As nursing students, learning to divide our time between school, part-time work, and family can be quite stressful. Even for those students who are fortunate to receive financial aid from the “Bank of Mom & Dad”, part-time work is often a necessary reality. In my case, this type of necessary employment was also an opportunity to supplement my nursing education. In 2001, I began my job at West Montreal Readaptation Center as a Rehabilitative Assistant, working with intellectually handicapped adults living in community residences.

The majority of the clients are affected with Down’s syndrome and other types of mental retardation. Several clients also have psychiatric co-morbidities such as OCD, schizophrenia and borderline personalities. In addition, these clients are more likely to suffer from other illnesses as a result of their developmental disorder, increased age and previous or ongoing treatment with older psychotropic medications. Specifically, my duties included medication distribution, managing behavioral episodes, providing feedback to educators, nurses and other members of the multi-disciplinary team and, when indicated, supporting patients’ transition to a clinic or hospital.

It is impossible to list all the lessons I learned through my work with these clients, but the most memorable aspects were lessons about human relationships and stigma. Before having this job, I had been taught by society to be fearful of these individuals. My five years of employment served as a training ground in compassion and helped to alter my mindset.

Ultimately, I was sensitized to the plight of this “silenced” group, whose daily existence is affected by the stigma that plagues mental health diagnoses. At times, my job was a source of internal turmoil as I was frustrated by the societal myths that existed about the intellectually handicapped. Also, I learned about the depth of emotion that is encapsulated in every human heart, regardless of the level of intellect. At the end of a long shift, receiving a hug of appreciation from a client with Down’s Syndrome quickly reminded me of the rewards of compassionate health care.

The clients reside in group homes, following the process of de-institutionalization in the 1990s. Almost twenty years later, integration into the community and acceptance from neighbors is still not an easy task. There is a clear need for nursing to be involved in patient advocacy and community outreach programs to combat ignorance that arises from fear by sensitizing the public to the true “face” of this client group.

For more information about various support services offered by the West Montreal Readaptation Center, visit their website at www.westmontrealrc.ca.
Signing Out and Moving On

ANNEMARIE HOFFMANN

As I sat down to write my last editorial for The Heart - Le Coeur, I tried to think of some inspirational and motivating pieces of wisdom to offer students still in the midst of their programs.

Retrospection does offer some clarity - for example, the fieldnotes and group projects start to make sense - but for me, the real “prize” is knowing that I am embarking on a new journey and however ill-equipped I may feel, this journey is where I want to be. I chose nursing very deliberately and after exploring various other options and avenues. I can honestly say that I am proud to be entering this profession, and most of all, proud of who my colleagues will be. My classmates and I are slowly dispersing - some moving West, others moving East, some staying put to reap the benefits of our wonderful nursing community in Montreal. At the end of three years together, we have each found what we are good at and what we enjoy in nursing, and we admire each other’s strengths.

In my year as co-editor of this newsletter, I have seen the uniqueness and strengths of all the students in the school of nursing, and it has been fun to see people contribute in meaningful and unique ways. I wish you all the best in the years to come, and I look forward to reading future issues!

Lessons in Dignity

AMY NYLAND

I’ve been thinking a lot recently about dignity. The topic came up in a seminar discussion several weeks ago. How can we ensure that it is maintained for patients and their families?

With each new hospital setting that I see during my training, I’ve noticed time and again how basic courtesies and simple kindness make an extraordinary difference in people’s experiences. In every unit I’ve been on, I’ve seen some members of the care team regularly bring smiles to sad and discouraged faces through small, thoughtful acts.

These people know how important it is to offer the same level of courtesy and respect whether someone is standing before them dressed in a three-piece suit, or lying in bed wearing a rumpled blue hospital gown and surrounded by tubes and monitors. They know how important it is to truly hear a person when they share what is beautiful and valued in their lives, as well as what they fear.

