NLN.ON

Newsletter of the
Nursing Leadership Network of Ontario

WINTER 2003

update

RNAO Registered Nurse's Association of Ontario

Message *from the* President

Susan Pilatzke, President NLN.ON

On behalf of the NLN.ON Board members, I would like to extend to each of you our best wishes as we enter into the new year. I'd like to reflect on the recent OHA session where Dr. Tim Porter O'Grady states "Now is the time to walk through the door, close it, the past is behind us, let us turnaround and face the future. It will never be the same as we knew it." We as nurse leaders cannot afford to keep doing things the same old way, and we have before us the opportunity of innovation, creativeness and a technology that challenges us to be global system thinkers.

As nurse leaders, it is very important for us to embrace the challenge, to develop those individuals working with us as knowledge workers. Skill sets of the future according to Dr. Tim Porter O'Grady include:

- Conceptual synthesis and assessment skills
- Competence care
- Multiple intelligences
- Outcome focus
- Fit value - interdisciplinary care, limited supervision, integrated care
- Team performance not individual performance.

Our reality according to Dr. Tim Porter O'Grady is to write the scripts. With scarce resources as evidenced by our global nursing and other health care shortages, we have to be creative. We have transitioned to a new era despite at times our unwillingness to acknowledge it. We take comfort in the knowledge we have, but soon recognize within us the fluttering of our hearts as we face unknown territory. Yet, individual and collective energy can take us to a better position of integrating, coordinating and facilitating the process of change.

Examples of leadership exist at every level in the world, in business and the political world, and in health care and the social economic world. Medtronic and Kaiser Permanente have been identified as corporations that are changing the way in which the business of health care is structured in the United States. Consumer driven health care is the model that is evolving. We need to examine these models and synthesize the information to understand what impact this will have on our future health care environments.

Strategic alliances are necessary to ensure that what we build today serves the health care consumer of the future — our children and their children's children. It's hard to imagine what that will look like! What a luxury many of us have through the life long learning experiences we are exposed to and the ability to apply this in practice.

The recent release of the Romanow Royal Commission report is applauded for its support of a publicly funded system with inclusions for community care including home care, pharmacare and palliative care. Each one of us will help craft what this can and will be like for the stakeholders we represent. Let's even look further beyond the next 30 years to the

continued on page 2

continued from page 1

generations that will follow. What evidence will take us to the future as Nurse Leaders? What technological advances will influence the way in which care is delivered and administered? Who will be involved?

As leaders we all have an opportunity to make a difference in 2003! I'd like to challenge each of you to take the opportunity to influence the course of health care history and more importantly, share with us your experiences in our newsletter.

Kindest regards,

Susan Pilatzke
President, NLN.ON

NLN.ON

NLN.ON Fee Change

Message from the President

At our board meeting in November, 2002 we approved an increase to the fees for NLN.ON from $40 to $45 per year. The board has identified new initiatives, which include: Regional workshops and development of a transactional web site for NLN.ON to facilitate and communicate with the members across the province. Over the past two years regional workshops have provided the board with valuable feedback on issues relevant to nurse leaders. Additionally we have identified that information and technology can improve our ability to connect with our members and will be enhanced through development of an interactive web site. The web site development will require a commitment of additional funds. We hope you share in our excitement and support us with this endeavour!

Kindest regards,

Susan Pilatzke
President, NLN.ON

HUB SCHOLARSHIP

The members of NLN.ON have an exciting opportunity to apply for the first ever Hub Fellowship, valued at $2,000. The Hub Group (Ontario) Inc., RNAO's home and auto insurance partner is pleased to introduce a unique opportunity to shadow RNAO's executive director, Doris Grinspun, for one week. The Fellowship is an exciting chance to experience firsthand the many facets of leading a growing and progressive organization during dynamic times in health care. The successful applicant will have the opportunity to experience strategic planning, network with key health care stakeholders, and observe the impact of political communication in the profession of nursing.

We are seeking NLN.ON members who have demonstrated leadership potential and commitment to the nursing profession. If you require additional information contact:

Dr. Colleen McKey
Chair, NLN.ON Research and Education Awards
mckeyc@mcmaster.ca
905-525-9140 Ext. 22409

NLN.ON Membership

Membership in **NLN.ON** is via RNAO.

