first reading

Vol. 6 No. 5 May/June 1988

a publication of the Edmonton Social Planning Council

Health Care

By far the majority of health care and related dollars spent in this province, and in this country are spent on treating sickness and ill health. Yet, there can be little argument that preventing illness saves not only lives but dollars — millions and millions of the latter.

Preventing illness is not in any way a new idea. By taking care of ourselves - eating properly, exercising, avoiding health hazards and controlling stress - we can expect to live healthier, more productive and longer lives. Why, then, don't we do it? There are, of course, more reasons than can easily be listed on this page. But perhaps our dependence and ultimate faith in the medical edifice which surrounds us is a primary one. There is a tendency to live along the lines of, "it won't happen to me, but if it does someone will fix it, and it won't cost me a cent."

Well we all know that there's no such thing as a free lunch but, again, we don't really seem to believe it. Government, of course, responds to our approach by giving us what we apparently want. More and bigger hospitals to fix us when we break down, more pollution, stress and workplace hazards to meet the general desire to consume.

In the end, it is pretty much up to us. We can learn to take care of ourselves, use doctors and hospitals when we need them and convince governments that some of our tax dollars might be better spent preventing illness than over-treating it.

This edition of *First Reading* examines some current issues facing our health care system. The articles within look at what health care is costing us, at some ways in which we can take responsibility for protecting our own health and at the growing public understanding of the role of nursing in the health care universe.

• • •

In the next edition of *First Reading* we will re-examine some of the issues with which this publication dealt in the past year, and also take a look at some items we never had the chance to examine.

HEALTH CARE EXPENDITURES IN ALBERTA

Richard H. M. Plain

Alberta health care consumers and members of the health care industry have been faced with a barrage of statements emanating from provincial policy-makers voicing concern with respect to the costliness of the Alberta health care system. The de-insurance of a number of health services last year, coupled with a reduction in the nominal dollar level of funding received by general acute hospitals and a freeze on the budgets of other institutions, clearly indicated that the provincial government was willing to incur the political and social costs inherent in reducing the rate of growth in health care spending. The recent reinstatement of some of the de-insured services, and the decision not to further reduce the current dollar value of the funding to major health care institutions has not signaled a return to the "good-old-days." It simply means that the rate at which real dollar funding is being reduced has slowed down. Many consumers of health services are understandably concerned with what they view as an erosion in health service standards, while a number of providers are concerned with job security and the constraints placed upon their incomes. It is instructive in the midst of this health care cost crisis to attempt to obtain an understanding of some of the major expenditure trends which have and are shaping the Alberta health care system. In particular, it is important to determine whether the escalation in health care expenditures is the cause of the present crisis and to gain an understanding of how Alberta's spending compares to that of its neighbouring provinces and to the nation as a whole.

Trends in Nominal and Real Expenditures

Total spending on health care from all sources both private and public increased threefold in the period 1975-1985. Expenditures rose from $567.90 to $1712.20 per person — a net increase of approximately $1153.30 per person. The largest portion of this increase occurred between 1980 and 1985, particularly in the period between 1980 and 1982 when total health spending rose by approximately 46.8 percent.

The institutional and related services sector of the health care system includes all the hospital, nursing home, home care and ambulance expenditures in the province. This grouping accounted for slightly over 51 percent of total spending in 1985. This compares to the approximately 21 percent spent on professional services, which is primarily dominated by payments made to doctors and dentists (70 and 21 percent respectively.) The drugs and appliances category is dominated by prescribed and non-prescribed drug expenditures (approximately 43 and 34 percent) followed by outlays on eye glasses, hearing aids and other appliances and prostheses. This sector accounted for approximately 10.6 percent of total per capita health care spending in 1985. A remaining category (I will refer to it as the "other" category) is composed of the cost of having insurance coverage (prepayment administration), public health, capital expenditures (expenditure on construction, repair, machinery and equipment of hospitals, clinics etc.), health research and miscellaneous expenditures. This "other" category accounted for 17.7 percent of total health care spending. It should be noted that over the course of the decade the percentage of total health spending attributable to the institutional and professional groupings has fallen, while spending on the drugs and appliances portion has remained virtually

unchanged. The other category has shown extreme volatility, rising from 12.7 percent of total health spending to a peak of 25.7 percent in 1982, then dropping to slightly under 18 percent in 1985. The major capital expenditure thrust which started in 1980 is the principal explanation for the wide variation in this expenditure category.

