Back to the future

Now more than ever, community health nurses are needed to build a healthy future for all Canadians
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Features

06  Countdown  
The world has been talking about community health for years. It's time to act—and for governments to listen  
By Dean Sioban Nelson

09  The invisible sector: public health nursing  
A look at four Bloomberg Nursing alumnae who are making the world a safer place  
By Lucianna Ciccioppo

12  Risking it all for baby’s daddy  
Why do African-American teen moms shun condoms, at the risk of contracting HIV/AIDS or STIs, to have sex with the father of their child? It’s not what you think  
By Lucianna Ciccioppo

14  Community care conundrum  
Now more than ever, community health nurses are needed to build healthier lives for all Canadians. But it’s not as simple as it sounds  
By Lucianna Ciccioppo

19  Double dilemma  
Doctoral student Ruth Lowndes investigates why group home residents with mental illnesses have sky-rocketing rates of diabetes  
By Lucianna Ciccioppo

20  The technological transformation of care  
How the wireless world is integral to the ‘new’ nursing  
By Lucianna Ciccioppo

Departments

04  Letters
05  Dean’s message
23  News
25  Events
26  Q&A  
A conversation with Dean and Professor Emerita, Dr. Dorothy Pringle, RN BScN, MS, PhD, OC

32  Opinions  
Weeding out the ad hoc approach to the acute care crisis  
By Shirlee Sharkey

36  Careers

38  Expressions  
Looking back, forging forward
Pulse lands its first award

_Pulse_ magazine landed a silver medal from the U.S.-based Council for the Advancement and Support of Education for an illustration in its inaugural issue, Fall/Winter 2008.

“The Lighthouse School,” by internationally renowned artist Gerard Dubois, won in the Excellence in Design: Illustrations category of CASE’s circle of excellence program, lauded as perhaps the most prestigious competition for advancement offices around the world.

Dubois’ piece was one of 23 entries, and only gold and silver medals were handed out in this category.

Clarification

Dr. Mary Jane Esplen is a professor, department of psychiatry, Faculty of Medicine, cross-appointed to the Bloomberg Faculty of Nursing. Incorrect information appeared in the last issue of _Pulse._

On the Cancer Issue, Spring/Summer 2009

As one of Canada’s first “street nurses,” I didn’t know whether to laugh or cry after reading the article on nursing and palliative care. It is both surreal and perverse to me why anyone would be doing research on how homecare can better serve homeless people or why government should improve palliative resources for dying homeless people. The so-called “unique health-care needs” of homeless people would disappear if they had somewhere safe to live. Homecare supports would have a place to visit, and there would be no need to try to create dignity in a public washroom because terminally ill people would have the dignity of their own home. What Ontario needs is affordable housing for all, and anyone with a life-threatening illness must be prioritized to obtain housing immediately. We do not need more “specialized” nurses out on the street with backpacks and research instruments, looking for dying people. Just how sick a society are we?

Kathy Hardill, RNEC 8T7
L’Amable, ON

Congratulations on a delightful article about Dr. Verna Huffman Splane. I was fortunate enough to be at a reception for Sioban Nelson, involving local international nurses, at the Splane home and Dr. Nelson had brought copies. Verna shared one of the copies with me. I thought you captured the essence of the charming, intelligent and influential Dr. Splane. I also enjoyed the other articles and item—and was most impressed by the wonderful photographs.

Glennis Zilm, Honorary Professor, UBC
White Rock, BC

Congratulations on an incredible journal, _Pulse_. I am reading the Cancer edition and find each page, photograph, article to be of superb quality. It’s fabulous in every way! I just wanted you to know how much I appreciate this journal and how it makes me feel proud to be a U of T Faculty of Nursing alumna!

Tilda Shalof, RN, BScN, 8T3
Toronto, ON
When we launched *Pulse* one year ago, we aimed to do something different. We decided to talk about what we are doing to tackle the issues facing the health-care system. By focusing on the amazing accomplishments of our alumni, our brilliant faculty and our outstanding students, we wanted to share with readers what is happening at the cutting edge of education, research and practice in health care and nursing practice today.

Our readers include alumni who represent the profession in every sphere of practice (past and present), nursing and health service leaders, as well as our wider community of donors and friends. Your feedback has told us we are on the right track. You want to know how we are preparing the next generation of practitioners, what new knowledge is transforming the face of health care and service delivery in the years to come, and how our alumni are making such an important contribution to the health of Canadians. *Pulse* magazine is showing you.

In this issue, we focus on the community sector and share just some of the remarkable work Bloomberg alumni, faculty and students are doing to address the big issue that has challenged our health-care system for decades: how to promote health and build health communities. As politicians and policy makers fret about the escalating costs of health care and voice concerns over the long-term sustainability of our current funding model, the solution-oriented work of the Bloomberg nurses showcased in this issue has never been more important. Our nurses are showing how to provide better care, how to support and promote better health for at-risk groups, and how to develop innovative solutions to access services and safer home living.

The good news stories in this volume range from advocacy for vulnerable groups (such access to screening services for people with mobility issues) and the surveillance and management of infectious disease (such as tuberculosis), to high-tech solutions to supporting independent community living (such as remote monitoring systems). These stories feature alumni working in public health, pediatrics, ambulatory care, long-term care and homecare, faculty researching challenging questions such as teenage sexual health or undocumented immigrants, and an interprofessional student-led project that takes on the challenge of providing direct care to a marginalized inner city community in Toronto.

In all of these stories, the theme is the same: the Bloomberg Faculty of Nursing is at the centre of a group of highly educated and motivated nurses who are creating solutions to the problems that overwhelm our individual citizens, their families and our health-care system. Whether it is working in direct care, or educating and mentoring future practitioners, or researching the knowledge base from which we practice, the Bloomberg Faculty of Nursing is providing answers to the big questions: how to keep people healthy and how to build a sustainable health-care system.

Read on and be inspired by the remarkable nurses featured in this issue, and be reassured that with all this talent the future is in good hands.
public health
Countdown

The world has been talking about community health for years. It’s time to act — and for governments to listen

By Dean Sioban Nelson, RN, PhD

Florence Nightingale once described hospitals as only an ‘intermediate stage of civilization’, believing health was something that arose from a healthy environment. While the world’s most famous nurse is best known for her work at the Crimean War and the establishment of the training school for nurses at St Thomas’s Hospital, London, her greatest passion was for public health. As a statistician and pioneer health science researcher, Nightingale’s monumental report that followed the war not only showed that more soldiers died of disease than as a result of enemy action, but that in peacetime a soldier’s mortality rate was high compared to that of civilians due to the poor sanitation of military barracks. This report led to major reforms in military housing as well as hospital design.

Less well known was Nightingale’s longstanding interest in India and her campaign to have the colonial government make the provision of clean water its major priority. Cholera originated in the Ganges Delta of India and is spread by contaminated water and food, and poor environmental management. Over the course of the 19th century, cholera killed millions of people in successive waves of epidemics across Europe, North America, Africa, Asia and, of course, India. According to the World Health Organization, cholera is once again on the rise and has re-emerged as ‘a global threat to public health and one of the key indicators of social development’ Nightingale’s plan for clean water for India lost out to commercial interests and the development of the Indian railroad. If she had succeeded, perhaps cholera would be a disease of the past and at least one of the WHO’s millennium goals would have been achieved.

In 19th century North America, crowded cities, poverty and infectious disease created enormous public health challenges which were taken up by remarkable women, such as nurse Lillian Wald, of the famed Henry Street Settlement in New York, which was founded in 1893 to work among the immigrant poor of the Lower East Side of Manhattan. Long before the concept of social determinants of health was coined, these nurses were driven by political idealism and commitment to justice to address the appalling health of immigrants, providing direct care to families, education on hygiene and nutrition, and eventually expanding to a whole range of other services.

Thus, by the time the catastrophic influenza of 1918-19 cut its swathe across the globe, in the UK and North America, there had been something of a 50 year tradition of what was to become known as public health nursing and community care. In the days before it was possible to manage common medical conditions, or to treat infections, it was recognized that what the system needed was an army of highly trained nurses to ensure the health of mothers and babies, to educate families, to work within schools to ensure healthy fit citizens for the future and to prevent the spread of infectious disease. This was the new public health nursing and in 1920 the nursing school at the University of Toronto, under the name Department of Public Health Nursing, was established to serve that end.

The sense of vulnerability to infectious disease that had been a simple fact of the human condition since the rise of agriculture actually began to wane in affluent countries during the 20th century, as immunizations became widespread and the management of acute conditions became increasingly effective. But of course that was merely an illusion. Tuberculosis, once the bane of the world and so effectively remedied with the development of streptomycin in 1943 and prevented through immunization programs, is back today and rising around the world, with multiple resistant strains causing near hysteria among quarantine agencies and the media. New diseases have emerged, such as AIDS, while other known diseases, such as influenza, have continued to mutate and cause widespread concern (H5N1 and H1N1). The category of influenza-like illness (ILI) is now the new risk. Interestingly this current issue that is occupying so much policy and media time illustrates well how far the circle has come. We are approaching H1N1 the way we approached many illnesses in the 19th century, when there was uncertain aetiology and/or few effective interventions. Then and now the best approach is supportive measures based on principles of infectious disease management. In other words: wash your hands, stay home if ill, keep well hydrated.

It is hard not to be struck by the ‘back to the future’ element to contemporary discussions about public and community health. The return of the sceptre of infectious disease is only one such ghost of the past that we now realize our health-care systems ignored at our collective peril. Twentieth century hubris about the progress of medical science solving society’s health problems has also led to the almost absurd situation that today, with our relative wealth, high levels of education and access to virtually limitless information, we are sick and getting sicker from ‘life-style’ diseases. Fast food and processed food of low nutritional value, inactivity and smoking are taking a disastrous toll on our collective health, and, most concerning, that of our children. Tragically, around the world, these health problems come hand in hand with economic growth and social development, burdening so many countries with diseases of both poverty and wealth.

It is sobering to think that the problems of western diseases that we now face were predicted decades ago — and solutions proposed. In 1978, the WHO proposed in the Alma Ata meeting that health for all could only be achieved through the establishment of a vigorous primary health-care network to serve and work with communities, identifying their needs and working with inter-professional teams to collaboratively create custom-made, effective strategies to prevent disease and promote health. Later, in 1986, the Ottawa Charter of Health Promotion pointed towards inter-sectoral collaboration, healthy public policy and community development, among other strategies, to produce health for all. Canadian
nurse academics have been teaching and researching about such ideas since their inception and those in practice have been working to achieve the ideal of health for all.