As an Interest Group of the RNAO, all our full standing members must be members of our professional association.

To join the NLN.ON
please contact RNAO in Toronto at
(416) 599-1925
and ask for their
Membership Services Department.

Please indicate that you wish to join
The Nursing Leadership Network of Ontario Interest Group.

Our fee for 2002/2003 is $40.00

This fee will be payable to the RNAO when you join our Interest Group.

RNAO Registered Nurse's Association of Ontario

ON-LINE PETITION

Dear Friends of Medicare,

Crucial decisions that will affect our future will be made in the forthcoming First Ministers' meeting on health care planned for early 2003. Prime Minister Chrétien and the Premiers must hear strong and loud the voice of Canadians who are eager to strengthen Medicare.

We urge you to sign the online petition that we have created demanding full implementation of the Romanow Report recommendations. It only takes a minute! Please access the petition at:

www.petitiononline.com/romanow

Please distribute this email as widely as you can — this is the most important thing you will do today! If you host a website, make sure to place a link to the petition prominently in your homepage. For analysis and information about the Romanow Report, go to: www.healthcoalition.ca

For inquiries about the petition, please contact: implement_romanow@yahoo.ca

Mike McBane
Canadian Health Coalition

InfoFinders

321 Hamstead Court, Waterloo, ON N2K 2B8
Phone/Fax: (519) 896-3167
Email: infofinder2@rogers.com

FOLLOWING THE BUSINESS & HEALTH LITERATURE

These articles were selected by InfoFinders, an information research company owned by two NLN.ON members, Linda Corso and Nancy Cobb. You may not have the time or resources to search out the overwhelming amount of published information or the journals may be difficult to find. InfoFinders operates a service specialized to the health sector and designed to save you time and money. Using the Internet, electronic databases or experts. Our clients include health consultants, hospitals, associations, and universities. We help to identify best practices, keep you current with professional literature, find research studies to support/validate your projects. You may not have the time or resources to search out the overwhelming amount of published information or journals may be difficult to find.

InfoFinders will locate relevant health and business information to provide you with the right information when you need it—for a project, to monitor the professional literature or assist you in completing your studies. Please contact us if we may help you locate information, find benchmarks or obtain any of the following articles.

This month the NLN.ON Board of Directors has requested a search about Patient outcomes, staffing complement and category.

Aiken, L.H., Clarke, S.P., Sloane, D.M. & The International Hospital Outcomes Research Consortium. (2002). Hospital staffing, organization, and quality of care: cross-national findings. International Journal of Quality in Health Care, 14(1), 5-13.

OBJECTIVE: To examine the effects of nurse staffing and organizational support for nursing care on nurses' dissatisfaction with their jobs, nurse burnout, and nurse reports of quality of patient care in an international sample of hospitals. DESIGN: Multisite cross-sectional survey SETTING: Adult acute-care hospitals in the U.S. (Pennsylvania), Canada (Ontario and British Columbia), England and Scotland. Study Participants: 10319 nurses working on medical and surgical units in 303 hospitals across the five jurisdictions. INTERVENTIONS: None Main outcome measures: Nurse job dissatisfaction, burnout, and nurse-rated quality of care. RESULTS: Dissatisfaction, burnout and concerns about quality of care were common among hospital nurses in all five sites. Organizational/managerial support for nursing had a pronounced effect on nurse dissatisfaction and burnout, and both organizational support for nursing and nurse staffing were directly, and independently, related to nurse-assessed quality of care. Multivariate results imply that nurse reports of low quality care were three times as likely in hospitals with low staffing and support for nurses as in hospitals with high staffing and support. CONCLUSION: Adequate nurse staffing and organizational/managerial support for nursing are key to improving the quality of patient care, to diminishing nurse job dissatisfaction and burnout and, ultimately, to improving the nurse retention problem in hospital settings.

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Publication Types:
Multicenter Study

Buchan, J. (2002). Magnet hospitals. Attraction of opposites. Health Services Journal, 112(5812),22-4.

US research suggests that magnet hospitals have better outcomes than other Institutions Key to magnet organisations are participative management style, strong professional development and flexible working practices. The magnet concept appears to be an effective way of tackling nurse shortages.