The breath-taking rise in total health care spending is of course reflected to varying degrees by the changes which occurred in each of the expenditure components. The institutional and professional components, the two biggest categories, increased by 2.8 times over the decade and by approximately 52 and 33 percent respectively between 1980-82. Between 1982 and 1985 institutional outlays and professional expenditures rose by approximately 28 and 26 percent, respectively.

A Real Dollar Analysis

The above, somewhat truncated, overview of health care expenditure patterns and trends is typical of the type of analysis which has formulated public policy thinking and debate in the health care sector during the past few years. It has led to the spectacle of one after another government minister chastising both the industry, for its unrestrained spending habits, and consumers, for purportedly demanding more and more services. Unfortunately, certain of the perceptions derived from the statistics I have presented are extremely misleading. The reason for this is that the 1970s and early 1980s were characterized by some of the highest recorded rates of inflation in Canadian history. If any meaningful economic sense is to be made out of an examination of health care expenditure patterns, then the analysis must be cast in terms of constant or real dollars. The following points should be noted:

1. Total per capita health care spending in terms of constant 1981 dollars rose by approximately 23 percent between 1975 and 1985. This rise occurred between 1979 and 1982. Real expenditures per capita remained unchanged between 1975 and 1979, and actually fell by three percent between 1975 and 1977 before rising to $1067.00 per person in 1979. Per capita outlays peaked in 1982 and, for all practical purposes, remained unchanged until the end of the decade (1975-1985). The net result is that, other than for one brief cost breakout between 1979 and 1982, real per capita health spending in Alberta has been constant. In effect, there is a low and a high cost plateau and the Alberta health care system is perhaps better characterized by cost stability rather than by cost escalations.

2. The rate of growth in expenditures appears to have been controlled both before and after the cost crisis of the early 1980s. It is useful to note that real per capita outlays in the institutional category remained below the 1975 level until 1982, and that total real per capita institutional expenditures only increased by approximately 11 percent over the decade. This somewhat surprising result is explained by noting that the capital construction and equipment component of hospitals is contained within the "other" category, which increased by approximately 99 percent over the period. This large increase is primarily accounted for by a major jump in capital spending, arising from the capital facilities program initiated by the province, accompanied by increases in public health outlays. (The public health sector definition contains general department administration in addition to other items over and above the standard mix of public health activities carried out in the province.)

The net result is that the relatively stable real total costs per capita attained in the latter part of the 1980s in Alberta were achieved by a reduction in "other" expenditures, primarily capital, which offset the rise in institutional, professional, and drugs and appliances costs. It should be noted that the rise in drugs and appliances costs between 1982 and 1985 markedly exceeded the increases experienced in any of the other major categories.

Interprovincial and National Comparisons

The foregoing discussion has highlighted the

Health Care Expenditures as a Percentage of PDGP
for the Year 1984, Relative to Alberta
Selected Expenditures: Alberta = 100

REGION	TOTAL	HOSPITALS	PHYSICIANS	DRUGS	PUBLIC	CAPITAL
B.C.	142.0	131.3	188.2	182.1	97.4	56.9
Alta.	100.0	100.0	100.0	100.0	100.0	100.0
Sask.	131.7	119.0	108.6	128.6	97.4	81.0
Man.	151.2	152.8	129.0	150.0	138.5	81.0
Ont.	125.9	122.2	150.5	171.4	61.5	62.1
Que.	147.7	175.4	138.7	121.4	107.7	62.1
N.B.	180.8	207.5	153.8	300.0	117.9	124.1
N.S.	174.6	212.7	166.7	332.1	69.2	60.3
P.E.I.	192.8	210.3	160.2	289.3	200.0	29.3
Nfld.	185.8	223.0	140.9	289.3	79.5	127.6
Canada	133.1	138.1	145.2	167.9	92.3	65.5
% of PGDP (Alberta)	6.41	2.52	0.93	0.28	0.39	0.58

Source of raw data: *National Health Expenditures in Canada 1975-85*, Health and Welfare Canada, 1988.

reasons why it is necessary to consider per capita constant dollar expenditure trends. However, it is quite common for various proponents of a health expenditure debate to turn to national and other provincial outlays in order to illustrate a point. The following points are of interest:

1. It is fair to say that Alberta had the highest total health care expenditures per capita in Canada in 1985. Manitoba and B.C. spent approximately six percent less than Alberta, while Ontario and Quebec spent seven and 13 percent less. Expenditure levels in the Atlantic provinces are markedly lower — roughly 25.5 percent lower in the case of Newfoundland and P.E.I.

