives a comprehensive introduction to health standards and the knowledge of life situations. It would seem to be necessary reading for *all* college students, especially as an essential contact with the mores and health controls today's social foibles demand.

Treated under five major divisions: mental health, personal health, family living, health hazards, and environmental health, the text gives a historic glimpse of health through several decades. Educational approaches to teaching health, appropriate readings, and teaching aids are also important topics. Instructors can assign parts of the book for study and other parts for free-time reading.

Updated three times since the first publication in 1954, *Healthier Living* is complemented by *Essentials of Healthier Living*, now in its second edition. New to Dr. Schifferes' third edition of *Healthier Living* are selected readings from a variety of sources: The prevalent controversy on drugs, their use and abuse, takes the student through explanations on drug definitions, and gives an insight into the use of drugs on the campus. Perspectives in sexuality is given thorough treatment under "Education for Family Living" (descriptive passages tell of the function of a family in marriage and as it relates in a technical society, the social control of sexual behavior, and the control of sexual desires commanded by personal philosophies).

Also new is a section on environmental health, showing man's physical environment, its changes, and problems. Key health questions are asked on the future of man's environment.

The author's premise that the promotion of health ("for which you may read happiness") is a matter of concern in a constantly changing world, is indeed vital; especially when we are told the coming decade is predicted as an era of massive change.

Therefore, instruction and guidance in health matters is a commodity that should be available to all educational levels. Perhaps the author might be persuaded to write a version of *Healthier Living* for students of all ages.

Couched in language easy to comprehend, yet challenging to the reader who wants to know more, this book can be used for home study and/or by the classroom instructor.

For the nurse, it could be a valuable source of philosophical evidence, shedding light on the healthful interpretation of the word "well-being," and exposing why the demanding word "happiness" is still an integral part of healthier living in an all-consuming electronic age. □

AV aids

Medical film library
A catalogue of medical films is available without charge from the Ayerst Medical Film Library, Room 402, 4980 Buchan St., Montreal 9, Quebec. All films are 16mm. and for use with a sound projector.

New Super-8 Movie System
This Synchronex sound-on-film movie system consists of a Super-8 camera and easy-to-carry transistorized cassette tape recorder. The system uses standard Super-8 color film cartridges and tape cassettes. The only difference from silent movie making is that while filming, the recorder and camera are connected by a coil cord that carries synch pulses from camera to recorder.

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This sound-on-film system permits editing and splicing without synchronization problems, since the sound and film cannot be separated.

The complete system, including carrying case, costs $295 in the United States. Made by the Synchronex Corporation of New York, this equipment is distributed in Canada by Hagemeyer Ltd., 18 Banigan Drive, Toronto, Ontario.

New Cancer Film
A 10-minute film on cancer research has been produced by the Canadian Cancer Society. *"The Flower"* tells about the discovery in 1958 of a cancer-killing drug called VLB (vincaleukoblastine) by a team of Canadian scientists. The team was directed by Dr. R.L. Noble, now head of the Cancer Research Centre and professor of physiology at the University of British Columbia. This drug, made from the periwinkle plant, is still one of the best for treating Hodgkin's desease.

The film was produced by Westminster Films and is being distributed by Astral Films Ltd. For further information write to the Canadian Cancer Society, 25 Adelaide St. East, Toronto, Ontario. □

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, *except Reference items* may be borrowed by CNA members, schools of nursing and other institutions. *Reference items* (theses, archive books and directories, almanacs and similar basic books) do not go out on loan.

Requests for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50, The Driveway, Ottawa 4, Ontario.

No more than *three* titles should be requested at any one time.

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1. *L'accord en français moderne* par Richard Bergeron 3. éd. rev. Montréal, Editions Pedagogia, 1966. 124p.

2. *The accreditation guide for extended care facilities.* Toronto, Canadian Council on Hospital Accreditation, 1970. 31p.

3. *Attendre un enfant* par Marianne Roland Michel. Tournai Belgium, Casterman, c1970. 171p. (Collection "vie effectuelle et sexuelle")

4. *Birth: the story of how you came to be* by Lionel Gendron. Translated by Alice Cowan. Montreal, Harvest House, 1970. 93p.

5. *Brady's programmed introduction to microbiology.* Washington, Brady, distributed by J. B. Lippincott, Toronto, 1970. 174p.

6. *Canadian Hospital Association office and association directory* March 1970. Toronto, Canadian Hospital Association, 1970. 60p.

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9. *Cornerstone for nursing education; a history of the Division of Nursing Education of Teachers College, Columbia University 1899-1947* by Teresa E. Christy. New York, Teachers College Press, 1969. 123p.

10. *Dynamic psychiatry in simple terms* by Robert R. Mezer. 4th ed. New York. Springer, 1970. 179p.

11. *L'écolier sa santé-son éducation* par Pierre Debray-Ritzen. Tournai, Belgium, Casterman, 1970. 235p. (Collection "E ")

12. *Emergency nursing* by C. Luise Riehl. Peoria Ill., Chas. A. Bennett, 1970. 286p. "Suggested reading: p. 241-246"

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14. *Everyman's United Nations.* 8th ed. New York, United Nations, Office of Public Information, 1968. 634p.

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17. *Health and the developing world* by John Bryant. Ithaca, N.Y., Cornell Univ. Press, 1969. 345p.

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19. *Illness and health. Action for mental health;* final report of the Joint Commission on Mental Illness and Health, 1961. New York, Wiley, 1961. 338p. "Science editions"

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21. *Is there a new design for the functions of nursing services.* Papers presented at the third annual meeting, Oct. 9-10, 1969, Cincinnati, Ohio. New York, National League for Nursing, Council of Hospital and Related Institutional Services, 1970. 47p.

22. *Neurological and neurosurgical nursing* by Esta Carini and Guy Owens, 5th ed. Saint Louis, Mosby, 1970. 386p.

23. *Nursing and the law* edited by Eric W. Springer. Pittsburgh Penn., Health Law Center, Aspen Systems Corporation, 1970. 188p.

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25. *Preparation for childbearing. 3d. ed.* New York, Maternity Center Association, 1969. 47p.

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27. *The role of the nurse in the outpatient department; a preliminary report* by Warren G. Bennis et al. New York, American Nurses Foundation, 1961. 88p.

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59. *Rehabilitation nursing workshop; course participants' attitudes toward certain aspects of rehabilitation nursing* by Dawn Elizabeth Marshall. Boston, 1967. 135p. (Thesis (M.Sc.N.) - Boston) **R**

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August 1970

The Canadian Nurse

convention report

my, you're getting big!

the Shouldice story

For Study Now -- for Reference Later

Second Edition

Creighton: LAW EVERY NURSE SHOULD KNOW

By Helen Creighton, B.S.N., R.N., A.B., A.M., J.D., University of Wisconsin, Milwaukee.

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246 pages. $8.10. June 1970.

Second Edition

Keane & Fletcher: DRUGS AND SOLUTIONS

By Claire Brackman Keane, R.N., B.S., formerly of Athens (Ga.) General Hospital, and Sibyl M. Fletcher, R.N., Athens General Hospital.

This text uses the proven methods of programmed learning to teach the administration of medications. The information is presented in short, easy-to-follow steps, with questions (and answers) that check the student's comprehension and reinforce her learning at every step. The conversion of dosages and calculation of fractional doses is made so clear and simple that the student can see the logic of each problem. All problems are solved by ratio and proportion, without confusing formulas. At the end of each section is a post-test, presented as an actual nursing situation. The answers are given at the end of the book, as is a final examination that reviews and reinforces the entire book.

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This handy pocket-sized book has helped tens of thousands of physicians and nurses in managing medical emergencies. The new Fourth Edition has been updated and expanded to include care not only at the site of injury or illness but also in the emergency department of the hospital. This book gives a quick summary of diagnostic and therapeutic information on more than 100 emergency situations from angina pectoris to attempted suicide.

733 pages, illustrated. $12.45. May, 1970.

Smith: RECOGNIZABLE PATTERNS OF HUMAN MALFORMATION

By David W. Smith, M.D., University of Washington School of Medicine.

This valuable new reference offers practical information on the etiology, natural history, and management of 135 patterns of human malformation. The author discusses morphogenesis, single syndromic malformations resulting in secondary defects, genetics and genetic counseling, dysmorphic syndromes of multiple primary defects, and minor malformations as clues to more serious problems. Original charts aid in counseling.

368 pages with 618 illustrations. $17.30. February, 1970.

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- ☐ Keane & Fletcher: **Drugs and Solutions** (about $4.00)
- ☐ Flint & Cain: **Emergency Treatment** ($12.45)
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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

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There was a strong feeling among CNA members at the 35th general meeting that the association must stop examining its own structure and get on with the business that really matters, namely, the provision of the best possible health care for the people of Canada. There was a strong demand that the national association should take a firm stand on social issues, such as pollution of the environment, abortion, unemployment insurance, and taxation.

The prospect of moving from an introspective phase to one of social action is exciting, and we hope *all* CNA members — not just those who attended the general meeting in Fredericton — will find the excitement contagious. There is no doubt that an organization of 82,000 *can* move mountains, if its members know what they want, are determined to stand together to obtain it, and are not afraid to speak out.

And how wonderful it would be if the nursing profession were at long last willing to shed its cloak of conservatism and take some liberal, realistic stands on issues that affect our society. For example, although we're too late to be the *first* health profession in Canada to state that abortion should be a matter that concerns only the patient and her doctor — the Canadian Psychiatric Association achieved that distinction in June — we *could* be the runner-up.

Despite our enthusiasm about membership's desire to make CNA an association of social significance, we cannot but wonder just how this will be accomplished. For without sufficient funds, an association is limited in what it can do.

We support the delegates' decision on the payment of fees, realizing there was no other alternative. But we also see it as a "Band-Aid" approach, in that it patches up the problem temporarily, but does not cure it. If CNA is to accomplish all the things its members demanded at the general meeting in June, it cannot operate indefinitely on the same budget year after year. —

V.A.L.

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Readers support permanent shifts

Congratulations on the overdue article by Helen Saunders, "Let's Have Permanent Shifts" (June, 1970). Her reasoning is true and excellent! At last someone is willing to admit that nurses are human.

I, too, believe that the permanent shift is the best answer for everyone. Many hospitals put a nurse on a ward that she dislikes and on a rotation that allows almost no personal life. Since this happens so often, many nurses hesitate to state a preference.

Married nurses with families make up a large percentage of the hospital staff. Rotating shifts usually mean serious difficulty for the nurse's family. Household help is unavailable, and children become the main victims. Husbands carry an extra and unnecessary responsibility every third or fourth week. Is it any wonder that married nurses are known as "until" workers? They will go back to work *until* the furniture is paid for, or *until* the husband is over his illness.

Many of these married women enjoy nursing, do an excellent job, and often bring a more human touch to their patients. Most would continue to work on a permanent shift that would allow them to make proper arrangements for their children.

No good nurse can turn her back on her first responsibility — her family. Society should accept this fact. Single nurses also have their own lives to live. For many years a nurse's first and only responsibility was supposedly her job. — *B.J. Buckman, Reg.N., Prince George, British Columbia.*

Blames nursing assistants

I have been a practicing registered nurse since 1941. Although for many years I have considered nursing to be one of the most uplifting professions for women, developments in the last few years have forced me to think otherwise.

I now see our hospitals flooded with nursing assistants and nurses' aides who are receiving the same status and approval formerly accorded registered nurses. Some may use the excuse that there is a shortage of nurses, but this has occurred only since the establishment of schools for nursing assistants. Too many nurses have used nursing assistants as an excuse to get away from the bedside, retreat behind a desk, and delegate responsibilities that should never have left the hands of qualified RNs.

Who is responsible? I blame the provincial registered nurses' associations. Although the result is not obvious now, in 10 years the result will be chaos.

Today there is more need than ever for good nurses. With the advance of science and advanced surgical and medical procedures, surely we cannot lessen our requirements for meeting patient needs, but rather increase them. This can only be done by updating our immediate contributions to patient welfare. — *Alfreda Ricketts, RN, Parkdale, P.E.I.*

Permanent shifts

The excellent review of the feasibility of permanent shifts by Helen Saunders (June, 1970) deserves careful attention from all concerned nurses.

That such a skeleton in the cupboard of nursing has been brought out for airing is a credit to the author and to the liberalism of *The Canadian Nurse.* — *N. Pamela Fairchild, R.N., Gabriola Island, B.C.*

Hospital routine necessary

I read with interest Pamela Poole's article, "Nurse, Please Show Me That You Care!" (Feb. 1970.) The type of individualized nursing care advocated by Miss Poole implies the need for an intensive care unit or a private duty nurse.

Attempting to cater to every patient's habits and desires at all times would create chaos. Many of these habits are unnecessary while a patient is in hospital. At home a person is in charge of his own affairs, but in the hospital he is dependent on the staff for treatment. Some kind of routine is always necessary. I think a hospital routine is more important than routine anywhere else; it could be improved but never dropped.

Having been a patient many times, I think that hospital routine is reassuring to a sick person. A patient is confident when meals, baths, and medications are given at regular times. I was never upset because a nurse awakened me, as long as she was friendly and interested. A cold, unfriendly nurse who treats the patient like an ailing machine does more harm to the patient's morale and wellbeing than any amount of rigid routine.

Rather than making nurses more concerned and understanding, dropping routine would increase confusion and make nurses irritable and inefficient. Surely the nurse could treat the patient kindly and intelligently while she does her tasks at the usual time.

Can't common sense be combined with routine? The patient could be asked his opinion about maintaining or relaxing routine. I have often heard patients grumble about being disturbed constantly, yet it was a good-natured and even boastful complaint that implied, "Look how important I am with all these tests and doctors."

One example of what can happen when hospital rules are relaxed can be seen from the trend toward more flexible visiting hours. The patient who wants to rest is often forced to put up with visitors for five or six hours.

Every nurse and doctor should be a patient a few times to know what the patient wants. — *Betty Kowalchuk, RN, Scarborough, Ontario.*

Prenatal teaching in hospital

Congratulations for having the courage to print "A Split in the Family" (April 1970). Seldom has an article in a professional journal fired me with such enthusiasm for my work.

The University of British Columbia School of Nursing recently sponsored a course on nursing care of the maternity patient, which nurses and other personnel from hospitals and public health agencies attended. During the discussions nurses repeatedly expressed the need for more continuity of teaching and sharing of knowledge, and suggested ways of achieving this need. Yet I left feeling that little change would be made, especially in hospitals. Maybe part of the problem is that the individual and her ideas get lost in the large organization.

I recently talked with nurses from maternity departments of several hospitals about the opportunity for prenatal teaching when a patient is admitted during pregnancy. The situation in most hospitals appears very much as Mrs. Rose described. Several nurses gave the reason that doctors do not like them to say too much to the patient. This is strange, when many doctors encourage their patients to attend prenatal classes in the community. — *Valerie Boyer, RN, B.C.*

Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

news

A Call To Action

An avid interest in the keynote address, given at the CNA 35th biennial meeting, continued after the convention's opening session. For those members who were not there, here is a synopsis of the highlights.

Nurses attending the Canadian Nurses' Association convention last June in Fredericton, New Brunswick, were told two old-fashioned words, *commitment* and *dedication,* were coming back into use, and society in the 1970s may be the better for them.

Verna M. Huffman, principal nursing officer for the department of national health and welfare, and keynote speaker at the opening of the week-long convention, said other important words need to be added to nursing today. She noted four, *outreach, involvement,* and *social action.* To each one, she said, it was necessary to add new concepts.

Speaking to a packed audience in Fredericton's Playhouse, Miss Huffman reiterated the call of the nursing profession, convened to discuss "Continuing to Care in the 1970s." An end to differences in care for the rich and the poor was one way in which nursing could provide a vital link in this theme, she said.

Commenting on three major professions meeting in conference during June (Canadian Medical Association — Winnipeg; Canadian Conference on Social Welfare — Toronto; and the Canadian Nurses' Association — Fredericton), Miss Huffman said a review of the doctors' and nurses' programs showed that both professions are concerned with the "Changing patterns in health care in the 1970s, and with their respective roles in relation to relevancy, practice, and quality of care."

In contrast, the Canadian Conference on Social Welfare focuses attention on major national issues in health and welfare.

Prevention and control of disease

Preventing and controlling chronic disease will be the major health challenge during the coming decade, said Miss Huffman. Measures taken will need to include the extension of existing programs, and new ones added to provide personal health services. These will have to reach out into the homes of the community, making services available to all.

Speaking on health and welfare services in Canada at the opening ceremonies of the Canadian Nurses' Association 35th general meeting in Fredericton, New Brunswick, Verna M. Huffman, principal nursing officer, department of national health and welfare, told of government concern for public health needs. As keynote speaker, Miss Huffman outlined positive approaches to nursing challenges in the 1970s. She called on her nursing associates to clarify what is meant by the extended role of the nurse, and asked that the CNA take a positive stand on social issues. Seated behind Miss Huffman *(right)* Sister Mary Felicitas, outgoing president, and The Honorable Wallace S. Bird, Lieutenant Governor of N.B.

Preoccupation with the treatment of the acutely ill at the expense of prevention and care of chronic disease, should not cloud the prime concern — without prevention, a healthy population cannot be produced.

Pollution

Touching on the subject of pollution, Miss Huffman said, "Prevention can no longer be left as a concept. It must be put to work in every avenue that touches on the health of man.

"It is time for all Canadians to take action and exert every conceivable pressure to halt the polluters in their tracks."

Expressing the federal government's concern on pollution control, Miss Huffman said, "... we are striving to increase the activities of the environmental health division of the department to bring a new code of clean air." She felt there was also a great need for the public, including professional associations, to become active in the drive toward pollutant control.

Social environment

Explaining why she felt major problems exist in our social environment which touch the young and the old directly, and many others indirectly, Miss Huffman made it clear to her audience that, in her estimation, "the spread of alienation among young people today is a phenomenon more analyzed than acted on.

"Students are questioning the long-held goals of their professions, or else charging that their profession has knowingly and willingly failed to fulfill its expressed goals," she said.

Citing law, medicine, and nursing as three professions affected by the alienation of the young from established practice, Miss Huffman termed student viewpoint on the establishment as a "sellout" to an exploitative, capitalist system, "with a double standard of

service for the privileged and the underprivileged."

The young people today can give us examples that show "inequality of rights between the rich and the poor — even the right to health care."

Continuing on the subject of equitable health care, Miss Huffman mentioned the health studies underway in Canada.

"We cannot deny the piles of studies which demonstrate an inextricable link between poverty and bad health. We cannot claim that our health personnel are distributed equitably according to population or need. The only answer is to reply to the challenge of the young by accepting their outlook and mending the gaps between theory and reality."

Faced by an audience of over 1,000 nurses, Miss Huffman turned her comments directly to the CNA when she asked the association to implement its brief to the Senate Committee on Poverty. She suggested the nursing profession could experiment with new models of community care and interdisciplinary community group practices.

"As a profession, we can shift the priority and financial resources in our education system over the public health and community health care training, seek closer working relationships with social agencies and workers, and talk to the self-organized low-income citizen groups as equal partners in developing better health and health education programs."

Appealing to the nursing profession, Miss Huffman said, " We *can* do these things if we care, but can we *not* care. To go without care is an outright national shame in a country rich in health personnel and facilities."

Calling for greater involvement in the country's nursing facilities, Miss Huffman described nursing conditions in Canada's north, where many of the nurses are foreign.

"Canada borrows nurses from countries which have a desperate nurse shortage, to fill the health needs in outlying communities in the North," she said. This is because "our own girls either cannot, or will not, take the necessary training and face the social challenge."

Health care for the aged also came under Miss Huffman's penetrating gaze. "It is true health care is provided for most old people," she said, "... but sometimes that care is neither within their reach nor within their ken."

She charged there appeared to be a "major breakdown in our communication with people about the resources available. There is a great need for Canadians to reexamine fundamental values, with particular regard to the aged."

According to Miss Huffman, nursing in the 1970s is moving into one of the most exciting periods in nursing history. She described it as a "... time of great change. A period requiring new sights, new horizons, new roles, and new relationships."

Referring to one new role that the nurse may be filling in the early 1970s, she agreed with the firm stand the editorial in the June 1970 issue of *The Canadian Nurse,* took on the doctor-assistant issue. Quoting from the editorial, she emphasized the need for the CNA to back up its concern for patient care by "taking a stand in this issue, and quickly."

Health demands in the coming decade will see a need for nurses "with a difference in preparation and perspective," according to Miss Huffman. She saw these differences as a connecting link between the patient, his family, and the health services, and affecting all areas of nursing as the role of the nurse moved toward greater involvement in health planning and care.

"There is already a need for the nurse who is capable of looking at the community as a whole, and capable of moving with firm logic from health needs to careful choices in the use of available resources."

The need for nurses to accept other nurses as colleagues was stressed on several occasions. Respect for the individual role and contributions not only of other nursing disciplines, but of working partners, became a theme throughout Miss Huffman's speech.

During the past six months, discussion on the appointment of a professional lobbyist for the Canadian Nurses' Association has been given frequent editorial coverage in the journal and news media across the country. Miss Huffman referred to the lobbyist "as a legitimate role for a responsible professional organization," but cautioned the association when accepting this responsibility to, "strive for a balance, one which seeks to promote change while keeping in mind the realities of the situation."

Questions asked

To an audience newly convened for a week-long session on nursing policies and nursing needs, the speaker posed several questions. She prefaced her remarks by stating that as a strong, organized profession, nurses probably have more experience with poverty and its effects than any other segment of the Canadian population. But, she asked, as a responsible group in numbers and weight of knowledge, "what social action has this organization taken to combat poverty?"

Miss Huffman continued, "An organization must have policy statements on important national issues... to initiate concrete action."

" What," she asked, "is the stand of this predominantly female association in the national issue of abortion? What is the stand on drug abuse?"

Applause almost drowned out her questioning as she came back to her listeners, asking if the association felt there is an "artificial distinction between legislation dealing with harmful narcotics!"

She cited as examples marijuna, which comes under the Narcotic Control Act [possession is an offense], and amphetamines, considered equally dangerous, but controlled under the Food and Drug Act [possession is not an offense].

" What is the association's stand on these issues?" she demanded.

It was following her questions on national issues and the stand taken by the association on major social concerns, that Miss Huffman detailed the words and concepts she felt would help the nurse in the 1970s identify her changed role in Canada's health system.

CNF Members Recommend Fee Increase Of $3

Fredericton, N.B. — Members of the Canadian Nurses' Foundation attending the annual CNF meeting June 15, expressed strong support for a membership fee increase. They voted unanimously to recommend to the board of directors that the annual fee be raised to $5 per regular member. The present fee is $2.

Concern was expressed about CNF's financial state. As of December 31, 1969, the surplus in the scholarship fund was $37,419; in the research fund, $1,917; and in the general fund, $5,144. The secretary-treasurer of CNF, Dr. Helen K. Mussallem, told the members it costs at least $3 to process each membership.

Several members said they were sure that those who now support CNF would be willing to pay the increased fee. One member suggested that the 99 nurses who have received CNF scholarships should be taxed $100 annually. Another suggestion was that CNF scholars should think of ways to help publicize the Foundation.

The president's address, presented by the CNF vice-president Albert W. Wedgery, pointed out that membership, too, is low: 1,294 regular members as of December 31, 1969; 16 sustaining members; and 1 patron — a total of 1,311. This is a decrease of 183 members from the previous year.

In summarizing, Mr. Wedgery said, "CNF needs members, convinced members. Their enthusiasm can be the most effective promotional factor for the Foundation in defining its purpose, interpreting its needs, explaining its operation, and spurring donations, bequests, memorials . . .. The challenge is to see the Foundation as an independently established corporation by 1972," he continued. "Can it be done? I think it could."

Report Urges Special Committee On Nursing Research Be Set Up

Fredericton, N.B. — Establishment of a special 22-member committee on nursing research was one of four recommendations made by the ad hoc committee on research of the Canadian Nurses' Association, and reported to membership at the 35th general meeting June 19. The committee report is being studied by provincial nurses' associations and will go to the CNA board of directors when it meets in the Fall.

The other three recommendations, made at an April meeting of the research committee, are:

- CNA should accord high priority to the need to allocate funds for research, including $100,000 per year to prepare nurses with the qualifications necessary to participate in and direct research projects.
- CNA should initiate discussions with the Council of Canadian University Schools of Nursing and with the department of national health and welfare for research in the field of nursing.
- CNA should adopt the complete statement of policy on nursing research as recommended by the research committee.

In this statement the committee said the role of CNA in relation to research would be: to provide a comprehensive picture of the profession; to encourage and influence the research activities of individual practitioners and of educational and service agencies; and to serve as spokesman for the profession in relation to research in health services.

The committee report was discussed at a special meeting of the CNA board June 18 during the CNA general meeting in Fredericton, N.B. Dr. Dorothy J. Kergin, committee chairman, attended to answer questions. She also presented a resume of the report to the general membership on June 19, for information purposes.

During the session on June 19, Verna Huffman, principal nursing officer with the department of national health, said a new committee on research projects has been set up by the department. It is headed by Dr. John Evans, dean of medicine, McMaster University, Hamilton; representing nursing on the committee is Pamela Poole, a nursing consultant with the department.

Specialization Calls For Nursing Changes

Interest sessions at the Canadian Nurses' Association 35th biennial convention in Fredericton were attend-

(Continued on page 10)

New Executive

Soon after president-elect E. Louise Miner *(right)* became president, following the 35th biennial meeting of the Canadian Nurses' Association in Fredericton, New Brunswick, she gathered her new executive together for the first official picture. *Left to right,* lst vice-president Kathleen G. DeMarsh, assistant executive director, The Winnipeg General Hospital, Manitoba; 2nd vice-president Huguette Labelle, director, Vanier School of Nursing, Ottawa; and president-elect Marguerite E. Schumacher, director, Health and Social Services, Red Deer College, Alta. Miss Miner is wearing her chain of office.

Dorothy J. Kergin, chairman of the CNA ad hoc committee on research, gives a résumé of her committee's recommendations on the national association's role in research. Over 1,000 nurses attended the CNA general meeting in Fredericton.

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news

(Continued from page 7)

ed by audiences eager to learn more about specialization in nursing.

Speaking at The Playhouse, June 18, on "The Expanded Role of the Nurse," three speakers expressed opinions, showing that nurses have already expanded their role into many areas of medical service.

Opening the afternoon session, Dr. F.B. Fallis of the department of family and community medicine, University of Toronto, said improved communications and a decrease in the cost of health care through universal medical coverage have "produced a strong new boldness and demand by the public," for more and better services.

Nurses and doctors should take another look at the basic aspects of their professional patterns. They should begin by reexamining educational preparation in all its phases.

Developing specific training for the nurse's role by teacher identification and well determined standards, he said was one approach. Another, setting standards for team skills and methods in a community setting.

He felt it would be difficult to see, "how the physician, with his extra responsibility for diagnosis, and medical and surgical therapeutics, was not the senior member of the community team."

"Featherbedding," he commented, "is keeping up an outmoded style of operations when a trade union insists on it." When the same thing is done in medicine, the explanation is "the maintenance of established professional values."

The problem of delegation must be solved, he said, but a professional relationship must also be maintained. The family physician on the team "must be able to assign those things which the team nurse, in her extended role, can do more effectively from a patient's point-of-view.

Following Dr. Fallis, Rosemary Coombs, clinical nurse specialist at the Ottawa Civic Hospital, spoke on the expanded role of the active-care hospital nurse.

Mrs. Coombs told her audience that to keep abreast of medical advances, nursing specialization had become a necessity. Because hospitals are being divided into highly specialized units, the role of the nurse has to take on certain functions of the medical specialist.

Today's multi-disciplinary approach to health care places the onus on nurses who "can and will... seek the knowledge and clinical expertise to establish themselves as interdependent partners of medical and paramedical personnel."

Speaking to fellow nurses who applauded her comments, Mrs. Coombs said, "You know that the Canadian public is concerned with the cost of health care and is demanding more accessible and more long-term care.

"What, then," she asked, "must happen to the role of the nurse, if she is to adapt to public, provincial, and national demands."

Participation in specialization is the answer, according to Mrs. Coombs, and she explained why.

Three major trends in the active-care hospital system are apparent: *Medical specialization* — requiring specialty units, nursing specialization, and assumption by nurses of some medical functions; *Better utilization of nurses* — leading to patient-focused care, progressive care, and patient-care classification within a health region; *Multi-disciplinary approach* — requiring peer relationships between all health professionals.

What kind of nurse do we need to answer the call medical change demands? Nurses who are trained in specialities, with an ability to recommend necessary change in medical therapy, supported with scientific reasons, said Mrs. Coombs.

To cope with the trend to a multi-disciplinary approach to health care, we need nurses who can and will "raise their heads from their traditional, dependent role and seek the knowledge and clinical expertise to establish themselves as interdependent partners of medical and paramedical personnel."

Preparing nurses to function in a changing health care pattern means, qualified nurses must be sent to universities for graduate work in a clinical specialty. These will become the *clinical nurse specialists,* who will demonstrate the expanded role of the nurse, and assist other nurses to do likewise.

Senior nurses should take short courses to qualify as *nurse clinicians,* and graduates from basic nursing programs should be assisted to develop clinical and technical expertise in the specialities to become *specialty nurses.* New graduates, *general nurses,* should be allowed easy mobility according to their clinical expertise and scientific knowledge.

Mrs. Coombs said her description of the extended role of the nurse is suggested as one nursing answer to the health delivery problems of Canada.

"If we [the nurses] want status, we will find it not only in a university degree, but if we function interdependently with all the health professions," she said.

Contributing her comments to the expanded role of the nurse, Monica M. Green, director of public health nursing, department of health services and hospital insurance, British Columbia, outlined the role of the public health nurse in promoting health service.

She said public health nurses have unique role, their activities are concerned with prevention, and with treatment and care.

The basic philosophy, she felt, would not change, but the delivery of public health nursing will, as health care needs in Canada change.

Prevention, including health promotion, is the traditional role of the public health nurse, said Mrs. Green. Her effectiveness in all areas of community nursing, including areas in the North, has been felt. She cited immunization procedures as one example. Although practised by the public health nurse for 25 years, it has not been universal in all provinces, said Mrs. Green. She quoted the federal task force report as recommending that immunization be done by the public health nurse as one cost control method.

Describing various trends in public health nursing change, Mrs. Green said organizational changes toward having the nurse's services available to physicians on a regional basis, or attached entirely to a medical practice, is one team concept of health care.

The role of the public health nurse has expanded from that of referral agent to active responsibility for developing community health services, she said.

Yet, few agencies provide the opportunity for this expanded role. "The public health nurse and agencies are still reluctant to give up old routines for new ones."

More opportunity to use her capabilities is required, Mrs. Green told her fellow nurses, rather than "expanded education."

Notice

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Spontaneity Is Key To Helpfulness Of Psychodrama

Fredericton, N.B. — The key to the helpfulness of psychodrama is its spontaneity of action, the director of nursing

at the Clarke Institute of Psychiatry in Toronto told an audience of over 400 on June 16.

Speaking at a special interest session at the Canadian Nurses' Association's 35th general meeting, Dorothy Burwell, who is also associate professor of psychiatric nursing at the University of Toronto, explained that psychodrama is a "special case of encounter," where patients are brought together on stage to enact scenes that have bothered them. "With spontaneity as the key, feelings begin to emerge," Mrs. Burwell said. "All the angry frustrations, fears, longings, loneliness, and confusion become shared with the group."

Mrs. Burwell then proceeded to demonstrate this spontaneity of action. She had no trouble in rounding up eight volunteers from her enthusiastic audience — four nursing students and four "head nurses of World War II vintage." Their assignment: to help each other bridge the generation gap and to air the misunderstandings that arise between students and nursing staff.

"Tell these head nurses what you don't like about them," Mrs. Burwell directed the student actors. One student reponded immediately: "We're sick and tired of hearing how *we* have it so easy, and how you head nurses had to work 12-hour shifts when you were students!"

The head nurses retaliated saying that patient care wasn't as good as it used to be, partly because students weren't on the wards long enough to learn the necessary skills, and seemed reluctant to accept responsibility.

At this point, several students in the audience, obviously annoyed at the head nurses' comments, voiced objection.

Roles were then reversed: students became head nurses, and head nurses became students. This reversal of roles seemed difficult for the actors, but they gave the impression they had obtained some insight into the other's problems.

At the end of the session, Mrs. Burwell received prolonged applause for her lecture and demonstration.

Research Session Sparks Enthusiasm

Many nurses gave up their chance to shop Thursday night during the Canadian Nurses' Association's 35th general meeting in Fredericton, to attend the 7:00 P.M. interest session on research. Their choice was a good one. The session, chaired by Dr. Dorothy Kergin, *right*, director of McMaster University's school of nursing, was interesting and lively, bringing an enthusiastic response from the audience. The two RNs who presented research papers are, *from left:* Susan E. Perry, lecturer, School for Graduate Nurses, McGill University; and Alice J. Baumgart, associate professor, University of British Columbia.

Nursing Consultant Criticizes Depersonalized Nursing Care

Fredericton, N.B. — Many of Canada's hospitals have become so depersonalized that there is almost more feeling of welcome in a hotel, according to Pamela Poole, nursing consultant with the department of national health and welfare.

Miss Poole showed this depersonalization and how it affects nursing care during an interest session on June 18 at the 35th general meeting of the Canadian Nurses' Association. She gave two presentations, one in English and one in French, speaking to a full house of some 400 nurses each time. The audience reception was excellent.

Miss Poole told the terrifying story of "Mr. Anybody" on his admittance to hospital. "His experiences are a composite of many patients' experiences," she explained. "Most of them happen somewhere in Canada, to some patients, every day."

In her presentation, Mr. Anybody's problems started when he tried to find the admitting office of the hospital. He felt like a prisoner in his room, had great difficulty getting any food, and was worried about the strict visiting hours.

Miss Poole said the nurses caring Mr. Anybody never took the time to explain the routines they were performing: why he had to have his back rubbed at 8:15 P.M. and his light out at 10:00 P.M., his temperature taken at 5:15 A.M.

The nurses would not explain why Mr. Anybody had to take a certain pill, or could not drink water one night. He found them rigid about unimportant things, such as washing from his own metal basin rather than the sink, even though the basin would not balance well.

Miss Poole showed that Mr. Anybody was made to feel embarrassed — by all the personal questions he was asked, by being forced to use a wheelchair when he could walk. He also felt isolated — he could not see his children (they were too young to be allowed into the hospital) and visiting hours were short.

When he went for his operation, nothing was explained to Mr. Anybody, and he was talked to like a child. Miss Poole showed that his whole experience of being in hospital was frightening and uncomfortable. She said nursing certainly shared the blame for this depersonalization of the hospital.

When a member of the audience asked how to teach nursing students to be perceptive and to care, Miss Poole suggested apprenticing them to an expert practitioner who *cares*, rather than to a hospital.

She questioned whether there would be a registered nurse on the ward to supervise nursing care 15 years from now. The people who foot the bills have not been convinced that professional nurses make a difference, she added. "The public can bring pressure, but will do so only if they want *you* to give nursing care," said Miss Poole.

Highly Planned Patient Care Essential, Nurses Told

Fredericton, N.B. — Organized planning of patient care has many advantages, including individualized patient

care and greater job satisfaction for nurses, according to Myrna Sherrard, nurse clinician, Moncton Hospital, New Brunswick.

Proper planning also provides for coordination of the efforts of all who provide care, eliminates many routines and ritualistic practices, and leads to more effective utilization of nursing care hours, Miss Sherrard told some 400 nurses attending the interest session June 18 during the 35th biennial convention of the Canadian Nurses' Association.

Organized planning is based on three well thought out steps, said Miss Sherrard. Assessment is followed by nursing intervention. "Perhaps one of the most difficult tasks in this whole process is to set for and with the patient realistic goals or objectives," she added.

The final step is evaluation of nursing action, probably the most commonly overlooked part of the process, said Miss Sherrard. "Nurses must accept as their responsibility providing the patient with the knowledge that will enable him to participate effectively in his own plan of care," continued Miss Sherrard. "It is only the patient who can evaluate the effectiveness of some of our nursing activities."

Huguette Labelle, director of the Vanier School of Nursing, Ottawa, presented the French-language interest session on planning patient care. She agreed with Miss Sherrard that an organized nursing care plan is essential for patient-centered care.

Mrs. Labelle also urged nurses to look after their own profession before others tell them what they should do.

A lively symposium on the lack of nursing textbooks published in French, brought an overflow audience to MacLaggan Hall, University of New Brunswick, during the Canadian Nurses' Association convention last June. "There's no more room," was the repeated comment as those wishing to take part in the discussion made every effort to find a seat. They packed the hall and stood in the corridor, a steady two-way stream, in and out as they strove to take in the sessions.

Urgent Need Shown For Nursing Textbooks In French

Fredericton, N.B. — An urgent need for nursing textbooks in the French language was expressed by over 130 nurses who attended a symposium held June 15 during the 35th biennial convention of the Canadian Nurses' Association.

Those attending decided committees should be formed within provincial nurses' associations to find out exact needs for French textbooks. These committees could also ask for funds from the health ministers of each province, and encourage nurses to write texts and help them get published.

The CNA general membership reinforced the findings of the symposium on June 19, when it passed a resolution asking the Board of Directors to consider ways and means of producting French-language textbooks.

At the symposium it was decided that a basic health manual was a priority. All participants favored the original production of texts in French, rather than a translation.

Representatives from eight publishing companies attended the symposium and answered questions. They pointed out the large cost of producing a book, whether original or translated, but said they were ready to help nurses if given specific requests for books.

Legal Implications Of Nursing Reviewed At Convention

Fredericton, N.B. — The health field is changing so quickly that the law has not caught up with it, Lorne E. Rozovsky told some 400 nurses at an interest session held during the 35th general meeting of the Canadian Nurses' Association June 14 to 19.

And Canadian nurses may be the victims of more legal suits because their relationships with doctors and nursing assistants are not clearly enough defined, said Mr. Rozovsky, solicitor for the Nova Scotia Hospital Insurance Commission.

The new legal specialty of health law may assist nurses in definition of their role, he added. However, since this specialty is so new there are still "large gaps of unanswered questions."

There are no longer "precise legalistic slogans governing the nurses' minute-by-minute conduct," said Mr. Rozovsky. And it is not true that so long as a nurse is following a doctor's orders, she will be protected from legal suits.

"If a doctor gives an order which is obviously wrong and which will or could result in injury to the patient, the nurse could well be held responsible either in whole or in part if she carries out the order," said Mr. Rozovsky. "If the nurse observes that the doctor has done something which is obviously negligent, she must not assist in that task."

She should obtain clarification of the order and, if still not satisfied, report the matter to her supervisor, he added.

The nurse is in a difficult position, said Mr. Rozovsky, because she may not substitute a medical decision, but she could be held liable if she followed a decision she knew was wrong or ambiguous.

"One has only the general legal guidelines of the ordinary prudent nurse to determine the role of the nurse and her relationship with the doctor," said Mr. Rozovsky.

The courts are guided as to proper nursing conduct by the testimony of

expert witnesses, he added, so "the nursing profession sets its own legal standards" to a large degree.

The nurse's responsibilities will become greater as educational standards are raised, said Mr. Rozovsky.

Nurses Told To Define Role, Look For Change In Profession

Fredericton, N.B. — The proper "care and feeding" by nurses of their profession will bring change, not comfort, according to C.R. Brookbank, chairman, Dalhousie University department of commerce, Halifax, Nova Scotia.

"If you avoid the crucial questions and thus hope to avoid change," he told some 1,000 nurses June 15 at the 35th biennial convention of the Canadian Nurses' Association, "you will not be comfortable because others will put you in what *they* consider to be your place, and continue to make inroads on your territory."

The major dilemma of the nursing profession today concerns the role of the registered nurse, said Professor Brookbank. He asked nurses to define their primary functions, which no one else can perform. "Which areas of knowledge belong to you alone? Every profession has them; if you do not, can nursing truly be called a profession?"

If it is truly a profession, continued Professor Brookbank, nursing must have "a diagnostic function which demands insight as well as technical knowledge, analysis based on a perspective which 'belongs' to the discipline, and responsibility backed by clear authority for subsequent action."

Nursing must have some core functions that cannot be performed by technicians or members of other professions, said Professor Brookbank. Also, nurses should not do jobs that lesser-trained personnel can do.

Professor Brookbank said the long-term success of all nurses' activities to advance their profession will depend on the valid answers they can provide to these questions of their functions.

Some answers may be found in the concept of team nursing, he said, especially if a registered nurse is the head of the team in a professional sense.

Professor C.R. Brookbank of Dalhousie University, Halifax, talks to over 1,000 nurses in Fredericton about the proper "care and feeding" of their profession.

One Million Children Handicapped, Commission Finds

Ottawa — Twelve percent of all Canadians up to age 19 — more than one million children — need attention, treatment, and care because of emotional and learning disorders, but only a quarter of them get adequate treatment. This is the finding of the Commission on Emotional and Learning Disorders in Children, whose report was released June 23.

The report, issued by CELDIC, a non-government commission set up four years ago by seven voluntary agencies, severely criticizes aid programs and calls for radical reorganization of the helping services throughout Canada. One hundred and forty-four recommendations call for sweeping changes in the organization and delivery of services, in the training of personnel and in the attitudes of governments, the professions, and society.

"In any other field a problem of this magnitude would be heralded as an acute epidemic or a national disaster," said R.H. Shannon, Commission chairman. "The saddest and rankest form of discrimination in our country today is against these handicapped children."

The Commission found that in most circumstances present efforts to meet the needs of these children are both confusing and ineffective. As a result, many thousands of children get no help at all.

The report calls for an emphasis on prevention and recommends that all services be planned locally. It says there must be a collaborative effort between federal and provincial governments to look after the children; both adequate funding and more permissive legislation are needed.

The report indicated that non-specialized professionals, such as nurses, should be of more help to handicapped children. For example, a public health nurse should examine the mental and the physical state of the child.

The organizations that sponsored the Commission are: Canadian Association for the Mentally Retarded; Canadian Council on Children and Youth; Canadian Education Association; Canadian Mental Health Association; Canadian Rehabilitation Council for the Disabled; and the Canadian Welfare Council.

Progress Report Issued On Implementation Of Health Costs Report

Ottawa — Enough recommendations of the task forces on the cost of health services in Canada should be implemented within three years to show an annual saving of two hundred million dollars, other costs being equal, according to G.B. Rosenfeld, head of the task forces secretariat.

He made this statement while introducing a progress report of the steering committee set up in March 1970 by the committee on the costs of health services. This steering committee, headed by Mr. Rosenfeld, will assess comments on the task forces report issued in November 1969, and get its recommendations implemented.

The committee is reviewing all recommendations of volume one of the three-volume task forces report to develop possible techniques for implementation. It has also established a program of activities that includes:

setting up some 60 main target areas from the 348 recommendations to achieve impact within the health care system; a time schedule for this impact; starting development of specific reports on danger areas in costs; and federal allocation of resources to meet objectives.

The progress report highlighted three other developments. The steering committee has recommended a sub-committee be set up to include representatives of the health professions and consumers. The sub-committee would advise on implementation of some of the task force recommendations in regard to timing, economic impact, and other factors.

Membership of the steering committee has been broadened to include representatives from British Columbia and the prairie provinces. It already had representatives from the Maritimes, Quebec, and Ontario.

The steering committee has asked all provinces to nominate persons who would act as liaison officers to help implement the recommendations.

ANPQ Workshop Studies Misuse Of Drugs

Montreal — Misuse of drugs was the topic of a workshop held on two successive days in April by District XI (English Chapter) of the Association of Nurses of the Province of Quebec.

Some 240 nurses attended on the first day and 260 on the second. The involvement of all nurses professionally and personally in the drug scene was emphasized by A. Arundel-Evans, Queen Elizabeth Hospital, Montreal. She called the drug question one of the most challenging problems in society.

Guest speaker Dr. Sidney Lecker of the Montreal Children's Hospital discussed the evolution of the drug scene. He pointed out the need for the traditional "humanistic" role of the nurse in all her relationships with drug users, and mentioned the lack of facilities available for treatment.

A panel of young adults, some of who had been drug addicts, described their experiences with drugs. Panelists conveyed their social background, philosophy of life, and their present needs and concerns for understanding and acceptance.

Another panel, which included people who work with youth using drugs, discussed the problems of helping drug users and preventing further misuse. Two films on the drug problem were also shown.

It was breakfast at 7 a.m. under the trees for these students at the CNA 35th biennial in Fredericton, New Brunswick. Dianne North (standing), whose experiences as the only Canadian RN in Biafra appears in *The Canadian Nurse*, March 1970, leads the group in an "after bacon and eggs singsong." The students were observers at the week-long convention. One word expressed their reaction to the sessions — great! They felt their understanding of nursing involvement in medicine was broadened as they listened to discussions on patient care.

Canadian Nurses Should Be Licensed By Endorsement, US Council Urges

New York — The USA Council of State Boards of Nursing agreed at a recent meeting to urge nursing boards to license by endorsement nurses licensed by the new Canadian Nurses' Association National Testing Service examinations.

This license by endorsement should last until a study can be conducted on the comparability of the CNA testing Service and State Board Test Pool examinations, said the Council.

This decision was based on information that Canadian examinations are being developed along the lines of the SBTP examinations and will include the same clinical nursing areas.

"Many US jurisdictions now require the SBTP examination of all applicants for licensure," explained Eleanor Smith, coordinator of the Sate Boards of Nursing Program of the American Nurses' Association. "In some instances this is required by board regulation, so boards of nursing should have no difficulty in amending the regulation to waive the examination for Canadian nurses licensed by the CNA examination."

The first set of examinations prepared by the CNA Testing Service will be written this month.

Nursing Studies Wanted

The Canadian Nurses' Association Library welcomes additions to its collection of nursing studies. Any nurse who has a thesis or a report on a research project conducted at a hospital or other agency is invited to send it to the CNA Library, 50 The Driveway, Ottawa 4, Ontario. Short abstracts of studies received are published in the *CNJ*.

Patient care Highlighted At NBARN Workshops

Fredericton, N.B. – Nursing service took the spotlight during February-April in New Brunswick when a series of workshops on planning patient care was presented in 11 centers throughout the province. Some 970 nurses from Moncton, Edmundston, Fredericton, Saint John, Chatham, Perth, and Bathurst had attended the sessions at press time.

Workshops were still to be held in Tracadie, St. Stephen, Cambellton, and Sussex. The one-day workshop was repeated in most areas so more nurses could attend.

The workshops were sponsored by the New Brunswick Association of Registered Nurses' nursing service and education committees. Chapter presidents and nursing service and/or education committees completed arrangements at the local level and served as coordinators during the workshops. Workshop leaders included New Brunswick nurses skilled in the area of planning care, who worked in pairs when presenting the program.

How to assess the needs of patients

and plan the care to meet these needs was the general theme of the workshops. The principles discussed were applicable to any nurse-patient situation, whether in the hospital, community, or nursing home.

Three areas in planning individualized care were outlined by the leaders: assessing needs, nursing action, and evaluation of the action.

The participants then broke into groups to develop a nursing history guide. Following the presentation of a patient situation, each group applied its guide to the presentation from which a nursing care plan was written. Nursing care plans from each group were presented and discussed by the total group.

NBARN hopes results of these workshops will lead to written nursing care plans for each patient in the province.

CNF Fellowship Awards

Ottawa — The Canadian Nurses' Foundation has awarded a total of $61,237 to 19 Canadian nurses to pursue graduate studies in the 1970-71 academic year.

They were selected for leadership potential and scholastic ability. Individual awards range from $1,500 to $4,500.

Lorene M. Bard, Regina, Saskatchewan; Jeannine Baudry, Boucherville, Quebec; E. Gail Carleton, Montreal, Quebec; Patricia Christensen, Vancouver, B.C.; Joan Crook, Halifax, N.S.; Lesley F. Degner, Winnipeg, Manitoba; Jean E. Fry, Windsor, Ontario; Agnes M. Herd, Regina, Saskatchewan; Janet I. Leitch, Winnipeg, Manitoba; Rita J. Lussier, Lafleche City, Quebec; Jocelyne Nielsen, Halifax, N.S.; Nora I. Parker, Toronto, Ontario; June R. Scollie, Winnipeg, Manitoba; Joan Shaver, Calgary, Alberta; Sharon E. Simpson, Toronto, Ontario; Phoebe Stanley, Montreal, Quebec; Marilyn M. Steels, Hamilton, Ontario; M. Louise Tod, Edmonton, Alberta; M. Anne Wyness, Toronto, Ontario.

One hundred and twenty-nine awards to 98 students have been made since 1962. Twenty-five students have received more than one award from CNF. CNF administers fellowships provided by: W.B. Saunders Company Canada Limited Nursing Fellowship; White Sister Uniform Incorporated Scholarship Award; Agnes Campbell Neill Memorial Fellowship (provided by the Nursing Sisters' Association of Canada); and Dorothy MacRae Warner Fellowship (provided by memorial funds).

The Foundation was incorporated to receive and administer funds for fellowships to prepare nurses for leadership positions. It is dependent upon gifts, donations, and bequests from individual donors and organizations.

CNA Wants Nurse On Task Force Committee

Ottawa — Grave concern that no nurse has been appointed to the steering committee set up by the federal government to study implementation of the Task Force Report, was expressed by the Canadian Nurses' Association in a letter to G.B. Rosenfeld, department of national health and welfare.

The CNA's executive director, Dr. Helen K. Mussallem asked, "May we anticipate that there will be nurses appointed to the proposed sub-committees that will work with the steering committee. I am confident that you are aware of the significant contribution that nurses can make in assisting the committee to achieve its goals."

She assured the department that CNA is ready and willing to collaborate with the department on every possible occasion. Nursing is an essential ingredient in medical services, said Dr. Mussalem, and we want to get into the act.

Published last November, the three-volume report has 348 recommendations proposing changes in Canadian health services. These affect the medical profession, including nursing, said Dr. Mussallem.

Announced in early July, the steering committee to study implementation of the report is made up of Dr. Graham Simms, executive director, Nova Scotia Hospital Insurance Commission; E.P. McGavin, commissioner of finance, Ontario Hospital Services Commission; Jean-Paul Marcoux, director-general, Quebec Hospital Insurance Services; and federal representatives Dr. D.F. Marcellus, J.E. Osborne, and Dr. R.W. Tooley.

Chairman of the committee is G.B. Rosenfeld, who headed the Task Force secretariat. Representation from the prairies has yet to be made.

CNA concern was reiterated in a news report from the Canadian Medical Association, which termed the CMA's reaction as "unhappy." One CMA member grumbled, "How would you like it if a committee planning extensive changes in the newspaper business was composed entirely of social workers?"

None of the steering committee members are practising physicians.

At Press Time...

Toronto, Ont. — The Registered Nurses' Association of Ontario greylisted the Peel County Health Unit on July 10.

Anne Gribben, director of RNAO's employment relations department, told *The Canadian Nurse* that negotiations between the nurses employed by the Unit and the Peel County board of health are at a stalemate. "The nurses offered to go to compulsory arbitration, but the board of health turned this offer down," she said.

Although the nurses voted in favor of strike action if the board refused their request for arbitration, they have not yet set a strike date.

According to the current issue of *RNAO News*, present salaries for Peel County public health nurses are: minimum — $6,250 with four annual increments of $350 to a maximum of $7,450. The board of health offers a 1970 minimum of $6,687, and for the second year of the contract, 1971, a minimum of $7,155 with the same annual increment of $300 for a maximum of $9,300.

In Ontario, hospital employees are not allowed to strike, so disagreements go to compulsory arbitration. As health units have no such provision, strike action is the only solution open to nurses if the employer refuses to meet their requests. □

Have you a Christmas

Story Or Message

To Share?

The Canadian Nurse

invites readers to submit original articles about Nursing at Christmas for possible publication in the December 1970 issue.

Manuscripts should be typed double-space on one side of unruled paper, leaving wide margins. The usual rate will be paid for accepted material.

Suggested length: 1000-2500 words.

Deadline date: September 1, 1970.

Send manuscript to: Editor, The Canadian Nurse, 50 The Driveway, Ottawa 4, Ontario

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.

Infant Formula System

Infant Formula System

Mead Johnson Laboratories, Toronto, has adopted a specially engineered continuous thread cap and new glass container for its Nursette disposable infant formula system.

The new cap is a lithographed metal closure with foamed plastisol lining and cut rubber gasket. The closure contains a vacuum detection panel for instant detection of proper vacuum. When opened, the cap makes an audible click, indicating the bottle contents are satisfactory for use. Discharge packs for new mothers incorporate a handy carry-home handle.

Nursette is sold through hospitals and retail drug stores across Canada.

Drug for Asthmatics

A new drug to prevent asthma attacks has been introduced by Fisons (Canada) Limited. "Intal" (disodium cromoglycate), available by prescription only, prevents the release of spasmogens from the mast cell following antigen challenge.

Intal is not a bronchodilator, corticosteroid, nor antihistamine, but a new agent with benefits for most asthmatics, such as reduced frequency of attacks, and reduced chest tightness, cough, and wheeze. The drug comes in powder form in cartridges. Administered by the "Spinhaler," a Fison product, it is delivered deep into the lungs by the patient's inhalation.

Intal is packaged in dispensing bottles of 30 cartridges, about one week's supply for a patient at the usual dosage of 4 cartridges a day. The Spinhaler is packaged in individual units.

For more information, write to Fisons (Canada) Limited, 26 Prince Andrew Place, Don Mills, Ontario.

New Safety Chart

A wall-size chart, "Emergency Procedures for Dangerous Materials," is available for laboratories, classrooms, and other locations. The chart gives emergency procedures and hazardous properties for dangerous chemicals.

All the hazard information is rated on a scale of 0 to 5 in terms of its health, flammability, and reactivity hazards, as well as degree of danger associated with eye contact, breathing, skin penetration, skin irritation and swallowing. Precautions that should be taken in storing, handling, and disposing of these chemicals are included. General first aid procedures are given for handling emergencies. In addition, a pressure sensitive label is provided for local emergency telephone numbers.

The chart is 35 x 45 inches, printed in four colors on washable Texoprint, and has metal mountings for hanging. Large type and color-coded data gives rapid access to safety information.

At a cost of $14.95, the chart is available from Safety Supply Company, 214 King St. East, Toronto, Ontario.

Drug for Asthmatics

Steri-Vac Gas Sterilizer

The 3M steri-vac brand gas sterilizer, distributed by the J.F. Hartz Company, is a new concept in the application of gas sterilization. Completely automated the steri-vac is rapid and economical and requires no attention during operation. Use of this sterilizer assures complete elimination of viruses, fungi, and bacteria.

The steri-vac is portable, and is available in three models. Once it is plugged in, a simple venting operation makes it ready for use. Heat and moisture sensitive articles, such as delicate instruments, plastic and rubber goods and books, can be sterilized without damage, prolonging their life indefinitely.

For further information, write to the J.F. Hartz Company, 34 Metropolitan Road, Scarborough, Ontario.

Steri-Vac Gas Sterilizer

Urine Collector

In addition to being neat and easy to use, this "large target" collection funnel prevents contamination of the specimen container. The plastic funnel is preconnected to the threaded edge of the container and protects it from contact contamination. When an adequate amount of specimen has been collected, the plastic funnel is easily and aseptically removed and the screw cap applied. No transfer of specimen is necessary.

The compact clean catch kit contains everything needed for midstream specimen collection: collection funnel attached to a specimen container; three antiseptic towelettes; individually packaged screw cap; and label.

This Macbick product is distributed in Canada through the Stevens Companies in Toronto, Calgary, Winnipeg, and Vancouver. In Montreal, Compagnie Medicale & Scientifique Ltée, and Quebec Surgical Company are the distributors.

Literature Available

A 12-page booklet, called *Defense Against Decubitus: The Conquest of the Hidden Epidemic*, is available free of charge from Alcanox, Inc. The booklet details the causes, symptoms, and prevention of decubitus ulcers.

Elements of the preventive program offered in this booklet include the use of topical applications and pressure-relieving materials. The relative merits of aerosol spray versus synthetic fibers as pressure-relieving materials are covered.

A special appendix and a suggested pocket-size directive manual for nurses and aides, which outlines a seven-point action program and features diagrams showing the body's 10 pressure points most prone to decubitus ulcers, are included in the booklet.

For a copy of this booklet write to Alcanox Inc., 215 Park Avenue South, New York, N.Y. 10003. Up to six free copies are available to any institution.

Urine Collector

Gomco Surgical Manufacturing Corporation, Buffalo, New York, has issued its 1970 catalogue of hospital, surgical, and medical equipment. The 28-page brochure illustrates and describes over 50 suction and pressure units and accesories offered by Gomco.

A selection guide and a repair and replacement parts list are included in this catalogue. A free copy of the catalogue, *Gomco Hospital Equipment in the '70's*, is available from the Gomco Surgical Manufacturing Corporation, 828 E. Ferry Street, Buffalo, N.Y. 14211.

The Pharmaceutical Manufacturers' Association of Canada has published a booklet, *The Medicines Your Doctor Prescribes*, which gives the consumer 25 guidelines and safeguards for purchasing and using prescription drugs.

According to an association spokesman, "The booklet is designed to combat drug abuse from another angle: that of ensuring that Rx drugs are respected for their legitimate purposes, and that they are properly used, not misused."

Although the booklet does not directly speak of drug abuse, it provides information to guard against unintentional abuse of medicines. Basic information about the drug industry — its accomplishments, research, quality control and competition — is given.

new products

Small quantities of this easy-to-read and attractive booklet are available free of charge, or at a cost of $6 per hundred, from PMAC, 141 Laurier Avenue West, Ottawa 4, Ontario.

An educational portfolio on feminine hygiene is available from Johnson & Johnson Limited.

The material includes an instruction guide for menstrual hygiene, a booklet entitled *It's Wonderful Being a Girl,* and a large illustrated chart showing what happens during menstruation.

Copies of this portfolio can be obtained from Johnson & Johnson Limited, 2155 Boulevard Pie IX, Montreal 403.

Adjustable Arthritic Crutches

Manufactured from aluminum alloy and plated steel tubing, these arthritic crutches are robust and dependable. The troughs are shaped to allow the weight of the body to be supported completely on the forearm, with the vertical adjustment of the upright tube allowing the crutch to be fitted to the patient. Velco fastening is used to secure the trough portion to the forearm, allowing instant closure and release.

A comfortable ergonomic hand grip, fitted to the adjustable horizontal tube, affords a safe grip to patients severely afflicted with arthritis in their hands. Each crutch is supplied with an Everest & Jennings Premier vacuum base, non-slip crutch tip. A pair of crutches weighs 3 1/2 lbs.

For complete information, write to Everest & Jennings Canadian Limited, P.O. Box 9200, Downsview, Ontario.

Postoperative Knee Brace

A postoperative knee brace designed to provide firm support following surgery is now available from DePuy, Inc. Featuring Velco fasteners and staves in the back and both sides, this knee brace may also be used to protect the knee following sprains and ligament injuries.

The brace is made of washable felt and comes in four sizes. It is priced at $9.95.

For additional information write to Guy Bernier, 862 Charles-Guimond, Boucherville, Quebec, or to John Kennedy, 2750 Slough Street, Malton, Ont.

Oxygen Controller

This new instrument from Sinclair Scientific makes possible automatic control of oxygen concentration in any enclosure. The controller is ideally suited for use with incubators, oxygen tents, and infant head enclosures.

The time-consuming and sometimes dangerously inaccurate practice of manual adjustment of flow rate and irregular sampling of concentration is unnecessary. Once the desired concentration is set, it is automatically maintained — the Sinclair Aerox controller does the rest. This saves nursing time, as there is no need for continual measurement and adjustment of the oxygen supply.

This instrument is distributed in Canada by Keith Ivey and Associates Ltd., 129 Carlingview Drive, Rexdale, Ontario.

Next Month
in

The Canadian Nurse

- Maritimers Have a TV Nurse
- Ottawa's Distress Center
- Coffee Break With a Difference
- Drug Abuse

Photo Credits for August 1970

Harvey Studios, Fredericton, N.B., pp. 5,7,11-14, 24-35

Tom Boschler Photography, Hamilton, Ont , p. 21

Blood Warmer

A new and efficient method for warming blood prior to transfusion has been developed by Fenwal Laboratories, a division of Baxter Laboratories. Designed for use in hospital operating and emergency rooms, Fenwal's unit warms stored blood that has been refrigerated at four to six degrees centigrade to the normal body temperature of 37 degrees centigrade during administration.

Fenwal's unit consists of two metal plates — heated between 32 and 37 degrees centigrade — which surround a maze of disposable tubing. The blood passes from the storage bag through the tubing and then enters the patient's bloodstream.

A metal casing encloses the unit, enabling it to be used safely near oxygen equipment. To prevent the blood from overheating, the unit automatically shuts down at 37 degrees centigrade; an alarm sounds should the temperature increase to 39 degrees centigrade. In addition, the danger of cross-contamination is reduced because the disposable tubing can be discarded and easily replaced by fresh tubing for each transfusion. The unit automatically and instantly adjusts to the flow of blood, so it can be heated uniformly and transfused at a constant temperature.

For more information about this blood warmer, write to Baxter Laboratories of Canada, 6405 Northam Drive, Malton, Ontario. □

dates

August 24-28, 1970

Workshop for library staff in nursing, hospital, and medical libraries, sponsored by the OMA, OHA, and RNAO, Wilson Hall, New College, University of Toronto. Topics to be discussed include administration of a library, collection development, organization of library materials, and library services. Applications are available from: Miss S.C. Maxwell, Librarian, Ontario Medical Association, 244 St. George Street, Toronto 5, Ontario.

September 1970

14th annual Registered Nurses' Association of Ontario conference on personal growth and group achievement. For further information write to: Professional Development Department, RNAO, 33 Price Street, Toronto 5, Ontario.

September 14-17, 1970

American Association of Nurse Anesthetists, Shamrock Hilton Hotel, Houston, Texas. For more information, write to the AANA, 3010 Prudential Plaza, 130 E. Randolph St., Chicago, Illinois 60601, U.S.A.

September 24-27, 1970

Meeting of the American Medical Writers' Association, Waldorf-Astoria Hotel, New York. For more information, write to the association's executive secretary, Mr. W. Wayne Curtis, 420 Lexington Ave., New York, N.Y., 10017.

September 26, 1970

The Nightingale School of Nursing in Toronto is marking its 10th anniversary with an open house and reception for alumni and invited guests. For further information, write to The Nightingale School of Nursing, 2 Murray Street, Toronto 2B, Ontario.

September 28-October 9, 1970

Two-week symposium on the nurse's role in prevention and treatment of acute and chronic respiratory insufficiency, Manitoba Rehabilitation Hospital, Winnipeg. Further details are available from Miss E.L.M. Thorpe, Consultant, Sanatorium Board of Manitoba, 800 Sherbrook Street, Winnipeg 2, Manitoba.

October 1-2, 1970

Annual Convention, Catholic Hospital Conference of Alberta. Chateau Lacombe, Edmonton, Alberta. For more information write to: Reverend Sister John Marie, President, Catholic Hospital Conference of Alberta, Seton Hospital, Jaspar, Alberta.

October 5-6, 1970

Institute on operating room and central supply room procedures, auditorium, Calgary General Hospital School of Nursing. Sponsored by the Alberta Association of Registered Nurses. For further details write to the AARN, 10256 — 112 Street, Edmonton, Alberta.

October 5-30, 1970

Advanced program in health services organization and administration, The University of Toronto School of Hygiene. The second part of this program will be held March 1-26, 1971. Fee: $200 for each part. For further information, write to: Dr. R.D. Barron, Secretary, School of Hygiene, University of Toronto, Toronto 5, Ontario.

October 7-10, 1970

Annual conference, Canadian Association for the Mentally Retarded, Hotel Vancouver, Vancouver, British Columbia. Special emphasis will be on the preschool child, residential services, and occupational-vocational programs.

October 8-10, 1970

Workshop in Test Construction for Teachers in Schools of Nursing to be held by the New Brunswick Association of Registered Nurses at Memramcook Institute, St. Joseph, N.B. Conducted by Vivan Wood, Associate Professor, Faculty of Nursing, The University of Western Ontario, London, Ont.

October 17, 1970

14th Annual Symposium on Rehabilitation, sponsored by the Rehabilitation Foundation for the Disabled and the Ontario Society for Crippled Children, Inn-on-the-Park, Don Mills, Ontario. Write to Mrs. Betty McMurray, Executive Director, Rehabilitation Foundation for the Disabled, 12 Overlea Boulevard, Toronto 354, Ontario.

October 25-29, 1970

National conference on the impact of the environment, sponsored by the Canadian Council on Children and Youth and The Vanier Institute of the Family, Winnipeg. For more information write to The Vanier Institute of the Family, 170 Metcalfe Street, Ottawa 4, Ontario.

October 26-27, 1970

Nursing sessions at the Ontario Hospital Association annual convention, Royal York Hotel, Toronto. Write to the OHA, 24 Ferrand Drive, Don Mills, Ontario.

October 26-28, 1970

Annual meeting of the Association of Registered Nurses of Newfoundland, St. John's. Write to the AARN, 67 Le Marchant Rd., St. John's, Nfld.

October 26-28, 1970

Ontario Hospital Association annual convention, Royal York Hotel, Toronto. Write to the OHA, 25 Ferrand Dr., Don Mills, Ontario.

October 26-30, 1970

American Public Health Association, Civic Auditorium, Houston, Texas. Write to the APHA, 1740 Broadway, New York, N.Y. 10019, U.S.A.

November 9-13, 1970

Course in occupational health for professional registered nurses in industry, offered by the department of environmental medicine of New York University School of Medicine, in cooperation with the American Association of Industrial Nurses. Limited to nurses with five years or less experience in occupational health. Tuition: $175. Special emphasis will be given to interviewing and counseling. For information and applications, write to the Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N.Y. 10016, U.S.A.

November 23-25, 1970

Conference for senior nurse administrators, Westbury Hotel, Toronto. Sponsored by the Ontario Hospital Association, 24 Ferrand Drive, Don Mills, Ontario.

November 30-December 4, 1970

Conference for nurses in staff education and staff development, Westbury Hotel, Toronto. Sponsored by the Registered Nurses' Association of Ontario. Write to: Professional Development Department, RNAO, 33 Price Street, Toronto 5, Ontario. □

names

The tragic air crash near Toronto on July 5 took the life of a well-known Canadian nurse. **Claire Gagnon - Mailhiot,** director of Laval University's School of Nursing, was killed with her husband en route to Los Angeles. They had been married one day.

A graduate of the Hôtel-Dieu de Sherbrooke School of Nursing, the University of Montreal, and Teachers College Columbia University in New York, Mme Gagnon-Mailhiot was for many years a head nurse and, later, director of nursing at the Hôtel-Dieu de Sherbrooke. In 1965 she was appointed director of nursing service with the Quebec Ministry of Health.

As director of Laval's School of Nursing, Mme Gagnon-Mailhiot played a leading role in its organization. Through her work on various committees within the University, especially the health sciences committee, she succeeded in introducing an original concept of the professional nurse's future role — a concept that is now being accepted in other schools of nursing in the province.

Mme Gagnon-Mailhiot was active in many professional associations. She was a past president of the provincial and national associations of the Catholic Nurses' Association, and in 1958 represented the Catholic Nurses' Association of Canada at the first World Catholic Health Conference in Brussels. She also was co-convenor, nursing service committee, Association of Nurses of the Province of Quebec, and a member of the Canadian Nurses' Association's committee on nursing service.

Nationally and internationally, Claire Gagnon-Mailhiot will be missed. She was a brilliant nurse educator, a respected colleague, and an outstanding person.

Alma Reid Honored At Tea

A tea was held recently at McMaster University, Hamilton, for Alma Reid, who retired after 21 years as director of the School of Nursing at McMaster. Directors of nursing from hospitals and schools across Ontario attended the tea for Miss Reid. Sister Mary Felicitas, past president of the Canadian Nurses' Association, *left,* talks with Miss Reid, *center,* and Margaret Wiseman (*back to camera),* a former teacher and teaching colleague of Miss Reid.

Effie Taylor, a Canadian-born nurse well-known internationally for her outstanding contributions to nursing, died in her native city of Hamilton, May 20.

As president of the International Council of Nurses from 1937 to 1947, Miss Taylor guided the council through the critical war years. "That the ICN had survived six years of war; that its history was unbroken during this period, and that it had retained its international character and carried on with many of its peacetime activities, is due in a large part to the indomitable courage and determination of Effie Taylor . . . ." This tribute comes from *A History of the International Council of Nurses 1899-1964 by* Daisy C. Bridges.

After graduating from Johns Hopkins Hospital School of Nursing in Baltimore, Miss Taylor studied at Columbia and Yale Universities. She worked on the staff of the Phipps Psychiatric Institute at Johns Hopkins. From 1926 to 1944, she was a professor of nursing and dean of the Yale University School of Nursing.

From 1923 to 1937, Miss Taylor served as executive secretary and president of the National League of Nursing Education in the United States.

A memorial service will be held for Miss Taylor at 2:30 P.M., September 26 in Dwight Memorial Chapel, New Haven, Connecticut. Anyone wishing to attend is welcome.

An Effie Jane Taylor Memorial Fund has been established at the Yale School of Nursing, 38 South Street, New Haven. In recognition of Miss Taylor's contribution to ICN, the memorial will be used mainly to assist international students studying at the school. In lieu of flowers, donations may be made to this fund.

Valerie Fournier, public relations officer for the Canadian Nurses' Association since November 1967, left the staff at the end of July. Mrs. Fournier plans to continue her career in Europe, probably Paris, where she and her husband Pierre are moving in the fall.

With degrees in journalism and honors history from Carleton University in Ottawa, Mrs. Fournier contributed much to the CNA. She initiated and chaired two public relation conferences,

names

the first ever held by CNA, for her provincial counterparts to prepare for the Saskatoon and Fredericton general meetings and the ICN Congress in Montreal. Mrs. Fournier kept members informed of the Association's policies and objectives through monthly newsletters, and established regular communication with representatives of the press, radio, and television.

She also wrote news items for *The Canadian Nurse* and is author of several articles published in the journal. Her most recent one is in the July issue, "She's a Regular at the Racetrack."

Johanna Plummer (S.R.N., The West Herts H., Hemel Hemstead Herts, United Kingdom; C.M.B., The British Hospital for Mothers and Babies, London; diploma, nursing administration, U. of Western Ontario, London; B.Sc.N., Lakehead U., Thunder Bay, Ont.) has been appointed director of nursing service at Owen Sound General and Marine Hospital, Owen Sound, Ontario.

Before coming to Canada, Miss Plummer was a head nurse at Miller General Hospital in London, England. She has held a variety of positions in hospitals in Ontario: staff nurse at Dryden General Hospital, the General Hospitals in Port Hope and Bowmanville, and Littlelong Lac Hospital in Geraldton; assistant director at Littlelong Lac Hospital; director of nursing at Sioux Lookout General Hospital; administrative assistant, director of projects, and director of nursing service at St. Joseph's General Hospital in Thunder Bay.

Active in the Registered Nurses' Association of Ontario, Miss Plummer is chairman of the chapter and regional administrator committee.

Rita L. Rovere (R.N., Misericordia H., Edmonton) has left Canada to serve a two-year tour of duty in Indonesia with MEDICO, a service of CARE. Miss Rovere has been operating room nurse at Misericordia Hospital in Edmonton since 1964.

Miss Rovere will spend her first three months in the Indonesian capital of Djakarta, training local nurses in operating room procedures as part of the MEDICO orthopedic program conducted there. She will then join a MEDICO team of Canadians, stationed in Surakarta in the province of Central Java, as operating room nurse with the team, which includes a physician and a registered laboratory technologist. In addition to treating patients, the team, which started work in January, is training medical personnel to staff the six major regions of the province.

Joan M. Dawes, R.N., U. of Alberta Hospital, Edmonton, Alberta; Dipl. in Teaching and Supervision, School of Nursing, U. of Alberta.) former director of nursing at Prince George Regional Hospital, Prince George, B.C., has been appointed director of nursing service for the B.C. Cancer Institute in Vancouver. Miss Dawes succeeds Miss Florence A. McDonald, who has retired.

Miss Dawes graduated from the University of Alberta School of Nursing, Edmonton, Alberta, in 1959, and received a diploma in teaching and supervision there in 1962. She was employed as a general duty nurse, clinical instructor in pediatrics and as nursing office supervisor at University Hospital in Edmonton prior to becoming director of nursing at Prince George Regional Hospital, in April, 1965.

Miss Dawes is a member of the RNABC Committee on Nursing Service and chairman of a task committee to review medical-nursing procedures.

Jacqueline Robertson (R.N., St. Boniface School of Nursing, Winnipeg; B.S.c.N., Lakehead U., Port Arthur, Ont.) has been named assistant director of nursing service at St. Boniface General Hospital in Winnipeg.

Miss Robertson has served as coordinator of inservice education at Grace Hospital in Winnipeg. She has held varied positions at St. Boniface General: general duty nurse and head nurse of a surgical unit, coordinator of inservice education, and director of nursing service.

Sheila Ryan (R.N., Alfred H., Melbourne, Australia; B.Sc.N., U. of Alberta) has been appointed associate director of nursing at University of Alberta Hospital in Edmonton.

Since 1958, Miss Ryan has been a member of the nursing staff of the University of Alberta Hospital, as a staff nurse, charge nurse, clinical instructor, and clinical coordinator.

Miss Ryan was awarded a Canadian Nurses' Foundation scholarship in 1969. She is completing the master's program in health services administration at the University of Alberta.

Elaine M. Sparks (R.N., The Vancouver General H.; B.Sc.N., U. of Alberta) has become director of nursing at Prince George Regional Hospital in Prince George, British Columbia. Miss Sparks has been assistant director of nursing at the hospital since 1967.

As a general duty nurse, Miss Sparks worked at Chilliwack General Hospital and Penticton General Hospital in British Columbia, and Rosetown Union Hospital, Saskatchewan. She also became an operating room nurse and director of nursing at Rosetown Union Hospital. ☐

in a capsule

Murdering the menu

If you have ever experienced a sinking feeling in an expensive restaurant when you are unable to recognize anything on the menu, you will understand the confusion of hospitalized children when they try to interpret their menu.

Hospital staff have not considered the limitations of a child's vocabulary. Thus, what should be one of the most enjoyable times of the day becomes a huge guessing game, often with disappointing results for the young pediatric patient. Faced with foreign-sounding names, the child hesitates to order something he does not recognize or understand. He may not be familiar with the term frankfurter for hot dog or hot vichysoisse for potato soup.

The *Journal of the American Hospital Association* had an article on pediatric menu terminology in its May issue. The author, Beatrice Bachrach, gave some amusing examples of the child's interpretations of menu items. For example, "a heavenly fruit mold salad" is moldy and no good; "consomme julienne" is a movie star; "hot vichysoisse" becomes a volcano; "molded citrus salad" is cactus; and "creamed eggs on dutch rusk" is egg pie.

We sympathize with the childrens' difficulties and agree with Miss Bachrach's proposal to simplify menu terminology and perhaps draw illustrations as well.

Nurses meet the Prince

Two members of the Victorian Order of Nurses met a prince last July. Prince Charles was guest at Government House during his first visit to Ottawa, July 2-4. Dawn Wigmore and Patricia McBride were among a group of young Canadians invited to a special dance held in honor of Prince Charles at Government House July 3. Miss Wigmore is nurse-in-charge of the Red Deer Alberta Branch of the VON, and Miss McBride is nurse-in-charge of the Medicine Hat and Redcliff branch in Alberta.

What did they talk about when introduced to the Prince? Full details of the conversation aren't known, but Prince Charles did express interest in the VON and spoke of Lady Aberdeen, the founder of the Order in 1897.

Tomorrow's cop today

Where do police mix with demonstrators like fish in water, pat 'em on the back when they get too heated, and grab rocks and other missiles before they start to fly? In Munich, Germany, the police are working out a new approach to crowd control, stressing psychology over force.

Recently a police officer was seen walking arm-in-arm with ranks of long-haired demonstrators through the city streets, much to the surprise of onlookers. The officer was guiding the protestors from an important traffic artery to a more quiet section of town where they could not do much harm. According to a news item in *German Features* in May, this new police technique has shown surprisingly good results. Street marches and demonstrations usually disperse peacefully and quickly, since there is nothing to resist.

The Munich police chief has employed a psychologist, has set up advanced training courses for officers, and has built new police dormitories that have broken the old, military-style tradition. The new police official will not just take orders and carry them out; he will have to think for himself and adjust to sudden changes in a situation. In addition to learning technical language, tomorrow's cop will need a thorough grounding in psychology and sociology.

Will this positive approach spread as quickly as violence does? Only time and the mass media will tell! □

"I understand this operation is going to be televised in living color."

CONVENTION REPORT

If dissension, followed by agreement, characterized the Canadian Nurses' Association's general meeting in Saskatoon two years ago, frustration, followed by determination to make the association a vital force in society, best describes the Fredericton meeting June 14 to 19.

The mood of the assembly of 1,283 seemed to change from day to day, depending on the issue being discussed. Even so, it was not difficult to grasp some strong underlying feelings: an impatience with the association's continual concern about its own structure, and a belief that CNA should move from introspection to social action; a demand that more specific stands be taken by the national association on issues affecting health and the practice of nursing; a desire for each member to have a say in the policies and positions taken by CNA; and a belief that the unique needs of each member association must be considered if national unity of the profession is to be maintained.

There was unparalleled vitality at this 35th general meeting. Members showed they were no longer content to sit on the sidelines and let others make decisions for them. They packed the business sessions — something unusual for CNA conventions — and made it clear they were interested in what the elected officers and staff of the association had said, spent, and planned on their behalf.

As further evidence of this increased interest, 50 members gave up part of their "free day" Wednesday and met to exchange views on issues such as the physician's associate and the practice of nursing. One motion the group drafted — later approved by membership — directed CNA to provide facilities and program time at future general meetings so that members could meet informally to discuss current issues affecting the profession.

The resolutions approved by the 173 voting delegates on the final day of the convention reflect this vitality. They cover a wide range of issues, from statements on the population growth and pollution of the environment, to a resolution directing the CNA board to consider as a priority, ways and means of encouraging publication of textbooks in the French language.

In retrospect, it was a week of ebullience, with moments of drama, tension, and occasional outbursts of anger. It was also a week of achievement. From the frustration, evident at the beginning of the week, came a sense of purpose, solidarity — if not unanimity — and determination. Members demonstrated their belief that the national association can and should be a dynamic force in society.

Tone of meeting set early

The tone of the meeting was set by Verna Huffman, principal nursing officer, department of national health and welfare, who gave the keynote address at the official opening on Sunday evening. Miss Huffman urged members to focus their attention outward, rather than inward, and *to act* on important national issues.

Citing poverty as one example of issues that should concern nurses, Miss Huffman said, "Sheer weight of numbers, 82,000 nurse members, represents a strong pressure group. In addition to that, it represents a weight of experience with poverty." She then asked, "As a responsible group having power in numbers and weight of knowledge, what social action has this organization taken to combat poverty?

"An organization must have policy statements on important national issues and be prepared to take concrete action on such issues," Miss Huffman continued. "What is the stand of this predominantly female association on the national issue of abortion?" she asked. "What is our stand on drug abuse?"

Miss Huffman said that commitment and dedication are old-fashioned words coming back into use. "To these we must add new concepts — *outreach, involvement, social action*. The degree to which the nursing profession embraces these concepts, lifting its sights beyond the limits of its own profession and its own place in society, will determine the extent to which it plays a meaningful and extended role in the '70s," she concluded.

The same call for action and involvement came from CNA president Sister Mary Felicitas in her address to the assembly Monday morning. Sister Felicitas told members their

decisions about CNA's objectives, role, and fee structure would determine the future of the national association. "What role do you want it to assume?" she asked. "Shall it be leadership, forethought, prevision? Do you wish it to be one of vigilence, guiding and pointing the way to the twenty-first century?"

The president urged members to be objective, to discuss with open minds, and to weigh the evidence in reaching their conclusions. "There is no place for preconceived ideas in a matter of this importance," she said.

Reports discussed

In her report to membership, Dr. Helen K. Mussallem, CNA executive director, said membership increased by almost 11 percent in the past biennium, from 74,744 in 1967, to 82,826 in 1969. She said CNA, as the voice of Canadian nursing, has grown in stature and recognition and commands increasing respect in the counsels of the allied health professions.

Outlining highlights of the association's activities during the biennium, Dr. Mussallem listed the various briefs submitted to government, CNA's relations with other agencies, meetings attended on behalf of membership, and staff activities. She said CNA has continued to press for representation on the Canadian Council of Hospital Accreditation, but was again turned down in 1969.

An Ontario delegate asked what nurses could do to convince CCHA that CNA should be represented on its council. A member of the board suggested the matter be drafted as a resolution and presented for delegate ratification. On Friday, the final day of the general meeting, a resolution was passed, directing CNA to "press more firmly for representation on the CCHA," and to seek support from other professional groups in obtaining this recognition.

The value of having CCHA's nurse surveyor on the hospital accreditation team was mentioned by several delegates. One said directors of nursing service should *demand* that the nurse surveyor be part of the team assigned to accredit hospitals.

The reports of the standing committees on nursing service, education, and social and economic welfare — presented on the second day of the convention — brought considerable comment. On the whole, the committee statements were well received, although some delegates said they were too general to be of use and should be more specific.

A Quebec delegate questioned the nursing service committee's recommendation concerning the medical assistant. She said the committee's recommendation, to let the Canadian Medical Association know "... we would welcome the opportunity to have dialogue" on this subject, was far too weak. " We should do much more than ask for dialogue," she said. " We must approach them. We have as much to say as the doctors about the gap that exists in health care."

Replying to this comment, Margaret D. McLean, chairman of the committee on nursing service, said the recom-

(Report continued on page 28)

And the band played on — literally. These enthusiastic musicians were at Fredericton, New Brunswick, airport to greet conventionists to the CNA 35th biennial. They played, but no plane arrived. Undismayed they blew harder, to the delight of waiting travelers. Directed by Alex McCulloch, The Episilon Y's Men's Youths Band plays at many local affairs.

Resolutions Passed at CNA 35th General Meeting

Whereas the needs of CNA member associations vary in accordance with the size of the province or territory and the number and geographic distribution of members; and
Whereas mechanisms have been developed and implemented to protect the voting rights of small member associations; and
Whereas both large and small member associations may have major problems associated with meeting the needs of their members; and
Whereas social, economic, or political conditions in any province or territory may alter needs of member associations and result in conditions which are threatening to the national unity of the profession; and
Whereas the viability of the CNA is dependent upon the sensitivity of all member associations to each other's unique needs and to changing social conditions across the country; therefore be it
Resolved that the association membership fee shall be $10 per member for associations whose membership is 20,000 or less, and $6.00 per member for associations whose membership exceeds 20,000.

Whereas the recommended fee formula will result in only slightly increased revenue for the CNA for the coming biennium; and
Whereas the current trend across the nation is towards tight budgeting; therefore be it
Resolved that the Board of Directors be authorized and encouraged to examine alternative ways of meeting membership needs such as will contain costs and at the same time increase opportunities for member association interaction.

Whereas members have indicated a desire for greater understanding of the financing of the Association; therefore be it
Resolved that the Board of Directors be requested to examine the method of budget preparation of the CNA with a view to making presentation of the budget more meaningful to members.

Whereas the CNA is committed to the concept of optimum health care for the people of Canada; and
Whereas the Task Force Report on the Costs of Health Services in Canada emphasized coordinated planning for delivery of health care; and
Whereas nursing departments in hospitals contribute substantially to the delivery of health care; and
Whereas nurses comprise the largest single professional group, and nursing accounts for fifty percent of the hospital budget; and
Whereas the department of nursing provides a twenty-four-hour, seven-day-a-week service, thus placing nurses in a unique position to assess the effect of hospital organization on the patient and his family; and
Whereas the CNA believes that knowledge of the effect of hospital organization is essential for identification of quality of patient care; and
Whereas the department of nursing is included in the assessment of hospitals for accreditation; therefore be it
Resolved
(1) that the CNA press more firmly for representation on the Canadian Council on Hospital Accreditation.
(2) That the CNA seek the support of other professional groups in this request.

Whereas the CNA recognizes the need to plan systematically to meet the health needs of the total Canadian population; and
Whereas the CNA recognizes that significant gaps exist in the delivery of health services to the Canadian population; and
Whereas the recommendations of the Task Force Reports on the Costs of Health Services in Canada suggest the development of programs to expand the nurse's role; and
Whereas the CNA recognizes the importance of working collaboratively to utilize the skills of medical and nursing personnel; and
Whereas the CNA believes it is unwise for the health professions to proceed unilaterally in the development of new roles or the expansion of existing roles, i.e., clinical nurse specialist, physician's associate, medical assistant, nurse practitioner; therefore be it
Resolved
(1) that the CNA request the department of national health and welfare to call a national conference prior to the spring of 1971 to study health matters which affect the total Canadian population;
(2) that this conference provide a forum for discussion among the major purveyors (nursing and medicine) and the consumers of health services;
(3) that the discussion focus on more effective utilization of medical and nursing manpower to fill the unmet health needs of Canadians;
(4) that special emphasis be on the development of complementary roles for nurses and physicians.

Whereas the CNA is a professional organization for nursing; and
Whereas the CNA has responsibility to the public for promoting the most effective utilization of nursing manpower for nursing; therefore be it
Resolved that the CNA prepare a position paper on the introduction of the new categories of workers into the health field, namely those referred to as the physician's assistant and medical practitioner's associate.

Whereas textbooks in the French language for the French-speaking students of Canada are practically non-existent; and
Whereas the urgent need to publish textbooks in French has been recognized during the Congress; therefore be it
Resolved that the CNA Board of Directors consider as a priority, ways and means of encouraging the production of textbooks in the French language.

Whereas the Federal Government's White Paper on taxation contains recommendations such as those pertaining to deductions for child care and housekeeping expenses; and
Whereas nursing is primarily a female occupation with an increasingly larger proportion of married practitioners with children; therefore be it

Members freely "spoke their piece" at the CNA 35th general meeting before voting on business matters. Thomas McKenna, voting delegate from RNABC, and Helen Taylor, president, ANPQ, present their point-of-view prior to counting votes.

Resolved that the CNA make a presentation to the Federal Minister of Finance on the White Paper on taxation.

Whereas every member attending CNA conventions is vitally concerned with issues being debated; therefore be it
Resolved that sufficient registration fee be charged so that each registrant may receive the same folio of information as provided for voting delegates.

Whereas every member of CNA has the right to assess the information on the expenditure of funds; therefore be it
Resolved that the audited financial report be printed in *The Canadian Nurse* and *L'infirmière canadienne*.

Whereas each voting delegate has both the right and responsibility to cast a ballot for each elected position on behalf on the provincial members he represents; and
Whereas the members of this Association have designated a considerable amount of responsibility to each elected officer; and
Whereas two separate vice-presidential positions must be filled; and
Whereas under the present system each voting delegate casts only one ballot for these two positions; therefore be it
Resolved that voting delegates be granted the privilege of voting for two nominees on the vice-presidential ballot.

Whereas many issues presented in The Task Force Reports on the Costs of Health Services in Canada affect nurses in the areas of service, education, and economic welfare; and
Whereas the Association should be prepared at all times to act upon such issues; and
Whereas we believe it is the responsibility of Canadian nurses to become increasingly involved at the decision-making level of policies and legislation that affect the social and economic welfare of nurses as members of their professional organization and members of their community; and
Whereas the Committee on Social and Economic Welfare has recognized the need for a lobbyist; therefore be it
Resolved that the Board of Directors give serious consideration to the appointment of a well-qualified nurse to assume the role of lobbyist for the CNA.

Whereas attendance at CNA general meetings affords a valuable learning experience for nursing students; and
Whereas basic nursing students now have the privilege of attending these meetings at a reduced registration fee; and
Whereas there are other categories of full-time students enrolled in nursing programs who do not now have this privilege and who may also have limited financial resources, therefore be it
Resolved that all nursing students enrolled full-time in diploma or university programs be permitted to attend CNA general meetings at the reduced student registration fee. The RNs so enrolled must provide evidence of some form of current membership in their provincial association.

Whereas there is a need for opportunities for members of the Canadian Nurses' Association to discuss current issues facing the profession; and
Whereas the full range of current issues affecting nursing may not be apparent to those who plan the program; therefore be it
Resolved
(1) that at future general meetings of the Canadian Nurses' Association, program time and facilities be provided so that nurses interested in discussing these issues can meet to explore them in open forums.
(2) that these forums be unstructured with no pre-announced topic unless it is one that grows out of the preceding sessions.
(3) that they be held midway through the general meeting, but prior to the deadline for submission of resolutions.

Whereas the Canadian Nurses' Association is a professional organization concerned with the health of the people of Canada; and
Whereas the present growth rate in population, pollution of our environment, and depletion of natural resources represent a serious and increasing threat to health; therefore be it
Resolved
(1) that the Canadian Nurses' Association support appropriate measures proposed for the control of the aforementioned threats to the health of all Canadians.
(2) that each individual member of the Canadian Nurses' Association be encouraged to become informed to take such action as is possible in his/her situation to assist in the solution of these grave threats to life in the world today.

mendation was made by her committee early in the biennium. She explained that since then the executive of the CNA had met with CMA and discussed the subject of the medical assistant. "We didn't only initiate 'dialogue,' " she said, "we 'dialogued' with them." Miss MacLean added that the topic was also discussed at a meeting of the CMA-CHA-CNA. "It is important that we are *for* something, not *against* something," she said. "We should come out with a statement saying what we can do to fill this gap."

On the final day of the meeting, delegates approved a resolution directing the association to prepare a position paper on the introduction of new categories of workers into the health field, namely those referred to as the physician's assistant and the medical practitioner's associate. They also directed CNA to request the department of national health and welfare to call a national conference, where doctors, nurses, and consumers of health services could examine more effective use of medical and nursing manpower and the development of complementary roles for nurses and physicians.

During the discussion of the nursing education committee's report, a British Columbia delegate questioned the recommendation that CNA become involved in research. Committee chairman Kathleen Arpin said this really means "when it is appropriate" for CNA to become involved. "There are times when an organization needs to engage in research that is unpalatable to other organizations," she explained. Earlier in the meeting, an Ontario delegate spoke of the urgent need to get more funding for research. "Persons outside of nursing get incredible sums of money for *outlandish* projects," she said. "Let's get money," she urged. "If we have to hold bingo games to get it, let's hold bingo games!"

The committee on social and economic welfare was asked by a British Columbia delegate if any thought had been given to the submission of a brief on the federal government's White Paper on Taxation. Committee chairman M. Louise Tod said the committee had not considered this. On the final day of the meeting, delegates approved a resolution directing CNA to "make a presentation to the federal minister of finance on the White Paper on Taxation."

Delegates also acted on the social and economic welfare committee's statement that the national association needs a lobbyist. They asked the board of directors to give serious consideration to the appointment of a well-qualified nurse to assume the role of lobbyist for the CNA.

Functions, relationships, fee structure

The report of the CNA ad hoc committee on functions, relationships, and fee structure (published in the March 1970 issue of *The Canadian Nurse),* was presented by committee chairman Jeanie S. Tronningsdal on the second day of the meeting. Only two of the committee's recommendations brought much discussion, but one of these, on fee structure, almost resulted in chaos.

The debate started after Mrs. Tronningsdal read aloud the committee's recommendation that the association be financed on a per capita fee basis, the amount to be determined according to the bylaws. A Quebec delegate, Helen Taylor, proposed an alternative method of financing, which had been approved by ANPQ members at a special general meeting in May: that the fee to CNA be $10 per member for the first 10,000 members, and $5 per member for the remaining members for all provinces, with a maximum of $175,000.

In presenting the ANPQ proposal, Miss Taylor said Quebec delegates recognized CNA's need for sufficient finances, but said the needs of a bilingual provincial association such as Quebec were also great. She spoke of the high costs involved in duplicating all ANPQ material in both languages, and said the formula Quebec proposed would actually give CNA a few thousand dollars more and would enable CNA to budget ahead.

Another Quebec delegate said Quebec was not asking for a gift, that other provinces with a membership of over 10,000 would also benefit. The Quebec membership of 28,000 is more than double the size of any other provincial association.

Several delegates replied, saying they had a mandate from their membership to approve the per capita fee, not a sliding scale.

Tension was high as Alice Girard, a past president of CNA, made an emotional appeal to all delegates. "Decisions such as this should not be taken in this atmosphere of aggressiveness," she said. "Please let us not take an action we might regret. Let's not take a decision until we have had time to consider."

A Manitoba delegate, Kathleen DeMarsh, moved that an ad hoc committee of delegates from each province be set up to consider other means of financing the association and to examine the implications of having a ceiling, such as the $175,000 proposed by ANPQ. The motion was approved, and Sister Felicitas appointed the CNA first vice-president, Marguerite Schumacher, as committee chairman.

This committee, which dubbed itself

Gourmet taste buds went wild at the CNA 35th biennial in Fredericton. The province of New Brunswick sponsored a banquet which featured local delicacies, including fiddleheads and wine — enticing row after row of nurses to come back for more.

the "night owl committee," reported its recommendations to the assembly on the final day of the general meeting. (See resolutions 1, 2, and 3, page 00.) The major recommendation was that the association membership fee be $10 per member for associations whose membership is 20,000 or less, and $6 per member for associations whose membership exceeds 20,000. In other words, the per capita fee basis of payment would be maintained, and the CNA would operate under the same budget as it did in the 1968-1970 biennium.

Most delegates had reservations about the recommendation, but emphasized it was designed to meet the present situation. As a Saskatchewan delegate said, " We are looking at the situation today, not 10 years from now." Several delegates mentioned the importance of maintaining unity of the profession. " We don't want to jeopardize our opportunity to work toward better solutions in nursing by denying the national association its unity," said one.

A delegate from Nova Scotia said she hoped if a smaller province had a problem, it would be given the same consideration. Representing New Brunswick, a delegate spoke of the importance of interpreting CNA to all members. "When members understand what CNA does, they'll be willing to pay more," she said. A BC delegate, obviously disappointed about the recommendation, said her delegation could not accept this proposed fee structure, that it did not represent a reasonable compromise. An ANPQ delegate said she believed a common understanding had been generated at the meeting.

The night owl committee's controversial recommendation on fees was approved by a majority vote.

Another recommendation of the ad-hoc committee on functions, relationships, and fee structure — that CNA appoint a senior member of staff, whose mother tongue is French, to provide French-speaking members with services comparable to those presently available to English-speaking members — was changed to read *"at least one* senior member." A motion to designate this person as associate executive director of the association was defeated.

Bylaws approved

The ad hoc committee on legislation, chaired by Jeanie S. Tronningsdal, gave its report Thursday morning.

"...and we will give the nurses good salaries," promised the Honorable Louis J. Robichaud, premier of New Brunswick, as he encouraged nurses to locate in the province's hospitals. The premier spoke at the provincial banquet honoring CNA convention members.

Before presenting the proposed bylaws for membership approval, Mrs. Tronningsdal briefly reviewed the background.

CNA functions under an Act of Incorporation passed by Parliament in 1947 and revised in 1954, Mrs. Tronningsdal explained. To obtain desired amendments to its Charter, CNA had to make application to come under the Canada Corporations Act Part II for Letters Patent, as Parliament no longer deals with amendments to private acts of this category.

In making application under the Canada Corporation Act, bylaws of the association have to be submitted. To conform with the Act, additions had to be made to CNA's bylaws to cover: the holding of an annual meeting; the withdrawal of members; and other, more technical, matters.

The proposed bylaws were drawn up to fulfil these requirements, Mrs. Tronningsdal said. During the interval between the circulation of the proposed bylaws and the holding of a special meeting of the association in November 1969 to consider them, confusion arose over the interpretation and implications of the withdrawal bylaw. However, the bylaws were approved without amendment at the special meeting.

Following this meeting, confusion still existed about the withdrawal bylaw, Mrs. Tronningsdal said, and certain provincial associations took action that resulted in the board of director's decision to withdraw the application for Letters Patent. At present, the department of consumer and corporate affairs is holding in abeyance CNA's application for Letters Patent.