Somehow, these particular people have managed to keep this knowledge in the midst of short-staffing, budget restrictions and long hours. Not everyone behaves this way, but the people who do are the ones I’d like to emulate. I know that it’s an easy thing for me to say right now, full of idealism as I head into my final year of the program, but if I ever lose sight of my ability and responsibility to ensure the dignity of patients and families, I sincerely hope that someone around me will take me aside and point it out. It’s much too important to forget.
When the opportunity to work in Tanzania presented itself, Kim Gartshore and I leapt at the chance to experience what we hope will be an exciting safari adventure! This August, we will be working at the Nyakahanga Hospital in Karagwe, the northwestern region of Tanzania. Affiliated with the Evangelical Lutheran Church of Tanzania, the hospital services the 400,000 people of the Karagwe District. It also serves as a district hospital for the government of Tanzania. Approximately 230 patients are admitted to the hospital every day, in addition to the 200 outpatients receiving care on a regular basis. The hospital has also instituted a number of vital community health initiatives, including an AIDS Control office, which we hope to learn more about during our stay.

Tanzania is one of the largest countries in Eastern Africa, with a total surface area of over 937,000 km². It is located directly south of the equator, bordering Kenya and Uganda to the North, Rwanda to the West, and the Democratic Republic of the Congo, Malawi, and Mozambique to the South. It has a population of approximately 38.3 million people¹, and is primarily agricultural in nature. The average life expectancy in Tanzania is 47.9 years², a number that may seem shockingly low to most Canadians, and is a direct consequence of the effects of the AIDS epidemic, malaria, poverty, and other health crises which have ravaged the country.

The community where we will be living and working is situated in a remote mountainside town, whose residents are predominantly poor farmers. The nearest city, Bukoba (overlooking the beautiful Lake Victoria), is two hours away by jeep. Our host and the Hospital Director, Dr. Amos Nyrienda, has offered us accommodation at “Dr. Buch’s house”, a hospital residence where nursing students from abroad have stayed in the past. He has also assured us that we will find plenty of work on the maternity ward and at the reproductive and child health clinic.

As we progress in our planning, Kim and I have come to realize that just getting to Karagwe will be an adventure in itself; not to mention the processes for obtaining the necessary passports, visas, vaccinations and medications well in advance! The first leg of our trip, a 7-hour flight from Montreal to Paris, will likely feel like a nursing coffee break, when viewed in the context of our complete travel itinerary. After a 15-hour layover in Paris, we will board a second 7-hour flight to Addis Ababa in Ethiopia. Three hours later, we will be whisked off to Dar El Salaam, Tanzania’s major city and capital. Almost there!

Currently it is practically impossible to book the country’s local charter flight (from Dar El Salaam to Bukoba) from outside the country. However, thanks to the kindness and experience of Dr. Nyrienda, arrangements are being made on our behalf. In Bukoba, we will meet our hosts, who will take us by jeep on a bumpy two-hour journey to our new home.

And so it is with our hearts on our sleeves and our nursing textbooks strapped to our sides that we will face the challenge of living and working in an environment far less privileged than anything that we have experienced in our own lives. “And so it is with our hearts on our sleeves and our nursing textbooks strapped to our sides that we will face the challenge of living and working in an environment far less privileged than anything that we have experienced in our own lives.”

Kim and Julia will be back in September with a report of their exciting Tanzanian adventure… stay tuned!

¹² World Health Organization, Core Health Indicators.
Managing cancer in the community: Patients’ and caregivers’ experiences and the impact of nursing care
Natalie Anderson
Advisors: C. Common, M. Eades, A. Arnaert

Experiences of relatives attending a retreat weekend for cancer survivors and their relatives
Vincent Ballenas
Advisor: A. Arnaert

The needs, expectations and experience of parents of hospitalized premature infants regarding their participation in a support group
Natacha Bielinski
Advisors: L. Charbonneau, V. Frunchak

This study was conducted to discover the experiences of parents of premature infants regarding their participation in a parent support group in the NICU and, more specifically, how did the group meet their needs and expectations. The overall goal is service quality improvement by providing data to restructure a support group in order to better fit the parent’s needs.