2. What is true of the whole is not necessarily true of the parts. Alberta had the highest overall public and private spending on health care. However, the statistics indicate that it spends less than certain other provinces on physicians and drugs. The point is that the claim that one province is the highest in terms of total spending does not necessarily translate to all of its parts.

3. When cost comparisons are based on provincial gross domestic product (PGDP), the available figures indicate that the size of the health care sector relative to total economic activity in Alberta is by far the lowest in the country (this does not hold for all health care expenditure sectors). The reason for this is that Alberta has by far the highest PGDP per capita of any of the provinces. This difference is more than sufficient to offset the somewhat higher total health spending.

It is worth noting that no evidence which emerges from a consideration of the Canadian health care expenditure data can be used to point to the existence of a critical value which could be used to limit the magnitude of health care spending within a provincial economy. Total health spending is 26 percent higher in Ontario than in Alberta, while in Saskatchewan and British Columbia it is 32 and 42 percent higher, respectively. In parts of the maritimes health care expenditures in some sectors are almost twice those in Alberta. It seems clear that within a relatively wide range there is no

magic ratio indicating whether a smaller or larger health care sector is better or worse for the economy. This is not surprising. One would expect that decisions regarding what is deemed to be the optimal size of the health care system would be linked to health status/health expenditure linkages, rather than just simply to health expenditure/PGDP ratios. What is so interesting is that this point is so often overlooked in health policy debates, and no serious sustained effort has been made to link wide variations in health care expenditures to the health status of the residents of the various regions.

Conclusion

It has been shown that Alberta is not experiencing a major escalation in health care costs. It is suggested that the current concern arises from a revenue crisis precipitated by the major drop in petroleum-related revenues, not from some marked inability on the part of the managers of the health care system to control health expenditures, or any uncontrollable urge on the part of consumers to utilize health services. It has also been shown that the "burden" of health care in Alberta, as measured by the ratio of total health expenditures to provincial gross domestic product, is the lightest in Canada. It was also noted that it is quite easy to fall into a logical trap and assume that what is true of the whole is true of the parts. Unfortunately, this fallacy of composition problem permeates interprovincial comparisons of health expenditures in Canada.

Richard H. M. Plain, Ph.D. is a health care economist and an Associate Professor, with a joint appointment to the Departments of Economics and Health Services Administration and Community Medicine, at The University of Alberta.

AN APPLE A DAY : TAKING RESPONSIBILITY FOR OUR OWN HEALTH

Judy Cochrane

Recent television and newspaper advertisements remind us to take care of our health; that "one less visit to the doctor" would help ease the strain on our overburdened health care system. Although there is a trend in the '80s toward wellness, the plague of modern society, health-wise, is stress-related illnesses and psychosomatic disorders. These problems are best treated not by visits to the doctor, but by changes in lifestyle.

The underlying belief of both the public and the medical profession that there is a "pill for every ill" leads to the persistence of unhealthy lifestyles which promote chronic disease. That we can run our bodies into the ground by destructive health habits - such as overwork, stress, poor nutrition, lack of exercise, smoking, drinking and drugs - then run to the doctor to be rescued, is a common expectation. Dr. Bernard Siegal, a New York

surgeon, feels that if his clients were given the choice between surgery or changing their lifestyle, the majority would say "operate, it hurts less!" Good health places demands on us; demands for self-scrutiny, self-knowing, discipline and, heaven forbid, *change*!

At the opposite extreme is the health addict, infatuated with youth, athletic prowess and slimness, whose desire for wellness (which is really the need for power over his fears of illness and aging) may in fact put him at risk of becoming sick. Illness and aging are not enemies to be rid of — they are an inevitable part of life, something to learn from, an experience of growth.