More recently, innovative approaches to primary health care and public health services are being acknowledged by governments in Canada and elsewhere as the way forward (even if those words are at times not being supported by resources). But despite its great virtues, the contemporary primary health-care team model is still about individuals getting themselves to a clinic to see a physician or a nurse practitioner, at least in the first instance. Homecare services are stretched with high volumes of vulnerable clients with complex care needs. Program specific public health services continue to stretch thinner and thinner across our communities serving target audiences. How many ordinary citizens do public health nurses reach today? How do any of these services even begin to address the social determinants of health, the root cause of so much ill health?

Community health-care costs are minor compared to those of the acute care sector. Nonetheless the acute sector has the gravitational pull of Jupiter on our health-care solar system dollar, and whenever the squeeze is on it is the non-urgent sector that, to our peril, keeps getting cut. Cuts to prevention services tend not to end up on the front page of the Globe and Mail for creating a disaster overnight. But disasters are certainly created in the long term. Our current ‘obesity epidemic’ was decades in the making.

Canada has much to be proud of: Alma Ata and the Ottawa Charter led the world in defining the true goals for health, and in recognizing that the critical ‘system’ in question is not the health-care system but society as a whole. There is no debate that poverty, inequitable access to education, unemployment and lack of services (such as health services) create the conditions for disease. Florence Nightingale would certainly have agreed with that observation. Today, as our leaders debate the ‘sustainability’ of our health-care system, Canadians need to be reminded of what community health nurses have long known: the promotion of health is the only way to build a sustainable future.

One wit described the current health-care funding model as buying more mops to fix an overflowing sink. Well, we are up to our waists in water these days, with an acute care sector stretched to capacity and flood waters gathering upstream. We are beyond mops now.

We know the answer is to keep people well. This century we just have to mean it when we say it.44

Only by fully grasping this issue, and its implications for the way our systems are organized, can we ever hope to dissipate the tsunami of acute-on-chronic disease that is heading our way as baby boomers age.

There is no question we need to continue to work to cure disease and to more effectively manage those who are suffering from the consequences of disease or injury in the acute-care sector, long-term care or in the home. Nurses, along with colleagues across the health sciences, play a vital role in this ongoing story. But as the health-care professionals who spend the most time with patients and families and who work in communities and in people’s homes, the real asset that nurses bring to the health-care system (and society) is the opportunity to prevent illness, to support individuals, groups and communities to engage in healthier practices, to advocate on their behalf when needed, and to establish partnerships with the population to share knowledge and encouragement to improve health and people’s quality of life. And despite a great many efforts on behalf of dedicated health professionals and service providers, in our hearts we all know that it is farfetched to think that effective education and support for behaviour change can take place while an individual is stressed, unwell and disconnected from her/his family or community during an acute episode, or during the pressured encounter of a clinic appointment or home visit.

If we all agree on the vision then, in the end, change is about commitment and resources. Transferring health-care dollars to the areas where they are needed to improve health, prevent the development of chronic disease, to guard against infectious disease and create communities with fewer accidents and injuries is easy to declare but hard to operationalize. We are caught in a trap of responding to urgent current needs, instead of creating a system that leads to decreasing the pressures on the acute system. Around the world—and Canada is certainly no exception—first and foremost the solution relies upon redirecting resources from individual clinicians (be they physicians, nurse practitioners or other fee-for-service providers) and placing our dollars in programs and salaries. One would think that in a publicly funded health-care system this would not be such a tough call, but it is. However challenging the politics of health care is on this matter, the fact remains primary health care in its broadest sense is not simply a case of having more individual providers, or even teams of them. It is about meeting people where they are, and working with communities and schools and grassroots organizations to promote health where it is produced: in people’s everyday lives, outside of a decreed clinical consult time. Only by fully grasping this issue, and its implications for the way our systems are organized, can we ever hope to dissipate the tsunami of acute-on-chronic disease that is heading our way as baby boomers age.
The invisible sector: public health nursing

A look at four Bloomberg Faculty of Nursing alumnae who are making the world a safer place

Stories by Lucianna Ciccocioppo

The forgotten neighbourhoods

Public health nursing is the care that goes on behind the scenes as the world whizzes by. It’s the linking to other services and advocacy for change that so many people, from so many walks of life, rely on. It’s the staring down of the social determinants of health that has a hold on our communities.

And yet, it’s the last stop of the health care funding train, says Ann Liddy, BScN 97.

“Everybody focuses on emergency responsiveness, not on pro-active care,” says the acting manager for the healthy families program at Toronto Public Health. “If all the funding is put into ‘fighting fires,’ there’s very little left over for preventing them.”

She’d like to see more support for initiatives such as “Investing in Families.” In 2007, Toronto Public Health embarked on a one-year pilot initiative led by Toronto Social Services, which also included Parks, Forestry and Recreation and Children Services. It focused on a small but high-priority area of the city—the neighbourhoods of Jane and Finch—and specifically on sole support parents on social assistance with children 6-17 years of age.

Each department worked together to cut red tape and service the families better. That meant a social services case worker accompanying a public health nurse in a home visit, instead of a single mother trying to head out to meet these people on separate appointments.

The departments each learned what the other had to offer, or couldn’t offer, says Liddy, and were able to work together more effectively in referring appropriate services.

“Working with public health nurses, Toronto Social Services saw first-hand the number of families that were in distress, and that were struggling with mental health and social issues,” says Liddy. “Many caregivers were also living with pain on a daily basis, due to some other health issue.”

It gave the case worker a better understanding of what families were dealing with, she says, and why some couldn’t get back on their feet. It provided the holistic assessment that was needed to help families become more self-reliant.

“As nurses, we worked intensely to link them to services, to find out what their needs were, and to connect them,” says Liddy. “We broke down silos, and worked through the red tape. We really had to reach out to these families, but meeting the nurse, and seeing the support from the other departments, made all the difference for them.”

The award-winning program—it landed a 2008 Award of Merit at the Public Sector Quality Fair—was extended, says Liddy with excitement, and is now expanding to different parts of Toronto.

Want to change the world? Call a nurse

Photograph: William Ciccocioppo

Ann Liddy

Dr. Angela Cooper Brathwaite
For Dr. Angela Cooper Brathwaite, PhD OT4, advocating to help make the world a safer place is simply part of her job as regional program manager for prevention of injury and substance misuse in Durham Region, Ontario.

It’s a large area, east of Toronto and bordered by three lakes, Ontario, Scugog and Simcoe, encompassing rural and urban clients, each with its own set of issues: children as young as seven using ATVs (all terrain vehicles) in farming communities, and getting injured—or killed—because of it; designer drugs, such as cocaine, infiltrating homes in Oshawa and Pickering and pushing up the incidence rates.

Her mantra is prevention, using various media to inform various audiences: YouTube, Facebook and the Internet for youth, advertisements, brochures, radio and newspaper spots for seniors.

“Unintentional injuries, such as falls, motor vehicle collisions, drownings, ATV-related injuries cost Canada $19.8 billion annually,” says Cooper Brathwaite, assistant professor (part-time) at Bloomberg Faculty of Nursing. “It’s a huge burden.”

An increase in alcohol-related collisions in recent years prompted several designated driver initiatives, such as “Keys to Us” with Durham bars and taxi companies. The health department educated bar owners and employees on legal liability, responsible service of alcohol and house policy development. Car keys from clients who had one too many drinks were taken away by bar staff, who then sent clients home in a taxi, with a $5 discount for the client. “‘Keys to Us’ is unique to Durham,” says Cooper Brathwaite.

She highlights Durham’s role in policy advocacy, and lists matter-of-factly the impact of her department’s work: reducing the maximum hot water temperature for all new apartment buildings in Ontario to 49 degrees Celsius, down from 60 degrees, due to the number of children, elderly and disabled people suffering from hot water burns; securing the one seatbelt for one person law, after a family outing in an overcrowded mini-van resulted in a collision with severe injuries and four deaths.

“The collision happened in the summer of 2006, and by fall 2006 the law was changed so that you cannot have more people in a vehicle than the number of seatbelts. We helped close that loophole,” says Cooper Brathwaite.

And for those addicted to their cell phone when driving, while pooh-poohing the hands-free option, you can thank Cooper Brathwaite’s team as part of the effort in creating Bill 118 and 126. These amendments to the Highway Traffic Act outlaw cell phone usage and texting while on the road. One change was effective immediately: the drop in legal blood alcohol concentration to .05, down from .08. “Public health units wrote a lot of submissions on these topics.”

Now she’s working with the Ministry of Transportation to change the Off Road Vehicle Act for ATVs and increase the legal age requirement to 16, up from 12. “It’s been three years,” says Cooper Brathwaite, “and nothing has changed yet. There are a lot of stakeholders—and many have economic interests.”

If we’re serious about making the world a safer place, says Cooper Brathwaite, there’s no shortage of work to be done—at the private, public and political levels.

Double duty nursing

When public health nurses set out on a Directly Observed Therapy Program, or DOT, they are monitoring a lot more than the medication part. These nurses are working with tuberculosis patients who need to follow a strict regimen of antibiotics, usually a cocktail of several daily drugs over six to nine months, to cure the sufferer and keep the disease from spreading.

But what intrigued Dr. Amy Bender, PhD OT9, assistant professor, Bloomberg Faculty of Nursing, was the ‘double duty’ nurses were performing because of other issues that came up during these home visits.

“There was this constant tension between ‘I’m here as the agent of the state to protect the public’s health’, says Bender, ‘and I’m caring for this individual as a nurse with all that I’ve learned in my educational background.’ And that means nurses have a duty to care for this individual.”

Bender says these nurses are in a surveillance role, since their job is to monitor TB, a reportable, curable, infectious disease. “These clients [with active TB] did not have a choice about having a nurse in their lives, and they certainly did not want a nurse watching them take their pills.”

Once considered a disease of the 19th century, tuberculosis is again a serious public health threat around the world. It’s a disease found in Canada’s First Nations people, in developing countries, and in terrifying proportions among Africa’s populations ravaged by the HIV epidemic.

Bender’s doctoral work focused on the relationship-building that develops as part of the DOT program, the relational skills of TB nurses, and the impact of this on the nurse-client TB experience.

“The advantage of having an RN in the program, as opposed to lay workers, is that regulated health professionals draw on a whole body of knowledge, because so much of their work is supporting people through the treatment, when they don’t want to take it.”

The side effects are brutal: possible damage to liver function, nausea, fatigue, vision problems and a whole host of smaller effects. And, after a
“If all the funding is put into ‘fighting fires,’ there’s very little left over for preventing them.”

few weeks, as soon as patients start to feel better, the uptake of antibiotics tends to fall off, if the regimen is not monitored.