Government of Ontario, Ministry of Health & Long-term Care. (2002). Project Symposium: Nursing and Health Outcomes Project. March 15-16, 2001, Toronto, Canada. Retrieved December 2, 2002 from http://www.gov.on.ca/health/english/program/nursing/symposium.html

The Nursing and Health Outcomes Project was created in response to recommendations 5 and 6 of the *Good Nursing Good Health : An Investment for the 21st Century* report. The purpose of The Nursing and Health Outcomes Project is to identify nursing-sensitive patient outcomes and their attendant nursing inputs and processes that could be abstracted from patients' charts or provided in other formats. This would allow administrators and researchers in the future to describe how different nursing interventions and different numbers and types of nurses (RNs, RPNs) affect patient outcomes. In the longer term, it may be possible to develop a funding formula that is nursing-specific. The project will focus on acute care, long-term care, complex continuing care and community care (home care). This conference describes the work of the Government of Ontario Project currently underway to identify nursing inputs and nursing-sensitive patient outcomes. This website describes the work of the project and includes a comprehensive bibliography.

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Lundstrom T, Pugliese G, Bartley J, Cox J, Guither C. (2002). Organizational and environmental factors that affect worker health and safety and patient outcomes. American Journal of Infection Control, 30(2),93-106.

This article reviews organizational factors that influence the satisfaction, health, safety, and well-being of health care workers and ultimately, the satisfaction, safety, and quality of care for patients. The impact of the work environment on working conditions and the effects on health care workers and patients are also addressed. Studies focusing on worker health and safety concerns affected by the organization and the physical work environment provide evidence of direct positive and/or adverse effects on performance and suggest indirect effects on the quality of patient care. The strongest links between worker and patient outcomes are demonstrated in literature on nosocomial transmission of infections. Transmission of infections from worker to patient and from patient to patient via health care worker has been well documented in clinical studies.

continued on page 4

Literature on outbreaks of infectious diseases in health care settings has linked the physical environment with adverse patient and worker outcomes. An increasing number of studies are looking at the relationship between improvement in organizational factors and measurable and positive change in patient outcomes. Characteristics of selected magnet hospitals are reviewed as one model for improving patient and worker outcomes.

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Publication Types: Review
Review, Academic

McGillis Hall, L. & Doran, D. I. (2001). The impact of nursing staff mix models and organizational change strategies on patient, system and nurse outcomes: Final report. Toronto, ON: University of Toronto. Retrieved December 7, 2002 from http://www.nursing.utoronto.ca/lmcgillishall.research/nsmos%20full%20report.pdf

The Nursing Staff Mix Outcomes Study (NSMOS) was a province-wide research project that was designed to assess the impact of changes in the composition and mix of nursing care staff in acute care teaching hospitals on patient, nurse and system outcomes. The study was conducted at 19 teaching hospitals across Ontario. In summary, the results of this study suggest that a higher proportion of RNs/RPNs on inpatient units in Ontario teaching hospitals is associated with better health and quality outcomes for patients at the time of hospital discharge and with lower rates of medication errors ad wound infections. Thereafter, the effect of staff mix variable is less evident. The environment in which nurses worked is also considered. These findings provide useful information about the linkages between nurse staffing and patient care, nurse and system outcomes.

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McGillis Hall, L. (2001, September 27). Nursing and Patient Outcomes Research: Canadian Perspectives. Retrieved December 2, 2002 from http://stti.confex.com/stti/sos13/techprogram/session_668.htm