According to Dr. Robert Giller, doctors, drugs and hospitals can only take credit for about 10 percent of our collective health, even though they account for about 80 percent of the total health care budget. This means that 90 percent of our well-being is dependent on personal health habits. It can take years of bad health habits (like indulging in a chocolate eclair for dessert and lighting up afterwards) before a serious disease results. We all know we should "clean up our act" and we usually know what we should do. "*So why don't we do it?*"

Dr. Larry Dossey blames what he calls the "Jonah Complex" — running from responsibility, an unconscious attempt to underachieve, a belief that we could be greater than we are if we only wanted to, but we don't choose to. There are many reasons for this, including fear of failure, a preference to trade off long-term health for short-term comfort or a desire to maintain control even if our choices are bad ones. We must look within to discover why we choose poor health habits.

We may even resent others who jog everyday, eat natural whole foods and abstain from nicotine, caffeine and alcohol. We label them as health "nuts," because they remind us of our failings. Doctors become frustrated treating patients with chronic preventable diseases of the lungs, heart, digestive system etc. Their advice to "lose weight, change your diet, stop smoking and drinking, slow down and take time off" is often unheeded. We all know of people at risk who are overweight, heavy smokers and drinkers with high-pressure jobs who die in their 40s and 50s of heart attacks. Why is it that they can keep their cars in perfect running order but neglect the only body they have?

Dr. David Hilfiker states that it is unjustifiable to spend time and health dollars ordering a battery of tests to try to nail down the cause of symptoms and to then prescribe treatment for illnesses most likely caused by our own destructive habits. In fact, treatment (including prescribed drugs) may itself have harmful side-effects. In his book *Beyond Illness: Discovering the Experience of Health*, Dr. Dossey states, "every physician knows there is a limit to therapies of every sort, beyond which they become downright meddlesome, interfering and even dangerous, causing one of the most common diseases of our day, iatrogenic (doctor-caused) illness."

Traditional and Holistic Medicine

There is a yearning for simpler times, when the family doctor knew his patients well - their families, their jobs, their lifestyles - and knew how to treat them as whole persons. The trend towards impersonal machines and technologies and drop-in medical centres has many disadvantages. Dr. Bernard Lown, a renowned Harvard medical doctor, says, "an important principle in medicine is the laying-on of hands, a practice that is rapidly atrophying because physicians are too busy with laying-on of tools."

As a result, there is a growing movement away from traditional medicine, with its focus on treatment, to a holistic approach to medicine, with its emphasis on prevention. Holistic medicine means treating the whole body, instead of its individual parts, in a total environment. The importance of spiritual, mental and emotional factors in well-being and disease are recognized and treated. The goal of this approach is individual responsibility for maintaining good health, with the individual considered an active partner in health care, rather than a passive recipient.

This holistic approach makes a lot of sense. Unfortunately for the health consumer who might

benefit from both the traditional and holistic approaches, there is a reluctance by both health professions to mutually accept and respect each other. We must wisely know the appropriate applications and limitations of each method. The holistic movement cannot reject scientific empirical-analytical methods or just trade old methods of treatment for new, or make unsubstantiated claims of miracle cures. Likewise, traditional medicine cannot reject the holistic principles of treating the whole person. There is room in our health care system for both approaches.

Some of the alternative methods of healing derive their roots from oriental medicine (acupuncture, shiatsu massage, herbal medicine, etc.) or Native American healing (music, dance, prayer and ceremony). Many of these have been practiced for centuries and with demonstrated benefits. Among modern alternative approaches are naturopathy, psychic healing, touch therapy, chiropractic medicine, osteopathy, encounter groups, massage and manipulative therapy, music therapy, reflexology, hypnosis, meditation, primal therapy, relaxation therapy, yoga and biofeedback [a detailed explanation of these approaches can be found in the book *From Acupuncture to Yoga: Alternative Methods of Healing* by Brent Hafen and Kathryn Frandsen]. Still, many of even these approaches cost money and are treatment-oriented. Better still, why not try some cost-free health promoting ideas at home?