In Toronto, TB cases primarily show up in new immigrants and a sub-sector of those are in marginalized groups. They may have other issues to face, such as displacement, depression, unemployment.

It’s not enough, argues Bender, for nurses to link such clients to other services, and then leave.

Allaying the fears and concerns of TB clients is a big part of the surveillance role and the daily or weekly nursing contact that made a difference.

“I had one client tell me he would have stopped taking the drugs had it not been for the visiting nurse. So there’s a psychosocial aspect to this program as well, which is the invisible work. And it’s really invisible in public health,” says Bender.

Bender wants to see this relational work supported and safely supervised for nurses, so they can network and learn from one another, and share issues and ideas in dealing with their clients. She’d like someone with a mental health background and counseling psychotherapy to be part of this network.

“We need to be referring these clients to the experts much sooner,” says Bender.

Airport adrenalin rush

If you think public health nurses miss out on that ‘adrenalin’ rush that their acute care counterparts talk about, think again.

It’s something Andrea Main, quarantine officer, experiences every time she gets that phone call from a customs and immigration official reporting a traveler with symptoms of a communicable disease.

Main is one of six public health nurses at Toronto’s Pearson International Airport, who work shifts or on call to take over when a screening officer (customs official) has concerns with an international traveler who presents at the airport.

“The situations we handle at the airport usually involve several emergency partners, and is considered a public health emergency,” says Main. “So time is of the essence, and we have to make decisions quickly and efficiently.”

“We’re at the major airports in Canada, and can handle calls by phone for land, air and marine border crossings,” says Main. “We’re looking for your typical flu-like symptoms.”

She completes a health assessment, documents and evaluates their signs and symptoms, assesses the severity and timing, collects a travel or contact and medical history. She then determines if the traveler imposes a risk to public health, and decides what further action is required.

She may require the traveler to report to the local health authority for follow up, or check into a hospital. “If they refuse, they can be detained.”

Translators are available for any language, so travelers know exactly what is going on, says Main. “And if they’re sick, we want to make sure they’re looked after.” She also collaborates with on-call quarantine medical officers of health for major issues.

Main started her quarantine job in 2004, a new role created by the federal government after the SARS episode in Toronto. These days, it’s H1N1 that’s keeping her and her colleagues busy.

“When things are not as busy, we work with the airport authority and local public health units, updating them on quarantine issues, and connect with the airlines, customs and immigration departments and emergency services about our role and what the quarantine legislation is,” says Main.

She’s currently pursuing her master’s degree at the Bloomberg Faculty of Nursing in the clinical community stream because of her interest in disease and population health. She says working at a public health agency has challenged her to start thinking from an international health perspective.

“We’re one piece of the larger puzzle.”

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“We’re one piece of the larger puzzle.”
Risking it all for baby’s daddy

Why do African-American teen moms shun condoms, at the risk of contracting HIV/AIDS or STIs, to have sex with the father of their child? It’s not what you think

By Lucianna Ciccocioppo

Sitting in his office on the second floor of the Bloomberg Faculty of Nursing, Dr. LaRon E. Nelson, a new assistant professor, still shakes his head as he explains the stories he heard as a nurse at a sexual health clinic in Rochester, New York.

He remembers adolescent teen moms, mostly African-American, coming in for assessments, diagnoses, and treatments, worried they had a sexually transmitted infection (STI). He would ask them to fill out the requisite questionnaire, asking, among other things, ‘Do you use a condom?’ with a box to tick for either ‘always,’ ‘sometimes’ and ‘never.’ Pretty cut and dry, except their answers were anything but cut and dry. Many told him ‘always’ or ‘sometimes’—then qualified it with a “But not with baby’s daddy.”

“I heard this once, twice, five times and more, and I didn’t understand it,” says Nelson, a former associate director of public health with Rochester’s Monroe County. “So I asked my colleagues in the clinic, ‘Have you heard girls say this before?’” The answer was yes, actually, they say that all the time, could you just tick off the ‘sometimes’ box, LaRon?

“They weren’t interested. They didn’t see how it could make a difference in how we treat them,” says Nelson. But that wasn’t good enough for this nurse. Maybe because he’s African-American. Maybe because his mother was a teen mom, and he has siblings who were teen moms. Says Nelson: “I wanted it to be my issue, and I wanted to figure it out.”

Using focus groups led by a female nurse, more than 30 adolescent girls between the ages of 15 and 19 and who identified themselves as African-American participated and opened up in an astonishing manner on the factors influencing their decision-making and risk-taking among sexual partners.

He discovered there’s a clear and categorical classification system of partners, complete with names and defining characteristics and rules—and it was a system that was consistent among all the girls. “Love, trust and perceived seriousness of the relationship factored into their decision-making about risk-taking with pretty much all the partners—except the baby’s daddy,” says Nelson. This partner was the only partner who held this title and was not tied to the emotional factors because of his biological role.

It didn’t matter if the baby’s daddy provided little or no financial or parental support. What mattered was trying to maintain some sort of relationship between the child and biological father. He heard comments like “I need him to come around and see the child.” Says Nelson: “And sex was a way to do that. Calling him up and saying ‘Come on over, let’s chill’ was code.” Just showing up and playing with his child would put a smile on the teen mom’s face. And then it was payback time, and if he didn't want to wear a condom, so be it.

“It was tough to hear that,” says Nelson. “There was this longing for a traditional family unit. In clinic, we conceptualize them as promiscuous girls. But when you talk to them—really talk to them—you think, ‘Oh my goodness, she wants a family.’”

For some girls, growing up without a father contributed to their actions. Others explained there was just no way to keep the baby’s daddy returning other than this ‘free pass’ to sex. Nelson says some teen moms stressed the biological father was more important than the current father-figure in the child’s life, perhaps a steady boyfriend, who helped out with babysitting so the teen mom could attend school. “From a nursing perspective, we pointed out to the moms that this is considered a family. But to them, a father-figure is not the same; it’s not the baby’s daddy,” says Nelson. The teens stressed there was a ‘connection’ that they shared with the father of their child.

Fear of contracting an STI or HIV/AIDS is not a deterrent, says Nelson. “A lot of adolescent girls did come in with an STI, and a lot would go back out and do the same thing. They saw it as a consequence of what they had to do, so their baby could spend some time with his or her father.” With other partners, there simply was no incentive not to use condoms.

It’s not about teaching them about their use, or where to find them, or helping them with negotiation skills. “These girls know where to find condoms, and how to use them. It’s about other issues that we don’t address at all. It’s about asking them about the relationship with the father of their child,” says Nelson. “I’ve never asked those questions in clinical practice, but now that the study is completed, I have some tools to use. I know what to ask next to help her.”

This research can help put a different emphasis on counseling at sexual health clinics, says Nelson, who presented his findings to the nurses at the sexual health clinic in Rochester. “They saw this issue differently for the first time, and I could see their perception of this
adolescent group of moms had changed,” says Nelson. Training sessions at the clinic now include information from Nelson’s study, and health-care providers are encouraged to ask questions about the father’s role. More discussions lead to more connections, as referrals to maternal and baby care and other public health nurses are increasingly made for this group.

There are similar stories on this side of the border as well, says Riffaat Mamdami, BScN ‘99, a health promotions consultant at Toronto Public Health, who has worked with teen moms in her nursing career. “There was this desire for some semblance of a normal family life,” says Mamdami, “at the risk of emotional or even sexual abuse.” Mamdami is currently pursuing her master’s in community nursing at the Bloomberg Faculty of Nursing and says these findings can be useful to help create practice guidelines for maternal health programs.

Nelson wants to engage these fathers in the health care of these children from the very beginning of pregnancy, in prenatal programs, not after the baby is born. “I don’t think we do a good job of involving fathers. Many of these programs are very focused on baby and mother. But after the birth, when the teen mom shows up in the sexual health clinic worried about an STI, we’ve missed nine months of having him engaged. And sex is now the leverage.”

“Calling him up and saying ‘Come on over, let’s chill’ was code for sex.”

Glossary of Sexual Partner-Type Terms

**Hubby:** is a partner, usually a boyfriend, who holds marital-like status. The adolescent mother perceives that she and this partner are in a life-long, committed, romantic relationship.

**Baby Daddy/Baby Father:** is defined by the Oxford English dictionary as “the father of a woman’s child, who is not her husband, or (in most cases) her current or exclusive partner.” Adolescent girls’ use of this term suggests biological paternity, while noting a lack of parental involvement.

**Boyfriend:** is a partner with whom the adolescent girl has established a romantic, committed relationship, one that does not, however, carry the same sense of permanency as “hubby.”

**Friend with benefits:** is a friendship in which occurrences of sexual activity are allowable and accepted within the bounds of the relationship. This partner-type often does “favours” for the adolescent girl, based on her needs, not as one-for-one transactions.

**Boo:** is a sexual partner for whom an adolescent girl has a lingering romantic attraction, and also possesses friendship-like qualities.

**Friend/Homeboy:** is a friendship in which occurrences of sexual activity are allowable and accepted within the bounds of the relationship. There is no lingering romantic affinity.

**Shorty/Booty Call:** is a partner contacted for the sole purpose of on-demand sexual encounters, which can occur any time of day, but are often arranged to take place in the late evening.

**One-Night Stand:** is a partner in a short-term, sexual encounter where no previous relationship existed or is expected.

**Pop (pop-off):** is a partner with an extraordinarily dense network of sexual partners, simultaneously reviled for their indiscriminate copulative patterns, and revered for their sexual prowess.

Source: “Influence of sexual partner-type on condom use decision making by Black adolescent mothers.” National Institute of Nursing Research, Study #F31NR008964.
Community care conundrum

Now more than ever, community health nurses are needed to build healthier lives for all Canadians. But it’s not as simple as it sounds

By Lucianna Cicocioppo

A commercial office cleaner gets up every day and follows the same routine before heading to work: she apologizes to her body for the self-harm she is about to commit at her job. She maintains a physically demanding workload, holding down two jobs, without proper masks, gloves and equipment to handle toxic chemical cleaners, and without appropriate tools to reach and clean far-away places, such as ceilings.

The pain in her shoulders is dulled by the fact her family back home is living a better life, thanks to her. In fact, many people abroad, mostly in developing countries, are living better lives thanks to the work family members are doing in Canada, work most Canadians refuse to do: in the construction, cleaning and hospitality venues.

