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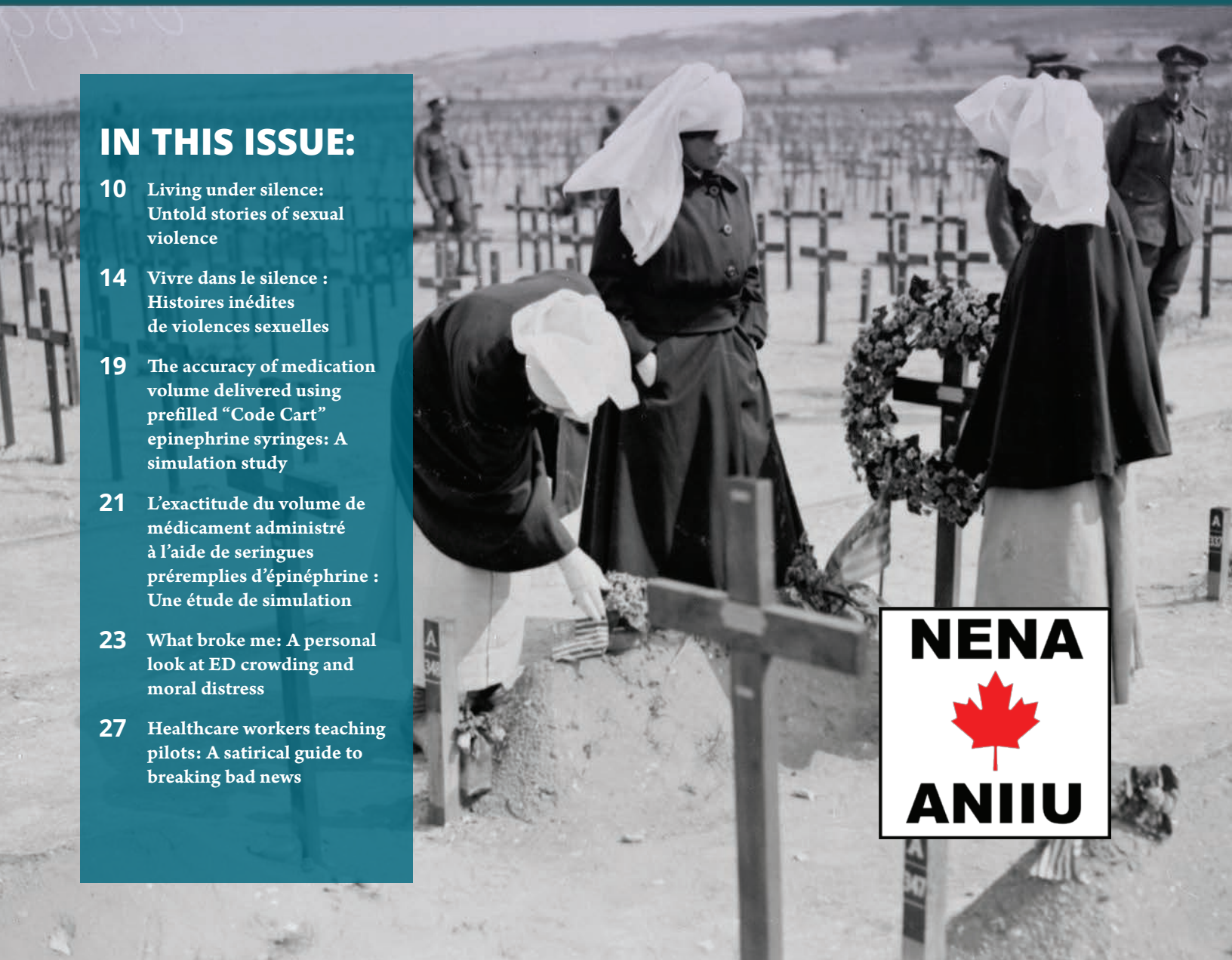

IN THIS ISSUE:

NENA

ANIIU

RECOGNIZING HS

DO YOU RECOGNIZE PATIENTS WITH HIDRADENITIS SUPPURATIVA (HS)?

DR. NEIL SHEAR
Head of Dermatology, Sunnybrook Hospital

"HS is a chronic, painful, inflammatory skin disease that affects 1-4% of the general adult population. It is characterized by boils usually occurring where certain sweat glands are located, such as under the breasts, buttocks, and inner thighs."

"People with HS come to the emergency room in severe pain and discomfort requiring assistance with the draining of the boils during a flare-up. It's not unusual for patients to go home undiagnosed."

DR. VU KIET TRAN
ER physician at University Health Network

DR. RALPH GEORGE
Associate Professor, University of Toronto, Division of General Surgery

"There is currently no cure for HS. Early diagnosis and proper management is important for a patient's quality of life. The first step for those with HS is to speak to their dermatologist to get an accurate diagnosis."

To learn more about HS from these specialists, go to www.RecognizingHS.com/CJEN

WHEN YOU SEE THESE LESIONS, DO YOU SUSPECT HS? DO YOU ASK ABOUT RECURRENCE?

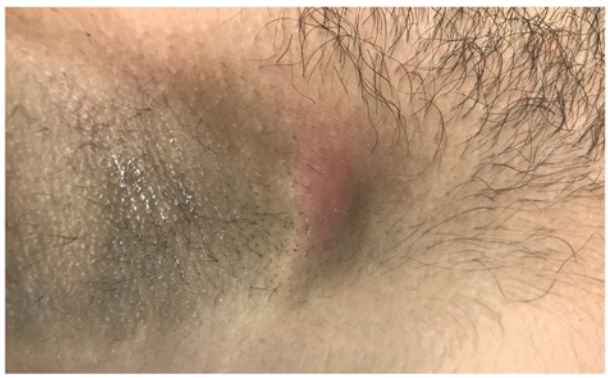

Photo compliments of Dr. Afsaneh Alavi.

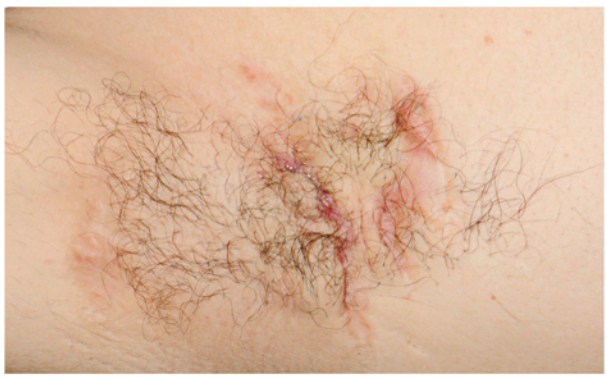

Photo compliments of Dr. Marc Bourcier.

ASSESSING PATIENTS WITH RECURRENT BOILS

Most HS cases can be recognized with high reliability by the presence of 3 main features:[1-3]

1. **Typical lesions:** nodules, sinus tracts, abscesses, scarring
2. **Typical anatomical location:** axilla, groin, genitals, under the breasts, others (perianal, neck, abdomen, buttocks)
3. **Relapses and chronicity:** ≥2 times per 6 months

Questions to ask your patients with suspected HS:[2]

1. Have you had outbreaks of boils during the last 6 months?
2. Where were the boils and how many did you have?

To confirm an HS diagnosis, please refer your patient to a dermatologist.