Sexuality-related concerns & experiences of young adults undergoing cancer treatment
Sonia Castiglione
Advisors: M. Dumas, C. Cloutier

Nurses’ knowledge of and beliefs about the hypoglycemia treatment protocol
Julie Cummins
Advisors: D. Lamarche, M. Purden, J-F. Yale

Isolation precautions in the Emergency Department: The experiences of patients and family members
Kimani Daniel
Advisors: M. Sherridan, M. Purden

Qualitative analysis of the experiences of people with cancer attending a healing retreat weekend
Angela Dublanko
Advisors: A. Arnaert, R. Rutledge

As the incidence of cancer and the survival rate of living with the disease are increasing, the health care system is challenged to develop programs attending to all aspects of the mind, body, and spirit as being diagnosed with cancer touches all the various fragments of one’s life. Healing retreats are convenient psychosocial interventions for persons with cancer and their families which provide information, teach coping skills and allow people to rediscover one’s inner sense of worth and to live a whole life. Despite the popularity of retreats little research is available. This qualitative study has therefore the aim to explore the experiences of people with cancer who attended the “Skills for Healing Retreat Weekend”. Nine people volunteered (out of 35 people attending the program) to participate in this study. Semi-structured telephone interviews were conducted about one month after they attended the weekend. Using the comparative method, data analysis revealed four key ingredients that stood out as being most influential in participants’ retreat experiences: mutual sharing, common experience, emotional openness and safe environment. The benefits stemming from these ingredients fall into two categories: cognitive-emotional benefits, which include perspective, insight, the feeling of being on the right track, knowing not being alone, and facing fears; and spiritual benefits, which include increased hope, experiencing a special energy and a sense of connectedness. The findings of this study reaffirm the value of retreats that teach skills for healing and can be used to improve existing holistic programs, develop new programs, and guide future research.
Evaluating nurses’ work life satisfaction
Marie-Josee Guy
Advisors: S. Bradford-Macalanda, M. Purden

Patient satisfaction and continuous quality improvement in an ambulatory oncology center: The issue of sustainability
John Harris
Advisor: L. McVey

Numerous studies have shown that when patients feel satisfied with the health care they receive, they have better medical outcomes than those who are not satisfied. In 2001, an ambulatory cancer clinic of a large metropolitan hospital in Montreal conducted a patient satisfaction survey in order to identify issues to be subsequently addressed by a continuous quality improvement (CQI) process. Two of the lowest rated areas were the length of time spent in the waiting room and that pharmacists did not inquire about the medications patients were taking. Continuing with the CQI process, changes expected to improve the two situations were implemented, and subsequent surveys of satisfaction levels indicated an improvement to acceptable levels of satisfaction.

A similar follow-up study was conducted in the same clinic in 2005. The goal of this paper is to compare the results to the 2001 study and to discuss the implications. Results indicated that the 2005 satisfaction levels on two of the lowest-rated issues from 2001 returned to their original low levels. A fundamental point of CQI is that the process must be continuous if an organization is to keep abreast of changes in patient satisfaction. Discussions with clinicians revealed that many significant changes in the clinic occurred in the years between the two surveys. Reasons for the extended interval between the surveys are discussed.

Factors that contribute to quality of life in an end-stage medical population
Annemarie Hoffmann
Advisor: R. Cohen

Despite the fact that end-stage, non-cancer illnesses are the one of the main causes of hospital death in Canada, there is a notable lack of palliative care for the end-stage medical population. Enhancing quality of life (QOL) is a pivotal aspect of palliative care and in order to provide effective care it is necessary to understand what contributes to the QOL of various populations. The objective of this project is to identify factors that affect the QOL of end-stage patients with congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD). From the findings, a comprehensive list of contributing factors will be generated; this list will serve as a useful reference for researchers developing instruments to assess QOL and seeking to apply such instruments to the end-stage medical population.