The bylaws proposed by the ad hoc committee on legislation were passed with few amendments. The controversial bylaw on withdrawal, which, as approved at the special meeting in November would have allowed an ordinary member to withdraw from CNA, now reads: "any association member may withdraw from the association... ."

One bylaw amendment concerned the chairmen of the three standing committees: they will be elected, rather than appointed.

The voting delegates then approved a resolution authorizing CNA to apply to the minister of consumer and corporate affairs for Letters Patent.

The final day

Delegates were weary, yet enthusiastic, as they prepared to vote on the resolutions. The satisfied feeling of, " Well, we've finally tied up a lot of loose, administrative strings, now we can tackle the really *important* issues," could be sensed.

One important issue, research, had been presented earlier in the day. Business was adjourned for 20 minutes, while the chairman of the ad hoc committee on research, Dorothy J. Kergin, gave a resume of her committee's recommendations on CNA's role

(Report continued on page 34)

Follow me lassies and lads

Opening day and they came in droves! Over 1,000 nurses attended the 35th biennial convention in Fredericton, N.B. *1* Jeanie S. Tronningsdal introduced two reports. *2* The CNA staff took notes. *3* Flower power, worn by the N.B. hospitality committee, welcomed members. *4* Action all the way was felt throughout the sessions. *5* The Hon. Wallace S. Bird, Lieutenant Governor of New Brunswick *(second right)* and *(left to right)* Mayor J.W. Bird of Fredericton and Capt. K.M. Jefferson talk to Louise E. Miner, then CNA president-elect. *6* The piper played and the CNA executive followed. *7* They trod the red carpet from the Lord Beaverbrook Hotel to the Playhouse. *8* A casualty, before the convention, walking into the Playhouse. *9* And an armed forces nurse made notes.

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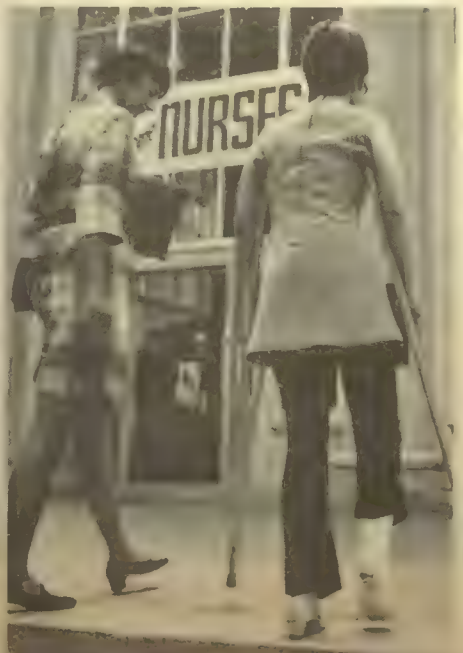

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They had fun . . .

boating, fishing, and buggy riding in antique cars, three of the many funtimes enjoyed by conventioneers at the CNA general meeting in Fredericton, N.B. If you were not there, these pictures will tell you... the weather was great and New Brunswick hospitality the finest!

What a picnic!

The whirling skirts and gay shirts of the Elm Tree Square Dance Club encouraged nurses to dance under the stars at a barbeque hosted by the city of Fredericton. Repairs on the spot were necessary though. Oophs! Was it a hole in her toe or her nylon?

Instantaneous translation was available throughout the CNA 35th general meeting in Fredericton, N.B. Seated in a box overlooking the audience, three bilingual translators relayed each speaker's comments via portable transmitters.

in research. (Complete details in News, page 7.)

Most resolutions were passed without much comment, although two sparked discussion. One, asking CNA to urge the federal government to remove the sections relating to abortion from the Criminal Code, was referred to the incoming board for further study. Several delegates questioned the legal implications of this resolution, asking if illegal abortionists could still be prosecuted if the abortion laws were removed from the Criminal Code.

An Alberta member said CNA "should go on record with intelligent action" on the abortion issue. "The association should have spoken two years ago, as the law probably won't be repealed for another two years at least," she said. Delegates from several of the provinces agreed it was time for CNA to take a stand on abortion. "We have to resolve our differences among members, but not in small groups behind the scenes," a BC delegate said.

The other resolution that brought discussion, mostly of an explanatory nature, was the one directing the CNA board of directors to consider as a priority, ways and means of encouraging the production of textbooks in the French language. An Ontario delegate pointed out there are only two books in French for French-speaking nursing students in Quebec, New Brunswick, Manitoba, and Ontario. In addition, a Quebec delegate said, the textbooks from France are really not much help to French-speaking nurses, as they do not correspond to the philosophy of nursing in Canada. The resolution was approved.

Standing ovation for president

Sister Mary Felicitas, CNA president since March 1967, was given a standing ovation for her contribution to the association. "It has been a privilege to serve you," Sister Felicitas said, "even though at times it has been heavy." The incoming president, E. Louise Miner, presented Sister with an engraved gavel as a memento of her years as president.

Before the meeting adjourned, M. Geneva Purcell, president of the Alberta Association of Registered Nurses, extended an invitation to all CNA members to visit Edmonton, Alberta, for the 36th general meeting June 25 to 30, 1972. "And stay for the Calgary Stampede and our celebrations of the Klondike Days!" Miss Purcell urged.

Summary

And now it has been told. The 35th CNA general meeting was an outstanding success. Attendance was high, discussion stimulating, and members seemed to know what they want and how they are going to achieve it.

And it wasn't all work. The hospitality and the efficient planning of the hostess association, the New Brunswick Association of Registered Nurses, were enjoyed and appreciated by all. The barbecue, sponsored by the City of Fredericton; the banquet, given by the province; the tours arranged by NBARN; the folk-singing concert; and the many little things that add to a conventioneer's pleasure — all contributed in no small part to the success of the meeting. □

AUDITORS' REPORT

January 21, 1970

To the Members of

CANADIAN NURSES' ASSOCIATION

We have examined the Balance Sheet of the Canadian Nurses' Association as at December 31, 1969 and the Statements of Revenue and Expenditure and Surplus and Reserve for I.C.N. Congress for the year then ended. Our examination included a general review of the accounting procedures and such tests of accounting records and other supporting evidence as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the Association as at December 31, 1969 and the results of its operations for the year then ended, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

GEO. A. WELCH & COMPANY
CHARTERED ACCOUNTANTS

CANADIAN NURSES' ASSOCIATION
BALANCE SHEET
as at December 31, 1969

ASSETS

	1969	1968
Current Assets		
Cash	$241,302	$136,267
Short term deposits—plus accrued interest	203,020	126,780
Accounts receivable	20,784	34,726
Membership fees receivable	33,260	68,562
Prepaid expenses	10,118	—
	508,484	366,335
Sundry Assets		
Marketable securities—at cost (Quoted value $12,205)	3,779	3,779
Loans to member nurses	17,565	13,365
Inventory of binders	—	1,050
	21,344	18,194
Fixed Assets		
C.N.A. House—land and building—at cost less Accumulated depreciation on building	679,268	711,135
Furniture and fixtures—at nominal value	1	1
	679,269	711,136
	1,209,097	1,095,665

Approved on behalf of the Board:

SISTER MARY FELICITAS *President*

DR. HELEN K. MUSSALLEM *Executive Director*

CANADIAN NURSES' ASSOCIATION
BALANCE SHEET
as at December 31, 1969

LIABILITIES

	1969	1968
Current Liabilities		
Accounts payable and accrued liabilities	$ 97,443	$ 26,711
Unearned subscription revenue	24,750	21,300
	122,193	48,011
Mortgage payable—6¾% due 1976 repayable in blended monthly instalments of $3,548 including principal and interest	428,001	441,590
Reserve for I.C.N. Congress—per statement	—	123,327
Surplus	658,903	482,737
	1,209,097	1,095,665

CANADIAN NURSES' ASSOCIATION
STATEMENT OF RESERVE FOR I. C. N. CONGRESS
for year ended December 31, 1969

Balance, December 31, 1968	$123,327
add:	
Excess of Revenue over Expenditure for year	7,636
	130,963
deduct:	
Transfer to Surplus	130,963
Balance, December 31, 1969	NIL

Submitted with our report to the Members dated January 21, 1970.

GEO. A. WELCH & COMPANY
CHARTERED ACCOUNTANTS

CANADIAN NURSES' ASSOCIATION
STATEMENT OF REVENUE AND EXPENDITURE AND SURPLUS
for year ended December 31, 1969

		1969	1968
Revenue:			
Membership fees		$697,754	$678,746
Subscriptions		30,903	22,617
Advertising		249,194	235,804
Sundry revenue		13,249	12,706
		991,100	949,873
Expenditure:			
Operating expenses:			
Salaries	384,534		351,056
Printing and publications	216,511		219,084
Postage on journal	79,304		12,234
Building services	72,930		66,922
Staff travel	9,684		15,849
Committee meetings	28,582		16,073
I.C.N. affiliation	31,214		29,982
Commission on advertising sales	18,261		17,686
Computer service	30,775		25,225
Office expense	25,559		26,511
Legal and audit	4,750		5,875
Translation services	2,533		2,102
Consultant fees	9,322		9,791
Sundry	938		1,411
Furniture and fixtures	4,826		10,075
Landscaping and improvements	16,157		—
Depreciation—C. N. A. House	31,867		31,867
	967,747		841,743
Non-operating expenses:			
I.C.N. Congress	—		20,666
1968 Biennial convention	145		500
Canadian Nurses' Foundation	3,131		1,906
	3,276		23,072
Allocation to Reserve for I.C.N. Congress		—	40,434
		971,023	905,249
Excess of revenue over expenditure for year before investment income		20,077	44,624
add:			
Investment income		25,126	8,301
Excess of revenue over expenditure for year		45,203	52,925
Surplus, December 31, 1968		482,737	429,812
Transfer from Reserve for I.C.N. Congress		130,963	—
Surplus, December 31, 1969		658,903	482,737

FINANCIAL REPORT

The financial results of the past biennium detailed in the auditors' report (pp. 35-37) reflect the actions taken by your Board of Directors in following the mandate of the 34th General Meeting contained in the following motion:

> That for the 1968-70 biennium only, in member associations whose membership exceeds 20,000 the full annual fee per member be $6.00 and in member associations whose membership is 20,000 or less, the full annual fee per member be $10.00 and that the board of directors be empowered to adjust the budget accordingly.
>
> CARRIED

A comparison of actual revenue and expenditures to budget is tabled below:

	Budget	Actual	(Over) Under
Revenue:			
Fees	$1,494,880	$1,376,500	$118,380
Expense:			
Board and Committee Meetings	290,006	220,479	69,527
Research and Advisory	257,120	238,576	18,544
Affiliation and Sponsorship	270,574	192,102	78,472
Journals	448,464	440,587	7,877
Library and Archives	137,528	105,443	32,085
Public Relations	91,188	81,186	10,002
	$1,494,880	$1,278,373	$216,507

It will be noted that expenditures in each category were well below budget and that total net costs were approximately $100,000 less than revenue available through fees. The latter was made possible principally through the significant financial support received from the provincial associations for the ICN Congress, plus additional revenues accruing from interest on ICN Congress funds.

Brief explanations of the means employed to hold net costs to this level are noted below.

Board and Committee Meetings. Generally only those meetings that were mandatory by by-law or resolution were held. For a major portion of the last half of the biennium the Board and Committees operated without support of four professional staff members, the positions for which were unfilled.

Research and Advisory. Salaries related to unfilled professional staff positions account for the total budgetary savings in this category.

Affiliation and Sponsorship. Included in this total is $61,196 representing ICN affiliation fees forwarded on behalf of the individual members. The remaining $130,806 represents CNA's contribution to the administration and operation of the CNF and the ICN Congress. By virtue of good attendance and by foregoing certain amenities, the ICN Congress was a financial success producing a small profit of $7,636.00.

The Journals. Included in net journal costs is an unbudgeted amount of $66,400 caused by a postal reclassification during the last eight months of the biennium. This was more than offset by the introduction of cost reduction methods in the production processes, by substantially increasing advertising and subscription revenues, and by maintaining operating costs at a minimum level.

Library and Archives. Major maintenance and operating expenses were deferred, acquisitions were held to a minimum, and the filling of one additional authorized staff position necessitated by increased volume was delayed until the last quarter of the biennium.

Public Relations. The public relations activities were concentrated primarily on the ICN Congress during the biennium which necessitated the deferral of part of normal CNA public relations programs.

My, you're getting big!

Have you ever wondered how a pregnant woman reacts when a doctor or nurse complacently pats her protruding abdomen, while commenting on its bigness? If not, this understanding report will help explain why empathy is as important during pregnancy as it is during any other period in the human life, and why acceptance of changes in the body image during pregnancy is vital.

Elaine A. Carty, R.N., B.N., M.S.N., C.N.M.

When I was working in a prenatal clinic, I frequently found myself patting a pregnant woman on the abdomen and saying, "My, you *are* getting big, aren't you?" I also noted the reaction. More often than not, this was a groan, accompanied by a pathetic facial expression.

This behavior made me think — perhaps all mothers-to-be are not happy at the sight of their enlarged abdomen during pregnancy. On the other hand, I argued, some prospective mothers can scarcely wait for their abdomen to give visible evidence of advancing pregnancy. These women show their maternal pleasure by wearing maternity clothes before they really need to, and walk with shoulders well back so that their abdomen protrudes.

Noticing that attitudes toward the figure-change during pregnancy differ, I wondered why. How do women react to the abdominal enlargement during pregnancy, I asked? Whatever these feelings are, do they present a problem? What role might a nurse play in relation to these feelings?

Body image

The more I thought about why many health workers remark gently on the fullness of a pregnant woman's abdomen, the more I thought — there must be an answer to differing reactions!

Pursuing the subject, I found literature that provided an insight into the way we view ourselves, and particularly our bodies. "Individuals do have ideas and attitudes concerning their bodies and this concept is known as body image."[1] These attitudes begin when an infant girl discovers her fingers and toes, and later, realizes something differs between herself and her mother. The child's reaction to her body image continues as she develops, and changes as she learns more about herself and interacts with others in her daily experiences. Her popularity with her peers, her achievements in her studies, sports, or music, for example, all affect how she sees herself and her body.

We all have some perception of our body, and as a woman's figure changes during pregnancy it would seem normal that perception of her body image must also change. The effect on a woman of a change in body image may be significant, because, as Seymour Fisher points out, "the female in her role as a woman is more explicitly identified with her body than is the male."[2]

Body identification is now inbuilt in the American culture. Through the medium of television, cosmetic advertisements, and beauty magazines, an ideal American girl has been established. She is presented as pretty and slim, with a curvy figure that makes her naturally attractive to the male. Today's woman is extremely body conscious.

Finding an answer

Hunches and feelings being all I had, I proceeded to find explicit information

Mrs. Carty is a lecturer at the University of New Brunswick, Fredericton, New Brunswick. This article was based on her thesis, "Women's Feelings About the Figure Change in Pregnancy," Yale Univ. 1968.

on why pregnant women differ in their reactions to their increasing girth. I started by interviewing 40 women in varying stages of pregnancy or in the immediate postpartum period. Their responses to my questions, and during our general discussion, were rated as positive or negative in relation to their figure change. The number of positive and negative responses were totaled, and each woman was placed on a five-point scale — ranging from complete satisfaction to complete dissatisfaction with the changes in her pregnant figure.

A woman was rated *satisfied* if all her comments seemed to be completely positive, and *dissatisfied* if all her comments were rated as negative. A *somewhat satisfied* rating was given where the majority of comments had a positive tone and only a few negative comments. The reverse was true of a *somewhat dissatisfied* rating. A *neutral* rating was established for the same number of positive and negative comments, or when the comments had a neutral tone and expressed no particular feelings one way or another. A nurse acted as a reliability check for the classifications.

Ratings discussed

None of the women were *completely satisfied*, 9 were *somewhat satisfied*, 10 were *neutral*, 17 were *somewhat dissatisfied*, and 4 were *completely dissatisfied*. The degree of dissatisfaction seemed to increase as the pregnancy progressed.

My own reactions to these interviews? If a woman views herself negatively during her pregnancy, it may affect her relationship with her husband and her unborn child. Which made me conclude — I see feelings about figure change as a potential problem area.

Most of the women who were from four to six months pregnant seemed uncertain how they felt about their enlarging abdomen. It was new to them, for they were just beginning to "feel a bulge." Some did express decided feelings. The primigravida at this time appeared to be quite happy with and thrilled about her enlarging figure, but the multigravida was not. Reactions given by some primigravidas made me think that, perhaps for women who have not had a baby before, the growth and development of a baby within themselves seems unreal, almost miraculous. Then when they do begin to bulge, there is real evidence that a baby, *their baby*, is growing within them.

The women who were from seven to eight months pregnant appeared to be somewhat more dissatisfied. They felt those things that were exciting in early pregnancy, seemed to have lost enchantment later. It was interesting that many women in this period expressed concern not only about the increased size of their abdomen but also the stretch marks left after the birth. Many women saw these as increasing their unattractiveness.

This last reaction made me ponder — perhaps the nursing profession takes the stretch mark for granted, assuming it to accompany pregnancy, forgetting to tell the patient that stretch marks may appear, where, and what they will look like.

I also talked with 10 women who were within one or two weeks of their due date. Again, the amount of dissatisfaction with their enlarging figures seemed to increase. These women reported they just wanted to get the pregnancy over, they felt uncomfortable and unwieldy.

It was only in the postpartum group that we rated anyone completely dissatisfied (there were four). These women were prone to think that once the baby was born, their nice, flat stomach would soon come back. Dissatisfaction was openly expressed when they found the abdomen was still a little big and lacked

muscle tone. I wondered if, as the baby had been separated from their body, perhaps they could easily express negative reactions without feeling they were saying something against the baby.

Nurse's role

If the purpose of nursing is to assist the individual, family, or group to adapt to health care and/or health related stressors,[3] then it would be well to look at what could affect the process of adaptation. It could be that in pregnancy, *how* a woman views herself could be a factor which determines *how* she adapts to her new role.

Certainly the pregnant woman has many feelings, positive and negative. The nurse's job is to support the positive feelings and prevent, reduce, or, remove the negative feelings. If a woman expresses negative feelings, why is it important for the nurse to question these feelings?

It seems to me that these feelings could affect both the husband/wife relationship, and the mother/child relationship. For example, if a woman feels she is unattractive because of her pregnancy, it may strain her natural relationship with her husband and affect the trust she has in him. She might blame him for making her pregnant and for making her "look this way." This reaction could mean additional strain on their relationship.

On the other hand, the husband/wife relationship might be strengthened if the wife is pleased with the way she looks during pregnancy. She might accept her bulging abdomen, taking comfort in sharing her feelings with her husband. She might even want him to feel her abdomen, so that he can feel the baby's movements and make a conjecture on its position.

If the mother is dissatisfied with her appearance, she might blame the baby, and if this is allowed to continue she might have difficulty developing a close relationship with her infant. It would seem that the mother-to-be who is pleased and excited about her appearance, is probably also pleased about the baby within her, and is able to identify closely with it. To me, the question seems to be, "How can we help the mother who is troubled by her, 'pregnant look?' "

Each nurse will have her own imaginative ideas on this subject. If acceptable, I hope she puts them into practice. Here are some of my ideas, particularly on the importance of being aware that different feelings exist among pregnant women. It is important to determine whether pregnancy was planned or not planned. Teaching as it relates to maternity clothes is also important, as is acquainting the husband with the stages of pregnant body change, and postpartum teaching on how to relate to body change.

Helping the mother

During the rating interviews, two questions seemed to detect whether the mother's feelings could be categorized as satisfied or dissatisfied. The first, "What were some of your thoughts when you first put on maternity clothes?" brought various responses. One example was, "Oh, I like maternity clothes, they are comfortable and I look good in them."

The following response rated as dissatisfied: "Well, here we go again! I think of them as a uniform. You have to wear them for your tour of duty. They are all the same style, and no matter how hard you try to fix yourself up, you can't."

The second question, "Some people think women look their best when pregnant. What do you think?" brought replies that seemed to be concerned with how their husbands viewed their appearance, or how they *thought* he viewed their appearance. These two examples indicated the different opinions: "No, I don't think so. I don't like my husband to see me this way. He has never said anything, but with this stomach and being so awkward, I just can't help but feel uncomfortable." "Well, I look my best. I feel good and happy, and my husband tells me I look grand when I am pregnant."

If a nurse wants to find out how a pregnant woman sees herself, one of the above questions might be a useful approach. Perhaps the first step in helping a mother is assuring her that feelings of uncertainty or dissatisfaction with the way she looks during pregnancy are not abnormal. (This information could be added to prenatal literature as anticipatory guidance.) If a pregnant woman knows that feeling unattractive is not unusual, she might be able to express her feelings on the subject easily to the nurse and her husband.

Attitudes

The way a woman views her enlarged abdomen may be indirectly related to whether or not the pregnancy was planned. For example, perhaps the pregnancy was not planned because the couple felt they could not then afford another baby. By referring to a social worker, help might be obtained through extra funds.

Perhaps a pregnancy was not planned because the wife felt she could not cope with another child, or did not then have the capacity to love another child. Negative feelings about the pregnancy might be expressed as dissatisfaction with the figure changes. Without interpretation of her dissatisfaction, this mother might not be *able* to love her baby when it is born, and neglect or abuse might result.

In the prenatal period the nurse can help the mother identify with her baby. She can encourage her to name the baby and think of it as a person. She can help the mother to be conscious of the baby's movements and position. Postpartum, the mother needs to claim her baby. This can be best achieved by letting her hold the baby as soon as possible after delivery.

My findings indicated that the way a woman sees herself in maternity clothes is a good clue to her satisfaction or dissatisfaction with her figure changes. The nurse might help by emphasizing the comfort of maternity clothes, and discuss why they are necessary for the enlarging uterus.

If the woman expresses feeling of boredom with her maternity clothes, the nurse could suggest inexpensive ways to make her clothes different. Adding a bow, a scarf, or a collar often enhances her appearance. The woman could be helped to use her own resources in many ways to brighten her appearance, so that she feels she *looks* nice in maternity clothes.

To take the focus off the enlarged abdomen, the nurse could comment on how attractive the patient looks. Compliment her dress or hairdo, or comment on her clear skin and shining eyes. It might also be helpful to encourage the mother to think of the abdomen in terms of the baby within it. One of the somewhat satisfied women I spoke to said, "I ordinarily do not like a big tummy, but a pregnant tummy is something quite different and beautiful."

No one functions in a vacuum. Intermeshed with every woman's own personal drama is another which is found in the reactions she creates within her tiny segment of society, her family. Her open or subtle indications of acceptance, ambivalence or rejections of her condition inevitably stir up responses and repercussions among her family members. They in turn set up reactions in the pregnant woman which are indeed consequent to the reactions she perceives among her key reference group members, in particular, her husband.[4]

Because of the increased emphasis on beauty in our culture, the pregnant woman wants to be attractive to her husband most of all. But it seems a husband often teases his wife about her big tummy! This appeared to upset some of the women with whom I spoke. Perhaps men do not realize how sensitive a wife can be about her enlarged abdomen.

Here the public health nurse might be able to talk with the couple about the teasing and reactions to it. Anticipatory guidance could be given by including this kind of information in prenatal classes. Nurses can also help men realize that their wives want and need to be complimented on their appearance during pregnancy. The husband could be encouraged to touch his wife's abdomen, feel the baby move, and accompany her when she shops for maternity clothes. This might help to involve him totally in the childbearing process.

Conversely, the woman should also be helped to understand that her husband might be somewhat awed, confused, or even amazed at the physical appearance of pregnancy, and that his teasing is done without really knowing another way in which to respond to his own feelings or reactions.

Postpartum idiosyncracies

During the interviews it seemed several women were not realistic about the way their figure would look postpartum. Perhaps the medical profession should be more explicit in teaching mothers about the weight distribution in pregnancy. For instance, they should know that the pregnancy itself accounts for only 16 to 20 pounds, and that anything over that becomes adipose tissue. They also should learn about the rectus abdominus muscle stretching during pregnancy, and the resulting postpartum flabbiness. Postpartum exercises should be discussed and emphasized before the pregnancy terminates.

It is also important for the woman to understand why she must begin postpartum muscle toners immediately postpartum if her abdomen is to become flat in a short while. The nurse should begin working on exercises with the mothers immediately postpartum. And so get them into a daily exercising habit.

Purpose

Helping the nurse become aware of the importance of body image in pregnancy has been the purpose of this article. I also wanted to share some of my research findings, and to suggest ways by which the nurse could support positive feelings, and reduce or remove negative feelings about figure changes during pregnancy. Most certainly this is only one small area in which the nurse must be concerned during her care of the childbearing woman. But the nurse who is actively conscious of figure change during pregnancy can contribute to making pregnancy a healthy and happy experience for all the family.

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The Shouldice Story

Crinolines were hoisted and tuxedo trousers dropped...

Max Ferguson

Some future day, when the inevitable emergence of a flourishing and dynamic Canadian film industry will enable Canada's story to be told to the world, I certainly hope they won't overlook the Shouldice Surgery. The very fact, gentle reader, that your eye-brows are now moving toward your hair-line and your lips are silently forming the query "What in Hell is the Shouldice Surgery?" is eloquent proof of the crying need for Canadians to cast off, at long last, this stifling national winding sheet of reticence, inhibition and self-depreciation so that all the world may know of the many things we do so well . . . the things which make this land of ours unique.

The Shouldice Surgery, occupying the spacious grounds of a former private estate and nestling in the pastoral charm of farmland just north of Toronto, is devoted exclusively to the repairing of hernias. Thanks to the development of a new and infallible surgical technique employing stainless steel wire, it can now be said that no one knocks in vain at the doors of the Shouldice. Age is no deterrent. Shrivelled, despairing men in their late eighties, whom no medical doctors would touch, have shuffled to the Shouldice and been made whole again, giving rise with ample justification to the credo that no doctor stands so tall as when he stoops to fix an old hernia.

The philosophical modus operandi at Shouldice seems to be an adaptation of the old Biblical exhortation "Pick up thy bed and walk." After the surgeon has completed his work, the patient rises from the operating table and walks back to his room. Following a three-hour rest period, he will be expected to make his way to the main floor of the hospital and participate in group therapy which consists of five minutes of setting-up exercices interspersed with five minutes of jogging on the double through the labyrinth of main floor rooms. All this is done under the supervision of a hospital matron whose unfortunate physical resemblance to Elsa Koch sometimes makes the whiners and slackers forget that there beats a motherly heart of gold underneath.

After three brief days of this physiotherapy, the patient is released to take his place once again as a useful member of society. With him, of course, go the best wishes of the hospital staff and only two minor stipulations. "Do not take a bath for one week and try not to laugh." I think any reasonable person can appreciate the Shouldice insistence that during the patient's sojourn there, the

Max Ferguson, Arts '46, a noted Canadian satirist, hosted a daily CBC radio program for many years. He was awarded the Leacock Medal in 1969 for his humorous writing. Reprinted with permission, The University of Western Ontario *Alumni Gazette*, May edition, 1970.

presence of liquor is prohibited. While I was there, one of my fellow patients — a mean, dour, bad-tempered Scot of 83 years — had two bottles of contraband whiskey taken from him. He had, of course, been in a nasty mood from the very outset since he felt his own son had betrayed him by suggesting an innocuous Sunday drive in the country and then whisking the stubborn, cantankerous old man into the Shouldice. During his entire stay he assiduously managed to overlook the fact that his double hernia had been completely cured for the first time in his life and insisted on referring to the staff as "heartless bastards, wi' nae a drap o' human kindness."

Although the revolutionary surgical techniques developed by the Shouldice Surgery attract medical men from all over the world as observers, it is not just this physical aspect which astounds me and evokes my most heart-felt praise. Rather, it is the incredibly solicitous — almost parental — concern which the hospital shows for each member of its graduating classes. And here I am not thinking simply of the annual letter which each ex-patient receives urging him to return to the hospital, wherever he may be, for a medical check-up. As a former resident, I react to those siren calls much in the way an exiled Scot would react to the strains of "Will Ye No Come Back Again?", but I can well appreciate that a cynic might justifiably view them as a standard, pragmatic procedure motivated only by the self-interest of the hospital to verify the efficacy of its surgical techniques. But how does one explain all the other literature? The considerate little reminders of social evenings or the fact that my "year" party is coming up on such and such a date affording the chance to be with old friends once again and re-live old and happy memories. I'm well aware of the old saying that "Familiarity breeds contempt" and since the Shouldice Surgery is situated right on Toronto's northern doorstep I suppose it's only natural that certain unthinking Torontonians, particularly those who've never been there, should refer to it glibly as "the Minit-Wash Hernia". I only wish, however, that such people could have been with me on that April afternoon four years ago when my phone rang at the CBC and I picked it up to hear the warm voice of Dr. Black . . . the surgeon who personally officiated at the healing of my hernia. "I certainly hope, Mr. Ferguson, that we'll have the pleasure of your company at our first annual ball in the Royal York next month." I suddenly found myself staring incredulously into the ear-piece of the phone as if searching for some visual proof of what I was hearing. True, the hospital had gone out of its way over the past few years to preserve the bonds of friendship that had sprung from my hernia operation but — a personal invitation to a Hernia Ball . . . especially since my hernia had been so "run of the mill" with not even a strangulation or any other distinguishing complication to raise it above the average. For a moment I gave way to a gnawing suspicion that the voice on the phone might be that of Allan McFee or some other CBC announcer with a sick sense of humour and a rather off-color retort was already forming on the tip of my tongue but the warm, compelling sincerity soon won me over as the voice continued. "As a matter of fact, Mr. Ferguson, we were hoping that you might even consent to act as MC for the evening." After accepting this additional honor with a rush I asked just what my duties would be. "Oh, there's really very little involved . . . a few words of welcome, an introduction to one or two short speeches and then at the conclusion of the dinner a reminder that a live orchestra is standing by in the adjacent ballroom awaiting the pleasure of those guests who might wish to dance."

This certainly sounded like a simple and pleasant assignment but just to be sure I had it straight I enquired if my services would only be required until the end of the dinner. "Oh certainly Mr. Ferguson because once the guests leave the dining room and move into the ballroom our own people will take over." "Your own people will take over, Dr. Black?" "Yes, we'll have two or three of our staff people waiting in a small anteroom which connects the dining room with the ballroom. As the guests move through to the dancing we'll be able to give those hernias just a quick check-up without really holding anybody up or interfering with the evening's fun. "I've always hated being a quitter but the thought of luring all the beauty and the chivalry of that evening into that tiny room, the mental picture of all those stunned expressions as crinolines were hoisted and tuxedo trousers dropped was just too much. If the sounds of revelry by night were going to be converted by probing thumbs into an anguished crescendo of coughs I didn't want to be the Judas bull who led them, all unaware, into such a thing. Though I never did make the first annual Hernia Ball at the Royal York I'm still staggered by the brilliance of the imaginative minds behind such a venture and, as I mentioned at the outset, when an emerging Canadian film industry begins to tell Canada's story to the world, I hope that somewhere up there alongside Lloyds of London, Wells Fargo and the other great milestones of cinematography will be the story of . . . "Shouldice, Mender of Men's Hernias." □

books

Man, Medicine and Morality by A.E. Clark-Kennedy. 214 pages. London, Faber and Faber, 1969. Canadian Agent: Queenswood House, Toronto, Ontario.

Reviewed by Eileen Healey, Associate Professor, School of Nursing, The University of Western Ontario, London, Ontario.

This timely and thoughtful book discusses disease, the problems of medical practice, and related moral, legal, and financial questions. The author relates these issues to the conflicting claims of human experience as reflected by religion and scientific interpretations of the nature of man. Although the author writes as a physician practicing under the British Health Service, his discussion of the problems of patient-doctor-state interplay, modern therapeutics, teaching, and research are relevant to Canada.

The beginning chapters present the essential facts of human growth and development. Moral dilemmas facing modern man are reconsidered in the light of rapidly increasing knowledge and avances in technology. The book is relevant in its consideration of the ethical problems or organ transplantations, the definition of death, and related medical-moral issues.

The author suggests that religion changes and adapts with increasing knowledge and human experience. The question of the genesis of religion is basic to subsequent considerations of the relationship of science to religion, and medical practice to human existence.

Today, science challenges the traditional assumptions regarding man and his place in the universe. The author proposes that chance determines the direction of human evolution. Chance determines one's parents, and which of their gametes fuse to engender their children's psychosomatic development. Chance, as an alternative to the concept of creation with purpose and direction, must be considered as an explanation of existence.

The first five chapters establish the basis for the discussion of morality, defined as "the right way of behaving in situations demanding choice." The basis for moral choice must be anchored to something, and the author proposes three possible anchors: the law of God, the welfare of other people, and personal integrity. Man is obliged to create an environment beneficial to himself and to others.

The author considers all kinds of organ transplantations. The legal issue of diagnosing death, the technical problems of tissue typing, and the functional deterioration of donor tissues are discussed.

This book is important to nurses, who are intimately involved with transplant patients, parents of deformed children, and dying patients. The author illustrates his concern for the rights of the individual under the British Health Service and discusses these as they contrast with physicians' moral and legal obligations to the state. He has written a sensitive and erudite account of the moral issues involved in today's health care service.

Modern Bedside Nursing by Vivian M. Culver. 841 pages. Toronto, W.B. Saunders Company Canada Ltd., 1969.

Reviewed by Thelma Pelley, Director of Nursing, Stratford General Hospital, Stratford, Ontario.

Basic concepts, principles, and procedures are presented in an organized, comprehensive, interesting, and thought-provoking way. Learning techniques are used to clarify basic facts about the science and art of nursing and to involve the reader in a questioning analysis, evaluation, and application of concepts, thus promoting personal competence and specific nursing skills.

In each chapter learning is directed toward specific accomplishment through suggested objectives of study, an introduction and summary of content, practical guides for study and discussion, provocative questions, and a suggested application of content in actual situations.

The author uses a patient-centered system approach. Emphasis is on observation and interpretation of signs and symptoms to develop specific techniques that meet particular human needs.

Units of study are presented in a logical sequence, but can be studied independently. Unit one orients the reader to practical nursing, to an understanding of learning principles, and gives an insight into understanding oneself and others. Vital issues, such as legal and ethical complications, are discussed.

Background theory of nursing practice helps the student acquire knowledge of the structure and function of the human body in relation to the physiological processes of specific systems and organs and the processes of normal growth and development.

The nurse is helped to interpret her role in relation to patient needs that arise from basic nutritional requirements, specific health problems, and drug therapies. Special consideration is given to maternal and child care and problems arising from mental illness.

The appendices provide an excellent reference source and include common abbreviations, medical terminology, procedural guidelines for specific nursing techniques, and a glossary and index.

Orthopedic Nursing, 7th ed., by Carroll B. Larson and Marjorie Gould. 486 pages. Toronto, C.V. Mosby Company, 1970.

Reviewed by Carole L. Martin, Mary E. Brown, and Carol L. Jenkin, Toronto East General and Orthopaedic Hospital, Toronto.

The chapters on introduction and general features of this edition have been greatly expanded and enlarged. In these chapters the nurse will find the well-

defined principles and basics of orthopedic nursing. The areas of good body alignment and positioning of the patient are fundamental aspects of orthopedic nursing and cannot be overemphasized.

The pages on traction are concise and descriptive in outlining all methods of application, with special reference to prevention of pressure areas and the importance of exercise. The nurse should understand the principles of traction described in this chapter to enable her to give effective patient care.

Inclusion of a chapter on rehabilitation is an excellent addition. More and more, the essential need for doctors, nurses, physiotherapists, and social workers to work together as a rehabilitation team to provide total patient care is being recognized.

The detailed chapter on trauma is a good reference. It emphasizes prevention of injury and principles of first aid. Anatomical diagrams of the injury are clearly illustrated, with treatment and nursing care outlined in detail.

In dealing with arthritis, further mention about the recent trend of increasing surgical intervention in the treatment of this disease could have been made, with discussion of relevant nursing care and physiotherapy. The emotional support described in this chapter is an important adjunct in dealing with the arthritic patient.

The remaining chapters, dealing with cerebral palsy, bone tumors, congenital deformities, infections, metabolic disorders, and the special operative procedures are well described. The authors have chosen the more prevalent diseases and discussed these thoroughly.

This book is an important reference on orthopedic nursing. The revised edition has a much improved index, facilitating quick reference. □

AV aids

Films on Food

Sets of 22 films dealing with food preparation, kitchen safety, and food and personnel sanitation have been distributed to the London, Hamilton, Kingston, Toronto, and Northern Ontario regional offices of the Ontario department of Health. These films are to be distributed to public health personnel involved in food protection services and programs for presentation to interested groups.

Each film is nine minutes in length and is in color. The films are directed to food handlers in institutions such as mental hospitals, homes for special care, nursing homes, correctional institutions, summer camps, and some educational institutions.

Address inquiries to the regional medical officer at the regional public health offices concerned.

New Films

The following films are new accessions to the National Science Film Library in Ottawa. All these films are available on loan from the National Science Film Library, 1762 Carling Avenue, Ottawa 13, Ontario, at a nominal fee.

- *Congenital Dislocation of the Hip in Saskatchewan Indians. Its Natural History and Etiology*. Canada, 1968. 16mm, color, sound, 25 minutes.
- *The Endless War*. Great Britain, 1967. 16mm, color, sound, 22 minutes. This film covers William Harvey and the circulation of the blood, Jenner and vaccination, Alexander Fleming and penicillin; present-day research into producing more efficient drugs; and trial testing on animals.
- *Gift of Life/Right To Die*. U.S.A., 1968, 16mm, black and white, sound, 15 minutes. This film on medical ethics covers four types of decisions that involve the question of life or death of a terminally ill patient and one who is in need of an organ transplant or emergency treatment. The controversy on this subject in the medical profession is described as physicians and a nurse discuss the occasions when a decision must be made to revive one patient rather than another. □

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, *except Reference items* may be borrowed by CNA members, schools of nursing and other institutions. *Reference items* (theses, archive books and directories, almanacs and similar basic books) do not go out on loan.

Requests for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50, The Driveway, Ottawa 4, Ontario.

No more than *three* titles should be requested at any one time.

BOOKS AND DOCUMENTS

1. *L'ABC du BCG: practique de la vaccination* par Armand Frappier, 3.ed. Montréal L'Institut de Microbiologie et d'Hygiène de l'Université de Montréal, 1969. 45p.

2. *L'alcool chez les jeunes Québécois: modèles de consommation d'alcool chez un groupe de jeunes* par Ezzat Abdel Fattah et al Publié pour Optat. Québec, Presses de l'Université Laval, 1970. 102p.

3. *Anesthesia*, Montreal, Ayerst, Pharmaceutical Research Laboratories, 1970. 121p.

4. *Annual conference. Proceedings*. 1965-1969. Ottawa. Canadian Library Association. 5v.

5. *Countdown; Canadian nursing statistics, 1969*. Ottawa, Canadian Nurses' Association, 1970. 161p.

6. *Dossiers de cinéma*, publiés sous la direction de Léo Bonneville. Montréal. Editions Fides, 1968. 15pts. in 1.

7. *The dyslexic child* by Macdonald Critchley. London, Heineman, c1960. 137p.

8. *L'étude et l'emploi du BCG au Canada* par Armand Frappier et Marcel Cantin, revu et corrigé novembre 1969. Montréal, Institut de Microbiologie et d'Hygiène de L'Université de Montréal, 1969. 28p.

9. *Hospital career information*. Toronto,

accession list

(Continued from page 47)

Ontario Hospital Association, 1970. 1v.

10. *Non-book materials;* the organization of intergrated collections by Jean Riddle et al. Prel. ed. Ottawa, Canadian Library Association, 1970. 58p.

11. *Preliminary 8mm film project report and listing of 8mm films.* Omaha, Nebraska, Nebraska University, College of Medicine, Communications Division, 1969. 1v. (looseleaf)

12. *Readings in development.* Ottawa, Canadian University Service Overseas, 1970. 1v.

13. *Report of Seminar on Mental Health in Developing Countries, Montreal, 11-13 November 1969.* Toronto, Canadian Mental Health Association, 1970 1v. (various paging) Seminar sponsored by World Federation for Mental Health, Canadian International Development Agency, the Canadian International Development Agency and the Canadian Mental Health Association.

14. *Sources of medical information,* edited by Raphael Alexander. New York, Exceptional Books, 1970. 84p.

15. *Structure and function in man* by Stanley W. Jacob and Clarice Ashworth Francone. 2d ed. Toronto, Saunders, 1970. 591p.

16. *Structure and function in man,* laboratory manual by Stanley W Jacob and Clarice Ashworth 2d ed., Toronto, Saunders, 1970. 253p.

17. *Tuberculosis and the general hospital.* New York, National Tuberculosis and Respiratory Disease Association, 1969. 1v. (various paging)

18. *Tuberculosis eradication; policies and program guides.* New York, National Tuberculosis and Respiratory Disease Association, 1970.

19. *A validation study of the NLN pre-nursing and guidance examination and related studies emerging from data gathered for the validation study.* New York, National League for Nursing, Measurement and Evaluation Services, 1970. 58p.

PAMPHLETS

20. *Communicating within the organization* by Leslie This. Washington, Leadership Resources Inc., c1966. 28p. (Leadership Resources Inc., Management series no.2)

21. *Delegating and sharing work* by David S. Brown. Washington, Leadership Resources Inc., c1966. 23p. (Leadership Resources Inc., Management series no. 4)

22. *Developing personnel* by Everett H. Bellows. Washington, Leadership Resources Inc., c1968. 24p. (Leadership Resources Inc., Management series no.6)

23. *Guide de morale médicale.* 7. ed. Preliminaire. Ottawa, Association des Hôpitaux catholiques du Canada, 1970. 5p.

24. *International development and assistance: an aid to study groups.* Ottawa, Canadian Institute of International Affairs, 1970. 26p.

25. *Let's be practical about a nursing career.* New York, National League for Nursing, Dept. of Practical Nursing Programs, 1970. 42p.

26. *Managing the changing organization* by Warren H. Schmidt and Gordon L. Lippitt. Washington, Leadership Resources Inc., c1968. 24p. (Leadership Resources Inc., Management series no.7)

27. *Masters education; route to opportunities in modern nursing.* New York, National League for Nursing, Dept. of Baccalaureate and Higher Degree Programs, 1970. 15p. **R**

28. *Medico-moral guide.* 7th ed. Preliminary. Ottawa, Catholic Hospital Association of Canada, 1970. 5p.

29. *National survey of educational programmes to be conducted in 1970.* Toronto, Canadian Council on Hospital Accreditation, 1970. 11p. **R**

30. *Organizing the enterprise* by Thomas Q. Gilson. Washington, Leadership Resources Inc., c1966 26p. (Leadership Resources Inc., Management series no.5)

31. *Planning for achieving goals* by Lowell H Hattery. Washington, Leadership Resources Inc., c1966. 24p. (Leadership Resources Inc., Management series no. 3)

32. *Understanding the management function* by David S. Brown. Washington, Leader-

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ship Resources Inc., c1966. 28p. (Leadership Resources Inc., Management series no.1)

GOVERNMENT DOCUMENTS

Canada

33. Bureau of Statistics. *Tuberculosis morbidity and mortality, 1966.* Ottawa, Queen's Printer, 1970. 81p.

34. Dept. of Labour. Economics and Research Branch. *Wages in Canada and the United States; an analytical comparison* prepared in the Wages Research Division of the Economics and Research Branch by Allan A. Porter and others. Ottawa, 1969. 153p.

35. Dept. of National Health and welfare. *Film library catalogue.* Ottawa, Queen's Printer, 1970. 284p.

36.— Emergency Health Services Division. *Emergency blood Services.* Ottawa, Queen's Printer, 1970. 48p.

37.— Research and Statistics Directorate. *Survey of residential and in-patient treatment centre for emothionally disturbed children.* Canada, 1968 and Directory of participating treatment centres. Ottawa, 1970. 370p. (Health care series no. 24)

38. Ministère de la Santé nationale et du Bien-être social. *Manuel du consommateur direction général des aliments et drogues.* Ottawa, Imprimeur de la Reine, 1970. 22p.

39. National Science Library. *Union list of scientific serials in Canadian libraries.* 3d ed. Ottawa, 1969. 1066p. (NRC no. 10770) **R**

South Africa

40. Dept. of Information. *Health and healing; hospital and medical services of South Africa's developing nations.* Pretoria, Gov't Printer, 1969. 119p.

U.S.A.

41. Dept. of Health, Education and Welfare. Public Health Service. *Annotated bibliography on inservice training for allied professionals and non professionals in community mental health.* Washington, U.S. Gov't. Print. Off. 1969. 3v. (U.S. Public Health Service Publication no. 1900)

42. Dept. of Health, Education and Welfare public Health Service. *Training methodolygy; an annotated bibliography.* Washington U.S. Gov't. Print. Off. 1969. 4v.

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

43. *Attitude des infirmières-hygiénistes et perception de leur role, face à l'aide à donner aux mères au sujet de la planification des naissances* par Lisette Arcand. Montréal, 1968. 73p. (Thesis (M.Nurs.)-Montreal) **R**

44. *Report of refresher programs in nursing pilot project for metropolitan Toronto 1968* co-sponsored by Ontario Hospital Association, Ontario Hospital Services Commission and Registered Nurses Association of Ontario by Margaret L. Peart. Toronto, 1970.101p. **R**

45. *Level of preparation in maternity and newborn nursing attained by senior nursing personnel* (Supervisors, head nurses and charge nurses) employed by a sample of Canadian hospitals in maternity and newborn services, survey report prepared by Ester Robertson for Subcommittee on Nursing, Maternal and Child Health Advisory Committee, Dept. of National Health and Welfare, May 1969. Ottawa, Queen's Printer, 1970. 18p. **R**

classified advertisements

ALBERTA

REGISTERED NURSES FOR GENERAL DUTY in 22-bed hospital immediately for permanent or holiday duty. Salary — $505.00 to $600.00. Residence available. Contact: Matron-Administrator, Consort Municipal Hospital, Consort, Alberta.

REGISTERED NURSES FOR GENERAL DUTY in a 34-bed hospital. Salary 1968, $405-$485. Experienced recognized. Residence available. For particulars contact: Director of Nursing Service, Whitecourt General Hospital, Whitecourt, Alberta. Phone: 778-2285.

BASSANO GENERAL HOSPITAL REQUIRES NURSES FOR GENERAL DUTY. Active treatment 30-bed hospital in the ranching area of southern Alberta. Town on Number 1 Trans-Canada Highway mid-way between the cities of Calgary and Medicine Hat. Nurses on staff must be willing and able to take responsibility in all departments of nursing, with the exception of the Operating Room. Single rooms available in comfortable residence on hospital grounds at a nominal rate. Apply to: Mrs. M. Hislop, Administrator and Director of Nursing, Bassano General Hospital, Bassano, Alberta.

GENERAL DUTY NURSES for active, accredited, well-equipped 65-bed hospital in growing town, population 3,500. Salaries range from $490 — $610 commensurate with experience, other benefits. Nurses' residence. Excellent personnel policies and working conditions. New modern wing opened in 1967. Good communications to large nearby cities. Apply: Director of Nursing, Brooks General Hospital, Brooks, Alberta.

GENERAL DUTY NURSES (2) for small, modern hospital on Highway no. 12, East Central Alberta. Salary range $477.50 to $567.50 including regional differential. Residence available. Personnel policies as per AARN and A.H.A. Apply to: Director of Nursing, Coronation Municipal Hospital, Coronation, Alberta.

GENERAL DUTY NURSES for 94-bed General Hospital located in Alberta's unique Badlands. $405 — $485 per month, approved AARN and AHA personnel policies. Apply to: Miss M. Hawkes, Director of Nursing, Drumheller General Hospital, Drumheller, Alberta.

Inquiries are invited from **GENERAL DUTY NURSES** for positions in a 330-bed active-treatment and auxiliary hospital complex. This is an ideal location in a city of 27,000 with summer and winter sports facilities nearby. 1970 salary schedules effective May 1, 1970, $490. — $610. Recognition given for previous experience. For further information, please contact: Personnel Officer, Red Deer General Hospital, Red Deer, Alberta.

BRITISH COLUMBIA

HEAD NURSE required for 30-bed hospital, B.C. interior. New 41-bed hospital in late planning stage. Salary and conditions of work in accordance with RNABC Contract. Excellent accomodation available. Community based on mining and ranching. Must have or obtain B.C. registration. Demonstrated leadership ability or capability required. Apply: Director of Nurses, Lady Minto Hospital, Box 488, Ashcroft, B.C.

A HEAD NURSE and STAFF NURSES will be needed for Child Psychiatry. The Head Nurse will participate in the clinical development and subsequent operation of the 20-bed unit anticipated for the Royal Jubilee Hospital's Eric Martin Institute of Psychiatry. Current registration with the Registered Nurses' Association of British Columbia is required. Enquiries should include background and experience and be made to the: Director of Nursing, Royal Jubilee Hospital, 1900 Fort Street, Victoria, British Columbia.

NURSES registered in British Columbia with **PSYCHIATRIC** experience are needed for the newly opened Eric Martin Institute of Psychiatry. When fully opened this 170-bed facility is anticipated to have a Day Hospital, 6 Acute Adult Psychiatric Units and a 20-bed Children's Unit. Attractive salary scale and liberal personnel policies. Apply to the: Director of Nursing, Royal Jubilee Hospital, 1900 Fort Street, Victoria, British Columbia.

REGISTERED NURSES FOR GENERAL STAFF required by TRAIL REGIONAL HOSPITAL. Trail has a 238-bed fully accredited regional referral hospital situated in the Columbia River Valley of southeastern British Columbia. Salary $549 rising to $684. 38 3/4 hour week. Apply to: Director of Nursing, Trail Regional Hospita, Trail, B.C.

GENERAL DUTY NURSES for modern 33-bed hospital located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply to: Director of Nursing, General Hospital, Fort Nelson, B.C.

GENERAL DUTY NURSES for modern 35-bed hospital located in excellent recreational area. Salary and personnel policies in accordance with RNABC. Comfortable Nurses' home. Apply: Director of Nursing, Boundary Hospita, Grand Forks, British Columbia.

OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing. RNABC policies in effect. Credit for past experience and postgraduate training. British Columbia registration is required. For particulars write to: The Associate Director of Nursing, St.Joseph's Hospital, Victoria, British Columbia.

MANITOBA

REGISTERED NURSES required for 68-bed hospital, modern, well-equipped. Starting salary $480-September $510. Residence accommodation available. Apply to: Administrator, Ste. Rose General Hospital, Ste. Rose du Lac, Manitoba.

MANITOBA

GENERAL DUTY NURSES: Applications are invited from **REGISTERED NURSES** for a 100-bed accredited hospital fifty miles west of Winnipeg on Trans Canada Highway. Salary range $480/565 per month increasing to $510/595 per month effective September 1st, 1970. Excellent fringe benefits plus evening and night differentials and academic attainment bonuses. Applications will be received by Director of Nursing, Portage District General Hospital, Portage la Prairie, Manitoba.

NEWFOUNDLAND

WANTED: PUBLIC HEALTH NURSES (2) to work with The Medical Services Division of the United Church of Canada, to cover coastal villages of the Baie Verte peninsula on the north coast of Newfoundland. Please contact: Dr. D.P. Black, Superintendent, The United Church Hospital, Baie Verte, Newfoundland.

NOVA SCOTIA

REGISTERED NURSES: Applications are invited from Registered Nurses trained in psychiatry for the position of **DIRECTOR OF NURSING** at the Halifax County Hospital, a 425-bed psychiatric hospital. Good salary, working conditions and fringe benefits. Please address applications to: Administrator, P.O. Box 1003, Halifax County Hospital, Dartmouth, N.S.

GENERAL DUTY NURSES applications are invited for active treatment hospital caring for medium and long term patients. Salary Range: $5,400. — $6,660. Excellent Fringe benefits and working conditions. Please apply to: Director of Nursing, Halifax Civic Hospital, 5938 University Avenue, Halifax, N.S.

ONTARIO

SUPERVISOR OF PUBLIC HEALTH NURSING, qualified, required for Huron County Health Unit. Generalized public health nursing service with new programs being developed. Excellent working conditions, salary minimum $9,000 per annum negotiable on basis of experience. Main office in Goderich, a pleasant town situated on Lake Huron. Vacancy immediately. Applications should be directed to: Dr. G. P. A. Evans, Director and Medical Officer of Health, Court House, Goderich, Ontario.

REGISTERED NURSES for 34-bed General Hospital. Salary $525. per month to $625 plus experience allowance. Residence accommodation available. Excellent personnel policies. Apply to: Superintendent, Englehart & District Hospital Inc., Englehart, Ontario.

REGISTERED NURSES needed for 81-bed General Hospital in bilingual community of Northern Ontario. French language on asset, but not compulsory. Starting salary $530. monthly with allowance for past experience, 4 weeks vacation after 1 year and 18 sick leave days, Unused sick leave days paid at 100% every year. Master rotation in effect. Rooming accommodation available in town. Excellent personnel policies. Apply to: Personnel Director, Notre-Dame Hospital, P.O. Box 850, Hearst, Ont.

REGISTERED NURSES required for a 12-bed Intensive Care-Coronary Care combined Unit. Post basic preparation and/or suitable experience essential. 1970 salary range $535-645; generous fringe benefits. Apply to: Director of Nursing, St. Mary's General Hospital, 911B Queen's Blvd., Kitchener, Ontario.

REGISTERED NURSES. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,500. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number, etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone: 826-3251.

September 1970

The Canadian Nurse

television brings nurse to maritimers

distress center helps with problems

coffee break answers questions

changing horizons

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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 66, Number 9 September 1970

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Canadian Press stories out of Toronto during July, told of a wage disparity in Ontario hospitals affecting registered nursing assistants. *(See News, page 9.)*

This category of worker, CP said, is paid less than a male orderly, even though her duties and educational requirements demand more.

A court order, granting female nursing aides at Toronto's Greenacres Home for the Aged equal pay with male orderlies, was cited as an attempt to "broaden the interpretation of the Ontario [equal pay] act."

What the stories failed to make clear was that the court's application of the Ontario labor statutory law at Greenacres exposed the wage disparity.

Male orderlies in some Ontario hospitals were on a higher wage scale than nursing assistants prior to the court order. By raising the wage level of the nursing aide to that of the male orderly, the anomaly was revealed.

The crux of the situation seems to be the interpretation of the word *similar*. Which in this case does not mean *identical*.

According to an official of the Ontario department of labor, job comparisons, under the province's equal pay act, are made between jobs that are *similar*. Perhaps this is a clue for nursing assistants when they begin to bargain.

But, then, the department would ask "Which hospital position do these nurses claim as similar?"

Apparently the answer is none!

It seems some of the male orderly duties are similar to those of the nursing assistant — but not all!

What tops the argument is, the basic educational and training requirements for both positions differ widely. The registered nursing assistant is way ahead.

Perhaps this is where Al Hearn, second vice-president of the Service Employees International Union, and M.E. Howard, director of the Ontario employment standards branch, should get together and spell out the interpretation of *similar*, as it applies to hospital workers (professional and service personnel).

A solution to the impasse might be — take a looksee at the wage ladder for *all* hospital personnel. By increasing salaries at the top, leaway could be given to lower paid groups — including the registered nursing assistant. — **M.C.R.**

letters

Letters to the editor are welcome.
Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Comment on poverty brief

It seems fitting to comment on the report of the Canadian Nurses' Association's brief to the Special Senate Committee on Poverty, in the July issue of *The Canadian Nurse*. Congratulations are in order to our association on the preparation of this brief and particularly to Trenna Hunter and her committee who prepared a document of such high caliber. The document presents the nurse's role in undermining poverty in Canada in a strong, straight-forward manner. Its challenge is directed to community health agencies in particular. The active nurse has a contribution to make in her professional role, and the inactive nurse has a contribution to make as a citizen. From my observations, public health nurses have given leadership in their communities and have expressed their citizenship in many ways, as active members of home and school associations, or local councils of women ratepayers associations. In this way, they have been producers of change.

I would urge nurses interested in this problem to read the full report which is available on loan from the Canadian Nurses' Association library. The ten recommendations now remain to be implemented. — *Isabel Black, Principal Nursing Consultant, Department of Health, Toronto, Ontario.*

Lack of nursing leadership

As a registered nurse in Ontario, I am disgusted about the lack of nursing leadership, that is, outspoken comment, about hospital administration and provincial government interference.

Every nurse should read the editorial in the May issue of the *American Journal of Nursing*. As the editorial indicates, the credibility gap in nursing is becoming disastrous. Staff nurses are being shunted around, some as much as six times a month. There are no public outcries from our provincial associations unless collective bargaining is involved. Moreover, the plan to reduce nursing programs to two years is ludicrous.

The dichotomy between diploma and degree programs in the United States has caused a civil war in nursing. Who is going to have the practical skills to train these two-year nurses in any specialty? Certainly not our degree graduates, who now receive very little practical experience.

Is it any wonder staff nurses are examining their consciences about continuing in a profession that has no association to support them and no leaders to speak for them? The leaders in nursing seem intent on keeping their own jobs by siding with government attempts to cut the budget and obtain a $3 million surplus.

Why doesn't *The Canadian Nurse*, for example, sponsor a panel discussion with some of our hospital consultants? Are these people at all in touch with nursing care?

I remember such articles as the one on individualized nursing care ("Nurse, Please Show Me That You Care!" Feb. 1970). Could the author of such an article be aware of the nursing shortage in some hospitals where there is one nurse for fourteen patients? Does the author know that in some so-called specialty units, the patients aren't even constantly observed by staff?

We will never attract young, intelligent nurses to join any nursing association that continues to issue pronouncements such as the Canadian Nurses' Association's comment that poverty causes ill health, which is surely the picayune understatement of the year. — *R.N., Toronto, Ontario.*

Permanent shifts

I was astonished to read the article by Helen Saunders "Let's Have Permanent Shifts" (June '70). In all the hospitals I have worked in, the majority of nurses prefer the day shift, but obviously, everyone can't work this shift permanently.

The article suggests that married nurses should be able to work the shift most convenient for babysitting arrangements. I think the majority of these nurses are on shifts best suited to their family situation anyway, and usually on a part-time basis.

Most hospitals are staffed with young, unmarried nurses who would prefer the day shift. I would refuse to work in a hospital whose administration told me that the only shift open was evenings or nights. The waiting list for permanent day duty would be endless.

The author of the article also suggests that permanent shifts would benefit patients. Does she not realize that permanent shift nurses have days off and might find a change in patient assignment on their return? Often a patient and his nurse have a personality clash, and it would be upsetting for him to see this same nurse continually.

Permanent shifts sound good in theory, but in all fairness to those doing active bedside nursing, I don't believe they would be practical. — *Irene Hodgson, Reg. N., Sarnia, Ontario.*

I was happy to read the article by Helen Saunders, "Let's Have Permanent Shifts" (June, '70). Having left general duty nursing four years ago because of weekly rotation, I have strong feelings about permanent shifts.

I am now in charge of an 80-bed special care home for the aged with a small registered nurse staff. All my nurses' aides are on a permanent shift basis, and this has been successful. There is little staff turnover because personnel work the shift best suited to their home and social situation, and the patients benefit from a happy and satisfied staff. This plan could be used for professional nurses in hospitals. — *E. Sanders, Reg. N., North Battleford, Saskatchewan.*

Part-time nurse disillusioned

I have thought of writing this letter for a long time, and I wonder if there are other nurses in my position who share my anger and disillusionment.

I married just before graduating from the Royal Victoria Hospital in Montreal and worked as a staff nurse in several hospitals until my son was born. A year later I returned to nursing on a part-time basis in one of Montreal's large hospitals.

Working for one day a week, I am placed on different wards, but my duties are always the same. I am assigned tasks that could easily be done by a nursing assistant. The excellent training I have is never called upon; my duties are repetitive, manual, and boring.

Why does a hospital employ a registered nurse if it doesn't make use of her skills? Part-time nurses are left out and ignored, and although staff nurses are pleasant and polite, they exclude

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By Maja C. Anderson B.A., M.N. 305 pages, illustrated Soft cover. $5.15. *March 1968.*

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letters

(continued from page 4)

the part-time nurse from duties that would test her knowledge or judgement. I have often wanted to get involved in decision-making and the planning of patient care, but when I offer suggestions or another perspective on how things might be done, I am not treated as part of the team and, having little status, I am politely ignored.

Could this be part of the reason why married nurses prefer to stay at home, rather than seek work? Have they felt as lonely and left-out as I have? Each week I hope for greater involvement and for greater demands being made of me, but I wonder if I will ever feel useful and challenged again.

Although my main function is that of homemaker and mother, I am still a well-qualified registered nurse. Why can't hospitals utilize their part-time RNs more effectively? Then, at the end of the day, we might feel more productive and less like manual laborers. — *R.N., Quebec.*

Visitors express appreciation

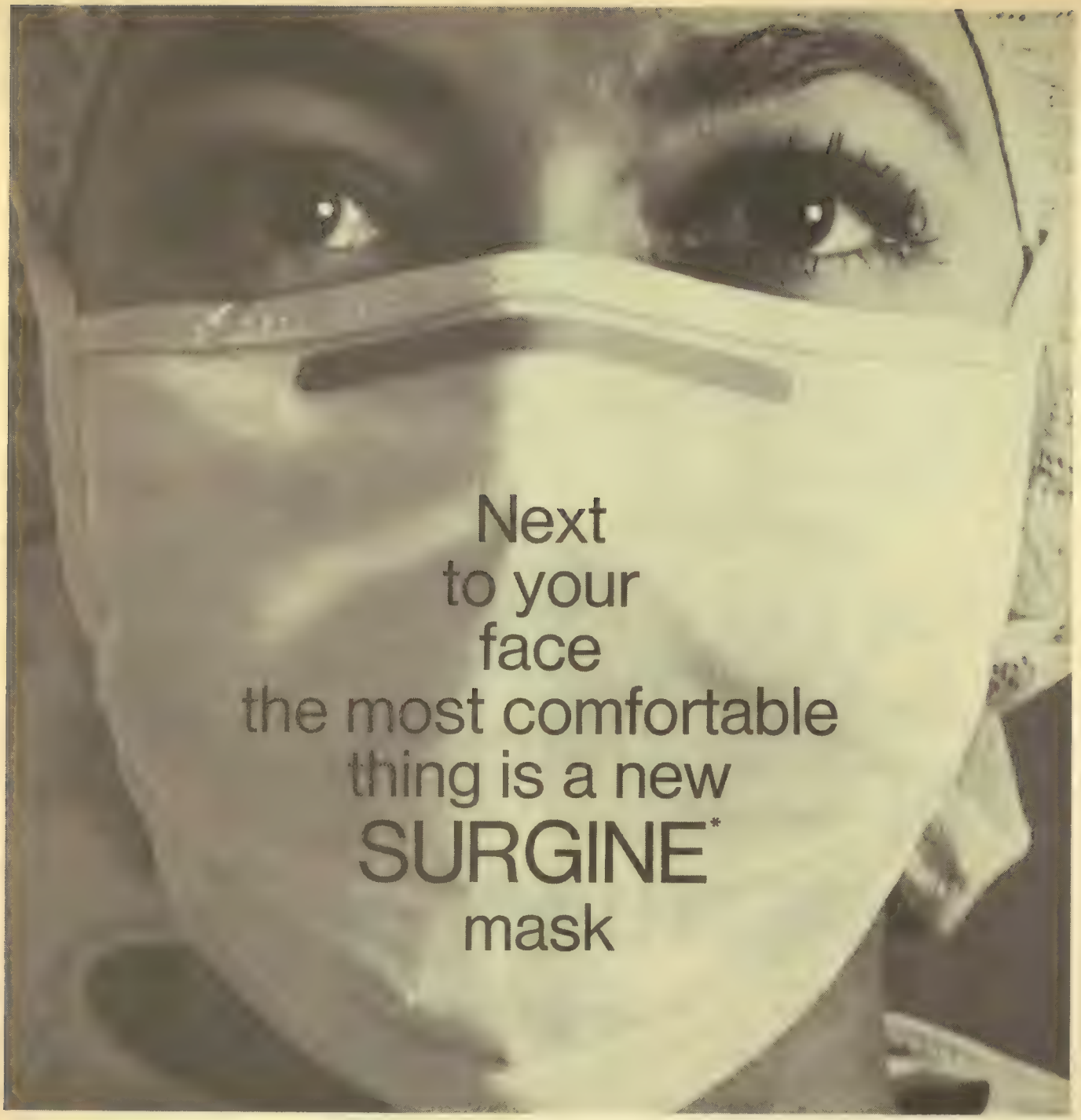
In the fall semester of 1969 I corresponded with the directors of integrated baccalaureate nursing programs in Canada, and during the past January and early February I had the opportunity to visit 15 of the schools to learn more about their programs.

I wish to acknowledge through *The Canadian Nurse,* my appreciation for the way in which I was received at each of these Canadian universities. The many personal courtesies extended to me by directors and faculty remain in my memory of you as a truly gracious people.

Even though I have expressed my gratitude along the way, I salute each of you for the professional leadership you have given and continue to give in your country and ultimately to all nurses. — *Sister Mary Beata Buaman, Dean, School of Nursing, University of San Francisco, California.*

I was delighted to receive a copy of the June issue of *The Canadian Nurse.* The editorial on doctor-assistants and various other articles were almost follow-up information on subjects I had discussed with nurses while in Canada.

I have requested that our department of health arrange for me to receive *The Canadian Nurse* regularly. — *Winnifred M. Ride, Melbourne, Australia.* □



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news

Salary Levels Of Ontario Hospital Workers Under Fire

Ottawa — Application of the Ontario equal pay act in a recent Toronto court case has disclosed wage differences between two groups of hospital workers in the province.

Registered nursing assistants are paid an average of $50 a month less than male orderlies, whose job requires less training and responsibility.

Al Hearn, second vice-president of the Service Employees International Union, said his understanding of the problem was mainly a lack of organized bargaining.

Disclaiming a Canadian Press story which quoted him as exhorting nurses to, "get out and fight for higher wages," Mr. Hearn said, "Nurses should collectively bargain through their provincial registered nurses associations, similarly to what is being done by bargaining units in some provincial hospitals in Ontario."

The wage situation was brought to light following a court order which granted female nursing aides at Toronto's Greenacres Home for the Aged equal pay with male orderlies. Grounds for the decision were based on requirements for both jobs involving the same skill, effort, and responsibility, even though not identical. The equal pay increase brought female nursing aides above the registered nursing assistants.

Speaking for workers in about 80 of the provinces unionized hospitals, Al Hearn said the SEIU is working hard to eliminate wage disparities. He was concerned that wages of registered nurses, the highest paid female hospital employee, remained low, eliminating the possibility of raising workers on lower rungs of the wage scale.

By asking hospitals to increase salaries of registered nursing assistants, to at least the same level as male orderlies, we invite an argument from hospitals," said Mr. Hearn.

According to the union official, hospitals say they can hire a registered nurse for the same price as a male orderly. (The minimum salary for beginning R.N.s is often within the range of the maximum salary for an orderly.)

Duties of the nursing assistant and the male orderly differ in responsibility, educational requirements, and training.

The nursing assistant takes a 35 week course approved by the College of Nurses, and in Ontario is required to have a minimum grade 10 education. An orderly is trained on the job, and must have a minimum grade 9.

Bedside care, involving lifting and clothing patients is part of each job, but the duties of the registered nursing assistant call for more nursing skills, such as changing dressings and reporting observations to the RN regarding a change in the patient's condition.

As Ontario's equal pay for equal work act requires job comparisons to be based on similar work, the registered nursing assistant is in a dilemma, says John Scott, an administrator in the provincial employment standards branch.

Since the two jobs are only partially similar, and there is no other hospital position with which to make a comparison, little can be done under the act to regulate the pay inequality.

The CP story cites M.E. Howard, director of the Ontario employment standards branch, as saying " . . .there is no legal way the province can force the hospitals to give this group of women workers equal pay."

Although Mr. Howard was not available when *The Canadian Nurse* contacted his office, an official said it was quite true — until a similar job comparison can be made, the registered nursing assistant wage disparity would remain unsolved.

NBARN Bargaining Council Acts For Hospital Nurses

Fredericton — Approximately 2,300 nurses employed in New Brunswick public hospitals now have the right to negotiate wage demands and working conditions. They have decided to fight for employment changes through the NBARN Provincial Collective Bargaining Council.

The council applied for certification to the Public Service Labor Relations Board last February and was accepted as the nurses' official agent in June. Certification came after agreement on the exclusion of 85 persons employed in managerial and confidential positions — directors of nursing and associate directors of nursing.

Notice to bargain for the hospital nurses' 1970 contract was served to the provincial treasury board June 25. Both parties met for the first time at the bargaining table on August 11. At press time, *The Canadian Nurse* had not received notification of any progress; but the discussions were expected to cover several areas of work conditions.

The NBARN Provincial Collective Bargaining Council won the right to represent another group of nurses last May. Contract proposals to be worked out for these 150 nurses, employed in civil service positions, were presented to the provincial treasury board July 9. A representative of NBARN reported that a second meeting, scheduled for July 31, would bring out the board's counter-proposals. Results from this meeting had not been released at press time.

In a CBC labor talk last July, Dick Wilbur of Halifax, Nova Scotia, aired his views on the New Brunswick labor situation, citing nurses in that province as an example of new-found bargaining freedom.

His opening comments depicted the apparent tranquil labor scene in New

Two well-known nurses in Prince Edward Island were given honorary membership in the provincial association during the 49th annual meeting of the ANPEI. *(Left to right)* Mary Bradshaw read the citation honoring Fidessa Reeves 23 years as staff nurse and supervisor at the Prince County Hospital, Summerside. Katharine MacLennan, director of nursing at the provincial sanatorium, and psychiatric nursing at Hillsborough Hospital was introduced by Laura Kitchen.

Brunswick as " a serious and at times an angry struggle," and compared it with the national postal tug-of-war. "All that's lacking," he complained of the New Brunswick labor situation, "is the publicity."

"Throughout New Brunswick's growing army of public employees, an all-out effort is being made to win the right to bargain for various groups."

He referred to the New Brunswick nurses as in an advanced stage of negotiations with the provincial treasury board. But did not state what the nurses were seeking in new contracts.

New Brunswick nurses won Mr. Wilbur's admiration for stepping out on their own and appointing the NBARN Provincial Collective Bargaining Council as their certified bargaining agent. He "heartily endorsed" the nurses' action. "It indicates that at long last nurses are determined to improve their own lot themselves — to fight doctors and hospital administrators for decent working conditions in keeping with their professional status."

Expressing his disapproval of opposition from the combined forces of hospital administrators and provincial treasury board officials, Mr. Wilbur said the nurses face an "even greater hurdle." He referred to a "mental rigidity, almost a knowledge vacuum, on the part of management and most government negotiators."

Slamming the government of Premier Louis Robichaud for not adhering to a "much heralded equal opportunity slogan," Mr. Wilbur compared wages of liquor store warehousemen with a temporary consultant for the provincial welfare department. He cited the consultant's wage as $120 a day and the top wage for warehousemen as $330. a month.

According to Dick Wilbur, it will be many years before the salary gap among government employees in New Brunswick is narrowed.

The labor-scene broadcaster did hand Premier Robichaud one bouquet — "the government took one giant step forward when it passed its Labor Relations Act." But he took some of the glorified perfume from the bouquet when he added, "... in the meantime, the government side of the bargaining table, composed mostly of well-paid lawyers with little experience in collective bargaining, is learning what labor relations are all about."

Study Issues, ANPEI President Asks Members

Charlottetown, P.E.I. — Nurses attending the 49th annual meeting of the Association of Nurses of Prince Edward Island, last May, were asked by President Bernice Rowland to form their own opinions on news items.

Miss Rowland spoke to the 118 nurses and 55 student nurses on a one-word theme *Contradictions*. "With the apparent contradictory statements being issued regarding news items, it is essential for people to study thoughtfully issues in any organization... to reach the goals set by the particular group," she said.

In a report to the general membership, executive secretary, Helen C. Bolger, spoke of the progressive educational program planned by the director and faculty of the new Prince Edward Island School of Nursing. She expressed concern that many qualified candidates for schools of nursing cannot be accommodated on the island.

"The new school admits about the same number of students as the three island schools combined... but still many young aspirants are turned away. We are hopeful that facilities will be made available in the near future to meet the needs of young people on the island in the educational field of their choice," she said.

Associate Executive Director of the Canadian Nurses' Association, Lillian E. Pettigrew, spoke at a luncheon meeting on the philosophy and role of a professional association.

"By public acclaim and by the efforts of practitioners, nursing has become a profession in modern society," Miss Pettigrew told her audience.

The eternal thrust of the nursing association must be toward "improved competence in the delivery of nursing care," she said.

Miss Pettigrew said her concept of the word *profession* is anchored to the

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(Continued from page 10)

exercised by the professional person cannot be standardized, she said, and cannot be regulated effectively by an authority outside of the person. To this comment she added,"... herein lies the word *judgment*. The kind of judgment ultimate responsibility of the real professional."

Two well-known nurses on the island were presented with honorary memberships. Katherine MacLennan is director of nursing at the provincial sanatorium, and nursing education in psychiatric nursing at Hillsborough Hospital. Fidessa Reeves has served as staff nurse and supervisor for 23 years at the Prince County Hospital, Summerside.

Two of the principal resolutions presented by Margaret Aiken, chairman of the committee on resolutions, presented the members' feelings on psychiatric nursing.

The first asked that, "Psychiatric nursing be included as an area of instruction and experience for all students of nursing, effective September 1970." The second covered registration examinations asking that, "Psychiatric nursing be a required registration examination for all candidates, ...effective January 1, 1972".

Another resolution supported the Canadian Nurses' Foundation by a voluntary donation of one dollar for each member annually; and others asked that new members of the ANPEI council be given orientation sessions on the functions and activities of the association; that emphasis is given to improving communication between the provincial association and district branches; that new members from other provinces are welcomed to the P.E.I. association by nurses in the community and invited to meetings; and that district presidents be invited to council meetings as observers.

New officers were announced: Constance Corbett, president; Ella MacLeod, president-elect; Beth Robinson, vice-president, and Flora Dickinson, Sylvia Mulligan, Mary Graham, Marion Chapman, and Norma Bowness, council members.

British RCN Requests Review Of Abortion Act

The new abortion act in Britain is causing nurses concern. They charge the increase in abortions in some British hospital has added pressure to an already short-staffed nursing service and has delayed admitting seriously ill patients needing immediate treatment.

According to a recent news release from the Royal College of Nursing in London, the added work pressure has had "adverse effect on staff morale."

In a letter to Sir Keith Joseph, secretary of state for social services, the RCN made an urgent request for a "review of the workings of the abortion act, and, in particular, the manner in which it is being interpreted."

The release states British nurses have expressed unhappiness about the in-

crease in abortions carried out in some hospitals.

General secretary of the RCN, Catherine M. Hall, stated that"... if this situation continues it could have an effect not only on the willingness of nurses to take appointments in operating theatres where large numbers of abortions are performed and in gynecological wards in which these patients are nursed, but in the long term recruitment to the nursing profession."

Serious concern for the interpretation of the abortion act, which was effective in 1968, was shown by the RCN a year ago, when a representative body carried a resolution calling for an enquiry. Action was deferred because facts and figures supporting the RCN beliefs were not available. Consultation with the British Medical Association and findings of an enquiry by the Royal College of Obstetricians and Gynecologists, later supported the RCN cause.

The release states that the RCN would support a nurse who decides to "opt out" of nursing duties authorized by the act to which she has a conscientious objection.

But the RCN made it quite clear that this support would only be given if the nurse acted "responsibly and gave adequate notice to her matron, so that other arrangements could be made for staffing the operating theaters."

A conscience clause in the act frees a person from any duty to participate in treatment authorized by the act to which he has a conscientious objection. But as a safeguard for the public, the clause cannot relieve a person from "any duty to participate in treatment which is necessary to save life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."

Alluding to publicity given to the actions of theater nurses in one hospital, the release states it would "be wrong to think that the actions of these nurses represent an isolated situation." An explanation of the nurses' action is not given, but an extract from the RCN letter to the secretary of state for social services, gives some enlightment: "The findings of the Royal College of Obstetricians and Gynaecologists bear out the growing unhappiness of nurses about the extent to which abortions are being carried out in some places."

Reaction by the British government to the RCN letter is not stated in the release.

Lack Of Health Manpower Acute In Developing Countries

Geneva, Switzerland — Delegates from a number of African countries speaking last May at the 23rd World Health Assembly, commented on a common chronic shortage of health personnel.

The representative from Rwanda spoke of the need to adapt all health plans and educational programs to the particular problems of these countries concerned. Rwanda, with a population of 3.5 million, had only 20 native born physicians educated in the country by 1969.

The Cameroon delegate stressed his government's desire to discard old-fashioned university programs that are unsuited to developing countries and to Africa in particular; where general practitioners and a form of health services are needed, if they are to meet the growing demand for them. African doctors should be trained in Africa, the speaker said.

The delegate from Malawi pointed out the serious medical manpower shortage in his country, which is entirely agricultural. For a population of over 4 million, there is only one doctor for 58,000 people.

Expensive medical treatment absorbs a large part of Gabon's available means, profiting only a limited number of people, to the disadvantage of preventive services that benefit the majority of the population, said the Gabon delegate. He listed the first needs as research on questions of fertility, health education, and teaching elementary medicine within the framework of maternal and child health. Later it would be necessary to strike a balance between preventive and curative medicine, he added.

According to the speaker, preventive medicine should be equipped to deal with endemic diseases such as malaria, parasitic diseases, tuberculosis, and leprosy.

news

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The delegate for Chad pointed out the severe lack of qualified health workers in his country: 60 physicians for a population of 4 million. Of these 60, three were native born, he said.

Federal Team Studies Nursing In The North

Ottawa — A study of the clinical training needs for nurses in the North is underway.

Two teams of medical and nursing experts flew north July 29, announced national health and welfare minister, John Munro. The doctor-nurse teams examined problems which occur when nurses have to take on responsibilities ordinarily borne by doctors.

According to a departmental news release, the teams will act as an advisory committee, to design a clinical program for departmental nurses working with Indians and Eskimos in isolated areas of Canada. The group will "prepare a report and recommendations for establishing a new kind of formal training program to qualify nurses in certain kinds of clinical work to meet the medical needs of their communities."

The department is responsible for 144 nursing positions and 194 health positions at stations scattered throughout the North and in the Territories.

Dr. Dorothy J. Kergin, director of McMaster University's school of nursing, and chairman of the Canadian Nurses' Association ad hoc committee; Anne Wieler, department of national health and welfare; Dr. K. O. Wylie, University of Manitoba; and Dr. W.D. Dauphinee, Royal Victoria Hospital, Montreal, visited northern Manitoba stations, going into areas such as Norway House and Nelson House, and the Territories.

The other team toured northern Quebec communities, going also into Cape Dorset and Frobisher Bay. In this team were : Huguette Labelle, director, Vanier School of Nursing and 2nd vice-president of the CNA; Pauline Laurier, department of national health and welfare; Dr. Fernand Hould, Laval Uni-

versity, Quebec; and Dr. James J. Wiley, University of Ottawa.

Final report of the committee's findings and recommendations is expected to be submitted to the minister by the end of October.

Federal Grant Aids Nursing Practice Research

Ottawa — Financial support by the federal government will aid a national conference on research in nursing practice.

Announcement of the $4,700 grant to the University of British Columbia was approved by national health and welfare minister, John Munro, last July.

Tentative dates for the conference, to be held in Ottawa, have been set as February 16-18, 1971. Project director will be Dr. Floris E. King, associate professor and coordinator of the graduate program at the school of nursing. University of British Columbia.

Goals for the meeting are the establishment of a coordinated program of studies, and improved channels of communication to provide new and better use of nursing manpower.

St. John's Bursaries Awarded To Nurses

Ottawa — Fourteen 1970 nursing awards from two St. John Ambulance Bursaries were announced recently by national headquarters.

Established 10 years ago in memory of Lady Mountbatten, Superintendent-in-Chief of the Commonwealth St. John Ambulance Brigade, 1941-1960, the Countess of Mountbatten Bursary Fund granted awards to finance post-basic, student, and continuing aid for nursing studies.

The memory of Margaret MacLaren, Superintendent-in-Chief, St. John Ambulance Brigade in Canada, 1946-1963, is honored in a bursary fund established under her name in 1964. Two awards for master's degrees were made from the Margaret MacLaren bursary.

Both funds have a similar aim : to provide financial assistance to Canadians entering or advancing in the nursing profession.

Financial support is drawn from members and friends of the brigade in Canada.

Countess Mountbatten Bursary (post-basic : Barbara Ann Wilson, Camrose, Alberta, bachelor of science, nursing, University of Alberta; Lorraine Lucas, Montreal, Quebec, bachelor of nursing, McGill University.

Countess Mountbatten Bursary (student) : Ruth Rogers, Moncton, New Brunswick, St. John Brigade Crusader, bachelor of nursing, University of New Brunswick, Fredericton, New Brunswick; Ruth Matheson, Sydney, Nova Scotia, St. John Brigade Crusader, 2-year course, Victoria General Hospital, Halifax, Nova Scotia; Nicole Legault, Ottawa, Ontario, St. John Brigade Crusader, Ottawa Civic Hospital, student nurse, Ottawa, Ontario; Gertrude E.A. Erickson, Saskatoon, Saskatchewan, St. John Brigade Crusader, University of Saskatchewan, bachelor of nursing science; Denise Lapensee, Ottawa, Ontario, St. John Brigade Crusader, Ottawa Civic Hospital, student nurse, Ottawa, Ontario; Eileen Neighbour, Clarkson, Ontario, Quo

A friendly exchange of ideas at a seminar for directors of nursing service, held by national health and welfare, division of hospital insurance. (Left to right) Dr. R.A. Armstrong, director, division of medical care, health insurance and resources branch; Margaret D. McLean, senior consultant, hospital insurance and diagnostic services; Huguette Labelle, director of nursing education, Vanier School of Nursing, Ottawa; and Dr. R.B. Goyette, director of hospital insurance and diagnostic services.

Vadis School of Nursing, New Toronto, 2-year training program; Julia Gordon, Ottawa, Ontario, bachelor of science, nursing, University of Ottawa; Sadie E. Barkhouse, Birch Cove, Halifax, Nova Scotia, Dalhousie school of nursing, bachelor of nursing.

Countess Mountbatten Bursary (continuing aid) : Heather Lewis, Pointe-Claire, Quebec, bachelor of nursing, psydiatric nursing, McGill University, Montreal, Quebec; Brenda Hunter, Winnipeg, Manitoba, St. John Brigade Crusader, student nurse, Winnipeg General Hospital, Winnipeg, Manitoba.

Margaret MacLaren Bursary : Mona Margaret Williams, Toronto, Ontario, master's degree, nursing education, University of Western Ontario, London, Ontario; Patricia Marilyn Hay, St. John, New Brunswick, master's degree, nursing administration, of Alberta.

ANPO Sets Up Claire Gagnon Foundation

Ottawa — Nurses from district nine, Association of Nurses of the Province of Quebec, have organized a fund-raising project to honor the memory of Claire Gagnon-Mailhot, killed in the July 5 air crash outside Toronto.

Known as the Claire Gagnon Foundation, the fund has collected to date $8,000 to be used in nursing scholarships.

Contributions may be sent to District nine, Association of Nurses of the Province of Quebec, Box 92, Haute-Ville, Quebec 4.

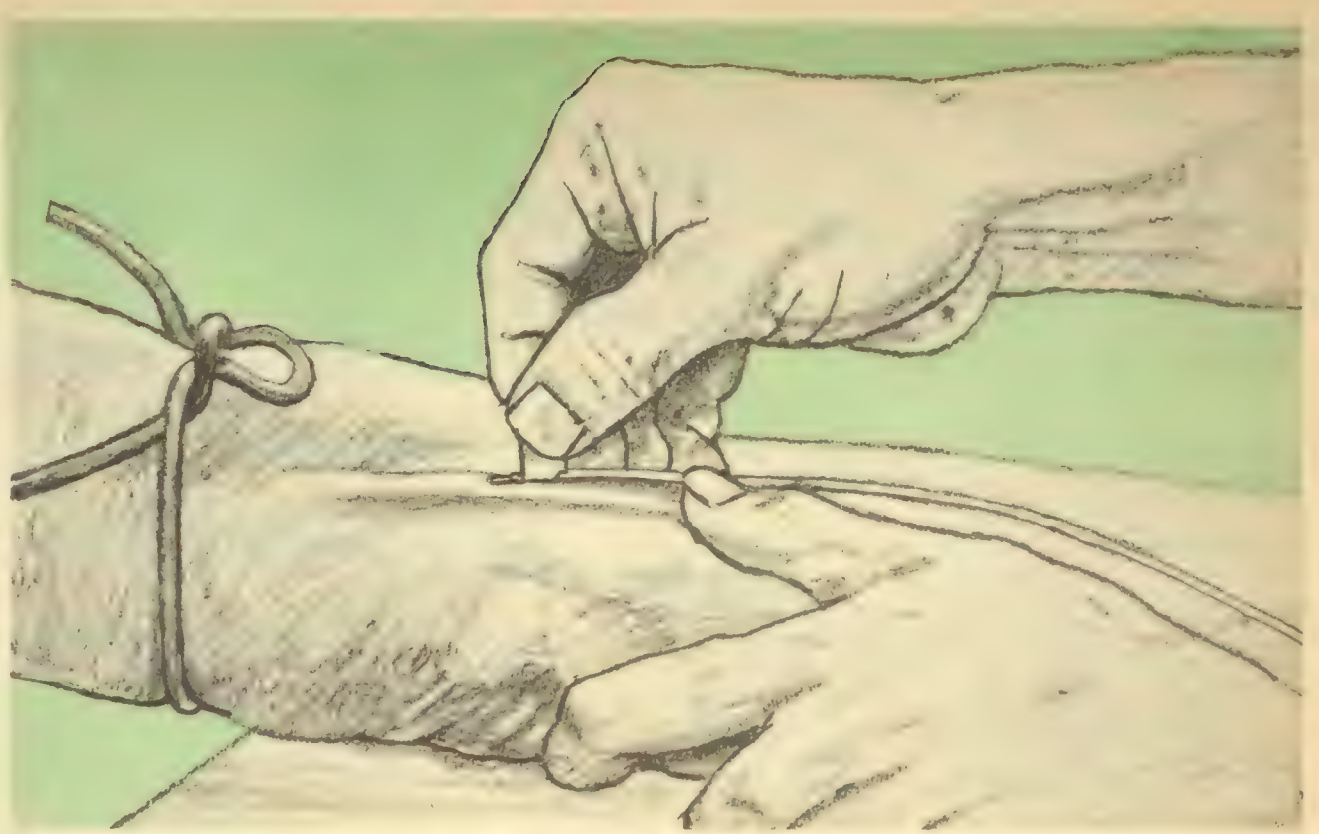
Internal Contraceptive Proves Successful In US Study

Chicago — Clinical data, reported at the American Medical Association Convention last June, showed the effectiveness of SAF-T-Coil, an intrauterine device. Its safety rating was stated as being unparalleled by any other contraceptive means — mechanical or biological.

The data summarized studies of 3,640 patients whose pregnancy prevention rates were as high as 99.7 percent, with removals of the intrauterine device for serious complications or infection, amounting to 0.2 percent.

New Nurse Member Makes CNF Donation

Ottawa — Following the 35th general meeting of the Canadian Nurses' Association in Fredericton last June, an anonymous member of the CNF made a $200 donation accompanied by this message: "I read with great interest the



Use Abbott's Butterfly Infusion Set in an adult arm?

Certainly. The fact is, today more Abbott "Butterfly Infusion Sets" are used in adult arms and hands, etc., than in infant scalps.

Good reason.

Abbott's Butterfly Infusion Set simplifies venipuncture in difficult patients. It has proved fine in squirming infants. But it has proved equally helpful in restless adults, and in oldsters with fragile, rolling veins. And, once in place, the small needle, ultraflexible tubing, and stabilizing wings tend to prevent needle movement, and to avoid vascular damage.

Folding Butterfly Wings

The Butterfly wings are flexible. Like a butterfly. They fold upward for easy grasping. They let you manoeuver the needle with great accuracy, even when the needle shaft is held flat against the skin.

Then, once the needle is inserted, the wings spread flat. They conform to the skin. They provide a stable anchorage for taping. The needle can be immobilized so securely and so flat to the skin that there is little hazard of a fretful patient dislodging or moving it.

Five Peel-Pack Sets

To accommodate patients of various ages, Abbott supplies Butterfly Infusion Sets in 5 sizes. Four provide thinwall (extra-capacity) needles. The Butterfly-25, -23, -21 and -19 come with a small-lumen vinyl tubing. The 16-gauge size, however, provides tubing of proportionately enlarged capacity, and thus is particularly suited to mass blood or solution infusions in surgery.

The sets are supplied in sterile "peel-pack" envelopes. Just peel the envelope apart. Drop the set onto a sterile tray—it's ready for use in any sterile area. Your Abbott Man will gladly give you material for evaluation. Or write to Abbott Laboratories, Box 6150, Montreal, Quebec.

ABBOTT

Abbott's Butterfly

Infusion Set

435Y

news

(continued from page 16)

detailed reports of the activities of the Canadian Nurses' Foundation.

"Knowing that the two dollar annual membership fee is too little to enable the foundation to reach its commendable goals, I enclose this cheque... . I know it is not very much but I hope it will encourage others to make the same gesture."

Quebec Inservice Education Seminar Assists Nursing Care

Montreal — The committee on nursing service, Association of Nurses of the Province of Quebec, chose Mont Gabriel in the Laurentian Hills just north of Montreal as the setting for a three-day workshop last March.

Improving nursing care through inservice education was the theme, planned to provide a strong program on education. Resource people, led by Dr. Malcolm Knowles, professor of education, Boston University, were Mary Buzzell, assistant professor, school of nursing, Western University; Mona Callin, lecturer in nursing, school for graduate nurses, McGill University; and Eileen Strike, associate director of nursing service, The Montreal General Hospital, co-chairman of the committee on nursing service. Miss Strike and Margaret Wheeler, assistant secretary, ANPQ, committee on nursing service, were the organizers of the three-day session.

Ninety nurses attended from all levels of the profession. From staff nurses to directors of nursing, and from inservice departments, the VON, and UNM, and one male nurse.

Dr. Knowles spoke on pedagogy and andragogy, presenting several concepts concerning adult education. Androgogy, derived from the Greek stem *andr* meaning *man* or *grownup*, formed the basis for the sessions.

"Adults learn differently from children," said Dr. Knowles. "Adults have a strong concept of self-direction, they desire to learn to satisfy immediate needs, whereas children learn for the future. The self-concept of the adult as an independent person causes him to resent ideas being imposed on him."

The doctor felt, "...the climate of most learning situations is an adult one, where the learner participates in diagnosing his own needs and is involved in the planning process of learning."

"Adults have also accumulated more experience than children. This affects the learning process and is the richest resource of the adult learner."

Dr. Knowles proposed changes that must take place in adult education. The Mont Gabriel workshop, he said, is an illustration of the techniques of andragogy, flourished by the enthusiasm of those present.

Participation was the keynote of the sessions. Although the basic topic was set and outlines of the program for the first day prepared, the structure of the workshop for the remaining two days emanated from the participants and resource persons. It was a "get-together" of ideas in a "fun" manner.

Different techniques of adult learning were demonstrated in the discussion groups : x *fishbowl technique,* illustrating group dynamics; role-playing; listening exercices; and a three-way interview with one person acting as an observer of the interviewer. Small group projects were also helpful.

An evaluation followed the workshop. It revealed appreciation for and an understanding of andragogy, and its difference from pedagogy and the realization of the need to use this new technology as part of education. Particular mention was made by the delegates of the climate setting, group dynamics, communication skills, and *feedback*.

Many of those attending the seminar felt a benefit when they returned to work. They mentioned a more flexible attitude, a new self-confidence, and an increased trust in the individual as a contributing member of the group. Many used techniques they experienced at the workshop.

Future workshops suggested includ-

(continued on page 20)

Notice

Changes of name and address that have been forwarded by the Post Office to the *CNJ* Circulation Department have proven unreliable in recent months and therefore will no longer be accepted. In future, only changes signed by the member or subscriber will be processed.

Build Your Students' Knowledge of Nursing Concepts

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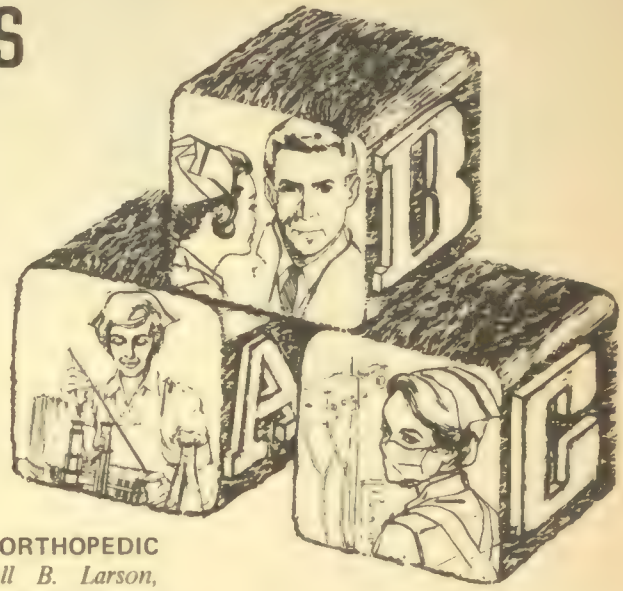

New 5th Edition! **PSYCHIATRIC NURSING.** *By Ruth V. Matheney, R.N., Ed.D., and Mary Topalis, R.N., Ed.D.* Consistently popular text on modern psychiatric nursing care stresses development of interpersonal skills for the nurse. Timely sections focus on crisis intervention, drug addiction, psychopathology, chemotherapy, and children's emotional problems. Primarily a guide to care of the hospitalized mentally ill, it also depicts care of patients in varied psychiatric settings. Helpful glossary, appendix and updated bibliography are valuable student aids. March, 1970. 359 pages, 33 illustrations. $6.90.

New 5th Edition! **NEUROLOGICAL AND NEUROSURGICAL NURSING.** *By Esta Carini, R.N., Ph.D.; and Guy Owens, M.D.* This is the most frequently used text in this challenging field. It clearly presents scientific principles and special nursing procedures, stressing the need for individualized care. Helpful guidelines explain how to alleviate patient fears. Contents include timely data on the blood-brain barrier, brain scan, stereotaxic surgery, botulism, rabies and tetanus. January, 1970. 398 pages, 122 illustrations. $10.85.

New 7th Edition! **ORTHOPEDIC NURSING.** *By Carroll B. Larson, M.D., F.A.C.S., and Marjorie Gould, R.N., B.S., M.S.* Give your students a comprehensive knowledge of orthopedic care with the most widely used text in this field! Helpful sections outline effective methods of care for the cast patient, traction patient, and orthopedic surgery patient. Fresh facts on rehabilitative care include strokes, body mechanics and range of motion, bed positioning and prevention of deformities. February, 1970. 486 pages, 377 illustrations. $10.45.

A New Book! **ORTHOPEDIC NURSING: A Programmed Approach.** *By Nancy A. Brunner, R.N., B.Sc.* Self-help manual emphasizes care of surgical orthopedic patient, yet includes material on non-surgical care. Helpful sections outline indications for treatment, current methods, and expected patient responses. Students learn the need for traction and its basic forms; also how to adapt their knowledge of body mechanics to orthopedic care. An excellent self-teaching aid; a lucid supplement to larger, more detailed texts. September, 1970. 181 pages, 126 illustrations. About $6.35.

New 4th Edition! **PRACTICAL NURSING: A Textbook for Students and Graduates.** *By Dorothy Rapier, R.N., B.S., M.S.; Marianna Koch, R.N., B.S.; Lois Moran, A.B.; J. R. Geronsin, R.N.; and Geraldine Phelps, A.A., R.N., B.S., M.S.* Comprehensive new edition of this widely adopted text encompasses all material the LPN must master to function effectively. Opening sections discuss her expanding role in hospital, clinic and home care, and offer helpful chapters on legal problems and vocational aspects. Revisions include new illustrations, new procedures, new drugs! September, 1970. Approx. 640 pages, 197 illustrations. About $8.80.