References: 1. Zouboulis CC, *et al.* European S1 guideline for the treatment of hidradenitis suppurativa/acne inversa. *JEADV* 2015;29:619-44. **2.** Lockwood SJ, *et al.* Diagnostic workup. In: Kimball AB, Jemec GBE, eds. *Hidradenitis Suppurativa: A Disease Primer.* Cham, Switzerland: Springer; 2016:27-37. **3.** Poli F, *et al.* Clinical presentation. In: Jemec GBE, Revuz J, Leyden JJ, eds. *Hidradenitis Suppurativa.* Berlin, Germany: Springer; 2006:11-24.

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Cover photo credit: Funeral of Nursing Sister Margaret Lowe, who died of wounds received in a German air raid.
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Cover photo caption

Canada's military nurses have played a pivotal role in defining Canada as a nation, nursing as a profession, and emergency nursing as a specialty. Canadian nurses were the first in the world to hold military rank and pay equivalent to men. Military nurses were instrumental in developing trauma and triage systems that remain central to emergency nursing. The Canadian Nursing Sisters who helped care for millions of people killed and injured in the great war, half million men in Passchendaele alone, helped define Canada as a nation. On the Centennial of Armistice Day CJEN recognizes and acknowledges the debt of gratitude that Canadians in general, and Canadian Emergency Nurses in particular, owe to the sacrifices of the 53 Nursing Sisters, who died while caring for the ill and injured of World War One.

"At the going down of the sun and in the morning, We will remember them" - Lest we forget.

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NENA 2018 Incoming and Outgoing Board Members

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Third Row: Joe Carr (NB director), Dawna Ramsay (outgoing PEI director), Colleen Brayman (outgoing secretary), Kitty Murray (outgoing treasurer)

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Calling all instructors

If your students have put the work into a presentation, a case study, a disease process, research, etc., encourage them to write it up into a brief article to be published in CJEN. Our section editors will work closely with them to help in the process, and they can see their hard work in print, help to educate emergency nurses across the country and add a publication to their resume—a win/win situation!

Articles can be submitted to the Communication Officer, **communicationofficer@nena.ca**

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NENA conference 2019—Speaker and Preworkshop

Conference Speaker

AnnMarie Papa, DNP, RN, CEN, NE-BC, FAEN, FAAN

AnnMarie Papa is an energetic and engaging leader who mentors and inspires many. She has presented on many topics related to leadership and nursing regionally, nationally and internationally. Holding a BSN and MSN from Villanova University, Villanova, PA, and a DNP from Waynesburg University, Waynesburg, PA, AnnMarie is also a Fellow in the Academy of Emergency Nursing and a Fellow in the American Academy of Nursing.

AnnMarie is a thought leader and sought-after speaker on leadership, mentoring and many other topics. She has been recognized for her exemplary leadership with local, state and national awards, including Health Leaders Media Top 20, the Villanova University College of Nursing Alumni Medallion, and the ENA Lifetime Achievement Award and is the only recipient of all 3 PA ENA Awards. In 2011, she served as the National ENA President and is currently Vice President and Chief Nursing Officer at Einstein Medical Center Montgomery, East Norriton, PA.

Please join us for Preconference Workshop May 23rd: Forensic Nursing

Sheila Early, RN, BScN

Sheila has four decades of experience in health care as a registered nurse, nursing administrator, nurse clinician and nurse educator in both emergency and forensic nursing. She is a graduate of University of Saskatchewan School of Nursing.

Sheila developed the first sexual assault nurse examiner program in British Columbia starting the process in 1992 (now known as the Forensic Nursing Services at Surrey Memorial Hospital). Sheila performed the first medical forensic examination by a B.C. nurse examiner in February, 1994 and remained a practising nurse examiner until 2007.

She also developed the curriculum for the first Advanced Specialty Certificate in Forensic Health Sciences (classroom delivery) in Canada (2005) at British Columbia Institute of Technology (BCIT). That certificate has been upgraded to a Graduate Certificate in Forensic Health Sciences as of September 2018. She recently retired from her faculty position as Coordinator of the Forensic Health Sciences Option within the Forensic Science and Technology Program at BCIT. She remains a part-time FHS instructor, as well as returning to her consulting role in SDE Consulting Forensic Nursing Education Services.

Her experience as a nurse clinician in emergency, legal nurse consultant for both criminal and civil legal matters and as a forensic nurse has provided her with the background to provide education to health care providers and other disciplines in forensic healthcare issues relating to violence, trauma and crime. She has provided the initial education for sexual assault nurse examiners in five provinces and one territory over the last 15 years, as well as continuing education both nationally and internationally.

She has been the recipient of several nursing awards including Canadian Forensic Nurses Association Inaugural Visionary Award (2017), BCIT Award of Excellence in Teaching (2014), University of Saskatchewan College of Nursing Nurse Alumni of Influence (2014) Achievement Award from the International Association of Forensic Nurses in 2010, "One of 150 Outstanding Nurses of BC" in 2008 from the BC Ministry of Health. She has also received the Award of Excellence in Nursing Practice from Registered Nurses Association of BC (2002) and Award of Excellence in Emergency Nursing Education from the National Emergency Nurses Affiliation (1997). Sheila was elected in 2014 as the first non-USA President of the International Association of Forensic (IAFN) after several years on the IAFN Board of Directors.

Sheila has several publications including articles in journals such as *Journal of Emergency Nursing*, *Journal of Legal Nurse Consulting*, and *Canadian Journal of Emergency Nursing*, as well as book chapters in several recent forensic nursing and law texts.

Sheila has been married to Peter for 53 years and has two daughters and son-in-laws with four grandchildren.

President International Association of Forensic Nurses 2015

Co-founder Forensic Nurses Society of Canada 2007

Canadian Triage and Acuity Scale (CTAS) Update

CTAS Revisions

- The CTAS revision team has been hard at work with producing an up to date education program for triage nurses. Sessions have been created that are interactive including video vignettes, quizzes, and games.
- CTAS participant manual has been completely overhauled and re-developed.
- Here is what will change:
  - CTAS Program includes on line and face to face education
  - On Line Modules
    Module One - The triage nursing role
    Module Two – Applying the CTAS to the age groups
    Module Three – CEDIS and presenting complaints
  - Face to Face
    Case studies and triage scenarios
- New on line registration system
  - Instructors will book courses on line, enter participant names
  - Certificate of attendance and payment through this system
  - All learning materials located in the registration system
- The revised program is almost complete. The CTAS revision team will be running pilot courses to fine tune the program.
- The revised course is expected to be released later in Fall 2018.
- CTAS instructors will be required to attend a webinar update session before teaching the new program. More to come!

CTAS Fees for participants and instructors

- The CTAS course fees are expected to change with the implementation of the revised CTAS education program.

CTAS OHA Transition

- CTAS Ontario instructors have now all transitioned to CAEP/NENA CTAS.