The purpose of this symposium is to discuss the relationships that have emerged in the study of outcomes research in the Canadian environment and present the results of several complementary research studies designed to evaluate linkages between nurse staffing and patient outcomes. The challenge of demonstrating the contribution of nurses has led many scholars to identify some outcomes as nurse-sensitive. These refer to outcomes for which individual nurses are held accountable and represent the consequences or effects of interventions delivered by nurses. The study of patient outcomes remains important to nursing and the health care sector, yet challenges with linking nurse staffing to specific outcomes of nursing care continue to confront the profession. This symposium fits within the "Health-Related Services and Systems Research" theme of the conference. In the first presentation in this symposium the results of a province-wide repeated measures study conducted in 19 hospitals in Ontario, Canada are outlined. The purpose of the study was to examine the impact of different nurse staffing models on the primary patient outcomes of pain and functional status, and the secondary patient outcomes of wound infections and medication errors. The importance of nurse staffing as a predictor of patient outcomes is highlighted and the need for a better understanding of the impact of different models of nursing staff mix is discussed. The second paper the results of a quasi-experimental study of the effects of a relationship-enhancing program of care (REPC) on residents, family members and on health care aides. The aim of the REPC was to enhance the way health care aides relate to their residents since it was proposed that meaningful interactions lead to close connections. Providing continuity of staff, ensuring health care aides have effective relational skills, and supporting them for their efforts, can have a positive effect on health care aides' ability to provide effective relational care to residents. The third presentation of this symposium shares the findings of a study that increases our understanding of the effects of nursing-related hospital variables on 30-day mortality for hospitalized patients. A '30-Day Mortality Model' was hypothesized, tested, and refined to explain relationships between predictor variables and 30-day mortality. The final presentation in this symposium describes the results of a comprehensive methodological analysis of the literature aimed at the identification of instruments for the measurement of nurse-sensitive patient outcomes. The goal of the analysis was to provide sound information for building a clinical database that documents the quality and the effectiveness of nursing care in acute, community or long-term care settings. The potential of nurse-sensitive outcomes measurement becoming an essential component of health care planning will be discussed. This symposium advances the state of the science on nurse-sensitive outcomes research, presenting evidence of linkages between nurse staffing, caregiving behaviour variables and patient outcomes. As well, a systematic process for the development of a database for the ongoing measurement of nurse-sensitive outcomes will be described.

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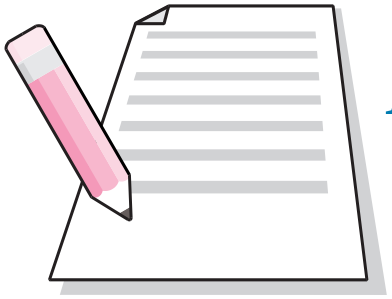
Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. New England Journal of Medicine, 346(22),1715-22. Retrieved December 6, 2002 from http://bhpr.hrsa.gov/nursing/staffstudy.htm

BACKGROUND: It is uncertain whether lower levels of staffing by nurses at hospitals are associated with an increased risk that patients will have complications or die. METHODS: We used administrative data from 1997 for 799 hospitals in 11 states (covering 5,075,969 discharges of medical patients and 1,104,659 discharges of surgical patients) to examine the relation between the amount of care provided by nurses at the hospital and patients' outcomes. We conducted regression analyses in which we controlled for patients' risk of adverse outcomes, differences in the nursing care needed for each hospital's patients, and other variables. RESULTS: The mean number of hours of nursing care per patient-day was 11.4, of which 7.8 hours were provided by registered nurses, 1.2 hours by licensed practical nurses, and 2.4 hours by nurses' aides. Among medical patients, a higher proportion of hours of care per day provided by registered nurses and a greater absolute number of hours of care per day provided by registered nurses were associated with a shorter length of stay ($P=0.01$ and $P<0.001$, respectively) and lower rates of both urinary tract infections ($P<0.001$ and $P=0.003$, respectively) and upper gastrointestinal bleeding ($P=0.03$ and $P=0.007$, respectively). A higher proportion of hours of care provided by registered nurses was also associated with lower rates of pneumonia ($P=0.001$),

shock or cardiac arrest (P=0.007), and "failure to rescue," which was defined as death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis (P=0.05). Among surgical patients, a higher proportion of care provided by registered nurses was associated with lower rates of urinary tract infections (P=0.04), and a greater number of hours of care per day provided by registered nurses was associated with lower rates of "failure to rescue" (P=0.008). We found no associations between increased levels of staffing by registered nurses and the rate of in-hospital death or between increased staffing by licensed practical nurses or nurses' aides and the rate of adverse outcomes. CONCLUSIONS: A higher proportion of hours of nursing care provided by registered nurses and a greater number of hours of care by registered nurses per day are associated with better care for hospitalized patients.

O'Brien-Pallas, L., Thomson, D., Alksnis, C., & Bruce, S. (2001). The economic impact of nurse staffing decisions: time to turn down another road? Hospital Quarterly, 4(3), 42-50.