Dr. Giller and Kathy Matthews, in their book *Medical Makeover: The Revolutionary No-Will-Power Program for Life-Time Health,* outline an eight- week program to help improve nutrition, exercise and stress-management, as well as eliminate caffeine, sugar, alcohol and nicotine from the diet. Dr. Giller feels that over 50 percent of North Americans are at risk of developing heart disease, hypertension, diabetes and cancer. He suggests that improving our diets would be the single most effective step in preventing chronic disease.

Nutrition

We all know that the typical North American diet is far too rich in meats, dairy products, caffeine, alcohol and processed "fast" foods which are laden with fats, cholesterol, sugar, salt and calories. But we aren't likely to change our eating habits unless we suffer ill-effects.

Few would argue that the goals of better nutrition should be to eat less fat, beef and pork, fried foods, commercial baked goods, processed foods, salt, white flour and white rice and instead, eat more poultry, fish and soy products, dried beans, peas, nuts, whole grains, fruits and vegetables.

In Dr. Giller's practice many symptoms such as headaches, fatigue, depression, irritability, moodiness, inability to concentrate and insomnia have disappeared when his patients cut out sugar and caffeine from their diets. Cutting out sugar may be difficult when it is hidden in almost every food we buy. Cereals, soups, sauces and even peanut butter usually contain sugar (alias corn syrup, fructose, glucose, lactose, maltose, molasses, maple syrup and sorghum). Read the labels! No wonder we eat between 100 and 128 pounds of sugar per person per year! Dr. Giller says that giving up sugar for a period of time will heighten the sense of taste and eliminate any sweet cravings. An excuse (white lie) that he uses to avoid the social pressure to eat sweets is that he is "prediabetic!" Too much sugar, he feels, can predispose us to diabetes, osteoporosis, hypoglycemia, heart disease and obesity.

Exercise

When you feel in charge of your body and health through good nutrition, you will have renewed energy to exercise. Exercise programs should be adopted as fun activities that are convenient, challenging and suited to your lifestyle. How many health clubs have we underused or exercise equipment have we bought that sits and gathers dust? Surveys suggest that 41 percent of North Americans do not exercise at all, 15-30 percent exercise sporadically and only 15 percent exercise regularly. The benefits of exercise to those polled were: 62 percent found they had more energy, 66 percent felt more relaxed, 43 percent felt more

creative and 46 percent made new friends. Ideally, exercise should be done at regular intervals, three to four times per week. Popular activities include walking, jogging, cycling, swimming, aerobics, dancing and skiing, all designed to give an aerobic workout where a target heart rate is reached. The aerobic workout, as well as a warm-up before and cool-down after exercising, are the principal requirements of a good exercise program.

Stress Management

A certain amount of stress is needed in our lives. We cannot avoid stressful situations, but we can choose ways of coping to short-circuit the physiological damage to our health. Stress build-up is common in all walks of life, and people often turn to bad habits - smoking, alcohol, junk food, drugs - to cope. Engaging in this addictive behavior is often a plea for help according to psychiatrist Dr. Gerald Jampolsky. Stress can cause measurable changes in bodily functions and has been linked to heart disease, cancer, ulcers, asthma and emotional difficulties. Common symptoms of stress include headaches, backaches, insomnia, irritability, impotence, fatigue, gassiness, cold or sweaty feet and hands, premenstrual tension, shortness of breath and increased blood pressure. Emotional symptoms include depression, apathy, boredom, fatigue, an urge to cry, nightmares, loneliness, resentment and anger. When a person feels in control of stress and is on-top-of nagging problems and pressures, it results in a boost in self-confidence. It is helpful to learn to recognize what triggers your stress and then to focus on how the conflict can be resolved, rather than dwelling on feelings of anger, defensiveness or low self-esteem. Many people cope with stress by physical activity — exercise or hobbies.

One of the best ways of handling stress is using Dr. Herbert Benson's "relaxation response." It can easily be done twice every day — at noon and in the evening. Find a quiet environment, free from noise or distraction. Choose one word with a single syllable to repeat silently and aid in removing logical thought and distraction. (e.g. "one," "sun"). Assume a comfortable position with your eyes closed. Be passive — allow no thought to interfere. Relax the muscles from your toes to your head, beginning with the feet, calves, thighs, lower torso, abdomen, shoulders, neck and head, especially the face. Breathe in through the nose and say your chosen word as you breathe out. Continue this for 10 to 20 minutes.