CTAS National Working Group (NWG) NENA Representatives

- NENA will be seeking for two positions on the CTAS NWG – one in the Fall, 2018 for a four year term ending June 30th, 2022, and one in Fall, 2019 for a 4 year term 2019–2023.

CTAS Instructor Renewals

- All CTAS instructors and instructor trainers are required to renew annually July 1 of every year. The renewal form is located on the CAEP website under "CTAS". Current NENA membership is required.

CTAS Inquiries for Courses – ctas@caep.ca

- Booking CTAS courses, course funds reports, course paperwork, instructor renewals

CTAS Instructor Inquiries – ctas@nena.ca

- Instructor approvals, instructor questions, course related questions or any triage query

CTAS NWG NENA representatives – ctas@nena.ca

- Margaret Dymond, Edmonton, AB
- Colleen Brayman, Kelowna, BC

CTAS·ÉCTG
CANADIAN TRIAGE AND ACUITY SCALE
ÉCHELLE CANADIENNE DE TRIAGE ET DE GRAVITÉ


Explore
New Brunswick
Canada's Picture Province
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NURSES
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National Emergency
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Saint John
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Living under silence: Untold stories of sexual violence

By Lily Crist

Lessons from female refugee victims of conflict-related sexual violence in Kosovo and the application of forensic science to the care of populations in Vancouver.

Growing up, I would hear stories that adults told, stories that kept me awake at night. They puzzled me by the complexity of unknown words that were foreign to my understanding and that wrapped me in wonder and awe. If you made yourself invisible to the world of adults or pretended to play and not pay attention while they shared their stories, you could learn much about their world. Whoever says that kids do not understand what is going on in the world of adults is mistaken.

As in Ancient Greece and in many Mediterranean cultures, the *gynaeceum* was a closed realm for women where they could be free to be together and share stories. The *gynaeceum* was often a room or place in a house where women, married and unmarried, enslaved and free, could come together and spend time with each other. For me, as with the *gynaeceum*, any gathering of women has brought to light many new words and ideas. Over time, a particular geography started to emerge as I learned about how men and women interacted and how gender expectations based on traditions, customs and morality impacted me and everyone around me. I learned as a child that some stories needed to remain untold for fear of retaliation or worse: they were so toxic that they could destroy everything around. Sometimes these stories emerged in fragments, incomplete and mysterious, then spread into every area of one's life. What happens when the truth is so unbearable to tell and, to continue living, one has to bury one's story deep inside oneself? What happens when there is no one to talk to?

Over the decades, it has been very important for me to understand the barriers a victim faces when she chooses to share her story—or when she is unable to do so—and the best ways of caring for victims of sexual violence. The focus of this paper will be the female refugee victims of Kosovo and the care provided to them in particular. In examining their situation, I hope to learn more about the challenges to accessing care and the ways in which, for this specific population, access to adequate care can be improved.

This paper will bring to light some approaches and responses to the care of these female refugee victims of conflict-related sexual violence and the role of forensic health sciences in that care. The focus will be on a specific group: ethnic Albanian women from the Kosovo region before and during the Balkan wars, mostly female refugee victims of sexual violence. Sexual violence can indeed be conflict-related, as it was during the Balkan wars. Many parallels can be drawn with other women in other war zones where military forces have used sexual violence as a tool against civilian populations. According to United Nations Security Council Resolution 1820, S/RES/1820 (2008), from June 19, 2008, sexual violence is conflict-related "when used or commissioned as a tactic of war in order to deliberately target civilians or as part of a widespread or systematic attack against civilian populations." The resolution notes that "civilians account for the vast majority of those adversely affected by armed conflict; (…) women and girls are particularly targeted by the use of sexual violence, including as a tactic of war to humiliate, dominate, instill fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group."

Trying to explain how a particular society functions and relates to female victims of sexual violence is complex and might not be possible in this limited format. Nevertheless, we can look at some reasons why victims of rape in this specific context do not disclose their situation to healthcare providers or law-enforcement officers and we will look afterwards at strategies to respond to the needs of female refugees. Focusing on the care needed by female victims of this conflict in the Balkans can bring to light some of the directions that healthcare providers (forensic nurses, FNE) have taken or can take. Canada has welcomed many refugees from war zones over the years, and a better understanding of female refugees and their needs can have a positive impact on both healthcare providers and their patients. In the past, Canada has been directly involved on the ground in Kosovo by providing military, medical and civilian teams.

A short anthropological introduction to establish the context of the conflict and a brief description of Albanian society and views on female victims will help to better comprehend some of the barriers to accessing care. First, some background information to better understand the Albanian culture and traditions in Kosovo. As soon as Slobodan Milošević came to power in the former Yugoslavia in the 1990s, even before the start of war in the Balkans, the ethnic Albanian population of the region of Kosovo was living under duress. Healthcare providers, teachers and many ethnic Albanians of the region lost their jobs merely because they were Albanian. Schools, universities, hospitals and all governmental organizations run by ethnic Albanians for their populations were closed and this for the subsequent ten years, until the end of the conflict in the Balkans. Ethnic Albanian healthcare providers in local hospitals were replaced by Serbs, whom the local Albanian population highly distrusted. In this context, there emerged a parallel illegal society that tried to resist the occupation. Prenatal care was almost nonexistent for many women and, for an Albanian woman, giving birth was a source of fear and danger. In this context, women internalized their concerns. They refrained from sharing them with healthcare providers whom they distrusted.

Violence against civilian populations increased in Kosovo and culminated during the war in 1998-1999. In the article

"How Long Can You Keep a Secret? For Kosovo's Wartime Rape Victims, the Answer is Maybe Forever" from Radio Free Europe/Radio Liberty, rapes committed by paramilitary Serbian forces were a way to terrorize, humiliate and stigmatize women (Rames, 2013). The war eventually ended, but for the survivors the hardships continued. Notably, the attitudes toward victims of sexual violence were very negative. Indeed, Albanian society has certainly sustained some egregious beliefs. One of them is that an Albanian woman's honour is more precious than her life and that a "good" woman must kill herself after a sexual assault to prevent bringing shame to her family and clan. In this manner, stigmatization has an impact on the ability—and opportunity—for victims to seek treatment.

The Albanian society of the Kosovo region was a rigid and codified male-dominated one, where women passed from the authority of their fathers, brothers and other male relatives to that of their husbands' or in-laws' families. The prevalence of the old code of traditional laws, the 15th-century Kanun that controlled matters pertaining to families, marriage, properties, clan life, etc., impacted the gender relations and views on victims of sexual and domestic violence. As they fled, many Albanian families from Kosovo were persecuted and displaced to neighbouring countries or killed during the war. Among female Albanian refugees, stories of violence and sexual violence were not shared with the outside world or even with spouses or other family members, for fear of abandonment, retaliation or rejection by their communities. Sexual violence was and is still a taboo subject in this society. Since August 2013, the Kosovo Rehabilitation Centre for Torture Victims (KRCT) has worked on a project called *Empowering Women Victims of Sexual Violence and Torture during Conflict in Kosovo* to help victims come forward and receive compensation and medical counselling. In the study commissioned by the United Nation called *Healing the Spirit: Reparations for Survivors of Sexual Violence Related to the Armed Conflict in Kosovo* (Rames, 2013), specific reasons for victims not disclosing incidents of sexual violence included the fear of stigmatization and related social consequences. Indeed, by coming forward, they would be ostracized by the whole family and their community; their spouses and families would abandon them and view them as pariahs. In addition, a key reason for which victims of sexual violence did not disclose their experiences was the shame that they felt. According to the article "Tracking Gender-Based Human Rights Violations in Postwar Kosovo" from the *American Journal of Public Health*, the fear of stigmatization was compounded—and still is to this day—by the lack of support services as a major obstacle towards disclosure of sexual violence (Desai & Perry, 2004). In addition to the regular barriers to access care, the victims of this conflict faced a greater stigma from their communities and families. *Healing the Spirit* (Rames, 2013) also mentions the lack of healthcare providers after the conflict due to their execution during the war and the overall destruction of infrastructure.