Until recently, best practices in nurse staffing decisions were difficult to implement due to lack of evidence. However, a study recently completed by nurse researchers at the University of Toronto provides analysis of resource allocation decisions and their potential impact on staffing.



A Student's Perspective

Marina Bitton

As a student in the Graduate Department of Nursing at the University of Toronto, I was invited to participate in the 2002 NLN Conference. Nurse leaders and administrators from across the province gathered to exchange professional perspectives on recent issues in health care. I had the honor to meet this strong and dynamic group of leaders. During the interesting open sessions they shared their daily triumphs and tribulations in an ever-changing environment. In depth analysis was provided about the most prominent dilemmas that nurse administrators, managers and educators face today. Guest speakers presented findings of the most recent and relevant research in their arguments about issues such as the impact of organizational mergers, advancement of excellence in practice and recruitment and retention strategies. All the participants had the opportunity to network and exchange educational ideas through group discussions and poster presentations.

Furthermore, it was an opportunity for me to understand the true meaning of leadership. I have learned that leaders are in a unique position to use their skills, training and advanced knowledge base to affect change both in the clinical practice at the bedside and in the inherent culture of their organization. These visionary and courageous leaders are able to overcome tumultuous changes in health care costs, delivery and service and bring revolutionary new approaches to meet current and future needs. Most of all, they are able to inspire others to follow their dream.

As a student participant I was encouraged and motivated to create my own vision and see it through. I would like to thank everyone who made me feel so comfortable at the conference and most of all I would like to thank the NLN President Christina Copplestone for devoting time and energy for students such as me, and exposing us to such intellectually and professionally stimulating opportunities.

Dr. Tim Porter O'Grady

will be coming to
Thunder Bay
to present a conference entitled:

Transforming the World of Work: New Ways, New Work, Changing Roles

JUNE 6, 2003
VALHALLA INN
THUNDER BAY

Much has been written, discussed and presented regarding getting ready for a new world of work in an altered healthcare system. However,there has been precious little focus on the essential requisites of a new learning organization. What are the new age characteristics? How doe one interact and work differently in the new age? How do we deal with the reality that the industrial age learning leadership roles are no longer validated or supported in the new quantum age? How does the new practitioner function in the quantum age, when most of what was learned about healthcare was obtained in the industrial age? This presentation will focus on whole systems thinking and quantum new rules for complexity, as applied to practice. The newer whole systems notions of healthcare will be applied to the role of the provider and practical elements for its application will be outlined. This session will challenge thinking and create a foundation for dialogue following the presentation.

Early registration is $125 before May 15, 2003 and $140 after May 15, 2003.

Watch for upcoming brochures and advertisements.

What is a racial dispute? How can we reach a level playing field?

By Rebecca Hagey PhD.

(Piece adapted from Hagey,R., Lum, L., MacKay, R., Turrittin, J., Brody, E. *Exploring Transformative Justice in the Employment of Nurses: Toward Reconstructing Race Relations and the Dispute Process.* Funded Research Report Submitted to the Law Commission of Canada, Ottawa).

A dispute is a special type of intense relation where disagreements can either be addressed or not, where intensity can either escalate or not, where balance in relations can either be reached or not. A grievable complaint of racial discrimination is determined by the presence of one or more of direct, indirect discrimination or discrimination by association or with adverse effects in Ontario [1] Procedures specify who may complain, what are the time limitations and what form the complaints must take. In the complaint process, evidence is based on the presence of race, colour national or ethnic origin. By contrast, under transformative justice, a racial dispute is an opportunity — a duty for the employer, we argue — to teach personnel about racial discrimination as a social process, about antiracism, relationship, diversity, equity, transparency, and responsibility. Before employer representatives can be accountable for supporting informal problem solving in race relations and racial disputes, they require substantive knowledge and skills. Perhaps more importantly, instruments of administration must be in place to support formal and informal discourse and conduct that systemically and directly counteracts racial discrimination.