Relaxation exercises have been used extensively by Toronto physician Dr. Robert Corey. He has had good results treating patients suffering from chronic pain but wanting to lead productive lives, without medication. Another effective technique is visualization, or creating mental images to rehearse an event with a positive outcome. Used in conjunction with conventional treatments for cancer, patients are encouraged to visualize their cancer cells as morsels of food, and white blood cells as PacMan, gobbling up the cancer cells and helping arrest the disease.

Two other therapies used to reduce stress are music and humour. So called "new age" music lacks the build-up, tension and release, or typical beat and imposed rhythm of other music. It allows the listener to choose their own natural body rhythm to flow with the music. In his book *Anatomy of an Illness*, Norman Cousins, who suffered from a life-threatening disease, tells how laughter, inspired by humorous stories, helped him to regain health. "Laughter is the best medicine." It reduces stress and helps people cope and feel connected. It is a blocking agent to protect against the ravages of negative emotion. Even with chronic or terminal cases, where illness becomes a focus, laughter can help people move from depression, to acceptance. In recognition of the positive emotions that both music and laughter can create, some hospitals are now setting up music and humour rooms complete with records, tapes, comics, cartoons and stories for patients to enjoy.

Attitude

Dr. Siegal believes that a person's attitude influences his health and that medical treatment is only as effective as the mind allows. This explains

how certain people will have spontaneous remissions of their disease, against all odds. Dr. Gerald Jampolsky suggests that the mind, through its will to live, can affect the course of an illness. We all have the potential to change our attitude by choosing the thoughts we think. Our thoughts can either support or lift us or they can sink us into a state of depression or helplessness. Dr. Siegal estimates that 15 to 20 percent of his patients with chronic and catastrophic illness are survivors who take responsibility to get well, while 50 to 60 percent sit back and let doctors direct their treatment and 20 percent are content to die. He tells them, "if they want to die, stay depressed; if they want to live, love and laugh." He also encourages them to express positive emotions of love, acceptance and forgiveness. Having warm, loving, close relationships is important — they are a prime source of emotional support.

To learn more about a person's attitude, Dr. Siegal asks them these four questions:

1. Do you want to live to be 100? (are they in control of their life),
2. What does your disease mean to you? (a challenge to overcome or a death sentence),
3. Why do you need this illness? (cry for love, nurturing or signal for time off), and
4. What happened in the year before you got sick? (90 percent of cancer patients have had significant changes in their lives, some devastating, some positive.)

Information and Support

The first step toward improving health is finding information and support. Many self-help groups, health programs and community resources are available. The more confident people become in their own abilities, the more likely they are to assume responsibility for their own health. One of the best ways to overcome health problems is to attend support groups whose members have coped with a similar experience and can offer understanding and help. Self-help groups exist to help people cope with virtually any type of illness, addiction, handicap, chronic pain and loss. Self-help groups can be reached through community health or social service departments.

With the advent of the women's movement, women's health collectives have formed in most major cities across Canada to provide education and counselling on health issues relating to women, children and families. Outreach programs provide support services to church groups, day care and community centres. In colleges in the United States, "wellness dormitories" have been set up to provide classes in such topics as cancer biology and prevention, with resulting behaviour changes (reduction of fat intake, increase in fibre consumption and regular breast and testicular self-examination) in the students.

There are many professionals working hard in the community to promote physical, mental and spiritual health through education and counselling. Community and occupational health workers, nutritionists, home care nurses, dental hygienists, public health inspectors, mental health workers, social workers, teachers and the clergy all provide valuable programs in various settings — clinics, schools, the workplace, churches and homes. Yet with only eight percent of the total health care budget in this province spent on preventive health care services, many of these programs are limited. With more government funding, the possibilities would be endless — free relaxation and stress management workshops, free nutrition courses, behaviour management programs, personal and family growth workshops, etc. all geared toward supporting people to live happy, healthy lives.

And yet, in the end, no matter what programs and resources are available, the decision to live a healthier life rests with the individual. The desire must come from within. The commitment is great, but the rewards are worth it.