From this conflict emerged some important new ways to care for female refugee victims of sexual violence. One of the approaches mentioned in the *Guttmacher Report on Public Policy* from 1999 was the distribution of reproductive health kits to the Kosovar refugees as reports started to emerge of systematic rape of Albanian women as they were leaving their country (The Guttmacher Report on Public Policy, 1999). In her 2014 article from *Nursing* entitled "Female Refugees: Sensitive Care Needed," Elizabeth Heavey provides a better understanding of nursing challenges and helpful strategies to care for female refugees. Patients who have experienced sexual violence during wars can show signs of post-traumatic stress disorder (PTSD) and use disassociation "as a coping mechanism." In the article, Heavey describes some of the health-risk factors observable among PTSD victims. They range from cardiovascular disorders to suicide. As she notes, "PTSD doesn't just affect mental health." According to Linda E. Ledray et al. (2011) in *Medical Response to Adult Sexual Assault*, reactions to traumatic events like sexual violence can take many forms: physical, emotional, cognitive and behavioural (pp. 215–216).

Heavey mentions that nurses can play a key role in helping victims. In her words, "Clear and compassionate communication is critical to optimize nursing and medical care." When patients are familiar with healthcare providers and feel safe with them, there is a greater chance for disclosure. Such is what Bridgid McGowan said in a guest lecture at the British Columbia Institute of Technology on February 17, 2015 in the context of a course entitled *Sexual Assault Nurse Examiner Core Education: Theoretical Aspects*. In her presentation, McGowan described how forensic and other nurses can help victims of trauma by giving the patient control over the medical process, creating a feeling of predictability and preventing the loss of safety. This course was taught by Aimee Falkenberg (RN FNE BSN SANE-A) (Falkenberg, 2018). In an exchange with me, she shared some of the wisdom and experience that she had acquired from her work with victims of sexual assault and trafficking. She brought up some important points with regard to victim assistance. Notably, she advised us not to make a survivor repeat her story to too many people, as it is difficult enough to share the story only once. Falkenberg put the emphasis on empowering the survivor by letting her know how proud you are that she came in looking for help. She also discussed the many barriers for victims trying to access care in the wake of sexual violence. Very few victims come to get help, so it becomes paramount to support those who do. She added that, as nurses and medical staff, we need to be mindful and to refrain from judging or deciding if sexual violence has occurred or not. We are there to provide the survivor with medical needs relevant to her stated history and to offer a path towards forensic nursing services, in this manner allowing the survivor to be in control at all times. Falkenberg also shared a key element to any interaction with victims, the need to listen. When we listen, we show compassion, and a victim is more likely to open up, sharing an enlightening anecdote or story.

Forensics does not only work within nursing. It can also apply to social interventions like those that occur at La Boussole, a francophone nonprofit organization in Vancouver that, *inter alia*, helps female refugees integrate into Canadian society. For a year, I was the executive director of La Boussole. Every week, francophones newly arrived in the city reached out to us. They required help in obtaining housing and work, counselling, financial advice and interpretation services. Our clients faced many barriers when it came to accessing healthcare and other services. Indeed, the languages spoken by the refugees whom we dealt with on a regular

basis were not necessarily understood by health professionals in British Columbia. As a consequence, our clients could have a hard time in making themselves understood and more generally in receiving the physical and mental care that they needed.

In this organization, employees accompany their clients to various institutions, including medical doctors' offices and hospitals, acting as interpreters and guides in their interactions with medical personnel. Such help is important, because refugees to Vancouver, particularly the female ones, face unique obstacles. For example, there might not be any spaces in transition houses for them, or there might not even be any transition houses in their neighbourhoods. They might not know how to contact such places or be able to interpret the rules once they have been admitted. In addition, their experiences in their countries of origin might cause them to be suspicious of law enforcement and the judicial system.

At La Boussole, the employees have the knowledge and experience required to aid refugees arriving in the city. They can listen impartially to refugees and act in accordance with well-established protocols in social work. Each employee brings her personal touch and especially her life experiences to bear when she assists refugees, guiding them through the bureaucratic maze that sometimes separates them from adequate health care. Our employees can adapt their interventions to each client on the basis of their empathy towards those whom they help, their knowledge of the community and their various sociocultural reference points. Their capacity to adapt their approaches in accordance with different clients' needs is essential, as those needs can vary tremendously. A client's personal characteristics are a factor, as well as how recent, immersive and severe their experiences of war and conflict have been. In the recent past, at La Boussole, we assisted women, often accompanied by their children, who had escaped from violent situations in their home countries, where sexual assault was an all-too-common practice. Some clients have also fled violence experienced in Canada.

The personnel at La Boussole accompanies clients for their medical appointments. In this context, the staff members do not merely act as interpreters on behalf of the clients. Through their moral support and guidance, they assist in making client interactions with the medical personnel as smooth and painless as possible. While respecting their clients' autonomy, they endeavour to ensure that client views are expressed and client preferences are defended. They also assist clients in following through with regard to a medical doctor's advice, prescriptions and attendance at follow-up appointments with the doctor or specialists.

My own educational and professional experience has prepared me well for supporting and guiding clients and for dealing with the challenges and even crises that arise from time to time. In particular, my health-science education at the British Columbia Institute of Technology has given me the knowledge and confidence to support—as best I can—women who have escaped from conflict zones and interpersonal violence. When someone called or showed up at La Boussole and felt comfortable about sharing her experiences with me, it was important for me to listen attentively, to show empathy and to observe telling details that the visitor was sharing. Doing so could help me establish a course of action suited to her needs. Indeed, in paying close attention to her life story and listening to what she emphasized, I could quickly develop a plan calibrated to her needs.

Forensic health sciences in relation to nursing have evolved over the recent past in a manner that can provide clarity with regard to epidemiological issues such as violent crimes (from sexual assault to murder), trauma, negligence and suicide, to name only a few. Nursing-related forensics are highly relevant in connection with those individuals so frequently encountered in our society, in drop-in clinics, emergency wards and elsewhere.