Governments at all levels in Canada turn a blind eye to these workers, the undocumented workers, says Dr. Denise Gastaldo, half a million of them who are critical to Canadian society, but live in the shadows of getting caught. “They usually over-stay their visas, so they’re called illegal workers,” says Gastaldo, an associate professor at Bloomberg Nursing. “They’re a hidden population about which we know so little. And yet we have international data that says this work has a huge impact on their health.” It’s a serious problem in Canada, as undocumented workers are the fastest growing form of migration worldwide, says Gastaldo.

“We know there are mental health consequences of being socially isolated, but there are also physical health consequences because of the precarious nature of their work.” This population is living under social exclusion—self-imposed and imposed by society—fearing that knock on the door that will ship them home. There are few initiatives or programs that include them, she explains.

There are addiction issues among men, depression for women. These illnesses remain largely untreated, until their condition nosedives into severity “when it’s too late,” Gastaldo says. “There’s a lot of human suffering caused by this economic situation.”

Groups in Ontario, such as the Ontario Council of Agencies Serving Immigrants (OCASI) and No One is Illegal have been asking governments for a moratorium, to give work permits to this population. “These groups need information to advocate, but it’s a catch 22—undocumented workers live in hiding because they fear for their jobs, but we don’t have the data, so we cannot advocate on their behalf,” says Gastaldo.

Gastaldo studies this phenomenon, in cutting edge research funded by the Canadian Institutes of Health Research to help advocate for this population. Community centres servicing this population are pressing for this data as well. Her work with the Women’s College Network for the Uninsured in Ontario revealed service providers in the community for undocumented workers have a huge burden because they lack the resources and money to help such groups.

Studies show health care service providers who work with very vulnerable populations, such as undocumented workers, have a magnified workload that’s hidden in the health care system. “Because undocumented workers have very little access to health care, they come to a nurse at the very end of a problem. These cases are more complex and time-consuming for nurses.”

Gastaldo speaks passionately about her work. The Brazilian has immigrated several times during her academic career, and knows the feelings of displacement and starting over. What she doesn’t know personally, but has seen up close, are the fears.

“They’re so vulnerable and apprehensive when they have to negotiate or request anything. With no medical coverage, they only seek services from particular community centres that serve uninsured people, but these are very few,” says Gastaldo. She explains that a wait of several months just to get an appointment is the norm even when people are very sick, and can’t get over-the-counter symptom treatments from a pharmacist. They may end up in a hospital emergency centre, and negotiate the bill later, all the while worrying about being deported.

“Health should be considered a human right for those who live in Ontario,” says Gastaldo. “We need a strategy for continuity of care. We need primary health care to develop community health, promote health, prevent and treat disease at the community level. We need a network of community agencies working together towards this goal.”

Last spring, Corey Liston, BScN0T9, was the first Bloomberg Nursing student to conduct her placement at the Don Jail in Toronto. She cared for clients afflicted with schizophrenia, schizoaffective disorder or depression. Together with her preceptor, she would see who was transferred in, required assessments and administered medications. She spoke to the clients before they saw their psychiatrist that day.

“I thought this sounded like such a completely different environment, and I would learn about so many different things,” says Liston. “The mental health aspect intrigued me as well. She was always interested in community nursing when she started her undergraduate degree at Bloomberg Faculty of Nursing, and says she was surprised at how hospital-based the program is. “It feels drilled into you that the hospital is the place to be,” says Liston.

All Bloomberg Nursing students have 320 placement hours in the community before they graduate, says senior lecturer, Dr. Geraldine (Jody) Macdonald, BScN 7T4. “It’s more hours than the Canadian average.” As former chair of a community health curriculum subcommittee, she’s working on introducing community nursing courses earlier in the program. “We need to be thinking about a broader scope
of practice, so when students graduate, they have a vision of themselves practising in either community or acute care settings,” says Macdonald.

The situation today, however, sees most students opt for the high-tech, fast-paced world of the hospital nurse, says Liston. “We feel we don’t have the assessment skills or knowledge to be on our own, like you would be as a community or visiting nurse. So starting off in a hospital is a good way to get more nursing experience, and gain more confidence, before going out in a more independent position.”

The problem, says Macdonald, is students don’t know what community nursing is. “Many courses that include community content are not labeled ‘community’, so students think it’s care of the elderly or young families. Today’s nursing students grow up watching TV shows such as ‘ER’, so that’s what they think nursing is. And the community aspect doesn’t hold that awe for a technological and adrenalin rush you get from working in the emergency department,” she adds. “Many of our students would graduate without ever having done a home visit.”

Nursing schools have difficulties in accessing community placements for students. And the competition mode of Community Care Access Centres, agencies funded by the Ontario health ministry to provide a range of services for the public, has forced providers to bid on contracts, and push costs down by hiring part time visiting nursing staff and offering lower pay. The last thing a busy visiting nurse may want to do is take on a student, to add to the workload, or take on the liability, if the student rides in the same car, explains Macdonald.

It’s a problem Durham Health Department’s regional manager and public health nurse, Dr. Angela Cooper Brathwaite, PhD oT4, has tackled by implementing a team preceptorship approach in partnership with the University of Ontario Institute of Technology in Oshawa. Preceptors supervise up to three students in the health department, over three terms per year.

“It’s a huge change,” says Cooper Brathwaite, a part time assistant professor at the Bloomberg Faculty of Nursing. “It takes a lot of our resources. Every semester I have six to eight students, and it uses a lot of my preceptors’ time. But in order to increase knowledge, we chose that model. In return, not only do we fulfill our professional responsibility to educate the next generation of nurses, but we also hire some of those students in the health department once they’ve finished school.”

The approach to future health care needs to be seamless, says Macdonald, something the World Health Organization has been arguing for years. In 1978, the Alma-Ata Declaration, conceived at the International Conference on Primary Health Care in the former USSR, underlined the importance of primary health care, and called for urgent action by member states to protect and promote the health of people everywhere in the world, particularly in developing countries by the year 2000. It declared health a socio-economic issue and a human right.

More than 30 years later, the majority of countries are grappling with sky-rocketing health care costs, and health human resource issues. And the world’s health systems are nowhere near the WHO’s vision of a focused primary health-care model.

But with an aging population, one that is living longer, many with chronic diseases, there are no doubts among health professionals that partnerships between acute care and the community will increase, and the solutions to the strained health-care system will come from care in the community. People enter hospitals the morning of their surgeries, and many are released the same day.

“Recovery is happening much more frequently in the community,” says Macdonald. “If you’re looking at the acuity of care in the community, there’s virtually nothing short of transplant surgery that isn’t happening in the community.”

Nurse practitioner and Bloomberg Nursing doctoral student, Krista Keilty, MN oT5, has fond memories of working with a family of a 14-year-old daughter with high needs and dependent on a ventilator. The patient was going home for the first time on her ventilator after a life in and out of Sick Kids Hospital. Since her childhood, she had progressed from eating by mouth to gastric-tube feedings and nocturnal non-invasive ventilation via face mask, to 24-hour invasive ventilation via tracheostomy (open airway in the neck), says Keilty.

“Her mother was a single parent. And the girl had an 11-year-old brother who was identified as the second care provider in the home. He participated in all the care training, to the same standards as his mother, to ensure he could participate and provide safe care for his sister,” says Keilty.

The family had to learn how to care for the tracheostomy, and to understand the signals if the tube gets blocked, or the ventilator doesn’t work and the child can’t breathe. Interventions include suctioning the throat, and changing the tube out of the stoma. “He wanted to learn how to do it with his eyes closed.” Adds Keilty: “He was the youngest family member that we worked with in that way. Transition [to the home] means readiness for the entire family.”

Keilty has been working in the area of transitioning ventilated children from Sick Kids Hospital to their home for about 10 years. “In order to assist families in setting up the home and ensure they feel confident and safe in their environment, we would help identify strategies to assist families in managing all this technology in the care at home. These home visits [by nurse practitioners, respiratory therapists and community nurses] can potentially avoid having a family travel to hospital for a clinic visit, and reduce admissions to hospital,” says Keilty. “We’ve had great success with that.”

Keilty visits and writes care plans directly with the visiting nurses and other team members involved. “During a home visit, as an NP I can write a prescription and just take care of it, rather than sending a prescription from the hospital to the community and finding out it’s not easily interpreted,” she says. Her doctoral work will research the impact of ventilation technologies in the home on the family care providers’ health and quality of sleep.

In the mean time, home visits carried out by Keilty and Sick Kids’ team members, such as nurse practitioner Arlene Chaves, MN oT7, ensure the hospital is regularly linked with all the care providers,
including the CCAC case manager, who can be updated on the child's medical history and prognosis at family case conferences.

CCAC case manager, Farzina Shivji, BScN 0T8, has seen the stress on family care providers once a member has been discharged from hospital into the home for recovery. “It’s hard for a family to absorb all the medical information, and there could be a language barrier,” says Shivji. She remembers one case where a patient required regular follow-up blood work. But the family care provider had the medical instructions tucked away in a coat pocket, and forgot to refer to it.

She uses her community nursing background to educate families on their new role as care providers. She also manages how the nursing is progressing for the patient. "If someone is getting nursing visits daily for months, we need to ask 'What's going on here? Why isn't the wound healing?" says Shivji.

“We need to focus on what causes these gaps in health and health care because much of this is modifiable.”

In a world of shrinking resources, Shivji says her job gets more challenging every day. “I find it difficult when services are continually being cut back, because I feel like that's my only tool to help people. When you take that away from me, what can I do when people can't manage anymore?”

Dr. Arlene Bierman, associate professor and Ontario Women's Health Council Chair in women's health at the Bloomberg Faculty of Nursing, has been busy these past few years leading a team of 60 investigators in a groundbreaking project called the POWER Study (Project for an Ontario Women's Health Evidence-Based Report.) The landmark study of inequities in women's health, funded by ECHO, an agency of the Ontario health ministry, has drawn international interest.

The POWER Study (www.powerstudy.ca) is designed to serve as an evidence-based tool to help policy makers, providers and consumers improve the health of and reduce inequities among the women of Ontario. The project is examining differences between women and men, and among subgroups of women associated with socioeconomic status, ethnicity and geography in health-care access, quality and outcomes across the continuum of care.

The first two chapters were released this year. Bierman says she was surprised with the findings, not about the health inequities in the province, but with how large they were. 'Women are more likely to develop disability, and men are more likely to die prematurely. However, differences in health status among women were often larger than those between women and men. The first chapter on the burden of illness study found low-income men and women were three times more likely to be in poorer health than those in a higher income group, and 41 per cent of low-income men die before age 75.

The cancer chapter found low-income women were less likely to be screened than higher-income women for cancers such as cervical, breast and colorectal—cancers with a high cure rate if identified and treated early. It also found many women with low-grade abnormal Pap tests were not receiving timely follow-up.