Although there have been exceptions, a grievable complaint does not entertain "reverse racism". [2] In antiracism policy however, the allegation of "reverse racism" is a sign that knowledge is lacking and reparative measures of transformative justice are needed. So we argue, in contrast to conventional procedures, transformative justice interventions can and should address claims of reverse racism and treat the contact time with the complainant of "reverse racism" as an opportunity for education. Also problematic are relational issues where nobody is naming racial discrimination and yet respect is patently lacking and inappropriate encounters are prevalent, requiring some intervention that can break through to new, mutually accountable relating. It should be noted that transformative justice views whole communities or workplaces to be victims in such environments often described as poisonous.

A general rule would be that if someone says they are experiencing racial discrimination, the issue must be dealt with. The point is to have issues effectively dealt with so employees do not have to embark on the long arduous journey of a formal grievance in quest for justice. All forms of racial disputes arise from historically constructed race difference that is manifesting problems in the current context. Contextual indicators therefore, might include:

- If there is race difference inherent in the composition of parties to the situation.
- If there is race difference integral to the history leading up to the incident.
- If there are racialized communities of interest that are stakeholders in the question at issue.
- If there are racialized images in the language of the situation that are ambiguous or negative to the complainant.
- If there is withholding, loss, or threat of loss, of power, privilege, immunity or rights of the member of a designated minority in relations either interpersonal or institutional.
- If behaviours contravene equity, transparency, accountability, balance in relations will be affected. Relations can either be moving toward balance or moving toward imbalance and transformative justice contends that balance can only be achieved if the underlying conflict is addressed. Supporters of visible minorities often experience discrimination because their reform agenda is seen as threatening to the organization.[3]

The Law Commission of Canada has pointed out a variety of responses to conflict. Its recent discussion paper defines conflict as a relational concept: "it occurs when one party defines the actions of another as inappropriate and therefore meriting some type of response." [4]

They list aggression, avoidance and toleration as methods of informal conflict resolution[5]. In everyday race relations in nursing we see all of these at work in the employment context. Avoidance and toleration are widespread strategies used by minoritized nurses to keep out of trouble and used by those who take advantage on the basis of race, to avoid accountability in relationships with minoritized persons. The following visual depiction shows the relational dynamics that we theorize are produced when accountability for conduct is being impeded by group-based power differentials. The ingroup/outgroup power jockeying is implicated in the adaptive responses of avoidance and toleration employed rather than the collaboration that is so idealized as the desirable feature of professional practice. On considering the relational elements of respect, trust and interdependence [6] of human agency required for collaboration we get the following:

Experience of relational elements because of endemic racial discrimination:

Ingroup	Outgroup
Oblivious of disrespecting the "other"	Perceives being disrespected
Ready to distrust	Perceives not being trusted
Collaborates to sustain power	Experiences barriers to collaboration
Takes agency for granted	Agency is intermittently subordinated

We are assuming (until research can show otherwise) that agency - we define agency as participation capacity such as voicing needs and realizing interests through decisions and actions—- is being supported by transparency and accountability when the resolution process is guided by astute nursing leaders committed to antiracism policy such as that issued by the Joint Provincial Planning Committee of the Ontario Hospital Association and the Ministry of Health in 1996. It may be true however that a requirement to participate will alter conventional norms about agency, especially in the employment context where time is a cost. We suggest this cost must be factored into the restitution program.

We argue that the underlying conflict — racial discrimination-structures negative (non-collaborative) relations that both are produced because of, and result in, inequality. In order to activate accountability in these relations of group-based, power imbalance new ground rules will have to be accepted. There can be intermittent teeter tottering [the ingroup is analogous to the heavier person on the teeter totter] but the justice principle of restitution calls for accommodation - the idea that "individuals or groups disadvantaged as a consequence of injustice done to them in the past deserve preferential consideration".[7] At a psychological level what may be required is apology. At a group level, strategies such as restitution, affirmative action and auditing are called for. These are initial mechanisms of accountability that can initiate balance in the relations toward shifting the weight in the teeter totter.

With the principle of restitution whether administered from a higher level of authority or negotiated in a more horizontal power format, or established in union contract, the heavier side — resisters of equality and employment equity — must be prepared to make accommodations. Acknowledging the need for restitution in the apology "to make up for omissions or commissions" is a requirement for mutual accountability and equality in collaboration. Such amends should be made routinely among colleagues. Our research shows nurses and students of nursing are very uncomfortable with naming the issue of racialization that begins with discrimination and can result in ingroup/outgroup segmentation and hierarchy if not dealt with. They have not grasped the concept of acknowledging lurking issues in order to clarify a common ground for a working relationship.