New 3rd Edition! **INTEGRATED BASIC SCIENCE.** *By Stewart M. Brooks, M.S.* Unique timesaving text integrates physics, chemistry, microbiology, anatomy and physiology. Fundamental concepts, laws and theories are presented first; discussions of the various body systems then apply these principles to practice. This edition features a new chapter on genetics, 316 lucid illustrations. Italics spotlight key terms. April, 1970. 522 pages, 316 illustrations. $11.00.

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Congratulations, and the flowers are lovely! The new president of the Canadian Nurses' Association, Louise E. Miner, wearing her chain of office, greets Marguerite E. Schumacher, president-elect, following the sessions at the 35th general meeting in Fredericton, New Brunswick, last June.

ed : practice in techniques of andragogy; team nursing; interdepartmental workshop on the technology of andragogy; evaluation of the relationship between inservice education and the quality of patient-care; and an evaluation process.

Newfoundland Nurses Reject Government Wage offer

Ottawa — An across-the-board offer of a $45 monthly salary increase was rejected by the Association of Registered Nurses' of Newfoundland last May. In a Canadian Press story at that time, the association was reported to have reaffirmed its demand for $100 a month.

Nurses in Newfoundland now earn a maximum of $420 a month. They asked for a $100 increase last January.

Association lawyer, Robert Wells of St. John's, told the association that provincial health minister, Ed Roberts, had agreed to discuss overtime pay and fringe benefits when the nurses appointed an official body to represent them in negotiations. A resolution passed in May appointed the association as the negotiating body, representing the nurses on wage demands.

As part of a pay offer to Newfoundland government employees, the proposed salary increase was accepted by non-professional hospital employees in western and central Newfoundland last May. The employees had threatened strike action to back up their wage demands.

No further news at press time had been received by *The Canadian Nurse* on labor demands by the nurses.

Summer Help For Nurses in the North

Ottawa — The University of Alberta School of Nursing extended its contract with the department of national health and welfare this year to include nursing students in a health program provided for northern regions of Canada.

Nine nurses from the school of nursing, University of Alberta, spent three to four months in nursing stations or hospitals in the North. Five of the nurses were graduates of the four-year degree program. The other four are enrolled in the post-basic degree program for registered nurses.

The number of registered nurses selected for northern duties is determined by the federal department, and depends on the number of replacements required for the summer.

An evaluation of the northern nursing program will be made following this first experience for summer replacements.

Seven of the nurses came from western Canada, one from England, and another from New Zealand.

Joan F. Aman, Diane E. Grout, Diane B. Hicks, Patricia A. Porterfield, all from Edmonton, were posted to Gjoa Haven Nursing Station, Copper Mine and Cambridge Bay, Igvolik and Frobisher Bay, and Inuvick respectively; Maureen Butler, from York, England, went to Tuktoyaktuk; Isabell A. Dixon, from Calgary, was posted to Inuvik; Mary P. McGee, from Jarvie, Alberta to Rankin Inlet; Mary A. McLees, from New Zealand to Broughton Island and Cape Dorset; and Lorraine E. Warwick, from Oyen, Alberta, to Inuvik.

Some of the nurses did general nursing on wards in hospitals, and those with public health training and/or experience were posted to nursing stations where they did clinical nursing, public health nursing, and treatment; their experience included treatment clinics of various types. For more serious cases they were in telephone or radio communication with doctors on the "outside". They also assisted the regular department of national health and welfare nurses.

names

Eleanor S. Graham (R.N., Vancouver General H. School of Nursing, Vancouver; B.A. Sc. in public health nursing, U. of British Columbia; M.Sc., in supervision and administration, public health nursing, U. of Chicago, Illinois) retired in August from her position as executive director of the Registered Nurses' Association of British Columbia.

Miss Graham has had a wide and varied career in Canada and Asia. She was supervisor of the Cowichan health unit; senior nurse, Prince Rupert health unit; nurse-in-charge of the Powell River health unit, all in British Columbia; second assistant superintendent, Victorian Order of Nurses for Canada; health instructor for the Metropolitan School of Nursing, Windsor, Ontario; director of nursing, Royal Columbian Hospital, New Westminster, B.C.; and regional nursing advisor for the World Health Organization South East Asia region, New Delhi, India.

Miss Graham has been with RNABC for 11 years. She began as assistant executive secretary, later becoming executive secretary. Her title was changed to executive director at the 1969 annual meeting of the association.

Margaret F. Myles, a leading authority on midwifery is giving 20 talks on midwifery, including pre- and postnatal care, during her visit to Canada in September and October.

Mrs. Myles left her home in Aberdeen, Scotland, June 5, on a world lecture tour that has included South Africa, Australia, New Zealand, Fiji, Honolulu, and San Francisco.

She arrives in Vancouver on September 16, and following a private visit to Victoria, Mrs. Myles will return to Vancouver on September 20 for two speaking engagements. She will visit Creston, British Columbia, September 23-26, and on 27, leave for Whitehorse, Inuvik, and Yellowknife, where she will stay until October 10.

Mrs. Myles concludes her tour with a visit to students in the advanced practical obstetrics program at the University of Alberta School of Nursing, Edmonton, October 10-14.

Mrs. Myles is a graduate of Yorkton Hospital School of Nursing in Saskatchewan, and has held several nursing and teaching posts in Canada and the United States. She was principal midwife tutor for 14 years at the Simpson Memorial Maternity Pavilion, Royal Infirmary, Edinburgh, Scotland, and retired in 1952. Mrs. Myles established the first school of midwifery in Ethiopia and visited that country's hospitals for the World Health Organization in 1959.

She is author of the well-known book, *Textbook for Midwives,* which is to be published in its seventh edition.

McMaster University, Hamilton, Ontario, has announced four appointments to its school of nursing. **Myrtle A. Kutschke** (Reg.N., Victoria H. School of Nursing, London, Ontario; B.Sc. N., U. of Western Ontario; M.S., Boston U., Boston) has been appointed associate director of the school of nursing.

A 1964-65 Canadian Nurses Foundation scholar, Miss Kutschke began her teaching career as an instructor at the Calgary General Hospital, Calgary, Alberta. She was also assistant professor at the University of Toronto School of Nursing. Miss Kutschke's two previous appointments at McMaster were as a lecturer and an assistant professor.

Shirley Smale (Reg.N., Belleville General H., Belleville, Ontario; B.Sc.N., Case Western Reserve U., Cleveland, Ohio; M.P.H., U. of Michigan) has been appointed an assistant professor at McMaster School of Nursing. Miss Smale will be responsible for teaching public health nursing.

Prior to this appointment Miss Smale was a nurse practitioner with the McMaster University department of family medicine, and a clinical associate on the school of nursing faculty. She was maternal-child health nursing consultant with the Wisconsin Division of Health in 1967-68, and supervisor of public health nursing, Yakima County Health District, Washington State, 1964-67.

Susan E. Perry (R.N., Victoria Public H., Halifax, Nova Scotia; B.N., McGill U., Montreal; M.S., Boston U., Boston) has been appointed an assistant professor, with responsibilities in psychiatric nursing and the integration of mental health concepts in all four years of the bachelor of nursing science program.

Miss Perry has been a staff and a head nurse at the Victoria General Hospital, Halifax; a clinical instructor at Allan Memorial Institute, Montreal; and a lecturer in psychiatric nursing, McGill School for Graduate Nurses.

Dorothy McClure (Reg.N., Victoria H. School of Nursing, London, Ontario; B.Sc.N., U. of Western Ontario; M.S., Boston U., Boston) has been appointed an assistant professor at the school of nursing. She will be responsible for supervision of the medical-surgical program.

Miss McClure's nursing experience includes: seven years as a general staff nurse at the Victoria Hospital, London, Ontario, Sunnybrook Hospital, Toronto, and Westminster Hospital, London, Ontario: and two years as a staff nurse with the North Atlantic Treaty Organization/Royal Canadian Air Force in France. She was a public health nurse for four years and a teacher at the Hamilton Civic Hospitals School of Nursing.

Esther A.D. Janzow (Reg.N., Royal Columbian H., New Westminster, B.C.; dipl. in teaching and supervision, U. of B.C.; B.Sc.N., U. of B.C.; M.A., U. of Washington, Seattle) has been appointed director of nurses' training at Vancouver City College, Vancouver, British Columbia.

Miss Janzow served as a general duty nurse at the Vernon Jubilee Hospital, Vernon, B.C., and as a ward supervisor and acting matron at the same hospital. She was an operating room nurse at the Medicine Hat General Hospital, Medicine Hat, Alberta, and assistant director of nursing at the Royal Columbian Hospital, New Westminster, B.C. After

names

a year of private duty nursing in Victoria, B.C., Miss Janzow joined the Victorian Order of Nurses as a staff nurse and later as a rehabilitation consultant in Victoria. She was rehabilitation consultant to the Greater Toronto Branch, Victorian Order of Nurses until 1968.

E. Marie Sewell (Reg.N., Wellesley School of Nursing, Toronto, Ontario; B.N., School for Graduate Nurses, McGill U., Montreal, Quebec) has been appointed director of nursing, New Mount Sinai Hospital, Toronto. Previous to this appointment, she was assistant director, nursing education from 1955-1970.

A past president of the Registered Nurses' Association of Ontario, Miss Sewell also served on the Ad Hoc Committee on Legislation and on the Ad Hoc Committee to study function, structure, and relationship of the Canadian Nurses' Association. She was a short-term consultant to South East Asia region for the World Health Organization in 1967.

Dorothy M. Morgan (Reg.N., Victoria H. School of Nursing, London, Ontario; B.A., U. of Western, London, Ont.; B.S., McGill U., Montreal; M.B.A., U. of Chicago) has retired after four years of service as director of nursing, Victoria Hospital, London, Ontario.

Miss Morgan began her career at the Kingston General Hospital as assistant superintendent of nursing. She went on to serve in various administrative positions at St. Barnabas Hospital, Minneapolis, Minnesota, University of Chicago Hospitals, Chicago, Illinois, and University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania.

She is succeeded by Davis W. Corder, a graduate of the Stracathro Hospital and School of Nursing, Angus, Scotland, and of the University of Toronto course in hospital administration.

Sister Mary Winslow was made a life member of the New Brunswick Association of Registered Nurses' at the 54th annual meeting. Life memberships are awarded for outstanding contributions to nursing development in the province.

Sister Winslow entered the nursing profession in 1934 and is former director of nursing at the Hotel Dieu Hospital in Chatham, New Brunswick.

Alice J. Baumgart

Irene M. Buchan

The chairmen of three standing committees of the Canadian Nurses' Association, have been annonced.

Alice J. Baumgart (B.S.N., of British Columbia; M.A.Sc., McGill U., Montreal) has been appointed chairman of the committee on nursing education. A Canadian Nurses' Foundation scholar, Miss Baumgart is associate professor at the University of British Columbia School of Nursing. She is a contributor to *The Canadian Nurse* and has worked on various committees for the Registered Nurses' Association of British Columbia.

Irene M. Buchan (R.N., Galt School of Nursing, Lethbridge, Alberta; B.N., McGill U., Montreal) has been appointed chairman of the committee on nursing service, she is nursing consultant to the health insurance and resources branch, department of national health and welfare.

Miss Buchan is a 1965 Canadian Nurses' Foundation scholar and was the assistant director of a CNA project to evaluate the quality of nursing service.

Marilyn Brewer (R.N., B.Sc.N., U. of Toronto School of Nursing, Toronto) has been appointed chairman of the committee on social and economic welfare. Mrs. Brewer has been a general staff nurse at the New Mount Sinai Hospital, Toronto, and a clinical instructor of surgical nursing at the same hospital. She was a public health nurse with the New Brunswick department of health, and editor of the New Brunswick Association of Registered Nurses news bulletin.

Helen Sundstrom (B.A., Brandon U., Brandon, Manitoba; B.Sc.N., U. of Saskatchewan, Saskatoon, Sask.) has been appointed coordinator of continuing education for the Manitoba Association of Registered Nurses.

Mrs. Sundstrom is coordinator of the two-year program at Victoria General Hospital, Winnipeg, Manitoba, and was an instructor at the Children's Hospital of Winnipeg.

Elsbeth Geiger (R.N., Royal Victoria H., Montreal, Quebec; B.N., Mc Gill U., Montreal; M.A., Columbia Teachers' College, New York) has been appointed chief of nursing of the Hospital for Sick Children, Toronto, Ontario. As chief of nursing, Miss Geiger is responsible for some 1,000 nurses.

She was president of the Registered Nurses' Association of Ontario in 1966-67, and is now president of the College of Nurses of Ontario. Miss Geiger is also a member of the test service board of the new Canadian Nurses' Association testing service which sets the examinations for nurses in schools across Canada.

Miss Geiger's appointment to the new position, chief of nursing, marks an administrative reorganization.

Alma Ferrier was named Alberta's nurse of the year at the 54th annual dinner of the Alberta Association of Registered Nurses. As nurse in the community of Blueberry Mountain, Miss Ferrier participated in a number of activities and contributed much to this isolated community.

Miss Ferrier, who has retired to Rutland, British Columbia, was born in Scotland and received her education there.

Dr. J. Douglas Wallace has been appointed executive director of the 22000-member Canadian Medical Association. He succeeds Dr. Arthur F. W. Peart, who resigned for health reasons last March after four years in office.

Dr. Wallace received his medical training at the University of Alberta, Edmonton. Following service in the RCAF medical service during World War II, he did private practice for 13 years in his hometown of Wainwright, Alberta. His first administrative position was as director of the Alberta Hospital Plan. In 1969, Dr. Wallace served as chairman of the federal-provincial cost of health services task force on salaries and wages.

Dr. Wallace is executive director of the Toronto General Hospital. He is also president, Ontario Council of Administrators of Teaching Hospitals, and past president, Association of Canadian Teaching Hospitals. □

dates

September 11 - 13

Clinical Cardiovascular Nursing — 1971, sponsored by the American Heart Association, Council on Cardiovascular Nursing, Georgetown University Medical Center, Washington, D.C. Address inquiries to the Canadian Heart Foundation, 270 Laurier Ave. West, Ottawa, Ontario.

September 14-17

American Association of Nurse Anesthetists, Shamrock Hilton Hotel, Houston, Texas. For more information, write to the AANA, 3010 Prudential Plaza, 130 E. Randolph St., Chicago, Illinois 60601, U.S.A.

September 19-20

Third national congress on medical ethics, sponsored by the Judicial Committee, of the American Medical Association, to be held at the Ambassador Hotel, Chicago, Illinois. For more information write to E.G. Shelley, M.D., Chairman, Judicial Council, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

September 24-27

Meeting of the American Medical Writers' Association, Waldorf-Astoria Hotel, New York. For more information, write to the association's executive secretary, Mr. W. Wayne Curtis, 420 Lexington Ave., New York, N.Y., 10017.

September 26

The Nightingale School of Nursing in Toronto is marking its 10th anniversary with an open house and reception for alumni and invited guests. For further information, write to The Nightingale School of Nursing, 2 Murray Street, Toronto 2B, Ontario.

September 28-October 9

Two-week symposium on the nurse's role in prevention and treatment of acute and chronic respiratory insufficiency, Manitoba Rehabilitation Hospital, Winnipeg. Further details are available from Miss E.L.M. Thorpe, Consultant, Sanatorium Board of Manitoba, 800 Sherbrook Street, Winnipeg 2, Manitoba.

October 1-2

Annual Convention, Catholic Hospital Conference of Alberta, Chateau Lacombe, Edmonton, Alberta. For more information write to: Reverend Sister John Marie, President, Catholic Hospital Conference of Alberta, Seton Hospital, Jaspar, Alberta.

October 5-6

Institute on operating room and central supply room procedures, auditorium, Calgary General Hospital School of Nursing. Sponsored by the Alberta Association of Registered Nurses. For further details write to the AARN, 10256 — 112 Street, Edmonton, Alberta.

October 5-30

Advanced program in health services organization and administration, The University of Toronto School of Hygiene. The second part of this program will be held March 1-26, 1971. Fee: $200 for each part. For further information, write to: Dr. R.D. Barron, Secretary, School of Hygiene, University of Toronto, Toronto 5, Ontario.

October 7-10

Annual conference, Canadian Association for the Mentally Retarded, Hotel Vancouver, Vancouver, British Columbia. Special emphasis will be on the preschool child, residential services, and occupational-vocational programs.

October 8-10

Workshop on Test Construction for 35 teachers from schools of nursing and the provincial hospitals, sponsored by the New Brunswick Association of Registered Nurses, in Memramcook, New Brunswick. The workshop will be conducted by Vivian Wood, Assistant Professor, Faculty of Nursing, University of Western Ontario. For more information write to Mary Russell, R.N., NBARN staff, Secretary to Nursing Education, 231 Saunders Street, Fredericton, N.B.

October 17

14th Annual Symposium on Rehabilitation, sponsored by the Rehabilitation Foundation for the Disabled and the Ontario Society for Crippled Children, Inn-on-the-Park, Don Mills, Ontario. Write to Mrs. Betty McMurray, Executive Director, Rehabilitation Foundation for the Disabled, 12 Overlea Boulevard, Toronto 354, Ontario.

October 25-29

National conference on the impact of the environment, sponsored by the Canadian Council on Children and Youth and The Vanier Institute of the Family, Winnipeg. For more information write to The Vanier Institute of the Family, 170 Metcalfe Street, Ottawa 4, Ontario.

October 26-27

Nursing sessions at the Ontario Hospital Association annual convention, Royal York Hotel, Toronto. Write to the OHA, 24 Ferrand Drive, Don Mills, Ontario.

October 26-28

Annual meeting of the Association of Registered Nurses of Newfoundland, St. John's. Write to the AARN, 67 Le Marchant Rd., St. John's, Nfld.

October 29-31

Second annual symposium of the Institute of Community and Family Psychiatry, Jewish General Hospital, Montreal, Quebec, on techniques in family therapy and the future of the family. Simultaneous translation is available in French. For more information and advance registration, contact: Philip Beck, M.D., registration chairman, Symposium, Institute of Community and Family Psychiatry, 4333 Côte St. Catherine Road, Montreal 249, Quebec.

Nov. 4-6, 1970 and Feb. 24-25, 1971

A continuing education course called Nursing Service Objectives is being sponsored by the University of Toronto School of Nursing. For more information write to: Continuing Education Program for Nurses, University of Toronto School of Nursing, 47 Queen's Park Crescent, Toronto 5, Ontario.

November 30-December 4

Conference for nurses in staff education and staff development, Westbury Hotel, Toronto. Sponsored by the Registered Nurses' Association of Ontario. Write to: Professional Development Department, RNAO, 33 Price Street, Toronto 5, Ontario.

February 16-18, 1971

A national conference on research in nursing practice will be held in Ottawa. For more details write to Dr. Floris E. King, Associate professor and coordinator of the graduate program, University of British Columbia School of Nursing. □

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I'm clear-faced and easy to read. My white back makes my markings stand out uniquely, whether you look at my backbone scale, or tilt me diagonally to read small amounts with the corner calibrations.

My hanger is the hanger that works well all the time. Hang it on a bed rail or a belt, it is always secure and comfortable. I'm always on the level with this hanger, whether my patient is lying, sitting, or walking around.

I have the only shortie drainage tube around, and it's miles better than any other you've ever used. It's easier to handle, and it won't drag on the floor, even with the new low beds. So out goes one more path to possible contamination.

I'm the unique new CYSTOFLO drainag[illegible] true-blue friend to nurses, physicians and [illegible] Why don't we get acquainted?

BAXTER LABORATORIES OF CANADA

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.

Saneen Infant Wipes

Facelle Company Ltd., Toronto, has introduced Saneen Infant Wipes, a specially processed two-ply tissue, reinforced with nylon threads to give exceptional strength when wet.

Made with facial quality cellulose tissue, they provide both softness, for the delicate skin of newborn infants, and high absorbency.

Saneen Infant Wipes measure 8 inches by 12 inches. They are packaged in polyproplene units of 50 for cleanliness, easy stock control and storage, and are delivered in cases of 2,000.

In addition to baby care, Infant Wipes may be used in the hospital where a strong, soft, absorbent and lint-free wipe or washcloth is required.

For further information write: Facelle Company Ltd., 1350 Jane Street, Toronto 335, Ontario.

Infant Wipes

I.V. Metering Device

Inexpensive and disposable, this device permits an immediate reading of solution flow rates, thereby controlling accuracy and improving patient care. Designed with adaptations to fit all I.V. bottles, the I.V. metering device minimizes setup time and provides greater infusion control.

Component parts include a bottle-to-device connector; a micro-drop or standard-drop meter which monitors drops per minute and ml. per hour on a slide indicator; a clamp and connecting tubes with needle adapter.

For further information write: I.V. Ometer, P.O. Box 1219, Santa Cruz, California 95060, United States.

Teflon-Coated Catheter

C.R. Bard, Inc., has introduced the Bardex coated Foley catheter with Teflon. The new catheter has been produced by bonding a specially-developed coating that contains Teflon on the inside and outside layers of the Bard catheter. This new coating facilitates catheter insertion, and will not peel or crack when the balloon is inflated. The slick surfaces reduce calcification formation on the outer and inner surfaces of the catheter. The incidence of urethral strictures following extended use is reduced, with minimal urethral discharge even after prolonged catheter drainage.

For more details write to C.R. Bard Canada Ltd., 22 Torlake Crescent, Toronto, 18, Ontario.

Cardioscope

A new nine-inch, four-channel cardioscope, specially designed to permit simple service and repairs by hospital personnel, has been introduced by Dallons Instruments.

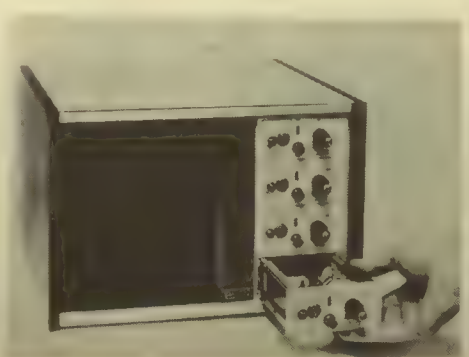
Designated type CM-9, the new monitor permits simultaneous display of four cardiac signals, with controls to provide independent positioning and amplification of each signal.

The machine is serviced by placing all the electrical parts on four plug-in circuit boards, any of which can be easily removed and replaced.

All circuits are protected against damage.

Preamplifiers are available for ECG, EEG, DC (blood pressure), and strain gage. Each preamplifier contains one printed circuit board which is easily removable from its plug-in connector.

Dallons is represented in Canada by Bionetics Ltd., 6420 Victoria Avenue, Montreal 252, Quebec.



Disposable OR Draping

Kimberly-Clark of Canada Limited has introduced a new disposable draping system. A variety of obstetric and operating room packs are available to fill every draping requirement. Individual components are also available to supplement the draping packs.

The basic draping material is made from a new fabric, Kaycel. This material has many advantages over the traditional linen. Standard linens, when wet, encourage bacteria migration. Kaycel moisture-inhibiting fabric eliminates this cross contamination. The components are light-weight, yet strong to eliminate tearing. All sheets, towels, and covers are lint and dust free. The soft pliable fabric is more easily draped over the patient than linen.

Each kit and individual supplementary pieces are double packed and guaranteed sterile. The sheets are functionally folded, sequence packed, and identified for easy use. This new disposable

(continued on page 28)

This decongestant tablet contends that a cold is not as simple as it seems on television

Coricidin* "D" tablets shrink swollen membranes with the best of them (note the 10 mg. of phenylephrine).

Unfortunately, the misery of a cold doesn't end with unblocked passages.

That's why Coricidin "D" **also** contains two antipyretic and analgesic agents. They cool down the steaming fever and suppress the aches and pains that go with the adult cold.

That's why we **also** help perk up sagging spirits with 30 mg. Caffeine.

And why we **also** include 2 mg. of Chlor-Tripolon* to combat rhinorrhea . . . and strike out at the very root of congestion.

Know of another cold reliever that gives your patient so many helpful **also's?**

Coricidin "D"
***comprehensive** relief*
of cold symptoms

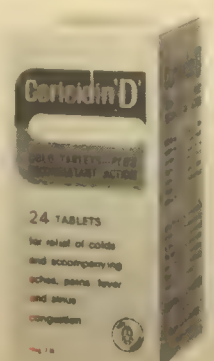
DESCRIPTION: Each CORICIDIN "D" tablet contains 2 mg. CHLOR-TRIPOLON* (chlorpheniramine maleate), 230 mg. acetylsalicylic acid, 160 mg. phenacetin, 30 mg. caffeine, 10 mg phenylephrine.

DOSAGE: Adults: one tablet every 4 hours, not to exceed 4 tablets in 24 hours. Children (10-14 years): ½ the adult dose. Children under 10 years: as directed by the physician

SIDE EFFECTS: Adverse reactions ordinarily associated with antihistamines, such as drowsiness, nausea and dizziness occur infrequently with Coricidin "D" when administration does not exceed recommended dosage.

PRECAUTIONS: May be injurious if taken in large doses or for a long time. Additional clinical data available on request.

*reg. Trade Mark.



For colds of all ages:
Coricidin tablets,
Coricidin with Codeine,
Coriforte® for severe colds,
Nasal Mist, Medilets
and Coricidin "D" Medilets
for children,
Pediatric Drops,
Cough Mixture
and Lozenges.

Schering Corporation Limited
Pointe Claire 730, P.Q.

new products

(continued from page 26)

draping system reduces storage, handling time, and laundry problems.

For further information, write to: Kimberly-Clark of Canada Limited, Medical Products Division, 2 Carlton Street, Toronto 2, Ontario.

Unit Dose Injectable Drugs

Moore-Thompson-Clinger Pharmaceuticals of Hamilton, Ontario, a subsidiary of Canada Packers Limited, has announced it is beginning to market a new line of unit dose injectable drugs to hospitals and institutions in Canada.

The first drug of the new line will be unit-dose sodium heparin injection, marketed under the brand name of Hepalean.

The primary use of Heparin is in the treatment of cardiovascular diseases due to blood clotting and agglutination. It is used extensively in open-heart surgery, kidney transplants, and artificial kidney treatments.

The drug is packaged in 1 ml. unit-dose ampuls, and 5 ml. and 10 ml. vials, in concentrations of 1,000, 10,000, and 20,000 units per ml. The vials and ampuls are color coded according to concentration. This enables medical personnel to readily identify the correct strength and dosage of the drug, which can be critical to the life of the patient, and where rapid treatment is imperative.

For more information write: Moore-Thompson-Clinger Ltd., 1890 Brampton Street, Hamilton, Ontario.

Extra-light Stethoscope

The Soloscope, a new stethoscope that weighs 1 1/4 ounces and offers a high volume of sound transmission, is a new product from DePuy, Inc. Made of a flexible plastic, that makes it easy to handle and clean, the Soloscope is reusable.

Despite its durability, its price is economical. As a disposable product, it is ideal for use in isolation or infectious disease wards.

Each Soloscope, individually packaged, costs $3.90 but must be purchased in minimum quantities of one carton which contains six Soloscopes.

For further information, write to : Guy Bernier, 862 Charles-Guimond, Boucherville, Quebec, or John Kennedy, 2750 Slough Street, Malton, Ont.

Unit Dose Injectable Drugs

Indocid

Merck Sharp & Dohme Canada Ltd. has made available a new dosage form of Indocid (indomethacin, MSD Std.) in 50 mg. capsules. Indocid is an anti-inflammatory agent with concomitant analgesic and antipyretic activities.

The addition of the 50 mg. capsules to the 25 mg. dosage form provides convenience, economy, and dosage flexibility for patients who need a higher dosage of Indocin.

The 50 mg. capsules are opaque, blue and white, imprinted with the potency level and the MSD trademark, and are available in bottles of 50 and 250.

For further information write: Merck Sharp & Dohme Canada Ltd., Kirkland, Quebec.

Quadruped Walking Aid

Designed to give maximum mobility and stability to handicapped users, this walking aid can be used singly or in pairs. The lightweight, die cast, aluminum hand piece is fitted with a nontoxic ergonomic hand grip, and the strong stable base has four non-slip, non-marking, grey rubber tips.

Instant height adjustment is achieved by means of stainless steel spring buttons, fitting into precision-punched holes with 3/4-inch graduations. There are two models to choose from.

For further information, write to Everest & Jennings Canadian Limited, P.O. Box 9200, Downsview, Ontario.

Tiltable Infant Bed

A Tiltable Infant Bed has been introduced by Bourns, Inc., Life Systems. The bed is designed to provide controlled positioning of the newborn during intensive care. It can be tilted from side to side to help prevent tissue damage of the infant resulting from prolonged pressures.

Obtaining arterial blood samples and suctioning are greatly facilitated by the bed. A removable panel in the bottom of the bed permits chest X-rays to be taken without disturbing the infant.

For further information write: Bourns, Inc., Life Systems, 6135 Magnolia Avenue, Riverside, California, 92506, United States. □

NO WAY!

There's no way airborne contaminants can accidentally get into VIAFLEX plastic containers unless you inject them. Unlike glass bottles, the VIAFLEX container has no vent—room air is kept out. It's the only completely closed I.V. system; airborne contaminants are locked out, and the system remains sterile throughout the procedure. Even when the spike of the set is inserted, air cannot get in—because the spike completely occludes the port opening before it punctures the internal safety seal. A self-sealing latex cap on the second port is provided for adding supplemental medication. VIAFLEX is the first and only plastic container for intravenous solutions. To assure your patient the safety of a *completely* closed system, it's the first and only container you should consider.

BAXTER LABORATORIES OF CANADA
DIVISION OF TRAVENOL LABORATORIES INC
6405 Northam Drive, Malton, Ontario

Viaflex

in a capsule

The word is communication!

Communicating in another language can be difficult, and when a word is used incorrectly, there may be some embarrassment. A much-traveled nurse tells of this amusing experience.

It was a wet and windy day when she arrived in Zurich by plane. A customs official asked if she had anything to declare; it was then she remembered her new Parisian wig tucked in its glamorous box, still sitting in the plane. "Mon poupon, mon poupon est sur le plane!" she cried.

The Zurich officials looked at the excited woman in disbelief. But, if what she said were true, then they must waste no time! She was immediately whisked off to the waiting plane in an open car.

When she had recovered her precious wig, she attempted to thank the man for his trouble, but he interrupted, "Votre poupon! Votre poupon?"

Blushing with embarrassment, our nurse friend realized the word she *should* have used was "ma perruque" for wig, *not* "mon poupon" for baby!

Perhaps the moral of the story is, when in doubt, try, try, again.

Hospital ombudsman

Who speaks for the patient? Doctors, nurses, and administrators have their professional associations. But who really knows what non-medical aid the patient requires?

"Your wife isn't feeling well, wants you to recommend a good doctor."

These questions were posed by Richard Cavalier in an article called "Ombudsman is Middle Man Between Clinic Patients and Hospital" in the january issue of *Modern Hospital.* The article describes the efforts of the ombudsman — actually one man and one woman — to act as patient spokesman at Michael Reese Hospital in Chicago. The program, started in 1969, has resulted in smoother communications and easing of tensions between patients and staff.

In a sense related to the Scandanavian ombudsman, who investigates complaints of citizens against government, the ombudsman at Michael Reese Hospital interprets prescription orders for the patient, and explains hospital procedure to him. He may also call attention to a patient who has come to the emergency room on a routine visit but who is in pain.

By gaining the trust and confidence of the patients, and the acceptance of the hospital staff, the ombudsman has shown that there is a need for service of this kind and for more patient advocates.

Chewing gum discovery

What is better than a toothbrush when it comes to keeping teeth clean and healthy? A special chewing gum, reports Dr. Karl Otto Heede of Goettingen, West Germany, in *German Features.*

After experimenting on a special chewing gum for 14 years, Dr. Heede says that his gum, which is a mixture of natural resins, chemically basic minerals, volatile oils, trace elements, herbs, and vitamins, successfully fights dental disorders such as cavities and periodontal disease. He hopes this gum will be on the market soon.

Dr. Heede claims that his invention fights decay actively through the ingredients, which restore the acid-base balance in the saliva. The substance has been tested by a clinic in Dusseldorf, which reported that a person's teeth are completely cleaned after chewing the gum for 15 minutes. The clinic says that not even a toothbrush can match this achievement.

The inventor gives a friend credit for the idea of the gum. After Dr. Heede's friend returned from a trip to Africa, he recounted that he had met some natives who had very white, healthy teeth, apparently because they often chewed certain tree resins. □

Fleet ends ordeal by Enema® for you and your patient

Now in 3 disposable forms:

- **Adult** (green protective cap)
- **Pediatric** (blue protective cap)
- **Mineral Oil** (orange protective cap)

Fleet — the 40-second Enema* — is pre-lubricated, pre-mixed, pre-measured, individually-packed, ready-to-use, and disposable. Ordeal by enema-can is over!

Quick, clean, modern, FLEET ENEMA will save you an average of 27 minutes per patient — and a world of trouble.

WARNING: Not to be used when nausea, vomiting or abdominal pain is present. Frequent or prolonged use may result in dependence.
CAUTION: DO NOT ADMINISTER TO CHILDREN UNDER TWO YEARS OF AGE EXCEPT ON THE ADVICE OF A PHYSICIAN.

In dehydrated or debilitated patients, the volume must be carefully determined since the solution is hypertonic and may lead to further dehydration. Care should also be taken to ensure that the contents of the bowel are expelled after administration. Repeated administration at short intervals should be avoided.

Full information on request.

*Kehlmann, W. H.: Mod. Hosp. 84:104, 1955

FLEET ENEMA® — single-dose disposable unit

QUALITY PHARMACEUTICALS
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Maritimers have a TV nurse

Education, whether for the young or not so young, is a demand never completely satisfied. Medical and nursing education is one of these ongoing needs. TV Nurse, a public service program produced in the CHSJ-TV studios, Saint John, New Brunswick, reaches out into the community to assist in educating the public on health procedures. Hostess Elaine Hazen is convinced the public welcomes information on health, particularly preventive measures. Here is a glimpse of her program and how it originated.

Mona C. Ricks

Answering nursing questions, and trying to help educate the public in health matters, has been the dedicated role of a petite, blonde nurse in Saint John, New Brunswick, for nine years.

Elaine Hazen hosts a unique, weekly television show, telling viewers, in her own way, why preventive medicine is the key to better health. She radiates this philosophy the moment her Sunday program opens, and continues as she questions guests on medicine and nursing.

"If only the public would realize that a moment taken to visit a doctor, could mean many years of well life," says Mrs. Hazen. "Then these programs would be abundantly repaid."

"This is TV Nurse, with Elaine Hazen," says an announcer, as the camera swings full view to a diminutive nurse in white uniform. The opening line of another informative half-hour begins, commented on later by a faithful audience.

Measured by the letters and telephone calls after each show, Mrs. Hazen feels TV Nurse has become an institution in the Maritimes. If the program has a motto it could be, *health education without fear;* an honest attempt to inform the public on health issues and medical advances.

Reaching out to a possible viewing audience of 600,000, it has brought the medical profession and the public health nurse closer to the Maritimer — in fact right into the community.

Beamed from CHSJ-TV, Saint John, and CHM-TV, Moncton, New Brunswick, it spans city and rural areas in three Canadian provinces, Prince Edward Island, Nova Scotia, and New Brunswick. And in Maine, U.S., another avid audience waits each week.

How did the program come about? Mrs. Hazen won't admit directly to this, but in conversation you'll find she frequently refers to the continuing expansion in medical knowledge, and the demand for medical communication.

And this is precisely what inspired her initial request for television time. It has held her interest through nine years of planning an exacting weekly show.

The lack of nursing help, and the need for greater communication between physician and public became evident when her husband, the late Dr. Frank Hazen, was medical health officer for Saint John and two nearby counties, Albert and Charlotte.

"My husband often mentioned the need for more nurses. His was, and still is, a very busy district."

After his sudden death, Mrs. Hazen thought more and more of her husband's

---

Mona Ricks was recently appointed assistant editor of *The Canadian Nurse*.

cry for additional nursing staff to reach the people.

Loneliness can be the reason for lethargy or activity — for Mrs. Hazen it was an awakening to nursing needs.

"I lay awake many nights wondering how I could answer my husband's call," she said.

Then the idea of a televised medical program began to form. "It seemed the logical medium to reach the public and to educate the people on the essentials of public health."

But an idea in thought is one thing, activating the idea is another. Especially one as wide open as public health.

Fortunately, Mrs. Hazen is a registered nurse, trained in public health, and with an educated knowledge of the medical profession.

She discussed her idea with William Stewart, program director at CHSJ-TV, Saint John. Within weeks a receptive director and an eager nurse had produced the first live TV Nurse program.

"It was a great success," says Mrs. Hazen. "I was overwhelmed at the number of congratulatory letters."

And that was nine years ago!

Shown every Tuesday at 6 P.M., the program continued in the same slot for six years. "It seemed a good time to reach the people, especially those in rural areas."

But audience reaction showed another time was wanted. As one farmer firmly pointed out, "If you'll discuss my particular problem, I'll even give up milking the cows to listen."

The program did change viewing time — to 12:30 P.M. on Sunday. And this is when Maritimers still "switch on" to listen to medical and nursing news each week.

A remarkable array of medical specialists have followed each other across the TV Nurse screen. And thousands of letters and telephone messages tell of its educational value in the community.

"Since the first program, when I was a greenhorn, in fact I still am," acknowledged Mrs. Hazen, "specialists from most medical disciplines have told of their work."

Illustrious names, such as Dr. Heinz Lehman of the Douglas Hospital, Verdun, Quebec and Dr. Robert Jones, Dalhousie University, both represented psychiatry. Pediatric specialists, Dr. Richard Goldbloom, also of Dalhousie University, and Dr. Leo Stern, Montreal Children's Hospital, told of their experiences in child care. Dr. André Barbeau from the University of Montreal and Dr. J.B.R. Cosgrove, McGill University, answered questions on neurology.

Dr. Robert Kinch from The Montreal General Hospital discussed social problems affecting the unwed mother, and Dr. Pierre Grondin, the well-known heart surgeon, told of his work in cardiac surgery.

Two former ministers of health also contributed to the program. One, Dr. Stephen Weyman, now a practising pediatrician in Saint John, was the first guest interviewed.

Searching for up-to-date medical news has garnered specialists from many countries outside North America. Britain, Belgium, and Switzerland among them.

Controversial subjects, such as pollution, LSD, and venereal disease

The first guest TV Nurse, Elaine Hazen, interviewed on her popular weekly show out of Saint John, New Brunswick, was Dr. Stephen Weyman. At that time the doctor was provincial minister of health; he is now a practising pediatrician in the area.

have brought yea's and nay's from an audience deeply involved in the vagaries of a technical age.

After seeing the program on the unwed mother, Dr. J.R. Cameron, director of the Atlantic health unit, Dartmouth, Nova Scotia, wrote, "Your program takes a positive approach. It generates faith and every attempt is made to counteract unwarranted fear."

Of greatest interest to viewers is a small word with a large meaning — obesity. Asked why, Mrs. Hazen said she felt obesity is one health problem affecting the majority — and not just older persons.

People are anxious to know how to "slim the bulge." They've tried dieting, and listened to friends divulge their own slimming secrets — but they never work.

Often letters from heavyweights are filled with appeals for medical help. But, they don't want to see a doctor. They are too embarrassed.

TV Nurse brings the doctor to them via the television screen. Questions, gleaned from letters, are answered as factually as possible. And so some overweight fears are allayed.

But, says Mrs. Hazen, we do not give TV medication — we try to alleviate concern by advising viewers to see a doctor. On one point she is adamant, "We never diagnose on the program."

Next to obesity, questions on skin diseases bring in many letters. One recently begged Mrs. Hazen for news on allergies. The writer had missed a show on the subject — and could she have some information, please.

With four children — all with hypersensitive skin problems — she wanted to learn all she could about allergies.

Multiple sclerosis and heart disease also bring a share of questions. On these problems, and many others, local and provincial organizations come into the picture.

Working with health associations in Saint John and other maritime areas, has given the health worker and the public an opportunity to get together. The team spirit is evident.

Health associations want to know public needs, and each individual in the community needs to know what services are available.

Getting to know, and telling the public, is an important part of the service TV Nurse contributes to the community.

Norman H. MacBeth, president of the Canadian Heart Foundation in New Brunswick, is always eager to help with information on cardiac questions. When Dr. Pierre Grondin told of his work in heart surgery, letters poured in asking for a repeat show.

The viewing public want to know more and more about the preventive measures taken by medical specialists, says Mrs. Hazen. They need to know what is being done in research on their behalf. They want to be involved, right in their homes, with advances in medical application. TV Nurse aims to do this!

Since her first program, Mrs. Hazen admits she has learned a lot about asking the right question to bring out the information needed by letter writers. "I learned the hard way, right before the cameras," she will tell you.

But according to her producer, Joe

As a community service, TV Nurse relays information on medical questions and scientific data. Here Mrs. Hazen discusses the CNA prior to the 35th convention. (Left to right) Mona C. Ricks, assistant editor, The Canadian Nurse; Louise E. Miner, CNA president; Elaine Hazen; Catherine Bannister, NBARN; and Margaret D. McLean, senior nursing consultant, department of national health and welfare.

McVicar, she is still the best person to host the special program TV Nurse has become.

He readily admits Mrs. Hazen is a neophyte in the subtleties of television knowhow. "And I hope she stays that way. It makes the show spontaneous."

Producing the program is a unique experience for Joe McVicar. He feels it keeps going because of the deep sincerity generated by its hostess.

"She brings medicine to the people in a way they can understand. She helps them overcome fear of medicine and the doctor."

He describes her audience appeal as honest, "...coming from a person who has a deep appreciation of human needs. She is never too busy to personally answer the letters which come in after every show."

Answering mail often means research far into the night to find the correct reply. Or calling a busy doctor to acquaint him with a health problem.

Programmed six weeks in advance to give guests an opportunity to schedule time and prepare scientific data, the show uses every medium available to back up medical information.

Visual aids, demonstrations, and discussions make up the bulk of the program; often staged to coincide with a provincial or national medical event.

While the Canadian Nurses' Association was holding its 35th biennial in Fredericton, New Brunswick, last June, two board members and a representative from the New Brunswick Association of Registered Nurses, met before the TV Nurse mike.

With Mrs. Hazen and one of *The Canadian Nurse* editorial staff, they relayed information on the association and answered questions about the convention.

After nine years finding answers to complex medical questions, and listening to community problems, what does Mrs. Hazen foresee is the future for TV Nurse?

"To keep the service going," is her direct reply.

Has the program taken over any duties of the general physician, especially in the rural areas? Does the program fill in gaps between the delivery of community nursing service and the medical practitioner?

To these questions Mrs. Hazen answers, "NO! It isn't the **prerogative** of a television program to fill in medical gaps, or override nursing service."

But, she will also tell you that some problems which plagued people in rural areas have been alleviated. Not because TV Nurse diagnosed the problem — but because the television screen is a responsive listener, inviting calls for knowledge. Those requiring help know they can ask for it.

"People seem to have a greater awareness of their health needs since we offered this service," says Mrs. Hazen. By acquainting them with early symptoms of a disease, and encouraging them to seek professional help, prevention has become their own special therapy.

"Have you brought the patient closer to the doctor?" Mrs. Hazen was asked during a press interview.

She smiled. "If it was needed, then I would like to think I have."

Perhaps one of the most revealing aspects of the service given by TV Nurse is Mrs. Hazen's reaction to what seems a strange question.

"Do you think folklore, attributed to medicine in some rural communities, has been dispelled by the revealing eye of TV Nurse?"

"I think doctors in both urban and rural areas would agree it has. People don't go to a doctor with oldtime apprehensions anymore. Call it what you like — folklore, or just lack of health knowledge — they certainly are able to relate with less fear than before our program was established.

"They know more about heart disease and its causes. They are aware of the ravages obesity can cause. They are concerned with the social implications of increased drug addiction."

Because health education in Canada is under review, cameras in the Saint John studio continue to scan a wider and wider horizon for medical news. Programs tailored for teenagers are built into the content. Educational authorities in the area assist.

One of the most popular TV Nurse programs is an interview with the school nurse. Sometimes this reveals another side of the nurse. Students know the nurse is there to care for cuts and bruises. Through television, they learn the nurse will also discuss their personal health problems and show how they can be attacked.

How does Mrs. Hazen keep the program going single-handed?

"I get out of breath sometimes, and wonder whether I should hand over the reins. At the end of the fourth year I did sign off the show with a farewell.

"The calls which followed kept me busy on the telephone for over an hour. So, I gave in. And here I am going into the tenth year."

Watching Mrs. Hazen as she talks about her show is like listening to the voice of reason. Everything she says about education, communication, and preventive medicine spills over into a desire to tell the public "what it's all about." Whether it's sex education, drug control measures, or world pollution.

And it does make sense!

The window to Mrs. Hazen's living-room looks out to a protected cove in a secluded corner of Saint John. Her show looks out to a world craving for the word *knowledge* — unleavened. □

Preventing hearing loss in industry

Intense noise for prolonged periods can produce hearing loss. In employment situations where noise is a factor, programs to test hearing and prescribe aids to prevent loss or further loss are essential.

Vera Hamilton

Of every 100 newly-hired workers in industry, about 20 to 27 are found to have hearing loss.[1,2] Frequently, the person is unaware of his hearing disability, and, by the time it is discovered, irreparable damage has been done.

All too often, the person's hearing loss has been caused by intense, prolonged noise in his work environment. To prevent this, hearing conservation programs are being established by employers to help their workers assess and protect their hearing. In most of these programs, occupational health nurses or public health nurses are very much involved.

Anatomy of sound

Sound waves travel through air at approximately 1,130 feet-per-second. If their intensity and frequency are within certain ranges, they produce the sensation of hearing.

Sound has two fundamental characteristics: *frequency* (which the ear receives as pitch) or number of sound waves per second; and *intensity* (which relates to loudness and pressure) or the amplitude of the sound wave.

Sound may consist of a single frequency (pure tone), such as that produced by a tuning fork or audiometer, or of a combination of many frequencies, such as those that make up industrial noises.

The human ear responds to frequencies ranging from about 16 to 16,000 cycles-per-second. The higher the frequency, the higher pitched the sound.[3] Middle C on the piano is about 250 cycles-per-second; the top note on the piano keyboard, about 4,000 cycles-per-second.

Sound intensity is measured in decibels (dB). Zero decibels represent roughly the weakest sound a person of good hearing can hear in a quiet place. A whisper registers about 20 decibels; a power lawn mower, 100-110; and a jet engine, 140-160.

A sound wave, carried through the air, reaches the outer ear and enters the auditory canal where it strikes the ear drum. This moves the ossicles, which carry the wave through the space of the middle ear to the oval window. The vibrations of the stapes against the oval window move the fluid in the inner ear, which, in turn, stimulates certain sensory nerve endings.

These nerve fibres, depending on the type of sound, transmit the sound

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Miss Hamilton graduated from the Soldier's Memorial Hospital, Campbellton, New Brunswick, and has a diploma in public health nursing from Dalhousie University, Halifax, Nova Scotia. She was employed as district nurse with the New Brunswick International Paper Company for six years before becoming in-plant occupational health nurse in 1962.

Author Vera Hamilton talks to employees in the shipping department of the New Brunswick International Paper Company, Dalhousie, New Brunswick. She always wears a hard hat when touring the plant.

via the cranial nerve to the brain. If hearing is perfect, all this takes place in less than 1/1,000 of a second.

Tones of different frequencies stimulate the nerve endings in hair cells in different regions along the inner ear membrane. Failure of this nerve mechanism to register and transmit sounds to the brain is called sensorineural deafness. Noise-induced deafness is an example of this. So far, it cannot be helped by medicine or surgery.[4]

Deafness

There are two basic types of deafness: conductive and sensorineural.

In conductive hearing loss, the damage is found in the external ear canal, the middle ear, or the Eustachian tube. Possible causes of this damage are: impacted wax; foreign body or cyst in the ear canal; infection or ruptured ear drum; and congenital malformations.

In sensorineural hearing loss, the damage is to the inner ear or auditory nerve. Some causes are head injury, certain drugs, and exposure to intense noise.

The onset of hearing loss from noise exposure is insidious. First signs usually appear in the hair cells responding to 4,000 cycles. Continued exposure lowing initial damage in the 4,000-cycle range may gradually spread into areas responding to lower frequencies. Not until these lower ranges are reached does the individual begin to experience some difficulty in hearing speech.

There is little evidence that low noise levels cause hearing damage, but where noise levels are high, steps must be taken to reduce noise and conserve hearing through ear protection.

Testing programs

When a hearing conservation program is considered, two things are basic: a person trained in audiometry to run the program, and a proper testing environment.

Valid measures of hearing acuity cannot be obtained unless sound levels in the examining room are low enough to avoid interference with pure tones used in the tests. Many centers have soundproof booths, but this is not always necessary.

If a soundproof booth is not available and the noise level in the room is excessive, steps can be taken to reduce it. These include: making sure there is a tight-fitting door at the entrance; having acoustic tiles placed on door, walls, and ceiling; and seeing that the floor covering is soft. Attention should be paid to light fixtures, as some produce a loud hum.

The most important piece of equipment for testing is the audiometer, which produces pure tones at various frequencies and intensities for measuring hearing acuity. It is a delicate instrument and must be handled with care. Rough handling, overheating, and exposure to dust will cause the audiometer to lose its calibration.

The nurse should periodically check the threshold hearings of at least two control subjects. If the instrument is used daily, a calibration check should be made at the beginning and end of the day. The nurse herself can be one of the control subjects. A record is kept of all calibration checks.

Before starting audiometric testing, sound level readings should be taken in all the work areas in the plant. Management can obtain the services of an industrial hygiene engineer from the department of national health and welfare, to carry out this study.

The engineer will make noise measurements throughout the entire mill with a sound level meter and octave band analyzer. He also can compile a comprehensive report of these findings, along with a list of the permissible maximum duration (minutes) of exposure for each shift in each area.

This report will assist the nurse by showing her at a glance where each employee is working, what the noise level is, and if hearing protection should be recommended. It also ends many arguments as to whether an area is noisy or not. It is not uncommon for an employee to tell you an area is not

Those who work in high-noise areas of the plant have an audiogram every eight months to a year. Miss Hamilton, who has special training in audiometry, tests the hearing of one of the company's employees.

really noisy at all — simply because he has become accustomed to the noise or because he already has a severe hearing impairment.

Getting started

The New Brunswick International Paper Company began its program for hearing testing in 1968. Before beginning, a letter was given to each employee along with his pay cheque, telling him he would have the opportunity during the next few months to have his hearing checked.

The test was not compulsory, but employees were advised to take advantage of the opportunity.

Letters were also sent to doctors in in the area informing them of our plans. We proposed a two-pronged program: testing and education. Doctors were advised that this audiometric testing was not diagnostic, but screening, in nature. Persons showing hearing loss would be referred to their own doctor.

Meetings were held with supervisory staff and with representatives of local labor unions. At these meetings, the nurse explained the program and discussed ear anatomy, effects of high noise levels, the kind of information required for records, the importance of seeking professional advice for hearing impairment, and the use of hearing protection. A film, entitled *How We Hear*, available from the Audiovisual Services, New Brunswick Department of Education, was used as well.

The first persons tested were management, supervisory foremen, and local union officers. Then we started in the various departments.

A hearing conservation program in its first stages is time consuming. Our management employed a second nurse to handle the industrial plant nursing work, so I could work almost exclusively on the hearing program. I also went to Colby College in Waterville, Maine, for a short course in audiometry.

of sound, audiometric testing, record keeping, ear protective devices, interpretation of audiograms, and legal aspects. At the end, nurses are certified as competent to perform pure tone air conduction audiometry.

Records must be kept of all tests. The audiometric record we use is a serial type record on which the results of many audiograms can be entered. A glance at the record shows if any change has occurred since the previous audiogram was taken.

The pre-employment audiogram record may be important at some future date in compensation claims. It may reveal a claim is legitimate, or it may be a defence against false claims.

The employee is usually interested in his record. It can be used as a motivating tool to convince him of the importance of wearing ear protectors, especially if we find he has a high-frequency hearing loss that was previously unknown.

The first audiogram takes approximately one-half hour. This includes explaining the procedure; taking a brief history; recording the results; discussing hearing protection with those who work in areas with high noise levels; discussing the results of the audiogram; and, if necessary, recommending that the individual visit his own doctor.

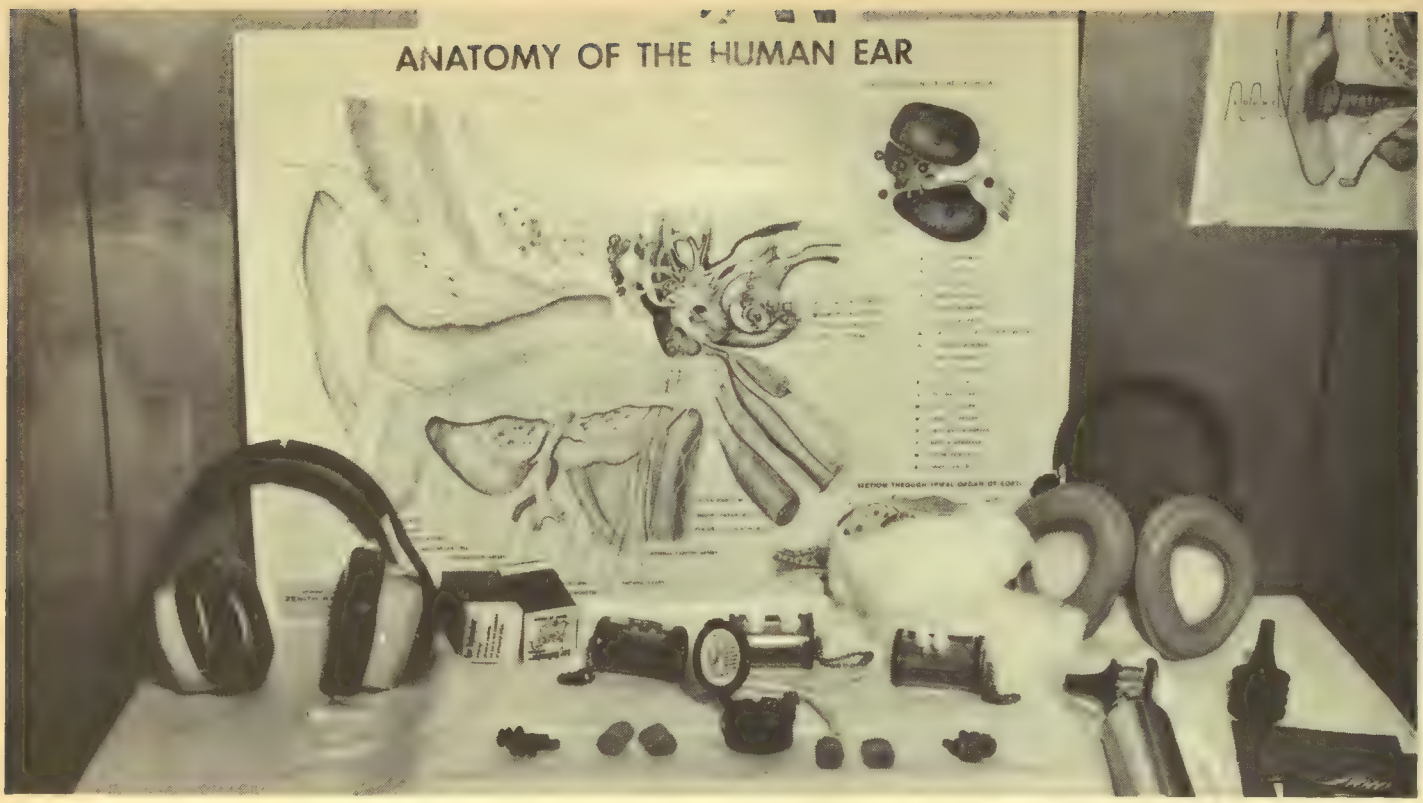
Repeat audiograms take less time, but the testing routine follows the same procedure each time so that comparisons of results are valid.

We try to test the entire work force on a revolving basis, which can take up to two years. Those working in high-noise areas have audiograms more frequently — every eight months to a year.

Hearing protection

There are two main types of hearing protection used in our plant: ear muffs and ear plugs. In some industries, where higher noise levels occur, employees wear a helmet-type protector that completely covers the cranium.

Ear muffs cover the whole ear; fitting is not a problem as they are easily adjusted and offer good atten-



An assortment of hearing protectors worn by employees in high noise areas. In some industries, where extremely high noise levels prevail, a helmet-type protector (not shown) is used by the employees.

uation. The disadvantage to muffs is that workers complain of discomfort when working in warm areas. Since many areas in our mill are warm, the muff-type protector is not popular.

Ear plugs are available in many types and in a variety of materials (rubber, neoprene, plastics). They must be fitted properly, but this is not difficult as a wide variety of sizes is available.

Plugs are the preferred protection in our plant. The disadvantages are that they require proper insertion daily by the employee for maximum comfort and effectiveness.

We have found disposable plugs work well, and use both the waxed cotton and Swedish wool (fine fiberglass down) types. They are popular even with employees who complain of discomfort with standard plugs. As they must be disposed of after a single use, the cost is slightly higher.

One type of plug will not prove satisfactory for all workers, mainly because ear canals vary in size and shape.

There seems to be more resistance to the use of hearing protectors than to other types of personal protective devices, such as hard hats or safety shoes. The two most common reasons given are that employees find hearing protectors uncomfortable, and that they are not convinced of the need to wear them.

Frequently, employees accept noise as a normal part of the occupation and do not worry about something that may not take place for several years. Older employees who have hearing loss need to be convinced that the wearing of protective devices will preserve their remaining hearing.

Our records show that those who have been wearing their plugs while working in noisy areas are the ones with the good hearing.

The educational program regarding hearing protection seems never ending, but it is a challenging and interesting part of my occupational health nursing.

One employee comes in for a hearing test and announces emphatically that he's against ear plugs "because they are no good anyway." He may go out still against ear plugs, despite all our efforts.

He may be followed by another employee who is afraid that his walk from the entrance to the nurse's office, without hearing protection, may have damaged his hearing. This employee prefers to wear a helmet protector all the time.

Fortunately, the majority of workers are somewhere between the two views. So we don't give up hope. Our aim is to see that, in future, *all* our workers will reach retirement age still able to hear all the sounds that are meant to be heard.

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□

"Distress Center — may I help you?"

At the Ottawa Distress Center, volunteers stand by to help telephone callers who are in need of reassurance, companionship, or simply a sympathetic ear. This type of service is providing valuable assistance to hundreds of depressed persons.

Dorothy S. Starr, B.A., M.N.

"This is the Distress Center. Dorothy speaking. May I help you?"

The person on the other end of the telephone may be shy and hesitant, or so sleepy with drugs taken in an attempt to end life, that the Distress Center volunteer leans into the telephone, trying to catch every word. Or the caller may come on booming — indignant, hostile, frustrated with the circumstances of his life.

Another caller will speak with a burst of sound, releasing pent-up emotion in speech so rapid and slurred that only when the torrent has subsided can the volunteer ask a few questions to understand the caller's basic problem.

An organization of listeners

The Distress Center is a community service, operated by volunteers who answer the telephone and talk with individuals who are disturbed. It is not a professional counseling service, but an organization of friendly listeners.

The need for a Distress Center arises from the anonymity of life in a city, where individuals may not know anyone well enough to talk over their problems as they would with a friend or family

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Mrs. Starr, a graduate of Yale University School of Nursing, New Haven, Connecticut, is Assistant Professor of Nursing at the University of Ottawa School of Nursing.

member. Several Canadian cities offer this telephone service: in Vancouver, it's called the "Crisis Center"; in Toronto, the "Distress Center"; in London, "Contact"; and in Montreal, the service is called "The People's Center."

Background of Ottawa center

A variety of people and concerns were responsible for the establishment of the Ottawa Distress Center. A young couple moved to Ottawa from England, where they had been active in The Samaritans — a telephone service started in 1953. At the same time, a social action committee of churches in downtown Ottawa was considering the need for a telephone service for troubled people, and wrote for advice to the Toronto Distress Center. The Toronto Center referred the Ottawa committee to the newly-arrived English couple.

After contact was made with the Social Planning Council of Ottawa, family service agencies, and the Canadian Mental Health Association, to determine the need for this telephone service, a steering committee of volunteers was formed. A year of organizing, recruiting, and training volunteers followed. When the Ottawa Distress Center was opened on March 17, 1969, 90 volunteers were trained and ready to man the telephones from 9:00 A.M. to 11:00 P.M.

The Ottawa center is financed by local service clubs, a grant from the Alcoholism and Drug Addiction Research Foundation, a grant from the regional municipality, individual donations, and fund-raising projects.

Volunteers well qualified

The volunteers who answer the Distress Center's two phone lines come from many walks of life; a significant proportion are nurses, both those actively engaged in professional practice and those who are full-time homemakers.

An initial six-week training course, consisting of a two-hour session each week, follows the acceptance of an applicant as a volunteer-in-training. During this course, the volunteer receives information about community resources, role-plays telephone calls, and discusses ways in which the Center's purpose of friendly listening or referral to professional agencies are carried out.

The leader of the training program — a professional with background in counseling and a knowledge of community resources — screens volunteers during the training course. Those who are accepted for service are placed on the duty schedule and are again screened in action.

Volunteers usually work in pairs, manning the two telephones for the day and evening shifts. When possible, a male and a female volunteer are teamed to meet the caller's preference to talk to a man or a woman.

In May 1970, volunteers numbered about 150, with a waiting list for the fall training courses. Whereas volunteers were at first recruited by word-of-mouth and by announcements made in churches, they now respond mainly to advertisements in newspapers and to radio and television publicity.

Sample calls

Who calls the Distress Center? Here are examples of the type of conversations I have received.

"May I help you?" is answered by the trembling voice of a young woman who says, "Talk to me!"

What have we here? A would-be suicide who has changed her mind? Someone who is mentally ill? A drug-taker who wants to keep in touch with reality? Find out a little more; try the echo: "Talk to you?"

The young woman continues: "I'm so lonesome for the sound of a human voice. My husband is away all week driving a transport truck and the children have gone to bed. Just talk to me."

"Certainly. What would you like to talk about?"

The caller, whose name is Mary, really means: "Please, listen to me." So I listen, asking an occasional question as Mary tells me what she's been planting in her garden, about her children, and also about her loneliness and feelings of isolation.

During the conversation I find out what triggered the call. If Mary is willing, we can then talk about what she would like to do to lessen her isolation. I may be able to suggest the "Y" program for mothers and preschoolers, or a nearby church group of young mothers. Mary may be so lonesome that she just hasn't been able to think of these things.

Another caller is an elderly man, crippled with arthritis, living alone "because my children don't want me," and bitter at the world. He sounds disagreeable. As he complains about the various social and medical agencies in town, I can imagine that he must have sorely tried the patience of the various professionals with whom he has come in contact.

It's much easier for me to talk with him on the phone, without any goal but to listen and be friendly, than it would be to meet him in my professional capacity. So I listen and make no comment on his vilification of the agencies and the workers who have tried to help him. Nobody is any good. Nobody cares about him. The doctors are all quacks, the nurses are all rough, and the social workers are all snoopy.

I feel a kinship with the social welfare workers and the public health nurse, and hope his call to the Distress Center may have relieved the pressure a little so that his next contact with these health workers may be more productive.

A 13-year-old girl calls to say her parents disapprove of her friends and won't let her stay out past 10:00 P.M., even on weekends. We discuss how she

might arrange for her parents to meet her friends. I curb my temptation to share with her my feelings for her parents, and try to let her see for herself how she feels about them and how she perceives their feelings about her.

Our talk ends with, "Well, I guess I could talk it over with mother. Maybe she'd let me ask some of the kids over to dance in the rec room, so she and dad could meet them." She thanks me warmly, and I wish her success with the proposed party.

The next call is trying: the caller is a patient in a psychiatric day hospital, who has been referred by the hospital to the Distress Center as an additional resource in the evenings. She is anxious and fearful, and wants reassurance that a Distress Center volunteer is willing to talk to her. I am unable to get a clear picture of any particular problem at the moment, but follow her lead for a rambling 20 minutes. I remind her that she may call us anytime. She seems more composed as she says "good-bye," but I find I need a cup of coffee.

I'm glad I had that coffee when I talk with the next caller. "May I help you?" is greeted by a belligerent male who snarls, "No, I don't think so, but try, just try to give me *one* good reason not to leave this —— —— world." The adjectives preceding "world" are not complimentary to the cosmos.

I don't take the bait, but instead try to find out what's bothering him right now. The picture that emerges gradually, between milder bursts of profane anger, is a grim one: out of work, a drinking problem, his wife left him six months ago and took their three children to her parental home.

The final straw that led to the call to the Distress Center is almost comic relief: last night he put his foot through the television set when he had been drinking, and just now realized he wouldn't be able to watch the hockey game. He has no money to get the TV repaired, and no money for a beer so he can watch the game at a nearby bar. I try to find out what he would like to do about the present situation. What emerges would require a magic wand — which the Distress Center does not include in its shabby office furnishings. The caller would like a lot of money, his TV fixed, and his wife and children home.

I enquire whether he has discussed his problems with anyone. He says he hasn't, but when I suggest a social work agency, he turns it down with an oath. So, we aren't going to get anywhere at the present time with a referral. Some of the steam seems to be drained from his anger; he sounds sad and depressed.

How serious was his implied threat of suicide? He says he hasn't decided on the method of suicide, so it seems less imminent. I ask whether he would like to talk over his problems with a Distress Center leader. Sometimes we can get a counseling process started in this way. He willingly gives me his name and telephone number so the leader can call him the next morning.

If I had sensed that he planned to commit suicide, or if he had already taken action to end his life, the procedure would be to have the other volunteer use the "hot line" to call the leader and, if necessary, the telephone company, to trace the location of the caller. The fastest way to get resuscitation and transportation to an individual whose life is in danger is through the police, whom we would notify when we had a name and address. This kind of action is rarely necessary, but a leader — who is on call for each 24-hour period — is notified to share responsibility with the volunteer.

Advantages to volunteers

As a professional nurse, volunteer work at the Distress Center has enriched my ability to practice nursing and to teach nursing in several ways: knowledge about our society and the problems people encounter is supplemented with actual experience; consumer reaction to health care is available in more direct, less censored, form than is provided to a person identified as a nurse; listening skill grows when one concentrates attention on this sense alone; appreciation of the helping ability of laymen (other volunteers) curbs any tendency to a professional "God complex."

The personal growth and development of each volunteer can be measured only by the individual, but I believe it must be a growing, learning experience for most. An ability to lessen another's distress satisfies personal needs and is reflected in performance of work activities and relationships with others.

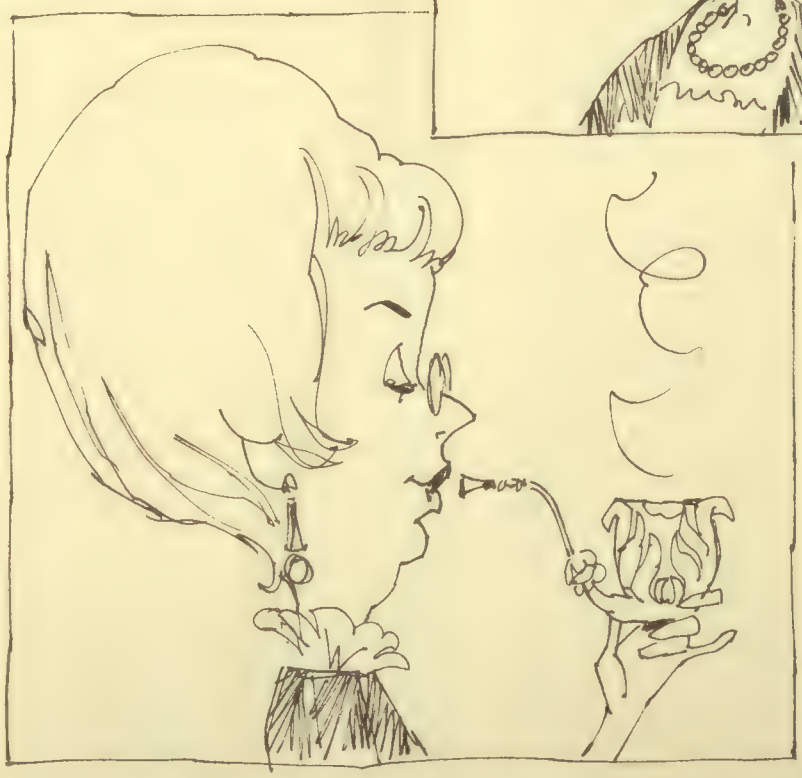
Distress Centers are meeting a real need in Canadian communities, as evidenced by the use made of their services. If there is a Distress Center in your town, you might like to consider being a volunteer. If there is not, you might work with other citizens to establish one.

However it is phrased, "May I help you?" is an answer to a cry for help. □

Call it what you will, discrimination, unfair practice, or another attack on sex equality, the situation described below surely calls for consideration!

Discrimination — that's what I call it!

Kay G. Roberts



It's gross, unjustifiable, unconstitutional discrimination against women. Besides, it's not fair!

I mean to say, we don't want to die a miserable death from lung cancer any more than the men do. Yet they have their cake and eat it too, and we can't. Those crazy social customs — established by men and condoned by women — are denying women the right to live and smoke.

Look at it this way. When a man smokes a pack of cigarettes a day, he is in for trouble. He is 10 times more likely to die of lung cancer than his friend who doesn't smoke. He's loading the dice against himself for a coronary, for bronchitis, for emphysema, and a mess of other nasty diseases. But he has an out! He can stop smoking cigarettes and switch to a pipe or a cigar. From the statistics available, these don't seem to undermine his health. He can puff away on his beastly old briar, or chew up to five fat cigars a day without detriment to his health. But can we women? Oh, no!

We have to remain sane on our own particular diet of cigarettes, or suffer the agonies of withdrawal with a stoical smile. We're not allowed an occasional stogey, or a pipe full of our favorite English blend, to calm our nerves during coffee break or at the coffee clutch in suburbia. Women frown on it because men frown on it because their mothers would have frowned on it.

In short, we female smokers can either take our chances of dying a premature death, induced by cigarette smoking, or live as neurotics, twitching with desire for just one more fag.

The answer, of course, lies in ourselves. We have to change the national mores. We have to change the customs so that we, too, can puff a cheroot delicately in public, or pull a pipe and tobacco pouch from our purse (in any social situation), and join the men who quit the butts for a briar or a Havana.

But right now the equipment for this is wrong. What we need is a designer of smoking utensils who will make the pipe and cigar feminine and socially acceptable.

What we need are the tools for the vice. We can't go around with a dirty old briar clamped between our teeth. It would look too disgustingly masculine. So why doesn't someone design for women a delicate, floral bowl in china, or one with classical figures in Wedgewood blue and white. We could pull

out our rhinestone pouch of *baccy*, load up with the men, puff away serenely, and still look feminine.

When it comes to cigars, we don't need to haul out a Churchillian monster. Why not slim cheroots, rolled specially for women? And we could draw the soothing smoke through elegant holders in silver, jade, or amber. After all, manufacturers have produced cigarette lighters and cases for ladies, and in one epoch, ladies snuff boxes. It's a question of fashion really, and social acceptance.

Which brings up another matter. Perhaps a female V.I.P. might be persuaded to popularize the habit on TV. The girls on Front Page Challenge, for instance, could be invited to smoke a cheroot or puff on a pipe.

Can't you just see a blonde in a TV spot ad selecting a long, thin stogey? Then beating off the men who rushed to light it! And can't you see the girls in suburbia comparing their latest pipes and pouches over coffee, and discussing their favorite blend of tobacco? With a well-planned campaign I can see a new industry rising from the ashes of the cigarette trade. What does a pipe or a cigar taste like? Hmmmmmm ... that's your problem. I'm talking about women's rights. □

The author of this controversial outcry is the editor of a national magazine.

Drug Misuse in Teenagers

David Lloyd, M.D.

One of the important problems among today's adolescents is the misuse of drugs. At The Hospital for Sick Children in Toronto there is an increasing need to understand more about the problem because, first, there has been some extension of drug misuse into younger age groups and second the Hospital recently extended the age limit for its patients upward from 16 to 19 years.

This is a very rapidly changing field and, for this reason, there are all too few people who can be called experts. Nevertheless, over a period of months, some penetration was achieved into the world of the teenage drug misuser and much current information elicited.

Any discussion of drug misuse must take place within the context of society's current views and practices with respect to all the substances that affect a person's mood and behavior. Choice of any particular drug by any one segment of the population at one time is generally less significant than the underlying personal and social reasons for the use or misuse of drugs.

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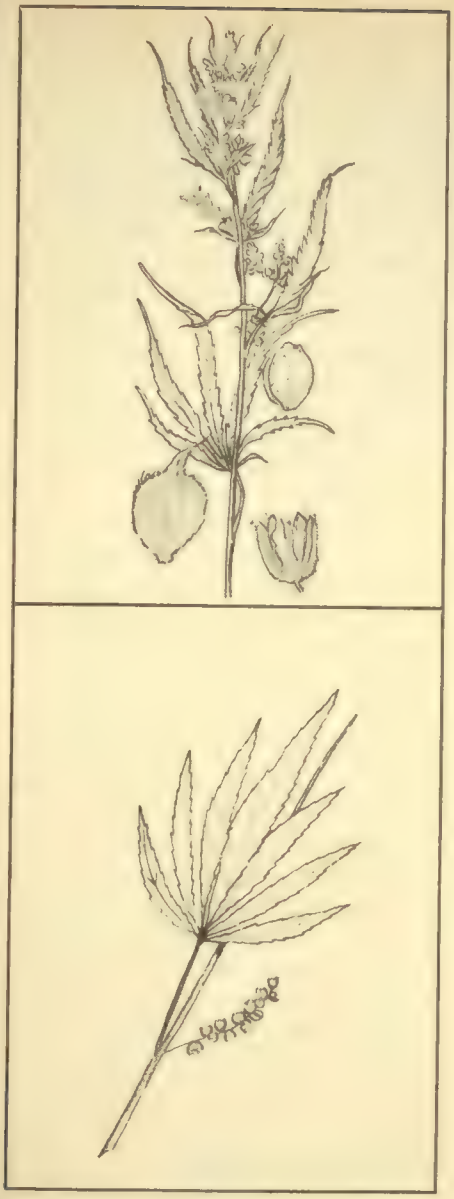
Reprinted, with permission, from *Applied Therapeutics*, Vol. 12, No. 3, March 1970. Although this article is directed to doctors, the editors of *The Canadian Nurse* believe it will be of interest to many registered nurses in this country.

Cannabis sativa

More commonly called "grass" in Toronto "on the street," Cannabis sativa (marijuana), presents a paradox in that it seems to be the cause for major concern despite indications in the most recent pharmacological literature that it is relatively harmless.[5] In our society the misuse of alcohol and other drugs, such as the barbiturates, poses a far greater problem than Cannabis in terms of habituation, functional and organic damage in the habitual user, as well as morbidity generally.

Slang terms for Cannabis are multiple and vary according to geographic regions as well as popularity of current jargon. Marijuana, grass, pot, mary jane are all popular in the North American idiom. In Jamaica the word is Ganja (meaning "the weed"), in India, Chagras; Acapulco Gold is a very potent form of Cannabis originating in Mexico.

The active ingredients in Cannabis are tetrahydrocannabinoids (THC's) obtained from the flowering tops and upper leaves of the unpollinated female Cannabis plant. The male plant has little or no pharmacological effect but, when harvested, is almost indistin-



Cannabis sativa

guishable from the female plant, making it a good control in any study of this compound's effects.

Hashish, also obtained from the cannabis sativa plant, has a higher percentage of cannabinoids. It is obtained from the resinous material exuded from the flower tops and leaves. Cannabis is similar to dry, crushed parsley in appearance — greyish-green to greyish-brown in color. Usually, the seeds and stems have been screened out.

Marijuana can be smoked in a thin, hand-rolled cigarette ("joint") or in a pipe. It can also be brewed in tea or baked in cakes, such as brownies. Hashish is sold in solid cakes or blocks. It ranges in color from light brown to black, and its consistency may be crumbly or hard and resinous.

Much has been written recently in the daily tabloids about the effects of Cannabis. A lot of this information is irrelevant, based on emotional appeal rather than scientific fact. The effect of any psychogenic drug will always vary with three factors: the user, the dose, and the circumstances in which the drug is taken. Marijuana and hashish (which have similar effects) are no exceptions.

Common effects are a sense of exhilaration and alertness, feelings of perceptiveness and self-confidence, talkativeness with outbursts of laughter. Appetite is stimulated and there is a slight rise in pulse rate and blood pressure. Conjunctival congestion and dry mouth may occur. In higher doses, hallucinations and perceptual distortions may be experienced.

In 100 subjects accustomed to Cannabis and given a fixed dose, exhilaration, talkativeness, lessening of fatigue and increased appetite were the most commonly reported effects.[1] Depression and mental fatigue were reported least. Inexperienced users generally reported fewer and less intense effects. Panic reactions occasionally occurred, particularly if the subjects were inexperienced and apprehensive at the time of intake.

The only literature on the long-term effects of Cannabis comes from countries where malnutrition and poor living conditions are rampant. From such studies it is difficult to distinguish whether any of the effects described are due to the Cannabis per se or the poor socio-economic conditions in the countries where the drug is popular.

It is uncommon to treat anyone taking pure Cannabis. Panic reactions that occur in inexperienced users can usually be handled by talking to the patient in a calm and understanding manner. Valium (Hoffmann-La Roche Limited) is used in the rare case where panic and agitation are extreme.

LSD_{25}
d-lysergic acid diethylamide

This drug is an example of those which have a hallucinogenic effect. "Acid," as it is called on the street, is related in structure to other hallucinogens such as psilocybin, psilobin and mescaline. All these compounds contain an indole ring as part of their structure.

Other hallucinogenic compounds include FUK (a phosgene derivative), which appeared in 1968. Its use, fortunately, was limited, following several deaths reported on the West coast. Another hallucinogen is DOM (2, 5 dimethyl-4-methoxy-amphetamine) referred to by its users as STP — serenity, tranquility and peace. Of these drugs, LSD_{25} is more commonly used.

LSD_{25} is a synthetic chemical obtained from a fungus belonging to the ergot family that grows on rye plants.

On the street, LSD_{25} appears in various forms—colored capsules or tablets in doses of 250 to 1800 micrograms. At the present time, it is usually combined with a stimulant.

The effects of the drug are influenced by the same variables that were discussed with regard to Cannabis — subject, dose and circumstances. Previous experience with LSD_{25} may also influence the effects.

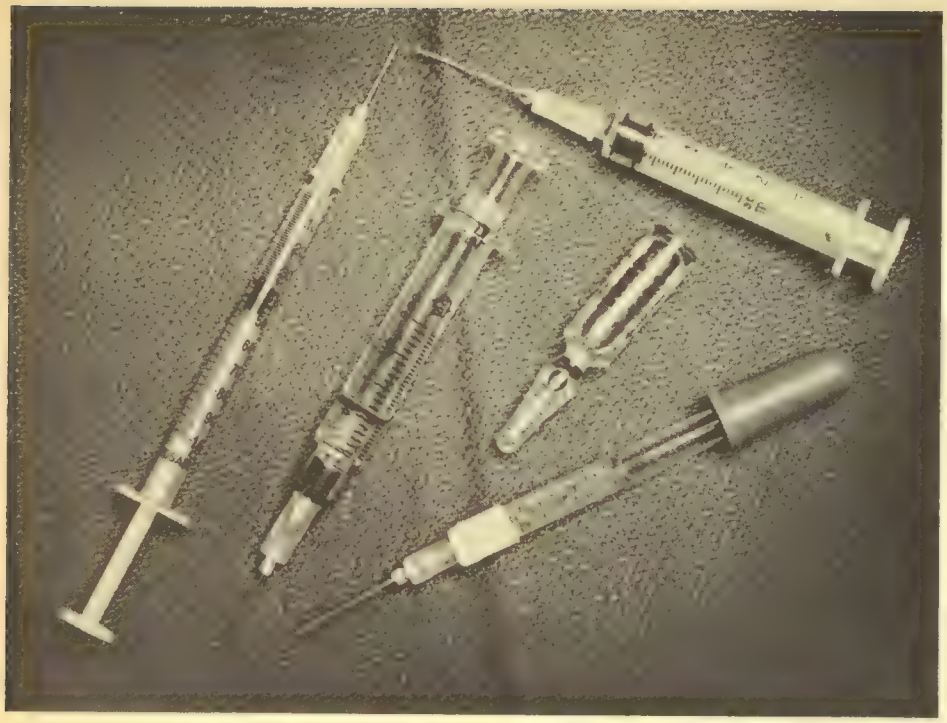
Visual effects, such as perception of intensified colors, distorted shapes and sizes, as well as movement of stationary objects, may be experienced. Auditory distortions may also occur, as well as disorientation. Emotional reactions are varied but increased self-awareness and dissociation of mind from body are reported. Negative emotional reactions are experienced, and these are very common when the pre-intake personality is disturbed in some way. The same user may have good "trips," or experiences, or bad "trips" on different occasions.

It is the bad experience or trip that presents a problem in management. When first seen, the patient is in a state of acute anxiety, but with a relatively clear sensorium. Visual and tactile hal-

Table 1

Summary of reactions of 100 subjects accustomed to cannabis smoking, after administration of ½ g to 2 g of ganja or charas through a pipe

Effects	Number
1. Euphoria and feeling of exhilaration	74
2. Depression	12
3. Increased energy, desire and capacity for work	39
4. More talkative	60
5. Mental activity and efficiency increased	30
6. Mental activity and efficiency decreased	10
7. Sharpening of appetite	58
8. Diminution of appetite	30
9. Appetite not affected	12
10. Feeling of constriction in the throat	40
11. Reaction to work as regards fatigue:	
(a) Less fatigue	60
(b) Sense of fatigue enhanced	20
(c) No effect	20



Laid out on a towel ready for use are these typical items used by drug abusers in Toronto. The three needles at left and top right are typical of those used to inject methamphetamines. The ampoule is of a type similar to those containing amphetamines. The eyedropper at right was converted to a hypodermic by taping a needle to it.

lucinations often accompanied by synesthesias are common. Such a person may be sensitive even to minor environmental stimuli and his focus of attention may shift quickly and frequently.

Paranoid suspicions and autistic withdrawal may occur in the same hour —in fact, the mental state may vary considerably. Thus, periods of apparent lucidity and normality tend to give way to abrupt recurrences of the bizarre, fearful state.

The principles in managing a bad LSD trip are: reassurance, reduction of threatening, external stimuli, and relief of panic with chemotherapy.

The treatment personnel are of the utmost importance in the successful management of a bad trip. In mild cases of anxiety and agitation, their sympathetic attitude toward the patient, combined with an understanding of his fear of loss of control over his environment, are all that is necessary for successful treatment. In anything but mild cases, however, the trip should be aborted chemically and as rapidly as possible. This seems to reduce the likelihood of so-called LSD flashes (recurrences) in the future. It is also not practical to have such a patient tear up an emergency ward. Within reason, start chemotherapy as soon as possible, before the patient harms himself or someone else.

Any person dealing with a "freaked-out acidhead" should avoid threatening legal or moral judgments and try to suppress any exhibition of hostility. Angry value judgments reinforce the patient's mistrust of treatment institutions and medical personnel. This widens the credibility gap that pre-exists in such a situation and lessens the chances of a patient or his friend returning to an institution where proper medical treatment can be given.

A simple attempt with a nasogastric tube can lead to a disastrous situation, as it can be interpreted as a very threatening move. Lavage is to be discouraged. It is a useless procedure where in most cases drugs have been ingested an appreciable period of time previously.

Most bad LSD trips are treated chemically and hospitalization is often advisable following this treatment as the patient tends to require such large doses of drugs in therapy that he may require monitoring of his vital signs. Whenever practical, however, the patient should not be admitted against his will.

When LSD_{25} made its first appearance in the drug sub-culture, chlorpromazine was used to decrease anxiety and psychiatric symptoms of a bad trip during the acute phase of agitation, which lasted anywhere from 8 to 24 hours.

Today, pure "acid" is rarely found in the streets and combinations of LSD are most common under such names as the "Peace Pill" (LSD, cocaine and mescaline), "LBJ Stayaway" (LSD, belladonna and atropine) and, more commonly, LSD and methamphetamine. The latter prolongs the LSD effects.

Atropine compounds enhance the hypotensive effect of chlorpromazine in a synergistic but non-dose-related manner. Too often, the administration of chlorpromazine to a patient who supposedly has taken LSD, has resulted in a cardiovascular collapse, cardiac arrest and even death. A similar picture results when chlorpromazine is given to "freaked-out" STP users.

In the initial assessment, any signs of atropine poisoning or a history of what was ingested can be helpful. But most of the time this is not available and, since all the underground pills resemble each other, it is best to treat in a manner which is likely to do least harm. Therefore, the use of chlorpromazine is discouraged. In the present treatment of bad trips, Valium is the most popular drug in Toronto and other major centres in North America.

In a Toronto series of 69 patients with acute hallucinogenic psychoses reported by Solursh and Clement,[2] 67 cases responded favorably to diazepam (Valium). The two patients who failed to respond had pre-existing psychiatric disorders (indigenous depression and paranoid schizophrenia) and required further chemotherapy.

Methamphetamine HCL

The third and last group of compounds abused by adolescents are the amphetamines, a group of synthetic, sympathomimetic stimulants, with a basic phenylethylamine structure. The proper medical use is limited to the treatment of narcolepsy and hyperkinetic behavior in children.

Unfortunately, amphetamines are very much abused. Thousands of housewives ingest them as a panacea for that terrible trio: obesity, fatigue and depression. Students use them to keep awake while cramming for examinations.

Although the present discussion relates to high-dose amphetamine abuse, the previously mentioned examples of low-dose abuse are relevant because they indicate that drug abuse is not confined to the sub-culture drug user. If you understand the relative ease with which the low-dose abuse evolves, it is easier to comprehend how high-

dose abuse can become such a problem among adolescents.

Amphetamines are the cheapest, least legally risky drug available. Possession is not against the law. Trafficking is illegal, but large quantities usually must be found by police before trafficking is considered to be present. Today, it is much easier to obtain amphetamines in Toronto than some other drugs, such as marijuana.

Methamphetamine, referred to as speed, meth or crystal, is the most common amphetamine in street use. It is manufactured illicitly by underground chemists using facilities where they work or their own small labs set up wherever feasible. The chemists are usually heavy users and generally have a sponsor with the necessary funds to set up the operation. The sponsor may be a loan-shark or an active partner.

A chemist can produce methamphetamine for about three dollars an ounce and will sell it for roughly nine dollars an ounce to a distributor. The distributor, rarely a heavy drug user himself, will dilute the product (one part drug to four of bulk materials) to increase the volume. He will sell this diluted product at $80 an ounce to "quantity dealers" on the street.

These latter individuals usually deal in a variety of drugs. Depending on the market, they sell to "street dealers" who may be high schoolers, motorcycle gangs, or similar people, and who are usually heavy users themselves. The street dealer will sell to the ultimate consumer for prices up to $100 an ounce. Almost all users deal some of the time, but not as consistently as the street dealers.

Amphetamines are sold in two forms, as solids in a white powder or tablets or capsules; or in solution ready for injection. Since the price of tablets is about 50 percent to 70 percent less than the injectable ampoules, the user often buys the solid form and turns it into solution for himself. Usually the solution is hot water from the nearest tap, "sterilized" in a spoon and injected intravenously.

The effects of amphetamines are predominantly on the central nervous system and include arousal, wakefulness, lessening of fatigue, a sense of increased energy and self-confidence, euphoria and, to a lesser extent, nervousness, insomnia and appetite reduction, with excessive motor activity.

Physically, the action of the amphetamines is close to that of adrenalin. There is an increase in heart rate and blood pressure; widely dilated pupils; dry mouth; sparse, thick saliva; relaxation of the gastrointestinal and minor smooth muscle; with diarrhea and difficulty in micturition.

For the speed freak (chronic amphetamine abuser), high-dose intravenous amphetamine abuse occurs in cycles, with periods of wakefulness lasting from two to five days and maintained by repeated injections, followed by 36 to 48 hours of sleep.

Injections produce an immediate result which has been described as a "total body orgasm." Initially, activity is purposeful, with marked loquaciousness (little useful being said and little remember by the speaker from one minute to the next). Yet the speaker has a sense of crystal-clear thinking and competence. As the amphetamine "run" proceeds, activity becomes less organized and initial relief of anxiety is replaced by self-consciousness and suspiciousness of others.

If the user injects more drug as he feels himself "running down," he will suffer increased agitation and suspicion. There is marked over-reaction to slight movements in the peripheral field of vision and, frequently, visual and auditory hallucinations appear. After several

Cannabis sativa—mood elevator

slang—marijuana, grass, pot, mary jane	
active ingredient:	tetrahydrocannabinols
source:	composed of the flowering tops and upper leaves of the unpollinated female **Cannabis** plant.
intake:	smoked, ingested (tea, brownies)
effects:	short term—varies with the dose, user and setting.
physical:	increased heart rate, increased blood pressure, redness of the eyes
mental:	sense of exhilaration, talkativeness, increased appetite.
treatment:	seldom required.

Lysergic Acid Diethylamide—hallucinogen

slang:	acid "A"
active ingredient:	synthetic chemical
source:	chemical derived from a fungus (ergot) that grows on rye.
effects:	vary with user, dose and setting
physical:	tremors, numbness, chills, nausea, weakness, cold sweaty palms, "goosepimpled" skin, loss of appetite, hyperventilation, increased blood pressure and pulse, dilated pupils.
mental:	visual effects, auditory effects, disorientation
combinations:	"LBJ," "Peace Pill"
treatment:	Don't use chlorpromazine

months of intravenous amphetamines, the user develops fairly well-organized delusions of persecution and personal ideations, though this is seldom a problem during early oral use.

The active phase may be terminated in two ways, by a psychotic reaction, or break-down, or because the patient is so exhausted, he may sleep for 24 to 48 hours. On awakening, he experiences a profound depression and is ravenously hungry. This depression is often so severe and intolerable that he may start another speed binge. The "speeder" who begins as a tyro with 20 to 40 mg. per shot, may work up to as much as six to seven grams per injection or even higher.

The therapeutic problems posed by the high-dose amphetamine user are, first, the exhaustion reaction. This is fairly simple and requires, mainly, supportive therapy. Second, the physical withdrawal reaction, in which severe depression, altered sleep patterns, difficulty in micturition, dry mouth and thirst may create a severe problem in treatment. Withdrawal initially may appear as paranoid schizophrenic psychosis in some persons and convulsions in others.

A third problem likely to be found in any emergency ward is the speed freak in an acute anxiety or full-blown psychotic reaction. These situations can sometimes be handled by calming the patient by the use of moderate drug therapy and non-threatening techniques on the part of the nursing staff. It is no affront to the nurses' ability if this fails. It would be a gross understatement to say that it is extremely difficult to be nonchalant and to stop yourself expressing hostility toward an aggravated, hostile paranoid "meth freak" who is tearing apart your emergency ward, striking the nursing staff and generally creating a chaotic situation.

The drug of choice in this situation is Valium or Haldol (McNeil Laboratories (Canada) Limited) (haloperidol) or more recently Tarasan, (Hoffmann-La Roche Limited). The latter two drugs are safe if you are sure no combined LSD or STP mixtures have been used. Barbiturates and morphine are also used in such centers as Los Angeles and New York.

The patient is hospitalized and observed for suicidal tendencies or convulsions. Eventually, if the patient acceps treatment, he is placed on Haldol as required, with Disipal (Riker Pharmaceutical Company Ltd.) to counteract the extrapyramidal side effects.

Tofranil (Geigy Pharmaceuticals) and Elavil (Merck, Sharp & Dohme of Canada Limited) are added if depression is a major factor, as is so often the case with speed freaks. Vitamins are also added. The patient is given supportive psychotherapy through the withdrawal phase, with social assessment as the long-term basis through the support of various suitable social agencies.

Some chronic amphetamine abusers are like alcoholic derelicts, and tend to return time and again to the emergency department. This frequently results in social and therapeutic mutual rejection by treatment centre staff and patient.

The indirect results of chronic amphetamine abuse have been thought until very recently to be the major cause of death in speed freaks. Research as recently as one month ago concluded that, besides causing morbidity in hypertension, phlebitis, hepatitis, chronic infections, septicemia, lung granulomata, cerebral vascular accidents, malnutrition and vitamin deficiency syndromes, high doses of intravenous amphetamines over a prolonged period act on body cells, and may cause enzyme damage in all the organs of the body. Thus, the amphetamines would be extremely dangerous, even without their indirect side effects.

What characteristics do chronic amphetamine abusers possess? There is some evidence that they tend to be passively dependent and chronically depressed, but much more research is needed in this whole area. What is the sociological significance of the existence of the chronic amphetamine abuser in the drug sub-culture? Currently studies are underway at our institution to elucidate this latter problem.

In conclusion I would like to offer some suggestions. When dealing in an office practice with a boy or girl misusing drugs:

1. Be knowledgeable about drugs and their effects. Stick to facts and avoid generalities. Kids are fairly knowledgeable themselves and know when you are putting one over on them.
2. If you find yourself hostile, refer the patient to someone more likely to prove understanding.
3. Build up the patient's confidence by dealing with his or her other health problems correctly.

Methamphetamine HCl—stimulant

slang:	speed, meth, crystal
active ingredient:	sympathomimetic, methamphetamine
sources:	synthetic
effects:	vary with dose, user and setting
low dose abuse	
high dose abuse	
short term	
long term	
direct—enzyme damage	
indirect—health problems	
characteristic speed freak:	chronic depressive
treatment:	Valium ®, Haldol ®, Tofranil®, Elavil ®.

Summary

1. Helping the teenage drug misuser is an important part of medical practice in many centers but it is far from easy.
2. Three of the common drug types is use by teenagers in Toronto are represented by Cannabis sativa (marijuana), LSD_{25} and similar hallucinogens, and the amphetamines.
3. Marijuana appears relatively harmless, seldom needs treatment. LSD_{25} is usually found now in combination with other drugs and, for this reason, chlorpromazine, once a treatment of choice, is specifically warned against. Valium is the drug of choice today. Recent research has shown the amphetamines to be dangerous in their direct effects on body cells and not simply in their indi-

rect influence on disease processes.

4. Personnel treating drug abusers should be particularly careful to avoid revealing hostility. Admittedly, this is sometimes difficult but it is important to show understanding and avoid judging the patient if he is to come back to the institution which can help him most.

Appendix

It is easier to bridge the communication gap with a drug misuser if you know the jargon he is likely to use. Here are some common terms:

Acid: — LSD.

Acidhead: — a person who regularly uses LSD.

Bad trip: — an unpleasant experience with a drug — usually LSD.

(to) Ball: — to have sexual intercourse with.

(to) Blow one's mind:— to break with one's personal reality.

(a) Bummer: — an unpleasant drug experience.

(a) Burn: — purchasing or using an ineffective drug.

"C" — candy, snow or coke: — cocaine.

Candyman: — cocaine dealer.

Cap: — No. 5 gelatin capsule.

Cool: — trust.

(to) Cop: — to purchase or acquire.

Coke freak: — a person who regularly uses cocaine.

(to) Crank, to shoot up, to hit: — to inject a drug intravenously.

Cunt: — an area or vein favored for injection.

Dime bag: — $10 worth of Cannabis — about an ounce.

Ditch: — the cubital fossa, a favored site for injection.

(to) Do: — to take (a drug).

(to) Do one's thing: — to perform a usual task.

(to) Do up: — to take mind-elevating drugs.

(a) Down (goofers, goof balls): — sedative or tranquilizers, usually barbiturates.

(to) Drop: — to inject.

(a) Fix: — an intravenous injection usually heroin or morphine.

Flash (rush): — an intense orgasm — like euphoria experienced immediately after an intravenous injection.

Flashing: — a periodic illusory perception of visual light flashes often a sequel of an LSD bad trip.

(to) Freak: — to hallucinate (not necessarily an unpleasant or undesirable experience).

(to) Freak out: — to feel loss of control over thought processes and have an unfavorable hallucinogenic drug experience.

Fuzz (the man, the pigs): — the police.