Six participants with end-stage CHF or COPD were interviewed. A thematic analysis revealed 9 main themes and these were divided into 4 broader categories of relationships, physical state, existential, and hospital / home. Further exploration needs to be done to clarify some themes, but it is clear that there is significant interaction between physical / environmental factors and relational / existential factors. The physical limitations imposed by symptoms had a strong effect on QOL. There is also evidence that end-stage CHF and COPD patients expect their QOL to deteriorate. The hospital versus home theme indicated that being in the hospital negatively affects QOL for these individuals, largely because it distances them from family members. Since the goal of palliative care is to enhance QOL, this finding emphasizes the need to tailor services for this population.

Attitudes of elderly people with depression using videophones as a method of care delivery
Jenny Klooster
Advisor: A. Anaert

Nurses’ attitudes & practices related to key elements of family-centered care
Katherine Logue
Advisor: J. Ritchie
Parents’ perceptions of the Webster-Stratton Parenting Program
Maria MacDougall
Advisors: R. Short, L. McVey

Nurses beliefs towards indigenous people
Misty Malott
Advisor: A. Arnaert

Organizational factors that support the implementation of a nursing Best Practice Guideline: Leadership and culture on two pilot units in the MUHC
Caroline Marchionni
Advisor: J. Ritchie
The implementation of best practice guidelines (BPGs) in healthcare has been extensively studied but there has been limited success in tailoring interventions to increase adoption. The context of the healthcare setting plays a crucial role in influencing implementation. In this pilot study, the Content, Context and Process model of strategic change by Pettigrew, Ferlie and McKee (1992) was employed as a framework to understand factors that may affect adoption. Organizational culture and leadership on two in-patient nursing units, where the Registered Nurses of Ontario BPG “Risk Assessment and Prevention of Pressure Ulcers “ (Registered Nurses’ Association of Ontario, 2005) was implemented, were studied. A quantitative survey approach, using the Organizational Learning Survey (Goh & Richards, 1997) and a modified Multifactor Leadership Questionnaire (Avolio & Bass, 2004), was employed. Results reveal the presence of a culture of learning and transformational leadership on these units but small response rates limit generalizability. Recommendations for future studies are offered.

The experiences and challenges of pregnant women coping with thrombophilia
Tanya Martens
Advisor: J. Emed
Objective: The purpose of this study was to explore the unique experiences, challenges, and coping strategies of pregnant women diagnosed with thrombophilia.

Design: A qualitative, descriptive approach with semi-structured interviews was used to develop a better understanding of the participants’ personal perspectives.

Participants/Settings: Nine women from the thrombosis clinic of a large urban hospital in Quebec, Canada participated in the study.

Data Analysis: Thematic analysis was completed throughout the processes of interviewing, transcribing and reviewing the data.

Results: Findings indicate that past pregnancy experiences influenced the meaning of diagnosis and treatment as well as the participants’ experience of uncertainty. Participants expressed a need for increased professional support in medical decision-making and information around injection techniques. In facing these challenges participants coped by taking control and maintaining perspective.

Conclusions: Pregnancy complicated by thrombophilia can be a stressful experience; however, the ensuing challenges are perceived as manageable discomforts in light of the outcome of a healthy baby.

A continuous quality improvement study: Incidence of central venous access device post-insertion complications within the paediatric patient population
Ashley O’Dacre
Advisors: K. Tanguay, M. Purden

A prospective, continuous quality improvement (CQI) study was conducted at the Montreal Children’s Hospital to obtain benchmark data related to the incidence of central venous access device (CVAD) complications within the patient population. Seventy-five CVADs of interest were inserted within the patient population during the study period. Major CVAD complications occurred in forty-eight of the inserted devices. The incidence of major CVAD complications was related to the catheter device type selected. The implementation of CVAD
CQI practices is critical in further guideline development aimed at lowering incidence of major complications in the future.