The time to stop the teeter tottering and make an adjustment toward balance can be before serious injury or after. Estimations of time, morale and morbidity/mortality costs to patient safety related to tension, disputes and grievances would favour time being spent on acknowledging experiences, perceptions and realities toward collaborative problem solving. Envision the players getting off the teeter totter and onto a level playing field.

1 Walter Tarnopolsky, Discrimination and the Law. Toronto: Carswell, 1999 (Chapter 15, see 86-88.2)

2 Ibid Chapter 5, p. 14

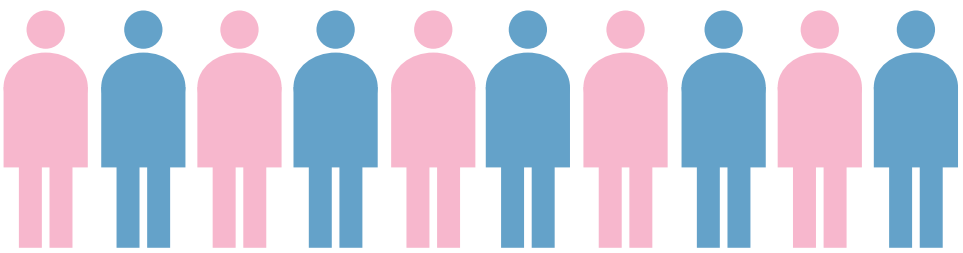
3 R. O'Day, "Intimidation Rituals: Reactions to Reform" (1974)) 10 Journal of Applied Behavioral Science.

4 Law Commission of Canada, From Restorative Justice to Transformative Justice (2000), Discussion Paper. Ottawa. p. 26

5 Ibid, p. 14.

6 Ibid

7 Michael Yeo, "Ethics and Economics in Health Care Resource Allocation" (1993). Administration, Health Sciences, Medicine: University of Ottawa (Queen's-University of Ottawa Economic Projects). Publication 93-07. p. 11.



Spotlight on a Board Member

Introducing

Diane Stephenson

RN, BScN., MA (Ed)
Chief Nursing Officer
Children's Hospital of Eastern Ontario

I am Diane Stephenson, a registered nurse with a clinical background primarily in critical care, oncology and management. I graduated with a hospital-based nursing diploma and subsequently received a BsCN, MA (Ed), and am a Wharton Fellow of the Johnson & Johnson Executive Nurse Program. I also hold a lifelong passion for both the art and science of nursing.

I have had the privilege of serving **Regions 9 and 10** on the NLN Board for the past two years. This experience has been rich in learning, friendship and fun. As chair of this year's NLN conference, "Leading with Integrity: The Leader Within", I see the topic as core to our personal and professional values in health care and nursing leadership.

Across generations of nursing (from "elders to nexters" there are now four in the workplace), the one unchanging value of integrity strikes as clearly through time as the pitch of a tuning fork. We know that as we uncover the "leader within" each of us, this value can promote the purest music of caring, the clarion bells of advocacy and the harmony of social and political accountability. In an era of necessary, torrential evolutionary change, our core values can anchor us to lead with both integrity and vision to a new future.

As I complete my term on the Board, I wish to thank the NLN membership of Region 9 and 10 for their support and my colleagues on the Board for continued learning. I hope to see you all March 20th and 21st at the Conference!

NLN.ON Board of Directors

NLN.ON 2003 Conference

March 20th & 21st

LEADING WITH INTEGRITY

THE LEADER WITHIN

Featuring These Outstanding Keynote Speakers

Faith Roberts **Dr. Robert Butcher**

NEW LOCATION

The Westin Prince Hotel
900 York Mills Road
Toronto

NOTICE: NLN.ON 2003 Annual General Meeting

Friday March 21st • 8:00 am • Westin Prince Hotel • Toronto

How to reach us?

Office Address:
NLN.ON

c/o First Stage Enterprises
1185 Eglinton Avenue East, Ste. 104
Toronto, ON M3C 3C6
Tel: (416) 426-7029
Fax: (416) 426-7336
Email: info.nln.on@firststageinc.com