Grass (marijuana, pot, rope, Mary Jane): — Cannabis sativa.

Hang-up: — physical or emotional problems, usually associated with external society.

Hash: — hashish.

(to) Have one's head in a good space: — to be in agreement with another individual's ideas, to have insight into a problem.

Into (a drug): — to take a drug.

Joint: — a Cannabis cigarette.

Juice: — alcoholic beverage.

(to) Lay it on: — to give something (an object or words).

LBJ Stayaway: — a combination pill popular in Toronto during the summer of 1968, containing LSD, belladonna and strychnine, and having a duration of action of about three days.

Narcos (narks): — narcotic agents, R.C.M.P.

Needle freak: — a person who gets a thrill out of using a needle.

Nickel bag: — $5 worth of Cannabis.

Peace Pill: — a combination pill containing mescaline, cocaine and LSD.

Pipe: — a large vein.

Pothead: — a person who regularly uses Cannabis.

Rig (point): — needle and syringe.

(to) Rip off: — to steal.

Schmeck (smack, horse, "H", junk): heroin (diacetylmorphine).

Scriptwriter: — a sympathetic MD, easily duped into writing prescriptions for drugs, one who forges prescriptions.

Shit: — commonly used to denote heroin, but more recently methamphetamine.

(to) Smoke: — to smoke Cannabis.

(a) Snow freak: — a person who regularly uses cocaine.

Speed (meth., crystal): — any stimulant but usually methamphetamine.

Speeders: — people who regularly use stimulants.

Snow: — cocaine.

Straight: — someone who does not seek to understand the drug sub-culture but instead rejects it without careful thought. That's where he's at: — that's what he thinks.

(a) Trip: — a drug experience.

(to) Turn on: — to become involved with.

Wired: — addicted.

Author's note

This glossary is meant as an aid to understanding the history as given by the patient. Use of such jargon by the doctor will likely appear to the patient as a sign of dishonesty and falseness, and should be discouraged as being unprofessional.

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idea exchange

A. Operative field showing position of pocket bag and suction tip

B. Nurse applies pocket bag to Velcro surface on drape

C. Pocket bag and suction tip in position

Protecting OR Drapes

Numerous patches around the aperture and at one end of the laparotomy drapes used at our hospital convinced us that we had to find a way to save the drapes from further damage. In discussing the problem with the operating room personnel, we learned that the holes were probably caused by towel clips used to fasten the abdominal suction or cautery tips within easy reach of the surgeon, or to fasten the head end of the drape around intravenous poles, used as the anesthetic screen.

To prevent this damage, we now use Velcro instant zipper material, a sewing accessory available in retail stores.

A four-inch strip of Velcro, sewn on one side at the open end of a 4-inch x 8-inch cloth bag, provides a safe pocket that the scrub nurse can attach firmly to another piece of Velcro sewn near the aperture on the drape. This pocket prevents the abdominal suction tip or the cautery tip from slipping off the sterile field, and avoids the holes made by towel clips.

Two more sets of Velcro material, each about 4 inches long, are sewn to the head end of the drape, two feet on either side of the center. The drape can then be fastened around the intravenous poles without tearing the sheet.

The addition of the "pocket bag" to our lapartomy bundle saves the drapes, improves technique by keeping items in place on the sterile field, and saves time that would be needed to resterilize or replace a tip that falls from the sterile field. – *Joyce Fredin, head nurse, Central Supply Room, Prince George Regional Hospital, Prince George, B.C.*

Coffee hour at the University of Alberta Hospital, Edmonton, is an informal affair, when parents of hospitalized children meet to talk over problems and share opinions. The Rev. R. K. Dougan and Anne Toupin, (standing) supervisor of the hospital's pediatric unit, are two staff members who have taken part in most of the coffee hour session.

Coffee Break With A Difference

She watches a nurse feed a small patient, looks down to the child held close in her arms, and her face mirrors the reaction within her. The unknown, the lonely wait, add up to apprehension, fear.

Mrs. Bennett is sitting in the pediatric ward, patiently waiting for her child to be taken to the operating room. She has seen nurses at work, has wondered how her child will accept new surroundings — changed suddenly from familiar home life to a hospital.

The child stirs, disturbed by the strange activities. A nearby door opens and an operating room attendant walks toward Mrs. Bennett. The child is taken from her arms, placed on a stretcher, and another stage of fitting into hospital routine begins for this small patient.

Mrs. Bennett continues to watch as her child is carried farther down the corridor. She picks up a crumpled blanket, wrapped moments ago around the infant, and goes to the waiting room to smoke a cigarette and wait, alone.

Elsewhere in the pediatric unit at the University of Alberta Hospital, Edmonton, Alberta, preparations are being made for the weekly parents' coffee hour. A brain-child of the hospital's pediatric core committee, the coffee hour gives parents of hospitalized children an opportunity to relax with a cup of coffee. With encouragement from the hospital chaplain and a nurse from one of the five pediatric wards, parents talk about their apprehensions, register complaints, and share opinions with each other on a variety of subjects.

A nurse's invitation relieves Mrs. Bennett of her lonely vigil and she joins other parents for coffee. The chaplain welcomes the parents and explains the purpose of the social hour. In the friendly atmosphere, Mrs. Bennett relaxes and joins in serious discussions of mutual concern.

"Nurse, I wonder if I should be coming to see my son as often as I do? He is so upset when I leave. Sometimes I have a feeling I am in the way."

Other mothers listen for the nurse's reply.

"We realize hospitalization is hard on you and your boy, and we will try to make a strange situation less difficult for him. But the staff feel your presence in the hospital is important to him, and encourage you to visit him as often as you can. Because visiting hours are unrestricted, you may spend as much time with your son as you wish. Let me assure you, the staff appreciate the value of your visits, and we certainly don't consider you 'in the way.'"

The hospital chaplain is listening. He agrees, says it is quite normal for a young child to protest his mother's departure. "With the mother's reassurance that she intends to return, the child usually accepts the situation, and settles down to play activities in the ward, the chaplain explains.

The discussion continues for an hour. Subjects vary from the weather to hospital diets, and to ointments for diaper rash. Mrs. Bennett sits quietly, listening. Frequently she glances into the hall for signs of the stretcher bearing her child back to the ward.

As the children's rest period ends, the mothers finish their coffee and return to the wards. An invitation to join in another parents' coffee hour is quickly accepted.

After the parents have left, the nurse and the chaplain review the verbal and emotional content of the coffee hour. Many worthwhile suggestions have been made and they want to determine if any can be adopted by the hospital.

An idea for changing hospital diets for toddlers is gleaned from one mother's comments. A misunderstanding of hospital policy by some parents indicates effective communication is needed between hospital personnel and parents. Mrs. Bennett's anxiety is noted and it is decided to consult the charge nurse of her child's ward regarding follow-up care.

The coffee hour at the University of Alberta Hospital began in February 1969 as a tryout. Parents and staff participants were asked to evaluate the effectiveness of the program by completing forms designed for this purpose. The result? An overwhelming vote in favor of continuing the coffee hour.

Parent evaluations showed some revealing reactions: "I feel these sessions were definitely helpful, particularly for parents who are new to the hospital situation."

"It was very gratifying to be able to air my feelings about the care given to the children, and to share the opinions of other parents in a group discussion."

"I feel the pediatric department cares and shows interest in patients by this coffee hour. It is a wonderful help for parents to know staff are willing to listen and try to better the care. I feel the coffee hour should be continued."

Comments by nurses participating in the program are also positive. "These meetings are an excellent idea. They give us a chance to inform parents about hospital procedure, to settle misunderstandings, and to health teach."

"I feel, by attending these social hours, the parents are made to feel part of the pediatric team."

Although the parents' coffee hour has run fairly smoothly and has received positive support from parents and staff, it has not been completely free from problems. Parents seem reluctant to voice negative views on the kind of care given their children. This is often contrary to the troubled attitude they display while on the ward. Sometimes, when the group consists of 10 to 15 people, one or two parents tend to dominate the conversation. Others may wish to participate, but find the size of the group inhibiting. When this situation occurs, the staff participants try to draw silent members into the conversation.

Parents are sometimes hesitant to discuss particular concerns in a group. It has been observed, however, that parents who are silent during the coffee hour, or contribute to the discussion only on "safe" subjects, will later approach the chaplain or nursing staff for assistance.

Since the coffee hour takes place after lunch, it is not surprising that more mothers find it convenient to attend than fathers. And because of its success in promoting communication, some pediatric staff feel the coffee hour should be expanded. They suggest an evening session, so that husbands and wives can attend together.

Efforts are being made to include this change in routine. Its solution will undoubtedly increase the effectiveness of the parents' coffee hour.

A philosophy of pediatric nursing sees optimum parental involvement as an important goal in the care of the hospitalized child. For its achievement, however, there needs to be trust in the pediatric ward. Trust seems to develop most readily when there is effective and meaningful communication among physicians, nurses, parents, and children. The parents' coffee hour at our hospital has stimulated the growth of good parent-staff communication. This is surely a concrete example of greater parental involvement in patient care.

— Diane MacTavish, charge nurse, pediatric unit, and Rev. R.K. Dougan, director, department of chaplaincy services, University of Alberta Hospital, Edmonton. □

research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Roach, Sister Marie Simone. *Toward a value oriented curriculum with implications for nursing education.* Washington, D.C., 1970. Thesis (Ph.D.) The Catholic University of America.

This study was initiated because of a concern for the widening gap between what is proposed as a Christian philosophy of nursing education and the implementation of this philosophy in a given nursing curriculum. The study is related specifically to values inherent in a Christian philosophy of nursing education and the possibility of directly confronting these values in a given curriculum through the medium of experiential learning.

The study rests on certain assumptions: 1. that there is a contemporary value crisis that has a bearing on education, and which, according to the writer, appears to be related to certain movements or trends — naturalism, modern atheism, and humanism; 2. that a Christian philosophy of education encompasses certain values that need to be identified, and if sufficiently concretized, can be taught, provided appropriate teaching-learning strategies are used.

Using an exploratory approach, a major purpose of the study was to provide a background for future curriculum planning in one undergraduate nursing program by drawing from philosophy a Christian perspective on value theory, and, from education sources insights into teaching and learning values.

An attempt was made to show what consequences a Christian theory of value, as presented in the study, would have for a curriculum that identifies human health as its central core concept. Since, in the study, human health was considered as ultimate harmony and integration transcending death itself, it was necessary to use theological insights to account for the paradox that constitutes an experiential reality for the nurse, namely, the problem of pain, suffering, and death.

The conclusion of this study is that values are objective and can and should be taught. Further attention needs to be directed to the process by which values are internalized, as well as to the methodologies that facilitate this process. Since man is central to the educative process and the central value in education, the character and direction of the curriculum will be related to the philosophy of man on which the curriculum rests. If a nursing curriculum is supported on a theocentric humanism, it would seem that Christian philosophy of man and theology are essential core courses.

The writer believes that a value-oriented curriculum is a possibility. The actual implementation, however, presupposes a greater refinement of the answer to the question, "What values?" Philosophical and theological foundations of the nursing curriculum need to be explored, and greater expertise in the selection and integration of content in these areas demonstrated.

Wadsworth, Patricia Mary. *A study of the perception of the nurse and the patient in identifying his learning needs.* Vancouver, 1970. Thesis (M.A.) The University of British Columbia.

The purpose of this study was to compare the perception of the nurse and the perception of the patient in identifying priorities for the patient's learning needs with respect to his medical condition and hospital environment. A Q-sort of statements related to these two learning needs was developed and used to test the nurse's perception and the patient's perception of these learning needs. The diabetic patient was selected for study because his learning needs with respect to his condition are well documented, and the general staff nurse was selected because she is responsible for direct patient care.

To test the hypotheses, the Q-sort was administered to 50 newly-hospitalized diabetic patients, to 50 general staff nurses directly responsible for the care of these patients, and to 50 general staff nurses having no contact with a patient or no direct responsibility for his care. The study was conducted in a large hospital in Vancouver, British Columbia. The hypotheses assumed that the two groups of nurses and the patients would assign different priorities to the patient's learning needs. The .05 level of significance was used in this study.

An analysis of selected personal characteristics of the patients provided a description of the patient population. The findings showed that all but one patient had been in hospital before, and that only three patients were newly diagnosed diabetics. An analysis of selected personal characteristics of the nurses indicated that there was no significant difference between the two groups. Thus, any differences in perception could not be attributed to these characteristics.

The Q-sort scores of all three groups were examined for differences in perception, and the selected personal characteristics were tested with respect to these scores. The results indicated that the patients and both groups of nurses assigned a greater degree of importance to the patient's learning needs related to his diabetic condition than those related to the hospital environment. Although the nurses attached a greater degree of importance to the former needs than did the patients, the difference was not significant.

The results of the study have demonstrated the value of the Q-sort technique as a procedure for acquiring data on the learning needs of the patient. The analysis of the data of the nurses and patients under their care provided a measurement of the quality of patient care. In addition, the analysis of the data of the patients provided a guide for the establishment of a desirable learning sequence for the individual patient. □

Nursing Studies Wanted

The Canadian Nurses' Association Library welcomes additions to its collection of nursing studies. Any nurse who has a thesis or a report on a research project conducted at a hospital or other agency is invited to send it to the CNA Library, 50 The Driveway, Ottawa 4, Ontario. Short abstracts of studies received are published in the *CNJ*.

books

The Professional Nurse by Kathleen K. Guinée. 177 pages. London, The Macmillan Company. Canadian Agent: Collier-Macmillan Canada, Ltd., Don Mills, Ontario, 1970.
Reviewed by Dorothy J. Kergin, Director, School of Nursing, McMaster University, Hamilton, Ont.

The jacket description of this book states that Professor Guinée "...seeks to develop in the beginning student of nursing an awareness of the many different roles and responsibilities of the professional nurse. She attempts to prepare the future nurse for the increasing complexity of the nursing profession and the constantly changing needs of the community."

Aside from the chapters on nursing education programs in the United States and on the purposes and activities of professional nursing organizations in that country, the text should be of use to nursing student in Canada. It is difficult to assess the level of student intended by the author, as part one has more substance and validity than part two.

Part One "Foundations of Professional Behavior," includes material on nursing, societal change, the professions, professional ethics, and teaching nursing. It also includes topics aimed at the beginning student in a basic nursing program. Following each chapter are bibliographies and seminar topics, including questions for discussion and projects for research.

Part two, "Development of Professional behavior," includes description of nurse behavior with patients. Although families are seldom mentioned, the focus is on the patient's perceptions. The level of content seems appropriate for only the most unsophisticated of beginning students, and one finds unsupported and imprecise generalizations, such as, "It is well known that patients feel better in the presence of a nurse."

The descriptions of the responsibilities of various levels of nursing and related personnel in hospitals and community agencies would serve as a useful review for students as they begin clinical practice. Part two would be of greatest value as a reference for secondary school students who wish to gain information on the opportunities available in nursing.

Any teacher of nursing is advised to assess carefully how well the text will contribute to the achievement of course objectives before considering its adoption.

Structure and Function in Man, 2nd ed. by Stanley W. Jacob and Clarice Ashworth Francone. 591 pages. Toronto, W.B. Saunders Company, 1970.
Reviewed by Mary J. Ross, Director of Nursing, Aberdeen Hospital, New Glasgow, Nova Scotia.

This book is designed for use by the first year nursing student. It looks at the human body as a whole and goes on to deal with its specific parts. Anatomy and physiology have been integrated throughout the text in the hope that the student would more readily understand life as an integrated process.

The subject is presented under four units which discuss normal functioning of the body, and deviations from the normal. In each chapter, the author presents a comprehensive summary of the topic discussed, and study questions for the purposes of review.

The section on bones, muscles, and articulations, is well illustrated and the diagrams are excellent. A separate chapter on skin and various abnormalities of the skin, along with diagrams is included to make the text more meaningful to the student.

The major asset of this text is its presentation of the subject matter. The book is written clearly, concisely, and in a logical sequence. It provides a valuable teaching and reference source for the first year student.

Arrows of Mercy by Philip Smith. 244 pages. Doubleday & Company, Garden City, New York, 1969. Canadian Agent : Doubleday Publishers, Toronto, Ontario.

This author tells the absorbing story of the development of curare for use in clinical anesthesiology. In describing how curare came to be used so widely for muscular relaxation during general anesthesia, he has also summarized the history of attempts from early times to the present to provide pain relief and unconsciousness for the performance of surgical operations. Philip Smith has captured the fundamental skills of the anesthesiologist, who is part physician, physicist, pharmacologist, diagnostician, and specialist in respiratory control. He has also placed in perspective the development of anesthesia and the development of curare. Descriptions in the book range from the frock coat surgeon of the pre-antiseptic era, to the modern transplant of a heart and other organs. It is interesting too for both the lay reader and the professional.

Part One gives a general history of research in surgery. In a colorful account, we learn of the groping toward medical knowledge, when the cavemen opened each other's skull. The operation is known today as *trepanning*.

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Canadian
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- Hospital Nurse Expands Role
- Epidurals and Childbirth
- Computer Aids Psychiatry
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Prince George Regional Hospital, Prince George, B.C., p. 53

University of Alberta Hospital, Edmonton, Alta., p. 54

books

The Rennaissance brought with it new medical advances which showed later in the work of Thomas Morton and Horace Wells, who successfully made use of ether to rid man of surgical pain.

Part Two discusses in depth the discovery and use of the drug curare.

Part Three summarizes the advances of anesthesiology in the nineteenth and twentieth centuries. It takes us from the natives of the Amazon to cardiac surgery by Dr. Christiaan Barnard and his first human heart transplant.

This is a fascinating and detailed account of the progress of medicine. It shows an unbelievable advance in medical technology in the twentieth century.

Readers who are excited by the romance of progress in medicine, who appreciate a lively storyteller, and the professional who enjoys medical folklore will find this book more than a textbook approach to medical history.

Human Nutrition and Dietetics, 4th ed., by Sir Stanley Davidson and R. Passmore. 899 pages. London, E. & S. Livingstone Ltd., 1969, Canadian Agent: Macmillan Company of Canada Limited, Toronto.
Reviewed by Lillian C. Sharp, Teaching Dietitian, University of Alberta Hospital, Edmonton.

This new edition of a well-known British text displays extensive knowledge and interest in human nutrition. The topics are well documented and comments are made on current research.

The book follows the same organizational pattern as previous editions. It is divided into six parts : Part I gives an account of the physiology of nutrition; Part II gives a general description of the chemical and nutritive properties of foods commonly used by man. Effects of food processing and a brief account of various forms of food poisoning are also included; Part III describes diseases caused by faulty nutrition; Part IV deals with defective diets as they contribute to general disease patterns and an account is given of treatment in which proper diet is necessary; Part V is concerned with nutrition in public health, emergency feeding, and outlines the work of the Food and Agriculture Organization of the United Nations; Part VI deals with special diets in pregnancy and lactation, athletic training, and extremes of climate.

Illuminating tables and charts are included throughout the text. These are for the most part, identical to the previous editions and whole paragraphs, even whole chapters, are transposed from the old text to the new. There are, however, some changes in terminology and word usage. For example the term retinol replaces vitamin A, and cholecalciferol is introduced as an alternative name for vitamin D_3.

An interesting item under new and improved foods suggests that the production of protein concentrates from yeasts, using petroleum oils as substrates, already useful in the feeding of animals, may benefit humans.

The reports on cyclamates, listing benefits and risks, are already outdated. Although sodium glutamate is mentioned, latest theories and findings about this flavor enhancer are not included. Similarly, although mention is made of the accumulation of DDT in fatty tissues, the latest decision to ban its use as an insecticide has not been mentioned.

A new section on hospital food discusses the wastage and the poor quality of the food, particularly in larger hospitals, comments on nurses being poorly informed about nutrition should raise a few hackles.

Modern contraceptive techniques are described as a method of voluntary control of the population explosion. Some methods of family planning in various countries are outlined, and the problems and difficulties which have yet to be overcome are noted.

The diets mentioned in the appendix are based on British products and British food habits and may not be readily understood by Canadians. However, these diets are quite usable and can easily be altered to suit any circumstance.

The book contains a vast amount of information and could be used as a reference text, especially in institutions conducting teaching programs. All members of the medical team will find it a valuable asset.

A Happier Life, by Alfred E. Eyres and Charles T. Pearson. 270 pages. Durham, North Carolina, Moore Publishing Company, 1969.
Reviewed by Carol Kotlarsky, formerly Editorial Assistant, The Canadian Nurse.

There is no magic formula for living a happier life, says the author of this book, but you may be able to help yourself overcome emotional difficulties. This well-organized book was written to provide psychiatric self-help, and cov-

(continued on page 60)

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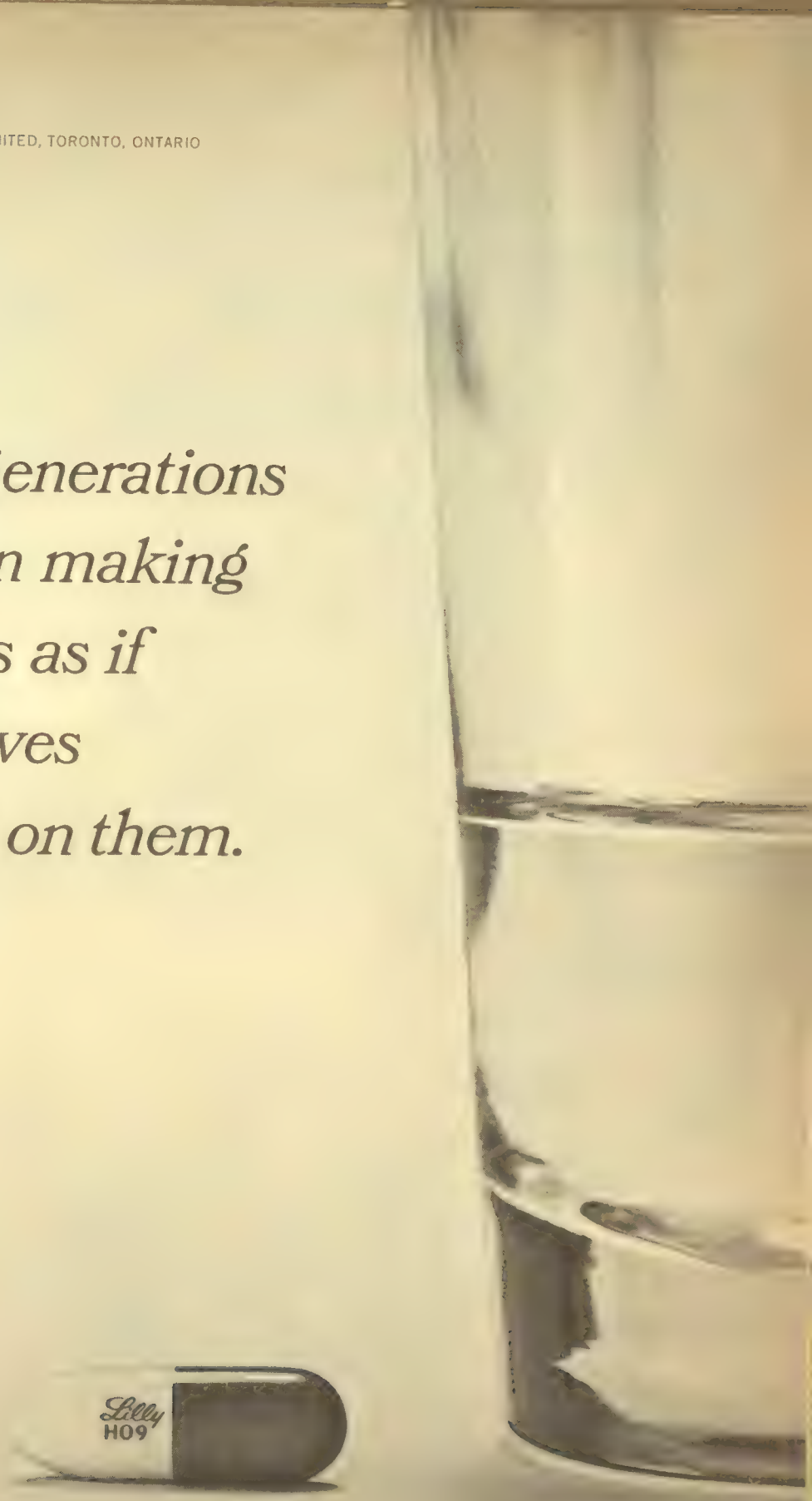

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books

(continued from page 58)

ers topics such as learning to budget your worries, training yourself to relax, and knowing if psychoanalysis can help you.

You don't have to be in the medical profession to understand what the author is saying, because all psychiatric terms are clearly explained and case histories give added meaning to words like paranoia, paradoxical intention, and schizophrenia. The book takes a realistic and practical approach to preventing emotional difficulties, and advises that one of the ways to maintain an emotional balance is through proper eating habits.

The highlights are listed at the end of each chapter, making an effective summary of the material covered. □

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, *except Reference items* may be borrowed by CNA members, schools of nursing and other institutions. *Reference items* (theses, archive books and directories, almanacs and similar basic books) do not go out on loan.

Requests for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa 4, Ontario.

No more than *three* titles should be requested at any one time.

BOOKS AND DOCUMENTS

1. *The art of translation* by Theodore Savory. Boston, The Writer, 1968. 191p.
2. *Behavioral concepts & nursing intervention* coordinated by Carolyn E. Carlson. Toronto, Lippincott, 1970. 341p.
3. *Canadian books in print* edited by Gérald Simoneau. Toronto, Canadian Books in Print Committee, 1969. 764p.
4. *Coronary care units in small hospitals — the Standish (Michigan) experience* by Eric H. Helt et al. Battle Creek, Mich., W.K. Kellogg Foundation, 1970. 99p.
5. *A doctor discusses narcotics and drug addiction* by Louis Relin. Chicago, Budlong Press, 1969. 90p.
6. *L'éducation des enfants et des adoles-*

cents handicapés. Tome 1 Les handicapés moteurs par Lucien Lefèvre et al. Paris, Sociales Françaises, 1969. 245p.

7. *Education in the health-related professions.* Consulting editors Joseph G. Benton and Richard S. Gubner. New York, New York Academy of Sciences, 1969. p.821-1058. (New York, New York Academy of Sciences. Annals, v. 166 art. 3)
Partial contents. — The feldsher in the USSR by Victor Sidel, p.957-966. — Nurse midwifery by Louis Hillman, p.896-902. — The pediatric nurse practitioner and the child health associate: new types of health professionals by Henry K. Silver, p.927-933. — The physician's assistant in the community hospital and in office practice by Hu C. Myers, p.911-915. — The physician's assistant in the university center by E. Harvey Estes, p.903-910. — Trends in nursing education by Joan Hartigan, p.1045-1049.

8. *Enrolment in educational institutions by province 1951-52 to 1980-81* by Z.E. Zsigmond and C.J. Wenaas. Ottawa, Economic Council of Canada, 1970. 306p. (Economic Council of Canada staff study no. 20)

9. *Family* by Margaret Mead and Ken Heyman. Toronto, Collier-Macmillan, 1965. 208p.

10. *Guide to the use of books and libraries,* 2d ed. by Jean Key Gates. Toronto, McGraw-Hill, 1969. 273p.

11. *Healthier living,* 3d ed. by Justus J. Schifferes, with a foreward by William Hammond. Toronto, John Wiley & Sons, 1970. 578p.

12. *Hygiène et prophylaxie* par G. Viguier. Paris, Librairie Maloine, 1970. 364p.

13. *An illustrated guide to medical terminology* by Helen R. Strand. Baltimore, Williams & Wilkins, 1968. 110p.

14. *Is your child on drugs* by Ralph E. Wendeborn, Lorrie McLaughlin and Michael E. Palko. Toronto, Mil-Mac Publications, 1970. 210p.

15. *Medical librarian examination review book. Vol. 1; 1500 multiple choice questions and referenced answers* compiled by Jane M. Fulcher. Flushing, Medical Examination Publishing Co., 1970. 186p.

16. *Medicine in the university and community of the future;* Proceedings of the scientific sessions marking the centennial of the Faculty of Medicine, Dalhousie University, Sep. 11-13, 1968. Edited by I.E. Purkis and U.F. Matthews. Halifax, Faculty of Medicine, Dalhousie University, 1969. 241p.

17. *Men money and medicine* by Eli Ginzberg with Miriam Ostow. New York, Columbia University Press, 1969. 291p.

18. *Nursing examination review book; 1600 multiple choice questions and referenced answers* edited by Martha M. Borlick et al. Flushing, Medical Examination Publishing, 1969. 255p. (Nursing examination review book no. 9)

19. *L'opéré abdominal; les suites normales et compliquées de la chirurgie abdominale* par Philippe Détrie. Paris, Masson & Cie, 1970. 653p.

20. *Orthopedic nursing* by Carroll B. Larson and Marjorie Gould, 7th ed. St. Louis, Mo., Mosby, 1970. 486p.

21. *Pharmacology and patient care* by Solomon Garb, Betty Jean Crim and Garf Thomas, 3d. ed. New York, Springer, 1970. 597p.

22. *The professional nurse; orientation, roles, and responsibilities* by Kathleen K. Guinée. Toronto, Collier-Macmillan, 1970. 177p.

23. *Promotion of physical comfort and safety* by Valentina G. Fischer and Arlene F. Connolly. Dubuque, Iowa, Wm. C. Brown, 1970. 94p. (Foundations of nursing series)

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25. *Psychology for a changing world* by Idella M. Evans and Patricia A. Smith. Toronto, Wiley, 1970. 444p.

26. *Psychologie et éducation* par Joseph Leif et Jean Delay. Montreal, Fides, 1965-1968. 2v. Contents. - t.1 L'enfant. - t.2 L'Adolescent.

27. *Qui conteste qui?* La contestation et la santé mentale, conférence tenue à Montréal du 4 au 8 mai 1969 organisée par l'Association canadienne pour la Santé Mentale, Division du Québec. Montréal, Association canadienne pour la Santé Mentale, 1969. 213p.

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29. *The role and preparation of the outpost nurse* by Ruth E. May. (*In* Medicine in the university and community of the future... Halifax, Faculty of Medicine, Dalhousie University, 1969. p.59-61.)

30. *Rules of order* by Henry M. Robert; a new and enlarged edition by Sarah Corbin Robert. Glenview, Ill., Scott, Foresman, 1970. 594p.

31. *Sample catalogue cards exemplifying the Anglo-American cataloging rules.* Compiled by K.L. Ball et al. 3d ed. Toronto, University of Toronto Press; for School of Library Science, 1969. 150p.

32. *Sources of medical information; a guide to organizations and government agencies which are sources of information in fields of medicine, health, disease, drugs, mental health and related areas, and to currently available pamphlets, reprints and selected scientific papers arranged by subject,* edited by Raphael Alexander. New York, Exceptional Books, 1969. 84p.

33. *Special libraries: development of the concept, their organizations, and their services* by Ada Winifred Johns. Metuchen, N.J., Scarecrow Press, 1968. 245p.

34. *The speech writing guide; professional techniques for regular and occasional speakers* by James J. Welsh. New York, John Wiley & Sons, 1968. 128p.

35. *State approved schools of professional nursing 1970.* New York, National League for Nursing, 1970. 116p.

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38. *Student's guide for writing college papers* by Kate L. Turabian. 2d. ed., rev. Chicago, University of Chicago Press, 1969. 205p.

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42. *Woman; a biological study of the female role in twentieth century society* by Philip Rhodes. London, Transworld Publishers, 1969. 191p.

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44. *Belleville General Hospital, School of Nursing, 1893-1970: historical information*. Belleville, 1970. 5p. *R*

45. *Extending the boundaries of nursing education; the preparation and roles of the functional specialist*. Papers presented at the fifth conference of the Council of Baccalaureate and Higher Degree Programs, Denver, Colorado, Nov. 12-14, 1969. New York, National League for Nursing. Dept. of Baccalaureate and Higher Degree Programs, 1970. 39p.

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47. *Guidelines for the purchase of services*. A report on the Canadian Welfare Council's task force on purchase of service agreements between non-governmental agencies and provincial and municipal government agencies, under the Canada Assistance Plan. Ottawa, Canadian Welfare Council, 1969. 21p.

48. *Public Affairs Committee. Pamphlets*. New York.

No. 436 *What about marijuana* by Jules Saltman. 1970. 21p.

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49. *Statement in nursing education, nursing practice and service and the social and economic welfare of nurses*. Geneva, International Council of Nurses, 1969. 10p.

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50. Bureau of Statistics. *Mental health statistics, 1967*. Ottawa, Queen's Printer, 1970. 196p.

51. —. *Survey of vocational education and training, 1967-68*. Ottawa, Queen's Printer, 1970. 98p.

52. Dept. of Labour. Legislation Branch. *Labour relations legislation in Canada*. Ottawa, Queen's Printer, 1970. 180p.

53. Dept. of Manpower and Immigration. *University, college and technological institute; guide; graduations, enrolments, salaries*. Prepared by... the Professional and technical Occupations Section, Manpower Information and Analysis Branch, Program Development Service. Ottawa, 1968. 45p.

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75. *The male patient — an opportunity and a challenge* by Albert W. Wedgery. London, Ont., 1960. 62p. *R*

76. *Nursing education in a changing society.* Published on the occasion of the fiftieth anniversary of the University of Toronto, School of Nursing, edited by Mary Q. Innis. Toronto, Univ. of Toronto Press. 1970. 240p. *R*

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AUDIO-VISUAL AIDS

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80. *Staff development.* Prepared by Myrtle Kitchell Aydeoltte. New York, National League for Nursing, 1970. 4 tapes (NLN Nursing services cassettes) □

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HEAD NURSE required for 15-bed hospital, 105 miles East of Edmonton. Leadership, Pharmacy and Supplies control, needed. Pleasant staff residence in lovely country with many recreational facilities. Alberta Hospital Association salary schedule. Apply Administrator, Mannville Municipal Hospital, Mannville, Alberta. 763-3621.

REGISTERED NURSES FOR GENERAL DUTY in a 34-bed hospital. Salary 1968, $405-$485. Experienced recognized. Residence available. For particulars contact: Director of Nursing Service, Whitecourt General Hospital, Whitecourt, Alberta. Phone: 778-2285.

GENERAL DUTY NURSES for active, accredited, well-equipped 65-bed hospital in growing town, population 3,500. Salaries range from $490 — $610 commensurate with experience, other benefits. Nurses' residence. Excellent personnel policies and working conditions. New modern wing opened in 1967. Good communications to large nearby cities. Apply: Director of Nursing, Brooks General Hospital, Brooks, Alberta.

GENERAL DUTY NURSES (2) for small, modern hospital on Highway no. 12, East Central Alberta. Salary range $477.50 to $567.50 including regional differential. Residence available. Personnel policies as per AARN and A.H.A. Apply to: Director of Nursing, Coronation Municipal Hospital, Coronation, Alberta.

GENERAL DUTY NURSES for 94-bed General Hospital located in Alberta's unique Badlands. $405 — $485 per month, approved AARN and AHA personnel policies. Apply to: Miss M. Hawkes, Director of Nursing, Drumheller General Hospital, Drumheller, Alberta.

ALBERTA

Inquiries are invited from **GENERAL DUTY NURSES** for positions in a 330-bed active-treatment and auxiliary hospital complex. This is an ideal location in a city of 27,000 with summer and winter sports facilities nearby. 1970 salary schedules effective May 1, 1970, $490. — $610. Recognition given for previous experience. For further information, please contact: Personnel Officer, Red Deer General Hospital, Red Deer, Alberta.

PUBLIC HEALTH SENIOR NURSE with D.P.H.N. (minimum) or baccalaureate degree, and supervision experience preferred, required for Minburn-Vermilion Health Unit. Good personnel policies. Salary range $7,552-$9,512. Apply: Dr. F.J. Covill, Director and M.O.H., Minburn-Vermilion Health Unit, Vermilion, Alberta.

BRITISH COLUMBIA

A HEAD NURSE and STAFF NURSES will be needed for Child Psychiatry. The Head Nurse will participate in the clinical development and subsequent operation of the 20-bed unit anticipated for the Royal Jubilee Hospital's Eric Martin Institute of Psychiatry. Current registration with the Registered Nurses' Association of British Columbia is required. Enquiries should include background and experience and be made to the: Director of Nursing, Royal Jubilee Hospital, 1900 Fort Street, Victoria, British Columbia.

NURSES registered in British Columbia with **PSYCHIATRIC** experience are needed for the newly opened Eric Martin Institute of Psychiatry. When fully opened this 170-bed facility is anticipated to have a Day Hospital, 6 Acute Adult Psychiatric Units and a 20-bed Children's Unit. Attractive salary scale and liberal personnel policies. Apply to the: Director of Nursing, Royal Jubilee Hospital, 1900 Fort Street, Victoria, British Columbia.

REGISTERED NURSES, G. NURSES and all Hospital personnell are available: Contact: PHILCAN PERSONNEL SERVICE, 5022 Victoria Drive, Vancouver 16, British Columbia. Ph. 327-9631.

GENERAL DUTY NURSES for modern 33-bed hospital located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply to: Director of Nursing, General Hospital, Fort Nelson, B.C.

GENERAL DUTY NURSES for modern 35-bed hospital located in excellent recreational area. Salary and personnel policies in accordance with RNABC. Comfortable Nurses' home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia.

OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing. RNABC policies in effect. Credit for past experience and postgraduate training. British Columbia registration is required. For particulars write to: The Associate Director of Nursing, St.Joseph's Hospital, Victoria, British Columbia.

NURSES' COME TO THE PACIFIC NORTHWEST — Gateway to Alaska. Friendly community, enjoyable Nurses' Residence accommodation at minimal cost. 1970 RNABC contract salaries in effect. Registered $549-$684. Non registered $522. Northern Differential $15 a month. Travel allowance up to $60 refundable after 12 months service. Apply to: Director of Nursing, Prince Rupert General Hospital, 551 5th Avenue East, Prince Rupert, British Columbia.

MANITOBA

GENERAL DUTY NURSES: Applications are invited from **Registered Nurses** for a 100-bed accredited hospital 50 miles west of Winnipeg on Trans Canada Highway. Salary range $510 / $595 per month effective September 1st, 1970. Excellent fringe benefits plus evening and night differentials and academic attainment bonuses. Applications will be received by: Director of Nursing, Portage District General Hospital, Portage la Prairie, Manitoba.

NEW BRUNSWICK

DIRECTOR OF NURSING required for 56-bed acute General Hospital. Salary commensurate with education and experience. Apply to: Administrator, Sackville Memorial Hospital, Sackville, New Brunswick.

NOVA SCOTIA

REGISTERED NURSES: Applications are invited from Registered Nurses trained in psychiatry for the position of **DIRECTOR OF NURSING** at the Halifax County Hospital, a 425-bed psychiatric hospital. Good salary, working conditions and fringe benefits. Please address applications to: Administrator, P.O. Box 1003, Halifax County Hospital, Dartmouth, N.S.

REGISTERED NURSES for active accredited 111-bed maternity hospital. Positions available in labor and delivery, antenatal and nursery departments. Please apply to: Director of Nursing, Grace Maternity Hospital, Halifax, Nova Scotia.

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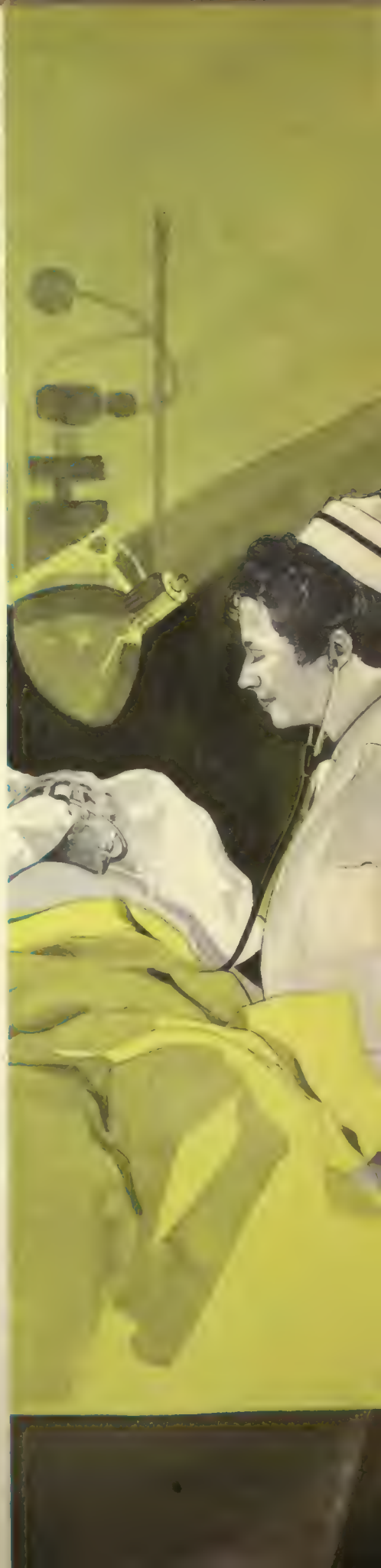
October 1970

The Canadian Nurse



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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

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At the Canadian Nurses' Association's general meeting last June, delegates approved a resolution directing CNA to ask the federal department of health and welfare to call a national conference to study health matters affecting Canadians. The resolution stated that this conference should provide a forum for discussion among the major purveyors (nursing and medicine) and the consumers of health services, and that special emphasis be on the development of complementary roles for nurses and physicians.

CNA received an encouraging reply from the deputy minister of national health in July, stating he supports the rationale of the resolution. He added however, "The resolution itself . . . is another matter. It seems to me there are a number of steps to be taken before such action could be productive."

Probably one step to which the deputy minister refers would involve obtaining data on programs where nurses have already demonstrated their ability to assume additional responsibility. This seems logical before embarking on a national conference, and would help set the stage for action, rather than mere rhetoric.

Nurses *are* expanding their traditional roles in many settings, and articles published in previous issues of *The Canadian Nurse* attest to this.

We are convinced, however, that change has occurred in other areas in nursing, but is not being reported. Whether this reticence by nurses to publicize their expanding roles and functions stems from a fear of criticism by physicians, or merely from self-modesty — we do not know. We do know, however, that unless nurses give a clear picture of what they are doing to fill the gap between the physicians' role and their own, the demand made by a few influential physicians for a new category of worker — the physicians' assistant — stands a good chance of being met.

This month we feature an article by a clinical nurse specialist describing how the role of the active-care hospital nurse in one center is expanding; an article slated for November will show how occupational health nurses in one industry are successfully assuming responsibilities once considered far beyond the competence of a nurse. Who knows, perhaps we will eventually be able to publish an article explaining how *nurse midwives* across Canada are helping to reduce the high incidence of maternal and mortality rates in this country!

— V.A.L.

letters

Letters to the editor are welcome.
Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Weight gain inaccurate?

It was rather astounding to read the statement in the article "My You're Getting Big" (August 1970), advising that pregnant women should limit their weight gain to about 16-20 pounds, when from press reports, the public is warned that "the current medical practice of restricting pregnant women to a weight gain of only 10 to 14 pounds may be contributing to the high infant mortality rate in the United States," by a United States Committee of the National Research Council. Further, a gain of around 24 pounds was being recommended, according to various reports.

Interested nurses are advised to read research reports, such as the *American Journal of Public Health, Part 2,* April 1970, and Dr. Charles Lowe's testimony before the Senate Select Committee on Nutrition and Related Human Needs, especially on new findings regarding protein synthesis by the brain, in utero, and in infancy. Dr. Joaquim Cravioto, the noted Mexican nutrition expert, gave additional information at the 12th annual meeting of the Canadian Federation of Biological Sciences in Montreal this June. *Nutrition Today* (USA) is another source of newer thinking available to nurses.

Perhaps it would be wise to delete dogmatic statements about the Canadian situation until all findings are in from the coming Canadian federal nutrition survey. Possibly our estimates of protein requirements will be raised considerably by this study and from some preliminary soundings. — *A. Cecilia Pope, R.N., M.R.S.H., Toronto, Ontario.*

The author replies:

Nowhere in my article was 16 to 20 pounds given as the *recommended* weight gain in pregnancy. The point was that the pregnancy weight itself accounted for 16 to 20 pounds, that is, uterus 2 to 3 pounds, placenta 1 pound, etcetera, and that the mother should be aware of this so she will not expect to be exactly the same weight and size postpartum as she was before she became pregnant. The point made was to emphasize the need for anticipatory teaching.

The additional information Miss Pope provides is certainly of interest and could be used in teaching mothers so they will be still more accepting of their "flabbiness" postpartum. — Elaine Carty, R.N., Kingston, Ontario.

Timely and revealing

I feel strongly about the excellent article "Negligence in the Recovery Room" (July 1970). It is a timely and revealing piece of information.

The nurses involved and, sadly, the patient, were sacrified to prevent a similar situation from occurring in high risk areas. When this disaster was made public, there was a province-wide reaction, and staffing in most hospitals was under close scrutiny by administration and nursing service.

The events that led to this tragedy were precipitated by the much maligned coffee break. It was suggested that a coffee break should be taken at the beginning of the shift. This is ridiculous. A break was designed to increase efficiency and to relieve tension or even monotony, if present in a working day. All of us have missed coffee and lunch breaks during peak periods, but how well and accurately were our duties carried out?

My point is that few have come to the defence of the nurses involved. The picture is quite clearly one of communication breakdown due to a tight budget and lack of foresight. Head nurses, supervisors, and nursing administrators are all involved and responsible for staffing during break periods. Our profession has condemned those responsible in this hospital, but it is time for provincial associations to evaluate staffing, make recommendations to employers, and provide support when these recommendations are not met.

Other professions stand behind their numbers as well as discipline them. Why can't we? Is it because we are predominantly a female profession?

Two excellent nurses have had their lives permanently scarred. I submit that the hospital staffing pattern is responsible for the circumstance, not the nurses involved. — *B. Hudson R.N., Surrey, British Columbia.*

Comments on abortion

"Abortion," you say, "should be a matter that concerns the patient and her doctor," (editorial, August 1970) Aren't you forgetting somebody? What about the tiny bit of life that exists in the mother's womb? Who is going to fight for and protect him?

Physicians, biologists, philosophers and theologians do not know when a fertilized ovum becomes a person. Are we, as nurses, so certain of the time when humanity begins, that we will advocate the abortion of an organism? Is there any difference between aborting a fetus and murdering a newborn baby? If you answer yes then let me hear your arguments. Prove to me that a fertilized ovum is *not* a human being.

In my graduation pledge, I promised to respect human life as sacred. Each patient is treated as a valuable, individual human being. Furthermore my students are taught to do the same. Now, you are asking me to belong to a professional association that denies

the value of human life. Where do you draw the line? Am I to return to my patients and students and say, "Yes, human life is valuable, but not the life that is unborn"? Do you expect anyone to believe me?

If the Canadian Nurses' Association advocates legalizing abortion, I will dissociate myself from it, and urge my fellow nurses to do the same. I will not practice and teach the value of life, and at the same time ignore it.

You will argue that legal abortions are more humane than those performed by back-alley abortionists, but the more fundamental question is, "Are we responsible for our actions?" We must accept the consequences of what we do, be they minor ones, like cystitis, or more serious, such as venereal disease or pregnancy. The treatment of the former consequences, however, does not involve the sacrifice of an innocent life. If we, as a professional association, advocate legal abortion, we are saying that people are no longer responsible for their actions. I am not willing to do this. Are you? — *Mary Ann Constantin Morgan, R.N., B.N. Montreal, Quebec.*

Editor's Note: The Canadian Nurse' Association has not taken a stand on the matter of termination of pregnancy. The ideas expressed in the editorial are the editor's opinions.

Permanent shifts

I wish to congratulate Helen Saunders on speaking out in her article "Lets' Have Permanent Shifts" (June 1970). In the past, nurses have been required to sacrifice their personal needs. Let's be a little more human.

When a nurse feels happy and secure in her work, she will give better service to her employer and to her patients. If an employer wants the respect of her staff, then she must follow one policy for all. No employer should tell some nurses that they have to rotate shifts, while others are permitted to work on a permanent shift basis. Staff will be more cooperative, will follow hospital policies, and economize willingly if there is no discrimination and everyone is treated alike with respect to shifts. — *Hazel J. McLaughlin, R.N., Port Credit, Ontario.*

Journal not educational

While browsing through files of *The Canadian Nurse*, I realized what a great journal we used to have. These issues were truly educational, to a degree not found in our present publications.

One example, the March 1964 journal, really made the point! It featured a complete cardiovascular series and included all the peripheral vascular diseases, excellent descriptions of anatomy and physiology, with open heart and catheterization procedures. If we could do this in 1964, think what we could offer today's subscriber.

Our journal should revert to being an educational series, with accurate medical terminology rather than the current lay terms now used. The latest August issue had *not one* article involving basic medical knowledge.

I would like to see less social news and more articles on continuing education. — *Doreen J. Stewart, R.N., Edmonton, Alberta.*

No unemployment protection

I have recently learned that thousands of nurses in Canada are completely unprotected against unemployment. Is there a valid reason for some nurses to be ruled ineligible for unemployment insurance?

Hospitals usually have their own unemployment insurance schemes. Nursing homes of any size now must include their nursing staffs in unemployment insurance contributions. But what happens to the many not-so-young nurses who are finding it almost impossible to get work? They have made no contributions and are thus ineligible for unemployment benefits. In many cases they cannot afford to keep paying for hospital and health insurance.

Cannot the provincial nurses' associations take the first step in looking at the reasons why nurses are a race apart? — *R.N., Ottawa.*

Time for rededication

I enjoyed reading the August issue, especially the editorial and the CNA resolutions. It is refreshing to hear talk of throwing off the "cloak of conservatism," although it is a long time coming. I support your ideas on abortion reform support, and on the problem of CNA fees. Payment of such fees ought to be manditory, despite the shrieks of protest this is bound to bring.

I also fully support the idea that we must begin to ensure that people everywhere in Canada be given the best possible health care. Thinking nurses have been afraid to speak out for better care for far too long, and sometimes have been unable to give better care due to other restraints, some of which have even come from other nurses. It is time for rededication. Let us tune in to the challenges of the seventies! — *Georgina Kish B.N., Montreal, Quebec.*

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news

French Nurses Not Being Recruited As Physicians' Assistants

Ottawa — France has a shortage of doctors, but to date there is no talk of nurses being recruited as physicians' assistants, according to two French nurses who visited Ottawa on a private study tour August 31 to September 4.

Marie-Claire Portehaut and Janine Prevot, postgraduate students at the International School of Higher Nursing Education in Lyons, explained that third-year medical students who had not qualified for a medical degree were used this past summer as an experiment to help fill the gap between the doctor-nurse services.

Although the two French nurses had not been in Canada long enough to make many comparisons between nursing in the two countries, they did note that the organized profession here is stronger than in France. One reason, they said, was because there are four nursing associations in their country, and not every nurse belongs to the national association. In France, many of the decisions affecting nursing are made by the department of health, rather than by the nurses' association.

When asked why the length of nursing education programs in France was being increased from two to three years in 1971, Miss Portehaut said the aim was to give students a broader education and include more of the behavioral sciences in the curriculum. This could be done only by extending the length of the program.

Most schools of nursing in France are affiliated with hospitals, Miss Prevot said, and as yet there are no university schools of nursing. "Our emphasis now is on raising the standards of admission to schools," she explained. "We are trying to convince government authorities that higher standards of admission, better salaries for nurses, and a more interesting curriculum would attract more people to the profession."

Miss Portehaut and Miss Prevot said they were particularly interested in learning about nursing education in Canada; the administration of nursing care and the kind of care being planned to meet the total needs of the patient; and the organization of the national association. During their week in Ottawa, they visited the Canadian Nurses' Association, the department of national health and welfare, the National Defence Medical Centre, and the Vanier School of Nursing. Their remaining six weeks will be spent in the province of Quebec, as guests of the Association of Nurses of the Province of Quebec, and they will return to France in mid-October.

Two postgraduate students from the International School of Higher Nursing Education in Lyons, France, visited the Canadian Nurses' Association in August. Marie-Claire Portehaut, *left*, and Janine Prevot, *right*, talk with Doris Crowe, CNA's recently appointed public relations officer.

CNA Ad Hoc Committee Meets For Final Discussion

Ottawa. — The final meeting of the Canadian Nurses' Association's ad hoc committee to study recommendations of the task force reports on the cost of health services in Canada, was held at CNA House August 24-27. The first meeting was held in April, and results of that meeting were presented to the CNA board of directors for discussion and approval at the June general meeting in Fredericton.

Committee chairman Lois Graham-Cumming, head of CNA's research and advisory services, said 59 recommendations were discussed at the August meeting, and one of the main issues was that of the nurse practitioner. The 14-member committee included chairman of the three standing committees: nursing education; nursing service; and social and economic welfare. Provincial associations were represented by an appointed member. Members were sent a detailed questionnaire and working papers to prepare for the meeting.

A final report will be submitted to the CNA board of directors meeting this month. The board is expected to take a stand on the nurse practitioner issue at this time.

Nursing Legislation Discussed At International Seminar

Geneva, Switzerland — Nurses representing 23 national nurses' associations met in Warsaw, Poland, from July 6 to 16 to discuss legislation affecting the nursing profession. Conducted in English and French, the seminar was organized by the International Council of Nurses, with funds from the Florence

Nightingale International Foundation. The Polish Nurses' Association was host, and organized a varied program of social and professional activities.

All participants at the seminar were nurses who are in a position to promote nursing legislation in their own countries. The Canadian Nurses' Association was represented by Helen M. Sabin, executive secretary of the Alberta Association of Registered Nurses.

Seminar participants looked at nursing legislation in relation to nursing education, nursing practice, social and economic welfare of nurses, and the role of auxiliary nursing personnel. The recognition and licensing of foreign qualifications, a code of ethics and standards for practice, and the role of the national nurses' association in nursing legislation were studied. Throughout the seminar, discussions were based on the publication *Principles of Legislation for Nursing Education and Practice — A Guide to Assist National Nurses' Associations*. It is the published result of the first stage of the FNIF project, which was the calling of an expert group on nursing legislation in 1968.

Those attending the nine-day seminar in Warsaw had the added responsibility of evaluating the meeting; their judgments will affect the planning of future legislation seminars. This first FNIF international seminar on nursing legislation will, ICN believes, meet the need voiced by member associations for assistance in formulating or reassessing the laws relating to nursing in their own countries.

Speakers at the seminar presented their own points of view, which were as varied as the countries they represented and did not necessarily reflect ICN's official position. Although the speakers emphasized that the legislative needs of a country can relate only to that country, they agreed that the same basic principle applies everywhere: nursing legislation must safeguard the care provided to the community, the education of the nurse, and the quality of her practice. The responsibility rests with nurses to assume leadership in promoting appropriate nursing legislation to meet the needs of their respective countries.

Seminar participants said the prime purpose of nursing legislation is to secure for society the benefits that come from the services of highly skilled nursing personnel. With the present mobility of people, every country must consider provisions for the licensing of nurses from other countries. Regardless of the approach taken, the minimum standard to be met must be comparable to the standard set for graduates of the country. Reciprocity of laws and agreements made between registration bodies safeguard a minimum standard of education and practice. In the development of this legislation, the professional association must participate so it can reflect the profession's viewpoint and uphold nursing standards.

The three consultants for the FNIF seminar were Mary Henry, registrar of the General Nursing Council for England and Wales; Dr. L. Krotiewska, director of the legal department, ministry of health and social welfare and lecturer at the postbasic medical center, Poland; and Julie Symes, registrar of the Nursing Council of Jamaica.

The list of speakers included Mrs. Sabin, Canada; Maja Foget, director, nursing education, national health service of Denmark; A. Bailey, registrar of the Nursing Council of Nigeria; M. Oostinga, administrative secretary of the National Nurses' Association of the Netherlands; Margaret Darby, hospital matron, North Canterbury Hospital Board, New Zealand; Anny Pfirter, head of the medical personnel section, International Committee of the Red Cross; and Margaret Pickard, ICN nurse adviser.

Jadwiga Izycka, member of the Board of ICN and of the Polish Nurses' Association, extended greetings to the participants on behalf of ICN's board of directors.

(Continued on page 11)

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DESCRIPTION: Each CORICIDIN "D" tablet contains 2 mg. CHLOR-TRIPOLON* (chlorpheniramine maleate), 230 mg. acetylsalicylic acid, 160 mg. phenacetin, 30 mg. caffeine, 10 mg. phenylephrine.

DOSAGE: Adults: one tablet every 4 hours, not to exceed 4 tablets in 24 hours. Children (10-14 years): ½ the adult dose. Children under 10 years: as directed by the physician.

SIDE EFFECTS: Adverse reactions ordinarily associated with antihistamines, such as drowsiness, nausea and dizziness occur infrequently with Coricidin "D" when administration does not exceed recommended dosage.

PRECAUTIONS: May be injurious if taken in large doses or for a long time. Additional clinical data available on request.

*reg. Trade Mark.

For colds of all ages:
Coricidin tablets,
Coricidin with Codeine,
Coriforte© for severe colds,
Nasal Mist, Medilets
and Coricidin "D" Medilets
for children,
Pediatric Drops,
Cough Mixture
and Lozenges.

Schering Corporation Limited
Pointe Claire 730, P.Q.

(Continued from page 8)

CNF Membership Rising Slowly

Ottawa — Only 78 new members have joined the Canadian Nurses' Foundation in the six-month period from February to August, 1970.

The interim membership of the CNF indicates a total of 1,389. Provincial membership is shown below:

Canadian Nurses' Foundation Membership as of 1 August, 1970

Province	*Membership*
British Columbia	371
Alberta	106
Saskatchewan	104
Manitoba	48
Ontario	317
Quebec	78
New Brunswick	212
Nova Scotia	90
Prince Edward Island	13
Newfoundland	14
Outside Canada	18
Total	1,371
Sustaining	17
Patron	1
Grand Total	1,389

Greylisting of Muskoka-Parry Sound And Peel County Health Units Ended

Toronto, Ont. — The Registered Nurses Association of Ontario has lifted the graylisting of both Muskoka-Parry Sound and Peel County health units.

On strike since May 18, the nurses at the Muskoka-Parry Sound health unit returned to work August 10. The new contract is retroactive to January 1, 1970, and provides salaries of $6,550 to $8,050 as of January 1, 1970; $7,000 to $8,500 as of August 10, 1970; and $7,500 to $9,000 as of July 1, 1971. Other improvements gained by Muskoka-Parry Sound nurses include increments for registered nurses not previously paid. The contract expires December 31, 1972.

Peel County nurses requested and received a greylisting of their Board of Health by RNAO on July 14. A strike vote was taken, but not acted upon, when settlement was reached. The contract is retroactive to January 1 1970 and expires June 30, 1972. Salaries are as follows: $6,700 to $8,200 as of January 1, 1970; $7,000 to $8,200 as of August 1, 1970; and $7,500 to $9,000 as of July 1, 1971. Peel County nurses will receive five annual increments in place of four, and holidays have also been negotiated. By 1972 nurses will be entitled to four weeks holidays after three years. In the previous contract, only nurses with seven years of service were entitled to a four-week holiday.

Salary Increase Awarded To Nova Scotia Nurses

Halifax, N.S. — An arbitration board awarded salaries of $5,700 to $6,840 in August to nurses employed by the Nova Scotia Civil Service Commission. The department of public health and four provincial hospitals, the Victoria General, the Nova Scotia (psychiatric) hospital, the Nova Scotia sanatorium, and the Point Edward sanatorium, are affected by this award.

In Nova Scotia, the Civil Service Act provides for a joint council to consider matters regarding employment for civil servants. Through their Civil Service Association, the nurses had requested a basic salary of $6,000. The council offered them a starting salary of $5,520. This offer was rejected and the dispute was brought to an arbitration board. Hearings held in June and July brought out discussions on: the comparative wage levels in other institutions of the same kind; the comparative wage levels of persons doing similar jobs in industry; the trends in wage increases, par-

(Continued on page 14)

Our best sponge ever is of course our popular TOPPER* Sponge. The TOPPER* Sponge owes its long-standing popularity to its all-round efficiency and economy. The outer gauze cover of this sponge encloses a layer of absorbent surgical viscose filmation of longer staple and greater purity than ordinary cotton filler, and a centre web of cellulose which serves to diffuse drainage laterally, thus assuring full use of the entire absorbent capacity of the sponge. Because of this unique design, TOPPER* Sponges retain up to 20% more fluid. In other words, they're just that much more sponge for the money! TOPPER* Sponges are available in various sizes in either bulk or Patient-Ready* form.

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Our best sponge yet is our new TOPPER* SPONGE WITH SOFNET* GAUZE. This remarkable new sponge has a number of major advantages over ordinary sponges. It is up to 25% more absorbent than ordinary sponges, making for not only convenience but economy, since less sponges will be needed. Too, it boasts virtually no wound adherence, to both facilitate removal and speed healing. It is extra soft and comfortable, cushioning the wound better and adding to patient comfort. The SOFNET* gauze cover makes this sponge uniquely easy to handle.

TOPPER* SPONGES WITH SOFNET* GAUZE are also available in various sizes in either Patient-Ready or bulk form.

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WITH

SOFNET* Gauze

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(Continued from page 11)

ticularly in local areas; concepts of what is just, fair, or reasonable; and the cost of living.

The raise will be retroactive to January 1, 1970, and one increment of $240, and three of $300 were also granted.

New Diploma Program For New Brunswick Students

Fredericton, N.B. — Official approval has been granted by the New Brunswick Association of Registered Nurse to the new Saint John School of Nursing, scheduled to open its doors this fall. The school, directed by Anne Thorne, will be the first of its kind in New Brunswick, and represents a totally new philosophy in the education of nurses.

Students will learn the practice of nursing through an educationally-controlled program of studies, rather than the traditional service-oriented approach. They will pay a tuition fee for their course and will not be required to live in residence.

The concept of the Saint John School of Nursing emerged as individuals involved in nursing education became interested in modernizing education for nursing in the Saint John area. Essential ideas relating to nursing education at the diploma level, incorporated by the Saint John School of Nursing, appear in such writings as *A Path To Quality*, by Dr. Helen K. Mussallem, and *Portrait of Nursing*, by the late Dr. Katherine MacLaggan. Support for the concept that nursing education can best be accomplished in an institution whose primary purpose is education, has also been expressed and reiterated by the NBARN for many years.

The program of the Saint John School of Nursing will be approximately two years in length. By the fall of 1970, with the admission of students to the new school, both local hospital schools of nursing will begin to phase out their present programs.

Included in the curriculum are general education courses and nursing courses. Facilities for nursing practice will include the Saint John General Hospital, St. Joseph's Hospital, and other health-directed agencies in Saint John. Graduates will receive a diploma in nursing.

The new program is supported by the Hospital Services Division of the New Brunswick department of health and welfare, and has its own board of directors, under the chairmanship of Dr. R.M. Pendrigh. Applications for admission are now being accepted.

Further information may be obtained from Anne Thorne, Director, Saint John School of Nursing, Brunswick House, Coburg Street, Saint John, New Brunswick.

New Coronary Teaching Aid Purchased By SRNA

Saskatchewan nurses had the opportunity to test their new $7,000 multimedia instructional system in coronary care (see AV aids, *The Canadian Nurse*, June 1970) this summer at two, five-day institutes held in Saskatoon and Regina.

The system is the first of its kind in Canada and was purchased from Rocom, through the new health education and information division of Hoffman-LaRoche Inc. of Montreal. A variety of educational techniques are involved in this system, including motion pictures, sound filmstrips, and texts, as well as lectures, demonstrations, discussions, case history presentations, clinical experience, and problem solving.

The purpose of the cardiopulmonary resuscitation and emergency care institutes was to improve a nurse's effectiveness in caring for patients with cardiopulmonary emergencies.

The multimedia instructional system expands and updates the basic course content of intensive coronary care —*A Manual for Nurses* by Meltzer, Pinneo, and Kitchell.

The SRNA has set certain policies to govern the use of the Rocom system. It will be loaned only on written request at least a month in advance. A nurse must sign for it and be responsible for accepting and returning the unit. The maximum period of the loan will be two weeks, and cost of shipment must be paid by the borrower.

Grant For University of Manitoba To Study Geriatric Hospital Care

Ottawa — A $12,520 federal government grant to the University of Manitoba to study the role of day hospitals in home care programs for elderly persons has been approved by the department of national health and welfare.

The demonstration project will be conducted by the Victorian Order of Nurses at the Deer Lodge Hospital and Winnipeg General Hospital.

The VON has been designated by the social service in Winnipeg as a coordinating agency for future developments in home care.

The three objectives of the project are: to demonstrate the feasibility of having a voluntary agency supervise a hospital-based activity and therapeutic program in a day hospital; to determine the management and operative aspects of such a day hospital operation; and to demonstrate the role of an integrated support program for geriatric patients in maintaining them in the community by providing social relief, the stimulus for continuing activity and continuity of care. This portion of the project will be carried out by comparison on a paired patient basis between the Deer Lodge Hospital, which has a day hospital component, and the Winnipeg General Hospital, which does not.

The project stems from a recommendation concerning the requirements of geriatric health care contained in the report of the task force on health services in Canada.

NB Committee Set Up To Study Nursing Education

Fredericton, N.B. — A committee to study and make recommendations on nursing education for the province of New Brunswick has been established. The announcement was made July 24 by the provincial health and welfare minister, Norbert Theriault.

The committee will include representation from nursing education, nursing service, the medical profession, hospital administration, the public, and the provincial departments of health and welfare and education. Chairman of the committee is Chaiker Abbis, Q.C., of Edmundston.

Among the topics to be studied by the committee are: the types and levels of nursing education; the number of nurses that must be educated to meet the anticipated need in nursing service, and the process of standard-setting, inspection, and enforcement of standards in nursing education.

The committee began work in September, and is expected to submit its final report by the end of this year.

CMAJ Editorial Says Abortion Should Be Patient's Choice

Ottawa — Doctors should not be obliged to assume the function of gatekeepers to decide which unwanted children should be allowed into this overpopulated world and which ones should not, says an editorial in the August 1 issue of *The Canadian Medical Association Journal*. "The moral aspect of this question should reside solely with the patient and not with the physician."

The editorial questions the present law in Canada that requires a hospital abortion committee of at least three physicians to review applications from physicians on behalf of their patients seeking abortion. Few of the applicants for termination of pregnancy are seen by the committees, the editorial says, thereby violating one of the most cher-

ished principles of medicine, namely, that one does not make medical decisions without at least seeing the patient.

"If the hospital abortion committee is really a judicial tribunal," the editorial continues, "society should be aware that it is made up of people who have no training in using the law to see that justice is done. Further, the women on whose fate the tribunal is deliberating has none of the legal rights and safeguards she would have if she were on trial in a court of law, namely the right of counsel and the right of appeal from the decision."

The *CMAJ* editorial says the present law is open to wide variation of interpretation and, as a result, inequities abound. Some committees are made up of physicians who hold a conservative view, and in such a hospital few applications are approved; physicians trying to get help for their patients become discouraged and turn to a hospital where the committee takes a more liberal view. "The latter facility soon becomes overwhelmed, while the former hospital is able to insist that it has an active abortion committee as the law demands but that few applications are received."

The editorial emphasizes that in all countries with a committee-type screening procedure, illegal abortions remain a serious public health hazard.

Most of the opposition to a truly liberal abortion law has to do with the rights of the fetus, *CMAJ* says. "The proponents of this argument must show an equal concern that the rights of the unwanted child are respected and guaranteed after it is born," it adds.

The *CMAJ* editorial says that the recent stand taken by the Canadian Phychiatric Association on the abortion issue, namely that the termination of pregnancy should be removed from the Criminal Code and should become strictly a medical procedure to be decided by the woman and husband, if she has one, will likely encourage other medical bodies and individual physicians to declare themselves openly on the subject.

Federal Grant For Symposium On Drug Users

Ottawa.— A $15,000 federal government grant has been awarded to the Canadian Hospital Association to support a national symposium on hospital handling of drug users.

National health and welfare minister, John Munro, said he hopes "... the symposium will try to examine the problems of drug users within the total context of the situation, and that health agencies outside the hospital field be invited to participate in the program."

1 ELASTOPLAST elastic adhesive bandages
give strong support, allow air to reach the skin and moisture to evaporate to promote rapid healing.

2 GYPSONA
Bandages and Slabs are available in 4 types for casts of great strength, minimum weight, and fine porcelain-like finish.

3 JELONET
Paraffin Gauze Dressings are non-adherent and open-meshed. Now available in individual sterile unit 'peel-apart' envelopes.

4 ELASTOPLAST dressing strips
are continuous elastic adhesive porous dressings. Strips are cut to fit the wound.

5 ELASTOCREPE
Cotton Crepe Bandage is a smooth surface non-adhesive bandage with unique properties of stretch and regain.

6 NIVEA CREME
is beneficial in a wide variety of skin conditions after deep x-ray therapy, plastic surgery, chafing, and as a lubricant.

7 SUPER-CRINX
Softstretch Bandages conform to difficult body contours. It's unique weave of cotton and nylon assures sustained tension.

8 PLASTAZOTE
Polyethylene Foam Splinting Material is light yet strong enough to form a variety of splints, supports, and prostheses.

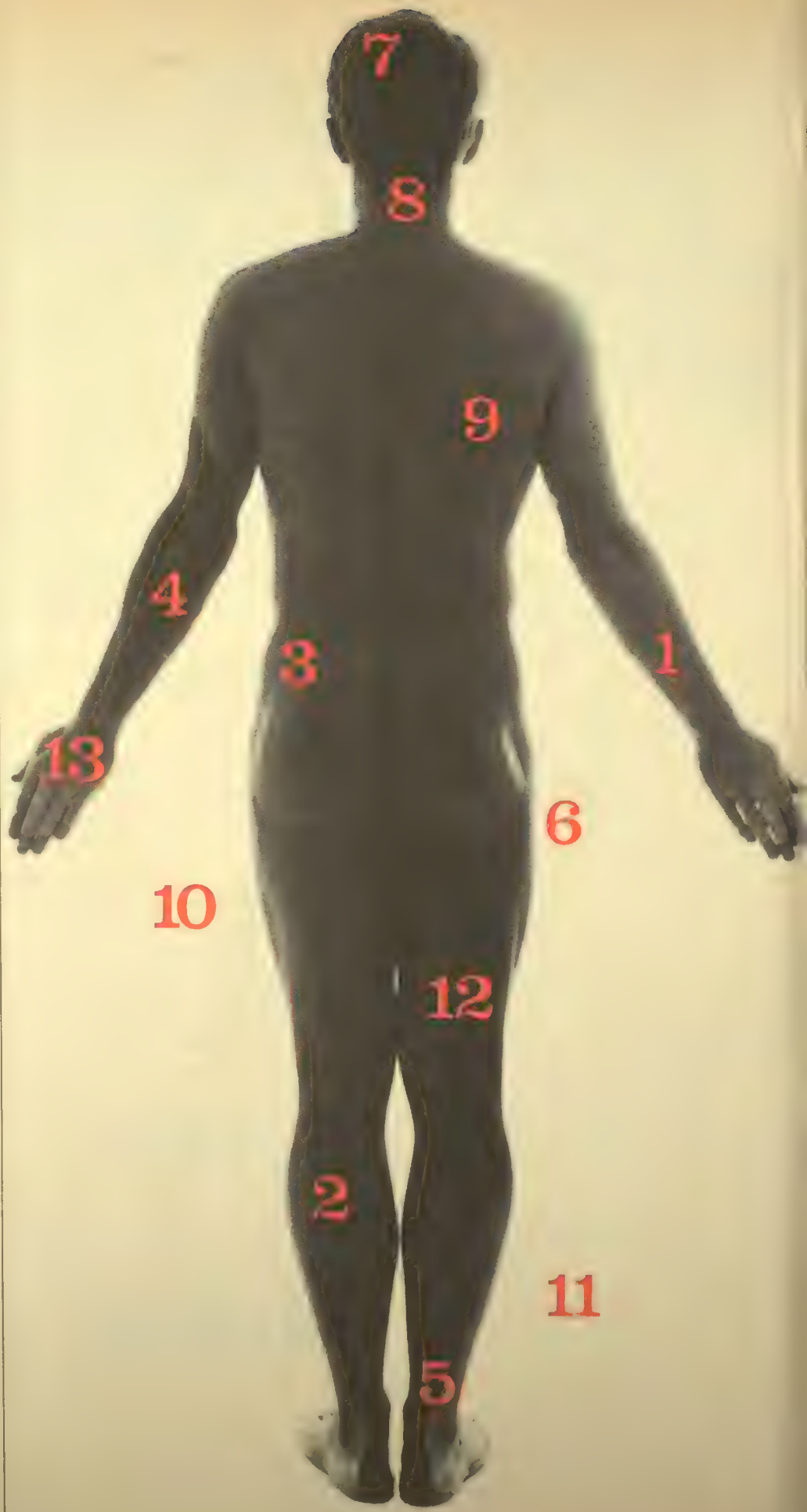
9 ELASTOPLAST 'airstrip' ward dressings
for the care of post-operative wounds–air-permeable yet water-proof to permit healing under ideally dry conditions.

10 DISPOSABLE
gowns, masks, caps, sheets, bed pan and urinal covers are for low-cost sanitary use in the hospital.

11 CELLOLITE
All-Cotton Thermal Blankets give maximum warmth and comfort with minimum weight and withstand the strain of repeated laundering.

12 ELASTOPLAST skin traction kits
are ready-to-use and provide the most efficient method of skin traction.

13 ELASTOPLAST anchor dressings
feature a porous elastic adhesive fabric—H-shaped to give firm anchorage on hard-to-dress areas.



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names

Liv-Ellen Lockeberg (R.N., Royal Victoria Hospital, Montreal; Diploma P.H., U. of Toronto, Toronto; B.A., Carleton University, Ottawa) has been appointed assistant editor of *The Canadian Nurse*. For the past five years she has been with the research development section of the department of national health and welfare, where her administrative duties centered around the public health research grant.

Miss Lockeberg has had 15 years of active nursing, including: Victorian Order Nurse in Ontario's Porcupine area; public health nurse in Deep River, townsite for the atomic energy plant at Chalk River, Ontario; and visiting nurse in the outlying counties served by the Ontario Hospital, London. She later joined the scribes in the Prime Minister's Office, remaining there during the tenure of Mr. Diefenbaker and Mr. Pearson.

Miss Lockeberg has a keen interest in people, outdoor activities, and the creative arts.

Jean Audrey Lister (R.N., St. Boniface School of Nursing, St. Boniface, Manitoba; Dipl. nursing service administration, U. of Western Ontario, London, Ontario; B.N. Lakehead U., Thunder Bay, Ontario.) has been appointed coordinator of inservice education at St. Boniface General Hospital.

Mrs. Lister obtained all of her nursing experience in Ontario. At McKellar General Hospital, Thunder Bay, Ontario, she held positions as general duty nurse, assistant head nurse, head nurse, and supervisor of inservice education. Following her hospital experience Mrs. Lister was appointed lecturer in nursing at Lakehead University, Thunder Bay.

Clare Chuchla (R.N., bachelor of science in nursing education, Gonzaga U. school of nursing, Spokane, Washington) has been appointed assistant director of nursing education at the Clarke Institute of Psychiatry, Toronto.

Miss Chuchla has had wide experience in psychiatric nursing education. She completed an eight-month internship at the Alberta Guidance Clinic in Calgary, Alberta — a provincial diagnostic and treatment service for children and young adults. Her most recent appointment was as instructor at the Mount Royal Junior College in Calgary. Earlier teaching positions were with the department of nursing education for mental health services in British Columbia; the school of nursing, University of Ottawa; the Jewish General Hospital school of nursing, Montreal; the Edmonton General Hospital and the Royal Alexandria Hospital, Edmonton.

Lynda Lafoley (R.N., St. Michael's Hospital School of Nursing, Toronto) has arrived in Honduras to serve a two-year tour of duty with MEDICO, a service of CARE.

She will join a MEDICO team stationed at Hospital de Occidente in Santa Rosa, a rural town in the western part of the country. The team is working to expand and upgrade med-

Nurse Honored at Convocation

Dr. Virginia Henderson, a nurse widely renowned for her work, writings, and research, was granted the honorary degree of Doctor of Laws, honoris causa, at the spring convocation of the University of Western Ontario. She is author of several books, including *The Nature of Nursing* and *ICN Basic Principles of Nursing Care*. Miss Henderson is presently working on the *Nursing Studies Index* from 1900 to 1957. Standing behind Miss Henderson is Dean Catherine Aiken of the University of Western Ontario School of Nursing. Dr. D.C. Williams, president and vice-chancellor of Western, read the citation that described Miss Henderson as "Leader, scholar, and author, whose devotion to the profession of nursing has elevated and distinguished it and whose personal charm is such that the prospect of having her care for one is the only argument known in favor of being sick."

ical treatment in the area and to train counterpart personnel.

Miss Lafoley will teach in the school for auxiliary nurses and supervise local nursing personnel in the wards. Previously she worked at the Ottawa General Hospital, and also served with the Canadian University Services Overseas in Ghana, West Africa.

Josephine DeBrincat (R.N., Winnipeg General Hospital School of Nursing, Winnipeg, Manitoba; Dipl. public health, U. of Toronto.) has been granted honorary life membership in the Canadian Public Health Association.

Miss DeBrincat, who retired in 1965, has been active in public health nursing. She was industrial nursing consultant in the Manitoba provincial department of health and public welfare; public health supervisor of the United Nations Rehabilitation and Relief Administration in Italy; and industrial nursing consultant, public health nursing consultant, and civil defence consultant to the department of health and public welfare, all in Manitoba.

She is an active member of the Manitoba Association of Registered Nurses and was secretary of the Manitoba Public Health Association. Miss DeBrincat was granted honorary life membership in the MPHA and was also made honorary life member of the Canadian Institute of Public Health Inspectors.

Lorette Morel (Reg. N., U. of Ottawa School of Nursing; Certificate public health, U. of Ottawa; B.Sc.N., U. of Ottawa; M.Ed., U. of Ottawa.) has been appointed health education and nursing consultant, Canadian Tuberculosis and Respiratory Disease Association.

Miss Morel is an active member of the Registered Nurses Association of Ontario, the Canadian Public Health Association, and the Canadian Health Education Specialists Society. She has worked as general staff nurse in her home town of Mattawa, Ontario, and public health nurse in: the Timiskaming Health Unit, Kirkland Lake, Ontario; the Northern Ontario public health service, North Bay, Ontario; the city of Ottawa health department; and the city of Calgary health department, Calgary. Miss Morel was also supervisor of public health, city of Ottawa health department.

Ginette Fallu-Treyvaud, *right,* and **Monique Charron,** *left,* staff nurses at the out-patient clinic of the Sacred Heart Hospital in Hull, Quebec, were among 20 Quebec nurses selected to participate in a seminar on the nursing profession and the public health fields in France in August.

Participants were chosen by the office of the France-Quebec exchange program, and were requested to submit a paper stating their conception of the nursing profession in Quebec for the next 15 years. Mrs. Treyvaud sees the nurse closely related to the computer world, acting as a physician's associate and assuming some of his present responsibilities. Miss Charron believes the nurse will eventually replace the family doctor and will aim toward public health and preventive medicine.

The Quebec nurses met medical and paramedical authorities of the French national public health and social security departments, and public health directors in Paris. They also visited French hospitals and held discussions with directors of nursing and leaders of the professional associations in France.

Heather B. Dawkins received a scholarship for excellence in psychiatric nursing at Ryerson Polytechnical Institute, Toronto, Ontario.

Miss Dawson plans to continue her studies in the nursing field with emphasis on psychiatry, educational psychology, sociology, and psychodrama.

Olivette Gareau (R.N., Hôpital Ste. Justine, Montreal; Dipl. P.H., U. of Montreal; B.Sc.N., and M.Sc.A.), director of nursing of the public health division, Quebec department of health, has been chosen by the World Health Organization to work with a multi-disciplinary team to evaluate the public health service in Thailand.

The team members will meet in New Delhi for a brief period of orientation and study of the situation before returning to their place of work. Miss Gareau will conduct an on-the-spot study and will hold interviews with persons responsible for academic preparation of nurses and with government authorities.

F.A. (Nan) Kennedy (R.N., Vancouver General Hospital School of Nursing; Dipl. P.H., U. of British Columbia; B.Sc.N., U. of British Columbia; M.A., U. of Washington, Seattle, Washington.) has been appointed interim executive director of the Registered Nurses Association of British Columbia. She will fill the vacancy created by the resignation of Eleanor S. Graham, in an acting capacity from August 31 to December 31, 1970.

Miss Kennedy joined the RNABC provincial staff in 1959 as director of education services. Her varied nursing career includes four years with the World Health Organization, first as a tutor in public health nursing in East Pakistan, and as a public health nursing consultant in Iran.

K. Marion Smith (B.S.N., U. of British Columbia; M.A., McGill U., Montreal) has been appointed assistant director of nursing at the Surrey Memorial Hospital, Surrey, B.C. She was executive assistant and assistant director of nursing at Vancouver General Hospital, prior to her new appointment.

Miss Smith served with the Victorian Order of Nurses for two years before becoming a nursing sister in the Royal Canadian Air Force in 1958. She is an active member of the Registered Nurses' Association of British Columbia and was honorary secretary from 1967-69.

dates

October 14-17
Joint annual meetings and scientific sessions of the Canadian Heart Foundation and Canadian Cardiovascular Society, to be held in the Chateau Laurier, Ottawa.

For further information write to Mr. E. McDonald, Canadian Heart Foundation, 270 Laurier Avenue West, Ottawa 4.

October 16
The School for Graduate Nurses, McGill University, is celebrating its 50th anniversary in conjunction with the McGill Homecoming, 1970. Dr. Sheldon Schiff, University of Chicago, will be guest speaker at a seminar, "The University and Professional Education." A wine and cheese party will also be held. For further information write to Miss Phoebe Stanley, School for Graduate Nurses, 3506 University Street, Montreal 112, Quebec.

October 17
14th Annual Symposium on Rehabilitation, sponsored by the Rehabilitation Foundation for the Disabled and the Ontario Society for Crippled Children, Inn-on-the-Park, Don Mills, Ontario. Write to Mrs. Betty McMurray, Executive Director, Rehabilitation Foundation for the Disabled, 12 Overlea Boulevard, Toronto 354, Ontario.

October 26-27
Nursing sessions at the Ontario Hospital Association annual convention, Royal York Hotel, Toronto. Write to the OHA, 24 Ferrand Drive, Don Mills, Ontario.

October 26-28
Annual Meeting of the Association of Registered Nurses of Newfoundland at the Holiday Inn, St. John's Newfoundland. For further information write to Executive Secretary, Association of Registered Nurses of Newfoundland, 67 LeMarchant Road, St. John's Newfoundland.

October 26-28
Annual meeting of the Association of Registered Nurses of Newfoundland, St. John's. Write to the AARN, 67 Le Marchant Rd., St. John's, Nfld

October 28-31
American Association of Medical Assistants' 14th Annual convention to be held in Des Moines, Iowa. For further information write to Secretary, American Association of Medical Assistants, 200 East Ohio Street, Chicago, Illinois, 6061.

October 29-31
Second annual symposium of the Institute of Community and Family Psychiatry, Jewish General Hospital, Montreal, Quebec, on techniques in family therapy and the future of the family. Simultaneous translation is available in French. For more information and advance registration, contact: Philip Beck, M.D., registration chairman, Symposium, Institute of Community and Family Psychiatry, 4333 Côte St. Catherine Road, Montreal 249, Quebec.

Nov. 4-6, 1970 and Feb. 24-25, 1971
A continuing education course called Nursing Service Objectives is being sponsored by the University of Toronto School of Nursing. For more information write to: Continuing Education Program for Nurses, University of Toronto School of Nursing, 47 Queen's Park Crescent, Toronto 5, Ontario.

November 9-13, 1970
Course in occupational health for professional registered nurses in industry, offered by the department of environmental medicine of New York University School of Medicine, in cooperation with the American Association of Industrial Nurses. Limited to nurses with five years or less experience in occupational health. Tuition: $175. Special emphasis will be given to interviewing and counseling. For information and applications, write to the Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N.Y.

November 30-December 4
Conference for nurses in staff education and staff development, Westbury Hotel, Toronto. Sponsored by the Registered Nurses' Association of Ontario. Write to: Professional Development Department, RNAO, 33 Price Street, Toronto 5, Ontario.

February 15, 1971
Six-week coronary course offered to nurses currently working on coronary care units. Enrollment is limited to six nurses, and total sponsorship by present employee is required. Registration fee is $75.

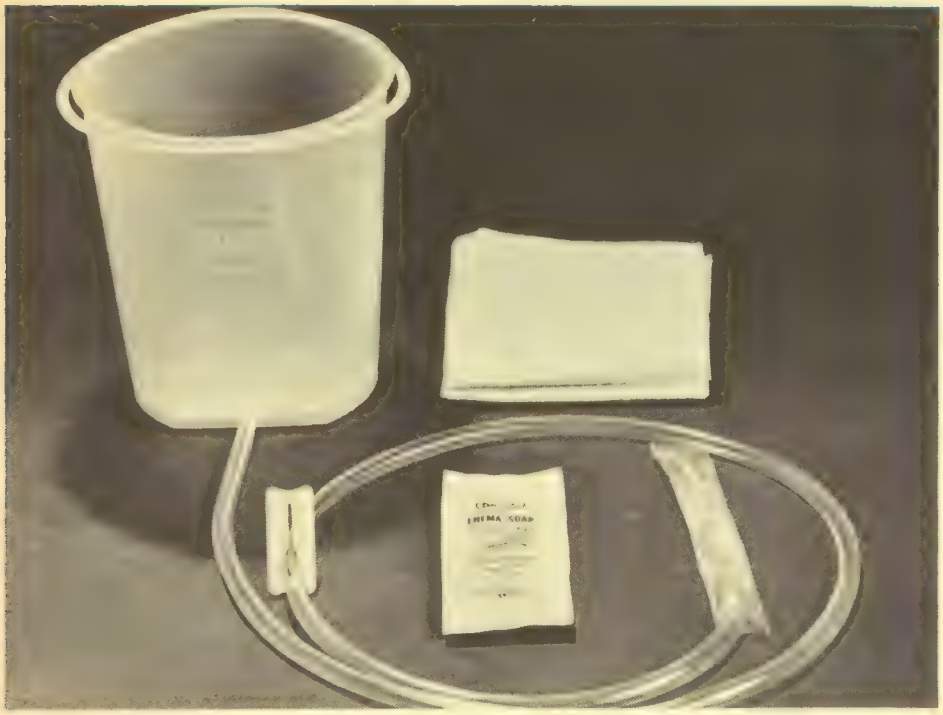
For further information write to the Course Coordinator, Intensive Care Nursing H601, Winnipeg General Hospital, 700 William Avenue, Winnipeg 3, Manitoba.

Feb. 15-19, 1971
Five-day course in occupational health nursing for registered nurses who have five or more years experience in occupational health nursing, and who work alone or with one other nurse. For further information write to: Continuing Education Program for Nurses, University of Toronto, 47 Queen's Park Crescent, Toronto 5, Ontario.

February 16-18, 1971
A national conference on research in nursing practice will be held in Ottawa. For more details write to Dr. Floris E. King, Associate professor and coordinator of the graduate program, University of British Columbia School of Nursing.

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.



Bucket-type Enema System

Bag-Type Enema System

Disposable enema systems

Convenience and fast administration are features of two new disposable enema systems available from Davol Inc. One system offers a 1600 cc. enema bag, and the other, a 1500 cc. bucket. All other accessories needed for routine administration, including prelubricated tip, are included with each.

One new Davol feature is a method of sheating the lubricated tip. A loose fitting plastic sheath leaves the lubricant essentially undisturbed on its removal.

The new Davol enema bag uses a self-sealing valve that opens easily for filling, yet retains the contents if the bag is laid on its side. A specially designed outlet eliminates the possibility of constriction at the point where the tube joins the bag.

Other features of the bag and bucket are a short, broad design that minimizes height requirements during administration, and a special slip clamp design that provides fast, effortless, on-off control. Each Davol unit is supplied with 48-inch tube with prelubricated tip and slip clamp, waterproof underpad, and a 2/3 oz. package of enema soap.

Davol products are available through Canada from leading surgical supply dealers.

Literature Available

The Council on Drug Abuse will distribute eight different pamphlets on drugs to more than 600 pharmacies across Ontario, with national distribution being planned. As part of its public information program, the CODA has made available pamphlets discussing stimulants, solvents, narcotics, and a drug reference chart.

Literature on depressants, drugs and the law, and hallucinogens will be distributed shortly to drug stores and drug sections of department stores, where they may be picked up free of charge.

General Electric Company has published a 12-page, color, brochure, that describes its Monitrol-series of diagnostic x-ray tables.

For a copy of this brochure, No. 4243, write to the General Electric Medical Systems Ltd., 3311 Bayview Avenue, Toronto, Ontario.

An eight-page, color brochure describing Trainex audiovisual programs for the health care field, is available from Trinex Corporation, a subsidiary of Simplicity Pattern Co., Inc.

The brochure also lists available audiovisual projection equipment for group or individual instruction.

For a free copy of this brochure, write to Trinex Corporation, P.O. Box 116, Garden Grove, California 92642.

A 16-page catalog on industrial skin protection called, *Ply... The Answer to Industrial Dermatitis,* is available from Safety Supply Company. The booklet lists common industrial skin irritants and the PLY counteragent most effective to combat them. A four-step hand care program is also included in the booklet. For a free copy, write to Safety Supply Co., 214 King St., East, Toronto, Ontario.

Therapeutic Whirlpool Center

Jacuzzi research Inc., now offers a complete line of water massage units for hospital physical therapists. A fiberglass hip tank includes a self-contained unit with contoured seat to permit complete immersion. The moving parts and electrical components of the unit are concealed. An optional 2,000 watt heater maintains desired water temperature automatically.

The Portable Jacuzzi Whirlpool Bath may be used in therapy tank or bathtub, and requires no special plumbing or electrical hookups.

The Jacuzzi distributor in Canada is Ramsley, Inc., 3856 Notre-Dame Street, Chomedey, Laval, Quebec.

Saneen Medical Towels Polywrapped

Facelle Company Limited's Saneen single-use medical towels are now polywrapped in units of 50 for cleanliness, easy storage, and stock control. The packages are wrapped in polypropylene to withstand autoclaving, yet are easily opened by a perforated band. The towels come in three convenient sizes and are suitable for many sterile, as well as non-sterile, procedures.

For further information, write to Facelle Company Limited, 1350 Jane Street, Toronto 335, Ontario.

Knee Straps

The Posey Company has introduced knee straps that provides a simple solution for patients who often slide forward in wheelchairs. A broad nylon strap attaches to the wheelchair frame and passes in front of the patient's knees. The belt stops the person from sliding, with no discomfort or restraint of freedom.

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Active-care hospital nurse expands her role

Expand, extend, change — nurses are told from day to day. Can the role of the nurse be expanded, extended, or changed? Do we really need doctors' assistants? This article reveals that nurses in one unit in an active-treatment hospital are responding to the demand for change and still retaining the concept and the role of the nurse.

Rosemary Prince Coombs, B.Sc.N., M.N.

With almost monthly regularity, nursing journals in North America remind us that the role of the nurse must be expanded, extended, or changed.[1] In addition, three national and provincial reports recently recommended changes in the nursing role of Canada's health delivery systems.[2] Adding pressure is a Canadian public concerned about the cost of health care and demanding greater access to health care and more long-term care.

What, then, are the changes required in the hospital nurse's role to respond to modern health care needs? What changes in health care delivery systems must the nurse adapt to?

Basis for expanding nursing role

Answers to these questions can only be made by considering three major indications for change in the active-care hospital system. These indications for change are basic to the expanded role of the nurse.

First, medical specialization is an accomplished fact, and the division of hospitals into highly specialized units or services is becoming an accomplished fact. Nursing specialization is necessary to keep abreast of medical advances and the effect on patient care. At the same time, there is a mismatching of doctor and nurse skills with the tasks they perform. With medical specialists attempting to cope with a wide spectrum of specialized and general care, nurses will have to assume some of the medical specialist's functions.

Second, nursing manpower must be better utilized. Nursing care must be planned and performed according to the needs of the patient and not based on ritual and tradition. Nursing care will have to take place in a progressive sense within a patient-care classification in a regional health system. Different nursing units will have to be populated by different care categories of patients requiring different levels of care. Non-nursing responsibilities will have to be eliminated as nursing functions.

Third, the multi-disciplinary approach to health care must be utilized for all the care categories of patients. This will necessitate all health professionals working in peer relationships.

Consideration should also be given to three worries that are a major concern to hospital nurses: we are losing contact with the patient, who is the reason for our existence; our basic nursing knowledge is woefully inadequate to cope

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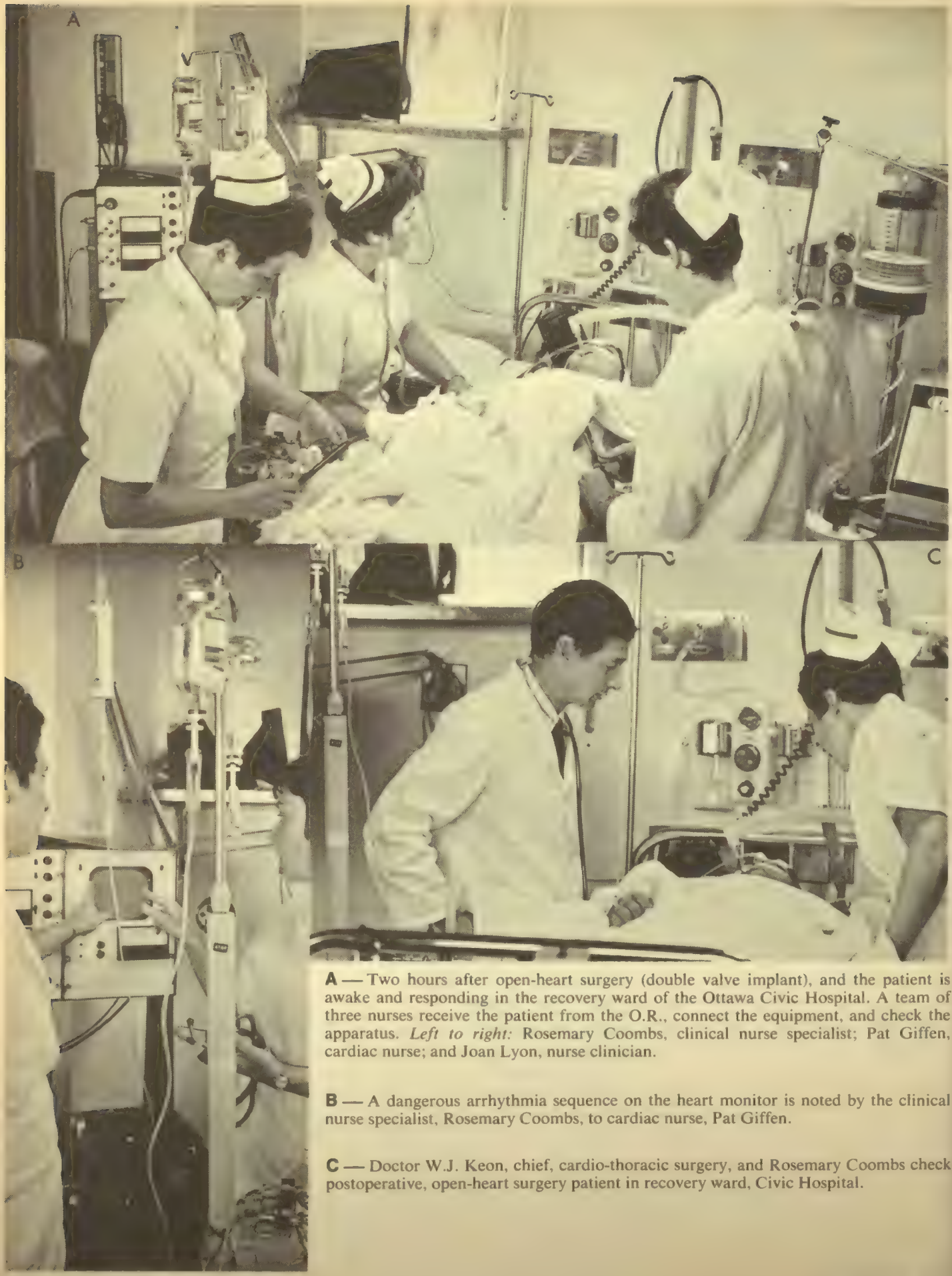
The author, a graduate of the University of Toronto School of Nursing and the University of Washington School of Nursing, Seattle, is Clinical Nurse Specialist at the Ottawa Civic Hospital. Mrs. Coombs was a Canadian Nurses' Foundation Scholar in 1963.