“The study identifies many opportunities for intervention and improvement,” says Bierman. "We need to focus on what causes these gaps in health and health care because much of this is modifiable.”

The findings found other issues. One in four low-income women and men in the province reported “food insecurity,” that is, not having enough to eat, worrying about not enough to eat, or not eating the quality or variety of foods desired due to lack of money. “This is a problem because cheap, high fat, high carb foods increase the risk of chronic diseases and lead to poor outcomes among those who have chronic disease such as diabetes, hypertension or heart failure,” says Bierman. In a rich province such as Ontario, “This is something we can tackle. We can ensure everyone in the province has access to a healthy diet. It’s a basic thing we can do,” says Bierman, a geriatrician and senior scientist in the Li Ka Shing Knowledge Institute at St. Michael's Hospital.

She argues for health promotion and disease-prevention strategies that address gender, income and educational differences. “Prioritizing chronic disease prevention and management is really the key to the health systems' sustainability, as the population ages,” explains Bierman. She’d also like to see more emphasis on disease prevention, primary care and community care in medical and nursing schools. “What’s unique about our project is our reports on population health and clinical health areas. We’re really trying to bridge population, clinical and public health services because you really need to integrate across those areas in order to improve overall health,” says Bierman. A number of LHINs (Local Health Integration Networks) are using the findings to help develop their integrated health services plans. And a professor at Lakehead University in Thunder Bay, Ont. plans to use the burden of illness chapter as a resource in her sociology and women's health course.

Bierman wants to add to the global discussion on health care and help stimulate change. “The WHO came out with an important report on the social determinants of health in 2008, so there’s a lot of focus around the world on tackling health inequities,” says Bierman. “People don’t realize the magnitude of the problem, and how much we can do about it. By measuring and reporting evidence-based indicators, we provide objective evidence to inform priority setting and the development of interventions for improvement. We can then track these measures over time to ensure we’re making progress.”

Still, Bierman remains hopeful and says the report found pockets of “great things happening in different practices and communities in the province. We just need to ensure it’s implemented everywhere.”

As anyone who has ever tried to kick a bad habit knows, behaviour change isn't easy. Dr. Jan Angus, BScN 7T8, PhD 0T1, associate professor at Bloomberg Nursing, is researching how to best support people when they want to modify their risk for cardiovascular disease. Her CIHR-funded project (www.mdpi.com/1660-4601/6/9/2481) looked at two different regions: one in the Toronto area and another in Sudbury and Districts, which represents a mix of northern urban or rural populations. The goal of studying the Sudbury area was to explore differences between anglophone and francophone experiences of risk modification.

Many participants called their behaviour change a “constant battle,” says nurse and co-investigator Isabelle Michel, a director at the Sudbury and District Health Unit. “People had to make fundamental
changes to their lives, and in some cases, had to change their friends and their relationship with their families,” says Michel.

But the francophone group seemed to have an especially difficult time making the necessary lifestyle changes. That’s because the ‘joie de vivre’ that they’re known for was, in the long run, probably going to result in serious cardiovascular health problems.

“The francophones really spoke with passion about their love for smoking, and their battle between good food and bad food, almost like a battle between good and evil,” says Michel. But isolating themselves from family and social gatherings was not the answer either, because social contacts are also important for their mental health, says Michel.

The problem lies in accessing health and health promotion services in French, a key issue, says Angus. Geography played another factor, since physical fitness opportunities, especially in the dead of winter, were challenged by other health conditions for the more senior participants. All groups in the study wished preventive education had been available to them sooner in life—the “if only I had known” factor.

“The study underlines the importance not only of access to primary care, but access to health information and support in one’s language.”

“We need nurse practitioners in family health centres to do these assessments, find out the cholesterol levels, identify other risk factors, and talk to patients about quitting smoking,” says Angus. “We also need community nurses to follow up with these patients, to perform the one-on-one coaching and create the programming to help at-risk people make these changes if they want to try.”

Participants commented how difficult it was to absorb the news they were at risk for serious heart disease, and spoke how important family, especially spousal, support was. Angus hopes nurses can use the findings to help with social marketing—tailoring messages not only to individuals, but also to everyone else affected by the lifestyle changes.

“Research helps us understand the implications of interventions as nurses, after our contact with the clients, even before our contact with clients,” says Michel. “The more we can adapt interventions to people’s lives, the more realistic and attainable changes become.”

Says Angus: “The study underlines the importance not only of access to primary care, but access to health information and support in one’s language.”

It’s an issue second-year nursing student Candie Sabel has experienced first-hand. As a bilingual student working a hospital job in the Centre de Sante Communautaire de Grand Sudbury, she saw the frustration when health care staff only spoke English.

“There weren’t enough primary care physicians to service them. Many had to bring in a family member to translate, but medical terms are hard to translate,” says Sabel. She herself had to accompany family members on such visits.

It got her thinking about access to care issues and community initiatives promoting health, especially for people in Sudbury and surrounding areas. “It’s a huge issue,” says Sabel. But an undergraduate degree in health promotion wasn’t enough to further her community initiatives goals.

Here at the Bloomberg Faculty of Nursing, she’s now volunteering as a co-chair of community partnerships in a one-of-a-kind student-led community clinic operating out of Queen West Health Centre in Toronto. Under the guidance of professional mentors, the IMAGINE (Inter-professional Medical and Allied Groups for Increasing Neighbourhood Environment) Clinic involves an inter-disciplinary team of students from most of the health sciences faculties at U of T, aiming to tackle the social determinants of health afflicting the homeless, mentally ill, unemployed, uninsured, Aboriginal and refugee populations. “It’s a streamlining of services in one place, with friendly faces,” Sabel explains.

Medical students kick-started the initiative in 2008, and soon pulled in their health sciences counterparts to create IMAGINE (www.torontomedics.com/imagine). “You can’t get this kind of inter-disciplinary education and learning in a classroom,” says former volunteer Hilary Hall, BScN 01, now a nurse at Princess Margaret Hospital. “It’s really a great way to break down some of the stereotypes attached to some of the professions,” she says.

“This is a continual learning process for everyone,” says Sabel. There’s an orientation for students who want to volunteer “to get them in the mindset you have to be in to work here,” dealing with clients who could be battling addiction issues, or prone to violence. And there will be debriefs after each clinic, says Sabel, once it’s up and running in January 2010, to discuss what went right or wrong, and more importantly, how to reach these people better.

“There’s a trust factor here,” says Sabel. “With our health education seminars, we’re helping to show the marginalized groups that we’re good people and that we’re trying to help them. If we can’t, we can refer them to those who can.”

It’s a step in the right direction coming from the right generation. But there’s more that can be done, argues Denise Gastaldo. “There’s a huge potential for nurses to be working in primary health care,” she says, and highlights studies in the Cochrane Review that discusses a model where primary health care is serviced mainly by nurses.

She talks excitedly about a continuity of care project in Spain, where she is the methodological adviser, involving 800,000 inhabitants in Madrid. The community centre nurse is also the home visiting nurse, who cares for patients and supports care providers in the home to look after the elderly, ill or recovering family member. “And when they realize the family care giver is over-worked, the nurse finds respite care. So not only is the nurse providing care for the patient in the home, but he or she is looking at the impact of care on the family providers and promoting health,” explains Gastaldo. “This is the nurse for everybody in the family. It’s a very interesting model and a very efficient one.”

Is she running a similar project here in Canada? “No one has ever asked me to do this in Canada, and I’ve been in touch with several people. Primary health care doesn’t seem to be a priority around here.”

But now that we are faced with an economic crisis, she adds, “We’re forced to rethink. Everything.”
Double dilemma

Doctoral student Ruth Lowndes investigates why group home residents with mental illnesses have sky-rocketing rates of diabetes

By Lucianna Cicocioppo

It was a case of too many familiar faces greeting nurse Ruth Lowndes, MN oT5, PhD (C), when she started working in the diabetes clinic at Southlake Regional Health Centre in Newmarket, Ont. These were not neighbours or family members, but people with mental illnesses living in group homes. She recognized many because Lowndes was once a group home owner and operator in Island Grove, Ont., on the shores of Lake Simcoe. As the coordinator for the Quality of Life Program, and a group homes social convenor, she got to know many residents in York region and surrounding areas.

“**If someone is living with mental illness, are these healthy lifestyle messages reaching them?**”

“I noticed a high rate of diabetes in this particular population,” says Lowndes. But it was a group that was sometimes not discernible from the general population attending the clinic, and the health-care providers were not always aware they were group home residents living with mental illnesses. Since Type 2 diabetes, the most common type, is largely preventable with lifestyle modifications, she started wondering if this population was taking and implementing their healthy living messages, such as more exercise and healthier diets, back home.

“If someone is living with schizophrenia, or other mental illnesses, are these messages reaching them?” says Lowndes. Probably not, since about 50 percent of group home residents with mental illnesses go on to develop diabetes, compared to about eight percent in the general Canadian population. She started checking some charts and saw diabetes rates for this population were not improving, their weight was climbing, and increasingly they ended up on medications and insulin. “Once people with diabetes are on insulin, their treatment regime becomes more difficult to manage,” says Lowndes, putting them at risk for kidney disease, blindness, lower limb amputations, heart disease, stroke and neuropathy.

This population is especially at risk, since the majority is on atypical anti-psychotic medications, which are known to cause diabetes, Lowndes explains. Mood disorders and schizophrenia also genetically put people at risk. The third factor is the group home setting, says Lowndes. Her current doctoral research the Bloomberg Faculty of Nursing looks at the social organization of diabetes care in the group home setting, and hopefully, her findings will shed some light on how to improve the outcomes for this population.

It’s a problem many homeowners are trying to address, as they care for anywhere from one to 80 residents under tight operating budgets. They don’t know where to turn. Many homes are located in rural areas, but trying to cultivate and maintain a garden of homegrown fruits and vegetables as healthy diet alternatives is time-consuming and difficult when caring for this population, says Lowndes. Transportation with accompanying staff to weekly clinics, supportive community involvement or medical visits must be factored in budgets, same for using gym facilities. “Paying for a staff member to go with residents, and paying for someone to remain behind in the home is a big issue; it would probably be a necessity in a lot of cases, but is it possible budget-wise?” she says.

Lowndes speaks passionately about her research “because it involves a vulnerable group. You can't stop prescribing the anti-psychotic medications because they have been extremely effective in helping people with mental illnesses function in society and in community settings. But I feel like we need to be doing more for these people. We need to increase awareness about these group homes and the people living in them. There is a group of people out there that needs our attention.”