Judy Cochrane is the Alberta co-ordinator for ICEA, the International Childbirth Education Association. She is also a B.Sc. in Nursing and a mother of four.

THE NURSES PERSPECTIVE
Irene D. Gouin

Mr. Alex (fictitious name) woke up with a start! Where was he? God, but his leg hurt! Oh yes, now he knew what had happened. He wasn't sure what was worse, breaking his leg or having it fixed. The pain was excruciating! In fact, every muscle in his body seemed to ache and he couldn't remember when was the last time he worked so hard to breathe.

He looked around and noticed the room in semi-darkness, the overbed table off to the side, and what were the bars up the sides of the bed for? Suddenly, he noticed a shadow coming from the doorway.

The nurse spoke in a low voice, "Watch your eyes, I'm putting the light on." After the light was on he could estimate that the uniformed figure in front of him was petite. Her muscular hand turned his right arm over to inspect the intravenous which he hadn't noticed. She went on to explain that his surgery was over and he was on a unit, in such and such hospital. Did he recall what happened to him? He was able to recite the incident that led up to breaking his leg, but could he have something to deal with this pain? She replied, as she picked both hands up and inspected them (a motion he found peculiar since his concern was the pain, not if his nails had been manicured lately), that she would get him a needle. Then she put a "breathing mask" on him and left the room.

Two hours later Mr. Alex found himself drowsily fighting a tube in his mouth. The tube was connected to a ventilator. Another nurse was telling him that it was necessary to have him intubated and sent to intensive care as he was having difficulty breathing. What happened during those two hours?

The unit nurse, the first nurse Mr. Alex remembered seeing, had gone to the desk and reported that he was experiencing severe shortness of breath, that his speech was slow when answering questions and that his lips and nailbeds were blue. The intern was called to assess Mr. Alex. After the assessment the intern informed the nurses that he was needed in intensive care, that they were to monitor the patient and keep the oxygen on him. The nurses, not being satisfied with this, went over the case with the intern and made suggestions of their own. These included frequent checking of vital signs (which they were doing anyway), a chest X-ray, some blood work and notification of Mr. Alex's physician. The intern insisted on the patient just being monitored, but did order a chest X-ray.

Mr. Alex's colour had improved with the oxygen, but the nurses decided to contact Mr. Alex's physician anyway. Upon relating their observations to the physician, they were told to continue monitoring until the morning when he would be coming to do rounds. The nurses, not impressed with the doctor's order, called the supervisor. The supervisor told them that the physician knew best and to hang in there since Mr. Alex's vital signs were stable for the moment. If Mr. Alex were to be transferred to the ICU she wouldn't be able to find the staff to go there. The nurses could empathize with the supervisor. It was well known that the nursing department had been under pressure as a result of calling in people for overtime. So the nurses monitored Mr. Alex.

You wonder if this would ever happen? Working as a nurse over the past eight years, I have seen it happen often enough to know that there are times when you have a gut feeling that someone is in imminent danger and yet, frustratingly, you

haven't enough evidence for the rest of the health care team's members to act on your suspicions.

Unfortunately, the quality of care an individual receives often depends on how the various team members perceive each other. In this case the supervisor felt the physician knew best and didn't know where she would get more staff for the ICU. The physician perceived the nurse as exaggerating, if not being an inconvenience. The intern felt that the nurses could not appreciate his list of priorities when it came to handling more than one crisis at a time. Poor Mr. Alex was simply too confused to know what was happening to him.

Nurses perceive themselves as professionals with a standard of practice that involves contracts with four different parties.

First of all, the nurse has a contract with the patient to provide the best possible care under the circumstances. In Mr. Alex's case that care did not only involve his broken leg and its pain, but any other affliction that Mr. Alex might experience. Thus, the nurse must check Mr. Alex from head to toe and be on the alert to any signs that may be revealing something about Mr. Alex and his state of health. It also involves prompting the physician to come in and take action and notifying other members of the health care team. Then, the nurse must take action based on the physician's orders, personal decisions and hospital policies.

The nurse also has a contract with the physician. That being reporting concerns and observations and following the physician's orders. But on occasion a nurse finds him/herself questioning those orders.

Then the nurse has a contract with the employer. That contract insists that a nurse follow hospital policies and provide competent nursing care. Finally, the nurse has a contract with society to provide safe care to those entrusted to her/him.