**Perceptions of the transition from CEGEP to university in an integrated nursing program**  
Amanda Rix  
Advisor: M. Beaulieu

**Mothers’ experiences with breastfeeding management & support: A quality improvement study**  
Irene Sarasua  
Advisors: V. Frunchak, C. Clausen

The purpose of this study was to examine the experiences of mothers with regard to breastfeeding support and management delivered by healthcare professionals on an acute care postpartum unit in a multiethnic, obstetrical referral center located in a large urban centre. The study’s convenience sample included 60 recently-delivered mothers. Findings indicated that primiparous women, and women who delivered by cesarean-section, consistently received more information about breastfeeding management than their respective counterparts. In addition, 67% of mothers who intended to breastfeed exclusively, supplemented with formula. Fifty-five percent of these mothers stated “milk insufficiency” as their primary reasons for supplementing. Overall, mothers perceived healthcare professionals be encouraging of breastfeeding, and 80% of the sample was “moderately” to “very” satisfied with the breastfeeding education and support received. These findings suggest that while the study hospital is moving in the direction of breastfeeding ‘best-practice’, differences in advice and support based on parity and type of delivery warrant further investigation. Likewise, an examination of the factors involved in high supplementation rates among women wishing to exclusively breastfeed is needed.

**Home respiratory programs in Canada for children dependent on respiratory technology**  
Jiemin Zhu  
Advisors: L. Caron, M. Purden

Objectives: To ascertain the current status of home respiratory programs (HRPs) across Canada for children chronically dependent on respiratory technology such as mechanical ventilation and/or oxygen therapy. The characteristics of HRP organization that were studied included the number of children registered in HRPs, the medical conditions of these children, the respiratory technologies accommodated within the home, the funding resources and health care support services available to families with children ventilated at home.  

Design: A descriptive survey questionnaire was sent both electronically and through regular mail to the medical directors of respiratory departments of major pediatric health centres across Canada.  

Subjects: Organized home respiratory programs within 16 major Canadian pediatric health centres.  

Results: Eleven pediatric health centres from 6 Canadian provinces provided an overview of their home respiratory programs. The survey identified 755 children registered within 11 participating HRPs, with some programs not including children requiring home oxygen therapy. The survey indicates that home health services and funding resources vary across provinces. It was reported that health services were not always readily available for families living outside the catchment area of their health centres. In addition, funding of home respiratory equipment was stated to be problematic when the provincial health plan did not provide complete coverage of the costs, oftentimes resulting in prolonged hospitalization for the children. Moreover, it was reported that the discharge process for children requiring respiratory technology at home could be lengthy and complex. Fifteen children from 5 participating health centres could not be discharged home to their families for several reasons.  

Conclusion: The current survey indicates that there appears to be an increasing number of Canadian children who depend on respiratory technology to live at home. The findings also show a significant
shift from hospital care to home care. The findings suggest that home respiratory programs are organized differently from province to province. Moreover, this current survey appears to indicate that improvement in community-based health services as well as coverage of equipment costs would assist families to provide better care for their children whose conditions require respiratory technology at home.

**Quality improvement project: Recording practices and satisfaction of haemophiliac patients using two different data entry systems**

Sophie Vallée-Smejda
Advisors: C. Rosmus, N. Aubin, M. Hahn

Record keeping is an integral part of home infusion practice for haemophiliac patients. Identified problems with paper diaries include suboptimal compliance and questionable data validity and quality. Advoy, an electronic data recording system offered by Baxter Corporation, provides patients with an alternate method of treatment reporting. Effects of this system on data quality, patient adherence, and satisfaction were investigated.