Says Lowndes: “The type of diabetes education we offer is geared toward self-care. So we assume people will take responsibility to monitor glucose levels, take their own insulin, make healthy food choices and exercise for at least 30 minutes each day,” she says. “There’s no real focus on people with mental illnesses. In the diabetes guidelines, that population is essentially not there.”

It took a nurse to start the research project rolling. “I thought this was an area that could really use a nurse, to educate people about this issue. I never thought it would bring my two worlds together.”

Photograph: William Cicocioppo
The technological transformation of care
How the wireless world is integral to the ‘new’ nursing

By Lucianna Cicciocioppo

For some people, wireless handheld devices, such as personal digital assistants (PDAs) and smart phones like BlackBerrys, are a vital necessity, a ‘how-did-we-ever-live-without-them’ part of their lives. For others, it’s a lifeline to better patient care. Katrina Owen, a visiting nurse with Saint Elizabeth Health Care in Barrie, Ont., uses her tablet personal computer, a wireless, hand-held PC, when visiting clients.

“I had one patient who was depressed about her rare, chronic illness. I found links on the Internet for support groups on my tablet PC, and showed her the interactive Web sites,” says Owen. “We sat together and went through them, and she was immediately uplifted.”

Owen has also used her Tablet PC to show educational videos on YouTube to clients. “There are great breathing and cardiac sounds on YouTube. I helped some parents understand what their baby’s cardiac disorder sounded like.” Educational support includes referrals to community networks for all the family members, not just patients, so she can help children who are ill, or people who are grieving. “It helps with the psychosocial aspect as well,” says Owen.

It’s a tool for more than just e-mails and Internet use. Applications for medical information, such as PEPID, can check drug interactions. Owen used the program for one client experiencing side effects. “When I listed all the drugs this patient was on and sent the information to the physician, the medications were changed,” she says.

Patient reaction is positive when they’re involved with the technology, Owen says. “It helps me be a better nurse; I’m definitely more informed on certain issues now. And I’m no longer afraid to say ‘I don’t know the answer to that, but I know where I can find out.’”

It’s a far cry from when Dr. Diane Doran first started her career in homecare nursing. “I used to carry textbooks of medical and drug dictionaries in the trunk of my car to search for information, but I wouldn’t bring them into the homes,” says the Lawrence S. Bloomberg professor and U of T director of the Nursing Health Services Unit.

Doran is the resident high-tech nursing expert and is leading two research projects funded by the Canadian Institutes of Health Research and the National Science and Engineering Research Council of Canada, with industry partners Nortel, RIM, Telus and HiNext. The research involves wireless and monitoring technologies in and outside the home to help manage chronic diseases more effectively.

A ‘smart’ apartment is being developed by engineers at Carleton University in Ottawa, where sensor technologies, such as a pressure sensitive mattress, can detect falls and instability and changes in weight, while sensors on refrigerator doors record eating habits, and those on pill bottles monitor compliance with medication. Patients from rehabilitation hospital Elisabeth Bruyère could be discharged to the ‘smart’ apartment and be assessed to determine if they can manage rehabilitation at home, says Doran.

Another project is with Wilfrid Laurier University geographer Dr. Sean Doherty, who tracks diabetic patients on their exercise levels with a Global Positioning System (GPS) chip in their BlackBerry wireless device. He’s developed an algorithm to monitor and translate data into meaningful information for health-care providers about people’s activity levels outside the home, applicable also to heart failure patients and cardiac rehab patients, and other chronic diseases in Canada. Doran is researching how these technologies support clinicians in
application called MedShare, an electronic health records and management system. “Nurses can do a fair amount of assessment with this tool,” adds Plourde. She talks animatedly of nurses being able to photograph a wound with their PDA, to document and monitor it—and, at the same time, streamline the mounds of paperwork involved in home-care nursing.

Doran knows VON nurses will be excited with their new tool. She led a research project involving PDAs loaded with information resources, such as the RNAO best practice guidelines, and Nursing PLUS, an e-mail alert and database system on the latest research areas of interest. “We found a significant reduction in nurses’ barriers to research utilization, and that’s what we were trying to do, increase access to evidence. We also found significant improvement in the quality of care, and a substantial increase in nurses’ job satisfaction.” Currently, she’s working on the second phase of this project, involving access to information resources and patient documentation.

Still, Doran admits not all nurses are on the technological bandwagon. “Newer generations are embracing it more,” she says. But colleague, Dr. Lynn Nagle, MScN 8T8, says this is the ‘new’ nursing. “There’s a mindset out there that this not relevant to professional practice, that it’s about computers, which it is not. It’s another facilitative tool.” Information and communication tools don’t drive practice but they certainly support practice,” says Nagle, assistant professor. “Technology needs to be embedded and integrated into the processes of nurses’ work.” That’s because there is increasing evidence that such tools do enhance patient safety, adds Nagle.

She’s working toward the creation of simulated e-health records for the Simulation Lab, a system that will “mimic the functions of those systems being put into live practice environments.” Students will use the e-health record system when learning their nursing skills. This project—unique to Bloomberg Nursing—can’t come soon enough for Nagle, who teaches nursing informatics at the graduate level, which students decry is too late.

“The message I hear year after year is: Why don’t we learn this sooner? Why isn’t anyone talking about this? Why isn’t this a basic requirement for every nurse?” With a doctoral level course soon to be launched, Nagle says there’s an emerging and growing interest in nursing informatics. “Many of my students have gone on to develop roles in this area. We need clinical people driving this. These are not IT projects. These are clinical initiatives.”

Says Nagle: “We’re talking about transforming care through technology.”
Spring Reunion 2009
More than 120 alumni reunited and reminisced on May 30 for Spring Reunion 2009, at the Bloomberg Faculty of Nursing. Guests enjoyed breakfast with classmates, toured the facilities and the innovative clinical simulation learning lab.

Class of 5T9 celebrated their 50th anniversary this year, and to mark this special occasion, classmates organized week-long activities. “This class really bonded,” says Denise Alcock. “We still support and care for each other even though some live far away.” The 5T9 group meets every five years for their reunions, even though their different paths have spread them out to locations such as Bangkok, Comox and Vancouver, BC, Roswell in Virginia, Solana Beach and San Diego, California, Sarasota, Florida, Ottawa, Calgary and more. “We faithfully come together for each reunion, and once we enter the room, the talking just starts as though there was never an absence,” says Alcock.

The celebrations this year started Monday, May 25 when some alumni gathered for lunch. During the week, they made trips to local Toronto landmarks, such as the newly renovated Art Gallery of Ontario. A group of eight 5T9 alumni who had roomed together during their time at the Faculty of Nursing went to the Briars Resort in Jackson’s Point mid-week before the reunion weekend. They later met at one of their fellow classmates’ home on Friday night for dinner, where scrapbooks and photographs provided fodder for conversations and memories. Following the Faculty of Nursing Alumni Breakfast on Saturday, they enjoyed dinner and an evening out at the Rosedale Golf Club, with spouses and children of some graduates.

Distinguished Alumni Awards
The Distinguished Alumni awardees are selected from alumni who were nominated by their peers and fellow alumni. Congratulations to all of the winners on your achievements!

Irene Elliott received the Award of Distinction for her work as a nurse practitioner at the Hospital for Sick Children where she cares for children and their families living with epilepsy. In her 30-year nursing career, Elliott has made outstanding contributions to the development of clinicians through her participation in interprofessional education and clinical preceptorship.

Mary Glavassevich received the Award of Distinction and was recognized by many of her staff members as a leader, clinical educator and mentor in her role as patient care manager, leader, clinical educator and mentor. She has made exceptional contributions to the profession through direct patient care, research, and evidence-based practice.

Donna Tweedell received the Award of Distinction and has used her clinical, teaching and research skills in various positions over the years, including on faculty at Ryerson and McMaster universities. Tweedell was one of the first clinical nurse specialists in psychiatry and transplantation at Toronto General Hospital.

Dr. Linda McGillis Hall received the Outstanding Achievement Award and is a recognized leader in nursing health services and systems research. She’s currently a professor and associate dean (research and external relations) at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto.

Bridgette Lord received the Rising Star Award – Clinical or community Nursing for her leadership role in the Rapid Diagnostic Breast Clinic at Princess Margaret Hospital, ensuring women are supported by an expert advance oncology nurse during the diagnostic process. This clinic is an innovation in rapid diagnostic assessment for women with a suspicious breast abnormality and Lord has acted as a co-ordinator.

For more information on the Distinguished Alumni Awards and complete recipient profiles, please visit: bloomberg.nursing.utoronto.ca/alumni/awards.htm

IMAGINE an interdisciplinary student-run clinic—volunteers wanted!
IMAGINE is an interdisciplinary collaboration that includes students from dentistry, medicine, nursing, occupational therapy, pharmacy, physical therapy, social work, speech-language pathology and health administration. In conjunction with its community partners, IMAGINE will provide hassle-free medical care and provide health education workshops for Toronto’s homeless and marginalized populations.

IMAGINE is looking for nursing alumni volunteers to mentor, supervise and guide students providing basic medical care in the Queen West Community Health Centre and/or delivering clinically focused health-education workshops at St. Christopher House.

Mentors are required to participate on Saturdays from 10:30am – 3:30pm at least once per school term (e.g. a total of three times per calendar year). Contact the Alumni Relations Office if you would like to be involved: (416) 946-7097 or development.nursing@utoronto.ca.

iPod winner
Congratulations to Alma Veronica Marinlarena, BScN 0T5 on winning the iPod Nano! We appreciate all the feedback we received from readers letting us know what they like most about Pulse. It is always great to hear from you!

Class of 3T3 alumna turns 100—and tells us all about it
Not too many people reach the ripe old age of 100, but a Bloomberg Faculty of Nursing alumna celebrated just that and hand-wrote a letter to us to tell all about it. Vera Webb Major Crosby was born in Stratford, Ont., in 1909 and turned 100 this past spring. Her nursing career began at Buffalo City Hospital Nursing School. Crosby returned to Toronto and graduated with a Certificate in Public Health Nursing from the University of Toronto in 1933. Listen to our conversation with Vera (and her tips for a long, healthy life) on our Web site: bloomberg.nursing.utoronto.ca/media/News_Stories/Class_of_3T3_alumna_turns_100_andWrites_all_about_it.htm
Class photographs: we need your help
If you have recently visited the Lawrence S. Bloomberg Faculty of Nursing, you may have seen our Alumni Wall. This display showcases class photographs dating back to 1926. Unfortunately, we are missing a few class years and we would like your help to complete the display. If you or a fellow classmate have the class photograph for the following years, please contact the Alumni Office at (416) 946-7097 or development.nursing@utoronto.ca: 1950, 1960, 1968, 1974, 1978, 2002, 2007.