More broadly, intervention has many facets as it involves a diversity of experts working in interrelated fields. People who aid victims work in law enforcement, justice, medicine and social work, among other areas. A background in forensic health sciences can assist people in all of these areas. It certainly has helped me. Forensics contributes to a better understanding of signs of violence—which can differ with regard to a victim's characteristics, including notably her age—and to an improved ability to ask the right questions. To succeed in assisting female victims of mental or physical abuse or violence, one needs to be curious and open-minded. One needs also to document and preserve evidence of harm. Familiarity with forensics can enable a healthcare professional to be more efficient in assisting survivors of sexual assault, violent crimes or other forms of abuse. In this regard, certain hospitals in the Lower Mainland offer nursing services adapted to the needs of victims of sexual abuse (Sexual Assault Nurse Examiner—SANE).

At BCIT, professor Sheila Early taught me that an inquisitive mind, active listening skills and a duty to care are at the heart of forensic nursing and that all of us have a role to play in putting an end to violence in society, be it in a clinical setting or in conversations among friends. Professor Early, in her teachings, often emphasized that a forensic nurse examiner needs to be perceptive, constantly questioning circumstances with the goal of getting at the truth in order to support victims as effectively as possible. Our clients do not always state in so many words what is troubling them, but an educated and experienced listener can often get at the heart of their problems. In this regard, female refugees who have survived sexual assault and other forms of violence might consult with medical practitioners for problems unrelated to their traumatic experiences while displaying symptoms of posttraumatic stress disorder including hypervigilance. A perceptive professional can detect these symptoms and adapt her treatment in accordance with her interpretation of the situation.

Unfortunately, the experiences of Albanian refugees from Kosovo who have settled in Canada are not exceptional. Facing the same challenges are many female refugees from other zones of hardship and conflict around the world, including refugee camps, which present their own dangers. In addition, one can apply one's knowledge in forensic health sciences to include working with people escaping difficult situations *within* Canada as well, whether they live in remote communities or disadvantaged urban and suburban neighbourhoods in larger cities. But the number of female refugees who have arrived in Canada from outside the country remains high, numbering 28,689 in 2016

alone (Government of Canada, 2017). Each refugee brings with her specific traumas and faces particular challenges.

The work of forensic nurse examiners and culturally sensitive approaches among all people who assist refugees are two ways to help with the healing process. For female survivors from Kosovo, access to justice and reparation programs are among the tools developed by the UN Secretary-General in 2014 as part of his Guidance Note on *Reparations for Conflict-Related Sexual Violence*. In the words of Siobhan Hobbs, Gender Adviser with the UN Women's Project Office in Kosovo, "That was really an attempt by the head of the UN to pool together the lessons learned, not just from the specific field of sexual violence, but also from reparations in general."

The devastation of a war continues long after it has ended and many initiatives and government programs are put in place to help victims of conflict, rebuild infrastructure and create a more just society, one in which there are no gender-based inequalities or violence. However, in a report from the UNHCR, the postwar situation of Albanian women is perceived to have deteriorated and, moreover, some young women from lower socioeconomic backgrounds have become victims of human trafficking (Baker & Hilde, 2002).

Some stories might not have been told yet, or they might be buried under a heavy wall of silence. Since childhood, I have continued to listen for such stories, now more in a quest for moments where victims find the courage to express their innermost feelings. In many such cases, it is their silences that are most eloquent. For them, to revisit the evils that war and conflict can bring is like opening a modern-day Pandora's Box. However, at the very least, female refugees from Kosovo who have experienced sexual violence will find at the bottom of the Box one last thing that can help them to rebuild their lives: hope. In Albanian, they call it "Shpresē" and little girls are sometimes named "Shpresa," the one who has hope.

Author's take-away

1. Clear and compassionate communication is critical to optimize nursing and medical care.
2. Nurses can help victims of trauma by giving the patient control over the medical process, creating a feeling of predictability and preventing the loss of safety.
3. Empowering the survivors by letting her know how proud you are that they came in looking for help
4. We need to be mindful and to refrain from judging or deciding if sexual violence has occurred or not
5. A key element to any interaction with victims is the need to listen.

About the author

As president of the Alliance des femmes de la francophonie canadienne, Lily Crist works to represent Francophone women in Canada in the nine provinces and three territories where they are linguistic minorities. She has been involved in the women's movement for the past 22 years. Ms. Crist has studied as an adult educator, a counsellor, and in Forensic Health sciences, leading her to be an experienced and knowledgeable supporter of victims of sexual violence. Ms. Crist helped to develop a pilot education project that brings information about healthy relationships, gender, and diversity to Francophone secondary schools. Working with La Boussole, Ms. Crist is part of the only Francophone organization working to combat homelessness and offering services to those living in poverty through a food bank, community courses, supporting mental health initiatives, and creating safe and open Francophone spaces in Vancouver. Additionally, Ms. Crist helped to establish the francophone crisis hotline Inform'elles, which offers support to French-speaking women living in Anglophone regions. As of September 2018, she is pursuing a Bachelor in Nursing Sciences at Vancouver Community College in Vancouver.

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Vivre dans le silence : Histoires inédites de violences sexuelles

par Lily Crist

Leçons tirées de femmes réfugiées victimes de violences sexuelles liées au conflit au Kosovo et application de la science médico-légale aux soins dispensés aux populations de Vancouver.

En grandissant, j'entendais des histoires que des adultes racontaient, des histoires qui me tenaient éveillé la nuit. Ils m'ont intrigué par la complexité des mots qui m'étaient inconnus et m'ont enveloppé d'émerveillement et de crainte. Si vous arriviez à vous échapper de ce monde d'adultes, ou si vous prétendiez être en train de jouer et ne pas faire attention au monde qui vous entoure pendant qu'ils partagent leurs histoires, alors vous seriez en mesure d'en apprendre davantage sur leur monde. Toute personne qui dit que les enfants ne comprennent pas ce qui se passer dans le monde des adultes se trompe.

Comme dans la Grèce antique et dans de nombreuses cultures méditerranéennes, le gynécée était un domaine fermé pour les femmes où elles pouvaient être libres de se réunir et de partager des histoires. Le gynécée était souvent une pièce ou un lieu dans une maison où les femmes, mariées et célibataires, esclaves et libres, pouvaient se réunir et passer du temps entre elles. Personnellement, le gynécée, et tout autre rassemblement de femmes, a permis d'apporter au monde de nouveaux mots et de nouvelles idées. Au fil du temps, une géographie particulière a commencé à émerger lorsque j'ai appris comment les hommes et les femmes interagissaient et comment les attentes liées au genre fondées sur les traditions, les coutumes et la moralité avaient un impact sur moi et les personnes de mon entourage. Durant mon enfance, j'ai appris que certaines histoires devaient rester inexpliquées de peur de représailles ou pire; elles étaient si toxiques qu'elles pouvaient avoir des impacts désastreux. Parfois, ces histoires apparaissaient par fragments, de façon incomplète et mystérieuse, puis se propageaient dans tous les domaines de la vie d'une personne. Que se passe-t-il quand la vérité est si insupportable à raconter et, pour continuer à vivre, il faut enterrer son histoire au plus profond de soi? Que se passe-t-il quand il n'y a personne à qui parler?