A — Two hours after open-heart surgery (double valve implant), and the patient is awake and responding in the recovery ward of the Ottawa Civic Hospital. A team of three nurses receive the patient from the O.R., connect the equipment, and check the apparatus. *Left to right:* Rosemary Coombs, clinical nurse specialist; Pat Giffen, cardiac nurse; and Joan Lyon, nurse clinician.

B — A dangerous arrhythmia sequence on the heart monitor is noted by the clinical nurse specialist, Rosemary Coombs, to cardiac nurse, Pat Giffen.

C — Doctor W.J. Keon, chief, cardio-thoracic surgery, and Rosemary Coombs check postoperative, open-heart surgery patient in recovery ward, Civic Hospital.

D — Teamwork in cardiac nursing continues in the intensive care unit. *Left,* Pat Chapman, cardiac nurse, and Joan Lyon, nurse clinician, compare stethoscope findings of an open-heart surgery patient.

E — Checking patient charts to assess immediate postoperative condition of open-heart surgery patient in the Civic recovery ward. *Left,* Rosemary Coombs double checks notations of cardiac nurses Pat Giffen and Heather Dowell, as Dr W.J. Keon asks questions. Each outgoing shift reports verbally to takeover shift.

F — Discussing electrocardiogram patterns of an open-heart surgery patient (coronary artery, bypass graft, and double implant) in the intensive care cardiac unit, Civic Hospital. Instructor is Rosemary Coombs, watched by Kathy Licari, *center,* and Judy Doraty, cardiac nurses.

G — "Take care" is the advice given by Rosemary Coombs to well patient Rev. H. Donald Joyce. It's three months since his open-heart surgery (bypass graft and double implant), and there are rehabilitation plans to discuss. Nurse Coombs contends that ongoing nursing care is essential for patients. She invites them to return for a chat. Problems may be averted this way, she feels.

with medical and technological advances; and if we don't fill the gap between the patient and the doctor, someone or something else will.

Finally, recognition of the two unique positions occupied by the hospital nurse is also basic to the expanded nursing role. Patients are admitted to hospital because they need 24-hour observation, and the hospital nurse is the only health professional who maintains full-time observation of the patient. The hospital nurse has contact with every health discipline involved in direct patient care.

Nursing role expanded

To cope with medical specialization, we need nurses who *can* and *will* learn to nurse in cardiac surgery, coronary care, intensive care, neurosurgery, neurology, paraplegia, hemodialysis, burns, hyperbaric, respiratory, perinatal, gastrointestinal, renal transplantation, ophthalmology, otolaryngology, maternity, and pediatric units.

Nurses are needed who can and will teach patients and their families what they want and need to know about their specialized therapy; work purposefully and safely with specialized equipment; observe all parameters of the patient's condition and report significant alterations to the medical specialist; understand the significance of abnormal laboratory reports; judge scientifically the necessity for medical observation and intervention; use a stethoscope to determine needed respiratory care, a cardiac irregularity, or the presence of bowel sounds.

We need nurses who *can* and *will* recommend necessary change in medical therapy and support the recommendation with scientific reasons; know the expected response of the patient's condition to medical therapy; use a cardiac monitor as a tool to *prevent* dangerous arrythmias, rather than to portray fatal arrythmias; remember to talk to, feed, cleanse, exercise, assist elimination, and provide rest and sleep for the acutely ill patient.

To develop better utilization of nurses, nurses are needed who can and will state when patients need intensive, moderate, or minimal nursing care, based on an admission and daily assessment of the patient's personal and illness problems; arrange physical ward layouts and staffing patterns so that 24-hour observation is a fact, and TV screens, monitors, and call systems do not come between the nurse and the patient.

We need nurses who can and will view each patient's hospital experience as part of a continuum: learn about the patient as he was before hospitalization; follow him through the stages of illness; and refer for necessary follow-up when he returns to the community.

Nurses are needed who can and will: activate changes, supported by scientific rationale, in care practices and organizational procedures to provide for and protect the patient; integrate the patient's family into the patient's pattern of care; teach the patient how to handle the drugs he takes at home (show him what they look like, draw up a drug-taking schedule); institute nursing procedures in accordance with the patient's condition and/or his drug therapy (for example, if a patient is receiving a diuretic, the nurse would order measurement of fluid intake and output and daily weight); arrange for a diagnostic test (such as an ECG or a blood test) to document findings of change in a patient's condition; teach other nurses how to nurse in intensive, moderate, or minimal care situations; and anticipate a patient's potential problems, and write preventive suggestions for on-coming nursing staff.

To join in the multi-disciplinary approach to health care, nurses are needed who *can* and *will* raise their heads from the traditional dependent role and seek knowledge and clinical expertise to establish themselves as interdependent partners of medical and paramedical personnel; discuss the patient's medical and paramedical problems with the appropriate personnel; understand and use the correct medical and paramedical terminology; refer patients who need a certain paramedical service; and seek methods to relay the information each health team member needs to know before he goes to the patient.

Finally, we need: nurses who will demand the education required to fill the role described; nursing administrators who will encourage clinical nursing functions and limit non-nursing functions; and medical and paramedical personnel who will share their specialized knowledge to help achieve these clinical standards.

Preparation for the expanded role

The Canadian Nurses' Association has endorsed two levels of professional nurses, distinguished by educational preparation at the baccalaureate and the diploma level. Issue must be taken with this differentiation for several reasons: The educationally-prepared nurses are not available, or are not attracted to the active-care hospitals of today. Also, upward mobility is denied to nurses with clinical experience and demonstrated clinical expertise.

Following are *four* categories of nurses. In three categories the educational qualifications are less rigid than those specified by CNA, so that those nurses available will be used, and some of the problems of 1970, solved.

Clinical Nurse Specialists

To encourage nurses into this category, interested and qualified nurses should be sent to universities that offer a graduate degree program with a major in a clinical specialty. These are the nurses who can demonstrate the *expanded role* of the nurse, and assist other nurses to expand their patient-care functions.

Nurse Clinicians

Interested and capable senior nurses, who have good clinical experience, knowledge of hospital functions, and demonstrated expertise, should be taken away from the present-day supervisor and head nurse roles, and their non-nursing duties eliminated. Nurses and doctors should be found who will teach the senior nurses what they need to know to cope with medical science advances. These nurses should be sent on short courses that include content in the clinical specialties and functions of the multi-discipline health team. These are the nurses who would become nurse clinicians.

Specialty Nurses

Graduates from basic nursing programs with six months to two years general nursing experience should be assisted to develop clinical and technical expertise in the specialties. These nurses could be prepared to function in the intensive care specialties by in-service teaching, and whenever possible, by attending short specialty courses. They would become specialty nurses.

General Staff Nurses

New graduates from basic nursing programs should be allowed mobility, according to their clinical expertise and scientific knowledge, up through the levels of patient care. These nurses would gain experience in patient care, knowledge of hospital functions, and the nursing maturity to move into the three other positions. They are the general staff nurses.

	CLINICAL NURSE SPECIALIST	NURSE CLINICIAN	SPECIALTY NURSE	GENERAL STAFF NURSE
Professional and Educational Qualifications	R.N., bachelor in nursing master in clinical nursing	R.N., bachelor in nursing, short course in chosen specialty (preferable)	R.N., diploma or bachelor in nursing	R.N., diploma or bachelor in nursing
Rationale for Educational Qualifications	Depth knowledge in specialty, broad preparation in medical and behavioral sciences	Short course ensures formal organized approach to specialty. Bachelor's degree offers depth knowledge in general nursing and beginning knowledge of total health field	General nursing knowledge on which to build content of specialty	General nursing knowledge on which to gain general experience
Minimum Nursing Experience Required	One year general nursing Two years specialty nursing. Experience in teaching, administration, or public health valuable	One year general nursing Two years specialty nursing (More than two years valuable)	Six months general nursing	General student nurse experience
Continuing Education Program	Time allowed for post-masters courses to update theory	Time allowed for repeated updating by short courses	Time allowed for short courses every two years of employment Minimum of three inservice education days/year	Minimum of three inservice education days/year observation of nursing in the specialty units
Nursing Functions	Gives, suggests, or teaches scientific specialized nursing care Collaborates with medical and paramedical personnel Concentrates all functions on the patient	Works with and uses the C.N.S. as a consultant in clinical nursing Functions (within limits of ability) are the same as functions of C.N.S. Responsible for organization of clinical nursing unit	Gives expert clinical nursing care in specialty unit	Gives general nursing care
Assignment of Patients	Selects case load of patients; moves from patient to patient wherever they are located; nurses patients whose problems fall in range of specialized knowledge - 15-60 patients dependent on the level of care required	Selects case load of patients (probably all in clinical unit) 15 - 60 patients dependent on the level of care required	Given daily patient assignment of acutely ill patients Nurse-patient ratio dependent on the level of care required Works within her specialty in clinical nursing unit	Given daily patient assignment in unit with minimally or moderately ill patients
Salary Scale	Senior nursing member, recognition of master's degree, clinical experience and responsibility	Senior nursing member, recognition of educational qualifications, clinical experience, responsibility	Junior nursing member, recognition of educational qualifications, clinical experience, additional responsibility of acute-care	Beginning nursing member, recognition of education qualifications

These four categories of nurses are concerned with clinical patient care. None of them would carry out either the major or minor administrative tasks presently assigned to clinical nursing, such as submitting budgets, developing master rotations, ordering supplies and drugs, telephoning for relief nurses. They would perform only administrative or clerical tasks that directly affect patient care, such as assignment of nurses to patients, evaluation of a nurse's clinical abilities, speaking by telephone or in person to the patient's family, training relief nurses, evaluating new equipment, and notifying nurses of changes in medical or nursing procedures.

Attached to each nursing unit would be a well-trained clerk, who would assume the clerical and administrative tasks associated with managing a group of health personnel and the service they provide.

The clinical nurse specialist has a staff position in which she can work with all levels of clinical nurses and all patients in her specialty. The nurse clinician has a line position in which she reports to an associate director of nursing service, and functions on a peer level with all health professionals. Both these nurses would be responsible for the selection of general staff nurses for the specialty nurse position. Both these nurses would orientate and evaluate the new specialty nurse after a trial period and recommend her for a permanent position as a specialty nurse.

Table 1, page 27, gives a description of the four nurse categories.

Four nurse categories at Ottawa Civic

The four previously detailed categories of nurses are being demonstrated in the cardiac surgery unit of the Ottawa Civic Hospital.

The number of clinical nursing personnel required to staff a unit is difficult to predict. It must be estimated by the clinical nurse specialist and the nurse clinician, considering the physical layout of their unit, the particular needs of their patients, and the level of nursing care required. These nurses must also choose the number and placement of nursing assistant personnel in each unit.

In the Ottawa Civic Hospital cardiac surgery unit, there is a clinical nurse specialist and a nurse clinician (presently titled head nurse); 17 full-time specialty nurses (known as cardiac nurses, receiving the same salary scale as a general staff nurse); 4 to 6 part-time general staff nurses (trained on the job and never given all the responsibilities of a specialty nurse); but no registered nursing assistants (these are considered to have insufficient knowledge for any nursing in the acute care setting). These 23 to 25 nurses care for two patients in the cardiac surgery recovery room, and four patients in cardiac surgery intensive care.

TABLE TWO
Three Levels of Hospital Patients

Level	Care Category	Nursing	Nurse Category
I	Investigative convalescent	Simple physical and psychological	General staff nurse Registered nursing assistants Clinical nurse specialist or Specialty nurse
II	Intermediate extended (long-term)	More complex physical and psychological care	General staff nurse Specialty nurse Clinical nurse specialist or Nurse clinician
III	Acute intensive	Highly complex physical and psychological care. Performs some medical functions	Clinical nurse specialist Nurse clinician Specialty nurse General staff nurse

The specialty nurses work in a master rotation, which allows the same number of nurses on day, evening, and night shifts. The surgical schedule and the nursing rotation are planned together, so that four major cardiac-surgical cases are scheduled and can be nursed each week. The rotation is planned so that the specialty nurses never leave the patients alone for longer than three minutes.

On every shift, seven days a week, one specialty nurse or a general staff nurse who has had some orientation to the unit, floats between the recovery room and the intensive care unit, providing meal and break relief and helping with acutely ill patients.

The specialty nurses care for the patients on a one-to-one ratio for the first 48 postoperative hours, and a one-to-two ratio for the next 48 postoperative hours. When possible, each specialty nurse has the same patient for at least three days.

The clinical nurse specialist and the nurse clinician move freely between the cardiac surgery recovery room and the intensive care unit (these two areas are at opposite ends of the hospital), and between the two or three surgical preoperative and postoperative convalescent wards. The two nurses divide the number of patients between them, each usually selecting every other patient scheduled for surgery. They follow the patient from his admission to his discharge from hospital, and spend several hours with him doing preoperative teaching.

Both nurses, along with a specialty nurse, receive every patient from the operating room into the recovery room. Later, the clinical nurse specialist and the nurse clinician visit acutely ill patients several times each day, and make daily nursing rounds to all convalescent patients. The two nurses are in charge of the 17-member specialty (cardiac) nurse team.

From March 1969, when the cardiac surgery unit opened, until September 1970, there have been 14 class days for specialty nurses, and the nurse clinician has been to a six-week course in coronary care nursing. Each specialty nurse receives a month's orientation to the unit. During this time she is never left alone with a patient.

Medical and paramedical communication

In the setting described above, medical and paramedical communication is informal and formal. The clinical nurse specialist and the nurse clinician communicate informally with the specialty nurse, the surgeon, and the anesthetist.

The clinical nurse specialist and the nurse clinician meet three times a week with the surgeons, cardiologists, and surgical resident staff for one "sit-down" and two "walk-around" rounds. These two nurses meet once weekly with the social worker, the physiotherapist, and a public health nurse to review each patient and discuss pertinent problems. Meetings with inhalation therapists, the pharmacy clinical coor-

dinator, and dietitians take place as necessary.

Patient care classification

Table II shows the placement of the four nurse categories within a patient-care classification system, adapted from Murray [3] and MacDonnell.[4]

The description of the extended role of the nurse as utilized in the Ottawa Civic Hospital is suggested as one nursing answer to the health delivery problems of Canada. The four nurse categories are open for experimentation, particularly those of the clinical nurse specialist and the nurse clinician. But experimentation must be carefully done. Nurses chosen for the new roles must have flexible and creative personalities, and they must have or they must seek theoretical knowledge in the clinical specialties.

Doctor-assistant — what for?

None of the previously named four nurse categories represents the equivalent of the proposed new paramedical role — the doctor assistant. I contend that, *if* nursing can expand the role of the nurse, the health care system of Canada does not need doctors' assistants.

If the doctor-assistant role is allowed to develop, there is great danger that we will lose the title, the concept, and the very existence of a *nurse*.

If we allow some new category of medical workers to develop, we are admitting that nursing cannot keep up with the demands of modern health care. If we allow some new worker to "inject new life into the medical care team,"[5] we are admitting that nursing cannot communicate with medicine to solve the problems of modern health care. If we allow nurses to take doctor-assistant apprenticeship-type courses, with a minimum of bookwork and examinations, we will never increase our basic nursing knowledge.

This article exemplifies an acute-care nursing program. I maintain the same nurse categories are readily adaptable to any extended health care setting.[6] Certainly, these categories show that nursing has the ability to achieve increased status, and the right to higher salaries.

Our patients have the right to assist us in stating our case. The following is the reaction of a patient who has experienced the expanded role of the nurse.

"This cardiac experience was the first time I had met a supervising nurse technician. [She was a clinical nurse specialist.] I cannot speak too highly of her part both before and after surgery. She came to see me three times on the day before the operation, each time giving me information and guidance about the procedure to be followed and the kind of support which would be around me in the coming days. Because I was knowledgeable about some aspects of surgery, she gave me as much detailed information as I was willing or able to absorb. She arranged for me to meet most of the people who would be ministering to me — the special nurses, respiratory technicians, and physiotherapists. She gave my wife information about where and when she might see me after the operation, and gave both of us wise and kindly counsel based on her own long experience. Perhaps most of all, she related to me as a compassionate human being, recognizing natural fears and anxieties, and meeting them with reassurance and with nothing of shallowness or sentimentality. In brief, she translated the skill and efficiency of a highly dedicated team of specialists into the warm humanism which is so necessary if the patient is to cooperate even in the twilight of returning consciousness.

"In the days following, she maintained daily visits, and despite a rigorous schedule, was ready to interpret and explain as a direct liaison between myself and the surgeon. As a highly skilled nurse and a specialist in cardiac work, she filled a vital role in my need for understanding and personal support. Once the clinical condition of the patient is assured, I am convinced that such a nurse is as important as the doctor in the total wellbeing of the convalescent. It means a great deal to me to know that any day during the coming months, I, or my family, can contact such a nurse by telephone, either to clarify some situation or to interpret it to the doctors."

Perhaps all that has been said on the expanded nurse role can be summarized in this way: If we *want* status as nurses, we will find it, not only in a university degree, but by functioning interdependently with all health professions; if we *want* an independent nurse function, we will get it by maintaining our 24-hour observation of the patient, and by coordinating the health professionals who are in contact with the patient; if we *want* to prove our role as nurses can change and is changing, then we need not resort to the title doctor-assistant, nor do we have to remain physicians' handmaidens.

In relating to all health professionals, we are, or we should be, associates in providing the best quality care that medical science and individual effort can offer.

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What is your will?

Perhaps you thought a will was for anyone but you to worry about. Your will is your concern. According to the author of this introduction to will-making — you should make your will NOW.

Robert J. Green, B.A., LL.B., C.A., Barrister-at-law

Do I really need a will?

You might reply, "Oh, I don't need a will, I haven't any property."

This is seldom the case.

Do you have a bank account? Do you own a car, a house? Is there a chance you might receive an inheritance? To what pension would a surviving relative be entitled? Do you own stocks or bonds? Do you own furniture, jewelry, life insurance?

Your affirmative answer to any of these questions indicates you do possess property, substantial or small. Undoubtedly you will want to pass on this property to chosen people and not just to anyone. To do this you need a will. For if you have not made a will, your property will be disposed of at your death as the law directs, and this may not be as you wanted.

As far as I am aware, a nurse, in carrying out her normal duties, incurs no greater risk of sudden demise than incurred by any other person. However, there is still the possibility of an accident or a sudden fatal disease. Thus a nurse should make a will now!

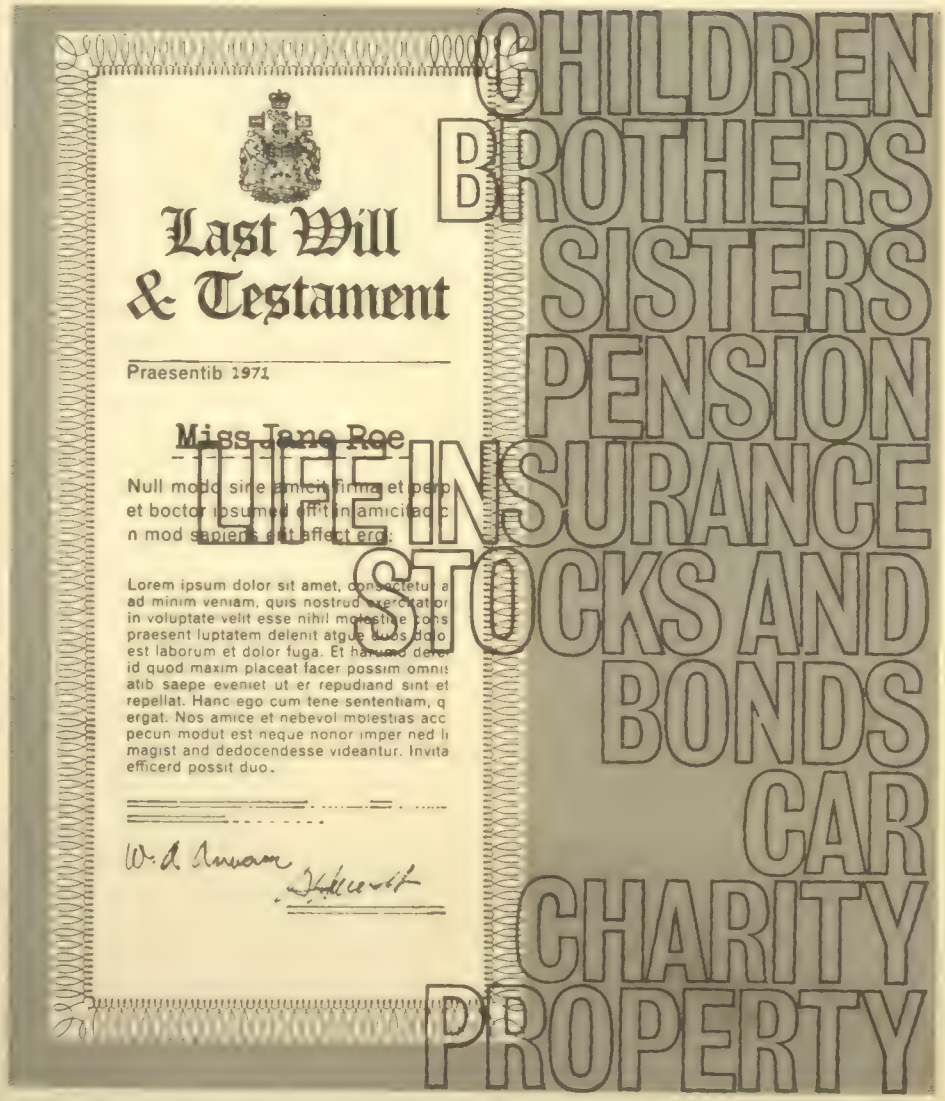
Mr. Green is associated with the law firm of Gowling, MacTavish, Osborne & Henderson, in Ottawa. He is also a member of The Institute of Chartered Accountants of Ontario, and he is a graduate of Queen's University, Kingston.

No will

To know why a nurse should make a will now, consider what could happen when a person dies without a will. Take the case of an unmarried nurse, Jane Roe (name fictitious), who died intestate — that is without a will.

Because nurse Roe died without a will, her property would go only to those whom the law directs. Generally, if Miss Roe is survived by one or more parents, brothers, or sisters, all her property (after payment of debts and taxes) will be divided equally among her immediate relatives. If she is without family survivors, her property would pass to her next closest living relative.

An exception might occur if Jane had a joint bank account with a friend; this account could become the property of the friend, depending upon the circumstances. However, before the friend could obtain complete possession of the joint bank account, certain legal requirements would have to be met, such as obtaining permission of the administrator of Jane Roe's estate. Also, before possession of the estate, in part or whole, is granted, Letters of Administration must be granted to the administrator.



A person usually wants to benefit members of her family. Sometimes, though, we may want to give a memento to a friend, or donate to a particular charity. Without a will this cannot be done.

As a nurse, Jane Roe might have wished to leave money to assist nurses or nursing, aid a named hospital, or to further medical research in an area of special interest to herself. To do this she needed a will!

To avoid Jane's mistake, and to make sure your own special wishes are carried out, ascertain if there is an organization which takes care of such donations. You can direct your lawyer to specify in your will that so much of your money is to be donated to such and such charitable organization or foundation. Of course you can also state *how* you want your money used.

If there isn't an organization able to handle your wishes, you can set up a trust fund through your will. But you would have to name a person or agency to act as trustee to carry out your wishes after your death.

Now consider the case of a married nurse. Our example deals with the husband, as statistics show it is mostly the husband who predeceases his wife. (A wife dying without a will presents practically the same situation.)

John Doe dies intestate leaving a wife and two children under 21 years. He owns a home, a car, stocks and bonds, and a bank account, all registered solely in his name.

Immediately upon John Doe's death his wife will experience difficulty dealing with the property registered in her husband's name. She will not be able to take any money out of the bank account beyond $2,500, and she will not be able to sell the stocks or the bonds. Until the estate is settled, she may even have to borrow money for food, clothing, and the mortgage or rent payments.

In Ontario (as in most provinces), for John Doe's wife to obtain possession of the property she must apply for Letters of Administration from the proper court. Letters of Administration appoint the wife personal representative of the deceased, with power to deal with her late husband's estate. Her actions will be governed by various laws, including those laws governing to whom the property is to be distributed.

The person applying for Letters of Administration must post a bond — a guarantee from persons or a bonding company guaranteeing proper administration of the estate.

Should the administrator not properly distribute the property of the deceased, there will be funds available to satisfy any resulting claims. A bond is normally obtained from an insurance company, and a fee charged, varying according to the value of the estate.

Legislation in most provinces spells out how the deceased's property is to be distributed when a person dies without a will. If the deceased is survived by a wife and or children, the property is divided among them. Funeral ex-

penses, debts, and taxes of the deceased have first claim on the assets of the estate, and must be paid.

After Mrs. Doe has been appointed administratrix, she may decide she could better support her family if she sold their home. To do this she might have to obtain permission of the court, and, in Ontario, might also have to obtain permission of a government agency known as The Official Guardian's Office. This agency protects the interests of children in the estate. It necessitates additional expenditure.

If the house is sold, then part of the proceeds might have to be paid into court when there are children involved in the estate. Money paid into court for a child would remain there until the child reaches 21 years, when his share is paid to him. At that time he is free to do what he wishes with the money.

Should the wife of the late John Doe need any of the money paid into court from the sale of the house for the education or maintenance of her children, then she must once again obtain permission of the court (and in Ontario permission of The Official Guardian), before withdrawing the money. She can only use it for the direct benefit of her children, and not for her own use, even though by spending it for her own use she may be improving the lot of her children. Once again expense and delay can be incurred.

If John Doe had been single and died without a will, his property would have been distributed in equal shares to his next of kin.

It is to avoid situations such as those described, and to ensure our property goes to whom we choose, that we should draw up a will.

The only answer to the question, "Do I really need a will?" is "Yes!"

Making a will

A will is a document in writing by which the testator — person making the will — directs how his property is to be disposed of at his death. It is prepared in accordance with the law governing wills. A will does not take effect until the death of the person (testator) who makes the will. At any time prior to his death the testator may revoke the will or dispose of his property.

Normally, a person who wishes to have a will prepared appoints a lawyer qualified to draw up the will to comply with all legal requirements. Any person authorized to practice as a lawyer in your province should be qualified to assist you in the preparation of your will. There is provincial legislation dealing with wills, including the proper manner for drawing up a will and signing it.

As a general rule, a will must be signed at the end by the testator in the presence of two witnesses, who must both be present at the same time, and who must both see the will signed by the testator. After the testator has signed the will, the witnesses, each in the presence of the other and of the testator, must then sign.

Care must be taken to make sure that a person signing as a witness is not named in the will as a beneficiary or is not the husband or wife of a person named in the will as a beneficiary. Were this to happen, the person entitled to benefit loses his right. This does not mean the complete will is void, only that portion which desigates the signee as a beneficiary.

Another rule : anyone under the age of 21 years cannot make a valid will. There are some minor exceptions to this rule. In New Brunswick and Saskatchewan, a married minor can dispose of his property by will, but in Alberta, a married person must be over 19 years to make a valid will. There have been recent moves in the provinces to reduce the voting age to 18 or 19 years; perhaps the age at which a valid will can be made will also be reduced. Until this is law, the general rule is — at least 21 years.

Also as a general rule, your will becomes automatically invalid if you marry after making it. One exception is a will made in contemplation of marriage to a named person.

The type of will discussed so far is sometimes referred to as an English will. That is, it is the type of will that came to us through the law of England. However, another will is valid in six Canadian provinces (Alberta, Saskatchewan, Manitoba, Quebec, New Brunswick, and Newfoundland). This is a holograph will, and does not need witnesses. It can be signed by the testator without any witnesses being present or signing the document.

In the province of Quebec community of property must be considered when drawing up a will. As a general rule, under community of property a wife is entitled upon the death of her husband to 50 percent of his property, provided at the time of the marriage the husband was living in the province of Quebec. If, at the time of your marriage, your husband lived in Quebec, then you should tell this to the person drawing up your husband's will. This problem can be circumvented by a marriage contract.

Sometime you may want to change all or part of your will. You can do this by using a codicil. The rules applied to other wills and previously discussed, also apply to a codicil. Often, a codicil is used when the change is minor. If the contemplated change is major, then it is better to draw up a new will. Signing the new will effects the revoking of an older will; a codicil does not do this.

Contents of a will

Property of the deceased must first pass through the hands of a personal representative of the deceased before it reaches those named in the will. The personal representative is in a position of trust, and is often referred to as a trustee. If the personal represen-

tative is named by the deceased in his will, he is called an *executor, (executrix* if female). If the deceased did not name an executor or executrix as his personal representative. In this case the permarried, a relative) can apply to the court to be appointed the personal representative. In this case the personal representative is called an *administrator (administratrix* for female).

In addition to distributing the assets of the deceased, the personal representative is responsible for paying out of the estate assets, any debts of the deceased, including taxes. This duty can involve a great deal of responsibility, particularly if part of the deceased's estate will not be distributed for several years.

This type of situation often arises when there are minor children, or where the spouse is given the right to the income of the estate and the children the right to the capital on the death of the surviving spouse. Thus, the position of executor should be carefully considered.

Any individual or trust company can be appointed executor. However, it is wise to obtain permission of the appointee, to be sure he would be willing to act. Even if named in the will as executor, he is under no obligation to act.

When discussing a will, taxes must also be considered. The federal government taxes estates under what is called the *Estate Tax Act*. Under its provisions property passing directly from one spouse to the other, or property to which the surviving spouse has the sole use during his or her lifetime, passes free of tax. Also under the Estate Tax Act, you can leave each of your children up to $10,000 before it is subject to taxation.

In addition, for those living in British Columbia, Ontario, and Quebec, there are provincial taxes called succession duties. This means that when drafting your will you must take into consideration the tax payable on your estate. Often this influences the disposition of property.

The main problem with which the testator is concerned is the disposition of his property. This is a personal decision which varies from person to person. You should consider the nature of your property, the ongoing needs of your family, friends, charitable and religious organizations, and the effect of taxation.

If the person named in your will predeceases you, the bequest lapses. That is, it ceases to take effect and the property named in that bequest passes to those to whom you have left the residue of your estate. The residue, simply means the balance of your estate remaining after all your debts, funeral, and testamentary expenses have been paid, and specific bequests have been made.

The expression "brothers and sisters" or "children" is often used in a will, rather than specifically naming each one. At the time you draw up your will you cannot be sure how many members of your family will be alive at your death. There may be more children born or some may have died prior to your own death. If you only want to benefit certain brothers or sisters, or children, then you *must name* these people or else all those considered by law as in the same "class" will benefit.

General

There is one piece of property over which no one has control, not even the spouse of the deceased (unless she is the executrix), and that is your body. It has long been established law that there is no property in a body, although it is the responsibility of the executor to arrange for burial of the body. This point is mentioned because many people want their bodies, or parts thereof, used for medical purposes, such as transplants.

The province of Ontario passed an act called *The Human Tissue Act 1962-63*, which recognized this problem. Under this act a person can, in writing at any time or orally in the presence of at least two witnesses during his last illness, request that his body or specified parts thereof be used after his death for medical purposes. Once a body is buried it cannot be used for medical purposes. Therefore, if you wish your body or parts thereof to be used for medical purposes, you should so advise your family and executor.

Although this article has only covered a few matters related to wills, I hope it has made you aware of the need for a will and the need for careful preparation of a will.

If you do not mind to whom your property passes on your death, then you don't need a will. If you wish to put your relatives to a great deal of trouble and cause unnecessary expense and delay in the administration and distribution of your property, then you don't need a will.

If, however, you do care what happens to your property after your death, and you wish to minimize the effort needed to administer and distribute your property — then you should make your will now!

Once you have had a will prepared, you should review it periodically, checking that it is suitable to meet changed circumstances.

"Epidurals" are here to stay

• • • particularly in obstetrics, where this method of analgesia is used frequently during labor.

Andrea M. Dillabough, B.Sc.N., and Ellen L. Rosen, B.Sc.N.

There have always been special problems associated with obstetrical analgesia and anesthesia. Probably the greatest problem is that there are two patients to consider, one of whom cannot be observed. As a result, many types of analgesia have been used, various combinations of drugs have been given, and several methods of "verbal preparation" have been tried.

One method that is becoming increasingly popular is continuous epidural analgesia and anesthesia. Its use has brought changes in the parturient's outlook on labor, in the climate of the labor room, and in the nursing care given.

As long ago as the 1800s, physicians attempted to use this form of anesthesia for gynecological and urological surgery. It was successful in relieving discomfort, but lacked the most important component — safety. It was not until 1930, with the introduction of new agents, that epidural anesthesia was employed more frequently. In several institutions, epidural anesthesia was given for the relief of pain in the second stage of labor; until recently, however, no one attempted to use it for continuous relief throughout labor.

In 1960, a study was undertaken by the anesthesia department of the University of Western Ontario to assess the effect of continuous epidural analgesia. The procedure, which involved the intermittent injection of a local anesthetic through a plastic catheter into the epidural space, was started when patient's cervix reached four to five centimeters dilatation.

During the course of the study, the use of this form of analgesia increased from five to fifty percent. At present, St. Joseph's Hospital and the Victoria Hospital in London, Ontario, use continuous lumbar epidural analgesia almost without exception for patients in labor.

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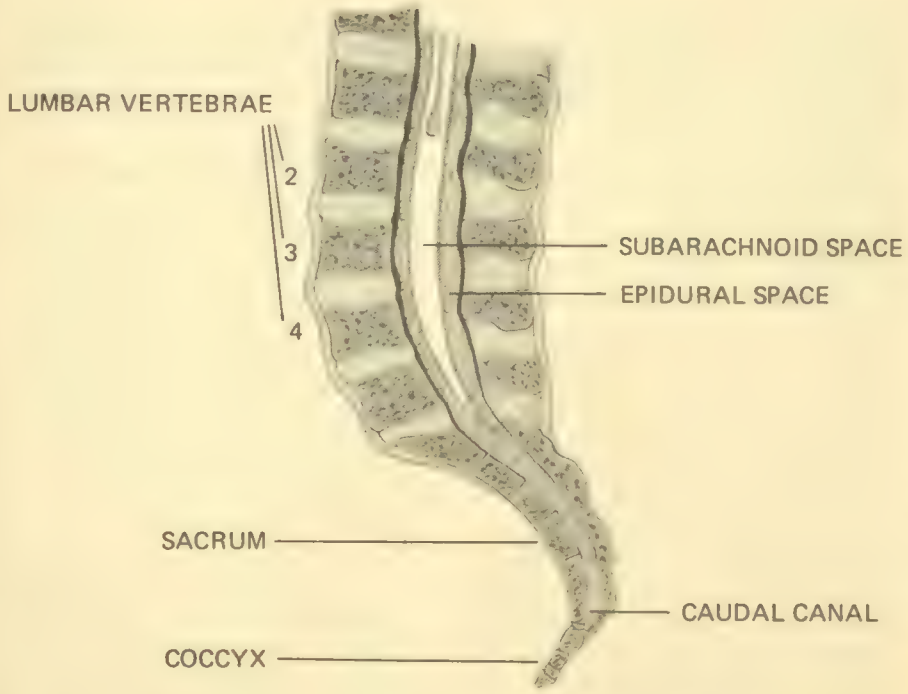
Method of administration

Lumbar epidural block is a form of extradural analgesia produced by injecting a local anesthetic into the peridural space in the lumbar region. The epidural space is a potential space that extends from the foramen magnum to the sacrococcygeal junction. The inner wall constitutes the dura; the outer wall consists of the periosteum and the supportive ligaments of the



The second, third, or fourth lumbar interspace is used when injecting the anesthetic for a lumbar epidural block.

vertebrae. The space is filled with adipose tissue, spinal nerves, lymph, and blood supply. When injecting the anesthetic, the second, third, or fourth lumbar interspace is used.

For insertion of the epidural catheter, the patient lies on her side with her legs and neck well flexed. The area is prepared with antiseptic solution and draped, using aseptic technique. A skin wheal is made over the entry site with a local anesthetic, then a 17-gauge Tuohy needle is inserted until it impinges on the ligamentum flavum. The stylet is removed from the needle, and a syringe with 2 cc of the anesthetic agent (Carbocaine or Xylocaine) is attached.

Firm pressure is applied to the needle to penetrate the ligament, which yields with a snap; the solution is then injected. A polyethylene catheter is threaded through the needle into the epidural space, the needle is removed, and the catheter secured with gauze and tape. If the patient has no side effects from the injection, she is positioned on her back and an additional 4 to 5 cc of anesthetic is injected.

Following injection of the anesthetic, the patient's blood pressure and the fetal heart rate are checked; these procedures are repeated in 15 minutes. Analgesia should be established within 10 to 20 minutes, and usually lasts 60 to 90 minutes.

If the patient's vital signs are stable, the nurse administers the hourly 6 to 7 cc dose of the anesthetic. When the patient is ready for delivery, the head of the table is raised and the anesthetist injects the final dose of 10 to 15 cc. This achieves anesthesia of the lower part of the uterus and the perineal area.

Effects of epidural anesthesia

The anesthetic acts on the sensory supply to the uterus and does not affect the motor nerves. It eliminates discomfort, but does not change the rate or force of the contractions. During the first stage of labor, the block that causes anesthesia at the T-11, T-12 levels relieves the discomfort of uterine contractions without affecting the efficiency.

In the second stage, the block can be extented to provide perineal anesthesia by injecting a larger dose. Although the anesthetic does not interfere with the mechanism of labor, it does eliminate the sensation of "bearing down." This is of no consequence, as the nurse can interpret this to the patient and help her to bear down as required.

The advantages of this type of anesthesia are many. The most important is that it is the least toxic to both mother and baby. Other advantages are :

1. Very few babies are flaccid at birth from analgesic effects.

2. Maternal glycogen stores, required to provide energy for each contraction, are not depleted. As a result, the baby does not have to endure the force of the contractions with a diminished amount of glucose.

3. Relaxation enhances uterine contractility and assists labor.

4. Pain and anxiety are eliminated. As a result, the motor nerves function efficiently without having to compete with the effects of the adrenalin that is released during anxiety.

5. There is no danger of maternal aspiration during anesthesia.

6. A more controlled delivery is achieved when "bearing down" sensations are absent.

Patients comment favorably on this method of anesthesia. They are able to understand labor and appreciate their increased freedom to participate in and to watch the birth of their child. The recovery time following this type of labor is faster, and the mother adjusts quickly to her new role.

The experience is more enjoyable for the father, too. He can sit with his

wife during labor without worrying about the discomfort she is experiencing. This does not make him any less devoted or less awestruck by what his wife is accomplishing, but it does relieve much of his apprehension, and increases his enjoyment and acceptance of the baby.

Toxic reaction

Side effects of epidural anesthesia are minimal. When they do occur, they are easily overcome. As some patients experience toxic reactions to the anesthetic, and initial test dose is given.

Toxic reactions range from drowsiness, to slight tremors, to convulsions. The latter are extremely rare. A minor drop in blood pressure may occur following administration of a dose of the drug, and this is overcome by turning the patient on her left side to relieve the pressure of the uterus on the great vessels. Checking blood pressure and pulse immediately after an injection and again in 15 minutes allows the nurse to detect hypotension. If positioning of the patient is not effective in returning the blood pressure to normal, intravenous infusions and oxygen therapy may be initiated. These latter measures are not usually required.

Other complications include tissue trauma, possible infection, and trauma to the spinal nerves — problems that have never occurred in our institution. Occasionally systemic anesthesia may occur if the agent enters the blood stream. This is characterized by ringing in the ears, circumoral paresthesia, syncope, or ineffectual analgesia.

The nurse or anesthetist may note the presence of blood in the epidural tubing. If the tip of the tubing is outside the intervertebral space, the patient will experience one-sided analgesia. Treatment consists of slight withdrawal of the catheter by the anesthetist. If this action is not effective, the anesthesia is repeated, using a different intervertebral space.

Another complication has been mentioned in medical literature. It occurs when the solution is injected too rapidly or when it is given during a contraction. Because of the limited size of the epidural space, the solution may be forced upward, causing anesthesia of the higher thoracic nerves with resultant respiratory difficulties. This is a rare occurrence, but must be promptly rectified by the anesthetist.

As a general precaution, whenever epidural anesthesia is being performed, all staff must be aware of the measures used to avert a crisis. Although only rarely required, these measures must be put into effect immediately.

The only contraindications to this form of anesthesia are : any form of neurological disease except epilepsy; chronic back conditions; hypotension resulting from untreated antenatal hemorrhage; skin infections; and sensitivity to local anesthetic agents.

Patient orientation

When a patient arrives in our labor room, she is given a general orientation to the department. The nurse explains the epidural anesthesia, if this is the method of choice, even though the patient's doctor may have discussed it with her during the antenatal period. The patient and her husband are told :

- When the epidural will be started.
- Time required for the insertion.
- Effect of the epidural. Initially, the mother will feel numbness, tingling, warmth and heaviness, starting in the feet and moving up the legs to the umbilicus. The epidural relieves the discomfort of the contractions by acting on the sensory nerve supply to the uterus, but does not deaden the skin, nor eliminate the sensations of heat, cold, or pressure.

If the patient is not properly informed, she will complain each time she feels any one of these sensations.

The husband is also given an apportunity to ask questions. The nurse explains that he will be required to leave the room while the epidural is inserted, but he may remain with his wife for the entire labor if he desires.

Effects on nursing care

How have epidurals changed obstetrical nursing? Almost all branches of nursing have experienced rapid change in response to technological advances. Obstetrical nursing, however, has appeared to be at a standstill. Until now, nurses in the labor room depended largely on their senses and observational skills to judge the mother's progress. Only on rare occasions were nurses allowed to examine patients, and then they were restricted to rectal examinations.

Nurses with extensive experience were usually capable of accurate judgment. However, a certain number of deliveries occurred before the patient reached the delivery room or before the doctor reached the patient. The nurse had to be observent during her first contact with the patient, as this gave her an indication of the patient's behavior to use for later comparison. These observations were important for, as labor progressed, the mother's personality and behavior changed.

In the early stages of labor, most women are quite communicative and aware of their surroundings. They are interested in what is happening and accept any health teaching offered. Later, there may be a "turning inward" of feelings as the mother focuses her efforts and energy on her contractions. She cannot discriminate between different nurses and really does not care. She makes overt behavioral responses to the stress of labor. Between contractions she usually sleeps or rests. Sudden changes in behavior and her degree of discomfort indicate her progress.

Now, with continuous epidural analgesia, nursing care and methods of observation must be reassessed. Because the patient is unaware of her contractions, she requires special attention. She does not need to have her

hand held, her brow wiped, or be reminded of her breathing for each contraction. She and her husband require a different type of support. They are interested in the type of work being accomplished by the uterus, and in the baby's condition. They want information that will help them to accept the newborn and their new role.

The nurse sits with her patient for longer periods, noting the length, frequency, and quality of the contractions. During this time, she keeps the couple informed of the progress in labor, and explains the mechanism of labor. This usually stimulates the parents to talk about the baby and the mother's hospitalization, and encourages them to air their anxieties.

The nurse still looks for the cues she needs to assess her patient's progress. While these are less obvious in patients receiving epidural anesthesia, they are still present in a more subtle manner. The patient whose epidural has been effective may suddenly begin to experience rectal pressure and discomfort. There may also be a sudden onset of nausea. These symptoms usually indicate transition into the second stage of labor.

Vaginal examination is the preferred method of assessing cervical dilatation, effacement, and station. Rectal examination is considered to be too uncomfortable and inaccurate. The labor nurses in our center have been taught to perform vaginal examinations under sterile conditions. Findings indicate there is a greater degree of accuracy, with no increase in infection.

What are the implications for nursing? Nursing education must change so that students are taught to understand their new role in obstetrics. Since not all Canadian hospitals use this type of anesthesia, inservice education must assume the responsibility for teaching registered nurses the knowledge and the skills they need to provide adequate care for these patients.

The nurse assists the anesthetist in the insertion of the epidural; she administers the hourly dose of anesthetic solution; and, with the anesthetist, she is responsible for its effects. She must know what precautions are necessary during administration of the anesthetic, and what action is indicated if untoward effects occur.

Nurses must also understand how the care they give after delivery is affected. Patients recover much faster following delivery under epidural anesthesia. They tend to have a very short "taking-in" phase, as Rubin describes it.* The "taking-hold" phase occurs sometimes as early as two days postpartum, and the new mothers have a tremendous need to regain complete control of bodily function so they can begin the tasks of "mothering."

Conclusion

The obstetrical patients at our center look forward to childbirth, and we try to make their experience as enjoyable as possible. Any hospital that intends to use this type of obstetrical analgesia and anesthesia must have a comprehensive inservice program to educate the staff and establish nursing responsibilities. This is extremely important to the smooth functioning of the department, and very necessary if epidural anesthesia is to be used to its fullest advantage.

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Manuscript should be typed and double spaced on one side of the page only, leaving wide margins. Submit original copy of manuscript.

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References, Footnotes, and Bibliography

References, footnotes, and bibliography should be limited to a reasonable number as determined by the content of the article. References to published sources should be numbered consecutively in the manuscript and listed at the end of the article. Information that cannot be presented in formal reference style should be worked into the text or referred to as a footnote.

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For book references, list the author's full name, book title and edition, place of publication, publisher, year of publication, and pages consulted. For magazine references, list the author's full name, title of the article, title of magazine, volume, month, year, and pages consulted.

Photographs, Illustrations, Tables, and Charts

Photographs add interest to an article. Black and white glossy prints are welcome. The size of the photographs is unimportant, provided the details are clear. Each photo should be accompagnied by a full description, including identification of persons. The consent of persons photographed must be secured. Your own organization's form may be used or CNA forms are available on request.

Line drawings can be submitted in rough. If suitable, they will be redrawn by the journal's artist.

Tables and charts should be referred to in the text, but should be self-explanatory. Figures on charts and tables should be typed within pencil-ruled columns.

idea exchange

Computer in Psychiatry

In some Canadian hospitals the computer is used to facilitate phases of medical work, such as recording patient admissions and ordering supplies. In May last year, the nursing service department at the Foothills Hospital, Calgary, Alberta, undertook a research project, computerizing nursing notes of psychiatric patients.

The aim of the project was to develop the notes into a checklist of adjectives which described patient behavior and progress, and could be computer tabulated. The assumption was that a well designed and usable computerized cheeklist would result in accurate, standardized records; provide guidelines for nursing students learning to observe and assess patient behavior; reduce the amount of clinical time spent by nurses in record-keeping; and provide a condensed, permanent store of readily available data for future psychiatric research.

The department of psychiatry, where the research took place, opened in 1966. There is an active-treatment center of two inpatient units (each containing 35 beds and facilities for milieu therapy). A day-care program is also in operation. Geared to accommodate all types of psychiatric patients, the department serves the city of Calgary, and accepts referrals from southern Alberta.

After a preliminary survey of current research on computerized psychiatric nursing notes, it was found the usage and meaning of psychiatric terminology varied from region to region. This meant a specific form was required to incorporate most used terms. The form was called *Observation Checklist*.

To determine what terminology nurses at the Foothills Hospital used to describe a patient's condition and behavior, nursing notes from some 350 patient files were reviewed. Expressions derived from this source described: sleeping habits, activity involvement, socialization, and other behavioral aspects. It was noted the nurse's notes reflected her training to observe and report, but not to diagnose. Many comments on the patient's condition were modified by, "seems, appears, looks, complains, expresses." However, traces of originality appeared from time to time in the comments, "patient behaving like a wet-weed" or "patient using poetic language, given reality therapy."

From the nursing notes, major categories, with an average of 75 adjectives, were set up. The range of verbalization, exclusive of the speech content, included description of type, speed, manner, quality, quantity, amplification, absence of speech, impediment, tone and pitch. Terms used by nursing personnel to designate a patient's speech included: abusive, aphasic, superficial, inappropriate, strained, slurred, slowed, flippant, babbling, moaning, muttering, spontaneous, and inconsequential. The final checklist was constructed by deleting all unusual or seldomly used expres-

sions, and combining or summarizing all synonymous terms under one adjective to determine the broadest meaning.

To measure degrees of behavior, words were selected which provided the extent and intensity of a patient's action or reaction. For example, *mood* was designated under three adjectives, bored, apathetic, flat, intended to convey emotional detachment ranging from mild or moderate to severe. Under the heading *cognition,* a section dealing with a patient's intellectual ability, descriptions such as alert, logical, and organized, decreased interest, forgetful, flight of ideas, and autistic were used to assist in differentiating between unimpaired thinking, mildly disturbed thinking, and thinking that indicates severe impairment.

An accompanying glossary defined the meaning of terms. Frequently, the definition assigned a term was the adaptation of several descriptions taken from nursing notes and combined. For example, if a patient was shown as demonstrating an attitude designated as self-centered, he might be described as "primarily concerned with his own desires, needs, interests, and problems, and indifferent to those of others; tending to be narcissistic and to resent or display jealousy of attention shown to others; selfish and often given to self-indulgence and self-pity."

As the planned activity program is an integral part of the psychiatric patient's therapy, provision was made in the *Observation Checklist* to record the extent and quality of his participation in the activities. A list, with a simple six-point grading scale for measuring the patient's degree and quality of participation in activities was set up.

Participation was designated by the words, "refused, attended, participated, satisfactory contribution, dominated, disrupted." These terms were intended to indicate: does not participate; passive participation; minimal, not particularly significant; satisfactory contribution; dominates, monopolizes or tries to control the activity; disturbs; is a negative member of the group or activity.

Included in the checklist was a section describing symptoms. The somatic problems listed (*e.g.,* vomiting, convulsions, diarrhea) referred to the manifestation of physical symptoms and disturbances whether organic or psychosomatic. The checklist was also designed to assist the doctor when diagnosing disease, drug effects, and other conditions.

To evaluate the new checklist as a patient progress record, it was used for two months on preliminary trial. A decision to continue with the standard nursing notes was made at the end of the trial period, and to use the new, computerized checklist in conjunction with these notes for the first two days following the patient's hospital admission, and weekly thereafter to evaluate the patient's behavior and progress.

As the checklist is composed of terminology used and understood by nursing staff, it was decided to use it in its newly computerized form, to replace the Whittenborn Psychiatric Rating Scale. The checklist form has been used in this way since last January, and has proved to be a worthwhile means of recording and assessing patient progress.

A weekly computerized summary of the form provides a concise reference when comparing a patient's progress week by week. It also produces recording uniformity. The checklist and accompanying glossary has also proved helpful for orienting new staff, students, and interns.

Information from the *Observation Checklist* is keypunched on 80 column computer cards. These are sent to the University of Calgary Data Centre and batch-processed. The printout is delivered to the hospital the next day. An improvement of the processing operation will cut approximately two hours from the present schedule. Under the new system, the computer cards will be entered via a remote card reader/printer on location — *Margaret Osborne is psychiatric nursing coordinator at Foothills Hospital, Calgary, Alberta. She received her bachelor of nursing from McGill University, and has experience in nursing education and nursing service in psychiatry. Geraldine Fordyce has been employed as a social worker with the city of Calgary social service department for several years. She is working toward a master's degree in social work.*

Home care of children with inborn errors of metabolism

A description of a metabolic disease unit that carries health services into 60 patients' homes. Although the unit does not provide general health care, it does undertake the consultative care of certain hereditary metabolic diseases, and the problems related to the primary disease.

Terry Reade and Caroline Clow

The hereditary metabolic disease unit at the Montreal Children's Hospital was established three years ago to provide constant monitoring of patients with inborn errors in metabolism, at the lowest possible cost to the community. If these patients had been treated by repeated visits to a physician or to an outpatient clinic, or by hospitalization at intermittent intervals, the cost would have been prohibitive and the frequency of supervision, insufficient. As it is, almost 90 percent of patient care is provided by two members of the unit, and home supervision of each patient is given at a cost of approximately two dollars per day.

Patients are referred to the unit by their physicians, or their disease is detected by the newborn screening program.[1] If the unit had to care for all these patients in the Montreal area, there would be about 26 new patients each year requiring medical supervision. The total number would accumulate annually, as many patients require long-term or permanent treatment. Fortunately, the Quebec government started a program similar to the Montreal Children's Hospital in October 1969.

TABLE 1

Hereditary Metabolic Diseases Treated By Home Care Program

Disease	*No. of patients*
Phenylketonuria	25
Hyperphenylalaninemia	5
Hereditary Tyrosinemia	1
Homocystinuria	2
Cystathioninuria	2
Cystinuria	3
Cystinosis	6
Fanconi Syndrome	2
X-linked Hypophos. Rickets	8
Vitamin D. dependency	5
Miscellaneous	5
Total	64

The authors, staff members of the hereditary metabolic disease unit at the Montreal Children's Hospital, provide the day-to-day care for 60 families in which there are one or more children with metabolic disorders. Mrs Reade is a graduate of the Hospital for Sick Children in Toronto. Mrs Clow, co-director of the unit, was trained for her role in the deBelle Laboratory for Biochemical Genetics, and is now a research associate with the Faculty of Medicine, McGill University.

Treatment

Hereditary metabolic disorders are gene-dependent traits that modify or impair the normal metabolism of a particular substance. The unit treats these conditions by various forms of "environmental engineering."[2] The

patients' biochemical values are monitored, and the various amino acids and minerals affected by the disease are kept within the proper limits by adjusting the intake of the substances through diet and medication.

This treatment may range from strict diet control to reduce the intake of phenylalanine in the phenylketonuric patients, to the administration of massive doses of phosphorus by mouth for X-linked hypophosphatemic rickets patients. In all cases, samples of blood and urine are analyzed and the results recorded. Metabolic charts are kept to record the progress of each patient.

Treatment requires close cooperation between the unit and the patients' parents. The parents have an important function because they are responsible, with the unit's supervision,for managing the diet, administering the medications and, in some cases, collecting capillary blood and urine samples. This close cooperation reduces the claim on the physician's time. Physicians review the charts regularly, but are otherwise called on only when some unexplained situation arises, or when a change in treatment seems necessary.

Without treatment, most of the inborn errors of metabolism have serious effects on the patient. Phenylketonuric patients can become seriously retarded if the phenylalanine levels in their blood are elevated for long periods after birth. Hereditary rickets can cause crippling deformities and short stature. Although the genetic defect can never be cured, its effect on the patient can be minimized, and damage to the patients avoided.

Much of the work of the unit involves counseling the parents, both in their homes and on the telephone. Chronic illness in general, and hereditary disease in particular, impose added pressures on family life; these pressures can be relieved by sympathetic understanding and advice on specific problems as they arise. Since these disorders are hereditary, parents will benefit from genetic counseling and family planning.

The unit words as an integral part of the deBelle Laboratory at the Montreal Children's Hospital, and the laboratory's full range of analytical equipment is available for monitoring the patient's biochemical values. A few of the non-routine tests are sent to other laboratories in the hospital for completion. Close liaison is kept with the radiology department because of the many x-rays required for the patients with hereditary rickets. Part-time services of a social worker and a dietitian are also used.

Much of the treatment for the amino acid disorders is handled in the laboratory. Parents of phenylketonuric patients are shown how to use a lancet and capillary tubes to collect heparinized blood samples. These samples are sent to the laboratory at regular intervals for one-way partition chromatography testing. If the phenylalanine levels are elevated, the parents are telephoned and the diet is adjusted.

Parents are encouraged to call the unit to discuss health and family problems related to their children's disorders. We have one phenylketonuric patient living 1,000 miles away, who has been successfully monitored by mail and telephone.

Home visits

Most home visits by the team nurse are made to patients with hereditary rickets. Calls are made regularly on a predetermined schedule in the greater Montreal area (approximately 200 square miles), with occasional home visits to patients in outlying areas. An analysis of home visits is shown in *Figure 1*.

Many parents find it difficult to make regular visits to an outpatient clinic, particularly if they have younger children to care for and no extra money for baby-sitting or transportation. A child with rickets may be in a cast, requiring transportation by ambulance — a further financial burden. Experience has shown that attendance at in-hospital clinics cannot be depended on. The vital need for regular monitoring of these patients makes it more economical to bring the medical services to them, rather than bring them to the central hospital clinic.

Home visits bring closer contact with the parents, and demonstrate to them that someone is interested in their plight. Many parents have guilt feelings about passing on a hereditary weakness to their children, and these feelings can be discussed better in the security of their own homes. Although there is nothing that can be done about the primary genetic disorder, something *can* be done about the way in which the disorder affects the child and his family.

Special family problems can be de-

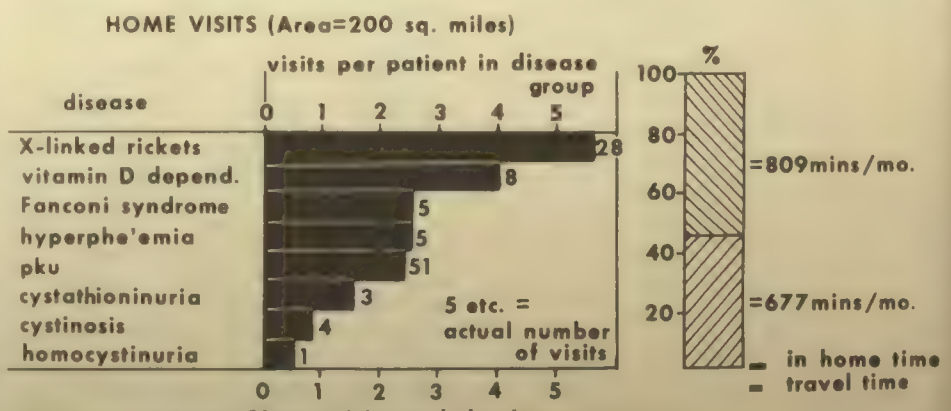

Fig. 1 An analysis of home visits made by the team nurse.

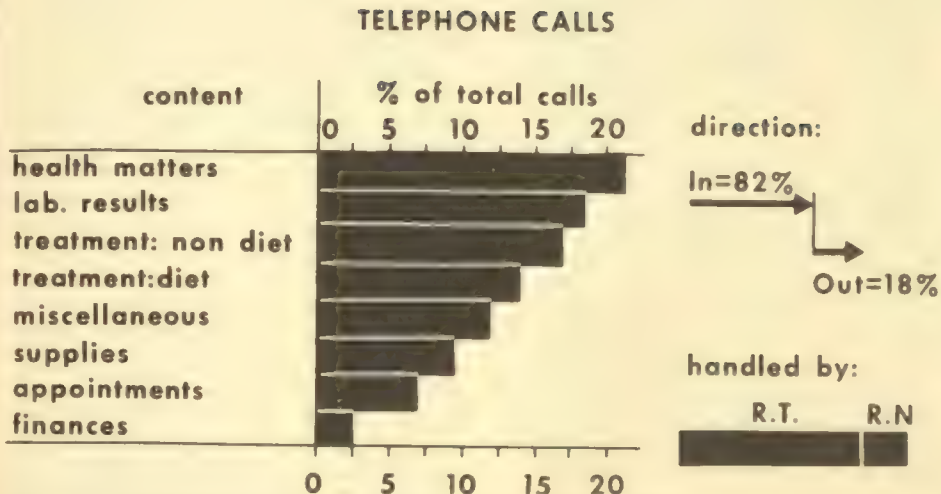

Fig. 2. A breakdown of the telephone calls made to patients.

tected and corrected in the home visits before they disturb the treatment routine. For example, one child with X-linked rickets lived with her mother in a small apartment belonging to the grandmother. The grandmother retired early in the evening and demanded that the others comply with her wishes, with no disturbances during the night. As a result, the child was not getting her nightly doses of phosphorus, and her blood levels of the mineral were too low. The hospital arranged for a social worker to counsel the mother, and the mother and her child were helped to move into an apartment so the child could receive medication on schedule.

Medications are supplied by the hospital pharmacy, and the cost is charged to our research grant. This allows us to calculate a true cost basis for the treatment of each disease. A running record is kept on the supply each patient has on hand. When the supply is low, a new supply is delivered on the next home visit. Samples of blood and urine are also collected during these visits, and records are kept of the height, weight, general health, and blood pressure, if required.

Parents of children with amino acid disorders play an important role in the treatment. To give them a forum in which they could air their problems, a parents' group was formed. This group meets once monthly, except during the summer months, to discuss mutual problems and to exchange ideas on how these problems are being handled. The subjects for discussion range from new recipes for their children's diet, to the moral problem of sterilizing retarded teenage girls. Nurses in the unit attend these sessions to provide leadership and medical knowledge.

Conclusion

Proper support is important to parents of children with chronic disorders. They have to know that someone else other than themselves cares about what happens to them and their children. They can become easily discouraged with the prospect of years of treatment ahead, and need to talk to someone who can reassure them that all their efforts are worthwhile.

But it is not only the parents who need the support. A young patient with rickets, who has endured previous osteotomies, needs personal support and encouragement when told that another operation is needed.

Close liaison with families in which there are one or more children with inborn errors of metabolism is proving successful. As evidence of success, there are now phenylketonuric patients with normal intelligence quotients, and X-linked hypophosphatemic rickets patients with normal growth rates and healed bones. Patients with other hereditary diseases treated in the Montreal Children's Hospital have also responded well, although not always in such a dramatic way.

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The authors express their appreciation to Dr. C.R. Scriver, Director of the deBelle Laboratory for Biochemical Genetics at the Montreal Children's Hospital, for his advice and encouragement, and to Drs. D.T. Whelan, H. Goldman, F. Glorieux, and K. Baerlocher, for their medical assistance. This study is supported by Dominion-Provincial Grant 6-4-7-643, (N.H. & W., Canada).

research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Roach, Sister Marie Simone. *The development of an instrument to measure selected affective outcomes of a diploma program in nursing from verbal responses of nurses on completion of the program.* Boston, 1967. Thesis (M.Sc.N.) Boston University.

The problem of the study was the development of an instrument to measure selected affective outcomes of a diploma program in nursing. The instrument was administered in a pilot study one month before graduation to one-third of the senior class of the cooperating agency, an independent school of nursing in Boston, Massachusetts.

A selection of nine objectives, used as a basis for the instrument, was made from data obtained through the assistance of 72 percent of the faculty of the agency. Test items were designed to measure selected behaviors of each of the nine objectives.

The instrument was organized into four parts, with each part employing a different measurement technique. One standardized test, the *Study of Values* (G.W. Allport et al, Boston, 1960) was used to obtain information on more complex value patterns.

Reliability estimates for internal consistency, using the Hoyt procedure, ranged from a .08 to a .94 coefficient. No tests of validity were applied, but at various stages of the study the faculty reviewed objectives, behaviors, and test items.

Mean scores for the *Study of Values* were compared with national norms and with one recent nursing study, as well as with responses of students to selected items of the instrument.

A major limitation of the study was the fact that the instrument was based on a limited sample of objectives and selected behaviors. Furthermore, the measurements were based on verbal responses only. No provision was made for follow-up performance.

The study provided evidence that affective outcomes of learning can be identified and appraised. The construction of the instrument allowed for an opportunity to experiment with the taxonomy of affective objectives and to discover the usefulness of this classification of behavioral terms for identifying levels of behavior and preparing test items.

A major insight gained at the conclusion of the study was a realization of the relevancy and urgency for further research, not only to identify and appraise affective outcomes of nursing education programs, but to consider ways of providing learning experiences so that students can develop the interests, attitudes, appreciations and values essential for the nursing practitioner. In light of the pressing need to increase the nation's complement of nurses and reduce the number of rejects and withdrawals from nursing programs, the study concluded that the problem justified further research.

Creeggan, Sheila Moreen. *Factors affecting faculty attitudes toward curriculum change in selected diploma schools of nursing.* London 1970. Thesis (M.Sc.N.) U. of Western Ontario.

This project was an attempt to explore factors affecting faculty attitudes toward current curriculum trends in nursing education in Ontario. Attitudes were evidenced by the degree of personal involvement in curriculum planning and expressed feelings toward the present trends in nursing education. Variables considered included personality characteristics, educational preparation, and age.

The investigator obtained information from nursing teachers in six hospital-based diploma schools of nursing. The instrument used for collection of data was an attitude measure consisting of 32 controversial statements, 16 oriented to change and 16 traditional. The participants were asked to score these statements on a nine-point scale from very strongly agree to very strongly disagree. These data were coupled with information on general personality traits obtained by using a standardized personality inventory (Jackson Personality Inventory) and general information relating to age, educational preparation, nursing and teaching experience.

Mass data processing was used to facilitate analysis and the Pearson Product Moment Correlation Coefficient was the statistic computed to show the significance of the relationship between expressed attitudes to current curriculum trends and the other variables being considered.

The 98 teachers who completed the attitude measure appeared to be oriented to change, rather than holding to traditional attitudes. The correlations showed a significant relationship at the 1 percent level for six of the seven selected personality traits (tolerance, breadth of interest, complexity, value orthodoxy, risk-taking, and innovation) with scores on the attitude measure. The correlation analysis showed that there was no significant relationship between involvement in curriculum planning and scores on the attitude measure. The percentage of high scores on the attitude measure was shown to be higher for teachers with a baccalaureate degree than for those with less academic preparation. Attitude scores decreased as school size decreased. A correlation coefficient significant at the 2 percent level was obtained between attitude scores and year of graduation from a basic nursing program. The findings indicated that young teachers were less bound by conventional standards.

Long, Linda. *A study of the withdrawal of nursing students at the Saskatoon City Hospital School of Nursing, Saskatoon, Saskatchewan, from September 1954 to September 1960.* Seattle, 1962. Thesis (M.N.) U. of Washington.

This study was planned to determine the number of students who withdrew from the Saskatoon City Hospital School of Nursing from September 1954 to September 1960 and the analysis of the reasons for withdrawal.

The main problem was that although the large number of qualified student applicants to the school of nursing allowed for better selection, and although involuntary withdrawal lessened, student withdrawal still occurred.

The descriptive survey method was used. Data were collected by the review of school records and content analysis. The classes of nursing students selected for the study were those admitted to the school of nursing from 1954 to 1960,

a period of acute competition with the University Hospital's three-year diploma nursing program.

Of 463 students enrolled in the school of nursing from 1954 to 1960, 82 students withdrew, 33 voluntarily and 49 by request of the school. Of these withdrawals, 68 left during the first year of the program : 35 of these students were in the centralized teaching program. Only five students withdrew during the third year.

The greatest number of withdrawals were from the 1956 and 1957 classes. Of the five major reasons for withdrawal, academic failure represented 41 percent of the total withdrawals. The other major reasons — pending marriage, dissatisfaction with the program, dissatisfaction with nursing, and health — accounted for a student withdrawal of 9 to 11 percent.

All reasons for withdrawal appeared during the first year of the nursing program. Only marriage and "breach of conduct" were reasons for withdrawal in the students' third year. Nearly all students who withdrew for marriage indicated a desire to continue in nursing. The greatest number of student withdrawals had an academic average on admission of 60 to 64 percent. Of all the reasons for withdrawal, academic failure accounted for the majority of students with the lowest admission average — 55 to 64 percent. One student of the Jehovah Witness religion withdrew because of religious conflict with medical practice.

Nearly three-fourths of student withdrawals were 18 years of age on admission to the school. A high school principal's reference, which was a stated school requirement, was available for only 10 student withdrawals, and these references were inadequate in content. Past employment was indicated for 15 student withdrawals.

No standard pattern of interviewing candidates for the school of nursing was apparent from the records. Pre-admission interviews — a stated requirement of the school — were recorded for 15 students. Content of these interviews was limited and descriptions of student behavior was too generalized in most cases. No student record presented the total information desired for the investigation.

The findings of the study indicated several suggestions for student selection as a means of approaching the withdrawal problem : a minimum admission academic average should be maintained, with consideration given to establishing a minimum average of 65 percent; and a pre-admission interview guide and form should be prepared by the school of nursing, and filed with the permanent record of each student withdrawal.

books

Behavioral Concepts & Nursing Intervention, coordinated by Carolyn E. Carlson. 341 pages. Toronto, J.B. Lippincott Co. of Canada, 1970.
Reviewed by M.A. Beswetherick, Assistant Professor, School of Nursing. The University of Alberta, Edmonton, Alberta.

This book is a collection of articles written by 16 different nurse educators. The authors attempt to identify, examine, and demonstrate social-behavioral and mental health concepts in a nursing context.

The content is broad and could be applied in nursing situations to identify patient problems and develop areas of research. Topics include: denial of illness; empathy; the professional nurse and body image; shame; grief and mourning; trust in the nurse-patient relationship; humor in nursing; listening; ambivalence; transactional analysis or communication and nursing; privacy; stigma; development of awareness of self for the professional nursing student; the process of role change; and relationship control.

Varied philosophical approaches are used throughout the text. For example, the one on stigma takes a sociological view of the problem, while those on shame and privacy are a combination of sociological, psychological, and psychiatric approaches. The discussion on the professional nurse and body image reflects the view of medicine and natural science.

Each article is related to the other and provides insight into the emotional complexities experienced by the patient. Because the topics or chapters are complete in themselves, it is unnecessary to read them in sequence.

A reference and bibliography are included with each article. This feature alone adds to the book's value as a teaching tool.

Textbook of Medical-Surgical Nursing, 2nd ed., by Lillian S. Brunner et al. 1031 pages. Toronto, J.B. Lippincott Co. of Canada, 1970.
Reviewed by Charlotte Hardy, Assistant Director of Nursing Service, Ottawa Civic Hospital, Ottawa.

The purpose of the text, to conduct an in-depth discussion of the clinical conditions and problems most frequently seen in nursing practice, is outlined in the first paragraph of the preface. The book achieves its purpose and, at the same time, shows a humanistic and compassionate understanding of the patient's problems, needs, and nursing care. In each section, the significance of the nurse's role in building the confidence of the patient is stressed.

Units and chapters divide the book in a logical sequence, beginning with assessment of the patient in unit one, cause and prevention of disease in unit two, and discussion of specific conditions of illness in later units. Illustrations and diagrams are precise and accurate, and effectively explain appropriate nursing procedures.

One of the highlights of this excellent teaching and reference text includes unit four, which gives a brief history of surgery. It also describes preoperative, intraoperative, and postoperative nursing care. Charts and diagrams are used extensively in unit four. Chapters in unit nine cover vascular disorders and discuss the common pathological conditions affecting the venus, arterial, and lymphatic systems. A section on patients with conditions involving the kidneys, the urinary tract, and the reproductive system is informative and uses illustrations to assist in explaining nursing care procedures.

Emergency and disaster nursing are covered in the last unit. Specific emergency situations are discussed, and treatment is listed step by step in order of priority.

This is an informative, clear, and stimulating text. It presents both basic and specific material required by every nurse.

Law Every Nurse Should Know by Helen Creighton. 245 pages. Toronto, W.B. Saunders Company, 1970.
Reviewed by Eileen C. Flanagan, co-chairman, legislation committee, Association of Nurses of the Province of Quebec.

The need for this book is shown by the extensive number of samples given of cases taken to law courts involving nurses either individually, or in conjunction with hospitals and with members of the medical profession. This may be an indication that we are failing in our duty to student nurses by not giving them the type of instruction needed to prevent the occurrences that result in so many court actions.

This book, which is concisely written, should assist teachers to improve instruction in this difficult subject, not only at the undergraduate level, but also in graduate schools. It will also serve as an excellent reference source for nurses in hospital administration, in public health organizations, and in private duty. Secretaries of State, provincial nurses' associations, and chairmen and members of legislation committees will find this book helpful in conducting their affairs.

The material on licensing, with clear explanations of the difference between permissive and mandatory laws, and the history of the struggle for licensing on the part of groups of sincere, energetic, public-spirited members of the nursing profession in many lands, with

its great influence on the status of nurses, are very important facts that all nurses should know.

Court actions relating to negligence and malpractice are becoming increasingly common, and the nurse today must be keenly aware of these hazards in her role, as the book illustrates in its many examples. Today's nurse must also work with many others on the health team — nursing assistants, technicians, aides, orderlies, and clerical workers — on whom she has to exercise a certain amount of supervision and assume some responsibility. This subject is discussed with good reason since the nurse can be legally involved in these relationships. However, the trend is to hold nursing assistants responsible for their own acts. For this reason, the material should assist nurses who teach nursing assistants.

The material dealing with new legislation in the health fields, the newer role of the nurse in the areas of chest, kidney and heart surgery, transplantation of organs, sterilization, resuscitation, and narcotics is most valuable. In the chapter on Canadian Law, it is pointed out that while nine provinces are under English Common Law, Quebec is governed by French Civil Law (except in the case of Criminal Law), and therefore it is important to know which law operates in your province. Quebec, Prince Edward Island, and Newfoundland have mandatory nursing acts.

In conclusion, the large number of examples of cases in which nurses have been involved in situations of negligence, should stimulate all nurse educators and nurse practitioners to apply themselves to the task of preventing such incidents. A serious use and study of this book will be a great asset in this endeavor.

Emergency Nursing by C. Louise Riehl. 286 pages. Peoria, Illinois, Chas. A. Bennett Co. Inc., 1970.

Reviewed by Major Margaret H. Hunter, Chief Nursing Officer, St. John Ambulance in Canada, Ottawa, Ontario.

The author has attempted to cover too many subjects in one book, resulting in briefness and simplicity of style. Perhaps it was intended as a quick reference book.

Descriptions in the text deal briefly with a hospital's emergency department and its administration, planning, personnel, physical layout, equipment, supplies, and legal matters involving the hospital.

Following chapters discuss such emergencies as respiratory resuscitation, cardiac massage, and injuries of the head, chest, abdomen, and bones. Infections, antibiotic therapy, burns and shock, medical emergencies, and emotional aspects of injury are also covered.

The concluding chapter presents guidelines for training ambulance personnel. By including this subject the author has touched on a weak area in the health field. Certain provinces in Canada have taken definite steps to train ambulance personnel to care for patients at the scene of the mishap and during transit to hospital. Although the program is not functioning in all areas, nurses realize that this is an important field. It is an area that needs to be coordinated and developed to maximum efficiency.

The author takes only a brief look at emergencies. Unfortunately, those emergency problems that dominate our present-day society, that is, drug addiction, psychiatry, and disaster nursing, have been omitted.

The content is over-simplified to the extent where I would question its value as an in-depth study text. It appears to be geared to the non-professional worker. Today's nurse must assume responsible functions, and needs much more knowledge than this book offers.

Most illustrations are not effective from an educational point of view, and therefore do not serve any useful purpose.

But, the author has done an excellent job in pointing out to nurses the importance of being aware of the patients and the family's deepest needs. In a busy and short-staffed emergency department, this aspect of nursing is often depersonalized and neglected.

AV aids

Films

Scott Paper Limited has introduced a complete teaching program on the subject of menstruation. The program centers around a 20-minute, color film, *World of a Girl*, which includes teenagers discussing their own feelings on the subject. The menstrual cycle is explained on film by a teacher talking to a live class and using illustrations.

A Teacher's Guide provides material for classroom discussion following the film. Each student receives a 16-page, illustrated booklet *World of a Girl*.

The film is available on loan free of charge by writing to World of a Girl, Modern Talking Picture Service, Inc.,

Next Month
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The
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- Continuing to Care — in the Air
- Preplacement Health Screening by Nurses in Industry
- Are We *Really* Meeting Our Patients' Needs?
- The Autistic Child

Photo Credits for October 1970

Crombie McNeill Photography, Ottawa, pp. 7, 24, 25

Julien LeBourdais, Toronto, p. 8

Studio C. Marcil, Ottawa, p. 18

Montreal Children's Hospital, pp. 42,43

AV aids

1943 Leslie Street, Don Mills, Ontario. Details needed are the name of the teacher, name and address of school, preferred showing dates, and an estimate of the number of participating students.

A Hospital Is . . .

The Canadian Hospital Association has made a 30-minute, color film on the day-to-day routine of a large city hospital. The film, entitled, *A Hospital Is...*, was produced by Crawley films, and was shown on CBC television August 28.

Directed to lay audiences, the film effectively portrays all aspects of hospital life in a fast-moving and realistic fashion. According to the film, a hospital is: the people who work in it; a community business; a beginning; a community health center; expansion; a factory for people; education; and, finally, change.

The birth of a baby and an operation on a sebaceous cyst are two scenes from the film. The CHA film offers lay audiences an insight into a hospital's operation. Nurses will notice, however, that although the film discusses the changing role of the nurse, she is shown in only traditional roles.

For more information, write to the Canadian Hospital Association, 25 Imperial Avenue, Toronto, Ontario.

Drugs

The following films are available from Educational Film Distributors Limited:

Monday is a 12 1/2 minute, black and white, film that looks at the world through the eyes of a young man using hard drugs. It has no dialogue, and apart from the main character, all actors were filmed on the spot, in a true-to-life style. Cost of this Canadian-produced film is $110.

Drugs and the Nervous System is an animated film that discusses the effects of drugs on organs and body systems. It explains the serious disruption of the nervous system caused by narcotics. This color, 16-minute film costs $215.

For further information write to Educational Film Distributors Ltd., 191 Eglinton Avenue E., Toronto 315, Ontario.

Films dealing with food preparation, kitchen safety, and food and personnel sanitation have been distributed to five regional health offices of the Ontario Department of Health. These sets of 22 films each have been sent to offices in London, Hamilton, Kingston, Toronto, and Northern Ontario, and will be presented to interested groups under public health personnel supervision. These color films are 9 minutes in length. Distribution is restricted to health personnel involved in food protection services and programs. For further information write to the Regional Medical Officer at the regional public health offices in your district.

accession list

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30. *Programmed instruction in arithmetic, dosages, and solutions* by Dolores F. Saxton and John F. Walter. 2d ed. Saint Louis, Mosby, 1970. 60p.

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GENERAL DUTY NURSES for 94-bed General Hospital located in Alberta's unique Badlands. $405 — $485 per month, approved AARN and AHA personnel policies. Apply to: Miss M. Hawkes, Director of Nursing, Drumheller General Hospital, Drumheller, Alberta.

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A HEAD NURSE and STAFF NURSES will be needed for Child Psychiatry. The Head Nurse will participate in the clinical development and subsequent operation of the 20-bed unit anticipated for the Royal Jubilee Hospital's Eric Martin Institute of Psychiatry. Current registration with the Registered Nurses' Association of British Columbia is required. Enquiries should include background and experience and be made to the: Director of Nursing, Royal Jubilee Hospital, 1900 Fort Street, Victoria, British Columbia.

NURSES registered in British Columbia with **PSYCHIATRIC** experience are needed for the newly opened Eric Martin Institute of Psychiatry. When fully opened this 170-bed facility is anticipated to have a Day Hospital 6 Acute Adult Psychiatric Units and a 20-bed Children's Unit. Attractive salary scale and liberal personnel policies. Apply to the: Director of Nursing, Royal Jubilee Hospital, 1900 Fort Street, Victoria, British Columbia.

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UNDER B.C.H.I.S. STAFF NURSES with leadership qualities to help initiate and promote quality care for the long term patient. Salary — under RNABC contract. Write Nursing Director, St. Mary's Priory Hospital, 567 Goldstream Avenue, Victoria, British Columbia.

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GENERAL DUTY NURSES: Applications are invited from **Registered Nurses** for a 100-bed accredited hospital 50 miles west of Winnipeg on Trans Canada Highway. Salary range $510 / $595 per month effective September 1st, 1970. Excellent fringe benefits plus evening and night differentials and academic attainment bonuses. Applications will be received by: Director of Nursing, Portage District General Hospital, Portage la Prairie, Manitoba.

NEW BRUNSWICK

DIRECTOR OF NURSING required for 56-bed acute General Hospital. Salary commensurate with education and experience. Apply to: Administrator, Sackville Memorial Hospital, Sackville, New Brunswick.

NOVA SCOTIA

GENERAL DUTY NURSES applications are invited for active treatment hospital caring for medium and long term patients. Salary Range: $5,400. — $6,660. Excellent Fringe benefits and working conditions. Please apply to: Director of Nursing, Halifax Civic Hospital, 5938 University Avenue, Halifax, N.S.

ONTARIO

ROTATING SUPERVISORS required for 180-bed General Hospital situated at St. Anthony, Newfoundland. Excellent personnel policies, fringe benefits. Residence accommodation available. Apply: Mrs. Ellen E. McDonald, International Grenfell Association, Room 701, 88 Metcalfe Street, Ottawa 4, Ontario.

PUBLIC HEALTH NURSING SUPERVISOR with preparation in advanced Public Health Nursing or Baccalaureate degree with Administration and Supervision, required for Hastings and Prince Edward Counties Health Unit, Shopping Plaza, 470 Dundas Street East, Belleville, Ontario. Good personnel policies. Apply to: Dr. C.R. Lenk, Director, Medical Officer of Health, Hastings and Prince Edward Counties Health Unit, Shopping Plaza, 470 Dundas Street East, Belleville, Ontario.

REGISTERED NURSES for 34-bed General Hospital. Salary $525. per month to $625 plus experience allowance. Residence accommodation available. Excellent personnel policies. Apply to: Superintendent, Englehart & District Hospital Inc., Englehart, Ontario.

REGISTERED NURSES needed for 81-bed General Hospital in bilingual community of Northern Ontario. French language on asset, but not compulsory. Starting salary $530. monthly with allowance for past experience, 4 weeks vacation after 1 year and 18 sick leave days, Unused sick leave days paid at 100% every year. Master rotation in effect. Rooming accommodation available in town. Excellent personnel policies. Apply to: Personnel Director, Notre-Dame Hospital, P.O. Box 850, Hearst, Ont.

REGISTERED NURSES required for a 12-bed Intensive Care-Coronary Care combined Unit. Post basic preparation and/or suitable experience essential. 1970 salary range $535-645; generous fringe benefits. Apply to: Director of Nursing, St. Mary's General Hospital, 911B Queen's Blvd., Kitchener, Ontario.

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REGISTERED NURSES (2) Night Duty, small 18-bed Chronic Hospital. Salary $495 to start, meals included, annual increments, fringe benefits, 8 statutory holidays. Apply: Superintendent, Beverley Private Hospital, 230 Beverley Street, Toronto 130, Ontario.

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REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS for 45-bed hospital. R.N.'s salary $525 to $600 with experience allowance and 4 semi-annual increments. Nurses' residence — private rooms with bath — $30 per month. R.N.A.'s salary $350 to $425. Apply to: The Director of Nursing, Geraldton District Hospital, Geraldton, Ont.

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REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS for 36-bed General Hospital in Mining and Resort town of 5,000 people. Beautifully located on Wawa Lake, 140 miles north of Sault Ste. Marie, Ontario. Wide variety of summer and winter sports including swimming, boating, fishing, golfing, skating, curling, bowling, etc. Six churches of different faiths. Salaries comparable with most northern hospitals. Excellent personnel policies, pleasant working conditions. Apply to: Director of Nursing, The Lady Dunn General Hospital, Box 179, Wawa, Ontario.

November 1970

The Canadian Nurse

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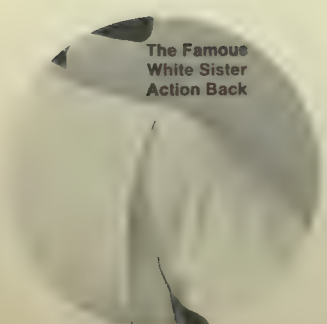

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The Canadian Nurse

A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

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In the past few months, the Canadia Nurses' Association has been besiege by telephone calls from the news medi asking the national voice of nursing t identify its stand on abortion reform CNA staff cringe when these calls com in, as they can say only that CNA ha taken *no* stand on the issue, althoug the implications of removing abortio from the Criminal Code are beir studied by the association's board o directors.

On October 8 — the same day th Speech from the Throne informe Parliament that the federal governmer will set aside time for special debate o abortion — the CNA board discusse the abortion issue, and passed a resolu tion stating that CNA "... reiterate i belief that *every* Canadian woman wh has decided to secure an abortion ha the opportunity of availing herself o the best health care possible." (New page 7.)

Between now and the next boar meeting in March 1971, the 10 pro vincial nurses' associations will stud the abortion issue further and repo their findings. Then, the Canadia Nurses' Association — the larges group of health workers in this countr — will undoubtedly take a stand on th vital issue and make every effort t promote its beliefs.

We believe CNA should take th following position, already adopted b the Canadian Psychiatric Association abortion laws should be removed fro the Criminal Code and become a medi cal procedure to be decided by th woman and her husband, along with th physician. To this we would add: n nurse should be asked to abandon he beliefs and be required to help carr out an abortion; by the same token, n nurse who opposes "abortion on de mand" should be able to impose *he* beliefs on those who favor it.

Naturally, *prevention* of conceptio is preferable to the termination of a unwanted pregnancy, and more in formation on this subject must be give to Canadians through sex education i schools, family planning centers etcetera. But no matter how compre hensive the information given, n matter how sophisticated the method of contraception used, unwanted preg nancies *will* occur.

An article on abortion in the Augus 1965 issue of the *Atlantic Monthly* poses this question to those who favo *only* preventive measures: "If it is mora to *prevent* conception, is it immora to interrupt an ill-advised pregnancy?"

— V.A.L.

letters

Letters to the editor are welcome.
Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Information on Velcro

As exclusive distributor for the product Velcro since its inception in the health field, I was most interested in the Idea Exchange published on page 53 of the September 1970 issue of *The Canadian Nurse*.

Miss Fredin's suggestions, although not new, are most interesting. However, I believe one of her comments could be confusing to many potential users: ". . . we now use Velcro instant zipper material, a sewing accessory *available in retail stores.*" (Italics mine.)

The fact is that Velcro is available, in limited widths, colors, etc., in *very few retail stores*, at prices much in excess of the established wholesale prices at which institutions can buy. For example: 1" Velcro per yard retail, costs approximately $2.80; however, 1" Velcro per yard wholesale, costs approximately $1.60.

As a Canadian and a tax payer, I am naturally concerned that institutions buy from the proper source and at the best possible price. — *B.C. Hollingshead, B.C. Hollingshead Limited, 64 Gerrard Street East, Toronto 2, Ontario.*

Defends registered nursing assistants

I am writing to defend myself and all registered nursing assistants against the insinuations made by Alfreda Ricketts (Letters, August 1970).

I, too, consider nursing one of the most uplifting professions for women, otherwise I would never have entered it; however, I was unable to afford the time and financial burden that a three-year program would have placed on me and my family.

RNAs are not on a plateau with registered nurses and never will be. We are trained to do specific types of nursing care and to do them well. We will never take on the more important tasks that someone else is better trained to carry out, although we will be asked to do so by some RNs. We are not trained to do procedures that require aseptic technique, nor to give some of the more complicated treatments that so many RNs expect us to do.

In many hospitals it is not the RNA who is taking over, but rather the RNs and the hospital administrators who are pushing the additional load on us by instructing us to do things that are not included in our original training.

From a medico-legal and moral point of view, I am concerned about the added load being forced on us. Who will stand behind us if we make an error? Who will commend us for refusing to perform a duty that is not within our area? Rather, we are condemned for not carrying out an order when we refuse. The sooner members of the health team realize what our limitations are and abide by them, the sooner the friction between RNs and RNAs will stop.

I am trained to give basic patient care including simple procedures and treatments and I do them well. But please don't ask me to do procedures that I was not trained or licensed to do. Instead, maintain your superiority as an RN, and keep the more important aspects of nursing for yourself.

Why should RNAs, for $350.00 per month or less, depending on the location, take on the responsibilities of the RN and let her take home the big money? We are happy as we are, otherwise we would not be working as registered nursing assistants. — *Louella Cassell, RNA, Kitchener, Ont.*

Well, Shades of Florence Nightingale! In this day of enlightened nursing care and progressive functioning of team nursing, Alfreda Ricketts, a registered nurse from Prince Edward Island takes us back 25 years in nursing care attitudes (Letters, August 1970).

Team nursing utilizes each member of the nursing team to the optimum of her ability, and within the limits of her classification. Nursing assistants were developed to do routine nursing care, thereby allowing the registered nurse sufficient time to carry out intricate duties that require more skill and judgment. Registered nursing assistants are trained in government-approved schools in most provinces, and pass qualifying examinations through the provincial nursing associations. The role of the nursing assistant on the team is clearly defined in the hospital policies and job description.

The shortage of RNs was a recognized problem long before the establishment of schools for RNAs. The problem has increased with the growing population and the need for medical services.

I ask — who is to blame? I disagree with the writer when she states the provincial nursing associations are to blame — they are a standard-controlling influence.

If the RN is taken away from the bedside, she can blame no one but herself. True, increased paper work keeps her at the desk; but if she wants bedside nursing, she can take advantage of every opportunity to give good bedside care. By delegating the correct amount of responsibility to the RNA, she is free to assume her own duties.

An intelligent RNA works within the limits of her classification and under the supervision of the RN. We should remember that the aim of team nursing is the optimum care and rehabilitation of each patient, with each team member cooperating to the fullest. — *Susan Higgins, RNA, Toronto, Ontario.*

Resigned, not retired

The September 1970 issue of *The Canadian Nurse* contained a pleasing and excellent write-up on Eleanor S. Graham, former executive director of the Registered Nurses' Association of British Columbia. However, the term "retired" was incorrect, and should have read "resigned" — a term that carries quite a different connotation.

Continuity of administration is the keystone of the RNABC structure, and the key person who carries the responsibility of this continuity is the executive director, in this instance Eleanor S. Graham.

Miss Graham, with her outstanding integrity and keen sense of responsibility for her position, made a great contribution to the growth and ethical advancement of the RNABC. Her resignation is indeed a serious loss to the association.

It is to be hoped that, after a vacation, Miss Graham will again share her

knowledge and experience by becoming active in the nursing profession of Canada. — *Janie E. Jamieson, RN, Victoria, B.C.*

Wage disparity

Having been an orderly for the past eight years, I was interested to read the editorial on the wage disparity between orderlies and registered nursing assistants. (September 1970.)

I had the good fortune to receive a 24-month orderly training program at St. Joseph's Hospital in Victoria, B.C. Grade 10 education was required for this course, which included: basic nursing arts, urology, orthopedics, oxygen therapy, and central supply Service. An advanced course was also available for those interested in becoming operating-room technicians.

We were taught postoperative nursing care of urologic and orthopedic patients, including the shortening of drains and the removal of sutures. We were also taught to give doctors assistance in setting up various tractions, or to do it ourselves when necessary; to apply and remove plaster of Paris casts, when requested by the physician; and to help with minor surgery in the emergency room.

More power to the nursing assistants if they can get more money, but I do not believe they should use the orderly's salary as a basis. If there is a registered nursing assistant in Ontario who has had a better training than I had, I would like to hear about it. — *Nursing Orderly, Brampton, Ont.*

Can one day a week be challenging?

In answer to the letter "Part-time nurse disillusioned" in September.

This part-time nurse would be surprised at the number of nurses who are looking for the type of nursing she finds unchallenging. She feels left out of the team? How would a football player coming to the field every ninth or tenth game be received by the team? Any nurse can tell us it takes a few hours to get back "into the stream" after an absence of two or more days. How can the nurse who comes into the inner circle only eight hours every six or seven days expect to have a challenging job?

As an employer of part-time nurses in an active general hospital, I try to appreciate their problems. Whatever their reasons for part-time work, their needs and the hospitals' needs must meet somewhere along the way. The best utilization of their services can be rewarding for both parties.

First, a personal interview is mandatory. I explain what we require and how it can be fulfilled. Sometimes concessions have to be made on both sides, but never at the expense of "less than best" nursing care. The regular staff nurses must never suffer from the awkward schedules of part-time nurses. Adjustments, yes; but unhappiness, no.

Second, all our nurses, full- or part-time, must undergo an orientation of at least two weeks in the day-time hours. Our greatest need for part-time nurses is in the evenings, nights, and on week-ends and statutory holidays. At these times the part-time nurses take charge of a unit or of a special unusual situation.

Nurses are never employed as an "extra pair of hands" or to do "leg work," and never for one day a week. Sometimes an adaptable nurse who knows the hospital well may be called in at the last minute for one day. After the orientation, the part-time nurse is assigned to a unit where her time is scheduled, along with the other nurses, one month ahead.

I have not heard of part-time nurses leaving us because of boredom. Personally, I wonder what kind of work could be challenging one day a week. In the helping professions I fail to see it, but then I do have poor eyesight. — *V.A.A.R., Montreal.*

Peaceful coexistence

Due to the technological advances in medicine and the monetary control of health resources, the workload of the nurse has increased almost beyond her capacity to function safely and efficiently within the allotted time element. To compensate for this, improvements within the physical and financial setting have been introduced by the registered nurses' associations.

But what of the interpersonal relationships between administrative and nursing personnel? This remains a sterile field, and the nurse has become a number to be appropriately or inappropriately slotted.

This situation affects the level and efficiency of patient care. The efficient functioning a department demands that the right person be in the right place at the right time — the reverse is chaos! In such a situation, those who try to make improvements create waves, resulting in discriminatory reaction to them.

A peaceful coexistence between employer and employee must be maintained, but not at the price of conformity to the past. It is time for the provincial associations to give judicial support to the internal problems that arise between employer and nurse-employee. Standards should be set for evaluation and placement of nurses, and associations should supervise the level of qualifications and competency of nursing administration. — Jean E. Nicholson, S.R.N., S.C.M., Victoria, British Columbia.

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news

CNA Board Discusses Abortion

Ottawa — When the Canadian Nurses Association is asked to state its views on the abortion controversy, the reply will reiterate the association's belief that every Canadian woman has the right to the best possible health care after an abortion.

The matter first came up at the 35th general meeting last June and was referred to the board. CNA directors were asked to study legal implications of the resolution that requested the national association to urge the federal government to remove from the Criminal Code those sections relating to abortion.

Some nurses at the June biennial reasoned they were aware of the often tragic results of criminal abortions; that the question of an abortion should be a medical matter, not legal; and that the decision for an abortion should be reached by the woman and her doctor.

A cursory explanation of the implications involved in the resolution was given by a lawyer at the Fredericton meeting, but was insufficient for the nurses to feel qualified to vote.

Following a lengthy discussion on what stand, if at all, the association should take on abortion, the board issued a resolution to clarify the situation.

CNA Board Takes Stand On The Physician's Assistant

Ottawa — The Canadian Nurses' Association board of directors, at its meeting October 7-9, spent considerable time discussing the question of the proposed physician's assistant. On the final day of the meeting, the board took a stand on the issue, which will be referred to the minister of national health and welfare, the provincial minister of health, and the Canadian Medical Association.

CNA's stand on the physician's assistant reads:

"The CNA views with grave concern a proposal to fill gaps in health services by introducing a new category of worker, namely the physician's assistant or associate.

"The CNA firmly believes that the health needs of the Canadian people can more effectively and economically be served by expanding the role of the nurse.

"The CNA sees at least four areas in which immediate action could be taken to utilize nurses fully:

1. primary care for ambulatory patients;
2. continuing care for convalescent and long term patients;
3. preventive care to preserve health;
4. care for patients requiring specialized services.

"The CNA takes this position for the following reasons:

1. In general, the preparation and potential of the nurse is not now being utilized to its fullest capacity In particular, a large number of nurses prepared in University Schools of Nursing at the baccalaureate level do not realize their full potential in the present health care delivery system.
2. Nurses constitute a large and ready pool of workers who with little or no added training could move in to assume greater responsibilities in relation to primary, continuing, preventive and specialized care.
3. Public health nurses already participate to a significant degree in the delivery of these services.
4. There are currently unemployed nurses in a number of Canadian cities who could quickly be available if new roles existed.
5. It would be less costly to provide short courses for nurses when necessary, than to fund entirely new programs for the preparation of a totally new category.

"The CNA, therefore, believes that the physician's assistant should not be introduced and urges that a fair trial be given to expanding the role of the nurse.

"The CNA believes that experimentation with various patterns of delivery of health care utilizing the nurse in an extended and more independent role is urgently needed. However, the CNA emphasizes the importance of proceeding jointly with the medical profession in these endeavors."