An exploratory approach was used to examine the sequential use of paper diaries and Advoy by 38 patients. Data were obtained from patients’ paper records for the 6 months preceding the use of the electronic record, and 6 months after the introduction of the electronic system. Completion of mandatory treatment and additional information fields was compared across the two recording methods. A significant increase (27.57% p<0.001) was observed in the recording of mandatory information with Advoy. As well, the percentage of completed additional fields nearly doubled (19.9% to 36.5%). Patients tended to complete a greater variety of additional fields at one given time with Advoy than with paper records. Finally, a higher percentage (29.4%) of survey respondents indicated they were “very satisfied” with Advoy compared to paper records (6.7%). The majority (94.4%) of survey respondents had previous experience with electronic programs.

The use of Advoy significantly improved patient adherence in recording mandatory information about their treatments. The increase in additional data provided by the patients was also found to be an added benefit of this technology.

**Programme d’orientation et expérience en pédiatrie: Perception des infirmières graduées**

Geneviève Tousignant
Advisors: M. Purden, E. Alexander
Towards a Discussion of Consent

DAVID WRIGHT

I’ve just returned home from lunch with a friend of mine. We were enjoying coffee and vegetarian sandwiches at a lovely Montreal café, discussing the current state of research ethics. How interesting it would be, we thought, if ethics boards could arrange for independent interviews of participants as an auditing mechanism. In this way ethicists could determine to their own satisfaction that participants were indeed engaged in fully voluntary and informed consent, rather than relying solely on investigator drafted proposals and signed consent forms.

We were interrupted at that point by a young gentleman who demanded to know why we thought this would be a good idea. During the course of the ensuing discussion it appeared to us that this young man believed the research process to be infallible, the medical establishment to be beyond reproach, and patients to be intrinsically incapable of understanding what is being asked of them; all of which seemed to offer a perfectly crafted anti-thesis to the ideologies put forth by the founder of our beloved McGill Model. For these reasons, he will hereafter be referred to as “Anti-Allen”.

Anti-Allen, who we later learned was a medical doctor who conducts research on human participants, despised this notion of informed consent. He proposed that patients do not have a capacity for understanding, and that their ignorance should not act as a barrier to “things moving forward”. Anti-Allen went on to describe his disdain for “outsiders” who stick their nose into other people’s research and stir things up. Anti-Allen explained that he did not see the need for informed consent because patients are not currently taken advantage of, and therefore are not in need of protection. If it isn’t broken, don’t fix it, seemed to be his mantra; “I can’t stand people who try to interfere with the process when there isn’t a problem. If there’s a problem, then come in with your regulations, otherwise, leave it alone.”

My response to Anti-Allen would be that the current “unproblematic” state, or status-quo that he so readily accepts, only came to be as a result of interfering with the process. Perhaps Anti-Allen would agree with the many researchers who currently feel that the Nuremberg code is highly artificial and does not apply to them. After all, how dare we compare enlightened researchers to Nazi scientists? However subsequent atrocities such as the Tuskegee trials, psychiatric challenge studies, purposeful Hepatitis A infections, and questionable fertility experiments demonstrate that we must always keep a close eye on health research and the people who conduct it.

“Atrocities such as the Tuskegee trials, psychiatric challenge studies, purposeful Hepatitis A infections, and questionable fertility experiments demonstrate that we must always keep a close eye on health research and the people who conduct it.”

“Towards a Discussion of Consent” by David Wright.

It is interesting to note that Anti-Allen, who happens to be the treating physician of the patients enrolled in his protocols, was not at all interested in a discussion about the concept of the therapeutic misconception. It could only be beneficial, he claimed, when one individual occupies the dual roles of treating physician and researcher.