Au fil des décennies, il me paraissait très important de comprendre les obstacles auxquels une victime est confrontée lorsqu'elle choisit de raconter son histoire - ou lorsqu'elle est incapable de le faire - et les meilleurs moyens de prendre soin des victimes de violence sexuelle. Ce document porte principalement sur les femmes réfugiées du Kosovo et sur les soins qui leur sont fournis. En examinant leur situation, j'espère en apprendre davantage sur les difficultés d'accès aux soins et sur les moyens d'améliorer, pour cette population spécifique, l'accès à des soins adéquats.

Ce document essaye de mettre en lumière certaines approches et réponses relatives aux soins de ces femmes réfugiées victimes de violences sexuelles dans les situations de conflit et au rôle des sciences médico-légales. L'accent sera mis sur un groupe spécifique : les femmes d'origine albanaise de la région du Kosovo avant et durant les guerres dans les Balkans, principalement des réfugiées victimes de violences sexuelles. La violence sexuelle peut en effet être liée aux conflits, comme lors des guerres balkaniques. De nombreux parallèles peuvent être établis avec d'autres femmes dans d'autres zones de guerre où les forces militaires ont utilisé la violence sexuelle comme outil contre les populations civiles. Selon la Résolution 1820, S/RES/1820 (2008) du Conseil de sécurité des Nations unies, depuis le 19 juin 2008, la violence sexuelle est liée à des conflits armés « quand elle est utilisée ou commanditée comme arme de guerre prenant délibérément pour cible des civils, ou dans le cadre d'une attaque généralisée ou systématique dirigée contre des populations civiles. » La résolution indique que les « civile constituent la grande majorité de ceux qui subissent les effets préjudiciables des conflits armés; (...) les femmes et les filles sont particulièrement ciblées par l'utilisation de violences sexuelles, y compris comme tactique de guerre destinée à humilier, dominer instaurer de la peur, disperser ou déplacer contre leur gré les membres civils d'une communauté ou d'un groupe ethnique. »

Avec ce format limité, il est assez difficile et complexe d'expliquer comment une société spécifique fonctionne et comment cela a trait aux femmes victimes de violences sexuelles. Néanmoins, nous pouvons examiner certaines des raisons pour lesquelles les victimes de viol, dans ce contexte spécifique, ne divulguent pas leur situation aux prestataires de soins de santé ou aux agents de la force publique. Nous examinerons ensuite des stratégies pour répondre aux besoins des femmes réfugiées. En se concentrant sur les soins dont les femmes victimes ont besoin, en ce qui a trait au conflit dans les Balkans, il est possible de mieux comprendre les chemins que les prestataires de soins de santé (infirmiers et infirmières médico-légaux) ont pris ou peuvent prendre. Au fil des années, le Canada a accueilli de nombreux réfugiés de zones de guerre, et une meilleure compréhension des femmes réfugiées et de leurs besoins peut avoir un impact positif sur les prestataires de soins de santé et leurs patients. Par le passé, le Canada a été directement impliqué sur le terrain au Kosovo en fournissant des équipes militaires, médicales et civiles.

Pour mieux aider à comprendre certains des obstacles relatifs à l'accès aux soins, une courte introduction anthropologique pour établir le contexte du conflit et une brève description de la société albanaise et des opinions sur les femmes victimes sont nécessaires. Premièrement, voici quelques informations de base pour mieux comprendre la culture et les traditions albanaises au Kosovo.

Dès que Slobodan Milošević est arrivé au pouvoir dans l'ex-Yougoslavie dans les années 1990, avant même le début de la guerre dans les Balkans, la population d'origine albanaise de

la région du Kosovo vivait sous la contrainte. Les prestataires de soins de santé, les enseignants et de nombreux Albanais de la région ont perdu leur emploi simplement parce qu'ils étaient albanais. Les écoles, les universités, les hôpitaux et toutes les organismes gouvernementaux dirigés par des Albanais de souche pour leurs populations ont été fermés, et ce pour les dix années suivantes, jusqu'à la fin du conflit dans les Balkans. Dans les hôpitaux locaux, Les prestataires de soins de santé d'origine albanaise ont été remplacés par des Serbes, des gens que la population albanaise locale se méfiait grandement. À cause de ce contexte, une société illégale parallèle a tenté de résister à l'occupation. Les soins prénataux étaient quasi inexistants et pour beaucoup de femmes albanaises accoucher devenait une source de peur et de danger. Avec une telle situation sur le terrain, les femmes ont décidé de ne plus partager leurs problèmes avec des prestataires de soins de santé en qui elles n'avaient aucune confiance.

La violence à l'encontre des populations civiles a augmenté au Kosovo et a atteint son point culminant durant la guerre de 1998-1999. Dans l'article « Combien de temps pouvons-nous garder un secret? En ce qui a trait aux victimes de viol durant la guerre au Kosovo, la réponse est probablement jamais » de Radio Libre Europe / Radio Liberté. Les viols commis par les forces paramilitaires Serbes avaient pour objectif, en partie, de terroriser, d'humilier et de stigmatiser les femmes (Rames, 2013). La guerre a finalement pris fin, mais les difficultés ont continué pour les survivants. Les attitudes à l'égard des victimes de violences sexuelles sont très négatives. Il est clair que la société albanaise a certainement maintenu certaines croyances flagrantes. L'une d'elles est que l'honneur d'une femme albanaise est plus précieux que sa vie et qu'une « bonne » femme doit se suicider après une agression sexuelle pour éviter de faire honte à sa famille et à son clan. Avec une telle mentalité, la stigmatisation a un impact sur la capacité - et la possibilité - des victimes de se faire soigner.

La société albanaise de la région du Kosovo était une société à dominance masculine rigide et codifiée, dans laquelle les femmes passaient de l'autorité de leurs pères, frères et autres parents de sexe masculin à celle des familles de leur mari ou de leur belle-famille. La prévalence de l'ancien code des lois traditionnelles, le Kanun du XV^{e} siècle, qui régissait les questions relatives à la famille, au mariage, aux biens, à la vie de clan, etc., avait une incidence sur les relations entre les sexes et les opinions sur les victimes de violences sexuelles et domestiques. Durant leur fuite, de nombreuses familles albanaises du Kosovo ont été persécutées et déplacées dans les pays voisins ou ont été tuées pendant la guerre. Parmi les femmes réfugiées albanaises, les récits de violence et de violence sexuelle n'ont pas été partagés avec le monde extérieur ni même avec les époux ou d'autres membres de la famille, par peur d'être abandonnées, soumises à des représailles ou d'être rejetées par leurs communautés. La violence sexuelle était et est toujours un sujet tabou dans cette société. Depuis août 2013, le Centre de réhabilitation des victimes de torture du Kosovo (KRCT) collabore à un projet intitulé « Renforcer le pouvoir des femmes victimes de violences sexuelles et de tortures pendant le conflit au Kosovo » aider les victimes à se faire connaître et à recevoir une indemnisation et des conseils médicaux.