Late News

MESSAGE OF SYMPATHY

SENT TO PREMIER ROBERT BOURASSA

FROM CNA PRESIDENT

On behalf of the 82,000 members of the Canadian Nurses' Association, I express my profound grief and extend my deepest sympathy to you, the Governemnt of Quebec, and to the citizens of the province on the tragic death of the Minister of Labour, Manpower and Immigration, Monsieur Pierre Laporte. Monsieur Laporte's dedication to his people and to the unity of Canada will long be remembered by the citizens of this country. — *E. Louise Miner, President, Canadian Nurses' Association.*

The CNA President also sent a telegram of condolence to Madame Laporte and her family.

Abortion Resolution

WHEREAS the decision of the Board of Directors to accept as one of its priorities for the 1970-72 biennium the matter of position papers on social issues, and

WHEREAS the quality of health care of Canadian women who have decided to avail themselves of whatever facilities are available in order to secure abortions *is very much a social issue,* and

WHEREAS the CNA has already gone on record as stating its belief that all Canadians requiring health care have the right to the quality and quantity of nursing care that is at a level appropriate to their needs.

BE IT RESOLVED that when questions concerning the stand of the CNA on the issue of abortion are raised, the CNA takes the opportunity to reiterate its belief that *every* Canadian woman who has decided to secure an abortion has the opportunity of availing herself of the best health care possible.

Canada And Britain To Exchange Nursing Personnel

Ottawa — Nurses in the Canadian Armed Forces and their counterparts in the British Army Nursing Service will soon have an opportunity to exchange know-how on nursing care and service.

Brigadier Barbara Gordon, matron-in-chief and director, Army Nursing Service, Britain, and Lieutenant Colonel Joan Fitzgerald, Director of Nursing, Canadian Medical Armed Forces, met recently to discuss the exchange of forces nursing personnel.

Brigadier Gordon said details and implementation of the program would be determined during her stay in Ottawa. Similar discussions were held in Washington.

Asked if she felt there were noticeable differences in nursing care between the two countries' armed forces, Brigadier Gordon said, "Not major differences. In fact British and Canadian practices are similar. Even more so than I was led to believe."

Explaining that nursing education in Britain is primarily practical, Brigadier Gordon said she regretted the strong demand for nurses to have a diploma or baccalaureate. I wish there were more of the old school practical nurses," she said.

As in Canada, continuing to care is a nursing theme in Britain, although we extend our care, said the senior matron. Nursing care in British military hospitals continues on through convalescence. The Canadian practice is to discharge service personnel to convalesce at home.

After touring a Canadian service hospital, Britain's chief military matron said she was surprised not to see women and children as patients. Military hospitals in Britain also care for service personnel dependents.

To the question, "Is the austere matron image still prevalent in Britain?" Brigadier Gordon answered, "The matron today is much younger, there's none of the old-time 'Carry on, matron' atmosphere."

Questions on drugs and the new abortion law in England, were parried with restrained replies.

Drug use by service personnel is not a grave concern, neither is there a noticeable increase in requests for abortions in military hospitals.

She admitted the image of the service is still important, especially to parents, and that the military nursing personnel always kept this in mind.

"We don't want our girls going to the back streets of Singapore to get help," said the brigadier. For this reason we have reviewed the content of our training courses dealing with contraceptives and abortion."

Promotion of a book on the wartime experiences of Dame Margot Turner, Brigadier Gordon's predecessor, was a topic during a press interview.

Brigadier Gordon said she encouraged Dame Margot to tell her story. "She was a courageous nursing sister — her story exemplifies the life of many of our nurses."

(Continued on page 12)

Canadian Nurses' Association 1970-72 Biennium

GOAL

To influence nursing practice in a changing health care delivery system through an informed membership and relevant policy statements.

Priorities

1. *Position papers and plan of action in relation to the expanded role of the nurse to include:*
   (a) the physician's associate or assistant;*
   (b) specialization in nursing on both a vertical and horizontal direction;*
   (c) the proliferation of workers (technicians) involved in the allied health field:*
   * (All of these have educational, legal, and financial implications that need to be explored.)
2. *Nursing Research:*
   - the need for nurse researchers (preparation and financial assistance needed)
   - the need to make decisions and take action on the report from the Ad Hoc Committee on Research.
3. *Position papers on social issues, white papers, and reports of commissions that have relevance to nurses and nursing.*
4. *Decisions and plan of action in relation to the problem of the publication of French books for education purposes.*

"Welcome" — Harriet Sloan, nursing coordinator, Canadian Nurses' Association, extends greetings to Brigadier Barbara Gordon, matron-in-chief and director of Britain's Army Nursing Service. Accompanied by Lieutenant Colonel Joan Fitzgerald, director of nursing, Canadian Medical Forces, Brigadier Gordon toured national headquarters during her visit to Ottawa. Discussion on an exchange program for British and Canadian forces nursing personnel was the focal point of the brigadier's talks at national defence. A similar exchange was discussed with army authorities in Washington

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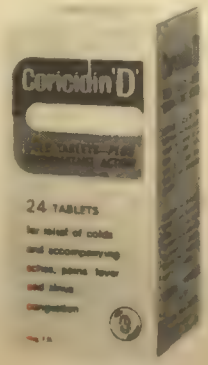

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(Continued from page 8)

RNs Participate In Nutrition Canada Project

Ottawa — Three registered nurses have been selected by the department of national health and welfare as team members for Nutrition Canada, a food and drug directorate project to provide basic information on the nutritional well-being of Canadians. The nurses are: Lenora Kane, Susan Theobald, and Barbara Howelett — all public health nurses. French-speaking nurses will be selected later, as the team to survey French-speaking Canadians is not scheduled to start work before February 1971.

The survey started in Ottawa Saturday October 3, after the nurses had completed an intensive training program to help them identify symptoms of malnutrition and do cursory physical examinations. Physicians will perform the cardiovascular, respiratory, and abdominal examinations, and dietitians, a lab technician, and a dental hygienist will complete the other aspects of the survey. The investigators will also determine the quantity of food additives, non-nourishing foods, and insecticides being absorbed by Canadians.

Twenty-one thousand persons will be interviewed and examined at clinics across the country. Those selected have been determined by the dominion bureau of statistics, according to geographical location, type of community, age, sex, and income level.

Susan Theobald, one of three RNs on the Nutrition Canada team, checks measurements of "patient" Stephany Blackstone, coordinator of public relations for the project.

Plans for Nutrition Canada were announced in the fall of 1969 by the minister of national health and welfare, John Munro, who reported that medical literature had cast considerable doubt that Canadians were as well fed as had been assumed, and that there were clear indications of malnutrition in certain segments of the Canadian population. Mr. Munro added there was growing concern about the use of food additives and pesticides in food supplies, and that the data indicated an urgent need for a comprehensive study of the food intake and nutritional status of Canadians.

Final results of the study are expected to be released in 1973.

Health Care Costs Need Closer Look

Ottawa — Soaring health care costs, "one of the largest and fastest-growing activities in the economy," was pinpointed as a major concern by the Economic Council of Canada in its seventh annual review released in September.

Urging careful attention to the economic aspects of health care, the council foretold rapid increases in expenditure for the 1970s, and warned that the public should be asking questions about the effective use of such resources.

Reflecting federal and provincial concern on the rising costs of health services, the council, however, dealt mainly with "getting more and better health care."

This was interpreted as including an equitable distribution of health care across the country, between rural and urban communities, and among the poor and minority groups. The report described the goal of health care as adequate, timely, efficient, and humane — for all Canadians.

Calling for improved productivity in the health care "industry," the report emphasized the need for public education on the effective use of the "industry." Preventive measures, including greater attention to good nutrition, pollution abatement, recreation, and safety programs, were mentioned.

Supplying health care personnel did not give the council concern. It found, "the lead time in training more workers is fairly short (two or three years for a

CNA Accepts Federal Unemployment Insurance Plan

Inclusion of Canadian nurses in a government operated unemployment plan has been accepted by the Canadian Nurses' Association. In a brief to the House of Commons standing committee on labor, manpower, and immigration last October, President E. Louise Miner *(left)* and executive director Dr. Helen K. Mussallem *(center)* said the association saw no reason why the plan should not benefit nurses. Speaking to committee chairman David Weatherhead *(right)*, Miss Miner asked if, under the white paper's proposals, unemployed nurses might be referred to other government agencies to be eligible for benefits, and so retrained out of the nursing profession. The association was assured this would not happen, even if there were an oversupply of nurses.

registered nurse; shorter still for some others), so that the supply of such personnel can be adjusted fairly flexibly in response to increased needs."

The increase in quantity and quality of services was given as two causes for rising costs. Intensive training of doctors, nurses, and other personnel, a wider range of diagnostic tests and other services, and the declining incidence of communicable diseases were cited as indicators.

To avoid unnecessary demands on the health system, the council suggested deterrent fees in the form of a "utilization" charge. This would have to include adequate safeguards for families and individuals in the low income bracket.

In the section dealing with economic aspects of health care, the report noted, "the most important proposal for economizing on limited resources is avoiding wasteful use of highly trained professionals." This could be overcome by "shifting tasks to less costly personnel."

The team approach in nursing was advocated, even though it meant greater specialization, increased delegation, and more group responsibility.

Stepped up training techniques in the team approach were suggested to facilitate the wide use of trained personnel.

If, said the report, changes were made in licensing laws, enabling paramedical personnel to do routine procedures under supervision, then another effective use of health care resources would be made available.

Turning to the administration of health care, the report urged a "more deliberate and concerted approach." It recommended better management of: work studies; staffing according to workloads and patient needs; scheduling diagnostic services; improved hospital design; computerized records; and other administrative concerns.

Long-term planning by government health agencies and private institutions, was given the bite by the council. Five-year budgeting should be a normal practice, rather than a rarity — as it now is.

Nurses Told Militancy Is Answer To Labor Problems

Hespeler, Ontario — "You're being whipped to death with your own professionalism," Donald O. Hersey, lawyer for the Registered Nurses' Association of Ontario, told a collective bargaining workshop here.

Organized by RNAO for nurses in the Guelph area, the workshop drew a responsive reaction to labor and legal representatives.

Counseling a liberal, as opposed to a legalistic approach to collective bargaining, Mr. Hersey said, "In an environment where you do not have the right to strike, where you will always be faced with an arbitration procedure, it makes more sense to be cooperative." He advised his audience to "achieve a working relationship with your employer... don't create a standoff situation."

The tough attitude of labor consultant Drummond Wren received applause from the group of 40 nurses. He told them management has retained those rights the employee hasn't taken away through bargaining, and described a labor agreement as "a document whereby you have taken away from the employer some of the dictatorial rights employers have had for years."

He said management is trained in and committed to the adversary system — without militancy and agressiveness you'll get nowhere.

Speaking with conviction, Mr. Wren called for action from the nursing profession, "The quicker you get some militancy, the quicker you'll get what you organized for."

Three executives of local association chapters gave advice on what to expect in employer-employee relations.

Communication between association

(Continued from page 13)

members and the employer was described by Pat Pettibone, nurses' association, York-Oshawa District, as probably the most important task of an association president.

"Good internal communication can often head off the formal filing of a grievance," she said. "But go in prepared."

She advised nurses to get guidance from provincial associations — especially if they felt insecure.

Mrs. Pettibone stressed objectivity when handling grievances, recalling the days when management decided what was best for "its girls." She likened this type of relationship as the "old parent-child" attitude.

Nurses now regard this as an attack on their emotional maturity, she said. "In those days a pliant, appealing, dependent attitude aroused father-protector emotions in the employer. This type of girl got a good salary — the militant type got a lower salary and was still expected to offer dedicated service."

Mardi Bullivant, nurses' association, Hamilton Civic Hospitals, told of a treasurer's job in a large hospital association with considerable funds to administer.

"Get things done properly from the start," she advised, "such as hiring an accountant, having a yearly audit, and keeping duplicate records."

Her own association's tactic in Hamilton was to "pick the brains of established large local unions."

A representative from the nurses' association, Queensway General Hospital, Toronto, stressed the opportunity for personal growth in association activity.

"It's been the greatest experience since my training days," Margaret Harris said.

"A good association member earns the respect of hospital management."

Student Nurses Enjoy Royal Visit

Winnipeg — During the royal visit to Winnipeg, July 15, 21 student nurses from five Winnipeg hospitals were guests at a dinner dance at the International Inn, Winnipeg, honoring their Royal Highnesses, Prince Charles and Princess Anne.

Nine students from Winnipeg General Hospital attended: Susan Kent, Theresa Ruth Tyler, Linda Louise David, Susan Jan McCallum, Shelley Bernice Isenberg, Tannis Joan Grant, Karen Joan Stavenjord, Janet Louise Bell, and Barbara Ann McClymont. Misericordia General Hospital was represented by Edward Oakly; Joan Rankin; Cecilia Li; and Melvin Dahl. From St. Boniface General Hospital, Patricia Semcow, Fay Charko, Caroline Shepherd, and Beverly Nield attended. Grace General Hospital sent two representatives, Edith Kliever and Clara Roy. And from Victoria General Hospital, Cheryl Dowd and Donna Braun also attended.

Health Care Explored At McMaster Seminar

Hamilton — Understanding attitudes and feelings surrounding the human experience of birth was the basis of a recent health care conference sponsored by McMaster University.

Two hundred nurses at the four-day seminar on *Birth and the Family*, were told by Karen von Schilling, McMaster nursing professor, that emotional and physical crises, if dealt with by untrained hospital personnel, can result in permanent emotional scarring. Miss von Schilling referred to an abnormal birth as such a crisis. Expressions and attitudes of delivery room staff tell a

Next Month
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- Nurses' Involvement in Student Drug Problems
- Monitoring the Mother and Fetus During Labor
- Chemotherapy in Hemodialysis

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National Film Board, Peter Phillips, p. 49

CMA House Officially Opened

The new headquarters of the Canadian Medical Association, located in the nation's capital, was officially opened October 2 by Dr. D.A. Graham, the oldest living past-president of the association. Designed by the architectural firm of Webb, Zerafa and Menkes, of Toronto, the two-story structure provides over 43,000 square feet of floor space. It presently houses several tenants, including the Canadian Nurses' Association Testing Service, the Academy of Medicine, the Canadian Medical Protective Association, the Medical Council of Canada, and the Canadian Association of Prosthetists and Orthotists.

mother that something is wrong. Without explanation, she is left to imagine the worst.

Miss von Schilling said nurses avoid answering a mother's request for information until she has talked to her doctor. This kind of treatment gives the mother a feeling she will be avoided, because of an imperfect birth.

Referring to a study of families following abnormal births, Miss von Schilling told the nurses medical personnel have little knowledge of the kinds of help parents need at such times.

In an overview of life continuum from conception through pregnancy, birth, infancy, and on to adolescence, marriage and again pregnancy, factors relevant to the nature and nurture of human life were discussed.

What are the values and attitudes of professional health workers toward nature versus nurture, and how do they influence human life experiences? were two questions put to the nurses.

Health care, and the role of professional health workers, was a major topic during seminar sessions. Examples of professional collaboration on health care issues was given by physicians and nurses.

Speaking after the conference, Miss von Schilling said, "It is hoped each group of nurses in health units will continue, or learn, to work with physicians and other health professionals in the community. This will enable health workers to communicate and coordinate efforts, providing effective family health care. Only by combining and coordinating services can optimal public health be provided."

Health Facilities Receive Federal Grants

Ottawa — Four provinces have recently received federal grants toward health facilities amounting to $1.75 million.

Training facilities for nurses in Thunder Bay and Fort Frances, Ontario, will benefit by $653,784. The largest slice will aid construction of a new building for the Lakehead regional school of nursing, Thunder Bay. Designed to accommodate 300 students, it will be completed by July 1971.

In Fort Frances, the registered nurses' assistants school, La Verendrye Hospital, has received a grant toward a one-storey unit, completed in 1969. The school provides training for 20 students.

The community and health center of the Toronto student health organization has also received a grant. The center was created as a community-oriented approach to comprehensive health care. Teaching experience for health science students is provided by the center.

Accreditation of Manitoba's hospitals will be assisted by a $13,000 grant. The project entails a detailed study of requirements to bring the province's hospitals in line with the Canadian Council on Hospital Accreditation standards.

Immunization data processing in a Saskatchewan health department is expected to be simplified after a study to reduce clerical work has been completed. The project was granted $15,060.

Two contributions amounting to $462,750 were approved by the federal government for the health sciences center and library at Memorial University, St. John's, Newfoundland.

Letters Patent Granted CNA

Ottawa — After four years discussing formalities required to amend its charter, the Canadian Nurses' Association has been granted Letters Patent under the Canada Corporation Act Part II.

Issued by the department of consumer and corporate affairs, July 15, Letters Patent enables the CNA to operate under new bylaws passed at the association's 35th biennial meeting in Fredericton, New Brunswick, last June.

Associate executive director, Lillian E. Pettigrew, said the association's 1966-68 rules and procedures will be revised to conform with current bylaw one, and renamed *Rules and Regulations*.

The Letters Patent under which CNA will operate, the bylaw, and the rules and procedures are to be published as one document, and will be available to CNA members early in 1971.

Nursing Practice Subject of Seminar

Ottawa — A four-pronged approach to research in nursing practice will be the main objective of a conference to be held in Ottawa, February 16-18, 1971. Identifying needs for research, exploring methodology, determining means of exchanging information about nursing studies, and coordinating research in Canada, will be discussed.

Dr. Floris E. King, associate professor and coordinator of the graduate program, University of British Columbia, Vancouver, has been named project director. A federal government grant has been made to aid the conference.

Screening Newborns Assists Disease Prevention Programs

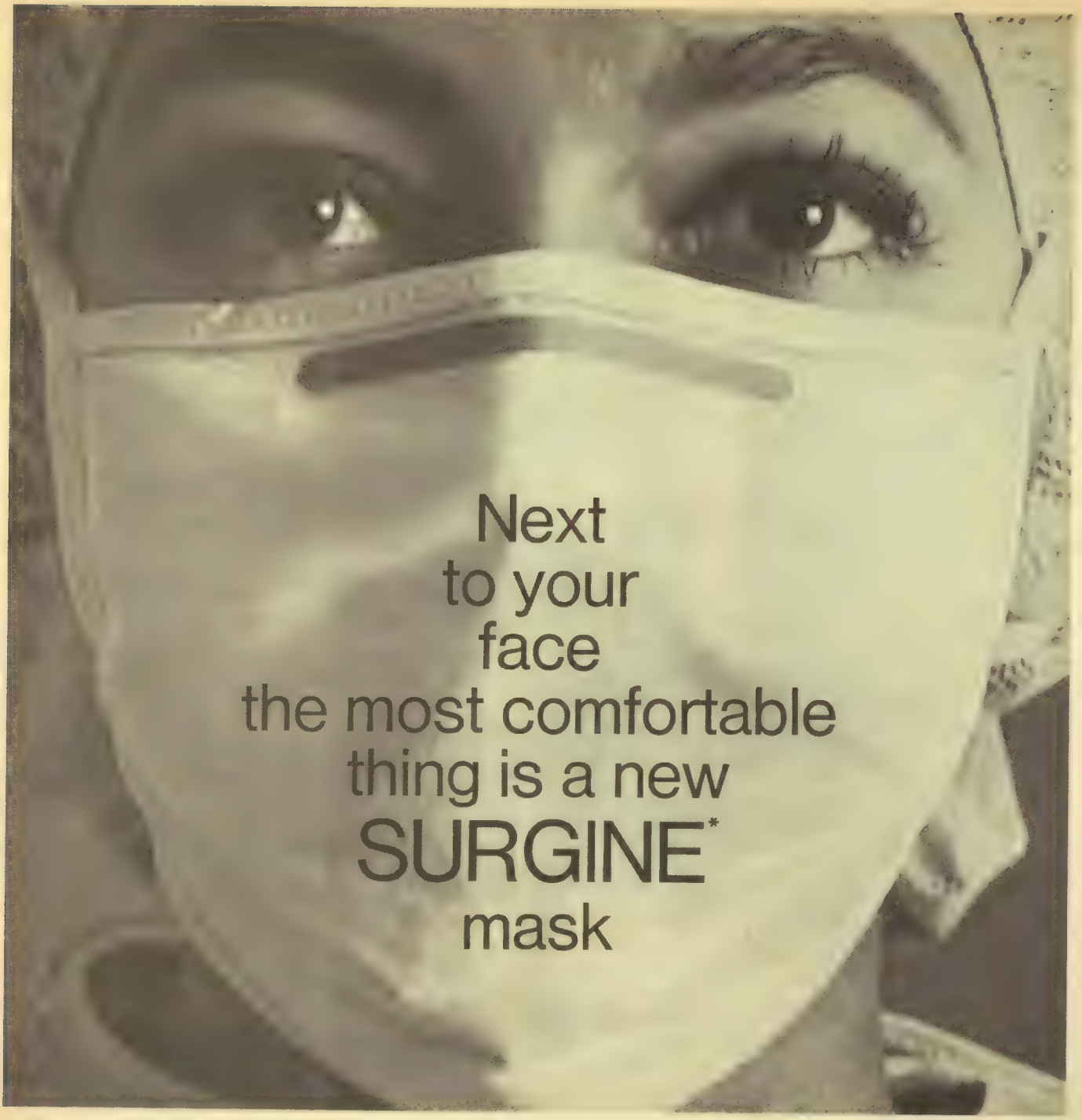
Quebec — Studying the characteristics of a newborn to assist prevention of disease, is part of a screening program undertaken by the hereditary metabolic disease unit of the Quebec department of health.

In collaboration with other Canadian universities, the department has set up a preventive system, making it possible to study genes of newborns.

A minute amount of blood from the baby's heel, and a sample of urine, taken between the fifth and seventh day after birth, form the basis of the study. Parents are informed of the test results three weeks later.

On With New, Out With The Old

It's goodbye to the old and on with the new. Neither midi or mini, the new Canadian Forces uniform for women personnel (including nursing sisters) sets its own fashion swing — elegant comfort. Compared with the outmoded, tailored silhouette, the new, free-style suit considers the whims of women's fashions and excludes the military look. During the last 20 years, nursing sisters and women personnel in Canada's army, navy, and airforce have worn similar fitted uniforms with a stiff collar and necktie, and shirt and insignia of each service. Now in 1970, and under a new title, *Canadian Forces,* women personnel (nursing sisters included) are issued fashion-oriented uniforms. It's the suave dark green look, a loose boxlike jacket to the hips, straight skirt to mid-knee, and light green, round neck blouse. Three gold buttons, scaled-down versions of the serviceman's size, and gold rank braid, complement the suit. Simplicity, and a nod to current fashion, are also seen in the dark green felt hat. The rounded crown and softly molded brim is standard for all ranks. Taupe stockings are worn with black pumps. All other accessories are also black. And for the ultra fashion-conscious armed forces miss — there's a black umbrella to keep off the raindrops. Talking to a Chelsea Pensioner during a visit to Queen Alexandra Hospital, London, England, is CNA nursing coordinator, Harriet Sloan. Miss Sloan retired from the Canadian Forces medical services in 1968. As matron-in-chief, Lt. Colonel Sloan wore the old-style uniform and was succeeded by Lt. Colonel Joan Fitzgerald, who wears the new issue and is known as Director of Nursing. Whether old or new style, both uniforms proudly bear the royal cypher, proclaiming the wearer as an honorary nursing sister to Her Majesty, Queen Elizabeth II. As director of Canadian Forces nursing personnel, Lt. Colonel Fitzgerald will retain the honor until she leaves her post. Located on each epaulette, the cypher is recognized by the initials ER.



Johnson & Johnson's newly developed SURGINE Face Mask — six years in the designing — is so extraordinarily comfortable you'll be almost as unaware of it as you are of your own skin.

The fact that the SURGINE mask fits so well is part of the reason it does such a superior job of bacterial filtration. Cheek and chin leaks are eliminated. But the main reason for SURGINE's efficiency is a new, specially developed filter medium. In vivo tests show an extraordinary average filtration efficiency of 97%.

For free samples of the new SURGINE Face Mask, contact your Johnson & Johnson representative. Or write to Mr. Mark Murphy, Product Director, Johnson & Johnson Ltd., 2155 Blvd. Pie IX, Montreal 403, Quebec.

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SURGINE
the comfortable face mask
Johnson & Johnson LIMITED
MONTREAL & TORONTO – CANADA

names

Margaret Mary Street spent a week in September at CNA House in connection with her forthcoming biography of Dr. Ethel Johns, whose distinguished career included many years as the first full-time editor of *The Canadian Nurse*.

Miss Street (R.N., Royal Victoria Hospital, Montreal; M.S., Nursing Service Administration, Boston University, Boston) is associate professor, School of Nursing, University of British Columbia, Vancouver. She has been awarded two Canada Council grants to make the work on this biography financially possible, and has been granted a sabbatical year from her professorship to devote full time to this monumental task.

Miss Street's aim is to present Ethel Johns, whom she knew both as a nursing leader and as a person, within the perspective of the historical era her life work spanned. As a true biographer, Miss Street subdues her own personality while speaking in glowing terms of the complex woman whose influence in nursing circles was apparent for nearly 60 years — years of great change within the profession.

Ethel Johns was a pioneer. Her life pattern was set when, as a little girl, she and her younger brother were left in boarding schools in Wales while their father was becoming established as missionary and teacher on the Ojibway Indian Reserve at Wabigoon Lake in Northwestern Ontario, and when, as a "teenager" she lived on the reserve with her family and had as tutor her erudite father. Little wonder then, that she had such a serious dedication to work. However, her writings when off duty displayed a delightful humor and a keen insight into a world that encompassed much more than her profession.

Miss Johns graduated from the Winnipeg General Hospital School of Nursing in 1902 and studied public health and teaching methods at Teachers College, Columbia University, in 1915. She held senior positions in several hospitals in Ontario and Manitoba before her dual appointment in 1919 as director of the nursing school of The Vancouver General Hospital and first nurse director of the baccalaureate program for nurses at the University of British Columbia. Between 1925 and 1929, as field director for the Rockefeller Foundation in their European office in Paris, Miss Johns helped to develop nursing schools affiliated with universities both in Hungary and Rumania. Then followed eleven years with *The Canadian Nurse*.

In 1948, four years after her active career had ended, Mount Allison University honored Ethel Johns by conferring on her a Doctor of Laws degree. During her quiet life of retirement in a little house in Vancouver, Dr. Johns continued to share her rich experience and wide knowledge by writing. *"Just Plain Nursing"* became a vehicle for her commonsense approach to the field, and her contributions to a history of the Winnipeg General Hospital and to a history of the Johns Hopkins School of Nursing were considerable.

Miss Street came to know this remarkable woman well during her declining years prior to her death in 1968, and believes that she can enrich the legacy of Dr. Ethel Johns by writing her biography.

Margaret Street would not wish to accept all the credit for her endeavor, for throughout any discussion on the subject of her biography she is full of praise for those who have so generously aided her in collecting biographical material and little known personal

Nursing Leaders Honored By Ottawa Friends

Royal Victoria Hospital (Montreal) graduates living in Ottawa had tea with Margaret E. Kerr, former editor of *The Canadian Nurse*, and Winnifred MacLean, formerly on the administrative staff of the RVH and then circulation manager of *The Canadian Nurse*, during their September visit to Ontario and Quebec. Seen above, *left to right*, are Irene Kierstead Brown, the hostess, and Liv-Ellen Lockeberg, assistant editor of *The Canadian Nurse*, greeting the guests of honor, Miss MacLean and Miss Kerr.

information. She expressed particularly warm thanks and appreciation to Margaret Parkin for making available the resources of the CNA library and to Dr. Dorothy Percy of Ottawa, Kathleen Ruane of Winnipeg, and Miss Edna Rossiter of Vancouver for their special contributions to the ultimate success of this work.

Nine committees of the Manitoba Association of Registered Nurses announced new chairmen early this fall: nursing service, **Jacqueline Robertson;** nursing education, **Joy Winkler;** social and economic welfare, **Shirley Paine;** education fund, **Marie Kullberg;** accrediting, **Marjorie Jackson;** legislation, **Mary Wilson;** credentials, **Margaret McCrady;** careers, **Grace Davis;** board of examiners, **Elva Cranna.**

The association announced that two other committees, house and finance, have been disbanded.

Sister Mary Felicitas, immediate past president of the Canadian Nurses' Association, was honored this month by her alma mater, The Catholic University of America. On November 7, Sister Felicitas received the University's 1970 Annual Alumni Achievement Award in the field of nursing, at a homecoming banquet in Washington, D.C. The award was given "to provide public recognition of the distinction[she has]achieved in her life work."

Sister Felicitas is director of the school of nursing at St. Mary's Hospital in Montreal. A graduate of Providence Hospital, Moose Jaw, Saskatchewan, and the University of Ottawa, she obtained a master's degree from The Catholic University of America, where her high standard of scholarship won her Phi Beta Kappa recognition.

An active member of the Association of Nurses of the Province of Quebec, Sister was vice-president of that association at two different periods, as well as honorary treasurer and chairman of District 11, English chapter. She served on the CNA board for many years before becoming president in March 1967.

Sister is also a member and past chairman of the Canadian Conference of Catholic Schools of Nursing. She was elected to membership in the Honor societies of Sigma Theta Tau (U.S. National Honor Society of Nursing) and Pi Gamma Mu (U.S. National Social Science Honor Society.)

Nursing Leaders Meet

Three nurses on World Health Organization fellowships are spending four months in Eastern Canada and the United States to study nursing service and nursing education. While in Ottawa, they were received by Verna Huffman, principal nursing officer, office of the deputy minister, and other nursing consultants at the Brooke Claxton Building, head office of the Department of National Health and Welfare. They are shown above admiring a photograph of the Department's head office. *From left to right:* Miss Huffman; Mary Clara Xavier, assistant superintendent of nursing, Uttar Pradesh, India; Louise Miner, president of the Canadian Nurses' Association; Kanchan Surendra Shah, assistant superintendent of nursing, Gujarat, India; Dr. Helen K. Mussalem, executive director of the Canadian Nurses' Association; and Mrs. O.A. Adewole, senior matron of the Ministry of Health, Nigeria.

Hisako R. Imai (B.N., McGill U., Montreal; M.P.H., Johns Hopkins U., Baltimore) is the new research officer at the Canadian Nurses' Association, Ottawa. A Canadian Nurses' Foundation scholar, she recently completed her master's degree in public health. Born in New Westminster, British Columbia, Miss Imai graduated from Moose Jaw Union Hospital, Moose Jaw, Sask., and obtained a diploma in operating room management and technique at The Montreal General Hospital, Montreal.

During her work in Japan and Okinawa for the United Church of Canada, she developed an interest in public health, and returned to Canada to obtain a degree in this field. She was appointed a public health nurse with the Toronto department of health, and taught for one year at the School for Graduate Nurses, McGill University. Her studies at Johns Hopkins included projects in mental hygiene, in the behavioral sciences, and in medical care.

Dr. Amy Griffin, professor and assistant dean (academic), Faculty of Nursing, the University of Western Ontario, has been elected chairman of the educational committee, R N A O. Dr. Griffin received her doctoral degree at Teachers College, Columbia University.

Honorary memberships in the Saskatchewan Registered Nurses' Association have been awarded to three long-time members of the nursing profession.

Hazel B. Keeler (R.N., The Vancouver General H.; dipl. in teaching and supervision, School for Graduate Nurses, McGill U.; B.A., U. of Saskatchewan; M.A., Teachers College, Columbia U.), was director, school of

nursing at the University Hospital before her retirement in 1969.

Grace Motta (R.N., Winnipeg General H., dipl. in teaching and supervision, U. of Toronto) retired in 1969 after 13 years as registrar of SRNA.

Laura Reynolds, a native of Manitoba, graduated from the Saskatoon City Hospital school of nursing. She was a private duty nurse prior to her appointment as school nurse for the Saskatoon public school board. Miss Reynolds joined the Saskatoon city public health department when the city took over school public health.

Madge McKillop was reelected president of the Saskatchewan Registered Nurses' Association at its 53rd annual meeting. Miss McKillop made particular note of two achievements in Saskatchewan nursing circles, made possible largely through the efforts of the SRNA: the first group of students had graduated from the school of diploma nursing at the Saskatchewan Institute of Applied Arts and Sciences in Saskatoon; and the first salary contract between the Saskatchewan Hospital Association and the SRNA had been negotiated and signed.

Yvonne Chapman is the new employment relations officer for the Alberta Association of Registered Nurses. She replaces Louise Tod, who is studying for her master's degree at the University of Colorado, Denver, Colorado.

Miss Chapman received her nursing diploma at the Victoria General Hospital, Halifax, and a diploma in nursing service administration from the University of Saskatchewan, Saskatoon. She graduated from McGill University, Montreal, with a bachelor of nursing degree in 1967.

Rachelle Marquis has joined a team of CARE-MEDICO personnel in Tunisia, on a two-year tour of duty. Miss Marquis had worked as an x-ray technician at Sacred Heart of Cartierville Hospital, Montreal. Her x-ray studies were taken at Institut de Technologie in Montreal.

Eight new appointments to the school of nursing faculty have been announced by the University of Calgary. Seven are assistant professors: **Sarla Setht** (B.Sc.N., Delhi U., New Delhi; M.A. in psychology, Dunjab U., New Delhi; M.A. in public health teaching, New York U.) was previously assistant professor at Laurentian University, Sudbury, Ontario. **Margaret J. Moncrieff** (dipl., Royal Jubilee H., Victoria, B.C.; dipl., O.R. Tech., sup. & man., The Vancouver General H.; dipl., teaching and supervision, McGill U.; B.S., U. of Washington, Seattle; M.Sc.N., U. of Western Ontario, London) was assistant professor at the University of Western Ontario. **Diana D. Pechiulis** (R.N., Holy Cross H., Calgary; dipl., teaching and supervision, U. of Alberta, Edmonton; B.Sc.N., U. of Colorado, Denver) was assistant professor, medical-surgical nursing at the University of Calgary, Alberta: **Mary A. Wise,** (B.N., Ellis H. School of Nursing, Schenectady, N.Y.; B.S., Columbia U., N.Y.; M.S., U. of Chicago, Ill.) was assistant professor at the University of Calgary, Alberta; **Annie E. Clark** (R.N., Calgary General H., dipl., public health, and B.Sc.N., U. of Alberta; M.N., U. of Washington).

Life Membership For Dr. Gladys Sharpe

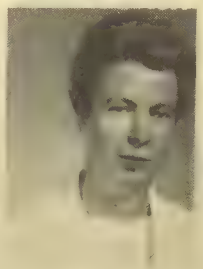
The South African Nursing Association conferred honorary life membership on Dr. Gladys J. Sharpe during her recent visit to the association in Pretoria, South Africa. Dr. Sharpe *(left)* accepted her certificate from associate president P.H. Harrison.

Outstanding contributions to the nursing profession by Dr. Sharpe have been numerous through her long and active career. As a nurse educator, she was well-known as the founder and first director of McMaster school of nursing. She retired in 1969 as senior nursing consultant, Ontario Hospital Services Commission. Dr. Sharpe is a past president of the Canadian Nurses' Association and the Registered Nurses' Association of Ontario.

Mary V. Peever (dipl., Royal Victoria H., Montreal; dipl., public health and B.N., U. of Manitoba; M.Sc.N., U. of Colorado) was a teacher at the Mount Royal College, Calgary. **Janet C. Kerr** (B.Sc.N., U. of Toronto; M.S., U. of Wisconsin) was director of inservice education at the Washington General Hospital, Fayetteville, Arkansa: **Jacquelyn Peitchinis** (Reg.N., Hamilton General H., Ontario; cert. nursing instructor and B.Sc.N., U. of Western Ontario, London; M.Phil., U. of London) is a part-time lecturer at the university. She had been an associate professor at the University of Western Ontario.

Two appointments to the Toronto Department of Health, although made during the fall of last year, are of interest to journal readers: **Madeleine C. Smillie,** is the department's assistant director, nursing division. Miss Smillie graduated from the school of nursing, University of Toronto in 1943 and returned to complete her bachelor of science in nursing degree in 1954. The department has been her only employer.

Muriel H. Davidson is the new director of health services. Miss Davidson obtained a certificate in public health nursing from the University of Toronto, and became staff nurse in the department. She graduated in 1968 with a bachelor of science in nursing degree.



S. June Agnew (Reg. N., Peterborough Civic Hosp., Ont.; D.P.H.N. and B.Sc.N., U. of Western Ont.; M.P.H., U. of Michigan) has been appointed lecturer at the school of nursing, Memorial University of Newfoundland.

Miss Agnew had been a staff nurse in the Peterborough, Ontario, health unit.

Eileen Healey, assistant professor, faculty of nursing, University of Western Ontario, has been elected president of the Ontario Region, Canadian Conference of University Schools of Nursing.

dates

Nov. 4-6, 1970 and Feb. 24-25, 1971
A continuing education course called Nursing Service Objectives is being sponsored by the University of Toronto School of Nursing. For more information write to: Continuing Education Program for Nurses, University of Toronto School of Nursing, 47 Queen's Park Crescent, Toronto 5, Ontario.

November 9-13, 1970
Course in occupational health for professional registered nurses in industry, offered by the department of environmental medicine of New York University School of Medicine, in cooperation with the American Association of Industrial Nurses. Limited to nurses with five years or less experience in occupational health. Tuition: $175. Special emphasis will be given to interviewing and counseling. For information and applications, write to the Office of the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York, N.Y.

November 30-December 4
Conference for nurses in staff education and staff development, Westbury Hotel, Toronto. Sponsored by the Registered Nurses Association of Ontario. Write to: Professional Development Department, RNAO, 33 Price Street, Toronto 5, Ontario.

November 30-December 11, 1970
First of two sessions in comprehensive health planning concepts and skills, University of Cincinnati, Ohio. Information from: Frank Heck, Public Information Officer, University of Cincinnati, Cincinnati, Ohio, U.S.A.

February-June
Continuing nursing education, non-credit courses, at the University of British Columbia have been scheduled for the first six months of next year. For further information write: The University of British Columbia, Health Science Centre, School of Nursing, Vancouver, British Columbia.

February 15, 1971
Six-week coronary course offered to nurses currently working on coronary care units. Enrollment is limited to six nurses, and total sponsorship by present employee is required. Registration fee is $75.

For further information write to the Course Coordinator, Intensive Care Nursing H601, Winnipeg General Hospital, 700 William Avenue, Winnipeg 3, Manitoba.

Feb. 15-19, 1971
Five-day course in occupational health nursing for registered nurses who have five or more years experience in occupational health nursing, and who work alone or with one other nurse. For further information write to: Continuing Education Program for Nurses, University of Toronto, 47 Queen's Park Crescent, Toronto 5, Ontario.

February 16-18, 1971
A national conference on research in nursing practice will be held in Ottawa. For more details write to Dr. Floris E. King, Associate professor and coordinator of the graduate program, University of British Columbia School of Nursing.

March 29-April 2, 1971
The third international congress of psychosomatic medicine in obstetrics and gynecology will be held at the Bloomsbury Centre Hotel, London, W.C.I. Scheduled conference theme is "Womanhood and Parenthood." Write for information to: Kurt Fleishmann and Associates, Chesham House, 136 Regent Street, London, W.I., England.

May 11-14, 1971
The 6th International Hospital Exhibition (Interhospital 71), held every three years, is to be held in Stuttgart, Germany. Exhibitors and visitors to previous exhibitions were world-wide. Information can be obtained from: R.F. Haussmann, 130 Willowdale Avenue, Suite 3, Willowdale, Ontario.

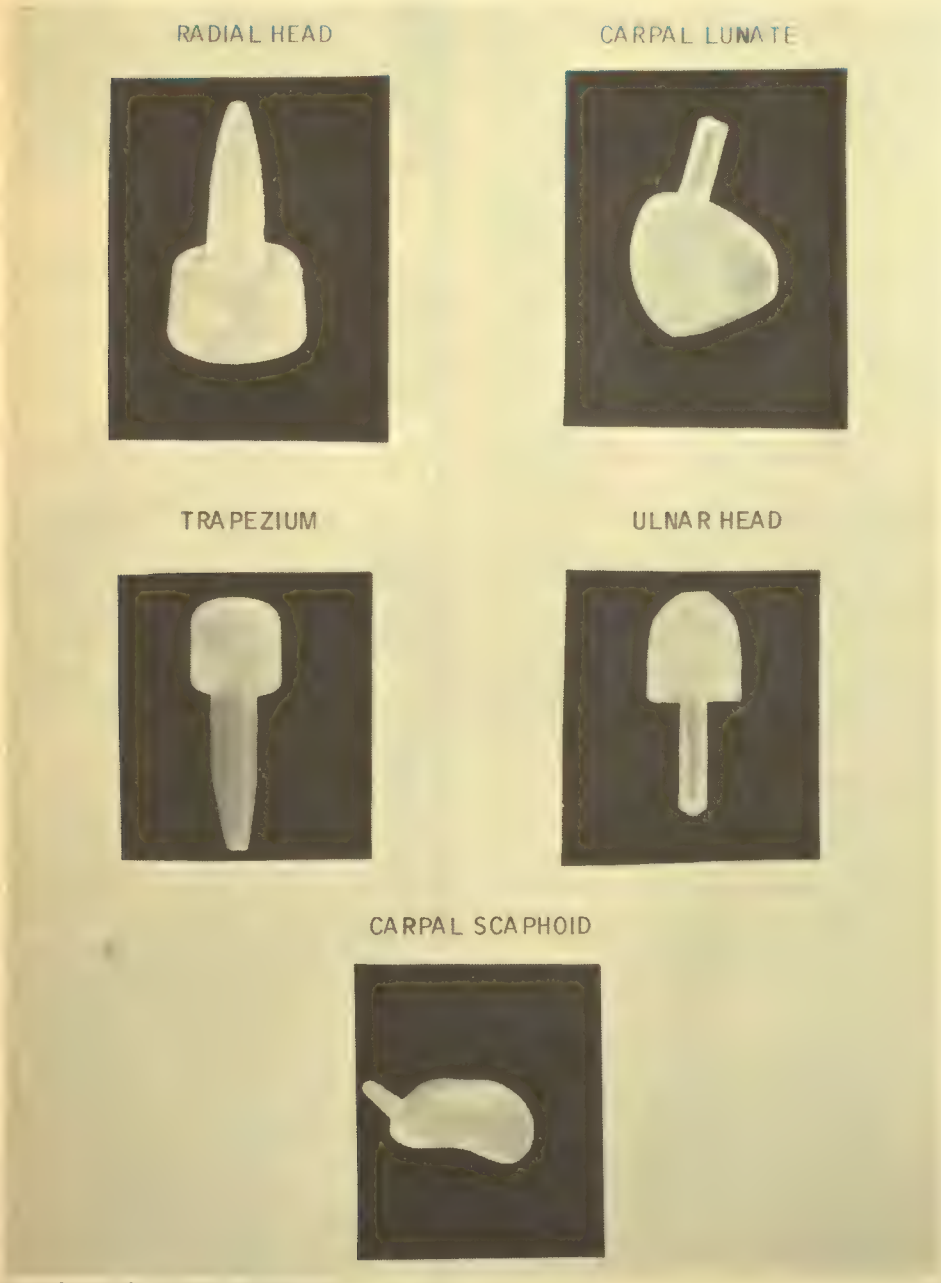
May 19-21, 1971
A nursing committee and the annual meeting, Catholic Hospital Conference of Ontario, will be held at the King Edward Hotel in Toronto, Ontario. Information can be obtained from: Sister Raymond Marie, Secretary Treasurer, Catholic Hospital Conference of Ontario, St. Mary's of the Lake Hospital, 355 King Street West, Kingston, Ontario.

May 26-29, 1971
Reunion of the Montreal General Hospital School of Nursing graduates to celebrate the hospital's 150th anniversary. Graduates should send addresses to: Miss Phyllis Walker, The Montreal General Hospital (Dept. of nursing), Montreal 109, P.Q.

May 30, 31 and June 1, 1971
The three-day annual meeting of the Manitoba Association of Registered Nurses will be held in Dauphin, Manitoba.

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.



Implants for Arthritic Joints

Dow Corning Silicones Medical Products Division has recently introduced five new products designed to restore normal function in joints affected by arthritic conditions.

Radial Head Prosthesis: A pliable, one-piece intramedullary-stemmed prosthesis designed to help restore articulation following radial head resection for rheumatoid, degenerative or traumatic arthritis, and to prevent migration of the radius on the ulna.

Trapezium Prosthesis: Designed to help restore function of thumbs disabled by rheumatoid arthritis, degenerative arthritis or trauma, and to maintain motion at the base of the thumb without loss of stability. Available in five sizes.

Carpal Scaphoid Prosthesis: Designed to preserve normal joint space relationship and to restore articulation following excision of the carpal scaphoid, without loss of stability. Available in three sizes for both right and left wrists.

Ulnar Head Prosthesis: Designed to help restore function following ulnar head resection and to help maintain physiological length of the ulna, thus preventing ulnar drift of the wrist when too much bone is removed. Available in three sizes.

Carpal Lunate Prosthesis: Designed to preserve a normal joint space and articulation following excision of the carpal lunate.

Made of pliable Silastic brand medical-grade silicone elastomer, these implants are non-reactive to bone and surrounding tissue. Permanent fixation is not required. Radiopaqueness allows x-ray evaluation.

For further information write to Dow Corning Silicones, Medical Products, 1 Tippet Road, Downsview, Ont.

Teslac

Teslac (Squibb Testolactone), a chemotherapeutic agent in the palliative management of advanced or disseminated mammary cancer, is now available from E.R. Squibb & Sons, Inc. as tablets for oral administration.

A lactone derivative of the androgenic hormone, testosterone, Teslac is the first steroid for advanced breast cancer that separates the wanted antineoplastic action of testosterone from that hormone's unwanted biological activity of masculinization.

Teslac has been found to be effective in approximately 15 percent of patients treated, according to the following criteria: those with a measurable decrease in size of all demonstrable tumor masses; those in whom more than 50 percent of nonosseous lesions decreased in size although all bone lesions remained static; and those in whom more than 50 percent of total lesions improved while the remainder were static.

As an oral dose, Teslac is a more acceptable form of treatment by the patient and the preferred administration by the physician. It is significantly free of uterotrophic, progrestional, glucocorticoid, gonadotrophiclike antiprogestational, antiuterotrophic, antiestrogenic, or cholesterol-altering activity.

Teslac is recommended in the palliative treatment of advanced or disseminated breast cancer in postmenopausal women when normal therapy is indicated. It may also be used in women

who were diagnosed as having had disseminated breast cancer when premenopausal and in whom ovarian function has been subsequently terminated.

Further information may be obtained from E.R. Squibb & Sons Limited, 2365 Côte de Liesse Road, Ville St. Laurent, Montreal, Quebec.

Disposable Needles

Total destructibility and safe, easy disposal are major features of all hypodermic needles and syringes used in the new Sterimedic system developed by Sterilon Corporation. Rigid polypropylene sheaths, color coded to assist in needle gauge identification, shield the needle from damage before and after use and protect hospital personnel from accidental injury. The sheath is also used, following injection, to snap the needle at its mid-point and to break the luer tip from the syringe to prohibit reuse. The shipping carton doubles as a disposal receptacle: used needles and syringes are pushed through a sunburst opening and the carton is taped shut. These safety measures are designed to reduce injury and infection within the hospital and to prevent the reuse of discarded syringes and needles by drug addicts and other unauthorized users.

The Sterilon Corporation's Canadian outlets are situated in St. John's, Nfld., Quebec City, Montreal, Toronto, London, Winnipeg, Calgary, and Vancouver, B.C.

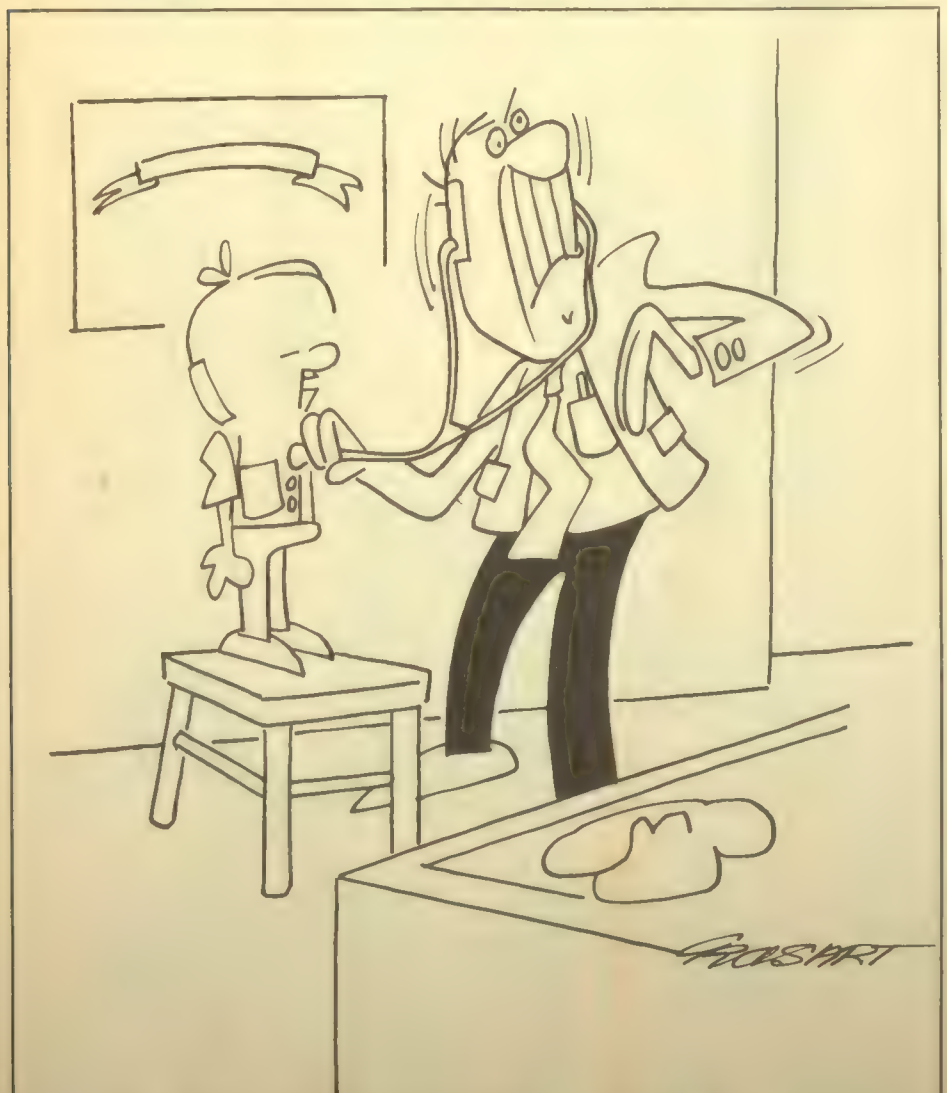
in a capsule

Time-study results surprise VON

"Clock-watching" is usually abhorred by employees and supervisors (depending on who is doing the watching), but a time-study carried out now and then in any organized activity can turn up some rather interesting information.

According to a recent issue of *News from National Office,* a newsletter of the Victorian Order of Nurses for Canada, VON branches have used time studies regularly as a means of evaluating work patterns and improving service. Last year, the VON decided to have the time study carried out at approximately the same time in all branches, and to have the results forwarded to the national office in Ottawa. From analysis of the overall statistics, the Order hoped to develop a better idea of what was reasonable or average for the time spent in the VON's three major activities: home visiting, office work, and travel.

The result was surprising: on a national average, only 55 percent of the nurses' total time on duty was actually spent in the home, even though, as a visiting nurse organization, the home is its prime focus for service. Time spent in the office was 18 percent, which appeared high, as administrative and supervisory time was not included in the statistics.



"Take it easy, Doc... my praying mantis is in that pocket...!"

There are pills and pills!

So British Columbia would like the federal government to hand over another $500 million!

'Tis said the reason is — B.C.'s population grows faster than anywhere in the country.

George Bain, *Toronto Globe and Mail,* advises the prime minister to "... give him [Premier Bennett] a giftwrapped case of birth-control pills, and offer to undertake a joint federal-provincial program to install cold showers." Fine, George, but what about those deserving gals in the rest of Canada? Would they have to "makedo" if British Columbia had the lions share of contraceptive goodies?

Living longer

The world's first patient to be fitted with a new type of heart pacemaker was discharged from London's National Heart Hospital in July, eight days after her operation. Powered by a nuclear battery, the pacemaker was designed to maintain the heartbeat of sufferers from heartblock for at least 10 years before an implant is needed. Power source is a tiny quantity of plutonium 238 sealed in a capsule. *(From British Information Service.)*

How much will they need?

Even though the tale of the Loch Ness monster is "old hat," it provides endless copy for members of the fourth estate.

Reuters, in the *Scotsman,* reported, "An American bid to entice the Loch Ness monster from its depths with 'sex essences' is doomed to failure because the old girl is past her prime."

The *Scotsman* says a scientific team from the U.S. will try to lure the monster to the surface with sex essence from eels, sea cows, sea lions, and other creatures of the deep.

Sounds great! But what if Nessie doesn't like the flavor of sex essences from eels, sea cows, and sea lions? What's the next medical step?

Midi or pantsuit?

Dramatic or traumatic! There's been some mighty big changes in nurses' uniforms over the years. And now they're wearing pantsuits — and with permission, thank you! Is the midi contemplated? Or did it ever leave the nursing scene?

Does Jane Cowell know the facts about dandruff?

Probably not!

The facts are dandruff is a medical problem and requires medical treatment. Ordinary shampoos cannot control dandruff.

New formula Selsun can!

The doctors you know are undoubtedly familiar with Selsun. And they prescribe it because it's medically recommended. And proven effective in 9 out of 10 severe dandruff cases.

Our new formula Selsun is as effective as the old. We use the same efficient antiseborrheic — selenium sulfide. We've simply improved the carrier. A more active detergent produces foamier lather — a finer suspension gives smoother consistency.

To top off new formula Selsun we added a fresh clean fragrance and put it in an attractive unbreakable white plastic bottle.

If you know someone with a dandruff problem tell them to ask their doctor about Selsun. And if dandruff worries you — ask your own doctor.

selsun* ABBOTT

(Selenium Sulfide Detergent Suspension U.S.P.)

A PRODUCT OF ABBOTT LABORATORIES, LIMITED

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A New Book!

Maternity Nursing

This sensitive new text is planned for concurrent classroom and clinical learning. Following the same format as the author's widely used *Workbook for Maternity Nursing*, it presents the entire maternity cycle as a normal physiologic process, with sections on the preparatory phase, pregnancy, labor and parturition, the postpartum period, and the neonate. These stimulating discussions can help your students counsel and support patients in the prenatal clinic and on the maternity ward. Besides a full explanation of normal pregnancy and delivery, this richly illustrated book includes a chapter on high-risk pregnancy, as well as detailed material on nursing measures to prevent postpartum complications. Practical teaching features include study questions, bibliography, and a comprehensive glossary. By CONSTANCE LERCH, R.N., B.S.(Ed.) July, 1970. 360 pages plus FM I-XII, 7" x 10", 190 illustrations. Price, $9.10.

A New Book!

Orthopedic Nursing
A Programmed Approach

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Preplacement health screening by nurses in industry

In industry, too, the nurses' role is being expanded. At Bell Canada, the occupational health nurses are responsible for carrying out preplacement health assessments and for advising the employer whether prospective employees meet the health requirements for the job.

Lillian B. Munro

Changing concepts in recent years about preplacement assessments, and the conviction of our medical director that nurses in industry should be used effectively, have added new scope and a challenging role for occupational nurses at Bell Canada. Since 1963, our nurses have assessed the health of more than 55,000 applicants and accepted the responsibility of advising management as to whether prospective employees meet the health requirements for the job.

Background of program

Bell Canada provides telephone service in the provinces of Ontario and Quebec, and has approximately 40,000 employees — 55 percent females and 45 percent males. About 80 percent are located in 9 major cities and have available to them occupational health services, staffed by 9 full-time and 16 part-time physicians, 45 full-time nurses, and several full-time clerical staff.

Another 17 percent of Bell's employees are located in smaller cities or towns where district nursing services are provided on a regular scheduled basis. In these areas medical examiners are appointed by the company to do examinations on a fee-for-service basis.

At present 97 percent of the employees have access to company health services; the remaining 3 percent are scattered throughout company territory in small numbers, and are not provided with company health services.

Throughout our health program the overall emphasis is on prevention and health maintenance. An assessment of health is required for all new employees, one reason being to establish a basis for future health follow-up. Over the past 20 years this area of our program has undergone many changes.

Prior to 1963, the nurse's role in the preplacement examination was to complete the health questionnaire with the new employee and do the laboratory, vision and hearing testing; in each instance the doctor was required to examine the applicant, assign the final health category, and complete the report that goes to the employing official.

Two main reasons, however, led to the transition from the doctor-oriented examination to the present screening procedure, known as the Initial Health Review (IHR), by health nurses.

First, available doctor-time in the company is always limited, and there is an ever-increasing need to assign more of this time to periodic health examinations.

Second, detailed analysis of results of the medical department program over the years showed: (a) there is consistently a low rejection rate of applicants for medical reasons (-1%); and (b) although a large number of health problems were identified, they were usually picked up by the nurses while doing the questionnaire or test procedures.

Nurses screen applicants

The IHR, a fully nurse-oriented screening procedure for female applicants, was introduced throughout the company in 1963. All nurses were given additional training for the new procedure and received adequate help and support from the medical staff for their new responsibilities. Meetings were held with management, employing officials, and union representatives to inform them of the change in the procedure and to gain their acceptance.

Over a five-year period, the results of the new program for female applicants were favorable. Certain factors had to be considered, however, before changing to a similar screening examination for men.

For example, there was some concern as to whether company management and the applicants would accept nurses carrying out the total procedure; also, some supervisory personnel

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wondered about undue risks for the company, and questioned whether a nurse is capable of assessing backs and knees of male applicants. This latter concern is realistic, as many of our male employees are required to climb ladders and telephone poles.

However, for several years now, as part of our preplacement examination, company nurses have been trained to observe carefully each applicant as he or she carries out a set of exercises specially designed to assess the range of movement of all the important joints in the body. *(Figure 1)*. These exercises take approximately three minutes to complete. When limitations of movement or deviations from normal occur, the nurse refers the applicant to a company physician for further assessment. This, of course, is standard practice when the nurse detects any problem beyond her scope.

Early in 1968, after minor revision of the questionnaire and careful review of all factors involved, a decision was made to extend the use of the IHR by nurses to include male applicants.

Our departmental statistics now show that 95 percent of all male and female applicants are given the complete IHR by nurses. The remaining five percent are required to see a company physician for advice on some health problem (such as hypertension, back conditions, history of rheumatic fever, or history of psychosis), which has been identified by the nurse during the Review.

IHR Procedure

The Initial Health Review consists of a health questionnaire, a series of tests, the assignment of a medical category, and the written recommendation to the hiring official.* As this assessment forms the basis for the employee's medical file, the nurse must obtain a complete and accurate health history.

The questionnaire is intentionally a departure from the traditional "Yes-No" answers opposite a list of illnesses. Instead, the questions are designed to be used with other questions by the nurse to obtain a concise, yet meaningful, summary of the applicant's past and present health history. All positive history and findings are recorded, along with any pertinent information on family history, nutrition, exercise, use of drugs, and smoking and drinking habits.

Immunization history and dates are also noted. The menstrual history of each female applicant is carefully reviewed, and data pertaining to the cycle and date of last menstrual period are recorded. Throughout the interview the nurse has an excellent opportunity at this initial stage to help guide the applicant's thinking toward improving present health habits or toward maintaining good overall health practices.

All company nurses are trained to check visual acuity and color vision by means of an Ortho-Rater, and to do hearing tests using audiometers. In addition, they check and record the applicant's height, weight, pulse, and blood pressure; inspect his oral hygiene, throat, scalp, ear canals, and skin; and assess his musculoskeletal system, using the exercises previously mentioned.

The applicant's urine is checked for albumin and sugar, and a hemoglobin reading, determined. Each applicant is required to have a chest x-ray.

Throughout the Review, the nurse closely observes actions, mannerisms, and responses so she can make a realistic assessment of the applicant's emotional health. Our inservice program for staff nurses provides considerable training on the various aspects of mental health — a valuable aid in the early recognition and evaluation of common emotional problems.

A summary of the positive findings from the health history and test procedures is recorded, and the results are readily evaluated from the standards

EVALUATION OF MUSCULO-SKELETAL SYSTEM MALE & FEMALE INITIAL HEALTH REVIEWS

1. Applicant stands facing examiner, forearms flexed on arms, hands in supination.
2. Applicant spreads fingers apart and brings them together, closes fists, opens fists, apposes tips of thumbs to little fingers, pronates, and again supinates.
3. Flex forearms acutely until fingers touch shoulders. Raise elbows anteriorly as high as possible.
4. Abduct both arms in this position and rotate shoulders.
5. Applicant in erect position — nurse back of patient notes any postural deformity, scoliosis, kyphosis, lordosis. If noted, ask whether congenital, acquired, or due to injury.
6. Raise hands straight up above head as high as possible. Bend over touching ground — with knees straight. Report distances — finger tips miss floor — if restricted.
7. Resume erect position.
8. Squat on heels and rise to original position.
9. Abduct first one leg and then the other.
10. Rotate the head from side to side.

If these exercises are gone through rapidly, they can be accomplished in about three minutes, and every important joint in the body will have been tested.

If any deviations from normal appear, consult a company doctor or medical examiner.

Figure 1. Nurses at Bell Canada use these exercises during the Initial Health Reviews to assess an applicant's musculo-skeletal system.

* Samples of the questionnaire used for the Initial Health Review can be obtained by writing to the author at Bell Canada, 161 Laurier Avenue West, Ottawa.

The author, Lillian Munro, about to check an applicant's ear canal.

for various job requirements as set up by our medical department.

A follow-up date is noted according to the findings, and a medical category — A, B, C, or D — is assigned for confidential use in the medical department. *Class A* indicates that the applicant meets all health requirements for the job. *Class B* applicants are recommended for employment only in specified jobs. These individuals may have noncorrectable conditions, such as monocular vision, an artificial limb, or a chronic condition, such as epilepsy or diabetes. They are required to be reviewed in the medical department prior to a transfer to another job that involves different physical qualifications.

Class C applicants are recommended for employment after correction of specific health problems, such as severe dental caries involving extractions, or refractive conditions of the eye. *Class D* applicants do not meet medical standards for employment in any capacity in the company, and are not recommended for employment.

The final part of the IHR procedure is the written recommendation to the hiring official. When an explanatory note is required on this form, care is taken to keep confidential information within the medical department. Only general, constructive data are released to the supervisor or hiring official.

The IHR procedure has proved to be an interesting and challenging part of our nursing program. All district nurses and nurses in the main health centers use identical equipment to carry out the Review. District nurses work out of large centers to a number of smaller centers on a scheduled basis, and bring the overall nursing program to the employees in the various areas of the company territory.

Rapport established

The initial rapport established between the nurse and the new employee at the time of the IHR proves invaluable for future contacts in following up health problems and when doing health counseling and periodic health evaluations. Besides continuity in relationship, a better understanding of the preventive role of the medical department and its objective is established early with the employee.

Problems most commonly identified

All Bell Canada nurses are trained to check an applicant's oral hygiene and throat.

As part of the health review, a nurse observes each applicant as he performs exercises to evaluate his musculo-skeletal system.

during the IHR are dental caries, refractive errors, obesity, and dysmenorrhea. Our experience shows that most new employees make a real effort to try to correct their individual health problems within the time specified for the follow-up visit. In many instances, however, further follow-up may be required over a number of months.

Since the change-over to a nurse-oriented procedure, our industry has realized a substantial economic advantage. In a five-year period, the expense of pre-employment health assessments has been reduced by one-third. This is equivalent to $150,000 in company savings. Further statistics show that in addition to the financial saving, some 1,500 hours of doctor time per year are now released for other areas of our program that specifically require the skills of well-qualified physicians.

It is recognized that minimal risks may be involved, as each new employee does not receive a complete medical examination. We also realize that the IHR procedure might not be acceptable to every industry. However, our medical director, who gives us full support, is convinced of the value of the program and is able to reassure management personnel that the present type of assessment being carried out by well-trained nurses gives an adequate, overall health evaluation, and is presently meeting the needs in our company better than ever before.

Summary

Occupational health nurses can effectively carry out comprehensive preplacement screening evaluation, provided they have added training, keen interest, and the full support of a continuing program of health supervision.

Initial Health Reviews by nurses at Bell Canada have been carried out on all female applicants since 1963, and on all male applicants since 1968. Ninety-five percent of all applicants are evaluated totally by nurses and considered for employment on their recommendations; the remaining five percent are referred to company physicians about findings indentified by the nurse during the Review.

The IHR procedure adds varied content to the overall nursing program, and staff nurses derive greater work satisfaction with the assurance they are making good use of their nursing capabilities.

The early relationship established between the nurse and the applicant at the time of the Review promotes better opportunity for follow-up on health problems, and better understanding on the part of the new employee regarding the preventive role of the medical department.

Occupational nurses will continue to experience a challenging role as long as they are encouraged and permitted to utilize fully their nursing skills.

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Continuing to care — even in the air

Continuing to care is a special medication prescribed by nursing personnel. Canada's armed forces demonstrates its own brand of nursing care in this report of a medical air evacuation. Heightened by a strong sense of esprit de corps, nursing personnel, air and ground crews, work as a synchronized team throughout each flight, returning patients and dependents to Canada.

Mona C. Ricks

The big bird flew low, touched ground, and moved along the flight path. Under neon-lit skies ground crews, ambulances, and a fire truck — waited. Another medical air evacuation had crossed the Atlantic, and eight patients showed relief.

It all seemed simple as the cargo door to "old faithful" slid open. With synchronized precision, 437 Transport Squadron, Canadian Armed Forces, moved to the next step — unloading patients and gear from the Yukon.

Simple, yes, because medical personnel, aircrew, and ground staff had worked "airevacs" many times. Simple, also, because they worked as a team.

I'd heard of an airevac long before I was invited to cover an "op," and had taken for granted patients crossing the Atlantic on regular bi-weekly runs from the armed forces base at Lahr, West Germany. But I was not aware of the vast communication system, trained personnel, and knowhow required to transport a patient from base A in Europe to destination Z in Canada.

Nor was I aware of the extensive training undergone by the nursing personnel.

My trip revealed all this!

On the way

We left Canadian Armed Forces Base, Trenton, on a regular service passenger flight, Boeing 707, Sunday, August 16, enroute to pick up eight patients.

We, meaning two armed forces nursing sisters, a medical assistant, an administration clerk, a photographer, and myself, plus a full passager list of armed forces personnel and dependents.

Destination?

Lahr, West Germany — seven hours away!

Mona Ricks is assistant editor, *The Canadian Nurse, Ottawa, Ontario.*

procedures mandatory for all airevacs: nature of patient illness, medical facilities required, and type of aircraft — but no indication of the intricate paperwork already completed to facilitate safe and easy delivery of the patients.

Moving my watch forward five hours meant a short night's rest. No time to think of baggy eyes. The first leg of the airevac had started minutes before we landed in Lahr.

Two hours later I was back on the flight path with photographer, Warrant Officer Bill Cardiff, waiting for a Hercules to deliver seven patients from Dusseldorf. It was Monday afternoon.

Pictures of frontline hospitals and films documenting war carnage have become a regular sight on television. But, as an armchair spectator, there's no involvement!

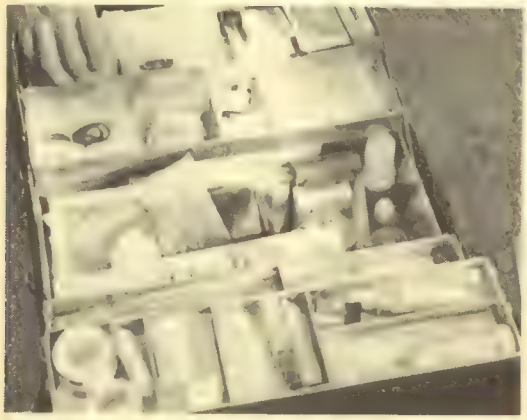
I realized this watching the first litter patient leave the Hercules — plastic I V bottle held aloft by a watchful flight nurse.

In the air they care

A. Preparing to load patients into the Yukon aircraft. The hoist acts as a conveyor belt, lifting litter patients through the cargo door. **B.** Unloading at Trenton, Canadian Forces Bases, enroute to final destination. **C.** Teamwork is vital for a successful airevac. This includes the aircrew. Capt. John Sled commanded the flight described in this story. **D.** The flight nurse's constant companion — a flying pharmacy. Used frequently, it contains a variety of medication and nursing necessities. **E.** Correct loading and unloading of patients is watched by the flight nurse. **F.** Turbulence sends the nursing team to litter patients, and belts are fastened for the patients' safety. **G.** French-speaking nurses are in demand for rescue flights of skiers in France. Capt. (N/S) Gertrude Dorais was flight nurse on the trip from Dusseldorf. **H.** Checking litter placement in the aircraft before takeoff.

B

C



D

E

F

G

H

Three litter patients and four mobile patients entered waiting ambulances. Warrant Officer Cardiff's camera clicked. I watched. We had become part of the airevac team.

Part of the team

In the nearby Canadian Forces Europe, medical center, the staff took over. Usually airevac patients are brought to the Lahr medical center at least one day before the ongoing flight to Canada. Enough time to assess patient medical and personal needs, and to determine if able to travel on a 12-hour flight.

While this was happening, I met the hospital commanding officer. Colonel Ross Irwin is also Surgeon, Canadian Forces Europe.

I wanted to know the *how* and *why* of a medical air evacuation, especially the nursing involvement.

Questions and answers

Colonel Irwin's answers to my questi ns told me.

Q. What is the responsibility of the Canadian Armed Forces Europe in an airevac?

A. To coordinate all requirements involved in transporting patients and dependents to Canada. This entails collecting patients by road or air from all parts of Europe, including England, also Cyprus.

Q. How does a request for help come?

A. By telephone or wire message, usually from embassies. The message, in code, tells the patient's condition, where to be evacuated from and destination, whether service personnel or civilian, and if dependents are to travel with the patient. Lahr medical center assesses the requirements and double checks: is the patient postoperative? are there complications which might preclude travel by air? The information is recorded and sent onto Canada. The message traffic on each patient is considerable. A format is followed, cutting time to a minimum, but still every piece of information on the patient is requested before transporting, to ensure safe delivery and correct medication on the way.

Q. How long does it take to set up an an airevac for one litter patient?

A. Quickly — within 24 hours notice our nursing staff in Lahr can pick up a patient as far away as England and meet a flight onto Canada the next day. We never have problems servicing emergency flights; these patients are usually kept in the Lahr medical center.

Q. What is the procedure for accepting patients at Lahr before going onto Canada?

A. The Lahr service doctors check patient documents, perhaps reexamine the patient to ensure if able to travel on. Medication is checked and assembled for each patient, sufficient for the flight. A list of 26 items is checked for every patient. Such things as: international vaccination certificate (is it updated? if not, the center gets this done); has the patient Canadian funds? if not, deutsche marks are changed; custom clearance arranged; family notified; traveling dependents made comfortable.

Q. Do you use a doctor on airevacs?

A. On each leg of the airevac medical personnel decide if a doctor is necessary. Otherwise a flight nurse and a medical assistant carry patient care responsibility.

Q. If a doctor is not on board, who is in charge of medical personnel?

A. Senior flight nurse.

Q. The nurse, then, takes on the doctor's role?

A. That is correct.

Q. Would you describe the senior nursing role? You say she is working as a doctor — what is expected of her?

A. We expect her to care for a patient as she would were she in a hospital ward. Occasionally she has to do things she would not be expected to do on a ward. She must meet emergencies as they arise. If we can predict a situation will occur, then a doctor is detailed for the flight. However, the flight nurse has considerable responsibility on the 12-hour trip across the Atlantic.

Q. Would you say the nurse today is no longer a bedpan carrier? That she has taken on wider medical responsibilities?

A. Yes, this is certainly true. I think there is a considerable amount of medical responsibility on the airevacs. Our service nurses readily volunteer to go on the flights, often at considerable inconvenience to themselves. All have taken the medical air evacuation course in Trenton.

A well-used hospital

It seemed we'd talked for hours. Colonel Irwin's explanation had in fact taken one hour. There was time to look over the medical center before dinner.

Familiar faces in wards off a wide corridor reminded me of the airevac from Dusseldorf. The seven patients rested.

To describe the center as modern would be like glamorizing a comfortable, but well used hotel. The slate grey, one-level building is "functional," and provides all the conveniences needed to handle mostly transit patients enroute to Canada. Seventy-five beds in bright, immaculate wards, staffed by highly trained workers, a well equipped kitchen, and administration offices are fitted into a small area.

The center is furnished to care for most emergency cases, and has a maternity unit. Neuro- and vascular surgery is usually done at the United States forces base in nearby Landstuhl.

You couldn't come away after peering into wards and administration offices without visiting the library. Canada's armed forces medical personnel in Lahr are avid readers — the up-to-date library included *The Canadian Nurse*.

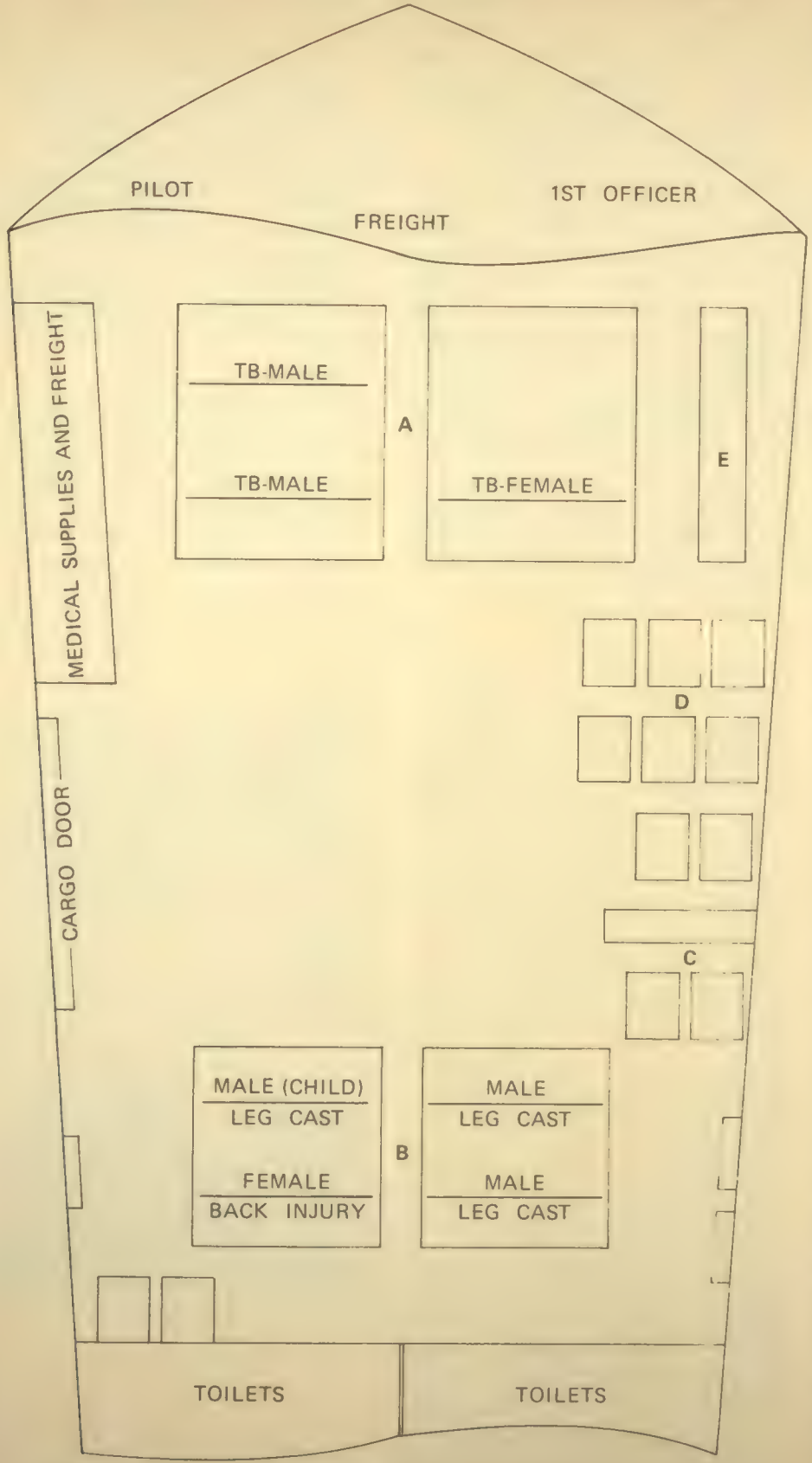
I thought I'd ferreted out most information on the medical center and airevac personnel by this time — but I'd forgotten the B and B report! The hospital staff in Lahr is bilingual, even trilingual. French speaking flight nurses work the airevacs. They are particularly needed for rescue flights evacuating injured skiers in France. Captain (N/S) Gertrude Dorais, a French Canadian, was flight nurse on the Dusseldorf airevac. She told me how pleased she was to work in Europe — even though her parents in Quebec had shown concern for her "soul."

Briefing time

Tuesday, August 18, 10:30 A.M. We're back at the medical center. It's briefing time. Airevac personnel meet the first ward nurse, an RN. She holds a pile of tags (base evacuation tags). I'm told these are vital papers and carry information on each patient from point of pickup to final destination.

Captain (N/S) Marj Whinfield, senior flight nurse on the airevac, is

AEROMEDICAL EVACUATION COURSE YUKON LOAD PLAN



A LITTER PLACEMENT OF CONTAGIOUS PATIENTS
B LITTER PLACEMENT OF PATIENTS WITH LEG AND BACK INJURY
C WORK TABLE AND SEATS FOR NURSING PERSONNEL
D PASSENGER SEATS
E OXYGEN TANK

briefed on patient diagnosis, treatment on flight, and foreseen problems. She meets each patient, describes flight preparations, discusses personal problems, and answers questions.

For those going on by air from Trenton, Captain Whinfield assures each patient he will be made comfortable at the base hospital overnight, and so will traveling dependents.

And now the airevac medical team get together. They've seen the patients, know their ailments and prescribed flight treatment — how they are to be placed on the aircraft is the next decision.

Corporal William Gunn, medical assistant, and Captain Whinfield plan configuration of the aircraft (load plan). Seven patients are listed as litter cases, three of these designated infectious and must be separated from other patients and traveling dependents, three have leg injuries, and one a spinal injury. The eighth patient, a psychiatric case, is mobile.

Placement of gear, oxygen tank, bedding, medical supplies, seating, and luggage must also be planned. Easy access to patients for treatment and traveling comfort is the prime concern.

Oxygen, important to the patients with tuberculosis, must be placed near them ready for emergency. Flying at a high altitude, even though the cabin is pressurized, the oxygen content of the air is still less than at sea level; turbulence could mean an oxygen need.

Configuration is an important part of the medical assistant's duties. I asked Corporal Gunn to explain configuration of a patient with a broken right leg. Where would he be placed in the aircraft?

Limb care is the deciding factor. If there is a double-tier of litters (two tiers side by side), and if the nurse is average height, the patient would be placed with his injured leg toward the outside of the litter, on a middle or lower berth.

Fortunately, both Captain Whinfield and Corporal Gunn are tall and can tend to patients in higher berths.

Because we were carrying infectious cases, arrangements for decontamination of the aircraft in Trenton had to be made before we left Lahr.

On this trip the flight nurse was in charge. To me this meant she was acting on a medical doctor's level.

I asked Captain Whinfield if this were so. Her modest answer is typical of the ego restraint I have become

accustomed to in the nursing profession.

"True to a certain extent. However, there are certain things a nurse cannot fill in for a medical officer — that's for sure!"

"But, supposing there was an emergency enroute?" I asked.

"We would deal with it to the best of our ability. We are trained to act with precaution."

"You, as an RN in charge of an airevac, work as a doctor then?"

"Well, yes, I suppose you could say that."

Captain Whinfield was insistent on one nursing practice necessary for every airevac — teamwork. She stressed the importance of the medical assistant's role (always a male), which compares with a civilian registered nursing assistant.

The airevac is on!

It was airevac day! Wednesday, August 19. Takeoff time 1028 hours Trenton time, 1528 hours Lahr time.

Custom officials cleared us at the medical center, medication on the airevac tags was completed and signed by the duty doctor, ambulances waited. The Yukon, its huge belly fitted as a flying hospital, also waited.

Captain (N/S) Marg Antwis, detailed to accompany me, and I board the aircraft. Patients, placed in positions already planned in the configuration, are strapped into litters, dependents' seat belts checked, luggage and gear strapped to the floor, and Captain John Sled, aircraft commander, signals "closeup."

We are airborne! But only after a long, slow takeoff. Restrictions on acceleration and deceleration are stringent. Again, for the safety and comfort of patients.

A passenger bulletin gave flight speed as 365 miles an hour, altitude 20,000 feet — the beginning of a 3,920-mile journey.

Now began the test of the nursing team in flight. Litter patients required constant attention. Turbulence could mean oxygen for anyone. Almost always a paper bag was at the ready. Individual medications must be carefully timed and recorded on the evactags.

Captain Whinfield works on GMT when timing medication. For her this is the only way to be sure treatment is on time during Atlantic time changes.

Two hours later, and all is quiet. Patients and passengers sleep.

A rough air spot and the nursing team straps patients to litters again, and mobile passengers to seats.

One question asked by a patient is answered soon after we are airborne. Litter patients are given individual privacy. Curtains separate each litter tier, and continue round the patient if treatment calls for constant privacy, or left open if the nurse orders.

Inventive skill must be part of the airomedical evacuation course. Throughout the flight the nursing team, backed by loadmaster Corporal Aubrey Delong, improvised. Gear boxes made fine table tops, and the flight nurse's kit made a handy tray rest, a patient seat for changing bandages, or a footrest. Fitted with trays, the black box is a flying pharmacy. Emergency drugs, adrenalin, coramine, and ergometrine are carried. Aspirin, codeine, gravol, bandages, dressings, and sterile instruments, thermometers, torch, tourniquet, safery pins, syringes, tracheotomy tubes — and other medical needs are always ready.

The kit was used frequently.

We arrive in Canada

It is 2210 hours. The Yukon has landed at Trenton. Patients are ready for unloading. Bedding, medical supplies, and gear are packed. The cargo door swings open. Ambulances stationed off the flight path move to the loading ramp, armed forces personnel board — one, two, three litter patients are carried to an ambulance. Three patients, listed as infectious, are unloaded after all others, masks across mouth and nose.

The Yukon's belly is emptied; patients are in Trenton base hospital, admitted and assessed by a forces doctor; traveling dependents are cared for; gear unloaded, aircrew debriefed. The nursing team also heads for the hospital. They check patients before turning in for the night.

All so simple — but the airevac is not completed.

Some patients are to travel on the next day. Another aircraft must be configurated, another nursing team and aircrew briefed. In Lahr, more patients are being collected for the next airevac — and in Trenton preparation for the fall aeromedical evacuation course is underway.

Thursday, August 20. I wake to marching feet and drum rolls. I am still at Trenton. There is more airevac information to come.

Communication! Who takes care of the paperwork? What training do flight nursing personnel take?

Colonel J.R.W. Wynne, Command Surgeon, Aeromedical Evacuation Control Centre, Trenton, answered question one.

Messages received from Lahr medical center, are relayed to the Trenton control center. Arrangements for aircraft and the base designated to supply a medical team are determined and coordinated by the center — a year-round administrative concern.

Question two is the responsibility of Captain Antwis, chief flight nurse instructor of the aeromedical evacuation course.

Captain Antwis received her nursing education in England and is a registered nurse in Newfoundland. She described the 18 working-day course as rugged, covering six main training units: airmanship, administration and documentation, unloading and loading patients (configuration), equipment, nursing (enroute care and treatment), and flight training. The first five units are covered during 15 days of ground school training, the sixth, practical training, during three days flying.

Only armed forces personnel can request the course or be selected. Nurses must be registered in Canada, and medical assistants must be in an advanced stage of trade progression.

In operation since 1963, the school runs six or seven courses each year. During seven years, 240 flight nurses and 320 medical assistants have been trained.

The first course was set up and conducted by Squadron Leader Ella Mannix.

Now late Thursday afternoon, surely all questions are answered. No, one more! What is the basic cost of an airevac (aircraft, crew, and fuel) from Lahr to Trenton? I'm told approximately $7,200 for a 12-hour flight.

It's five days since I left for West Germany. I'm heading back to Ottawa, leaving behind nurses, doctors, and other armed forces personnel to plan and carry out another airevac.

Are we really meeting our patients' needs?

The author criticizes the present organization of nursing services, and suggests some ways to upgrade nursing care. Nurses should stop thinking in terms of illness, she says, and think more of people, patients, and health.

Nicole Du Mouchel, R.N., M.N.

Our patient is a complex human being, accustomed to living in highly-organized social groups. Each group he belongs to in the community is organized to meet its members' needs to the fullest extent possible. To this end, the group has its own language and its own characteristic functions. Within this secondary group of an ethnic society, our patient has been influenced by several other secondary and primary groups and his socialization affected by a set of circumstances and by his personal experiences.

Man lives all his life in various groups, both inside and outside his family, at work, in his neighborhood, and in his recreational and religious activities. Life in the group is important to him, and his behavior is influenced by the different groups to which he belongs. Koos explains, "Social interaction can be thought of as a continuum ranging from one extreme to another. At one end of this continuum is complete adjustment; at the other end is outright conflict. Man is always at one point or the other on this continuum as he interacts with others."[1]

The author is Consultant, Canadian Council on Hospital Accreditation. She presented this paper last April at a seminar for nursing directors of Canada, sponsored by the Department of National Health and Welfare, Ottawa.

Man also has to earn his living, and his work has a great influence on the way he adapts to the various circumstances of life.

The patient and his fears

The patient who comes to us arrives at the hospital at a certain level of maturity and at a certain point on the social interaction continuum; he is also strongly influenced by his knowledge, beliefs, and prejudices. He is a person who cannot resolve his health problems and who is asking our assistance to restore him to a state of equilibrium.

The balance has been destroyed and our patient is worried: he is afraid of pain, and of leaving our hospital as something less then when he came in. He does not wish to be among us. He wants to be with his family, to work, and to go about his normal daily activities. A few days ago he made plans for the future; today, he finds himself in an unknown world, a world to which he attempts to adapt himself. He is afraid of losing his identity, of not being treated as a father, an industrialist, or a farmer, but rather as an interesting case of jaundice, a strange clinical development, or a troublesome kidney.

The nurse is called on to help all kinds of people: the unconscious pa-

tient admitted to the intensive care unit; the young mother having her first baby; the child hospitalized as a result of an accident or who is suffering from diabetes; the mother suffering from a terminal disease; the businessman, accustomed to the activity involved in directing his company, who has to remain at complete rest; the aged person, overcome by feelings of uselessness, who is waiting to be placed in a home; the patient with a physical handicap who requires rehabilitation. All these people need our help to restore them to balanced health, and our task is often difficult.

Psychiatry, medicine, surgery, cardiology, pediatrics — each specialty involves specific patient needs to be met in different ways, according to the disease in question. There are as many individual reactions to illness as there are persons in any given department.

Certain health units specialize in a particular type of patient care. Others cover all or several medical specialties. The more specialties there are in a given center, the more complicated it becomes to organize our nursing care in terms of the individual patient. Whatever the situation, all nursing directors must undertake a serious study of the patients under their care to ascertain their needs and establish policies geared to them as members of family groups in the community.

Individual human needs

As hospital services should be organized in terms of patient needs, a review of the theories on fundamental human needs seems appropriate.

Satisfied needs, whether conscious or not, enable man to fulfil himself. Fundamental needs are hierarchical. As one category of needs is satisfied, there is an evolution to a higher level and a new need arises.[2]

The first human needs requiring satisfaction are the physiological needs, such as the need to breathe, eat, drink, and sleep. A patient who is unconscious or critically ill will want these needs satisfied before thinking what he will do if he remains ill for a long time. Only when the critical stage has passed will the psychological needs emerge. The efforts of the nurse at this stage will therefore be concentrated mainly on the satisfaction of physiological needs, although she must always remain on the lookout for the first signs of unsatisfied higher needs.

However, we have specified that our patient lives in society and is a member of a family, which will also have acute fundamental needs to satisfy during this period of the patient's hospitalization. The nursing staff has to be able to identify these needs, because they will be on a different level from those of the patient hospitalized in the intensive care unit, when physiological needs predominate until they are satisfied and channel all the body's resources as efficiently as possible to that end.

The need for security, predominant in the sick person, is well illustrated in the behavior of children. In the pamphlet, *Who Am I? I Am Your Patient...*, published by the Ontario Hospital Association, this need for security is explained in these terms: "I appear normal but I have left my equilibrium at your door. Although I am mature, I have suddenly become a child who is afraid of the long black nights."

Maslow describes certain behavioral patterns which may indicate that this need for security is unsatisfied: ". . . an individual may attempt to maintain his security by adopting an overbearing and superior attitude. He would not have taken this attitude unless he felt rejected and disliked. However, this very attitude makes people dislike him even more, which in turn reinforces in him the necessity for this overbearing attitude." [3]

If the physiological needs and the need for security are sufficiently satisfied, the needs for affection and a sense of belonging will emerge. The patient may feel isolated, may miss his friends, his wife, and his children. He will hunger for close relations with other people, especially to affirm his place in the group, and he will expend intense efforts attempting to satisfy this need.

Following very closely on the need to belong, comes the need to love and respect oneself. Maslow explains that everyone in our society has a need or desire to hold both himself and others in high esteem.[4] There are two aspects of this need: first, the desire to be strong, to succeed, to be equal to the situation, to have confidence in society, and to possess independence and liberty; second, the desire to protect one's reputation, to attain prestige, and to have status. The satisfaction of self-love leads to feelings of confidence in oneself, and gives one the impression of being useful and necessary to society. However, neglect of these needs produces feelings of inferiority, weakness and inadequacy.

The need to belong to a group, which is strong in the adolescent, is further amplified, if, as a result of a chronic ailment such as diabetes, the adolescent fears he will no longer be able to remain with his group. The need for self-love will be threatened in a person disfigured by an accident or who has undergone surgery, such as mastectomy, amputation, colostomy, which has made him in some way incomplete.

And what about the need for self-esteem in the aged person, who has lost his sense of usefulness and who feels himself rejected by the family group? If we reduce our care because his is not an interesting case; if we do everything for him because he is too slow; if we make him feel, through our system, that there is no place for him in our health center, giving him — a person who has always worked and been active — nothing at all to do, then we are doing all we can to prevent his need for self-esteem from being satisfied.

When there is a lengthy period of convalescence, there is a strong chance that once the condition of the patient has improved he may fall prey to feelings of discontent and restlessness because he cannot resume his customary activities. This is particularly apparent in the case of a physically-handicapped person who has to undergo a long period of rehabilitation and be retrained for another type of work and a different way of life. Does our hospital system enable us to help this patient satisfy his need for self-fulfillment by adapting our routines to prepare him for his return to his family and his community?

The more information the public has about health problems and hospital

life through the media, the more it needs to know and understand. This is a need that raises many problems for the nursing staff. The patient needs to know that postoperative depression is a normal state; he needs to know that he can care for himself when his condition improves. He needs to understand our work methods and know his nurse; and, he needs to be taught *how* to continue his own care when he returns home. The new mother must be trained in the care her child requires, and the business man must learn and understand that he must lead a more balanced life.

Verbal indications of certain needs may often be signs of other unconscious and unspoken needs. The patient who tells us his coffee is cold, is perhaps trying to inform us that hot coffee symbolizes the security of home, whereas cold coffee signifies a strange environment. He may complain about the indifference of the nursing staff; perhaps he is trying to tell us that he feels lonely and neglected. Has the nurse been trained to identify, through the various spoken or unspoken communications of the patient, the deeper fundamental needs? Does she have the time for this? Are our methods of assigning staff designed with the patient in mind, or do they merely serve traditional routine?

This subject is certainly not new. We have heard it time and again. But how often do we think of the patients and their needs when we establish our policies and when we experiment with new work methods in our nursing services?

Present situation of nursing services

Does the care given in our health centers *really* meet the needs of the patient? Let us take an honest look at the present situation.

Maslow gives the conditions required for the satisfaction of needs: "Such conditions are freedom to speak, freedom to do what one wishes as long as no harm is done to others, freedom to express oneself, freedom to investigate and seek information, freedom to defend oneself, justice, fairness, honesty, orderliness in the group . . .These conditions are defended because without them the basic satisfactions are quite impossible, or least severely endangered." [5]

Do we give thought to the needs of our patients when drawing up policies to govern our nursing services, or do we think more of having beautiful writings to impress our visitors? It is easy to evaluate the policies and practices simply by looking at what goes on in each unit, by stopping and speaking to the staff, by listening to them and assessing their attitudes and their approach to the patient. It is easy to see whether the established policies are constantly being renewed and really implemented, or whether they are merely on paper for display.

When a director studies the distribution of her personnel, does she consider the general needs of the patients in each clinical specialty, or is she simply concerned with filling positions that have been determined by tradition, without analyzing each situation and seeking the best distribution for each unit? When the time comes for the annual budget and staffing assessment, is the director concerned with meeting the needs of administrators, doctors, unions, and financiers, instead of basing her decisions on a serious and documented analysis of the various needs of the patients?

Do we meet the needs of the patient when we blindly accept ready-made solutions dictated by tradition and unproven by scientific research? Certainly it is easier to accept unquestioningly the policy that four or five hours of care in medicine or surgery is required, together with a certain proportion of professional staff, than to undertake experiments to advance the profession.

Do we meet the needs of the patient when we establish the same rigid policies for all the units without exception? Do we sacrifice the patient's need to efficiency? Abdellah states correctly that unless each practice and policy can be measured in terms of the patient's needs, there can be no justification in perpetuating them. [6]

Can we really be concerned about the patient's needs when we are ignorant of research in nursing care or, what is worse, when we do not collaborate in research studies initiated in other health fields to improve patient care? Is it traditionalism or lack of initiative and preparation that slows down the efforts of nursing personnel studying the improvement of patient care? In certain health centers, the nurses not only dislike the studies undertaken in health fields, but even condemn or oppose them.

How can we meet the needs of our patients if senior staff members never visit them? In many health centers, the management of the nursing services is too far removed from the patient and from the activities of the hospital. There are still some directors who have never seen their hospital in operation in the evening or at night!

When you read the minutes of the various nursing service committees, you soon realize that the nursing staff is preoccupied with the needs of all the other services in the hospital, but very little with nursing itself. The patient is almost never referred to, nor is there any mention of nursing methods and practice and their evaluation. There is talk of equipment, interdepartmental relations, dripping taps, lights, laboratories, leaves and wages, but never of the patient — the justification for our existence in the health field.

Evaluation of nursing services

The patient's physiological needs ought to be the easiest to satisfy, but look what happens. The patient needs sleep, yet, we bring him his breakfast early in the morning, meeting a need he does not have. Also he must feel this need for food at the proper hours, otherwise he will have to wait for the next meal to satisfy his hunger. The patient needs to breathe, yet we never think of opening a window in the evening.

Do we meet the patient's need for security when we neglect to prepare him for discharge? How can the patient feel secure if he has to leave the hospital abruptly, where everything has been done for him, and get along by himself at home. The nurse has the best opportunities to give such instruction while she is carrying out the daily care of the patient. How often does she profit by this opportunity? Too often she is so

preoccupied by the task to be accomplished, that she forgets to start instructing the patient.

Of course there is the form requesting visits by a nurse, but since everything is decided at the last minute, full information is not given to the visiting nurses. This means they have to start from scratch to obtain the details they require. How can the patient feel secure when he suddenly learns he is being sent to a extended care center, and when, in addition, the hospital has not contacted the nurse in this center to give her information about him? When are we going to have a system for conveying nursing care information to the various health services?

At some point during his hospitalization, the patient may feel the need for social contact, for communication with other people. Are these needs met? No. We continue to leave him in his room, we do not make it possible for him to have his meal with other patients in the day-room. If he has to be hospitalized for a long period and requires help in adapting to life in society, do we ever think of putting him in contact with people in the community, or of taking him to the cafeteria or the gift shop?