At the end of our stimulating and at times heated discussion I thanked Anti-Allen for confirming my suspicion that there are probably patients out there who are being enrolled in trials who could stand to benefit from a little more knowledge and empowerment. I shared with him my enthusiasm for research progress, that I am in no way a protectionist, and that if anything I would like to see more research conducted with ‘vulnerable’ populations, for instance research with persons with serious mental illness, and research with young girls having abortions without parental consent to name a few. However perhaps our fundamental difference lies in the fact that I believe research
The Missing Link: Policy-content in Nursing Education

IRENE SARASUA & ANNEMARIE HOFFMANN

Many people believe that nurses are in an ideal position to advocate for enabling health and social policies. Three key reasons for this are: 1) nurses possess “expert knowledge” that is central to developing relevant and effective policies; 2) nurses intimately understand how individual policies might affect the people that they care for; and 3) nurses are generally positively viewed in the community and can often gather a lot of support.

Political activism in nursing is especially relevant as Canada faces continuous threats to universal healthcare, extreme nursing shortages, and increased use of expensive technologies that carry serious ethical implications. Nurses have the potential to influence more than health policies, they can also mobilize around such issues as housing, human resources, immigration, welfare, and the list goes on. There are, however, some key challenges to building a stronger nursing presence in policy-making. One important challenge is the lack of training around policy processes, advocacy, and lobbying. Health and social policy is not a significant area of study in Canadian undergraduate or graduate nursing programs. Canadian nursing students receive relatively little course content on policy-making, or on the tools required for meaningful political engagement. As a result, many nurses are uncomfortable with the idea of political activism and hesitate to get involved in policy-making.

When policy content is taught, it is often delivered in the context of other nursing courses (e.g. “professional issues in nursing”, “nursing leadership”, etc.) and it rarely stands alone. Also, most policy-related nursing courses offered in Canadian universities are either graduate-level courses, upper-level undergraduate courses, or elective courses. Canadian nursing students might be introduced to the most basic policy concepts, but only late in their nursing training.

In order for nurses to have a greater impact on public and healthcare policy, they require specialized training in legislative processes and policy analysis. Nurses (or nursing students) who learn to critically examine policy and to understand the various factors influencing population health will understand these to be core elements of their professional role. They will also be better equipped to assume a proactive position in Canadian and international health and social policy arena. In this way, political training is not only useful in that it helps to develop relevant knowledge and skills, but it also helps to shape a more politicized nursing identity.

Education that empowers nurses and demystifies politics and policy processes can also help nurses to overcome perceptions of powerlessness and frustration. These are important barriers to nursing participation at all organizational and political levels. Nursing education should provide students with the tools to understand the importance of nursing’s role in policy agenda-setting, to analyze health and social policy, and to become active and motivated policy players. "Nursing education should provide students with the tools to understand the importance of nursing’s role in policy agenda-setting, to analyze health and social policy, and to become active and motivated policy players.”

In closing, one might argue that one of the most important roles for us as nurses and nursing students is to lobby for meaningful inclusion of policy content into nursing programs.

For more nursing and policy resources, see page 12.

1 Andreoli et al. 1987
2 Martin, White & Hansen 1989
Opinion, from page 9

should be done with these participants. Research should not be hindered; it should be encouraged, but never at the expense of certain inalienable rights of the individual, of which autonomy over one’s own mind, body, and body tissues is one of the biggest. I wholeheartedly disagree with Anti-Allen that patients do not have a capacity for understanding. Patients are often smarter than we are, and as nurses we are in a unique position to advocate for their voice in the research process.

Finally, it is because of my faith in the importance of research that I am so concerned with sound research ethics. The public needs to trust the research establishment, and when adequate safeguards are not in place the integrity of scientific research is highly susceptible to attack. It is only with, and not in the absence of, stringent ethical supervision, especially over the informed consent process that things will indeed “move forward”.