Dans l'étude commandée par les Nations Unies et intitulée *Healing the Spirit: Reparations for Survivors of Sexual Violence Related to the Armed Conflict in Kosovo* (La guérison de l'esprit : Réparations pour les survivantes de violences sexuelles liées au conflit armé au Kosovo), la peur de la stigmatisation et les conséquences sociales qui en découlent sont des raisons spécifiques pour lesquelles les victimes n'ont pas révélé d'incidents de violence sexuelle. En effet, en se présentant, elles seraient ostracisées par toute la famille et leur communauté; leurs conjoints et leurs familles les abandonneraient et les considéreraient comme des parias. En outre, la honte ressentie par les victimes de violences sexuelles est l'un des raisons pour lesquelles elles ne partagent pas leurs histoires. Selon l'article intitulé « *Tracking Gender-Based Human Rights Violations in Postwar Kosovo* » du American Journal of Public Health, la crainte d'être stigmatisé a été aggravée - et l'est encore à ce jour - par le manque de services de soutien et comme principal obstacle à la divulgation des violences sexuelles (Sapna et Perry, 2004). Outre les obstacles habituels liés à l'accès aux soins, les victimes de ce conflit ont été confrontées à une stigmatisation accrue de la part de leurs communautés et de leurs familles. « La guérison de l'esprit » mentionne également le manque de prestataires de soins de santé après le conflit en raison de leur exécution pendant la guerre et de la destruction générale des infrastructures.

Ce conflit a permis de dégager de nouveaux moyens importants pour prendre en charge les femmes réfugiées victimes de violences sexuelles. L'une des approches mentionnées dans le « Guttmacher Report in Public Policy » de 1999 était la distribution de trousse de santé reproductive aux réfugiées kosovares au moment où commençaient à apparaître des cas de viols systématiques de femmes albanaises quand elles essaient de quitter leur pays (The Guttmacher Report on Public Policy, 1999).

Dans son article de 2014 publié par Nursing intitulé « *Female Refugees: Sensitive Care Needed* » (Les femmes réfugiées: des soins sensibles requis), Elizabeth Heavey fournit une meilleure compréhension des défis posés par les soins infirmiers et des stratégies utiles pour prendre soin des femmes réfugiées. Les patients qui ont subi des violences sexuelles pendant les guerres peuvent montrer des signes de trouble de stress post-traumatique (TSPT) et utiliser la dissociation « comme un mécanisme d'adaptation ». Dans l'article, Heavey décrit certains des facteurs de risque pour la santé observables chez les victimes souffrant de TSPT. Ils vont des troubles cardiovasculaires au suicide. Comme elle le note, « le TSPT n'affecte pas seulement la santé mentale ». Selon Linda E. Ledray (2011) dans « Medical Response to Agression Sexual Adult », les réactions à des événements traumatisants, tels que la violence sexuelle, peuvent prendre plusieurs formes : physique, émotionnelle, cognitive et comportementale (pp. 215-216).

Heavey explique que les infirmiers et infirmières peuvent jouer un rôle clé dans l'aide aux victimes. Selon elle, « une communication claire et une empreinte de compassion sont essentielles pour optimiser les soins infirmiers et médicaux ». Quand les patients connaissent les prestataires de soins de santé et se sentent en sécurité avec eux, les victimes ont plus tendance à

vouloir partager leurs histories. Tel est ce que Bridgid McGowan a déclaré lors d'une conférence donnée à l'Institut de technologie de la Colombie-Britannique le 17 février 2015 dans le contexte d'un cours intitulé « *Sexual Assault Nurse Examiner Core Education: Theoretical Aspects* » (Enseignement de base des infirmières examinatrices en matière d'agression sexuelle - Aspects théoriques).

Dans sa présentation, McGowan a expliqué comment les infirmiers et infirmières en médecine légale et autres infirmiers et infirmières peuvent aider les victimes de traumatismes en leur donnant le contrôle du processus médical, créant ainsi un sentiment de prévisibilité et en prévenant la perte de sécurité. Ce cours a été enseigné par Aimee Falkenberg (RN FNE BSN SANE-A). Lors d'une discussion avec moi, elle a partagé une partie de la sagesse et de l'expérience qu'elle avait acquises grâce à son travail auprès des victimes d'agression sexuelle et de traite de personnes. Elle a soulevé des points importants concernant l'aide aux victimes. Elle nous a notamment conseillé de ne pas demander à une survivante de répéter son histoire à un trop grand nombre de personnes, car il est déjà assez difficile de ne la raconter une fois. Falkenberg met l'accent sur le renforcement de la victime en lui indiquant à quel point elle peut être fière d'être venue chercher de l'aide. Elle a également évoqué les nombreux obstacles rencontrés par les victimes qui tentent d'accéder à des soins à la suite de violences sexuelles. Très peu de victimes viennent chercher de l'aide, il est donc primordial de soutenir celles qui le font. Elle a ajouté qu'en tant qu'infirmières et personnel médical, nous devons être attentifs et éviter de juger ou de décider si des violences sexuelles ont eu lieu ou non. Nous sommes sur place pour fournir à la victime des besoins médicaux correspondant à ses antécédents et pour lui offrir une voie vers des services de soins infirmiers médico-légaux, permettant ainsi à la victime de garder le contrôle à tout moment. Falkenberg a également partagé un élément clé de toute interaction avec les victimes, la nécessité d'écouter. Lorsque nous écoutons, nous montrons de la compassion et une victime est plus susceptible de s'ouvrir, en partageant une anecdote ou une histoire pertinente.

La criminalistique ne fonctionne pas seulement en soins infirmiers. Cela peut également s'appliquer à des interventions sociales comme celles qui se déroulent à La Boussole, une organisation francophone à but non lucratif de Vancouver qui, entre autres, aide les femmes réfugiées à s'intégrer dans la société canadienne. Pendant un an, j'ai été directrice exécutive de La Boussole. Chaque semaine, les francophones nouvellement arrivés dans la ville nous contactaient. Ils avaient besoin d'aide pour obtenir un logement et un travail, des conseils, des conseils financiers et des services d'interprétation. Nos clients se heurtaient à de nombreux obstacles pour accéder aux soins de santé et autres services. En effet, les professionnels de la santé de la Colombie-Britannique ne comprenaient pas forcément les langues parlées par les réfugiés que nous rencontrions régulièrement. Par conséquent, nos client pouvaient avoir du mal à se faire comprendre et plus généralement à recevoir les soins physiques et mentaux dont ils ont besoin.

Au sein de cet organisme, les employés accompagnent leurs clients vers diverses institutions, y compris les cabinets de médecins et les hôpitaux, jouant le rôle d'interprètes et de guides dans leurs interactions avec le personnel médical. Une telle aide est importante car les réfugiés à Vancouver, en particulier les femmes, se heurtent à des obstacles uniques. Par exemple, il peut ne pas y avoir d'espace dans les maisons de transition ou même pas de maisons de transition dans leurs quartiers. Elle peuvent ne pas savoir comment contacter ces lieux ou être capables d'interpréter les règles une fois qu'elles ont été admises. En outre, leurs expériences dans leurs pays d'origine pourraient les amener à se méfier des forces de l'ordre et du système judiciaire.