Returning to the elderly patient we considered earlier, let us remember he may have been in the habit of going to bed at 7:00 P.M. and getting up at 5:00 A.M. He must now adapt to our routine and go to bed at 9:00 or 10:00 P.M. and sleep until 6:00 A.M. His need for sleep has diminished with age, and at 4:00 AM he is up and strolling around the ward. In so doing, he disturbs our beloved routine and is classified as a "difficult case." To reestablish order, he is given a sleeping pill; in the morning he is confused, which does nothing to help him achieve the status of "model patient." Has anyone ever considered that, without disturbing the whole ward, he could be made happy by being allowed to smoke his pipe, chat, enjoy a warm drink, or do a simple job for someone?

Young paraplegics have a strong need to belong to a group, but their rehabilitation and retraining often require lengthy hospitalization in extended care centers where the average age of the patients is 80. Do we cater to their needs by drawing up a special program for them? Do we provide them with a place where they can go and act their age, a place they can fix up according to their own tastes?

How can we say that nursing care meets the patient's needs, when nurses take no active part in the work of the health team, are not informed of every detail of the treatment program, and do not contribute by reporting what they know of the patient and his problems?

There are treatment plans, but try to find a report on the patient's needs, or a care program drawn up by the nursing staff! You will find the medical aspect is well protected, but the nursing aspect is ignored. How can the night staff help to satisfy the patient's needs if it does not know what approach was used by the day staff? This lack of information about the patient's reaction to his illness and the educational aspect of his treatment program can completely destroy the progress accomplished over several weeks of work.

We established the team system throughout hospitals without examining whether it was necessary or preferable for all units. Do we recognize that, because of the lack of preparation of senior nurses, the information given at team conferences is not even listened to? The basic concern is to check whether assignments have been carried out!

Meeting the patients' needs

I have painted a black portrait of our nursing care, based on first-hand observation of nursing facilities throughout the country. However, I assure you that nursing care *can* be organized to meet the needs of the patient, and that a number of encouraging experiments are currently underway. Not every need can be met and every frustration eliminated, but a good many needs *can* be met, and nursing care *can* be improved if we keep the patient in mind when establishing nursing procedures and policies.

Even if the physical facilities do not allow all the necessary flexibility to meet the various needs of patients in each unit, some adaptation is possible. For example, a bed or bedside table can be moved to allow the patient to enjoy a different arrangement from time to time.

When the nursing director participates from the outset in the preparation of the plans for a new hospital, she is able to design the various units to meet the particular needs of each group of patients, keeping in mind that efficiency requires a certain degree of uniformity. There will be an obvious difference between the pediatric unit with its playroom; the extended care unit with its dining room, lounge and larger cupboards for the patients' belongings; and the medical ward. A few Canadian hospitals have benefited from knowledge acquired in thorough preliminary studies and from significant participation by the nursing staff in the planning stages.

Nursing care will suit the needs of the individual patient if the nursing director, when deploying her staff, makes a thorough study of: the population served by the hospital; the physical facilities; the treatment programs; the established policies; the approved methods of assigning staff; and the categories of patient requiring care and the specific needs of each.

Lambertsen has stated that improved use of nurses is an excellent thing in so far as its aim is to provide better patient care.[7] In support of this statement, she cites the example of a decision made at Brooklyn Methodist Hospital to reduce the anxiety of pediatric patients. Earlier research had clearly demonstrated the importance of a continuous personal relationship in child care and the extent to which this was helpful in reducing stress in the hospitalized child. The staff therefore decided that meals would be served by the nursing staff in the pediatric ward. In all other units, meals would be the responsibility of the dietary service. This is an example of an administrative decision to which nurses contributed.

There is a greater likelihood that nursing care will meet patient needs if the nurses are involved in the life of the community and familiar with the patient's way of life. They should not,

therefore, shut themselves away in an ivory tower and forget that other health facilities exist outside the hospital.

Hospital nurses must have frequent communication with nurses in other health services in the community to make them aware of their capabilities and limitations. Hospital staff will thus be led to think of medical care in broader terms, and to prepare patients to move from one treatment sector to another with minimum disruption. It will then be as natural for a nurse to refer her patient to another source of nursing care as it is for a doctor to refer his patients to a colleague.

Lydia Hall maintains that if the patient's needs are to be met, he must be attended exclusively by professional nurses.[8] The Loeb Center in New York, where everything has been arranged with the patient's needs in mind, offers concrete evidence of her views. In the belief that fragmentary treatment is to be avoided, she deployed her staff to provide total care. She felt that professional nursing care was not only essential, but should at times predominate in the provision of an integrated health service for the hospitalized patient. If we really believe in this approach, our use of nursing staff will be influenced accordingly.

Treatment will meet individual needs when nurses providing direct patient care make a systematic examination of the patient's needs, and determine priorities for the care program by observing psychological symptoms in the patient and by listening to his comments. The standard of care will improve when nurses know how to question patients to obtain the information required. The ideal will be reached when the care program becomes a real working tool that provides information for the *entire* nursing staff.

We will thus achieve a uniform approach by the nursing staff and continuity in the care provided. When the care program follows the patient when he leaves the hospital to return home or for admission to another treatment facility, we shall be able to say that our nursing care really meets the basic needs of our patients.

If the patient is able to take part in social interaction within the treatment unit, he will be happier and his recovery facilitated. He will thus be restored to health more quickly. Brown tells us there are a number of ways to involve the patient, which will remind him of his normal life, thus helping to reduce boredom and to give him back his independence.[9] Patient participation must take place largely within the treatment unit and must be planned, supervised, and stimulated by the nursing staff.

The care we provide is likely to be better adapted to the constantly changing needs of the people we serve if the nursing care methods and practices are subjected to regular assessment at all levels. An overall approach must be adopted, embracing procedures in general, staff, methods, and patient records. This assessment should be decentralized and carried out at the ward level.

The care is more patient-centered in establishments where administrative committees set aside some of their time to discuss treatment, practices, and new methods and discoveries in the various fields of health care. If this is done at the health-team level, the attention of the nursing staff will be directed more toward the total treatment concept.

None of these approved methods can begin to succeed unless the nursing director exercises firm leadership in providing individual nursing care. This will be reflected in her management techniques. She is responsible for the continuous training of her staff in this field, and must encourage them to adopt a broader and more creative approach to the daily care of the patient.

The nursing director must convince her staff that the encouragement of the patient to undertake psychologically-beneficial activities is the very essence of nursing. All the lectures in the world will fall on deaf ears if the nursing staff do not realize the importance of these activities.

It is futile to believe that the nursing staff will be attentive to the needs of the patient if their own needs are not considered. On this point, Donovan states that our own needs and shortcomings are reflected in the manner we adopt toward patients and their visitors.[10] The best demonstration a nursing director can give of the importance she attaches to the consideration of basic human needs is the example she gives in working with her staff. She wants her staff to evaluate the needs of the various patients for whom they are responsible. She will therefore have to set an example by evaluating the needs of the members of her nursing staff, without forgetting the evening and night staff.

I have touched briefly on a number of requirements that must be fulfilled if the nursing care we provide is to meet the needs of the patient. This care will be satisfactory if we keep the patient in mind in everything we do as professional nurses. The more we work *with* the patient — and not against him — the more success we will have.

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The Autistic Child

Have you ever wondered how you would recognize an autistic child and how you could help him? The author describes the major signs of this syndrome and the nursing measures used when caring for a child with this illness.

Valerie Whitlam, B.Sc.N.

Autism is confusing in many ways. For example, the term "autism" may be used as a diagnosis or as an adjective describing behavior. Also, in diagnosing children, it is difficult to differentiate between autism, mental retardation, brain dysfunction, schizophrenia, and other psychoses. *(Table A.)* The symptoms overlap considerably, and some children have more than one of these problems. Once diagnosed, there is controversy over what methods of treatment are most helpful.

Major signs of autism

Several authorities have described the major signs of autism, and these signs are found in most autistic children.[1,2]

Autistic children do not relate to people in the usual way, beginning at birth or sometime before the age of two. They tend to be unresponsive and do not cuddle when being carried. They seldom make eye contact, do not seem to like being around others, and often treat people as objects.

Annette, a four-year-old on our unit, showed this indifference. She appeared to look right through us, and would walk into us if we were in her way. She appeared neither concerned nor happy when told it hurt.

Although these children neither relate to people nor appear to notice them, they sometimes *are* aware and will recall apparently unnoticed incidents. For example, Bobby, an eight-year-old blind boy on our unit, would curl up on the floor with only his back exposed to view, and did not seem to notice those around him. Months later, he recited the names of people with whom he had only brief contact and asked where they were. Staff and parents must keep this awareness in mind and refrain from discussing the autistic child as though he were not present.

Some autistic children have no speech, while others are able to talk, but seldom communicate verbally. When they do talk, their tone is wooden and not reinforced by gestures. Their speech lacks questions and is often echolalic. For example, the child will repeat, parrot-like, the question "Do you want a candy?" rather than answering it. Or he will suddenly say something completely out of the blue, such as, "He's been blind since birth." Many will repeat from memory lists of names, nursery rhymes, and songs. This may show intellectual potential, and will help to differentiate autism from simple retardation.

The autistic child's speech is also characterized by a lack of pronouns. He will say, for example, "Want candy," instead of "I want a candy." He reverses pronouns, when he does use them, and will say "Pick you up," for "Pick me up." His vocabulary lacks words: "Go walk" is used instead of "I want to go for a walk."

Another sign of autism is the child's obsessive need to have things the same. He may not want the furniture moved; he may not want to leave the house; he carries out certain rituals at special times. Young Annette would not start a meal without being told to do so. Until we said, "Eat your soup," she would look intently at us and repeat in a pressured tone, "Eat your soup," or whatever she wished us to say. Going home Friday and returning on Sunday upset her. Each Friday she handled this by taking her mother's purse to the playroom, muttering phrases as if she were her mother, and waiting there until her parents had talked to staff and were ready to go. All week she would repeat "Home Friday, hospital Sunday."

Although autistic children do not seem interested in people, they are often fascinated with objects and handle them skillfully. Sometimes this leads to a high level of excitement. For example, Jerry, age four, could spin almost any-

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TABLE A
Ways to Differentiate Autism From Organic or Genetic Difficulties

	Autism	Mental Retardation	Brain Dysfunction
Intellectual function	Usually functions below age level in all areas, but performance levels are inconsistent. May show potential in good memory.	Deficit levels are uniform and consistent — level depends on degree of of retardation.	Wide range, but generally normal potential.
Tests that help decide	Hard to test.	IQ test.	EEG, psychology, Ritalin.
Speech	Lack of speech, echolalia. Wooden, flat speech, pause in phrases and sentences.	Delayed development, degree depending on degree of retardation.	Normal for age — there may be articulation difficulties.
Motor Coordination	Usually good.	Poor in both gross and fine motor, related to degree of retardation.	Poor in both gross and fine motor.
Physical appearance	Healthy, often intelligent looking.	Physically underdeveloped, delayed mile-stones, such as walking.	Usually normal.
Perceptions	Often use only one sense for recognizing objects.	Impaired in severely retarded.	Higher sensory CNS functions, such as auditory discrimination, are affected.
Behavior	Withdrawn, ritualistic.	Normal to sluggish, depending on degree of retardation. Possibly aggressive outbursts.	Hyperactive, aggressive, low attention span. Responds well to medication, especially to the amphetamines.
Ego functions	Severely impaired. Lack of reality testing, preoccupied.	Fairly normal, but low frustration tolerance.	Low frustration tolerance.

thing — dice on their corners or flat discs on their edges — and would get many objects spinning at once. He watched them as if in a trance, jumping up and down and laughing and quivering with excitement.

Many autistic children will hold a small bright object in hand, and then rapidly flick their wrists back and forth, either staring in fascination or paying no attention. Often these children open and close doors endlessly, or turn the lights off and on.

There is some controversy about the autistic child's intellectual potential in some areas (for example, memory), while he is functioning below his age level in other areas. It is extremely difficult to assess his intellectual abilities because of his lack of speech or his unusual use of it, and his resistance to testing. However, these children usually have islands of intellectual ability, and if there is some meaningful speech by the age of five, they may be able to learn adequately in most areas. Even so, areas concerning people and communication tend to lag.

Other features

In addition to the major symptoms, we have seen other characteristic behavior in our autistic children. They often walk shoeless and on their toes, rock and twirl a great deal, use odd hand gestures, and enjoy rhythmic music. In addition, they frequently have sudden, unprovoked anxiety responses, and may appear frightened for no apparent reason. Their perceptions seem unusual. For example, the child may show no response to pain, but be very sensitive to sounds.

An all too common feature of autistic children is their habit of slapping, pinching, biting, or hurting themselves in some way. There are many theories about why they do this. Some psychiatrists believe the child is turning inward his anger and frustrations, and, having done this, discovers this behavior elicits a strong response from his environment. Others believe this self-abuse helps the child know where he "ends," and therefore may help him realize he exists.

Theories about autism

The autistic child seems to have difficulty from the beginning of life. Normally an infant is one with his environment, especially with his mother: she seems like part of him, and he, part of her. This continues until around six to nine months, when the child begins to become a person in his own right. However, autistic children seem unable to allow this very necessary first step of fusion.

What leads to this difficulty? There are various ideas. A widely-accepted theory is that the child has some genetic defect. This would play an important part in etiology, but would not rule out the importance of the environment. Generally, the parents of an autistic child are intelligent, obsessive, and emotionally cold. It should be remembered, however, that the autistic

child's unresponsiveness would affect even the warmest parents and lead to their emotional withdrawal.

When treating these children, some therapists (known as "learning theorists") are particularly concerned with the child's small repertoire of behaviors, much of which is maladaptive. Treatment programs attempt to increase new adaptive behavior such as speech with rewards, and decrease maladaptive behavior with punishment.

Nursing approaches

In caring for these children, we have attempted to adapt theories of development, learning, and interaction.

First, one nurse is assigned to the child to allow a caring, continuing relationship to develop. Naturally, others care for the child, but we attempt to keep the same people and limit the number of persons who come in close contact with him.

The nurse's first approach to the child is designed so each can get to know the other. To do this she has to find ways of communicating with him. This may involve imitating his sounds and actions; sharing anything he enjoys, such as tickling, and music; being with him; and commenting on his action. The approach has to be gentle, supportive, and patient, otherwise it may cause further withdrawal.

To satisfy the child's need for sameness and routine, we try to have a regular daily program so that changes become predictable, thus minimizing the child's anxiety. We may warn him a few minutes before an activity changes.

Because these children like to be alone, we allow this at certain times each day; gradually the time can be decreased. At first the autistic children do not tolerate other children near them, but gradually they can be in a room with others and will show interest in playing with another child.

If we are sensitive to the child's communications, we can discover what he needs most.

For example, when staff or children left the unit permanently, Bobby would talk about ambulances and fire engines. After a few months he started to void on the floor when this occurred. We realized he needed help to deal with his feelings of separation. We started by commenting, "You wet your pants." He would grin gleefully. "You must be pretty upset about something," we'd add. We did not push him to talk, but suggested, "I don't like it when my friends leave." A week later he said, "It's happy to say hello." We commented that we got sad and mad when people left us. "What do you do?" he asked. One nurse said, "Oh I might stamp my foot" (a common response of Bobby's), "or I might say I'm mad." Bobby then asked, "Do you swear?" Soon he was saying "Damn it!" and gradually got to "I don't want you to leave, it makes me sad." This change took a year.

Some autistic children react to stress by beginning or increasing enuresis, having physical complaints, or becoming resistant to everything by withdrawing. It is difficult to discover the source of stress, but if discovered and eased, symptoms often decrease. Bobby, for example, was being encouraged to learn new concepts, to run and jump, to talk in a normal voice that he seldom used, and to taste all food at meals. Talk and play about fire engines increased, he took longer to dress, spent an hour on the toilet (thus missing gym period) and was less spontaneous. We then decided that only his special nurses would encourage the food tasting and the use of his normal voice, but the other pressures would continue. This helped, and his progress resumed.

Besides setting up a relationship of caring and letting the child know it is safe and even fun to interact with others, we use a structured learning program. Our goals are to help the child learn new concepts, communicate meaningfully and spontaneously, and get used to sitting and working so his attention span will increase and he can adapt to a classroom setting.

We find it helpful to have half-hour school periods each day, the number depending on the child's stress tolerance and his other activities. At first we keep the child alone, but later may bring in another child to increase his ability to share and interact with his peers.

During these school periods, concepts of "yes-no," colors, shapes, numbers, body image, and "I-you" are learned, and the child has an opportunity to use his different senses.

Anne, a nine-year-old blind girl, used only her sense of hearing. We asked her to smell jars of jams, fruits, honey, and sugar, and to identify them. Then we asked her if she would like a taste, giving her a sample when she responded "yes." Her nurses encouraged her to use her new classroom learning on the ward. When she knew shapes and directions, we put her in a box-on-wheels, which had a triangle, circle, and square cut out of its sides. She was to identify the shape in front, in back, and on her left. A correct answer meant a ride; an incorrect answer meant she would have to try again or get another child to guess.

Our third approach involves working with the parents, especially the mother. We have found that early contact is helpful. On the child's admission to our unit, his nurse takes a home history to get information about him and a feeling about the parent-child relationship. We explain our program and routines and try to be open with them.

Parents often feel we are judging them, blaming them for their child's difficulties. Although they hope we can help, they often fear our success in reaching and handling their child, as it seems to confirm *their* incompetence. This feeling is often revealed when the parents concentrate on the physical care of their child. If he is messy, hair disheveled, has new scrapes and bruises, and looks sloppy, they feel we are not caring for him.

We explain that we believe in good hygiene and safety, but that it is also important for the child to play and try new activities. If the parents continue to worry about our care of the child, we have a meeting with them and encourage them to voice their feelings. This usually improves the nurse-parent relations and the child's progress.

Annette is an example of the importance of such a meeting. She was making progress in our terms, and was exerting her will, becoming resistive, and negativistic. Although she was expressing anger directly, she started to have temper tantrums and developed enuresis. Her parents were concerned that we had undone their accomplishments. Meeting with us, they expressed these feelings and stated they felt we were not concerned about the child's behavioral change. We explained why we saw the general trend as progress, and said we, too, were concerned about the bed wetting and were counting the number of times it occurred. The enuresis decreased drastically the next week. Perhaps the sense of cooperation eased the tension around Annette and she no longer needed to wet the bed.

Another difficulty parents voice is that, when their child shows progress, they feel replaced in his life and thus feel even more inadequate. To counteract this, we have them visit the ward for half days or for full days to observe, participate in the program, and plan the next steps with us. We emphasize they are the most important people in

the child's life, and that we can only help, not replace, them.

As yet, we have done little home visiting, but believe this would be helpful, as we could see their situation on their home territory and give continued support after the child returns home.

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Take a Child...

BY TERRY LYNN CARTER

Take a child, disturbed
Lost.
Hold him close
For he's very frightened
And his fear is twice his size.

Take a child, disturbed
Angry.
Hold him tight.
He has the right to his anger.
The world has hit him hard
Again and
Again
Beat him into the ground

And battered his body
With fists of hell
Show him it's O. K.
To want to hit back

Take a child, disturbed
Burning with madness.
Hold him secure.
Teach him to turn his hell
Outward
Not inward
To self-destruction.

Take a child, disturbed
Protect him.
Soothe his wounds.
Caress his scars.

Build on the tissue
That has been destroyed.
Teach him
That good exists
And although he has three strikes
Against him.
He's in
Not out.

Take a child, disturbed
Emotionally.
Grow him straight
Although he's bent.
Grow him tall
Although he's small.
Pick him up
When he falls
And make him try again.

Take a child, disturbed
And chart his course.
He has the right to live.
The right to dream.
The right to achieve.
The right to hate.
The right to love.

Take a child, disturbed
In so many ways.
Walk his hell
With him
In his world of black.
Show him what's wrong.
Show him what's right
And in the depth of his hell
In the depth of his night,
Your gift to him
Is a patch of light.

Winter isn't so very far away!

Before you head for the ski slopes . . . here are some safety rules to help lessen your chances of an accident. If you are an experienced skier, already aware of accident possibilities, the excitement of this winter sport is wide open. For the less experienced skier, these few tips by a nurse, who is a member of the Canadian Ski Patrol, can alert you to ski dangers.

Barbara Williams, B.Sc.N.

Author Barbara Williams and her husband pose before the first-day run. Warm clothing, and proper equipment checked for use, is a must for all skiers, they say.

Mrs Williams, a graduate of St. Joseph's Hospital School of Nursing, London, Ontario, and the University of Western Ontario, is presently Assistant Director of Woodstock General Hospital School of Nursing.

When a nurse expounds on the benefits of physical fitness to a patient, it would seem essential that the nurse is physically fit herself. I have found a sport that bolsters my physical fitness theory — skiing! This is one activity that quickly burns unwanted calories, heightens the color in your cheeks, strengthens muscles, and almost makes you wish winter lasted the year round. When you are in good physical condition, the chance of catching a cold is lessened, and you look what you feel — healthy!

For the nurse, this can mean less fatigue on ward duty.

You may assume you get adequate exercise stomping the wards — enough to prepare you for the ski slopes anyway. Not so! You should begin early in the fall to strengthen your arm, leg, and chest muscles, and to improve your general coordination. Ski exercises can be fun, especially when practiced in a group. From books and magazines, newspaper articles, or from your local ski store, you can find the best type of exercises for each set of muscles. If you faithfully maintain a good exercise program, you will ski better and for longer.

Proper equipment important

The type of ski equipment you use can add to or detract from your skiing enjoyment. A reputable sports store

When mechanical failure puts a chairlift out of service, the ski patroller lowers himself from the chairlift by using a self-evacuation kit. Skiers are evacuated by slides or other means of evacuation. These two illustrations were taken during a rescue demonstration, prior to the ski season opening.

can advise you on the ski that is best suited to your skiing ability. Whatever ski you choose, make sure it has a metal edge that can be repaired and sharpened easily.

of binding to have mounted on your ski, if the bindings are adjusted properly for your weight and type of skiing. They are made to release your foot easily from the ski when you fall, lessening the chances of breaking a leg. Release bindings should be checked for correct adjustment before the first run. This check is important. Bindings can be changed by vibrations, which occur when carried, or by overnight weather changes.

A satisfactory method of testing the binding release mechanism is to stand with a ski securely attached to a foot, and with the other foot, kick the side of the ski boot sharply, just behind the toe. Your toe binding should release.

To test the heel release, lean forward at a 45-degree angle with both skis on. If your heel releases are properly adjusted, they will not release at this angle unless you jump forward.

It is absolutely necessary to buy strong and preferably two-point safety straps that attach boot to ski. Otherwise there is nothing to prevent a ski from becoming detached, sliding downhill, and possibly injuring someone.

The proper type of clothing is also necessary if you are going to enjoy this sport. Long underwear is a must, preferably the kind that can absorb perspiration without remaining damp. A two-layer wool and cotton type is satisfactory. Two pairs of socks are best, but they must fit well. Socks should be worn under ski pants; if worn outside, they trap snow.

Ski pants are fashionable but expensive, and not necessary if you have pants that allow ample movement and shed the snow. On extremely cold days, it is a good idea to wear a shirt under your sweater, plus a warm, windproof jacket. Leather gloves, or mitts, keep your hands much warmer if they overlap the cuffs on your jacket, and it is wise to protect your ears from frostbite. With all this wearing apparel, you may think you are warm enough for skiing, but beware — the ride on the tow can be cold!

Start the day right

Limber up at the beginning of your ski day by climbing a hill several times. Be sure to keep to the sides of the hill, away from skiers. Although you may find the hill-climbing tiring until you become accustomed to the added exercise, you will feel warmer and relaxed.

Ski areas have a map showing which hills are best suited to the novice, intermediate, or expert skier. Before starting out, study this map to be sure you do not ski into an area you are unable to handle with confidence. But be honest with yourself. Do not consider that you are a better skier than you really are. It's much more fun to ski on a hill where you are relaxed and confident, rather than being overconfident, trying to ski on a hill that is beyond your scope. You will only become tense and nervous. If you think you are in a situation you cannot handle, ask a ski patroller for assistance. He is there for your safety and service.

You may have already discovered that it is more fun skiing with a companion. It is also safer! If you injure yourself, your partner can go for help or can assist you until a ski patroller arrives.

Learn basic rules

Ski lifts are a problem for some people. Unfortunately, bad lift accidents do occur. If you don't know how to use a lift, ask the operator for instructions, or ask a ski patroller to ride with you.

When you ride the lift your ski pole straps should be off your wrists and the poles held so they don't drag in the

Rescuing an accident victim and preparing him for transport downhill on a toboggan to an ambulance are other facets of ski patrol duties.

snow. Poles can get caught on chunks of snow or branches and pull you off the tow. Loose clothing can catch in the tow equipment, resulting in personal injury or damage to your equipment.

Sometimes skiers ski from the top to the bottom of the hill completely out of control. A skier can be held liable if he runs into another downhill skier, even if the other person is out of control. You must be able to turn and stop at all times.

If you find yourself in a situation you can't control, put your knees and skis together and sit down, leaning back and to one side. If you are relaxed when you fall, you won't hurt yourself or anyone else.

After you have fallen, remember to fill in any holes you have made in the snow. Another skier may not see this danger and get his skis caught in your "sitz mark," causing a serious fall.

If you find you are falling too often, you may need to take a coffee break and give yourself time to relax; or, you may need to take lessons from a qualified instructor. Statistics show that the chance of ski accidents are reduced by fifty percent when skiers take professional lessons. These may seem expensive, but the enjoyment you receive from skiing well is worth every cent. After all, professional instruction is less expensive than mending a broken leg. Most large resorts have ski-weeks, which include lessons at reduced cost.

Safety on the slopes

The Canadian Ski Patrol System, a national volunteer organization devoted to promoting safety in ski areas, gives first aid to accident victims, and tries to prevent accidents. Patrollers, who must be highly qualified in first aid, are assigned an area to ski two or three nights a week. They watch for people who may require assistance.

Most accidents treated by the ski patrol involve the legs, especially from the knee down. The majority of these accidents are caused by those who ski beyond their ability. The first thing a patroller does at an accident is to instruct the person to lie still while be examines him for injuries. Extra patrollers and a transport toboggan can be summoned by using whistle signals. The toboggan carries a supply of cardboard splints, which can be used to immobilize an injured limb. Patrollers carry packs containing triangular bandages, sterile pads, safety pins, scissors, tongue depressors, and various other items needed for an emergency. After the splint is secured with triangular bandages, the victim is transported by toboggan to a car or ambulance.

In areas serviced by chairlifts, patrollers are required to learn proper chairlift evacuation procedures. Some are taught to lower themselves from the chair, by using self-evacuation kit, then evacuate the skier by slides.

There are many more tips for better skiing. I have given only those that are essential. If you want to know more about the Canadian Ski Patrol, write to the Western Zone, Ontario Division, Box 242, Burlington, Ontario. If you live outside this division, your request will be forwarded to the proper address.

Even though the sight of snow-clad hills seems months away — it's never too early for those limbering-up exercises.

Try a few each day. One, two, three — bend and stretch.

The Canadian Nurse

50 The Driveway, Ottawa 4, Canada

Information for Authors

Manuscripts

The Canadian Nurse and *L'infirmière canadienne* welcome original manuscripts that pertain to nursing, nurses, or related subjects.

All solicited and unsolicited manuscripts are reviewed by the editorial staff before being accepted for publication. Criteria for selection include : originality; value of information to readers; and presentation. A manuscript accepted for publication in *The Canadian Nurse* is not necessarily accepted for publication in *L'infirmière Canadienne*.

The editors reserve the right to edit a manuscript that has been accepted for publication. Edited copy will be submitted to the author for approval prior to publication.

Procedure for Submission of Articles

Manuscript should be typed and double spaced on one side of the page only, leaving wide margins. Submit original copy of manuscript.

Style and Format

Manuscript length should be from 1,000 to 2,500 words. Insert short, descriptive titles to indicate divisions in the article. When drugs are mentioned, include generic and trade names. A biographical sketch of the author should accompany the article. Webster's 3rd International Dictionary and Webster's 7th College Dictionary are used as spelling references.

References, Footnotes, and Bibliography

References, footnotes, and bibliography should be limited to a reasonable number as determined by the content of the article. References to published sources should be numbered consecutively in the manuscript and listed at the end of the article. Information that cannot be presented in formal reference style should be worked into the text or referred to as a footnote.

Bibliography listings should be unnumbered and placed in alphabetical order. Space sometimes prohibits publishing bibliography, especially a long one. In this event, a note is added at the end of the article stating the bibliography is available on request to the editor.

For book references, list the author's full name, book title and edition, place of publication, publisher, year of publication, and pages consulted. For magazine references, list the author's full name, title of the article, title of magazine, volume, month, year, and pages consulted.

Photographs, Illustrations, Tables, and Charts

Photographs add interest to an article. Black and white glossy prints are welcome. The size of the photographs is unimportant, provided the details are clear. Each photo should be accompagnied by a full description, including identification of persons. The consent of persons photographed must be secured. Your own organization's form may be used or CNA forms are available on request.

Line drawings can be submitted in rough. If suitable, they will be redrawn by the journal's artist.

Tables and charts should be referred to in the text, but should be self-explanatory. Figures on charts and tables should be typed within pencil-ruled columns.

research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Miller, Kathleen Ruth. *A study in the use of role playing with a select population.* New Haven, Connecticut, 1970. Thesis (M.Sc.N. Yale University.

The purpose of this study was to demonstrate the use of role playing in assisting low income, female, post-hospital, mentally ill clinic patients to improve their functioning in everyday life. Participants were subjected to role playing or group discussion, or to no intervention by the researcher. The inconclusive results seen after comparing the functioning of the three groups were attributed to the small sample of patients and to insufficient exposure to the independant variables.

Although her belief that the role playing group would show the most improvement was borne out only to a limited extent. the author remains convinced that role playing is an effective, but little-used method by which nurses can treat large numbers of low income patients in a form that does not symbolize less status. An additional finding of the study was that professional nurses and low-income patients differed as to how they perceived the problem of daily living experienced by the patient group.

Pepler, Carolyn Joan. *Cognitive functioning of patients under stressors of impending and recent surgery.* Detroit, Mich., 1967. Thesis (M.S.N.) Wayne State University.

A field study was carried out to investigate changes in cognitive functioning shown by patients before and after surgery. The main hypothesis was that patients undergoing scheduled abdominal surgery would have their poorest cognitive functioning one day preoperatively, a moderate performance three days postoperatively, and their best performance one month postoperatively. The second hypothesis stated that patients in the higher mental ability group would show more variation in performance than those in the lower group. It was also hypothesized that, when compared with the lower mental ability group, the higher group would show more change in conceptual ability than in perceptual ability.

To test the hypotheses, one test of perceptual ability (Embedded Figures Test) and one test of conceptual ability (Word-Sorting Test) were given to 13 female patients the evening before abdominal surgery, three days postoperatively, and approximately one month postoperatively. Subjects were divided into two mental ability groups on the basis of performance on the Wonderlic Personnel Test.

Analysis of variance and a test of differences between pairs of means were shown to analyze the data. The hypothesis was not confirmed. Analysis showed that there was no significant difference between performances on the perceptual task in the three stressor situations. There was a significant decrement in ability in conceptual functioning on the third postoperative day, but there was no significant variation between the preoperative performance and the performance one month postoperatively. This was not the hypothesized pattern of change. Concerning the second and third hypothesis, the effect of interaction between mental ability and the stressor situations was not a significant source of variation.

Possible explanations as to the lack of support of the hypotheses include the combined effect of physiological and psychological stressors, different levels of motivation in the three testing situations, unanticipated stressors during the testing one month postoperatively, and the small population studied.

Riley, Marion Smith. *The effect of working conditions on nursing care in eight hospitals as perceived by general staff nurses and patients.* London 1970. Thesis (M.Sc.N.) U. of Western Ontario.

This study was undertaken to determine the areas of nursing care perceived as most satisfactory and those perceived as least satisfactory by general staff nurses and patients, and to determine their perceptions of the effects of working conditions on the provision of nursing care. Questionnaires were completed by 96 patients and 70 general staff nurses on medical and surgical units in eight general hospitals in southwestern Ontario.

A validated tool, developed by Dr. Faye Abdellah and Dr. Eugene Levine in 1956, was used to measure the patients' levels of satisfaction and dissatisfaction with nursing care, and an open-ended questionnaire was used to obtain the perceptions of the nurses.

The nurses perceived the physical aspects of nursing care and delegated medical tasks as the areas of nursing care being given most satisfactorily. They perceived emotional or psychological support of the patient, and patient teaching and rehabilitation, as the areas needing the most improvement. The highest levels of dissatisfaction among patients were in the categories of rest and relaxation, dietary needs, and contact with nurses. The areas of least dissatisfaction were personal hygiene and supportive care, reaction to therapy, and elimination.

Factors in the hospital environment perceived by the nurses as the most

helpful in the provision of nursing care were their working relationships with co-workers, with head nurses, and with physicians, and also the availability of adequate physical facilities. Factors perceived as a hindrance were insufficient staff, inadequate physical facilities, and some hospital policies.

The patients perceived inadequate physical facilities and the nurse not being available because she was too busy, as the major deterrents to satisfactory care.

Lindstrom, Myrna. *Nursing problems of the paraplegic patient as seen by the nurse.* Vancouver 1970. Thesis (M.Sc.N.) U. of British Columbia.

A body of nursing knowledge in rehabilitation cannot be attained until the specific problems nurses encounter in their work are identified. The purpose of this study was to identify some of the specific nursing problems in relation to the paraplegic.

This study included interviews with 17 nurses caring for paraplegics during the three stages of their rehabilitation: the acute stage; the time of intensive rehabilitation; and after returning to the community. A basically unstructured interview method was used, permitting the nurses a wide scope in identifying nursing problems they had encountered. The specific nursing problems were summarized within components of a typology developed during the study.

Sixty-eight different, specific nursing problems were identified a total of 247 times. Fourteen different specific nursing problems were within the component of the typology of psychological-emotional problems. The psychological-emotional problem identified most frequently, 12 times, was that of trying to help the paraplegic face the future as a disabled person. The largest percent of the total number of nursing problems identified, 35.22 percent, were within the component of the typology of physical problems. The three most frequently identified nursing problems were within this component. These were: maintaining the bowel and bladder function, 31 times; maintaining the integrity of the skin, 20 times; and being alert for complications, 16 times.

The largest number of different nursing problems, 30, and the greatest percent of the total number of nursing problems, 63.56 percent, concerned the paraplegic himself. Seventeen different nursing problems (19.84 percent of the total number of nursing problems identified) concerned the paraplegic's relationship to those outside of the health care system. There were 16 different nursing problems, (12.96 percent of the total number of nursing problems) concerned with the

research abstracts

paraplegic's relationship to the health care system. The remaining 3.64 percent of the total number of nursing problems, five different ones, concerned the paraplegic's inanimate surroundings.

Research should be done to discover the best way of solving the specific nursing problems identified in this study. Many of them are currently being dealt with by intuition or by trial and error; others are being ignored. It would be advisable to discover what identifiable needs or problems paraplegics have as they move through the various stages of the rehabilitation program. Nurses involved in helping the paraplegic accomplish his goals should be alert to what he regards as his problems and help him arrive at a satisfactory solution to them.

Taylor, Elizabeth Ann. *A study of selected factors affecting the communication process employed by general staff nurses in eight hospitals in referring patients with a long-term illness to the community setting.* Vancouver, 1970. Thesis (M.Sc.N.) U. of British Columbia.

This study was prompted by concern for the method of promoting continuity of care for persons discharged from hospital. Descriptive in design, the purpose of the study was to examine selected factors affecting the communication process employed between general staff nurses in hospitals and personnel in community agencies with regard to the referral of patients with a long-term illness from the hospital to the community setting.

The data were gathered by means of a self-administered questionnaire, designed to seek information related to each of the study's three hypotheses. It was completed by 57 general staff nurses on selected nursing units of eight general hospitals in and near Vancouver, British Columbia. The units were chosen on the basis of the average number of patients with a long-term illness usually present in the unit.

From analysis of the data the following conclusions were drawn. Although general staff nurses who participated in this study could recognize needs in patients which indicate the necessity for referral to community resources, they did not appear to have an adequate knowledge of available community agencies. When these nurses made referrals, the lines of communication used were frequently indirect.

books

You Are Barbara Jordan. 72 pages. Hospital Research and Educational Trust, 840 North Lake Shore Drive, Chicago, Illinois, 60611, 1970.

The in-basket exercise *You Are Barbara Jordan,* a unique training program for developing administrative knowledge and skills in nurses, was prepared to provide an actual learning experience to help nurses recognize the need to establish priorities; evaluate their ability to delegate authority; practice reading and writing communications; perceive relationships between problem situations; develop sensitivity to attitudes of co-workers; and analyze the factors that affect the decision-making process.

Participants in the program play the role of Barbara Jordan, director of nursing in a 205-bed, short-term general hospital. They must appraise and act on 24 items of written communications, ranging from routine to emergency, which are in Barbara Jordan's in-basket.

The *You Are Barbara Jordan* exercise was tested with nursing supervisors in a hospital setting, with directors of nursing at an American Hospital Association institute, and with students at the department of nursing education, Teachers College, Columbia University.

Materials for each participant are in a workbook that contains background information on Barbara Jordan's hospital and her department, and 24 tear-out messages that she must answer. A 9" x 12" cardboard in-basket is packaged with the workbook to give realism to the teaching. An instructor's guide explains how to conduct the simulation exercise and gives suggestions for leading follow-up discussions.

Cardio-Vascular Surgery for Nurses and Students by W.H. Bain and J. K. Watt. 174 pages. London, E. & S. Livingstone. Canadian distributor: The Macmillan Co. of Canada, Ltd., Toronto, 1970.
Reviewed by J. David, Supervisor, Surgical Services, The Vancouver General Hospital, Vancouver, B.C.

The authors have explained in simple terms the basic knowledge and techniques of cardiovascular surgery. Comprised of 20 chapters, the first 9 deal with the heart. Following a brief review of the normal anatomy and psysiology of the heart, the hemodynamic consequences of heart disease are explained, along with the presenting signs and symptoms.

An explanation of techniques used in cardiac surgery encompasses the closed and open heart surgical methods. A description of the lesion and the surgical treatment is clearly outlined for: 1. chronic rheumatic disease of the heart valves; 2. congenital defects; and 3. occlusive disease of the coronary arteries.

The chapter on postoperative care deals primarily with the procedural responsibilities of the nursing team in the immediate care of the patient who has undergone cardiac surgery. Steps to be followed in the preliminary preparation of the care area are followed by an ordered description of the procedures to be undertaken when the patient is admitted to the area. Vital functions are clearly outlined with specific reference to changes that can occur and the significance of these changes.

The latter portion of the book gives a comprehensive coverage of peripheral-vascular disease and related surgical treatment.

The format for the remaining chapters is similar, covering the artery or system of arteries affected by disease; investigative techniques; preoperative management of the patient; operative steps; postoperative care; complications; and the final results of surgery. The use of anatomical sketches, diagrams, and photographs throughout the book assist the authors in presenting a clear, concise picture of the cardiovascular system, and make the corrective surgical techniques meaningful.

This book would be a useful adjunct to the library of those wishing to acquire a basic knowledge of the techniques of cardiovascular surgery, and for the staff nurse who wished to expand her knowledge in this particular branch of surgery. Although brief mention is made of the patients' psychological needs, the reader should not expect to find guidance for a comprehensive approach to nursing the cardiovascular patient. More detail in the table of contents would have been helpful.

Contemporary Nursing Practice; A guide for the returning nurse by Signe Skott Cooper. 348 pages. Scarborough, Ont., McGraw-Hill Company of Canada Ltd., 1970.
Reviewed by D. O'Donovan, Head Nurse, Pediatric Unit, Western Memorial Hospital, Corner Brook, Newfoundland.

This book meets its objective, and should be of interest to nurses hoping to return to active practice. Also, it would be an excellent review for all nurses, especially for those working in specialized areas, whose thoughts and reading may be limited to the latest developments in their own area of interest.

The author's approach to the subject shows an understanding of the needs of both the returning nurses and the active, 1970-oriented nurses. In her first chapter, she issues a wise warning: "It is imperative that the returning nurse keep an open mind and avoid saying, "That's not the way I was taught..."

books

Divided into four sections and 19 chapters, the text is clearly presented and well illustrated. Each chapter concludes with references and suggested activities.

The topics include: hospital facilities; community resources; current health problems, including drug addiction; and responsibilities and opportunities for the professional nurse. There is a good chapter on the legal aspects of nursing.

In summary, this book would be a useful addition to any nursing library, and should prove valuable to nurses involved in planning refresher courses.

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

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BOOKS AND DOCUMENTS

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15. *Manual of clinical laboratory procedures* 2d. ed. edited by Willard R. Faulkner and John W. King. Cleveland, Ohio, Chemical Rubber Co., 1970. 354p.
16. *Matters of life and death* by Francis Camps et al. London, Darton, Longman & Todd, 1970. 60p.
17. *New methods in nursing service administration and nursing education* selected

CREIGHTON:

Law Every Nurse Should Know 2nd Edition

By Helen Creighton, R.N., B.S.N., A.B., A.M., M.S.N., J.D.

Here are the legal facts that every nurse should know. Written by a nurse who is also a lawyer, this book covers every aspect of the law that is important to the nurse, from her obligations as an employee to her responsibilities in witnessing a will. The first edition became a standard reference and helped thousands of nurses avoid legal entanglements. This new edition is substantially larger, including such topics as "good samaritan" laws, child abuse, telephone orders, sterilization, and organ transplantation.

246 pages. $8.10. Published June 1970.

COLE:

The Doctor's Shorthand

By Frank Cole, M.D.

This new manual is a handy guide to medical abbreviations, notations, and symbols. Nurses will find it indispensable in reading medical records and orders. Nearly 6,000 entries are included; a special section depicts and defines symbols used in medicine.

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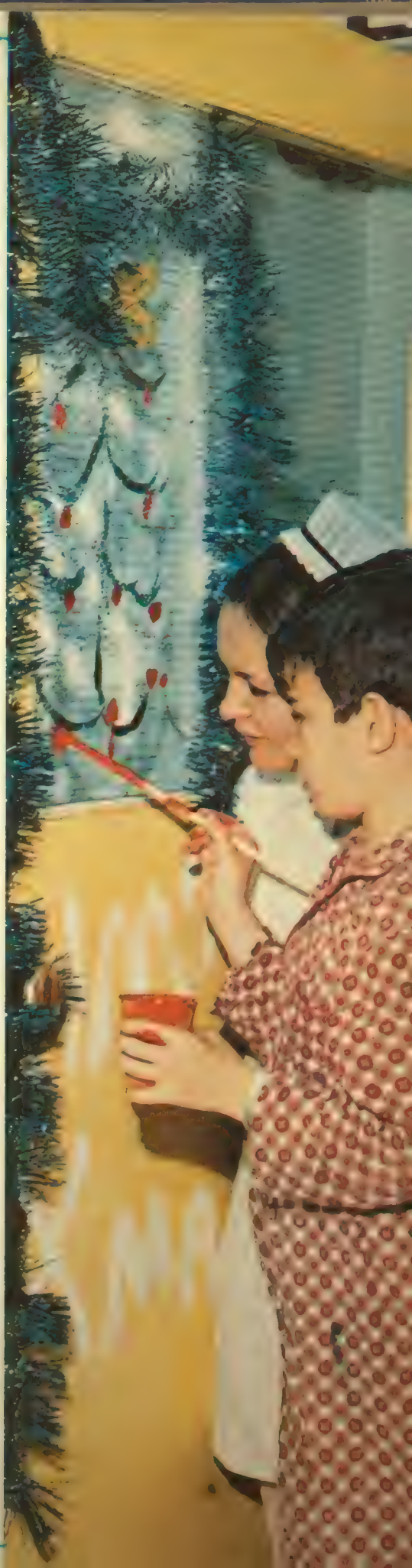

students have a right to make mistakes

monitoring the mother and fetus during labor

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The Canadian Nurse

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Volume 66, Number 12 December 1970

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Cover photo by Julien LeBourdais, Toronto, taken at The Hospital for Sick Children in Toronto. Nurse Karen Toppings and patient Bill McBride help to bring the Christmas spirit to the pediatric unit.

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a wish for peace at this holy season

From the editorial staff

letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Defends nursing orderlies

As a nursing orderly student, I read with interest your September editorial comparing nursing orderlies with nursing assistants. I believe this is an unjust comparison, and that it is your duty to find out what is being done to correct the conditions you mentioned and tell your readers this, too.

Our nursing orderly school requires Grade 10 for entrance, accepts persons from 18 to 55 years of age, and offers a 30-week program. A graduate is able to change dressings, report observations to registered nurses on changes in a patient's condition, and chart. A trained orderly can give the same care as a nursing assistant, and, in addition, is required to lift patients for the nursing assistant. A good nursing orderly deserves the slightly extra salary he now receives.

Anyone interested in information about our training program could write to: Nursing Orderly School, 10006-107 St., Edmonton, Alberta. — *Ronald Colp, Edmonton, Alberta.*

Reaction to abortion comments

The August 1970 editorial stated "that abortion should be a matter that concerns only the patient and her doctor..." It also expressed regret that the Canadian Nurses' Association was not the first health profession to advocate legalizing abortions.

Some would have us believe that life is not present from the moment of conception. If this is so, how can the fertilized ovum develop into an embryo, then a fetus, and finally a baby? There can be no growth or development without life.

How can abortion be a matter that concerns only the patient and her doctor? Abortion is the deliberate killing of a living, though unborn child, and is therefore murder. All life is sacred and must be protected or no life will be safe. Remember Dachau and Buchenwald? Do not say it could not happen here. Abortion is only the beginning.

Nurses should be dedicated to preserving life, not destroying it. I hope the Canadian Nurses' Association will never take the stand advocated in this editorial. Rather, our association should be protecting its members by demanding that nurses be given the right to refuse to assist in abortion cases. This right should be written into the contract with hospital management.

There must be hundreds of genuinely concerned nurses in Canada with true Christian principles. Let us hear from them. — *M. Smith, R.N., Vancouver, B.C.*

In reply to the letter, "Comments on abortion" (Oct. 1970), it is a shame that nursing is a profession in which the members think they are in a position to moralize and pass judgment on others.

Abortion, in my opinion, is a private matter between doctor and patient. Bringing an unwanted baby into this overpopulated world is a crime. In this advanced society we are indeed backward when we deny people a simple operation that can prevent a life of misery for an individual who was a "mistake." A family or individual life can be ruined because a woman was unfortunate to become pregnant and was unable to afford an abortion under the old law. — *R.N., Victoria, British Columbia.*

I was most disturbed by one reader's views on abortion (Letters to the Editor, Oct. 1970).

The statement, "We must accept the consequences of what we do . . . such as venereal disease or pregnancy" sounds to me like making a value judgment on the situation in which the patient finds herself. If we refuse abortion to a woman, we should also refuse to treat a woman injured in an auto accident that was her fault, because by this reasoning, she must accept the consequences of her actions. This stand seems punitive.

We may "not know when a fertilized ovum becomes a person." This question is not to be dismissed lightly. However, as nurses we must be aware of patients' needs and how best to meet them. If an unwanted pregnancy takes its course, the needs of neither the mother nor baby can be fulfilled.

Let the champions of the unborn fetus' rights state how the unwanted child will be saved from neglect, abuse, and indescribable hardships. Let us get away from lofty statements like "human life is sacred." What about the *quality* of that life?

I sincerely hope the Canadian Nurses' Association takes a stand in favor of abortion as a matter between a woman and her physician. If we are to regard ourselves as belonging to a progressive organization, there is no other choice. — *Catherine Melnitzer, Toronto, Ontario.*

Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

Expanding role of nurse

Caps off to Mrs. Rosemary Coombs for her excellent article, "Active-Care Hospital Nurse Expands Her Role" (Oct. 1970). I have read nothing in any nursing journal more pertinent to the restructuring of present-day nursing service on a more effective clinical basis.

The question that arises as a positive reaction to the article is: how many of us are ready and willing to put forth the individual effort to prove ourselves nurses in the interests of the most efficient and economical provision of nursing care?

One may quibble with the four categories of clinical nurse outlined in this article. Perhaps such a concentration of specialized nursing care is possible only in the largest active-treatment hospitals where the administration is inclined to direct all the effort and means at its disposal toward its immediate purpose — care of the sick. These categories, however, provide a starting point for discussing realignment of all nursing personnel in a new framework of clinical activities.

It is encouraging to see that the registered nursing assistant, who has a contribution to make in the care of patients not requiring complex care, has not been omitted from the nurse category. What better way is there to utilize these workers than to define and limit their work to the patient classification they are prepared to nurse, thus relieving registered nurses for more intensive duties in the clinical specialties.

Mrs. Coombs is right to suggest that expanding the nurse's role into a

clinical specialist is one answer to the doctor assistant proposal. For years the best nurses have often been the eyes and ears of the doctor in diagnosis and treatment. A new category of worker could easily widen the nurse-patient gap. Any rational step that will help keep nurses in contact with patients reduces the likelihood of someone or something filling the vacuum.

The constant improvement of patient care implies readiness to change in accordance with the indications for change in our health delivery systems. By expanding or extending the hospital nurse's role in the clinical specialties where experience and abilities can be properly utilized for patients requiring intensive care, and eliminating non-nursing functions, we will make a progressive move toward a truly professional service.

We should thank Mrs. Coombs for showing us a way that Canadian nurses can realize this goal and expand our clinical horizon in the right direction. — *Albert W. Wedgery, Reg. N., M.A.*

Although I agree wholeheartedly with the principle of clinical expertise in nursing, the editorial in the October 1970 issue puzzles me. I carefully read the article "Active-Care Hospital Nurse Expands Her Role" and I do not see the experts referred to in this article as substitutes for doctors' assistants.

In discussing physicians' aides, we are talking about people fulfilling more of a field role, which involves making diagnoses, prescribing treatment, delivering babies, and so on, in all areas where a physician is unavailable. If nurses are reluctant to accept this kind of role, or if the law is unwilling to permit them to accept it, there is no alternative.

We have two choices. We can press for legislation and subsequently educational programs to obtain from the best of our own ranks people willing to fill a role that involves diagnosis and treatment, with all the implications. The success of nurse-midwives in almost all commonwealth countries except our own, and of nurse-anesthetists in the United States, shows that this is safe and in keeping with the legitimate functions of nursing.

Our second choice is to watch a second category of health worker emerge. If we are true professionals, we will welcome this person and not feel threatened by him. Our vanity will have to be replaced by recognizing that with the present shortage of doctors, a new team member is needed. Professional pride is fine, but it must never come before the all-important consideration of the right of every person to have comprehensive health care. If we abdicate this role, we must be prepared for the arrival of someone who will accept it.

We must always remember that our colleagues, the doctors, are only now approaching a matter that we are well on the way to solving: overwork and proper utilization of staff. Our problem was solved by nursing assistants, a worthy group of people who, under direction, perform many aspects of care once left to us. Surely the doctors cannot be denied the same kind of help. — *Sandra Klyne, R.N., Montreal.*

RNABC president replies

As someone who was actively involved in the organized attempts of the Registered Nurses' Association of British Columbia to help the two nurses referred to in the letter "Timely and revealing" (Oct. 1970), I feel bound to comment on this letter.

The RNABC set up a committee to look into the situation referred to. (See "Negligence in the recovery room," July 1970, *The Canadian Nurse).* The outcome of the review was that no nurse was condemned by the RNABC, no license was withdrawn, and no reprimands given. However, we were not meeting to challenge the decision of the court, as we cannot do that. What was published was the court's decision, not ours.

This committee, I believe, recognized that head nurses, supervisors, and nursing administrators are all involved and responsible for staffing during break periods. Staff nurses are also responsible to see that their tasks are adequately delegated when they leave patients for coffee breaks, for they too are considered professional people and are increasingly being held responsible for their own actions. If they are to be considered professional, they should be.

The action that the RNABC took regarding individual nurses in this case was to counsel and advise them. Further, recognizing there were implications for all our members arising from this judgment, the committee recommended that several statements about the position of the registered nurse with respect to the law, and to the chart as a legal document, be published and brought to the attention of all members. This was done through the *RNABC News.*

The most important implication, that of adequately staffing hospitals in increasingly tight budget situations, is not within the jurisdiction of the RNABC. Repeated attempts have been made, however, to inform the responsible authorities that in the opinion of the association, the level of nursing care in British Columbia hospitals is becoming unsafe. — *Monica D. Angus, President, RNABC.*

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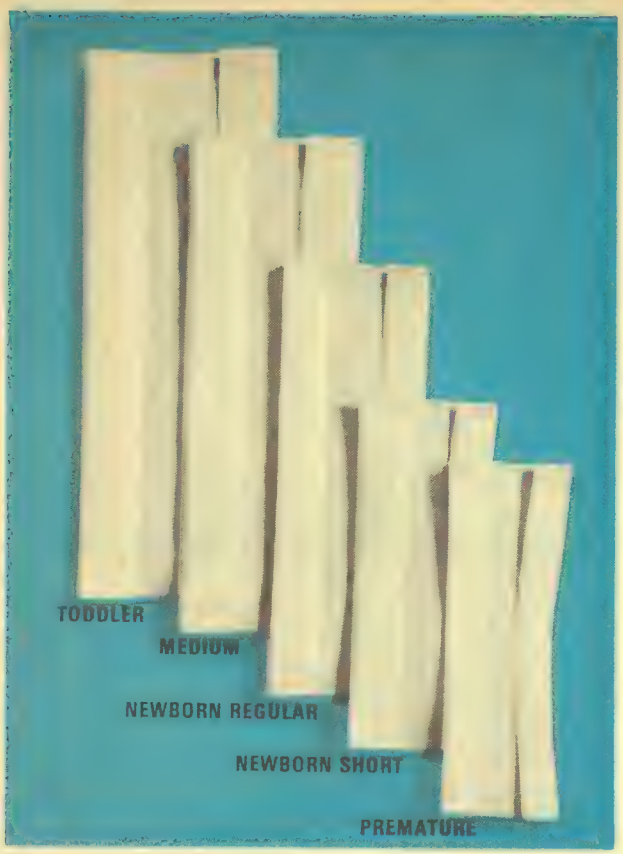
*the basic CCU course, "Intensive Coronary Care — A Manual for Nurses" (Meltzer, Pinneo, Kitchell), expanded and brought up to date.



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Committee On Nursing Research To Be Established By CNA

Ottawa — The Canadian Nurses' Association will set up a special committee on nursing research as soon as possible. This decision, made by the CNA board of directors at its meeting October 7-9, was based on a recommendation of the CNA ad hoc committee on research, which presented its report to the board in June, 1970.

As approved by the board, the composition of this special committee will be: a member appointed by each provincial association; the principal nursing officer, department of national health and welfare; the director of CNA research and advisory services; and the president of CNA (ex officio). The chairman will be elected from among the members.

CNA board members questioned the need to have a representative from each provincial association, saying the primary objective was to have a committee composed of persons with expert knowledge of research methods and an interest in the development of research programs. The board then approved a motion stating that each provincial association could decide whether or not to appoint a member.

The board accepted the ad hoc committee's recommendation "that the complete statement of policy with respect to nursing research be adopted by CNA." This statement of policy is that CNA's role in relation to research be: 1. to provide a comprehensive picture of the profession; 2. to encourage and influence the research activities of individual practitioners and of education and service agencies; and 3. to serve as spokesman for the profession in relation to research in health services.

The ad hoc committee on research recommended that CNA initiate discussions with the Canadian Conference of University Schools of Nursing and the department of national health and welfare on the relative areas of responsibility of CNA, CCUSN, and DNHW for research in the field of nursing. This was also accepted by the CNA board.

One of the ad hoc committee's recommendations, that CNA "accord high priority to the need to allocate funds for research, including $100,000 per year to prepare nurses with the qualifications necessary to participate in and direct research projects," was amended by the CNA board. The amended recommendation now reads: "That the association accord high priority to the need to locate funds to prepare nurses with the qualifications to participate in and direct research projects in nursing." Although board members agreed with the intent of the ad hoc committee's recommendation, they believed that other means of funding for research should be investigated before specifying any set amount of money.

Members of the CNA board agreed that the special committee on research, which will report its progress to the CNA board, could meet up to three times a year if necessary.

CNA Board Of Directors Accepts Second Ad Hoc Committee Report

Ottawa — Salary increments and the physician's assistant sparked a lively dialogue at the Canadian Nurses' Association board of directors meeting October 7-9 when the second report of the CNA ad hoc committee on Task Force Reports on the Cost of Health Services in Canada was presented to and approved by the board.

The ad hoc committee had studied in depth recommendations having implications for nursing, and had accepted all but four of them. They had rejected three and had commented on one that had been insufficiently clearly stated for a decision to be made.

Discussion at the board meeting centered on the task force recommendations and on the ad hoc committee's decisions, quoted below:

Recommendation 35 (volume 2, page 160 Task Force Reports): "That the annual salary increment programs for health service workers based solely on time in employment, be phased out," was rejected.

Recommendation 36 (volume 2, page 160): "That criteria for salary administration in the health services be developed on the basis of levels of responsibility and professional or technological proficiency required, that salary scales be developed according to such levels, and that progression within established salary ranges be based on improvement in performance rather than on length of time in service," was accepted with the following comments: "The first idea in this recommendation is good, however, the idea about merit rating is unacceptable at this time for the reasons given for Recommendation 35 of this Task Force."

Basically, those reasons are: "... that until the majority of nursing service administrators are prepared through educational programs and experience for the position of management of the nursing service department *(Recommendation 20, page 84, volume 2,)* or are replaced with a qualified person; until objective standards for nursing care have been established; until a method of measuring the quality of nursing care has been developed; until criteria for measuring the productivity of individual nursing personnel has been established; until job standards for each position in nursing service departments are clearly outlined; until nursing service departments have the staff capable of assessing personnel accurately and objectively (evaluation as good as evaluator); support of the principle of merit rating in salary administration as applied to nurses is premature, and would be detrimental to collective bargaining programs in each province of Canada. Improved personnel policies are desirable, but should be achieved through collective bargaining for all those nurses eligible and have the right to collective bargaining."

Recommendation 28 (volume 3, page 63): "That promising proposals for more effective employment of allied health personnel in the delivery of medical care be evaluated using well designed demonstration projects" was accepted without comment.

Recommendation 29 (volume 3, page 63): "That a project be funded under the National Health Grants to train at least a pilot class of 'practitioner-associates' in a university teaching unit under medical direction and to evaluate their utilization" was rejected "because it is premature until demonstration projects in relation to recommendation 28 (above) are conducted and evaluated."

Recommendation 93 (volume 3, page 383): "That further study in the use of physician-associates is required and that such study should take into consideration the relationship between

family physicians and public health" was accepted "on the assumption that it is complementary to and not independent of recommendation 28, (above)."

The summary statement of the comprehensive report to the minister of national health and welfare will appear in the January issue of *The Canadian Nurse*.

CNA Librarian At Meeting Of Interagency Council On Library Resources

New York, N.Y. — Margaret L. Parkin, librarian at the Canadian Nurses' Association, chaired the October 2 meeting of the Interagency Council on Library Resources for Nursing. The council, which meets in New York twice annually, works to promote better library resources for nursing and to provide nurses with improved library services by all health science libraries.

At the October meeting, the council's name was changed from the "Interagency Council On Library Tools for Nursing." Miss Parkin told *The Canadian Nurse* the name was changed because the council is now looking at library resources for nurses in a much wider way. "The ideal is to have the nursing library as part of a health sciences center. This gives each discipline a much broader outlook," the CNA librarian said.

The council appointed a committee to update the publication *Guide For the Development of Libraries in Schools of Nursing* by the National League For Nursing. This publication, Miss Parkin pointed out, is used all over Canada.

CNA is the only non-American agency on the council, which next meets in March 1971.

CNA Submits Proposals For Tax Reform To Minister Of Finance

Ottawa — The Canadian Nurse's Association has acted on a resolution passed by delegates at the association's general meeting in Fredericton June 14-19 that CNA make a presentation to the minister of finance. This presentation was to include a recommendation that the minister, in his deliberations on the White Paper Proposals for Tax Reform, consider including as deductible expenses, money married nurses spend to care for children or other dependents while they practice nursing.

In a 10-page submission to the minister, CNA noted that the present tax structure "lacks incentives to enable nurses to make provisions from after-tax salaries for the care of dependents while they are working," and discourages married women from remaining in, or re-entering the work force. The submission stated that adequate inducements would mean that the large numbers of nurses in Canada who are not active in the profession could be practicing, which in turn would alleviate many alleged nursing shortage problems. Also pointed out were CNA statistics that 84 percent of nurses working part-time are married, and 84 percent of registered nurses not nursing are married.

CNA also recommended that revisions in the Income Tax Act be made to permit single women to deduct housekeeping expenses from taxable income.

In its conclusion, CNA said that a modernized tax structure, which recognizes the role of the married woman in the work force and permits, as tax deductions, expenses incurred in the care of family dependents, would free them to engage in useful or essential work in the Canadian work force and would provide beneficial effects in the field of national health.

Margaret Myles Demonstrates Art of Midwifery To Nurses Of The North

Margaret Myles, author of *A Textbook for Midwives,* is above all a teacher, her subject — midwifery. Here she demonstrates delivery in a case of vertex presentation to outpost nurses gathered at Whitehorse, one of her many points of call during her recent visit to Canada. With Mrs. Myles are, *left to right,* Alice Letitia Hodges (Gjoa Haven), Muriel Jane McKenzie (Fort Simpson), Sister Charlotte (Fort Providence) and Ruth E. Sutherland (Cambridge Bay).

International Nursing Index Loses Canadian Subscriptions

Washington, D.C. — The International Nursing Index Editorial Advisory Committee held its annual meeting October 30 at the National Library of Medicine in Bethesda, Maryland. The INI is the nursing equivalent of Index Medicus, the classic index for medical sciences.

Librarian of the Canadian Nurses' Association, Margaret L. Parkin, attended the meeting on behalf of the CNA executive director. CNA is particularly interested in this periodical nursing index, Miss Parkin says, because it is the only nursing index that gives access to French-language literature.

As Canadian subscriptions to INI have always been the largest proportion of foreign subscriptions, Miss Parkin was "distressed to find the number of Canadian subscriptions has dropped from 103 to 86." She sees this decrease as a reflection of the move from hospital schools of nursing to community and technical colleges. These new colleges have not yet picked up the subscriptions, Miss Parkin explained to *The Canadian Nurse*.

A French-language subject heading guide was prepared for INI to assist French-language users. To date, only

four copies have been requested from the American Journal of Nursing Company, Miss Parkin said.

The meeting of the Editorial Advisory Committee was held at the National Library of Medicine so the members could see the library's facilities, particularly the MEDLARS machine indexing and retrieval system.

CNA Librarian Consults With Nursing Library Staffs

Ottawa — More and more schools of nursing are asking the librarian at the Canadian Nurses' Association for help or suggestions concerning their libraries. And as far as CNA librarian Margaret L. Parkin is concerned, the more requests the better. As she sees it, an important part of her job is to provide advice on library resources for nursing.

Miss Parkin was invited to Edmonton October 13 and 14 to consult with the school of nursing at the University of Alberta. She told *The Canadian Nurse* the library resources at this school of nursing were interesting to see, as they are combined with the overall health sciences. "This is the optimum situation for a nursing library." said Miss Parkin.

During her visit at the University of Alberta, the CNA librarian spent time with the faculty at the school of nursing and the medical librarian. A library committee has been formed, she said, consisting of nursing faculty and the medical librarian.

Nurses Seek Comfort, Style

These head nurses at Toronto's Wellesley Hospital have introduced what is now optional dress for the nursing staff. Joyce Pember *(left)*, Eileen Ryan *(center)*, and Florence Smart *(right)*, show off their new dacron and cotton pantsuits, which they say are ideally suited for bending, stretching, and climbing. Also taken into consideration was that "they're new and in fashion." Many other nurses at the hospital are panting to follow suit, we understand.

Public Health Nurses Strike In Scarborough

Toronto, Ont.— Following the breakdown of contract negotiations between the Nurses' Association of the Scarborough Health Department and the borough of Scarborough early in October, the 65 public health nurses working for the health department voted unanimously to strike on October 16. The Scarborough Health Department has been greylisted by the Registered Nurses' Association of Ontario.

According to the nurses' association, the strike occurred because conciliation processes failed and the council of the borough of Scarborough refused to accept the nurses' offer to be bound by voluntary arbitration.

Salary is not involved in the dispute. The nurses' demands center around car allowance, vacations, posting of vacancies, and hours of work, which the employer has said are non-negotiable. The offer made to the nurses in July, which gave them a 10 percent salary increase this year, an eight percent increase next year, 75 percent of medical benefits paid this year, and 100 percent paid next year, was made on condition that the nurses drop all other proposals.

Behind the issue of car allowance is the fact that ownership of a car has been a condition of employment. Nurses must carry business insurance if they use their car for work. They receive 15 cents a mile up to 2,000 miles per year. Approximately half the nurses drive less than 2,000 miles per year, the nurses' association says. The nurses, arguing that allowable expenses for mileage *only* do not begin to pay the cost of keeping a car, are asking for a flat rate based on the cost of maintaining a car.

The Scarborough nurses, who receive a four-week vacation after 20 years' service and three weeks after one year, want four weeks' vacation after working one year. The majority of public health nurses in Ontario receive four weeks after one year, the nurses' association says.

Also demanded is the right that the nurses be notified by the employer when vacancies occur in any area of the health department. As well, the nurses want starting and stopping hours of work to be stated in the contract; they want the employer to state that these are day-time hours so any scheduling that involves work after 5:00 P.M. will bring overtime or shift differential pay.

RNAO Replies To Ontario Report On The Healing Arts

Toronto, Ont.—In its brief to the Ontario minister of health, submitted in July in reply to recommendations of the Report of the Committee on the Healing Arts, the Registered Nurses' Association of Ontario noted that "many areas. . . require joint consultation with other groups concerned with the delivery of health care in the province."

For this reason RNAO asked the government to postpone action on the recommendations until December 31, 1970. The Ontario government received the report from the three-man committee April 28 after nearly four years of study.

The brief outlined the RNAO position on the report's recommendations on nursing, contained in a chapter that discussed the role of nurses, conditions of work, relations of registered nurses with other groups, manpower considerations, nursing education, regulation of nursing, and psychiatric nursing.

One recommendation by the Committee on the Healing Arts was that "an attempt be made by the disciplines concerned and the department of health to develop a nurse-midwife in Ontario . . .regarded as a clinical specialist in nursing. The committee foresees that nurse-midwives would work in the hospital setting under the general direction of physicians but might in addition undertake pre-natal and post-natal care in outpatient clinics and group practices."

In reply to the nurse-midwife proposal, the RNAO said it did not have a policy, but was studying this recommendation from a nursing point of view and would be pleased to meet with other groups to discuss implications of implementing the recommendation.

The RNAO supported a recommendation that "Ontario enact appropriate legislation to facilitate collective bargaining for nurses, ensuring. . .safe-

guards to maintain essential services and that the legislation also provides for compulsory arbitration of disputes. Such legislation should not specifically designate any agency as the exclusive bargaining agent for nurses but should be broad enough to encompass the Registered Nurses' Association of Ontario which might act as the bargaining agent when requested by the majority of nurses employed in a given bargaining unit."

But the RNAO also questioned this proposal on bargaining. The association asked, "Is it the intent of this recommendation that such legislation would provide collective bargaining rights for all nurses — i.e., nurses in 'management positions' as well as those who are considered 'employees'? Is recourse to compulsory arbitration as the means of settling a dispute if negotiations break down, to be available to all nurses in collective bargaining units, not just those in hospitals?"

Two recommendations on which the RNAO withheld comment concerned the College of Nurses of Ontario. One of the Committee's recommendations was that the College "remain the certifying and regulatory body for registered nurses in Ontario, but that there be representation from the department of health and significant lay representation on the board of the College." RNAO said it would first like the phrase "significant lay representation" clarified, and wanted to know how such representation would be chosen.

Replying to the recommendation that "responsibility for the certification and discipline of registered nursing assistants be removed from the College of Nurses and assigned to the proposed Health Disciplines Regulation Board through a division for registered nursing assistants," RNAO said it would discuss this with the College of Nurses of Ontario and the Ontario Association of Registered Nursing Assistants.

MARN Centennial Workshop On The Wagon

Winnipeg, Man. — During the spring and fall of 1970, the Manitoba Association of Registered Nurses, as part of its celebration of the province's centennial, has sent its Centennial Workshop Wagon program to all parts of the province.

Workshop Wagon teams, made up of different people from time to time, met with nurses to discuss problems of mutual interest and to give advice and assistance where possible. Schools and hospitals were visited, and community programs were organized in some communities. In Portage La Prairie the mayor proclaimed a "MARN Week" and attended a public meeting arranged for the workshop group.

The MARN Centennial Workshop Wagon was received enthusiastically by nurses throughout the province, including these nurses at St. Boniface General Hospital. Standing beside the Centennial Wagon are, *left to right*, E. Aucoin, M. Cloutier, L. Arnal, E. Jacques, P. Martel, Sr. A.M. LeFebvre, Sr. I. Pepin, and L. Jutras. The workshop program was held in schools and hospitals in numerous communities throughout Manitoba during the spring and fall of 1970.

This workshop project, which was financed by commissions from the sale of centennial sweepstake tickets — a promotion undertaken by the Manitoba Centennial Corporation — created so much interest that plans are underway to continue the visits.

Three Schools Of Nursing Get Together For Workshop On Nursing Care Planning

Barrie, Ont. — In September, a three-day Workshop on Nursing Care Planning, with some 100 nurses participating, was held at Soldiers' Memorial Hospital School of Nursing in Orillia, Ontario. The nurses were from nursing service and education at the Royal Victoria Regional School in Barrie, the Owen Sound Regional School, Owen Sound, and Soldiers' Memorial Hospital School.

Doris Carnevalli, associate professor in the school of nursing at the University of Washington, Seattle, and co-author of the recently-published book, *Nursing Care Planning*, conducted the workshop. Films, lectures, group discussions, and work sessions were part of the workshop program. A visit to a local hospital and nursing homes gave the nurses a chance to interview a patient, using the skills learned in the workshop.

"Think big, start small," was an idea stressed by Mrs. Carnevalli in setting up a system of nursing care planning. She explained that when a nurse begins something new she has to start with an area that is manageable and reasonable for her. The nursing care plan system can be spread gradually from use with one patient to use with a complete ward, she said.

Mrs. Carnevalli also urged instructors working with nursing students to "start small" and help the students use a care plan for one patient until they are skilled enough to use the nursing care plan system for their total patient assignment.

The workshop leader stressed the importance of skillful observation of the patient, which involves recognizing the cues in the patient's responses. It is necessary, she explained, to base a judgment on groups of cues to be sure the inference made from the cues is valid. She also pointed out the value of writing down recognized cues on nursing care plans to help others make more accurate judgments or serve as a baseline for future judgments as the patient's condition changes.

In discussing the collecting of nurs-

ing histories, Mrs. Carnevalli explained why she thinks the person who collects the data should formulate the initial plan of care. This person, she said, would have first-hand knowledge of the patient's response during the nursing history interview, and this could also help convey to the patient that he and "his nurse" are working together to plan his nursing care.

Guidelines she gave for collecting data for histories were: collect only information you plan to use, as this will build up the patient's trust; be flexible — it isn't necessary to fill out every space on the form; make a note of things as they occur in conversation with the patient; choose the earliest, yet most convenient interview time for both nurse and patient; use methods other than asking questions for a more creative interview session.

Mrs. Carnevalli emphasized that students should be given complete explanations of what nursing care planning is and how it should work. Because of limited space on the Kardex, they should learn to think through their patient's care, but write down only the priority problems, she said. She also suggested that the students try nursing actions or orders already on the Kardex and that they receive feedback on whether their nursing care plans are functional.

Over 250 alumni of the University of Western Ontario's School of Nursing who attended a special forum on October 16 were welcomed by the former dean of the faculty, Dr. Edith M. McDowell *(center)* and the present dean, Professor R. Catherine Aikin *(right)*. Isobel Black, *(left)*, principal nurse consultant of the Ontario department of health's research and planning branch, read the minister of health's speech in his absence.

Faculty Of Nursing At UWO Celebrates 50th Anniversary

London, Ont. — A homecoming conference for nursing alumni of The University of Western Ontario on October 16 commemorated 50 years of nursing at the university.

"Nursing: Evolution Or Revolution" was the theme of the conference, chaired by Dean R. Catherine Aikin and Dr. Amy Griffin, assistant dean of the Faculty of Nursing. Louise Brown, associate professor on the faculty of nursing, was chairman of the ad hoc committee for the anniversary celebrations.

Speakers participating in the discussion of the diverse opinions on the projected roles of nursing included Dr. Loretta Ford, professor and coordinator of community health nursing at the University of Colorado Medical Center, Denver; Jessie Mantle, assistant professor on the faculty of nursing at Western; and Dr. Ruth Elder, school of nursing and department of sociology at the State University of New York in Buffalo.

In her speech, Professor Mantle discussed the development of clinical nursing specialties. Stating her belief that nursing is under pressure to develop a formally-organized and professionally-sanctioned structure of clinical specialties, she emphasized that the nature of the nursing needs of patients "should be the organizing focus"; that research must be conducted into the needs of the patients to give intelligent direction to the development of clinical specialization; and that "concurrently with the undertaking of necessary clinical research should go experimentation with the role of the clinical nurse specialist.

"The most eloquent appeals for direction and education in clinical specialization are coming from nurses themselves," Professor Mantle said. "The demands of new technology, the increasing complexity of medical management, the general increase in knowledge, and changes in the values related to health care and patterns of delivery of health services long ago made obsolete the idea that every nurse must or can be au courant with the same nursing knowledge and skills," she continued.

The amount of formal education required to be a clinical specialist was considered by Professor Mantle. She referred to the position of the Canadian Nurses' Association, which states that the preferred education is a master's degree in clinical nursing. Disagreeing with this statement, the speaker said she does not believe there is enough evidence to support this, "due to the absence of research findings defining the kind of knowledge necessary for specialization and where this instruction should be obtained. Thus to argue for a particular level of academic preparation is premature at this time."

A suggestion put forward by this speaker was that "short-term research courses could be offered on an experimental basis to registered nurses. This would hopefully increase their awareness of currently available research findings, develop a more critical user of research, and provide more knowledgeable assistants for clinical research teams.

"The clinical specialist role may well represent the concrete symbol that clinical practice is on an equal footing with teaching and administration as a professional goal," said Professor Mantle.

Pay Increase To Nurses Prevents Strike

Amherst, N.S. — Nurses of Amherst's Highland View Hospital will be richer by $600 this year. On November 7 the 44 members of the nurses' staff association of the Highland View Hospital achieved a salary increase of $50 per month retroactive to January 1, 1970, with a further increase of $25 per month

for 1971. The 1970 increase brings the nurses' monthly salary to $475.

The Amherst nurses were the first group to be certified under the Nova Scotia Trade Union Act, the first to begin collective bargaining, and the first to vote to strike in the province.

Negotiations and conciliation procedures over a period of 13 months resulted in amelioration of all problem areas except that of salaries. The resulting impasse prompted 43 of the 44 association members on October 9 to consider strike action, with the vote date set for October 28.

The nurses did resort to the withdrawal of some activities, such as carrying trays and ignoring verbal orders, but did state that in the event of a full-blown strike, all essential services would be maintained.

Ontario Health Minister Announces End Of Internship For Diploma Nurses

Toronto, Ont. — Thomas Wells, Ontario Minister of Health, told hospital trustees and medical staff attending the annual Ontario Hospital Association convention October 27, that the province will phase out the hospital internship year for diploma nurses, beginning in September 1971. The minister's talk was reported in *The Globe and Mail* October 28.

Phasing out of the two-plus-one program, begun in Ontario in 1965, will mean that by 1973 registered nurses will graduate in two years, Mr. Wells explained. He added that about 23 nursing schools can end their internship requirement in 1971, 15 schools in 1972, and another seven in 1973. According to the health minister, the goal set in 1965 to increase the number of graduate nurses each year to 5,000 has almost been reached.

Before this announcement the OHA had passed a resolution calling on the minister of health for a guarantee that the government would provide hospitals with extra funds for post-graduate inservice training for two-year nursing graduates.

Stiff Competition For Jobs Faces Nurses In B.C.

Vancouver, B.C. — Following press reports that many registered nurses recently graduated in British Columbia cannot find employment in the province's hospitals, a spokesman for the Registered Nurses' Association of British Columbia told *The Canadian Nurse* the employment situation for nurses is competitive with that in other professions and reflects the economy in general.

F.A. Kennedy, executive director of RNABC, said the association has been announcing since 1962 that there is no shortage of nurses for first-level positions in the province, but it could not convince anyone that this was so. "For many years nurses had no trouble obtaining employment in British Columbia, and now the situation is competitive," Miss Kennedy said.

RNABC's executive director pointed out there is still some turnover in nursing positions, although nurses may have to wait for positions as they open up and no longer be as selective about shifts and job location. Adding to the problems nurses experience when they are unable to find work for several months is the fact that they are ineligible for unemployment insurance, Miss Kennedy added.

An RNABC survey of 100 registered nurses newly enrolled with the association's placement service during the period of September 1 to October 26, 1970, showed that 85 nurses were looking for employment at the end of this period. A follow-up found that 41 of these nurses are now employed and 19 are still unemployed. The remaining 23 nurses could not be reached.

A total of 278 nurses was taken on staff at five British Columbia hospitals in July, August, and Septem-

ber; 150 of these were British Columbia graduates and 128 were graduates from outside the provice.

RNABC is warning nurses outside the province not to come to British Columbia unless they are already assured of employment. At the present time there is no change in the association's recruitment program, although the RNABC is emphasizing that students who qualify should enter the university program.

RNAO Membership Fee Increased To $50

Toronto — At a special meeting of members of the Registered Nurses' Association of Ontario October 3, an amendment was made to the association's bylaw, which sets $50 as the annual regular membership fee, including subscription to *The Canadian Nurse*.

At the association's 1970 annual meeting, the membership year was changed from January 1 - December 31 to November 1 - October 31, effective November 1, 1970. As current members and affiliates had already paid fees to the end of 1970, and as the 1971 membership year will be a short one, it was decided to adjust the fees accordingly.

To apply the principle of an adjusted fee to all 1971 members, the regular membership fee for those who were not members in 1970 will reflect a two-month fee at the rate of $35 per year, and a 10-month fee at $50 per year.

Fees for 1971 and 1972 for regular members and affiliates holding 1970 certificates are $42 and $50; $15 and $18 for affiliate non-working members and affiliate post-basic students; and $10 and $12 for affiliate out-of-province members. For members not holding 1970 certificates, regular members will pay $48 in 1971 and $50 in 1972; affiliate non-working members and affiliate post-basic students will pay $18 for both years; and affiliate out-of-province members will pay $12 for both years.

Nurse Claims Task Force Sees Symptoms, Not Causes

Toronto, Ont. — The sections of the task force report on the cost of health services in Canada related to nursing service in hospitals is largely a report on the symptoms, rather than their underlying causes, according to one nurse. Shirley M. Stinson, professor in the division of health services administration at the University of Alberta, was addressing directors of nursing at a panel discussion at the annual convention of the Ontario Hospital Association in Toronto October 26-28. She was replying to an address by Peter E. Swerhone, executive director of The Winnipeg General Hospital, who outlined the report's findings and recommendations.

In reply to the commission's recommendation that nurses set up objectives, Dr. Stinson said nurses already have objectives. Their main problem, she said, is that they are not always realistic. "Too often we pay only lip service to the objective of patient care, and in the real situation it is some other objective that is met first." She also pointed out the difference between the objective of health care given by the task force, "the greatest good for the greatest number," and the one generally held by nurses, "whatever is best for the individual." Neither, she said, could stand by itself, but the conflict ought to be recognized.

Dr. Stinson agreed with the report's recommendation that criteria be set up for the evaluation of nursing efficiency, but pointed out their present lack does not mean it is totally impossible to evaluate nursing care. She emphasized it is not only nurses who need criteria, and that the approach must be an interdisciplinary one. She called for the upgrading of skills in all personnel, including hospital administrators and doctors. "Nursing cannot be judged in a vacuum," she said.

The application of industrial and management techniques to nursing is of limited value, according to Dr. Stinson, as the patient is not a consumer with whom certain risks can be taken as on the industrial market. What is needed, she added, is a systems approach in which the quality of nursing care would be studied at the same time as its efficiency and cost.

"But the application of management techniques must be selective," she said. "A group of yes-men would result from the task force's recommendation to reward extra service monetarily beyond salary. Money is not the only reward of good nursing."

M.J. Gerrow, assistant administrator of Ajax and Pickering General Hospital, and Margaret Charters, director of nursing of Hamilton General Hospital, also spoke briefly. The session, attended by a capacity crowd, was chaired by Sylvia Burkinshaw, director of nursing at the Kingston General Hospital.

The uniform designed for students at the University of Calgary's new school of nursing are made of white, anti-static material. Students can change the color if they wish, says the school's director, Dr. Shirley R. Good, and the skirt lengths won't be regimented either. "Whether or not caps will be a part of the uniform remains for the students to decide. If sixty percent of the students want to have caps, they will be asked to design a style, and then they will have to live with it, she added."

University Of Calgary Accepts Its First Class Of Nursing Students

Calgary, Alberta — Fifty young women have been admitted to the first class of the University of Calgary's new school of nursing. The students, mostly from the Calgary area, started a four-year bachelor of nursing program in mid-September.

The new program is "people-oriented," says the school's first director, Shirley R. Good, who was consultant in higher education for the Canadian Nurses' Association prior to assuming her present post. Emphasis is on preventive and remedial care, and the program has been developed to prepare students for the changing role they will be required to play in providing adequate nursing care for the future. "What we are hoping to do is to turn out graduates who can see the whole nursing picture, and are equipped to care for the patient's total health needs — physically, mentally, and emotionally," Dr. Good said.

names

It is with a sense of loss that we at CNA House say farewell to **Lois Graham-Cumming** who has made such a contribution to nursing in Canada. She was part of the brain drain from the U.S.A. when she came to Canada to become the bride of Dr. George Graham-Cumming. It is due to his retirement from the department of national health and welfare that Lois is leaving — after all, she has to look after her man, and he has chosen to retire to Vancouver. So, in a sense, we're not really losing our director of research and advisory services of seven years, for we're sure her nursing talents and know-how will be sought after in her new milieu.

Besides re-activating the concept of research in nursing, and administering the area of national nursing consultation, Mrs. Graham-Cumming found time to initiate the most valuable of references, *Countdown*. Its continued publication will be her legacy to the Canadian Nurses' Association.

Fay Lawson McNaught (R.N., Winnipeg General Hospital; B.N., University of Manitoba) has recently been appointed director of nursing education of the Grace General Hospital School of Nursing, Winnipeg. Mrs. McNaught is also the first vice-president of the Manitoba Association of Registered Nurses.

Lillian Pettigrew Honored At Investiture

Lillian E. Pettigrew, associate executive director of the Canadian Nurses' Association, was invested as a serving sister in the Venerable Order of St. John of Jerusalem by His Excellency the Governor General, at the Investiture held at Rideau Hall, October 24, 1970. Miss Pettigrew, one of many honored on this occasion, has had a distinguished career in nursing, having been executive secretary and registrar of the Manitoba Association of Registered Nurses for several years prior to her appointment as CNA associate executive director.

Maila Maki (Wellesley Hospital, Toronto) was elected president of the Canadian Association of Neurological and Neurosurgical Nurses at its first annual meeting held in Toronto in June. This meeting was held in conjunction with the fifth annual meeting of the Canadian Congress of Neurological Sciences.

Other members of the executive are: *Past President:* Jessie F. Young, Toronto; *Vice-President:* Lorina Friesen, Vancouver; *Secretary:* Jacqueline LeBlanc, Montreal; *Treasurer:* Carol Schick, Winnipeg.

Council members elected are: Lorina Friesen, representing British Columbia; Lynn Baldwin, Alberta; Janet Barrie, Saskatchewan; Carol Schick, Manitoba; Maila Maki and Jessie F. Young, Ontario; Jacqueline LeBlanc and Geraldine Hart, Quebec; Catherine MacDonald, Nova Scotia; Patricia Courtney, New Brunswick, Prince Edward Island, and Newfoundland.

Dean R. Catherine Aikin has announced appointments to the faculty of nursing at The University of Western Ontario.

Robert C. Leonard (Ph.D., University of Oregon) — visiting professor for the 1970-71 academic year. Dr. Leonard is on leave as professor of sociology from the University of Arizona in Tucson. He has been a consultant in research methodology of the college of nursing at University of Arizona for the past six years and was assistant professor of nursing and sociology at Yale University from 1960 through 1964. In addition to research consultation with the nursing faculty, Dr. Leonard will be a consultant to the other health science faculties and to the sociology department, assisting in the development of a medical sociology program.

Sheila M. Creeggan (Reg.N., Toronto General Hospital; M.Sc.N., University of Western Ontario) — assistant professor. Miss Creeggan taught obstetrical nursing and basic sciences at the Ottawa Civic Hospital and was director, school of nursing, Public General Hospital, Chatham, Ontario.

Hattie Shea (R.N., Dallas Methodist Hospital, Dallas, Texas; B.S.N. Ed. and Graduate Study, University of Texas) — assistant professor. Her experiences include head nurse, office nurse, public health nurse, OR supervisor. Her last position was teaching medical-surgical nursing at the University of Texas Nursing School, Austin, Texas. *(Cont'd. on page 18)*

names

(Continued from page 17)

Elizabeth Weber (Reg.N., Victoria Hospital, London, Ont.; B.Sc.N., University of Western Ontario) — lecturer. Mrs. Weber was on the teaching faculty of the school of Nursing, Women's College Hospital, Toronto for five years. She taught psychiatric nursing for one year at the Atkinson School of Nursing, Toronto.

Carolyn Petersson (Reg.N., Victoria Hospital, London, Ont.; B.Sc.N., Wayne State University) — instructor. Mrs. Petersson has experience in general duty and psychiatric nursing and in public health nursing with the City of Toronto.

Lorraine Mahoney (R.N., Moncton Hospital School of Nursing; B.N., McGill) — instructor. Miss Mahoney's previous experience includes medical-surgical areas and teaching at the Hamilton Civic Hospital School of Nursing.

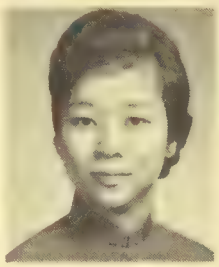
Vera R. Peacock has retired as assistant director of nursing at the Manitoba Rehabilitation Hospital - D.A. Stewart Centre, Winnipeg. Miss Peacock taught school in rural Alberta before training as a nurse at the St. Boniface Hospital School of Nursing. After four years as an outpost nurse in the northland, she returned to teaching — to establish a training pogram for practical nurses at the St. Boniface Sanatorium, then to instruct at the Central School for Practical Nurses in Winnipeg. Following a University of Manitoba course in teaching and supervision, she became science instructor at the St. Boniface Hospital School of Nursing. For the past eight years Miss Peacock has worked at the Manitoba rehabilitation Hospital.

Rachel Young, Assistant Director of Nursing, Alberta Hospital, Edmonton, has retired. Mrs. Young began her nursing career in 1939 at the Alberta Hospital, Ponoka. In 1943 she moved to the Alberta Hospital, Edmonton, where she has worked throughout most of her career.

The Director of the School of Nursing, Dalhousie University, Halifax, has announced the following staff appointments:

Ann Gwendolyn Jackson (B.Sc.N., M.Sc., McGill School for Graduate Nurses, Montreal) as assistant professor.

Marilyn Riley (R.N., Payzant Memorial Hospital, Windsor, N.S.; dipl. hospital nursing service administration, University of Saskatchewan, Saskatoon; B.N., Dalhousie University; M.Sc.N., University of Western Ontario, London) as assistant professor. Miss Riley was a Canadian Nurses' Foundation fellow while at the University of Western Ontario.



Maggie Chan Kong (Reg.N., Mount Vernon Hospital, Northwood, Middlesex, England; B.N.S.c., nursing education and public health nursing, Queen's University) has been appointed assistant director of the Scarborough Regional School of Nursing, West Hill, Ontario. Mrs. Kong's nursing education experience includes Hotel Dieu Hospital, Kingston, Ontario; Brandon General Hospital, Manitoba; Scarborough General Hospital and Whitby Psychiatric Hospital. She succeeds Mrs. Veronica Orton-Johnson, who has taken up residence in England.

Dr. John J. Deutsch, principal of Queen's University, has announced new appointments to Queen's University School of Nursing, Kingston:

Ruth Miller (B.N.Sc., University of British Columbia; M.Sc.N., Yale University), as assistant professor of nursing. For the past two years Miss Miller has studied at Yale as a Canadian Nurses' Foundation fellow. She has been an instructor in mental health services in British Columbia and a consultant in psychiatric nursing at the Kingston General Hospital.

Marie Powers (B.S.N., Nazareth College, Rochester, N.Y.; M.Sc.N., Boston University School of Nursing) as assistant professor of nursing. Miss Powers was supervisor at Babies Hospital, Columbia University Medical Center, New York, and more recently assistant professor at Corning Community College, Corning, New York.

Barbara Kisilevsky (B.Sc.N., M.N., University of Pittsburgh School of Nursing). Mrs. Kisilevsky has had experience in institutional nursing and as instructor in a hospital school of nursing. Her husband, Dr. Robert Kisilevsky has also joined the faculty at Queen's University.

Kathryn Shrum (B.Sc. in food science, University of Toronto; M.Sc., University of Toronto) as half-time lecturer in the school of nursing and half-time therapeutic dietitian at the Kingston General Hospital, Kingston, Ontario.

Muriel E. Small (R.N., Montreal General Hospital; B.N., McGill University, Montreal; M.A., Washington University) as assistant professor. Miss Small worked for many years with the Metro Health Services of Vancouver, and was associate professor at the University of Toronto School of Nursing, prior to returning to eastern Canada.

Jo-Ann (Tippett) Fox (R.N., The Montreal General Hospital; B.N., University of New Brunswick, Fredericton) as assistant professor. Mrs. Fox has been studying toward an M.Sc. degree in physiology from Queens University, Kingston, and expects to graduate in 1971.

Margaret Arklie (R.N., Victoria General Hospital School of Nursing; Dipl. Nursing Service Administration, Dalhousie University; B.N., Dalhousie University) as instructor. Miss Arklie has been assistant head nurse at the Calgary General Hospital. Its staff nurses' association scholarship enabled her to earn a diploma in nursing service administration at Dalhousie University in 1967.

Evelyn Joyce Carver (R.N., Prince Edward Island Hospital School of Nursing; Dipl. in Public Health and B.N., Dalhousie University) as instructor.

Judith (Hattie) Cowan (B.N., Dipl. Pub. Health, Dalhousie University) as instructor.

Margaret Rose Matheson (B.Sc.N., Mount Saint Vincent University, Halifax) as instructor.

Nancy Elizabeth Riggs (R.N., Victoria General Hospital School of Nursing, Halifax; B.N., with diploma in teaching in schools of nursing, Dalhousie University) as instructor.

Linda Robinson (Reg.N., Nightingale School of Nursing, Toronto; B.N. and dipl. in teaching in schools of nursing, Dalhousie University) as instructor.

Gail Dronyk (R.N., University of Alberta Hospital, Edmonton; B.Sc.N., University of Alberta, Edmonton) was recently appointed nurse-in-charge, Victorian Order of Nurses, Owen Sound. She replaces Loretta Baerg who has returned home to Edmonton.

The New Brunswick Association of Registered Nurses awarded scholarships of $500 each to undergraduates in the baccalaureate degree course in nursing: **Jacinthe Chiasson** of Lamèque, who is a student in the basic program at the University of Moncton; **Anna May Doak** of Doaktown, who is enrolled in the basic program at the University of New Brunswick School of Nursing, Fredericton; **Judith Walters,** R.N., of Fredericton, who is enrolled in the degree course at the University of New Brunswick; and **Yim Wong,** R.N., of Dalhousie, who is in the degree course at the University of Ottawa.

Authority on Midwifery Visits British Columbia Institute of Technology

Mrs. Margaret Myles, author of the authoritative *Textbook for Midwives,* visited the British Columbia Institute of Technology in September to address nurses on her chosen topics: "Every maternity nurse as a teacher," "Critical survey of methods of pain relief," and "Newer methods of obstetric practice." Those present included nurses from many parts of British Columbia engaged in maternity nursing, public health nursing, and in teaching.
With Mrs. Myles above, *left,* is Mrs. Barbara B. Kozier of the BCIT, who is department head of patient care services.

Lois James (Reg.N., Victoria Hospital School of Nursing, London, Ont.) has just begun her second two-year term with MEDICO in Surakarta, province of Central Java, and will be involved in training student nurses and upgrading nursing services at local hospitals.

Miss James, who previously served with MEDICO in Honduras as director of the School of Certified Auxiliary Nurses at the Hospital de Occidente in Santa Rosa, believes "only by a long-term team effort can we assist the local people in upgrading nursing and improving health conditions in a developing country."

Mary Roberta Noseworthy (B.N., School of Nursing, Memorial University of Newfoundland) was granted the first award of the Annual Faculty of Nursing Award ($200). Miss Noseworthy is now staff nurse at St. Clare's Mercy Hospital, St. John's, Newfoundland.

The University of Alberta, School of Nursing, Edmonton, has announced appointment of three lecturers:

Patricia L. Sullivan (B.Sc.N., Mount Saint Vincent University, Halifax; M.Sc.N., Boston University).

Peggy (Keith) Wilson (R.N., Calgary General Hospital; B.Sc.N., University of Alberta, Edmonton).

Brenda (Bayston) Wroot (R.N., University of Alberta Hospital, Edmonton; B.Sc.N., University of Alberta, Edmonton).

new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.

Overhead Laundry Handling System

Continuous Flotation Therapy

The FloteBedPad, developed by DePuy Inc., provides continuous flotation therapy from wheelchair to bed. Used with or without water, it distributes body weight evenly, thus eliminating excessive pressures and permitting restoration of blood circulation to the decubitus sites. The pad measures 18" x 22" x 2" and fits into a polyurethane foam leveling mattress. The leveling mattress fits on a hospital bed of standard size.

Other total flotation products manufactured by DePuy are the FloteBed and the FlotePad.

For additional information write Guy Bernier, 862 Charles-Guimond, Boucherville, Quebec, or John Kennedy, 2750 Slough Street, Malton, Ontario.

Overhead Laundry Handling System

Eaton Yale & Towne's Automated Equipment Division has introduced a new overhead handling system that increases production capabilities of commercial and institutional laundries by as much as 600 percent.

Called the American Monorail "Gravity-Flo" Laundry Handling System, it employs overhead monorail equipment for speeding soiled linen through complete laundering cycles by means of heavy duty slings. The American Monorail 401 track can be bent or turned, elevated or lowered to meet all types of building requirements. Heavy duty "Gravity-Flow" 4-wheel trolleys with 1000-lb. carrying capacity convey one or more slings through the system in fast production cycles. Systems are available complete with slings, sorting equipment, carts. Installation is included in cost.

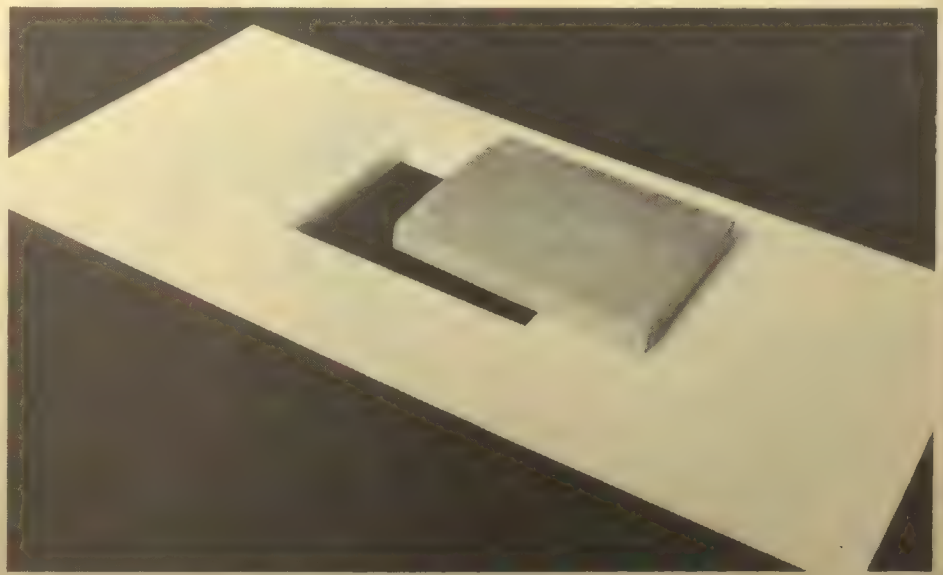
For more information write Automated Equipment Division, Eaton Yale & Towne Inc., Cleveland, Ohio 44117.