In Memoriam:
Dr. Jacqueline Sue Chapman, 1935 – 2009
The Bloomberg Faculty of Nursing extends its sincerest sympathies to the family and friends of Dr. Jacqueline Sue Chapman, professor emerita, who succumbed to illness on July 9, 2009 at Lakeview Manor, in Beaverton, Ontario.

Lauded by many as an inspiration to nursing, Chapman was one of Canada’s most noted nurse researchers and devoted professors. Chapman was the first nurse in Canada to be awarded the prestigious National Health Research Scholar Award, when nursing research was in its infancy, says Dr. Dorothy Pringle, professor emerita and a former dean of nursing.

“This was hugely significant,” says Pringle. “Most schools back then weren’t doing any research. But Jacque was a well-trained researcher. She gave nursing a ‘toe hold’ in research enterprise in Canada.”

Among her many honours, Chapman was named an American Nurses Foundation Scholar and was a founding fellow of the Nightingale Society. She obtained her BSN from UBC in 1958. She quickly advanced to head nurse roles and then to instructor positions at UBC and at several American universities.

She earned her MSN from Case Western University in Cleveland and her PhD in nursing from New York University. Her doctoral supervisor was Dr. Martha Rogers, a prominent nursing theorist. Chapman’s doctoral studies led to care improvements in neonatal nurseries.

She became a full professor at the University of Toronto and was a part of the team that helped establish the PhD program here. She was an ardent, but quiet, supporter of U of T, and was an active member of many faculty committees.

“She was on all the management committees because her judgment was so good,” says Pringle, “and she knew how to train PhDs.”

In retirement, she became an active member of her church and community, sharing generously in the lives of those around her. She maintained a special passion for infants, children and education. She was an ardent traveler (she visited the Arctic and Antarctica) and enthusiast of the arts.

She will be remembered fondly and missed by many, particularly by all the “grandchildren of her heart.”

Elizabeth Anne (Betty) Burcher, 1949 – 2009
The Bloomberg Faculty of Nursing is saddened with the sudden passing July 5, 2009 of Betty Burcher, public health nurse, senior lecturer, colleague, alumna and friend. Burcher began at Bloomberg Nursing in fall 2002, after a stellar career spanning more than 30 years as a public health nurse, which included senior management positions in the teaching health unit, health information and research, and also health planning at Toronto Public Health.

“We knew we had scored a coup when this high-powered public health manager chose to teach with us,” says Maureen Barry, a close friend and senior lecturer at the Bloomberg Faculty of Nursing. But she never left her public health career entirely. Her indefatigable work during SARS supported faculty and students through the unexpected crisis, and her contributions to pandemic planning will not be forgotten.

Burcher earned a sociology BA (Honours) in 1971 from the University of Waterloo and a BScN 1976 and MSc 1992 from the University of Toronto. She demonstrated tremendous collegiality and vision within the Faculty and with interprofessional education colleagues. Burcher was an outstanding teacher, supporter and mentor of students, before and after they graduated, and a recipient of several teaching awards. She taught at the undergraduate and graduate levels.

“She never explicitly stated it, but Betty was the kind of teacher you knew you could approach at any time,” says recent nursing graduate, Hilary Hall. “She gave so freely of her time to student initiatives with very little fanfare.”

“I think of her patience as a teacher, and her ability to explain concepts in multiple ways,” says former student, Jay Bass-Meldrum.

“Betty encouraged me to be aware of the politics of nursing,” says Hall. “She talked often of ‘hats’ and in one conversation would share each moment her ‘hat’ was changing from faculty, public health to simply nursing colleague in the profession. Her sensitivity to the subtleties of language and her ability to negotiate bureaucracies so effectively were immensely instructive.”

Burcher was best known for her passion for public health, politics, social justice and women’s rights. She was respected and loved by a legion of friends, co-workers, students and family. Her outgoing nature, her passion for life, and her willingness to go above and beyond will be much missed.

“The classrooms and corridors of the nursing building at 155 College St. will be strangely quiet without the sound of her infectious laugh,” says Barry.

Burcher died due to complications arising from surgery to repair a brain aneurysm. Our thoughts and condolences go out to her partner, Doug Croker, and her son, Nick Croker, and her many friends in nursing across the University of Toronto campus and beyond.

In her memory, the Betty Burcher Award in Community Health has been established for graduate students at the Bloomberg Faculty of Nursing. Call 416-496-7097 to donate or visit: bloomberg.nursing.utoronto.ca/Assets/Alumni/documents/InMemoriam/Burcher+new+donation+form.pdf
Celebration in honour of Convocation
A reception will be held November 10 for the 2009 BScN students and their families. MN and PhD students will be invited to celebrate Convocation with their families at a reception in Spring 2010.

Tuesday, November 10, 2009
2:30 pm to 4:00 pm
Music Room, Hart House
7 Hart House Circle

RSVP by October 26, 2009, maximum 2 guests
(416) 946-7097 or development.nursing@utoronto.ca

Dinner with 12 strangers
It’s a simple and fun idea: local alumni host dinners in their own homes for students, faculty and fellow alumni in an effort to make U of T a smaller, friendlier place. An alumnus from the Faculty of Nursing will host an evening of good food and good conversation. The program offers participants an opportunity to make new friends and valuable connections. Dinners will take place on a weekend night (Monday – Thursday) from about 6 – 9pm throughout the academic year. If this sounds like an event you may be interested in, please contact our Alumni Relations Office at (416) 946-7097 or development.nursing@utoronto.ca.

Spring Reunion 2010—save the date!
Join classmates, friends and colleagues at the Lawrence S. Bloomberg Faculty of Nursing for the Annual Alumni Breakfast on Saturday, May 29, 2010.
More details to follow. Please feel free to contact the Alumni Office at (416) 946-7097 or development.nursing@utoronto.ca if you have question, or if you would like to get in touch with you graduating year to plan your reunion.

Want to contact old friends?
For assistance in contacting your fellow alumni, please do not hesitate to call us at (416) 946-7097 or at development.nursing@utoronto.ca.

Find us on Facebook
Want more nursing friends, or looking to stay in touch with old ones? Look for the officially sanctioned Lawrence S. Bloomberg Faculty of Nursing Alumni group on Facebook. Nursing students and alumni are welcome to join, and stay in touch, learn about lectures, events and other Faculty or alumni news.

Alumni lifelong learning series
This is a new program exclusively for our alumni and is hosted over lunch. Upcoming topics and speakers include:

Oct. 23, 2009 Dr. Linda McGillis Hall: Gone south: Canadian nurse migration to the US
Health Sciences Building, 155 College St., Room 208
12:00 – 2:00, including a luncheon

Oct. 30, 2009 Dr. Denise Gastaldo:
Undocumented workers’ health issues in Ontario: Working conditions and access to health care
Health Sciences Building, 155 College St., Room 208
12:00 – 2:00, including a luncheon

Nov. 6, 2009 Dr. Louise Rose:
Hot topics in critical care
Health Sciences Building, 155 College St., Room 215
12:00 – 2:00, including a luncheon

Manulife Financial
To RSVP, please contact:
Alumni Relations Office
(416) 946-7097
development.nursing@utoronto.ca

“I was raised by a single mom who couldn’t afford to help me through school. Without this scholarship, I wouldn’t be able to pay my tuition.”

KEVIN D. SHIELD Pursuing a Master of Health Science in Community Health and Epidemiology

Leave a gift to the University of Toronto and change a student’s life.
Contact Michelle Osborne at 416-978-3811 or michelle.osborne@utoronto.ca
A conversation with Dean and Professor Emerita, Dr. Dorothy Pringle, RN, BScN, MS, PhD, OC

Pulse: You’ve been called a ‘transformational’ nursing leader, having rejuvenated and revitalized the program at Laurentian University, and shifting the University of Toronto’s program from a professionally focused faculty to a research-oriented one. What impact have these changes had in nursing, and health care?

DP: Nursing has become an accepted part of the health research enterprise in Canada. We’re not still knocking on the door, trying to ‘get in.’ We’re in all the nooks and crannies of that enterprise. Nurses Nancy Edwards and Joy Johnson are scientific directors of two Canadian Institutes of Health Research institutes. We’ve had a nurse on CIHR council since its inception; it’s simply unremarkable now. We’re just part of the scene. It’s important that we are part of this bigger picture about health research and contribute to how the questions get asked. The implications for nursing care are answered in the course of doing that.

Pulse: How do you feel about helping to make the Bloomberg Faculty of Nursing the premier provider of advanced practice nurses and PhD-educated nurses across Canada?

DP: I’m ecstatic, in the sense of having had the opportunity to be a part of it. And quite frankly it was because my timing was right so I got credit for a lot. I was dean at a point in time when it began to be possible to recruit excellent, doctorate-prepared faculty members, which was very hard to do before the ’90s in Canada. We also had people on faculty who were prepared to take risks. And they drove many of the changes.

We developed the PhD program because the PhD taskforce [Drs. Jacquie Chapman, Jane Graydon, Ellen Hodnett, and Hilary Llewellyn-Thomas] were effective, and they listened and incorporated input from the faculty as they developed the program proposal. Next—and we took a deep breath on this, and we did it in two phases—we moved to a practice-oriented MN program and got out of the thesis program at the master’s level because we had limited supervisory capacity. We made the decision to give the PhD program priority when it came to supervising theses. This decision influenced other Canadian nursing faculties that also had big master’s programs with theses. We also believed that a non-thesis master’s created opportunities to incorporate practice-relevant courses that we could not do if the students were doing a thesis. It also gave us a chance to emphasize research application rather than creation at the master’s level.

We launched the acute care nurse practitioner program; we were out in front in that. I’m very proud of our ACNP program and the leadership that was shown around it. We had the right people who developed the program and taught it. They had great credibility.
Finally, the two year second-entry undergraduate program was a very important leadership step for U of T. U of T introduced the first four-year university based nursing program in Canada in 1936 and so it seemed appropriate that U of T would introduce the next major innovation in BScN education 60 years later.

**Pulse:** What was the thinking behind that decision?
**DP:** I wish I could say it was based on some strongly held philosophic position but it was budget cuts. We didn’t have enough money to keep offering all our programs. The options were to get out of the undergraduate business entirely, since we had Ryerson University and York University doing a four-year program, or to create a small second-entry program. It was cheaper and it was intended to be a boutique program, designed for 30 students. It didn’t catch on right away and the second year when we did not fill our class, [U of T] President Robert Prichard asked me if we got it right. By the third year, we had no difficulty filling the class and the rest is history. Now virtually every university in the country has a second-entry program but we are still the only one to focus exclusively on second-entry nursing education for undergraduates.