Summer Plans

MSCI EXTERNS QUALIFYING YEAR

Andrea Witkowski
Neurology at the Montreal General Hospital

David Wright
CPC-3 at the Douglas Hospital, a long term inpatient unit in mental health care

Lyndsay Hodgson
Surgical 9 East at the Royal Victoria Hospital, kidney, liver and pancreas transplants and hepatobiliary issues

Anelise Santo
15th floor at the Montreal General Hospital, internal medicine

Charleen Magee
F7W at the Royal Vic, postpartum

In a research project funded by the McGill University Faculty of Medicine’s Summer Bursary Program, Samantha LaRue will help examine existing evidence of cross-cultural validity for a set of health screening instruments. These instruments will ultimately be used in a prospective study focusing on the health of newcomer women and their infants.

Another project funded by the Summer Bursary Program has Naomi Burton-Macleod helping to develop and evaluate an educational tool to be used by educators in occupational and physical therapy, nursing, and medicine to promote patient-centered, collaborative practice.

Agnes Dzialo will work with School of Nursing faculty member Catherine Gros at the Douglas Hospital on a project studying the use of restraints in a geriatric psychiatry unit.

Sasha Dyck will spend the summer working as a nursing extern in Washington, D.C.

The Art of Nursing

Sylwia Bartosik, our cover artist who just completed the MScI year of the Direct Entry Master’s Program, has combined part-time work during her studies with entrepreneurship and artistic expression. She creates unique hand-embroidered clothing using pre-existing clothes as well as accessories. Many of her pieces are medically inspired. For instance, she created a t-shirt with an anatomically correct heart stitched on. She also does custom-made work on request. Her items are sold at “Local 23” (23 Bernard West in the Mile End district, 514-270-9333). Check it out to support a student and an artist!
Dear Flo,

I’ll be graduating from McGill this year, and I’ve already begun looking for a job. There’s no shortage of work for nurses, of course, but I’m having a little trouble finding something to suit my schedule. Every floor wants me to do nights and weekends, and then go back to days! I’m a little concerned about when I’ll fit in my bi-weekly massages, crystal therapy, trampoline lessons, karaoke training and doggie yoga with my Shar-Pei, Sheila. Can you help me sort this out, Flo?

Multitasking Madness in Montreal

Dear Multitasking,

The nurses in my time lived in dorms at the hospital during their entire training, and were not permitted to leave for frivolous reasons. Patients are unwell all day and all night long, that certainly hasn’t changed since my day. There was far too much to be done in the wards to be concerned with one’s own diversion. Dusting away germs, purifying water for the patients, preparing bandages, cleaning instruments and the like were all part of a nurse’s duties, not to mention cooking restorative foods like boiled eggs and wine jelly. How often do you carbohydrate patients’ beds these days anyhow? They tell me it isn’t so common anymore. Quite honestly, I can’t imagine when you even have time to starch your cap. My advice, dear, is to spend a little more time at the hospital (yes, even overnight), and a little less time realigning your chakras.

Questions? Worries? Ask Flo! Send your pressing concerns to theheart.lecoeur.nursing@mail.mcgill.ca

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Questions? Worries? Ask Flo! Send your pressing concerns to theheart.lecoeur.nursing@mail.mcgill.ca

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Nursing and Policy Resources

- Canadian Nurses Association: “Getting Started A Political Action Guide for Canada’s Registered Nurses” & “Nursing is a Political Act - the Bigger Picture”: www.can-nurses.ca
- The Registered Nurses Association of Ontario: Political Action Tools: www.rnao.org
- American Nurses Association: Political Power Website: www.nursingworld.org/gova
- Canadian Social Planning Network / Canadian Council on Social Development: www.ccsd.ca
- National Anti-poverty organization: www.napo-onap.ca

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Congratulations!

Some of the 2006 Grads! Back: Sonia Castiglione, Maria MacDougall, Annemarie Hoffmann, Tanya Martens, Amanda Rix, John Harris, Middle: Julie Cummins, Irene Sarasua, Ashley O’Dacre, Front: Kate Logue, Natacha Bielinski (and daughter Chloe), Sophie Vallee-Smejda, Caroline Marchionni, Angela Dublancko.