Slow-K Tablets

Ciba's Slow-K tablets each contain 600 mg. of potassium chloride in a unique, slow-release core specifically designed to release potassium chloride gradually from an inert base during transit through the alimentary tract.

Slow-K tablets provide, in palatable form, the correct salt where potassium supplementation is necessary, particularly during prolonged or intensive diuretic therapy. Because of the three to four hours required for the complete release of the potassium chloride, Slow-K is unlikely to produce hyperkalemia in patients with a degree of renal impairment.

The range of indications for Slow-K may be summarized as follows: as a supplement to diuretics; ulcerative colitis; hypochloremic alkalosis; steatorrhea; Cushing's syndrome; chronic diarrhea; liver cirrhosis; regional ileitis; diseases characterized by persistent



Continuous Flotation Therapy

vomiting or diarrhea, continuous withdrawal of gastrointestinal fluids; digitalis therapy; ileostomy; neoplasms or obstruction referable to the gastrointestinal tract.

When administered as a potassium supplement during diuretic therapy, a dose ratio of one Slow-K tablet with each diuretic tablet will usually suffice but may be increased as necessary.

Slow-K is supplied in the form of tablets (pale orange, coated), each containing 600 mg. potassium chloride in a slow-release, inert wax core; bottles of 100 and 1000.

Ciba Company Limited, Dorval, Quebec will provide further information on request.

Drape Packs and Surgical Gowns

Johnson & Johnson Limited, Montreal, has introduced moisture-repellent drape packs and surgical gowns. Made from reinforced nonwoven fabric, these packs and gowns provide guaranteed sterility, uniform pack design, complete disposability, and storage convenience.

For more information write to Johnson & Johnson Ltd., 2155 Pie IX, Blvd., Montreal 403, Quebec.

Literature Available

Market Forge announces the availability of a newly published, full-color, loose leaf brochure describing its Hospital Modular Systems Work Units called HMS — a unique modular systems concept to solve material storage and usage problems.

HMS combines stainless steel or plastic laminate work surfaces with modular shelf components that become a highly functional storage/work unit designed to improve operational efficiency.

The brochure illustrates the benefits of open storage HMS; the basic modules that compose HMS; construction details, optional accessories, typical layouts for actual hospital situations, and HMS specifications.

HMS satisfies the specific work flow and storage requirements of such diverse areas as central sterile supply, operating room, anesthesia work rooms, inhalation therapy, as well as nursing service areas.

HMS units are shipped knocked down to reduce shipping costs. Installation is simplified due to the elimination of field bolting, grouting, plastering, and trimming.

In HMS installations the reduction in the number of doors, hinges, handles, latches, drawers, and related casework hardware cuts costly maintenance expense. Since HMS stands free, no wall mount supports, filled floor tile or built-in masonary work are required. Renovation or redesign of areas is thus readily accomplished.

Next Month
in

The
Canadian
Nurse

- Nursing — Evolution or Revolution?
- Management of Parkinson's Disease With L-Dopa Therapy
- Congenital Rubella — One Approach to Prevention

Photo Credits for December 1970

Julien LeBourdais, Toronto, cover photo.
Yellowknife Photo Centre, Ltd., Yellowknife, N.W.T., p. 10
Roy Nichols Photographer, Willowdale, Ont., p.11
Manitoba Association of Registered Nurses, Winnipeg, Man., p.13
Dept. Information Services & University Publications, University of Western Ontario, p. 14
University of Calgary, Calgary, Alta., p. 16
Studio Impact, Ottawa, Ont., p. 17
Royal Victoria Hospital, Montreal, P.Q., pp. 29, 30
Hôpital Christ-Roi, Quebec, P.Q., p. 36
Sudbury Star Photo, Sudbury, Ont., p. 41

new products

(Continued from page 21)

The brochure may be obtained through Gordon G. Brown Co. Ltd., at Suite 23, 1875 Leslie St., Don Mills, Ont., or at 25 Westminster Ave. S., Montreal, Que.

Footguard to Prevent Footdrop

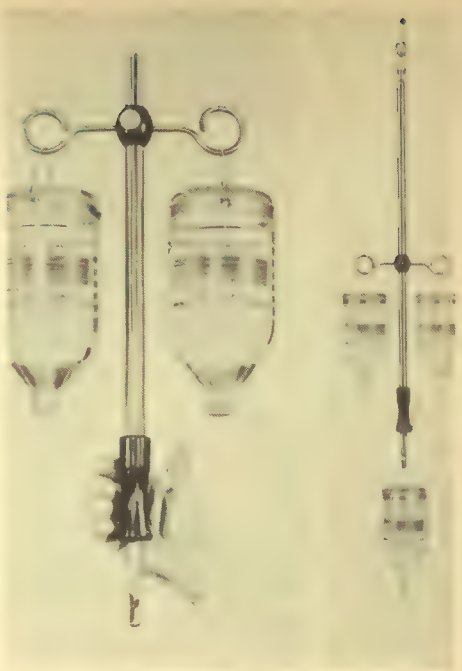
Now being marketed by the Posey Company is a new footguard designed to provide foot support and to prevent pressure buildup on the heel or ankle. Of non-breakable plastic, the guard is light in weight but sturdy, and shaped to fit the contour of the heel or ankle. The insert of synthetic fur may be removed and laundered. The use of a T-Bar Foot Stabilizer (attached with Velcro) prevents foot rotation.

For further information write Enns & Gilmore, Ltd., 1033 Rangeview Road, Port Credit, Ontario.

Suspended IV Unit

The Karapita intravenous unit eliminates the danger of the accidental bumping of a floor stand and the spilling of liquids because it can be mounted either on a track or from the ceiling. It saves floor space, and with no obstructions, the patient is rendered more accessible to the nurse and to the doctor. The unit can easily be adjusted to any desired height, using one hand.

The unit is designed to hold several bottles at one time and is constructed of stainless steel for maximum durability, cleanliness, and ease in following sterile procedures.



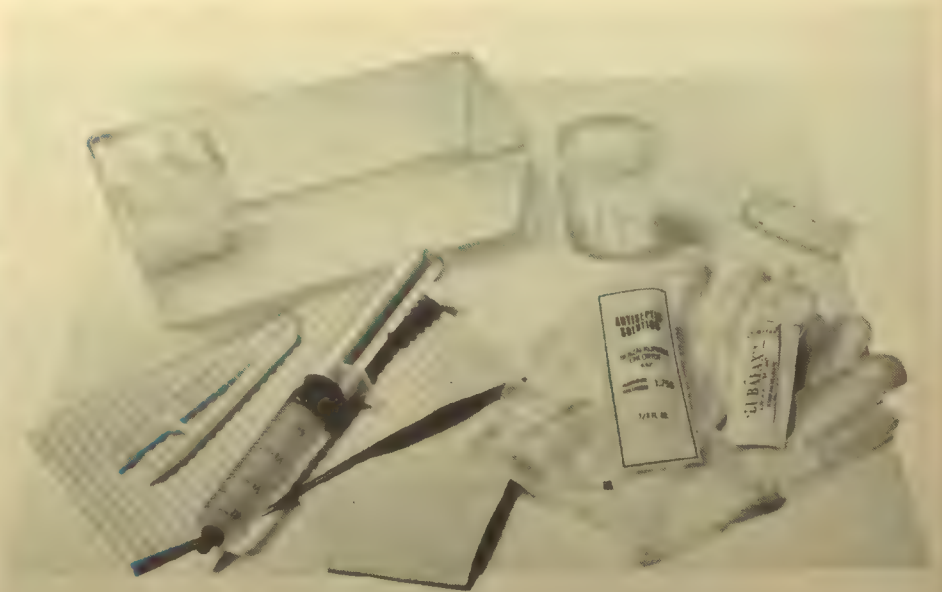
Suspended IV Unit.

For complete information on the Karapita intravenous suspension unit, write to ATM Industries Limited, 6380 Northwest Drive, Malton, Ontario.

Catheter Insertion Tray

C.R. Bard, Inc. has introduced a catheter insertion tray with a choice of either a 10 cc syringe or a 30 cc syringe. The trays are adaptable to any bladder care system used in hospitals, and contain all items needed for catheterization, except the catheter, in a sterile package.

For further information, write C.R. Bard (Canada) Ltd., 22 Torlake Crescent, Toronto 18, Ontario.



Catheter Insertion Tray

dates

February-June
Continuing nursing education, non-credit courses, at the University of British Columbia have been scheduled for the first six months of next year. For further information write: The University of British Columbia, Health Science Centre, School of Nursing, Vancouver, British Columbia.

February 15, 1971
Six-week coronary course offered to nurses currently working on coronary care units. Enrollment is limited to six nurses, and total sponsorship by present employee is required. Registration fee is $75.

For further information write to the Course Coordinator, Intensive Care Nursing H601, Winnipeg General Hospital, 700 William Avenue, Winnipeg 3, Manitoba.

Feb. 15-19, 1971
Five-day course in occupational health nursing for registered nurses who have five or more years experience in occupational health nursing, and who work alone or with one other nurse. For further information write to: Continuing Education Program for Nurses, University of Toronto, 47 Queen's Park Crescent, Toronto 5, Ontario.

February 16-18, 1971
First National Conference on Research in Nursing Practice, Skyline Hotel, Ottawa. Purpose of this bilingual conference is to stimulate research in nursing practice. Registration is limited to 200. Fee: $10 per day; $5 per day for nurses enrolled in graduate programs. For further information and registration forms, write to: Dr. Floris E. King, Project Director, School of Nursing, University of British Columbia, Vancouver 8, B.C.

March 29-April 2, 1971
The third international congress of psychosomatic medicine in obstetrics and gynecology will be held at the Bloomsbury Centre Hotel, London, W.C.I. Scheduled conference theme is "Womanhood and Parenthood." Write for information to: Kurt Fleishmann and Associates, Chesham House, 136 Regent Street, London, W.I., England.

March 31, 1970
Canadian Nurses' Association annual meeting, business sessions only, Chateau Laurier, Ottawa, Ontario.

May 11-14, 1971
The 6th International Hospital Exhibition (Interhospital 71), held every three years, is to be held in Stuttgart, Germany. Exhibitors and visitors to previous exhibitions were world-wide. Information can be obtained from: R.F. Haussmann, 130 Willowdale Avenue, Suite 3, Willowdale, Ontario.

May 19, 1971
Catholic Hospital Conference of Ontario, nursing committee, annual meeting, King Edward Hotel, Toronto, Ontario.

May 20-21, 1971
Catholic Hospital Conference of Ontario, annual meeting, King Edward Hotel, Toronto, Ontario.

May 26-29, 1971
Reunion of The Montreal General Hospital School of Nursing graduates to celebrate the hospital's 150th anniversary. Graduates should send addresses to: Miss Phyllis Walker, The Montreal General Hospital (Dept. of nursing), Montreal 109, P.Q.

May 30, 31 and June 1, 1971
The three-day annual meeting of the Manitoba Association of Registered Nurses will be held in Dauphin, Manitoba.

June 1971
Canadian Association of Neurological and Neurosurgical Nurses, second annual meeting, St. John's, Newfoundland. For further information contact the Secretary: Mrs. Jacqueline LeBlanc, 5785 Côte des Neiges, Montreal 209, Quebec.

June 2-4 1971
Canadian Hospital Association, National convention and assembly, Queen Elizabeth Hotel, Montreal, Quebec.

June 6-10, 1971
Ninth Canadian Cancer Conference under the auspices of the National Cancer Institute of Canada, Honey Harbour, Ontario.

June 9-12, 1971
Canadian Psychiatric Association, annual meeting, Lord Nelson Hotel, Halifax, Nova Scotia.

July 13-19, 1971
International Hospital Federation Congress, Dublin, Ireland.

in a capsule

Stamping out stinging insects

We always like to hear of success stories, and this one is no exception. As the saying goes, nothing breeds like success.

By catching male mosquitos and using x-rays to cause sterility, West German professor Hannes Laven thinks he has discovered a way of eradicating stinging insects such as gnats and mosquitos.

The director of the Mainz University Institute for Genetics has been experimenting in the field for the past two years. The theory behind his method is that since mosquitos normally multiply rapidly, sterility caused by x-rays should result in a generation dying out within two or three weeks.

According to *German Features*, Professor Laven was so successful that in his own experiments he was able to achieve up to a 15 percent reduction in offspring in one generation. As a result, this method is now being tested in France and India.

Advertisers look to women

Perhaps women don't realize the power they have, or could have, in the marketing world. The possibilities of influence yet to come have been raised by Jacqueline Brandwynne, president of a New York ad agency, who addressed the annual meeting of the Institute of Canadian Advertising in Montebello, Quebec.

Reported in *Marketing* October 19 were some interesting predictions made in her talk. For example, she foresees that in the 70s women will buy products historically sold to men because they will be earning more money. To marketing men she says this will mean women will have great financial power, the single woman's market will increase enormously and create innumerable new product needs, product life will shorten, families will become smaller and marriage less important, and daily life will become computerized.

A young woman between the age of 16 and 25 will travel to Europe 15 times more in her lifetime than the two-time traveler of the past, the speaker said. "This means she'll need everything from mini-TV to collapsible sporting equipment to a sauna-in-a-suitcase," the speaker added. Freeze-dried beauty products that require minimum space and can be activated by a drop of water seem a sure bet to her. We can also look forward to "culture . . . in cartridges.

"With the continuing disappearance of well-trained sales personnel, department stores will have to provide new customer services to keep customer loyalty." Illustrating what such services might be, the advertising expert predicted that department stores will have to provide educators to teach customers nutrition, decorating, crafts, and so on, and could even offer gyms where shoppers could take time out for yoga.

Taking stock of supermarkets, the speaker looked ahead to the not-too-distant day when they, too, will have to supply individualized services, such as giving special cooking classes and unlocking secrets of Chinese cuisine. "Walking through your friendly supermarket now feels more like entering a male-oriented aggression country than shopping in an environment appealing to a woman. Does higher visibility really require poor and sloppy design, screaming colors and crowded cartons?"

Today's young woman, she noted, has a greater understanding of art and appreciation for esthetics.

"Whatever happened to the silent majority?"

Fleet ends ordeal by Enema® for you and your patient

Now in 3 disposable forms:

- **Adult** (green protective cap)
- **Pediatric** (blue protective cap)
- **Mineral Oil** (orange protective cap)

Fleet — the 40-second Enema* — is pre-lubricated, pre-mixed, pre-measured, individually-packed, ready-to-use, and disposable. Ordeal by enema-can is over!

Quick, clean, modern, FLEET ENEMA will save you an average of 27 minutes per patient — and a world of trouble.

WARNING: Not to be used when nausea, vomiting or abdominal pain is present. Frequent or prolonged use may result in dependence.
CAUTION: DO NOT ADMINISTER TO CHILDREN UNDER TWO YEARS OF AGE EXCEPT ON THE ADVICE OF A PHYSICIAN.

In dehydrated or debilitated patients, the volume must be carefully determined since the solution is hypertonic and may lead to further dehydration. Care should also be taken to ensure that the contents of the bowel are expelled after administration. Repeated administration at short intervals should be avoided.

Full information on request.

*Kehlmann, W. H.: Mod. Hosp. 84:104, 1955

FLEET ENEMA® — single-dose disposable unit

Charles E. Frosst & Co.

Students have a right to make mistakes

Dorothy S. Starr, B.A., M. N.

Several years ago, after reading an article of mine in *The Canadian Nurse* in which I wrote about the acceptance of mistakes as motivation in learning, a nurse sent me a letter saying how she wished she had known as a student that it was all right to make a mistake. Her comment has haunted me ever since.

I am sure this nurse is not alone in feeling this way. Many nurses expect constant "rightness" from themselves and their co-workers. They have learned, as students, that an individual should consider herself obligated to learn all the skills and techniques, to acquire the helping attitudes necessary to nursing, and *to make no mistakes!*

It is simplistic to say that since nursing involves the care and responsibility for other human beings, mistakes must not be allowed to occur. Teachers, ministers, lawyers, social workers, and doctors are all students of some aspect of care for human life. The forms of insurance against injury to the client upon whom the learner practices are varied, but minimizing the potential danger of an error — rather than seeking to prevent it altogether — is an assumption typical of the education of groups other than nursing.

To say that nursing students have a right to make mistakes is to say that nursing students have a right to be learners. Equating a student with a learner seems redundant, but nursing students are subjected to censure on the first performance of a nursing technique. Nurses behave as though performance without error is the minimally acceptable standard, whether on the first try or the fortieth.

If nurses are *not* to make mistakes, it is necessary to evolve a pattern of behavior that will produce a high degree of conformity, regardless of situation, which will give a clear pointer to the individual guilt of non-correct performance. Isn't this what we have done? And when an area of nursing proved not amenable to this approach, did we come to believe that it was not significant?

The crying patient, the dying patient, the cranky patient, the bedraggled woman who stares out the window and answers in monosyllables — do we give these people physical care and avoid spending time with them? If we are conditioned to make no mistakes, we probably do. There are no procedures for interpersonal relations; there can be only a thought-through approach with acceptance of a high risk of failure. If we have to make no mistakes, we will leave these people and many others, alone.

If we cannot tolerate mistakes in our own nursing care, we will be unable to accept mistakes in others' care, so our students and staff members will be discouraged, subtly, silently, from trying something new and possibly making a mistake.

If we want new solutions, fresh ideas in nursing, we must encourage creativity. Dr. Floris King has written: "The discouragement which hurts creativity most is that which comes from those we regard most highly. Consequently, it is essential to have a setting which encourages ideation, one which even welcomes mistakes. The very essence of creativity is to keep on trying and trying, harder and harder — and that is almost too much to expect of human nature without an expression of encouragement."[1]

If we want nursing students to learn by discovery, we must provide learning situations in which the answer is not immediately known; we must construct problems in which the student will seek answers, will make mistakes, and, through discussion of the unworkable approaches, will discover new ways of thinking about problems, identify information gaps, and become aware of personal biases. Students have a *right* and a *need* to make mistakes that arise from new approaches to old nursing problems.

One of the ways in which Hippocrates antedated his colleagues by centuries was his insistence that records should show failures of medical treatment, as well as the successes, leading to growth of knowledge.

Involvement is the key to learning, but the involvement must be with minimal fear of harm to that significant other, the patient. We need to protect learning situations by such means as role playing, the teacher as role model, discussion in pre- and post-care conferences. The pertinent questions are: In what setting will students' discoveries and experimentation take place? How will students be assisted to use the mistakes as aids to further discoveries?

We need to distinguish between a careless mistake and a mistake resulting from false reasoning or inadequate data. The repeated mistake is a different matter from the mistake made in a fresh approach to a problem.

Medication errors are of prime concern. The student who gives a wrong medication to a patient by failing to read his wrist Identi-Band, and the student who misjudges a patient's ability to give self-medication have made mistakes of a different order. Whatever may be true of roses, a mistake is not a mistake is not a mistake!

Mistakes that come as part of the problem-solving process are the kind of mistakes I believe students have a right to make, because they have a right to try to solve problems. And, as a sociologist said to a group of nurse educators, "The right to try always and necessarily involves the right to fail."[2]

Let's set up more teaching situations in which the answers aren't known by students; let's let them discover the application of facts for themselves; let's let them be wrong and find out why, and then be right in a fresh, original way that is new to them, and perhaps new to all of us.

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Monitoring the mother and fetus during labor

Intensive monitoring of high risk obstetrical patients is gaining acceptance as a way to decrease maternal and perinatal mortality and morbidity. This article describes the program at Montreal's Royal Victoria Hospital, and gives the advantages of monitoring the mother and fetus during labor, the nurse's role, and the patient's reaction to the care she receives.

Tanna Willis

Present perinatal and maternal mortality rates in Canada are high. In 1968, for example, the number of perinatal deaths in this country was 8,727 out of 369,241 deliveries, or 23.7 deaths per 1,000 deliveries.[1] In the same year, the maternal mortality rate was 27 per 100,000 patients.[2]

In the Province of Quebec, 1968 statistics show that the incidence of perinatal deaths in the 98,678 deliveries of infants over 1,000 Gm. was 1,946, or 19.7 deaths of infants over 1,000 Gm. per 1,000 deliveries. Of these 1,946 deaths, 994 were stillborn, and about one-third of these stillbirths occurred during labor.[3] The 1968 maternal mortality rate in the province was 37 per 100,000.[4]

To decrease this mortality rate of infants and mothers, new methods of diagnosis, treatment, and care have been devised. Intensive monitoring of the mother and fetus in labor, when there is potential or real danger to one or both, is becoming widely accepted as a valuable method of reducing the mortality rate.

Background

The monitoring of a fetus during labor is patterned after the unit and studies of Dr. Roberto Caldeyro-Barcia in Montevideo, Uruguay. He developed a method of measuring uterine activity by introducing a thin polyethylene catheter through the anterior abdominal wall into the amniotic sac, to record the amniotic fluid pressure.[5] The catheter was connected, through a Sanborn electromanometer (an apparatus that is also used by cardiologists to record adult heart rate patterns), to a Sanborn "recording Poly Viso," and the contractions were visualized on a graph expressed as millimeters of mercury.

Later, the catheter's route of insertion was changed from the abdominal wall to the vagina, after artificially rupturing the amniotic sac. This vaginal route is used in our perinatal unit.

Caldeyro-Barcia also studied the effect of the synthetic hormone Syntocinon on uterine contractions, and concluded that oxytocin infusion is the most accurate, safe, efficient, and easy way to increase uterine contractility for the induction and/or enhancement of labor.[6]

Besides the monitoring of the patient's uterine contractions in labor, many studies have been conducted on monitoring and assessing changes in fetal heart rate during labor. Dr. Edward H. Hon did extensive studies on various fetal heart rate patterns, showing which patterns were physiologic (early decelerations), and which were pathologic (late and variable decelerations).[7]

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A continuous recording of the fetal heart rate and fetal electrocardiogram is obtained by placing a small "fetal electrode" on the presenting part in utero, after rupture of membranes. Made of a Michel clip coated with silver chloride, the electrode is attached to two insulated, twined-wire threads, and connected through an amplifier to a channel in the Sanborn machine. Both the uterine contractions and the fetal heart rate patterns are constantly assessed. *(Figures 1, 2, and 3.)*

Another means of assessing the welfare of the fetus during labor was introduced by Dr. Erich Saling in Berlin. Acting on the theory that, "almost any disturbance affecting the fetus results in an accumulation of acidic compounds . . . which is easily recognized by blood pH measurements,"[8] he devised a method of obtaining capillary blood samples from the fetus in utero. The doctors in our unit at the Royal Victoria Hospital follow this technique.

An amnioscope is inserted into the vagina to expose the presenting part. By using a tiny blade on a long scalpel, a minute incision (2 mm.) is made, the blood is withdrawn by sucking it into a long capillary tube, and then tested for pH and pO2. In our unit, as in Dr. Saling's, this technique has proved to be an excellent means of assessing fetal wellbeing or distress. *(Figure 4)*

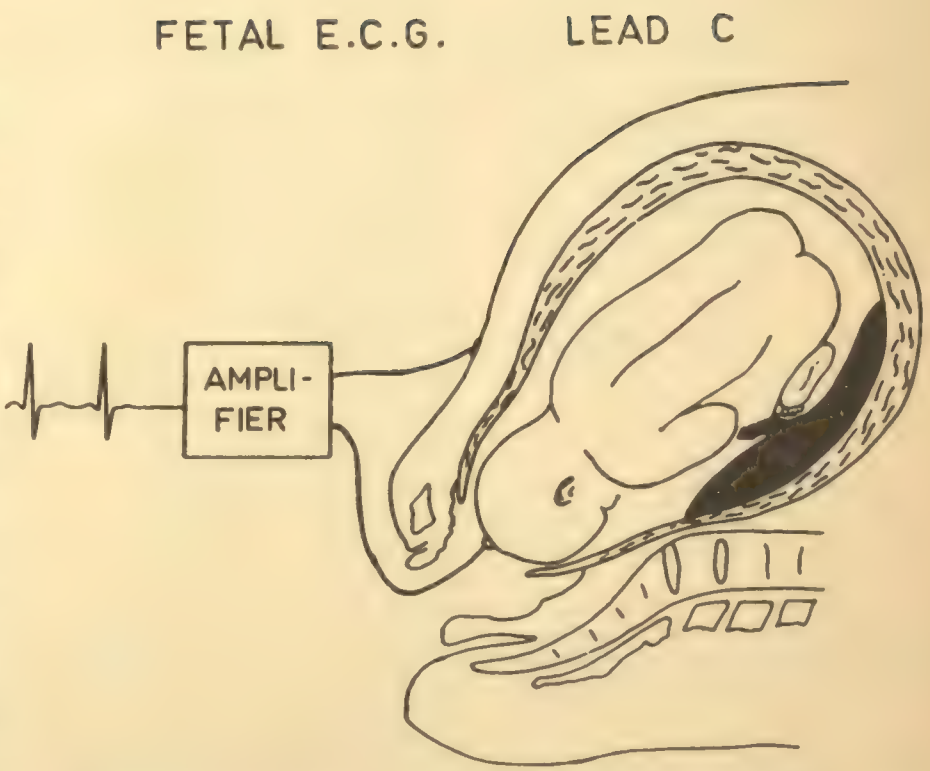

Fig. 1. Electronic monitoring of fetal electrocardiogram. The method is similar to obtaining an adult ECG. Through an electrode placed on the fetal scalp, the ECG is transferred to the monitor to picture the fetal heart rate pattern (average beats/min.) and ECG.

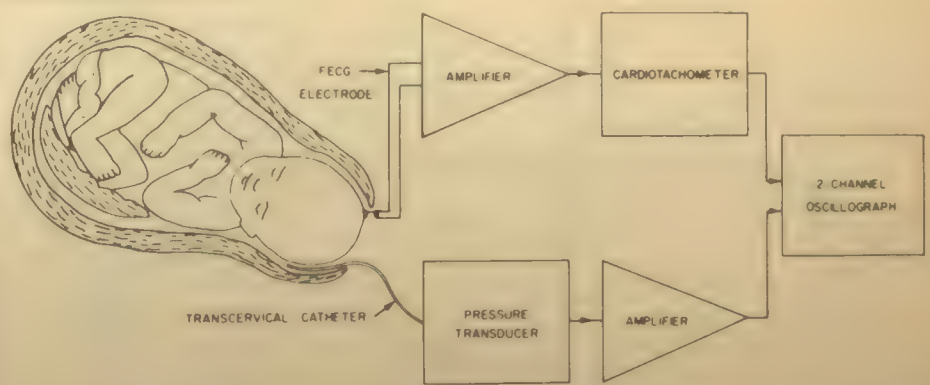

Fig. 2. Fetus being monitored in labor. Fetal electrode and intrauterine (transcervical) catheter in place.

Fetal distress

These are the methods of monitoring the fetus during labor. But how do we know when a fetus is "at risk" or in distress, and needs to be monitored? Because of limited facilities, we cannot monitor every labor.

Fetal distress is difficult to define.

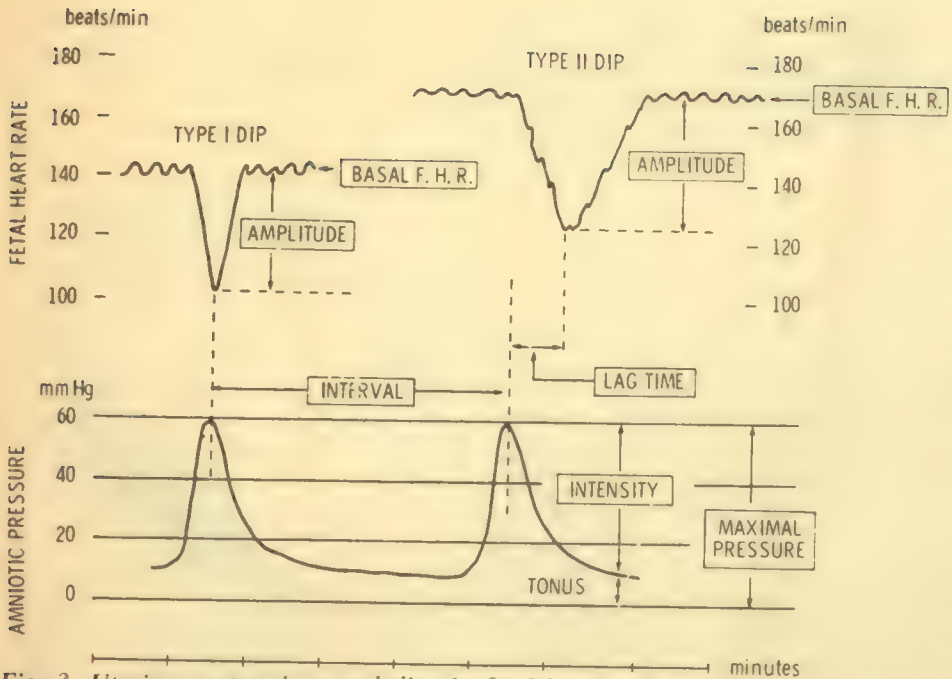

Fig. 3. Uterine contractions and dips in fetal heart rate as seen on monitor. A Type I Dip (early deceleration) is considered normal and nonpathologic; a Type II Dip (late deceleration) is considered a sign of fetal hypoxia.

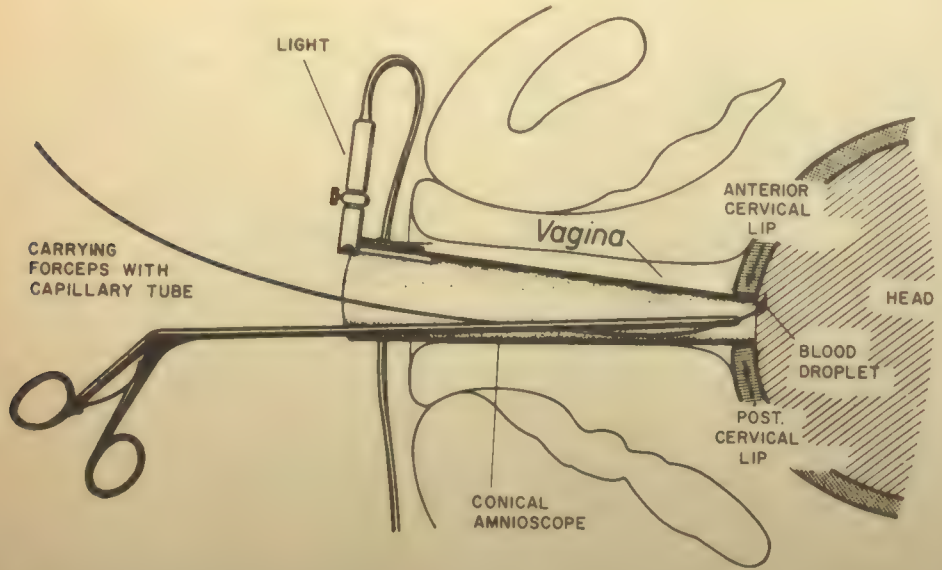

Fig. 4. Diagram showing method of obtaining a fetal blood sample.

According to Drs. N.J. Eastman and L.M. Hellman, "There is no consensus regarding the precise definition of fetal distress . . . . Disturbances of fetal physiology might well be considered part of the syndrome . . . . Prolonged slowing of the fetal heart rate, and, in vertex presentation the passage of meconium, are generally considered signs of fetal distress . . . . Irregularity of the fetal heart beat and abnormal vigorous fetal movements . . . are sometimes included in the syndrome of fetal distress."[9]

These symptoms, manifested during labor, have guided our doctors in deciding which fetuses should be intensively monitored. But it is also important to know, *before* labor, which pregnancy is a potentially "high risk" to the mother or fetus. To do this, we have devised a Point Count System of assessement according to the mother's family and personal history, age, parity, previous and present complications in pregnancy, and coexisting diseases, such as diabetes, cardiac disease.[10] These high risk patients are selected to be monitored through their labor and delivery in the perinatal unit.

The nurse's role

By explanation and by getting to know our patients, we help to overcome their anxieties about the strange equipment and the techniques. For example, the evening before a mother is to be induced, we visit her, introduce ourselves, explain in some detail what will happen to her, and answer her many questions. She meets the same nurses and doctors the next day for her labor and delivery. Postpartum, the nurses visit her again.

The mothers seem to enjoy this continued contact with the same nursing and medical staff. Several have said, as they got to know the staff they developed confidence in them and so

were more relaxed. As nurses, we were pleased to hear this, because we, too, feel a stronger attachment to the patient when we can stay with her until the end of her labor. This is ideal nursing care.

Our patients say the intensive monitoring assures them their baby's safety is always guarded. Many show interest in the recording of their contractions and the baby's heart rate. The husbands, who are welcome to stay with their wives during labor, are particularly fascinated by the electronic equipment. Often they will watch the graph and tell their wives when the next contraction is starting.

There is some discomfort to the mother with this monitoring. Before or during her stay in the unit, she must have a major shave preparation, have blood drawn for cross-match, and refrain from eating or drinking to be ready for a cesarean section at any time.

At present, because of the location and type of monitoring equipment, the mother must stay on the same bed throughout her labor until her baby is delivered. The vaginal insertion of the intra-uterine catheter and the fetal electrode is uncomfortable, and the nurse can help the patient relax during the procedure.

The perinatal unit will eventually include antepartum, intrapartum, and delivery areas. Nurses must be versatile in all these areas and in the operating technique for cesarean section. They must also have knowledge in general medical nursing, as the patients selected often have disorders such as toxemia, diabetes, or cardiac disease.

The satisfaction we gain from working in this unit comes from our involvement in giving stimulating and comprehensive patient care. By working as a team, with medical, electronic, and technical personnel, we find we accomplish much more than if we worked in isolation. The patients sense our enjoyment and feel comfortable and secure.

We hope the intensive care given on this unit will help to decrease the perinatal mortality in this hospital and possibly in the surrounding areas. Between the end of August 1969, and May 1970, we monitored and delivered 170 high risk obstetrical patients. Our experience shows we have definitely helped to prevent stillbirths during labor and neonatal deaths.[11] Also, we can recognize during labor early signs of fetal asphyxia and deliver the baby when indicated, thus preventing fetal morbidity, particularly cerebral damage from asphyxia neonatorum. These babies can be saved from mental retardation and grow up to be healthy, active members of society.

If this intensive perinatal care achieves these goals, it is worth the cost and effort.

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Chemotherapy in hemodialysis

Although hemodialysis is usually the treatment of choice in terminal renal failure, certain common drugs play an important role in the therapeutic picture.

Christine Frye

New equipment and techniques have been developed over the past 10 years to provide long-term, life-saving treatment for patients with chronic kidney failure. The treatment of choice in terminal renal failure is usually hemodialysis, sometimes leading to a kidney transplant. However, certain drugs are frequently used to alleviate symptoms not adequately prevented or controlled by dialysis therapy.

About a dozen common types of drugs, all familiar to the general staff nurse, may be used in conjunction with dialysis therapy. The emphasis in this paper is on the application of each to chronic renal failure and hemodialysis.

Hemodialysis is the procedure in which a patient's blood is shunted from his body through membranes immersed in a chemical bath and then back to his body again. The bath solution contains those chemicals normally found in blood, mixed in warm tap water. Any substance — other than blood cells and most proteins — that is more concentrated in the blood than in the bath will dialyze through the membrane from blood to bath. Water is also removed from the blood by osmotic and hydrostatic pressure.

Dialysis can be used to treat chronic and acute renal failure and drug or fluid intoxication. This paper deals only with patients requiring *chronic* hemodialysis. Depending on his condition and on the type of artificial kidney machine used, the patient is usually dialyzed for 10-36 hours per week.

Pharmacophysiology

Many factors influence the safety and effectiveness of drugs, including distribution in the body, absorption, metabolism, excretion or removal by dialysis, effects of retention, and adaptive limits or impairment of organs. The rates of absorption and elimination determine the amount of a drug in the body at any given time after administration.

Drugs are eliminated by excretion and by transformation into metabolites, each drug having its own rate. At least a fraction of almost all drugs is normally excreted by the kidney. In renal failure, the amount of any substance filtered by the glomerulus is decreased. Most drugs are not significantly reabsorbed by the renal tubules; barbiturates and salicylates are exceptions. Most active drugs are bound to proteins that act as a reservoir, preventing marked fluctuations in plasma levels.

Plasma levels of some drugs, their activity, and potential toxicity are determined largely by renal function. Thus the size and timing of doses of these drugs must be determined for each individual renal failure patient. The use of p.r.n. orders is ill-advised, and orders for drugs must be reevaluated frequently. The toxicity of certain compounds, such as opiates and sedatives, is enhanced in the presence of uremia, even when excessive blood levels are not reached.

The kidney itself is particularly vulnerable to toxic damage for many reasons, including high blood flow and high metabolic activity. The pathologic changes induced by renal failure can cause therapeutic problems. The most obvious of these is irritation and ulcer-

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The author expresses her thanks to Miriam Ridley, Clinical Pharmacy Coordinator at the Ottawa Civic Hospital, and to the pharmacy staff for their cooperation and help. Dr. Bernd Koch and Dr. S.L. Jindal, nephrologists at the Ottawa Civic Hospital, contributed valuable criticism and suggestions. The cooperation of various artificial kidney units and pharmaceutical firms in eastern Canada is acknowledged as well.

ation of the gastrointestinal tract, resulting in nausea and vomiting, bleeding, and intolerance to food and drugs. Indiscriminate use of diuretics in renal failure may lead to sodium and potassium depletion, alkalosis, and dehydration.

In renal failure the nitrogen and hydrogen ion and electrolyte content of drugs is significant. Examples of this are the magnesium in laxatives and antacids; the potassium in salt substitutes and penicillin potassium; the sodium content of sodium bicarbonate and intravenous solutions; and acidifying agents, such as vitamin C. Drugs may also be metabolized to acid or nitrogenous waste products, or they may stimulate catabolism.

Dialysis is known to remove certain common drugs at varying rates, but there are no available data for most drugs. Conversely, trace metals, glucose, and other substances present in the bath water may cross the membrane and cause symptoms in the patient.

Bone disease resulting from dialysate fluoride levels is being investigated in many centers. Two papers presented in 1969 to the American Society for Artificial Internal Organs dealt with hemolysis and death from copper intoxication.[1,2] The apparent cause was exhausted deionizer columns in the central bath delivery system, which released acid to work on the hot copper coil.

Anticoagulation

Probably the most commonly used drug in hemodialysis is heparin, as dialysis without anticoagulation would not be possible. The patient's blood is in contact with foreign material while outside the body for at least a few minutes. Without adequate heparinization, this blood would clot in the membranes, requiring an immediate end to the procedure.

Every dialysis unit has its own protocol for anticoagulation, but generally what is called "systemic heparinization" is used for routine dialyses. A calculated amount of heparin is injected into the system, either at intervals of one to three hours or by continuous slow infusion. Both the patient's clotting times and the machine's clotting times are thus kept well above normal limits, and there is no danger of clotting in the membranes or tubes.

Heparin is prepared from animal liver or lung tissue and is effective in various stages of blood clotting. The principal action is interference with the change of prothrombin to thrombin. Adverse reactions following the use of purified heparin are infrequent. The unit of measurement commonly used is the USP unit, established in 1942 by the Health Organization of the League of Nations. The gram weight of heparin bears no direct relationship to the unit of activity.[3,4]

The main problem of anticoagulation in these patients is undesired bleeding. The patients have external arterio-venous shunts or internal arterio-venous fistulas that provide ready access to the circulation. Bleeding may occur in these areas, particularly with a shunt. Also, uremic patients tend to have excessive gastric acidity that may lead to hemorrhage during anticoagulation. There seems to be considerable variation in heparin metabolism, and the prolonged clotting time may extend for several hours following dialysis. If the patient has had recent major surgery, there is danger of fresh bleeding from the wound.

Fortunately, there is a readily available drug that counteracts the anticoagulant effect of heparin. Protamine sulfate, a complex protein-like substance, is itself an anticoagulant when given in high doses. However, when combined with heparin, the two drugs neutralize each other's anticoagulant activity. Each milligram of protamine neutralizes 78 to 95 USP units of heparin. No specific contraindications are known to the use of protamine; however, sensitivity is possible due to its protein-like nature. It must be given by slow intravenous injection, never more than 50 mg. in any 10-minute period.[5]

The prevention of bleeding in a dialyzed patient is accomplished by "regional heparinization." This is generally used for fresh postoperative patients and for anyone suspected of having a bleeding problem, such as a peptic ulcer. In this procedure, a calculated dose of heparin is infused slowly into the tubing leading to the kidney machine. The correct dose of protamine is infused at the same time and rate into the tubing leading back to the patient. The protamine neutralizes the heparin before the blood reaches the vein. The machine's clotting time is elevated, while the patient's clotting time remains normal.

Antihypertensives

One of the common causes of hypertension is kidney disease. Two types are seen frequently in chronic renal failure patients: renoprival and renal.

Renoprival hypertension occurs in patients with no functioning kidney tissue, and is caused by sodium and water retention. The treatment of choice is dialysis to keep the patient at his normal dry weight. The removal of several pounds of fluid weight during dialysis will effectively lower the blood pressure. Renal hypertension results from the renin-angiotensin complex in the kidney and is treated by drugs and, if necessary, by bilateral nephrectomy.

Alpha-methyldopa (Aldomet-Merck, Sharp and Dohme) reduces both standing and supine blood pressures without directly affecting cardiac or renal function. It is usually well absorbed after oral administration, but can be given parenterally as well. It is largely excreted by the kidneys, so patients with impaired renal function may respond to smaller than usual doses. It is not strongly bound to plasma protein, and has been found to dialyze rapidly and completely.

Aldomet is one of many drugs that

initiates red cell destruction by an immune reaction. For this reason, patients taking Aldomet may have a positive Coombs' test, and difficulty may result when crossmatching blood or after a transplant.

A second commonly used drug is hydralazine HC1 (Apresoline — Ciba), which reduces both systolic and diastolic pressures and increases cardiac output and renal blood flow. Apresoline has no sedative component, but may potentiate the narcotic effects of barbiturates and alcohol. It is given both orally and parenterally, and is used cautiously for patients with coronary disease, advanced renal damage, and cerebrovascular accidents. Although many varied side effects have been noted, particularly those associated with hypotension, they tend to disappear as treatment continues. If they do not disappear, combination therapy with other drugs, such as reserpine or a diuretic, may be advisable.

Antibiotics

Chronically ill patients are always susceptible to infections, particularly when they have suffered from weight loss and inadequate nutrition. Patients with chronic uremia are no exception; in fact, infections of various kinds are among the most frequent complications of renal failure.

Wound infections following surgery, upper respiratory infections, and urinary tract infections occur frequently and must be treated vigorously. Repeated insertions of peritoneal dialysis catheters may lead to peritonitis, and local infection leading to septicemia is a common complication of an A-V shunt. The use of an A-V fistula whenever possible eliminates the latter problem.

In treating any infection in a chronic renal failure patient, the doctor recognizes that the kidneys are the major route of excretion for many antibiotics. Thus, the dosage may have to be reduced to prevent a buildup of dangerously high plasma levels. On the contrary, some of these drugs are highly dialyzable, and a large portion of an administered drug may be lost through the machine. In these cases, it is sometimes best to give the required dose intravenously at the end of dialysis, so the patient will receive the full benefit in the ensuing hours.

Considerable research is being done on the elimination and dialyzability of various antibiotics. Results are often conflicting, and little definite information is available. Of interest is the anti-anabolic effect of the tetracyclines, which may produce an increased blood level of non-protein nitrogen. In patients with significant renal impairment, higher serum levels may occur with development of azotemia, hyperphosphatemia, and acidosis. The elevated blood urea may not accurately reflect changes in renal function; serum creatinine is a more reliable parameter.

Analgesia and sedation

As with any chronic disease, there is a danger in chronic renal failure of drug dependence and habituation. However, certain symptoms deserve treatment, and prominent among these are discomfort, anxiety, and insomnia.

Patients may complain of headaches, muscle cramps, and peripheral neuropathies. Many react to the stress of dialysis therapy and dependance and are not quite able to cope with their new way of life. Inactivity for disabled or unemployed patients, worry about financial or family problems, and discomfort all tend to prevent easy sleep. For these patients, analgesics and sedatives provide welcome relief. With so many of these drugs available, it is impossible to consider them all in this brief review. However, the most commonly used are the salicylates and the barbiturates.

Both local and widespread pain of low intensity is alleviated by the salicylates, which have a lower maximal effect than narcotic analgesics. Salicylates are frequently combined with other drugs, such as phenacetin, caffeine, and codeine, to provide more effective pain relief.

Orally-ingested salicylates are readily absorbed from the stomach and upper small intestine, and appreciable plasma concentrations are reached in less than 30 minutes. Salicylates are excreted mainly by the kidney and in trace amounts by other channels. Although the drug can be found in the urine within a few minutes after administration, excretion is relatively slow. Because of this, fairly constant blood levels can be maintained with doses spaced at four- to six-hour intervals. Urinary pH directly affects the clearance.

Salicylates are removed by hemodialysis four times faster than they would be by exchange transfusion or peritoneal dialysis. Perfusion through charcoal is even more effective.[6] The other components of the ASA compounds are small enough to be moderately dialyzable, with protein binding being a limiting factor.

Codeine is generally absorbed from the gastrointestinal tract. It is metabolized in the liver and excreted chiefly in the urine, largely in inactive forms.

Research is continuing on the role of analgesics, particularly phenacetin, in renal papillary necrosis. Because a uremic patient has relatively little functioning kidney tissue, there is less danger to him than to a person with healthy kidneys who abuses analgesics. Nevertheless, the patient must be warned of the risks involved in taking excessive amounts of APC tablets after a successful transplant.

The tranquilizer we find most useful in the unit at the Ottawa Civic Hospital is diazepam (Valium — Hoffman-La Roche), which has sedative, muscle-relaxant, and anticonvulsant properties. It is indicated for the symptomatic management of mild to moderate degrees of anxiety, but is not recommended for psychotic or severely depressed patients.

Valium is well absorbed from the gastrointestinal tract, and its effects appear one-half to one hour after oral administration. Results from parenteral injection appear in 15 minutes. It is detoxified in the liver, and the metabolites are excreted in urine and stool. Safety and efficacy in pediatrics and

obstetrics have not yet been established.

Other antidepressants, narcotics, barbiturates, and alcohol may potentiate the action of Valium. Also, abrupt cessation after prolonged administration may precipitate acute withdrawal symptoms. The most common side-effects are drowsiness and ataxia, making it effective for bedtime sedation as well as for the treatment of anxiety. No specific antidote is known, and hemodialysis does not significantly lower blood levels.

Perhaps the most commonly prescribed sedatives are barbiturates, of which there are over 30 types. They depress activity of nerves, skeletal and smooth muscle, and cardiac muscle. However, barbiturates are unspecific in their effects and are capable of depressing a wide variety of biological functions. They are generally divided into two groups: long-acting and short-acting, depending on the rate they are metabolized in the body.

Barbiturates not destroyed in the body are excreted unchanged in the urine. As much as 30 percent of a total dose of phenobarbital may be excreted this way. When kidney function is impaired, barbiturates that depend on the renal route for excretion may cause severe depression of bodily systems, thereby further reducing kidney function. Uremia may increase sensitivity to these drugs.

Depending on the specific drug involved, hemodialysis generally removes barbiturates 10 to 30 times faster than diuresis. Removal of short-acting drugs by diuresis and dialysis is limited by protein binding and by sequestration in body fat from which removal is slow.[7] It is believed that hemodialysis removes barbiturates about four times faster than peritoneal dialysis; albumin added to the dialyzing fluid binds the drug and nearly doubles the removal rate.

Digitalis

Uremic patients are apt to develop physiologic changes suggestive of cardiac muscle disease. One form of cardiomyopathy is due to the specific toxicity of the potassium ion on the myocardial muscle cell. A second form is due to hypertension, which has already been discussed. A third form is the result of arteriosclerosis, and a fourth, the apparent congestive heart failure produced by sodium and water overload. Anemia may also play a part in the development of heart failure.

Various preparations of digitalis are sometimes used to treat these cardiac symptoms. Digitalis has three principal effects: it increases the force of the systolic contraction, decreases heart size and increases muscle tone, and slows the heart rate. It is indicated in congestive heart failure and in auricular flutter and fibrillation. The digitalis compounds are excreted primarily as unchanged glycosides in the urine. Excretion is prolonged in the presence of renal insufficiency and in renoprival humans.

Toxic levels of digitalis preparations produce anorexia, nausea and vomiting, and cardiac arrhythmias. Of special interest in dialysis patients is the relationship between potassium and digitalis. Potassium depletion sensitizes the heart to digitalis intoxication and may produce arrhythmias even with recommended doses. Frequently, patients with renal failure do not excrete their potassium and the serum level builds up between dialyses. An attempt is made to remove this excess potassium during dialysis, as too high a level may cause a cardiac arrest. Caution is taken with any patient receiving digitalis to avoid wide swings in potassium levels.

Toxicity from digitalis is also seen in aged and debilitated patients, those with hypothyroidism, and advanced hepatic disease. Increased myocardial irritability, which may accompany some of the biochemical changes of renal failure, adds to the therapeutic problem. For these reasons, digitalis is ususally avoided in dialysis patients, especially since more often than not congestive failure can be controlled by a negative sodium/fluid balance.

One study performed in the United States in 1967 demonstrated the extent to which digoxin is removed by dialysis.[8] It appeared that the largest portion of the drug was stored in tissues, and the small amount available in plasma was the major factor limiting its removal by dialysis. These experiments indicated that the amount of digoxin dialyzed out is sufficiently small to be ignored in choosing doses for chronic dialysis patients.

Other commonly-used drugs

The kidneys play an important role in maintaining the acid-base balance of the body. In the presence of chronic renal failure, plasma bicarbonate sometimes falls to dangerously low levels. The most convenient form of raising the level is by giving sodium bicarbonate tablets, but rapid intravenous administration of sodium bicarbonate may be necessary in a crisis. Also, commercially-available dialysate solutions contain sodium acetate or sodium bicarbonate, and dialysis with a slightly alkaline bath will temporarily restore plasma pH to a level compatible with survival.

Raising the plasma bicarbonate level to 15-18 mEq/L is usually sufficient; full correction (to approximately 23-26 mEq/L) is not justifiable, as it carries with it the risk of overloading the system, upsetting sodium and water balance, and causing tetany. Therefore, treatment is reserved for the patient whose plasma bicarbonate level is below 15 mEq/L, the level at which symptoms of acidosis commonly occur.

Among the compounds formed in the gastrointestinal tract is aluminum phosphate, which passes unabsorbed. Dialysis patients tend to have high serum phosphate levels, so are often given aluminum hydroxide gels that bind the phosphate in the intestine and lower the serum level. Large amounts are usually required to be effective, and nausea or constipation can result from continued large doses. All aluminum-containing antacids are non-systemic in effect, because their insolubility prevents their entering the blood stream.

Although vitamins are generally helpful to a chronically ill patient, the

vitamin B complex preparations may be of additional benefit to a patient with chronic renal failure. These complexes contain a large number of vitamins that differ greatly in chemical structure and biological action. They are grouped together because they are all water soluble and are obtained from the same sources.

It appears that the most beneficial effect of the B vitamins is in treating peripheral neuritis, parasthesias, and other nervous system symptoms. Peripheral neuropathy, including the "restless leg syndrome," painful, burning feet, and so on, is a relatively common and disabling complication of uremia.

Vitamin C is widely used for the treatment of such diverse symptoms as infections, anemia, malnutrition, and hemorrhagic states. However, little data exist on the relationship of vitamin metabolism to uremia, and perhaps the most valid reason for giving vitamin supplements is that many diets for uremic patients lack standard vitamins. Loss by hemodialysis has been suggested, but not proven.

One dialysis patient, who was given several injections of 50 mg. of thiamine (vitamin B_1) intramuscularly, experienced difficulty in speaking following these injections. Whether or not this was due to the thiamine is difficult to say. Goodman and Gilman report that isolated clinical evidence exists of toxic reactions to the parenteral administration of thiamine, which probably represent rare instances of hypersensitivity.[9]

Male sex hormones are known to have anabolic effects. Different brands of testosterone are often prescribed for male uremics because they cause an increase in muscle mass and body weight, with retention of nitrogen, phosphorus, potassium, and calcium. Since muscle breakdown is diminished, there is less protein waste product accumulation in the blood stream. It is these waste products that produce the elevated serum urea and creatinine levels seen in uremia.

Excessive or prolonged use of testosterone can lead to physical and sexual changes, and it is contraindicated in the presence of prostatic carcinoma. Androgens tend to promote retention of sodium and water, always a risk in renal failure, and hypercalcemia may occur. An androgen is usually given in an oil-soluble form by intramuscular injection, at three- to four-week intervals.

One manifestation of uremia is anemia, which may cause symptoms such as weakness and dizziness, palpitations, or heart failure. The trend in chronic hemodialysis is to transfuse patients as seldom as possible, but these patients do require occasional donor blood. When symptoms of anemia occur, or before elective surgery, packed red cells are given during the dialysis. As with any transfusion, a reaction may occur, despite careful crossmatching.

Antihistamines reduce the intensity of allergic and anaphylactic reactions. They are readily absorbed from the gastrointestinal tract and from parenteral injection sites. After oral administration, effects can be noted in 15 to 30 minutes. Diphenhydramine HC1 (Benadryl — Parke, Davis), probably the most commonly used, leaves the circulation rapidly and reaches peak concentrations in tissues in one hour. Little, if any, is excreted unchanged in the urine.

The most common side effect of antihistamines is sedation, and this may be accompanied by other nervous system effects. This is of real importance in hemodialysis, as the patients are usually discharged soon after the termination of dialysis. If an antihistamine has been given, the patient must remain in hospital until the sedative effect has worn off, unless he can be taken home by a responsible adult. The digestive tract may also be affected by antihistamines, but gastrointestinal disturbances are uncommon with Benadryl. Despite its antipruritic action, Benadryl does not alleviate the itching commonly associated with uremia.

Summary

A totally inclusive review of drugs used in connection with chronic renal failure and hemodialysis is impossible, as the uremic syndrome involves the entire body, and the number of possible symptoms is limitless. Routine drug orders vary from center to center, depending on the preferences of the physicians and the drugs available in the hospital pharmacy. This paper has dealt only with drugs commonly used in most hemodialysis units.

Two points must be drawn from any discussion relating pharmacology to hemodialysis. Dialysis cannot do the job alone, and many symptoms of chronic renal failure require appropriate medication as well as adequate dialysis therapy. However, more dialysis is often the best treatment of uremic symptoms, and in many cases the use of drugs would merely mask the patient's symptoms.

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Esophageal manometry

A record of esophageal motility, combined with a careful history and x-ray results, can contribute to the physician's investigation of the patient with a suspected esophageal lesion.

Huguette Robidoux-Poirier

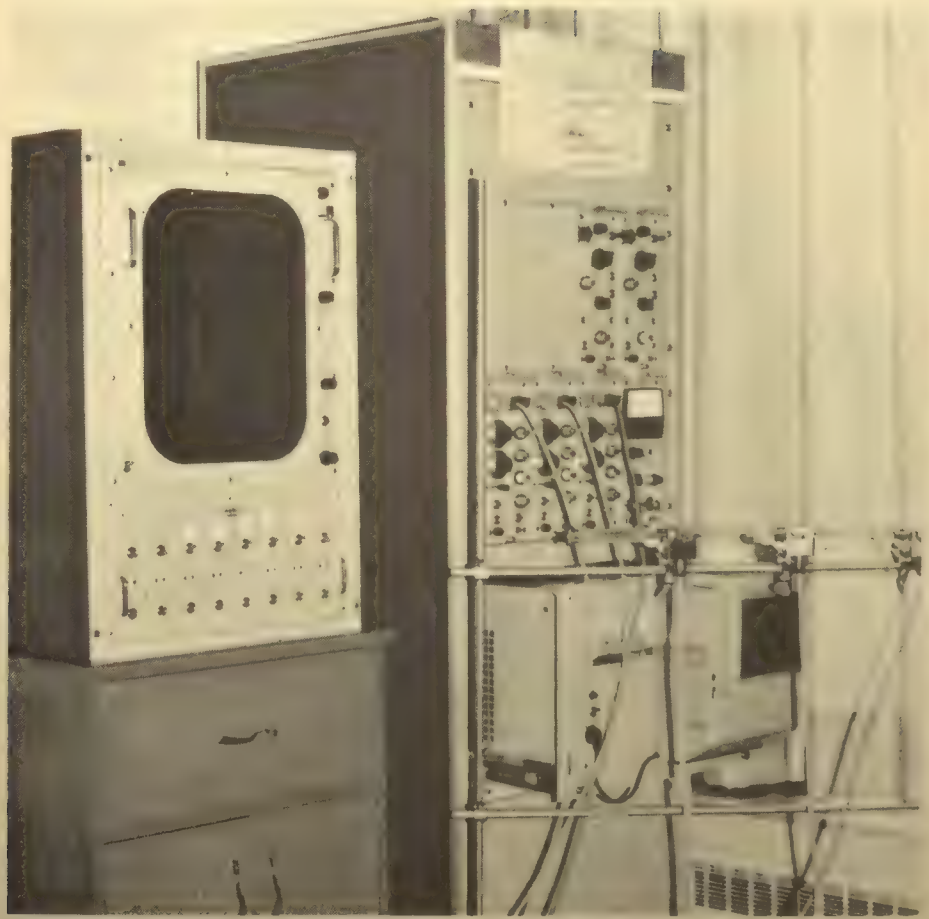

Fig. 1. The esophageal manometer used to record esophageal motility.

Differential diagnosis of chest pain is complicated by similarities in the symptoms produced by cardiac and esophageal lesions. This is not surprising, as both the heart and the esophagus are innervated by the vagus nerve.

A patient may complain of retrosternal pain, radiating down the left arm or both arms; diaphoresis; weakness; and may actually have diffuse esophageal spasms. His discomfort may even be relieved by nitroglycerin, with the result that angina pectoris is suspected. If, under such circumstances, the electrocardiogram is normal, a tracing of esophageal motility may be the deciding factor in establishing a definitive diagnosis.

Determining the underlying cause of dysphagia may be easy or difficult. It can be an unpredictable symptom, sometimes appearing only under the stress of great emotion, or during inges-

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tion of cold fluids. Again, manometry may provide the answer. Achalasia, characterized by defective sphincteric relaxation and loss of normal peristaltic action in the body of the esophagus, usually is accompanied by severe dysphagia and postprandial vomiting of non-acid foods. On the other hand, difficulty in swallowing has much less relevancy and is a comparatively minor factor in diffuse spasm of esophagus.

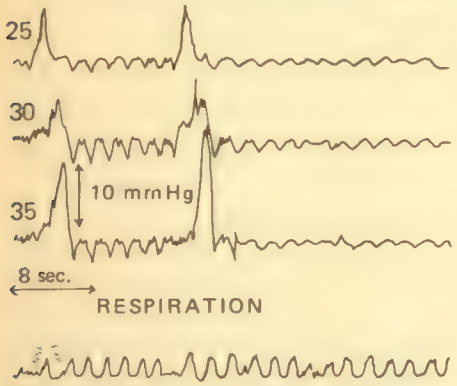

Fig. 2. An example of normal sequential peristalsis.

Esophageal manometry has particular value in diagnosing scleroderma when cutaneous signs are minimal. Epigastric or retrosternal burning produced by reflux of hydrochloric acid is indicative of possible hypotonia of the esophageal sphincter or diaphragmatic hernia. As these abnormalities are sometimes difficult to demonstrate radiologically, manometry may be helpful.

Equipment and technique

An electronic recording device and three polyethylene catheters comprise the equipment. These intra-esophageal catheters are connected to transducers that register pressures from several areas simultaneously. The oscilloscope picks up variations in pressures immediately and a permanent record is registered on photographic paper.

The completed graph shows four bands: the first three correspond to the pressures transmitted by the catheters; the last one, to respiratory movements. The pressures registered at each level are compared at the end of inspiration and expiration.

The nurse's main responsibilities are to check for proper functioning of the equipment and to prepare the patient, whose cooperation is essential.

The patient is placed in a supine position, and the polyethylene catheters are passed into his stomach. Each catheter has a single opening, and the three catheters are arranged so that when in place the openings are spaced at five, ten, and fifteen centimeters from the distal ends. A closed circuit permits the introduction of a physiological solution into each catheter. The pressures produced in the esophagus are then transmitted to the transducers. The catheters are withdrawn gradually, centimeter by centimeter. Respiratory movements are recorded by a pneumograph strapped around the patient's chest.

The most critical areas are the points of high pressure and pressure inversion. The high pressure zone extends for three to six centimeters, and corresponds to the gastroesophageal sphincter. A positive pressure is recorded in the stomach during inspiration; a negative one, in the esophagus. The point of pressure inversion corresponds to the line of demarcation between abdomen and thorax. It usually occurs in the middle of the high pressure zone, and corresponds to the diaphragmatic hiatus.

The first recording is a "resting study," with the patient refraining from swallowing. The procedure is repeated, during which time the patient is requested to swallow at regular intervals so that peristaltic action can be observed. Normally, the waves are sequential, that is, they move in an orderly fashion from the top to the bottom of the esophagus. In disease conditions the patient may show abnormal repetitive contractions occurring in various portions of the esophagus simultaneously. During this second reading, the relaxation of the lower esophageal sphincter, which precedes the peristaltic wave, is studied. This action is faulty in achalasia.

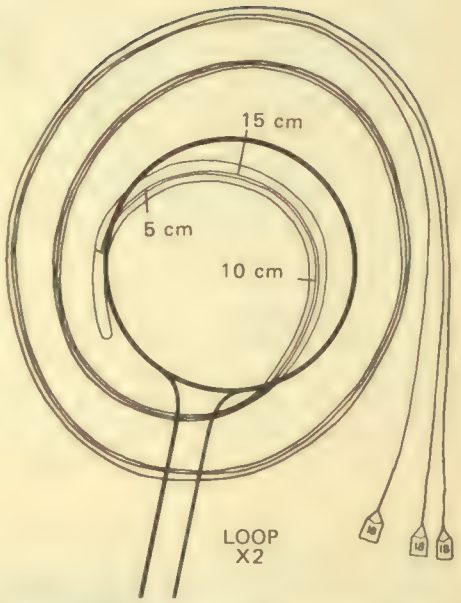

Figure 3. The sketch depicts the three polyethylene tubes with their respective openings.

In conclusion, esophageal manometry has significant value in the clinical investigation of patients suffering from chest pain of questionable cardiac origin, dysphagia, or gastroesophageal burning.

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On the edge of a cliff

Drug addiction in the schools is an accepted fact; therefore it was not necessary for The Canadian Nurse to attempt an exposé. While delving into the extended role of the nurse, it became clear the drug scene was another facet of the nurse's greater involvement in paramedical duties. Indirectly, the school drug problem led to an insight into social responsibilities and fundamental issues requiring cooperative community action.

Mona C. Ricks

Some charge it's the fault of parents, others say it's the thing to do. Whether young people are shifting the blame for their actions on others or not, facts show — drugs have entered the school scene, and at many levels. What is being done to prevent and control the *ogre* seems hazy. Much depends on the origin of help.

Social, health, and federal agencies, maintained by public and tax donations, have set up programs aimed at preventing and controlling. But the programs are hampered by isolation. They lack coordination of purpose. Perhaps this is attributed to a theory — he who works alone achieves the most.

Even though drug education is included in school health programs, the increasing number of students known to be on drugs surely calls for a program review.

One public health official, in a northern Ontario town, places the weight of responsibility for in-depth drug education on a program of pooled knowledge, managed by educationists familiar with the need.

"Prevention is the greatest educational need," Florence Tomlinson, director of public health nurses in Sudbury, contends. "If only we could get together as a team, we might get to the students. As it is, drug education is splintered, handed out piecemeal. Each organization jealously guards its own program, approaching the problem from all angles."

Miss Tomlison's call has yet to be fulfilled.

What is being done to educate young people on the dangers of uncontrolled drug use? Why should they listen to adult reason, when adult reason cannot control its own drug demand?

What, why?

The *why* is echoed by students, not only in high schools, but also at the elementary level.

Why, they ask, can't we do what we want with our own lives? Why can't we take drugs as adults do — and with wild results?

It would be nice if the drug-aware agencies could give a pat reply. Better still, that medical and school authorities could cry, "Hold, here is the answer." But they cannot. And the young people know this — and laugh!

Apparently the Ontario and federal governments are aware of the situation. Through the Ontario-sponsored *Addiction Research Foundation,* (ARF), an Ottawa board of education survey acknowledges that between 10 and 20 percent of the Ottawa student population has tried drugs. And in a department of national health and welfare

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Mona C. Ricks was assistant editor of *The Canadian Nurse* when she wrote this article.

supplement, information supports the long-known fact that drugs are part of the Canadian school scene. But what is being done to prevent it, and what is being done to assist habitual users, is inconclusive.

To get a nurse's reaction to the school drug problem, *The Canadian Nurse* went to a public health unit in Sudbury, Ontario. How does the public health nurse fit into the drug education program — how does she attend to the needs of students on drugs — how does she meet the drug challenge?

Director of public health nurses, Florence Tomlinson, said her staff is aware of the problem. Coping with it is a matter of meeting each case as it comes, and hoping for the best.

Asked what the public health nurse did when a student sought help, Miss Tomlinson said, "So many come with headaches, it's difficult to know right away if there is a drug problem. But, if the nurse sees symptoms of drug use, she tries to encourage the student to talk it out.

From then on the course of action is a thorny experience. The nurse is not committed to *protect* the student from ensuing consequences. Although the student may not want parents or school and medical authorities to know, she *must* get help for the young drug user.

Contact with parents is usually the nurse's first move. The response isn't always encouraging. Often parents get angry and refuse to believe their child takes drugs. They show little interest. A few listen quietly and agree to talk it over with the nurse and student.

Public health nurse Lola Holmes of the Sudbury health unit, said parent reaction to the problem is a determining factor in getting at the problem. Will they help or will they disown the child?

Many students are scared to go to their parents, and have to be talked into accepting this as the first step the nurse must take.

With parent consent, the young drug user is usually referred to the family doctor, who may seek counseling assistance from an outside agency, such as the ARF.

Mrs. Holmes explained students feel a school principal may take a strong legalistic position and may bring in the police. The kids want help, not punishment; they close ranks

when they feel police are on a case. It's fashionable to go against the law and the kids feel this is the thing to do.

The nurse acknowledged a principal does have a responsibility to the law and must notify police when a student is known to take or push drugs. What is frightening, is that the students look on a principal and the police as enemies. Yet, the parents hold the principal and the law responsible for the well-being of the student in school. Contrary opinions clash with the demands of law. The student is a mash, held between absolute application of the law, and an understanding nurse who wants to help without causing fear and hostility.

Miss Tomlinson says she has sympathy for a school principal, who is in a difficult position. "He has to abide by the law and yet try to help the student."

The head of Sudbury's public health nurses is sure a cooperative approach to drug education in the schools would come to grips with the situation. Talks with the local ARF have shown agreement on this. The preventive role drug education needs to take is a vital issue, according to Miss Tomlinson. What better than all agencies getting together and working out a program which can reach young people, without causing hostility.

"If we can have a student die of drugs — if we can have them say they do not understand that drugs are dangerous — then something is wrong with the educational system. We are not getting to the kids if they are not fully aware of what can happen to them under drugs. We (adults) have failed. We've missed the boat."

For the public health nurse it's a matter of looking at budgets carefully to see that more help can be made available. "We have a public health problem here, and an educational one," admits Miss Tomlinson.

Nurses in Sudbury public health unit were against the appointment of a central body to coordinate the efforts of provincial and local agencies. As they put it, "We don't want to confuse, we want to sort out the scrambled mess." They were more concerned with working with what is available. In their view, the ARF is the obvious agency to take the leadership role in Ontario.

Public health nurse Jean Erion's reaction to the drug problem is an unending concern, mixed with helplessness.

"What *can* we do for young people?" she asked.

In her visits as a volunteer in a downtown Drop-In Center, Mrs. Erion says she meets young people high on all types of drugs. They experiment with hard and soft stuff — opiates, heroin, morphine, barbiturates, and a poor mixture. Amphetamines, marihuana, and hashish are treated as a "regular thing."

"They don't care what they take when they are hooked, as long as they get drugs. They'll even 'shootup' banana oil."

She hasn't given up hope.

Known users are starting to seek her advice. Previously, students covered up "very nicely" for each other, "it was a real underground movement."

Now, drug talk is open. Students talk freely in and out of school. But the nurse admits there is a long way to go before students really trust the authorities.

"They clam up if they feel we are part of the establishment. We have to feel our way with them. It's touch and go all the time."

Getting to know the students' home life is usually the key to why a young person takes drugs. The root goes deep into family life. When asked why they take drugs, the reply is parrot-like. The nurse says she can predetermine the answer.

"Fed up at home. Need to get away from problems at home and at school. Sick of being pushed around. They (the parents) take the stuff. They don't have time for us."

Public health and ARF workers agree, the home environment is the root cause why young people start on drugs — not necessarily economic.

Students admit you don't have to be in the money to get drugs. If you want them, there's always someone to take care of you. What they don't get in their own family they find in peer communities — love and a family feeling. There's a community among the student drug faction that makes drugs readily available. They help each other, even if it means only a few square feet of floor space to sleep off the effects.

Sudbury's help for the young drug addict isn't any more or less than another city or town with the same problem. So why choose Sudbury as an example? Because the health unit and the ARF applauded the journal wanting to get something to a public apparently deaf to a social need.

For the provincial government sponsored ARF, work with drug and alcohol addiction is a continuous educational demand. What the agency learns from close studies is passed to the public in hordes of pamphlets and in audio-visual outlets.

ARF Director of Northern Programs, Basil Scully, says the agency is only skimming the top of the school drug problem. He, too, wants to see a coordinated school drug program — even though it means extensive changes in the present approach.

Educational material on drugs and drug abuse from ARF is constantly under review. Until the beginning of this year most of the literature was directed to the adult. Hardly a sentence recognized the adolescent problem. During the last nine months the material has either been rewritten or new copy composed to meet the needs of young drug users.

Research on the adolescent use of drugs has not been easy. According to Mr. Scully young people are sceptical of adult interest in adolescent drug use. They view material on the subject as propaganda. If a film or piece of literature is slanted, it looses its objective — student attention is turned off.

The Sudbury ARF director maintains adolescent drug users do not face the realities of the world around them — another reason why he and his co-workers try to avoid *preaching* when telling what drug abuse can cause.

But there are many miles to tread before students accept the dangers of drug abuse. Education in the schools is still an experimentation. More hard

facts are needed.

Describing how ARF gets into the schools, Mr. Scully said, "When we started to approach the high school system in Sudbury our work was mainly with the young alcoholic. School reaction was unfavorable. Then the drug scene erupted, parents and teachers got upset, and requests for drug information came rolling in."

The foundation goes into the schools only after a request has been received from the school authorities.

Individual classroom discussion, involving the teacher, although not ideal, at least gives the student a chance to talk out problems. One of Basil Scully's greatest concerns in school drug education is how to involve the teacher. "So often the teacher feels inadequate to discuss drugs. The kids know this. They sense when the teacher is uptight."

As the public health nurses say, so agrees Mr. Scully: drug abuse in the schools is a community and parent responsibility — cooperation is vital.

Talking to students in their own language, in a meaningful dialogue, and by a recognized authority, is another necessary approach to pooling educational ideas.

According to Mr. Scully the public health nurse is an important factor in getting at the school drug problem. He described her role as a facilitator — one who applies pressure on school authorities to have drug discussions in the school. Her contact with known drug offenders gives her an insight into the problem long before it comes to the attention of school authorities.

It is also a nurse who talks to the students when foundation workers go into the schools.

On the Sudbury ARF staff two full-time counselors are registered nurses. With permission from school authorities they conduct classroom discussions on drugs and alcohol. Personal problems are often revealed, and the student is encouraged to seek advice and help.

Kathleen Lauzon and Rose McCann have had many years experience as registered nurses in community work. Training nursing students on alcohol and drug problems is another part of their work with the foundation. But, says Mrs. Lauzon, we are barely touching the problem. We could do with many pairs of hands.

Lola Holmes, shown entering a Sudbury school, says the nurse's first step is to persuade the student to tell his parents about his drug problem.

If Kathleen Lauzon and Rose McCann have an extensive hat wardrobe, it is because their work so demands. They change hats frequently, counseling marriage, social, welfare, alcohol, and drug problems.

Doctor Bernard Lavallee, director of the ARF Sudbury Centre specializing in prevention, works with the nurses. He says they are important to the team. One strength they must have above all others — empathy. If the nurse can radiate an understanding of the student's problem, she is indeed a jewel.

Asked if nurses were taking over paramedical duties in the foundation's work, Dr. Lavallee's positive reply came quickly. He wondered why there should be any question. "It is an accomplished fact. I think many doctors' duties have hung on through tradition. The doctor spends years establishing a little empire, the nurse must know how to crack it."

Doctor Lavallee described school interest in the drug problem as "controversial."

Most students the foundation is asked to help are dropouts — 14, 15, and 16-year-olds. Some are younger — 12 and 13. He said his research found neither the student nor the school were enamored of each other, and parents had lost contact. "There's not much time left when they get to us."

Praise for follow-ups and interviews with parents by Sudbury public health nurses came from the ARF medical director. He agreed, the total perspective of drug prevention and help is still inadequate.

Total perspective, according to the doctor, means *all* agencies working together. "Make no bones about it, drug abuse in the schools is a problem — we'd better move fast to help."

Dr. Lavallee's bull's-eye shot was directed to education — not only do students need to know *what* drugs are, but also *why* they started to take them.

"Many kids live under family turmoil — an instant setup for drugs and alcohol. They are exposed to parents taking drugs to go to sleep and stay awake, drugs to relax and pep up, and alcohol to make merry."

Therapeutic counseling for the drug user is a strong arm of the ARF. In Sudbury Algoma Sanitorium, two full-time workers keep watch on inpatients. Assistant medical officer, Doctor Klara Waldmann, and social worker, John Scott, are in daily contact with school drug users, not infrequently requiring medical treatment for side effects of drugs.

A 17-year-old female drug addict, voluntarily in the sanitorium undergoing detoxification and treatment for hepatitis, described drugs essential for her to keep going. Conversation with her went like this: *Why did you start taking drugs?* I wanted to get a kick, was fed up with my home and school, and I didn't care anymore. The first thing I took was two tabs. I got

them from a guy at school. I didn't get off the first night, so I dropped some more during history class the next morning. I felt awful, but I didn't care. I just wanted to get off. Then I started to giggle, hallucinate, and wander — right there in class.

Were you scared? A bit. When I talked to the kids after school, I found this was regular in my class. Many of the kids were getting off.

Did you think this was the only way to get away from your problems? It was the only way. From two or three times a week on different drugs, cocaine and smoke, I got to need them daily. Then I moved to speed.

How did you get the drugs and money to buy them? I became a pusher. I went to Toronto, got the stuff, and pushed at school. I always had dope for myself and enough for the kids.

What caused you to stop? I didn't want to. Someone I knew got busted for pushing. My parents got wind I was in the gang and went to the police. They were told I was being watched. So I left home in a hurry, went to Spadina in Toronto, and got sick. I saw a doctor who referred me to my family doctor in Sudbury, and I was brought to the attention of the foundation, and then to the san.

How are you feeling now? After four weeks being brought down I'm feeling a little better. It's terrifying being brought down. I still want the drugs.

Do you want to get rid of the drug desire? I haven't decided.

When you leave the san, what will you do? Is there anything that will deter you from taking drugs again? Nothing. Probably be a repetition of what I've gone through for the last two years — taking and pushing drugs, and getting busted.

Where do you think this will lead you? It'll probably kill me.

Aren't you worried? No. I'm more concerned with finding myself. I want to know me. I haven't the slightest idea how to start — but I have to.

Do you think drugs can help you find yourself? It seemed so when I was on them. I got some kind of security and strength. I felt lost when drugs were taken away.

Do you want to go back to school? No. I don't think they will have me anyway. I've no ambitions.

On the other side of the fence, talking to three children of a Sudbury community worker brought these comments: Two said they were not at all interested in drugs. They knew of the school drug problem, but had never felt inclined to be involved. Both were university students, both acknowledged they knew students who were supposed to be on drugs. The elder of the two said she wondered how anyone could want to take drugs — and if enough was said to warn kids on drugs. The third teenager said she was aware of the drug problem in Sudbury. She had been a curious drug-taker herself for a short time. She found smoke wasn't what she wanted. But there were others who were "stuck on drugs."

Because she was happy at home, this teenager's curiosity remained as such. She was able to talk about it with her parents, found the kick was mostly talk, and soon dropped the habit. Drugs, she said, are easy to get in Sudbury. "You can start at one end of the main street and by the time you get to the other end you can have enough money for a fix — the gang takes care of the gang."

One case under the care of Nurse Lauzon was described as typical of student turmoil and parent perplexity. An 18-year-old, grade 13 student, averaging 90 percent marks, went on speed. Six weeks later her average dropped to 70 percent. She was distraught and escaped to Toronto, where she found her peers. Sickness drew her back to Sudbury. Referred to the foundation by her father, the girl was hostile, wouldn't talk, regarded the nurse as the establishment image, would not trust. Many hours talking between the girl and the nurse and a rapport was established. Mother and father joined the talks. Both parents had a problem. The father felt isolated in the family, the mother a martyr to self-appointed tasks. Each had a hangup, blaming one another for the daughter's drug problem. Family communication was nonexistent. The daughter escaped family pressure through drugs.

Success was Nurse Lauzon's finale to this story. The family learned to communicate, the girl dropped drugs, went to university, and achieved good marks.

But sunshine doesn't always follow a stormy night. As the sanatorium patient said, "It'll probably kill me."

In the meantime, perhaps someone will compose a recipe for the young drug addict's search for himself. It's been done for alcoholic hangovers.

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books

Pharmacology and Patient Care, 3rd ed., by Solomon Garb, Betty Jean Crim, and Garf Thomas. 598 pages. New York, Springer Publishing Company, Inc., 1970.

Reviewed by N.S. Sutherland, Director of Pharmacy, Colchester Hospital, Truro, Nova Scotia.

The third edition of this text presents new and revised material to bring its content up to date. The addition of Dr. Garf Thomas, B.S., M.S., chief hospital pharmacist of the University of Missouri Medical Center, to the editorial staff, shows a recognition of the need for a team approach in the teaching of pharmacology.

Several new chapters are introduced in this edition. A unique chapter on drug interactions and incompatibilities reflects the increasing frequency with which medication problems are encountered. Here tables are used extensively to clarify the relationships between drugs.

The chapters in Part I present an orientation to the subject and its significance for nurses. Basic pharmacologic information is presented in Part 2. When practical, a single prototype drug is discussed fully, and similar drugs are related to it by means of tables. The involvement of pharmacology and drug therapy in patient care is demonstrated in Part 3.

Subject matter is presented as simply as possible, but extensive references for every chapter allow the student to obtain more detailed information if desired.

Although the use of chemical or generic names is basic, the American trade names in the tables could be confusing in Canada. A cross reference of Canadian trade names would be necessary for this book to be of general use as a textbook in this country.

Community Health Nursing Practice by Ruth B. Freeman. 229 pages. Toronto, W.B. Saunders Company, 1970.

Reviewed by Carole McIlhagga, Public Health Nurse, Ottawa-Carleton Regional Area Health Unit.

Ruth Freeman proves to be an invigorating communicator in *Community Health Nursing Practice*. She has a thorough understanding of her subject matter and has done extensive research for her most recent book. Data are well fused with a tone of experience and understanding. It is these basic ingredients plus clarity, conciseness, the use of example, and categorization that relay to the reader structured and meaningful information.

Dr. Freeman is realistic when discussing the various aspects of community health nursing. She considers the family to be the basic unit of the community structure. With the expansion of nursing responsibilities in the community, the goal is to involve family members in the health care of the individual. Problems of the aged, of long-term illness in the home, of child upbringing and development, and care during illness of the mentally ill are among those dealt with. Emphasis is on the need for family responsibility. The author strongly advises preserving family ties and, at the same time, family cooperation and function. Education, assistance, support and guidance extended to the family in solving problems are the nurse's greatest tools for prevention and treatment.

How the nurse can best educate her community is discussed. Channels for health education are present in the schools, in occupational health settings, in neighborhood clinics. The nurse learns how to draw out the leaders in her community and how to utilize these people with skills she can provide to them through education. Community programs of family planning, disease control, e.g., tuberculosis, and care of the mentally ill and the aged, are only a few of those studied.

The value of *Community Health Nursing Practice* is not limited to the nursing profession. This book provides a clear insight into the role of the community nurse to members of social agencies, community services, and other organizations. Thus, in cooperation with the health services available, each service may offer its best facilities to a community.

Community Health Nursing Practice is a valuable reference book. Topics discussed are not new to the health field, but the nurse can benefit from exposure to Dr. Freeman's interesting approach, to her projection into the community health field, and to her realistic suggestions for improvement.

Crisis Intervention; Theory and Methodology by Donna C. Aguelera, Janice M. Messick, and Marlene S. Farrell. 132 pages. Toronto, C.V. Mosby Company, 1970.

Reviewed by Karen V. Walker, B.Sc.N., former assistant director of nursing education, Clarke Institute of Psychiatry, Toronto, Ontario.

The first five chapters of this book deal with the historical development of crisis intervention in the United States, a differentiation between psychoanalysis, brief psychotherapy, and crisis intervention methodology, an overview and evaluation of crisis group therapy, an outline of sociological factors that can act as barriers in the psychotherapeutic process, and a paradigm of intervention clarifying the sequential steps of crisis development and resolution. This section of the book is objective and complete and includes reports on research studies evaluating the approaches described.

The chapter discussing sociocultural barriers to therapy is particularly interesting. The authors point out that traditional treatment methods identify with middle class cultural values and goals — the background of the majority of professionals. The opinion is expressed that crisis intervention is more effective with lower socioeconomic groups.

The next two chapters of the book present a brief analysis of case studies of individuals in crisis, along with related theoretical concepts and a description of the intervention. In chapter 7, the author describes six typical situational crises, such as the delivery of a premature baby, a status and role change, experimentation with LSD, divorce. The cases are organized into the maturational crises of the life cycle based on the theories of Erikson, Piaget, and Cameron.

Case studies effectively demonstrate the application of the crisis intervention methodology outlined in the first section. This section of the book is exceptionally clear and well-organized. The paradigm of intervention introduced in the fifth chapter is outlined for each case, adding to the clarity.

The short final chapter focuses on the authors' rationale for the nurse's role as therapist in crisis intervention. The objectives and learning experiences of the training program of the Benjamin Rush Centers in Los Angeles are briefly

outlined. The authors also include a brief projection of the manner in which registered nurses at *all* levels of educational preparation might be utilized in a community mental health center.

The authors' objective of providing a comprehensive overview as well as an introduction and guide to crisis intervention is well achieved in this clear, concise and all-inclusive little book. It should be of interest and value to nurses in education and service — particularly to those concerned with community health and mental health.

Nursing Studies Wanted

The Canadian Nurses' Association Library welcomes additions to its collection of nursing studies. Any nurse who has a thesis or a report on a research project conducted at a hospital or other agency is invited to send it to the CNA Library, 50 The Driveway, Ottawa 4, Ontario. Short abstracts of studies received are published in the *CNJ*.

AV aids

Films

A matter of fat

The National Film Board of Canada has just produced a most interesting feature length film (running time 1 hr. 39 minutes) entitled "*A Matter of Fat.*" Written and directed by William Weintraub, produced by Desmond Dew, and narrated by Lorne Greene, *A Matter of Fat* is designed to be shown in theatres. It is also a good teaching film, in that it deals sympathetically with one-quarter of the population of North America, 60,000,000 overweight people who are made to feel miserable in a society that worships youth and the slender, though well-proportioned, figure.

A Matter of Fat is more than the documented story of 37-year-old Gilles Lorrain, accountant for a firm located in a town about 100 miles from Montreal, who decided to do something about his burden of 358 pounds. His admission to a Montreal hospital for treatment led to a well-monitored regime of starvation — black coffee and mineral water for periods of up to 30 days at a time, relieved only by short weeks of nourishment not exceeding 800 calories daily. All in all it took seven harrowing and discouraging months to shed 140 pounds. Through it all, Gilles showed great fortitude and much wry humor. Furthermore, he proved to be, as one might say, a natural for his role. A year later he had succeeded in maintaining his weight.

Threaded through the story are glimpses of weight watchers meetings, beauty resorts costing $700 a week or more, camps for fat children, researchers at work in their laboratories, learned authorities warning of the dangers of pills prescribed by quacks, the fattest lady in the world, scientists debunking the mysteries of obesity, and so on.

Information on showings of this film may be had by writing to the National Film Board of Canada, 150 Kent Street, Ottawa 4.

As we see it

This 16 mm. color, 26 1/2 - minute film features a group of creative youngsters who set up their own closed circuit TV documentary to persuade their parents to give up smoking. Their dramatic presentation includes a parental confrontation.

A group of young pre-teen reporters then go on location to interview three outstanding medical experts on various aspects of the smoking problem. Seen in the film are Dr. Charles Tate, Dr. Stephen Ayers, and Dr. Oscar Auerbach.

As We See It presents its message by indirection in that youngsters attempt to convince their parents to give up smoking. The film evolves with a high degree of drama and emotion and contains a well-integrated amount of basic educational information. *As We See It* is suitable for both youthful and adult audiences.

Produced by the National Tuberculosis and Respiratory Diseases Association, *As We See It* is distributed by the Section of Education of the Quebec Christmas Seal Society Inc., 264 rue Chenier, Quebec 8, P.Q.

Immediate post-surgical prosthesis

Although *Immediate Post-Surgical Prosthesis* (United States Veterans Administration, 1966) is not a new film, it graphically portrays the work accomplished during the Seattle Prosthetic Research Study conducted by Dr. Burgess and his team. It traces the progress of a man of 60 who, because of a long history of osteomyelitis, has his leg amputated below the knee and is fitted immediately with a prosthesis. This procedure permits early clean healing of the wound, early discharge from hospital, and early fitting of a permanent prosthesis. This procedure, now gaining wide acceptance, may be considered reconstructive rather than destructive surgery.

This was aptly demonstrated at a recent one-day course on amputations at the Ottawa Civic Hospital, sponsored by the Ottawa District of the Canadian Physiotherapy Association.

Here, the hospital team of orthopedic surgeon, physiotherapist, social worker, and prosthetist used the film as the basis for evaluating newer methods. Several local amputees came to the meeting to demonstrate how well they had adjusted to their loss of limbs, how well their new appendages functioned, and how much they enjoyed their renewed health and ability to live a normal life — well, almost normal.

This film (running time 27 minutes) can serve as a valuable teaching aid. It is obtainable on loan from the Central Office Film Library (037B1), Audio Visuals Service, Veterans Administration Central Office, Washington, D.C., 20420, U.S.A., or Bert Mason & Son, Inc., 1070 Bleury Street, Montreal 128, Quebec.

Cancer

The following films on cancer are available from The Canadian Cancer Society, Ontario Division, 204 Eglinton Ave. E., Toronto 12, Ontario. All films are 16 mm, sound, and in color.

After Mastectomy, 20 minutes
Cancer in Children, 27 minutes
Cancer of the Skin, 26 minutes
Cancer of the Stomach, 19 minutes

Cancer of the Thyroid, 29 minutes
Early Diagnosis and Management of Breast Cancer, 34 minutes
Nursing Management of the Patient with Cancer, 29 minutes
What is Cancer? 21 minutes

accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, *except Reference items* may be borrowed by CNA members, schools of nursing and other institutions. *Reference items* (theses, archive books and directories, almanacs and similar basic books) do not go out on loan.

Requests for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa 4, Ontario.

No more than *three* titles should be requested at any one time.

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classified advertisements

ALBERTA

REGISTERED NURSES FOR GENERAL DUTY in a 34-bed hospital. Salary 1968, $405-$485. Experienced recognized. Residence available. For particulars contact: Director of Nursing Service, Whitecourt General Hospital, Whitecourt, Alberta. Phone: 778-2285.

BRITISH COLUMBIA

SUPERVISOR Evening and night for the over all coordination and management of a 150-bed acute hospital (additional 111 beds under construction). Position open December 1, 1970 B.C. R.N. personnel policies in effect. Salary range — $659.00 to $883.00. For further information, write to: Director of Nursing, Chilliwack General Hospital, Chilliwack, British Columbia.

GENERAL DUTY NURSES for modern 33-bed hospital located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply to: Director of Nursing, General Hospital, Fort Nelson, B.C.

GENERAL DUTY NURSES for modern 35-bed hospital located in excellent recreational area. Salary and personnel policies in accordance with RNABC. Comfortable Nurses' home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia.

BRITISH COLUMBIA

OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing. RNABC policies in effect. Credit for past experience and postgraduate training. British Columbia registration is required. For particulars write to: The Associate Director of Nursing, St.Joseph's Hospital, Victoria, British Columbia.

MANITOBA

GENERAL DUTY R.N.s for 17-bed active hospital, owned and operated by United Church Board of Home Missions, 90 miles north of Winnipeg. Starting salary $530 per month with allowance for experience. Single accommodation, meals available. Apply to: Director of Nursing, Crowe Memorial Hospital, Eriksdale, Manitoba. Phone: 739-2611.

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GENERAL STAFF NURSES (VACANCY), 4 weeks annual vacation, transportation advanced, pension plan, Group Life, Blue Cross, etc., private room in residence $25.00 per month. Salary scale $5,340 — 120 — $6,140 per annum. Apply: Mrs. Shirley M. Dunphy, Director of Personnel, Western Memorial Hospital, Corner Brook, Newfoundland.

NOVA SCOTIA

STAFF NURSES applications are invited for a 76-bed active treatment hospital. Nurses interested in the interest in retroactive functions of the patient would Progressive Patient Care Concept, and having a keen be preferable. Salary based on N.S.H.I.C. current scale, taking into account individual experience etc., Applications and enquiries should be directed to: Director of Nursing, Halifax Civic Hospital, 5938 University Avenue, Halifax, Nova Scotia. Phone: 422-1731.

ONTARIO

NIGHT SUPERVISOR required immediately by Wingham and District Hospital. Good personnel policies, salary commensurate with experience. Apply: Miss G. Norris, Director of Nursing, Wingham and District Hospital, Wingham, Ontario.

SUPERVISOR — PUBLIC HEALTH NURSING — for generalized program in the Oshawa-Ontario County District Health Unit. Good personnel policies and salary schedule. Position requires Diploma in advanced Public Health Nursing and Supervision or a Baccalaureate Degree with Administration. Apply to: Miss G. H. Tucker, Director of Nursing, Oshawa-Ontario County District Health Unit, 50 Centre Street, Oshawa, Ontario.

REGISTERED NURSES for 34-bed General Hospital Salary $525. per month to $625 plus experience allowance. Residence accommodation available. Excellent personnel policies. Apply to: Superintendent, Englehart & District Hospital Inc., Englehart, Ontario.

REGISTERED NURSES required for a 12-bed Intensive Care-Coronary Care combined Unit. Post basic preparation and/or suitable experience essential. 1970 salary range $535-645; generous fringe benefits. Apply to: Director of Nursing, St. Mary's General Hospital, 911B Queen's Blvd., Kitchener, Ontario.

ONTARIO

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REGISTERED NURSES for 100-bed General Hospital, situated 40 miles from Ottawa. Excellent personnel policies. Residence accommodation available. Apply to: Director of Nursing, Smiths Falls Public Hospital, Smiths Falls, Ontario.

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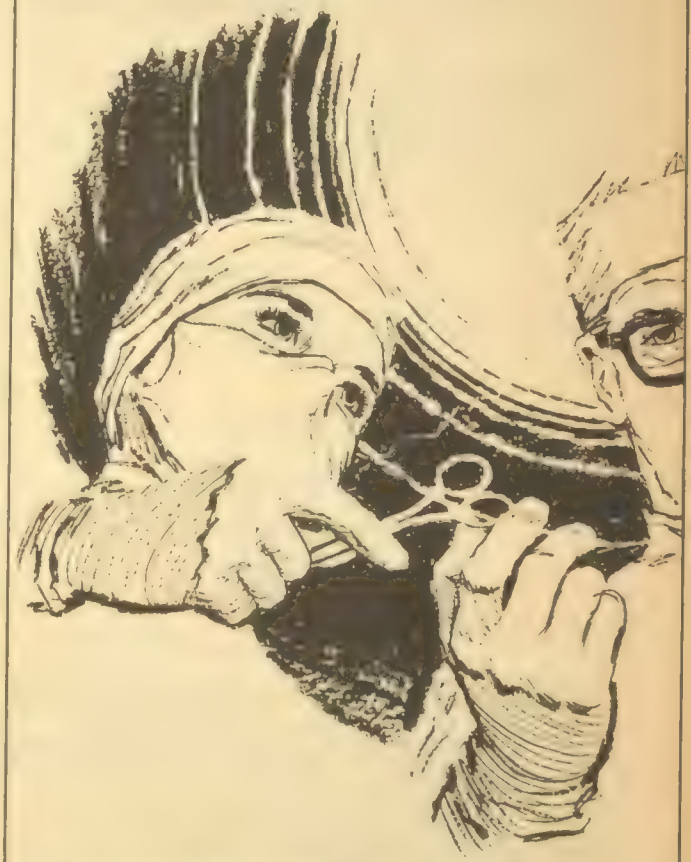

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BRACKSTONE, Margaret J.
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BRADLEY, Margaret L.
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CASTONGUAY, Therese, Sister
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CHAPMAN, Yvonne
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CHURCH, Jean G.
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EMORY, Florence H.M.
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PAGET, Cynthia
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PARKER, Patricia
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PARKIN, Margaret L.
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PASSMORE, D. Jean
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PEACOCK, Vera R.
Retired as Assistant Director of Nursing at the Manitoba Rehabilitation Hospital, 18 (Dec)

PEARCE, Terry
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PECHIULIS, Diana D.
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PEEVER, Mary V.
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PEITCHINIS, Jacquelyn
Part-time lecturer, University of Calgary, 22 (Nov)

PELLEY, Thelma
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PEPLAU, Hildegard
Appointed interim executive director of the American Nurses' Association, 24 (Mar)

PEPLER, Carolyn Joan
Cognitive functioning of patients under stressors of impending and recent surgery, (abst), 52 (Nov)

PEPPER, Evelyn
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PERRY, Susan E.
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PETERSSON, Carolyn
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PETTIGREW, Lillian
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PFISTERER, Janet
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PHILLIPS, Margaret
Associate professor Univ. Toronto School of Nursing (port), 22 (Apr)

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PILL, Miriam
Director of Nursing at Maimonides Hospital and Home for the Aged in Montreal, (port), 16 (Jul)

PITTUCK, Ellen J.
Retired as Director of nursing, Ontario Hospital School, Orillia, (port), 12 (Jan)

PLUMMER, Johanna
Director on Nursing Service at Owen Sound General and Marine Hospital, Owen Sound, Ontario, (port), 22 (Aug)

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PORTEHAUT, Marie-Claire
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POVERTY
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Poverty is cause of illness, CNA tells senate committee, 5 (Jul)

POWERS, Marie
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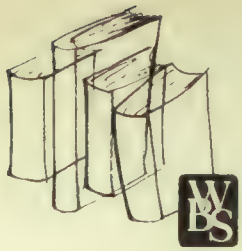

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