**Pulse:** Given your expertise on aging and patient care, how do you see the nursing sector addressing the issues and challenges stemming from an aging population, one that is living longer with chronic diseases—will the solutions come from community care?
**DP:** I think the community will play a larger role than it does now, but I fear that it will be more by default, than by design. It’s not that we don’t have lots of good models of community care with nurses as the core profession demonstrated over and over again, but we haven’t had uptake at the political level. We know that as people move into advanced old age they prefer to remain in their own homes and programs of support can make that possible at no more cost and with less demand on the acute and long term care sectors than we have in our current chaotic ad hoc way of doing things. It costs money to do well. There are pay-offs down the road but we need to continue to fund our very expensive current structure, and even in the boom days, there was never a sense from government that we had enough money to take on these new models and fund them so that they are able to demonstrate their worth. We need to look five to 10 years down the road to do that.

We outsmarted ourselves. We’ve become very good at living to old age. For many, the last eight years of life are fraught with health challenges. To manage health problems and to bring quality of life to those last eight years requires considerable resources. We have the model where nurses play a role but we have not been able to enact them; we certainly don’t have them in place in Ontario. It’s appalling.

**Pulse:** What does the future hold for nursing?
**DP:** Nursing at its best is probably the most valuable component of the health care system because of our range and capabilities: intensive care, emergency room care, the whole life-saving end of acute care, to caring in the community. We know about health promotion, we know the prevention piece. We’ve been given long-term care as essentially our exclusive domain, but I seriously question if, as a profession, we have embraced it. And we don’t treat it as opportunity to demonstrate how well it can be done...

But, when nursing is at its best, it’s a beautiful thing. On a bad day, I worry about nursing, about how to make it possible for nurses to work at the bedside for their entire career and retain their health and sustain their compassion and humanity, when they’re working shifts, weekends and every other Christmas with a sore back and sore feet, and are trying to connect with and care about what a poor 85-year-old woman is trying to tell them. That worries me a lot about nursing and nurses.

On other hand, at this point in time, we have a better educated nursing workforce than we’ve ever had before. We have nursing research and health research to call on, to assist us on a day-to-day basis, to find better ways of providing care. Importantly, nurses have never before had so many career choices within nursing and so many educational opportunities to turn to. On a good day, I look at all these assets we bring. We’ve never been better positioned to design the kind of patient care that is required.

**Pulse:** Which was more exciting to receive, the Order of Canada, or the U of T honorary degree?
**DP:** They are so different. The Order of Canada was so unexpected, and there’s a bit of majesty with it all. I am enormously grateful to have it. But I have to say, the honorary doctorate from U of T was wonderful. I felt loved at U of T; I didn’t feel loved when got the OC. I felt respected and that was terrific because a wide range of people are receiving the OC so to be in that company, I think ‘Wow!’ They’re both quite breathtaking in their own right, but ask me which one I enjoyed more? The honorary doctorate at U of T. I was with people whom I love, respect, worked with—and who know my foibles. I got an honorary degree from U of T despite the fact they know me [laughs] so that’s quite special.

**Pulse:** If you could invite anyone, dead or alive, to a dinner party, who would it be and why?
**DP:** I’d have a hard time choosing between Alice Munro and Margaret Laurence. These are Canadian women writers who capture the art of being Canadian, a woman, of being real and of aging. I would like to talk to them about how they know. And where that comes from.

**Pulse:** What’s your idea of perfect happiness?
**DP:** I never think of perfect happiness. It’s an underdeveloped concept and not necessary. I guess I think of happiness as having an opportunity to do and be what’s important to you. That can be on a very small scale or very large scale. You define what it is; and I don’t think it needs to be perfect. I think you can handle a lot of ‘not perfect’ if you have enough of what happiness means to you.

And a few million dollars helps [laughs].

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Dr. Dorothy Pringle is editor-in-chief of the Canadian Journal of Nursing Leadership, and is a recipient of the Jeanne Mance Award from the Canadian Nurses Association for lifetime contributions to nursing. She is also a fellow and board member of the Canadian Academy of Health Sciences. She received her honorary Doctor of Laws degree from U of T the 2009 spring convocation. She was dean of the Bloomberg Faculty of Nursing from 1988-1999.
Cultivating a new solution to the acute care crisis

By Shirlee Sharkey, president and CEO, Saint Elizabeth Health Care, adjunct professor, Lawrence S. Bloomberg Faculty of Nursing

After a steady stream of company all summer long, fall weekends at the cottage often afford the time to start working in the yard again. However, along with clearing things out and straightening things up, I often find myself getting preoccupied with dealing with the weeds. Within hours of arrival, I am pulling out every tool in the shed— the lawn mower, the weed whacker, the garden shears—all the while pledging that next year, we will bring in the topsoil, get the right plants and lay the groundwork for a yard that is less overrun by weeds.

I share this analogy to illustrate that the seemingly never-ending chore of weeding, in the absence of architecture, is a decidedly down-stream and ineffective solution. It strikes me that this is not entirely dissimilar to our current approach to solving the growing crisis in acute care.

Today, acute care hospitals are under tremendous pressure to improve patient flow, increase efficiency and reduce wait times. At the same time, more than 5,000 beds at Canadian hospitals on any given day are occupied by patients who no longer need hospital care and are waiting to be discharged. Studies show alternative level of care (ALC) patients in 2007-08 accounted for five per cent of hospitalizations and 14 per cent of hospital days.

Fast forward to 2015, when there will be more people in Canada over the age of 65 than under the age of 15, and it is clear that, in the absence of new and creative solutions, the picture is poised to get worse before it gets better.

What we need is a two-pronged approach that includes interventions to deal with the crises of today while simultaneously laying the foundation for a larger solution that is optimized for tomorrow’s reality. Home and community health care can play a key role on both of these fronts.

In the more immediate term, Ontario’s Aging at Home initiative is providing seniors with an expanded range of innovative home care and community support services to help them live independently. In addition to supporting non-traditional partnerships and greater system integration, many of these projects are now targeted at decreasing the number of ALC patients in hospitals as well as reducing pressures on emergency rooms.

As a result, home care nurses are increasingly working in partnership with acute care colleagues and community partners to help facilitate timely discharges and smooth transitions, whether it’s providing patients with a safe and reliable alternative to hospitalization for short-term care and recovery, or offering the necessary supports to help them return and settle in at home.

While these programs are both beneficial and encouraging, in light of demographic trends, talent shortages and rising costs, it is doubtful that such interventions alone will be enough to unleash the potential of individuals and families in their everyday lives, in order to ensure the future sustainability of our health-care system.

To solve the acute care crisis in the long-term, we need to begin to lay the foundation for an integrated health-care system that is designed, organized and funded not only to embrace all levels of care, but also consumer needs, choice and preferences. This requires us—as a profession, a system and a society—to collectively re-imagine the way we understand, access and experience care. In the future, with the opportunities with knowledge dissemination and technological advances, location will no longer be the determining factor.

For many, many years, the home care sector has been viewed in a limited way as a substitute for acute care or a delay tactic for institutionalization. This has resulted in a historical fixation with understanding the cost-benefit of one part of the system versus the system as a whole. Today, research shows that 90 per cent of Canadians would prefer to spend their final years at home. What an incredible opportunity this could be to reframe the starting point of our health-care system in order to realize the true potential of homecare programming, a community approach and the desires of people and their health-care providers.

The type of cultural shift that is required to move the system forward is not a simple or speedy undertaking. It involves alignment, collaboration and synchronicity across the health-care continuum. It requires alternative delivery models, funding structures and incentives. And it necessitates that we tailor the entire system to individuals and the communities they are a part of, not the other way around.

This presents an exciting leadership role for nurses. As a profession, we have the opportunity to not only incorporate the patterns of illness and treatment, but to use our knowledge and experience to lead and initiate change in an environment we are passionate about.

By virtue of their focus, Community Care Access Centres, public health agencies and home care providers are building a cadre of nurses that must incorporate the behaviours and preferences of individuals and families in their homes and communities. I encourage all nurses and everyone working in the health-care system to understand and respond with sensitivity to people in the broader context of their lives. This is fundamental to laying the foundation for a transformed health-care system.

In the ‘busyness’ of everyday life, it is easy to lose sight of the long-term and focus only on what needs to be done today. Creative solutions and sustainable approaches require time and collective effort. To truly solve today’s acute care crisis, we must dig a little deeper and avoid getting overcome by the weeds."

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90 years of shaping nursing education, research and practice

Do you remember your first practical class? Can you help us track down the first male nursing graduate? Do you know of any alumni who helped with the war effort in the 1940s? Share your memories, stories, ideas and photographs with us, as the Bloomberg Faculty of Nursing gears up to celebrate 90 years of innovative, forward-thinking nursing education and research. From certificates and diplomas to BScNs and PhDs, from maternal and baby care, to SARS and H1N1, more than 11,000 nurses have graduated from this Faculty, as clinicians, practitioners, researchers and educators, providing the answers to the questions shaping the future of Canadian health care. We want to hear these stories for a special anniversary edition of Pulse. We’ll also have numerous exciting events planned throughout 2010, such as the 90th Anniversary Awards, recognizing 90 outstanding alumni. Visit http://bloomberg.nursing.utoronto.ca/alumni/news/events.htm for regular updates. Contact development.nursing@utoronto.ca or call 416-946-7097 to be a part of our celebrations, as we look back... and forge forward. |
**IMAGINE** an interdisciplinary student-run clinic helping the most vulnerable people in Toronto.

Volunteers Wanted!

IMAGINE is looking for nursing alumni volunteers to mentor, supervise and guide students providing basic medical care in the Queen West Community Health Centre and/or delivering clinically focused health-education workshops at St. Christopher House.

If you would like to be involved, contact the Bloomberg Faculty of Nursing Alumni Relations Office at (416) 946 –7097 or development.nursing@utoronto.ca.

(Left) Students and IMAGINE volunteers Naureen Siddiqui (health administration), Cindy Chow (speech language pathology), Jen Galle (medicine), Ryan McGuire (pharmacy), Anatoli Chkaroubo (pharmacy), Daniella Moss (nursing), Candie Sabel (nursing), Carol Aiga (occupational therapy), Allison Rowe (social work), Fahreen Ladak (physiotherapy) and Nadine Lam (pharmacy).
First in Nursing


Our outstanding team of clinicians, educators and researchers are part of the answers to the questions shaping the future of health care in Canada. In 2010, the Bloomberg Faculty of Nursing celebrates 90 years of world-class research and education that has helped to shape the discipline of nursing.

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