What does this all mean? It means that at times, as a nurse, you find yourself in a dilemma. In order to meet the obligations you have to society and your patient you may come into conflict with other parties, such as the physician and the employer, to whom you also have obligations. The world of nursing can be complex. The ways in which others perceive the role of the nurse makes things even more complex.

The physician's perception of nurses can be puzzling. As a nurse, it has been my experience that my concerns, observations and suggestions are more valued when I work on a specialty unit, compared to when I work on a more general practice unit. I bring the same level of education and experience to both types of service. This tells me that many physicians base their value of nurses more on impressions than on reality. And, too often, there are those physicians who treat nurses like "hand maidens."

The employer's perception of the nurse is still based on the "master-servant" mentality. Staff nurses are not represented on many of the decision making committees of hospitals. For example, hospitals continue to make no effort to consult nurses over decisions which will have a direct impact on the nursing staff or on the patients. Such decisions may involve the type of nutrition that will be provided, the type of equipment that will be utilized, the number of bed closures that will occur or the patient to nurse workload ratio.

Frequently, to address the nursing shortage, an increasing number of patients, or a larger number of sicker patients, are becoming the responsibility of the nurse. In addition to this added work load the nurse is being given more administrative responsibilities.

On the positive side there is the public's changing perception of nurses. There seems to be a greater recognition that nursing is a career, not just a vocation. Further, there seems to be an understanding that if nurses are to be able to carry out their duties they must be given the means to do so. But more than ever before, the public appears to have realized that in order to keep people in nursing, nursing must present itself as an attractive career to remain in.

Irene D. Gouin is a Registered Nurse working in Edmonton.

COUNCIL NEWS

Publications

1988 Poverty Lines

This publication provides an explanation of Statistics Canada's low-income lines, with National Council of Welfare estimates for 1988 and actual lines for 1983-1987.
Free: $2.00 postage and handling

1988 Poverty Profile

This publication, also published by the National Council of Welfare, provides tables and explanatory text on the most recent statistics on proverty, average income and income distribution in Canada. The report analyzes both recent and long-term trends, and highlights groups with an above-average risk of poverty.
Free: $2.00 postage and handling

Policies for Full Employment

Edited by Duncan Cameron and Andrew Sharpe, this publication was the result of the Symposium on Policies for Full Employment organized by the Income and Employment Committee of the Social Planning Council of Ottawa-Carleton. The essays within challenge present employment policies and suggest options available to reduce and eliminate unemployment.
$15.00 plus $2.00 postage and handling

Access and the Policy-Making Process

This report is the first stage of the Canadian Council on Social Development's examination into the scope, nature and effectiveness of citizen participation in the development of social policies in Canada. It looks at the formal and informal channels for citizen input into the policy-making process.
$4.00 plus $2.00 postage and handling

New Support Group

The Council would like to take this opportunity to introduce its readers and the community to *Unemployed People's Support*. The Edmonton Social Planning Council, in conjunction with the Family Life Education Council and the City of Edmonton Parks and Recreation department, is delivering U.P.S. (Unemployed People's Support), a newly founded group that aims at meeting the social, emotional and recreational needs of people who are out of work, job seeking and "feeling down" about their job search. Group meetings will begin in early June and address a wide variety of topics related to being unemployed. For more information, please call the Edmonton Social Planning Council at 421-9570.

Upcoming...

Through the efforts of a summer student, the Council is hoping to offer an updated version of "Research Libraries, Social Issues: A Guide to Social Development Information in Edmonton." It is hoped that this updated publication will be available to interested people this fall. Keep watching this space for further news and ordering information.

FIRST READING *is published six times per year by the Edmonton Social Planning Council.*
If you would like to receive the publication on a regular basis write to FIRST READING, *#418, 10010 - 105 Street, Edmonton, Alberta T5J 1C4, or telephone (403) 423-2031.*
Opinions expressed are those of the authors and do not necessarily reflect the views of the Council.
The editor of FIRST READING *is Joseph Miller.*
The financial assistance of the United Way is gratefully acknowledged.
Second Class Mail Registration No. 6390
i.d. 06/88
ISSN 0824-197X