À La Boussole, les employés possèdent les connaissances et l'expérience requises pour aider les réfugiés arrivant dans la ville. Ils peuvent écouter les réfugiés de manière impartiale et agir conformément aux protocoles bien établis en matière de travail social. Chaque employé apporte sa touche personnelle et ses expériences de vie lorsqu'il aide des réfugiés en les guidant dans le dédale bureaucratique, les empêchant parfois de recevoir des soins de santé adéquats. Nos employés peuvent adapter leurs interventions à chaque client sur la base de leur empathie envers ceux qu'ils aident, de leur connaissance de la communauté et de leurs différents repères socioculturels. Leur capacité à adapter leurs approches en fonction des besoins des différents clients est essentielle, car ces besoins peuvent varier considérablement. Les caractéristiques personnelles des clients sont un facteur, de même que la gravité de leurs expériences récentes, immersives et graves, de la guerre et des conflits. Récemment, à La Boussole, nous avons aidé des femmes, souvent accompagnées de leurs enfants, qui avaient fui des situations de violence dans leur pays d'origine, où les agressions sexuelles étaient une pratique très courante. Certaines clientes ont également fui la violence vécue au Canada.

Le personnel de La Boussole accompagne les clients pour leurs rendez-vous médicaux. Dans ce contexte, les membres du personnel ne font pas simplement office d'interprètes pour le compte des clients. Par leur soutien et leurs conseils moraux, ils aident à rendre les interactions du client avec le personnel médical aussi harmonieuses que possible. Tout en respectant l'autonomie de leurs clients, ils s'efforcent de faire en sorte que leurs points de vue soient exprimés et que leurs préférences soient défendues. Ils aident également les clients à donner suite aux conseils, aux ordonnances et aux visites de suivi avec un médecin ou des spécialistes.

Ma propre expérience éducative et professionnelle m'a bien préparée à accompagner et guider les clients et faire face aux défis et même aux crises qui se produisent de temps à autre. En particulier, mes études en sciences de la santé à l'Institut de technologie de la Colombie-Britannique m'ont permis d'acquérir les connaissances et la confiance nécessaires pour soutenir, du mieux que je peux, les femmes qui se sont échappées des zones de conflit et de violence interpersonnelle. Lorsque quelqu'un appelait ou se présentait à La Boussole et se sentait à l'aise de partager ses expériences avec moi, il était important pour moi d'écouter attentivement, de faire preuve d'empathie et d'observer les détails révélateurs partagés par le visiteur. En faisant cela, j'étais en mesure d'établir un plan d'action adapté à ses besoins. En effet, en prêtant une attention particulière à l'histoire de sa vie et en écoutant ce qu'elle soulignait, je pouvais rapidement élaborer un plan adapté à ses besoins.

Les sciences médico-légales en matière de soins infirmiers ont évolué au cours des dernières années pour mieux clarifier les problèmes épidémiologiques, tels que les crimes violents (de l'agression sexuelle au meurtre), les traumatismes, la négligence et le suicide; pour n'en nommer que quelques-uns. La criminalistique liée aux soins infirmiers est très pertinente pour les personnes que l'on rencontre si fréquemment dans notre société, dans les cliniques d'accueil, les salles d'urgence et ailleurs.

Plus généralement, l'intervention revêt de nombreuses facettes car elle implique une diversité d'experts travaillant dans des domaines interdépendants. Les personnes qui aident les victimes travaillent entre autres dans les domaines de l'application de la loi, de la justice, de la médecine et du travail social. Une formation en sciences médico-légales peut aider les gens dans tous ces domaines. Cela m'a certainement aidé.

La criminalistique contribue à une meilleure compréhension des signes de violence - qui peuvent différer en fonction des caractéristiques d'une victime, notamment de son âge - et à une meilleure capacité de poser les bonnes questions. Pour réussir à aider les femmes victimes de maltraitance physique ou mentale, il faut être curieux et ouvert d'esprit. Il faut également se documenter et préserver les preuves de préjudice. La familiarité avec la criminalistique peut permettre à un professionnel de la santé d'aider plus efficacement les victimes d'agression sexuelle, de crimes violents ou d'autres formes de maltraitance. À cet égard, certains hôpitaux du Lower Mainland proposent des services de soins adaptés aux besoins des victimes d'abus sexuels (infirmière examinatrice en matière d'agression sexuelle [IEAS]).

Au BCIT, la professeure Sheila Early m'a appris qu'un esprit curieux, une écoute active et un devoir de sollicitude sont au cœur des soins infirmiers légistes et que nous avons tous un rôle à jouer pour mettre fin à la violence dans la société, que ce soit une clinique ou dans des conversations entre amis. Dans ses enseignements, la professeure Early a souvent insisté sur le fait qu'un infirmier examinateur légiste devait être perspicace et interroger constamment les circonstances dans le but de découvrir la vérité afin de soutenir les victimes le plus efficacement possible. Nos clients ne disent pas toujours ce qui les trouble, mais un auditeur instruit et expérimenté peut souvent aller au cœur de leurs problèmes. À cet égard, les femmes réfugiées ayant survécu à une agression sexuelle et à d'autres formes de violence pourraient consulter un médecin pour des problèmes sans lien avec leurs expériences traumatiques tout en présentant des symptômes de trouble de stress post-traumatique, notamment d'hypervigilance. Un professionnel perspicace peut détecter ces symptômes et adapter son traitement en fonction de son interprétation de la situation.

Malheureusement, les expériences des réfugiés albanais du Kosovo qui se sont installés au Canada ne sont pas exceptionnelles. De nombreuses femmes réfugiées d'autres zones de difficultés et de conflits dans le monde, y compris des camps de réfugiés, sont confrontées aux mêmes problèmes et présentent des risques qui leur sont propres. De plus, on peut appliquer ses connaissances en sciences médico-légales à des personnes qui fuient des situations difficiles au Canada, qu'elles vivent dans des communautés éloignées ou dans les quartiers urbains et suburbains défavorisés des grandes villes. Cependant, le nombre de femmes réfugiées qui sont arrivées au Canada en provenance de l'extérieur du pays reste élevé, avec 28 689 en 2016 seulement (gouvernement du Canada, 2017). Chaque réfugiée apporte avec elle des traumatismes spécifiques et fait face à des défis particuliers.

Le travail des infirmières examinatrices judiciaires et les approches sensibles à la culture, parmi toutes les personnes qui aident les réfugiés, sont deux moyens d'aider au processus de guérison. Pour les femmes survivantes du Kosovo, l'accès à la justice et les programmes de réparation figurent parmi les outils élaborés par le Secrétaire général des Nations Unies en 2014 dans le cadre de sa Note d'orientation sur les « réparations des violences sexuelles liées aux conflits ». Siobhan Hobbs, Conseillère pour les questions de genre au Bureau des projets des Nations Unies pour les femmes au Kosovo, a déclaré: « Il s'agissait en réalité d'une tentative du chef des Nations Unies de mettre en commun les leçons tirées, non seulement en ce qui a trait aux violences sexuelles, mais aux réparations en général ».

La dévastation d'une guerre se poursuit longtemps après sa fin et de nombreuses initiatives et programmes gouvernementaux sont mis en place pour aider les victimes des conflits, reconstruire leurs infrastructures et créer une société plus juste, caractérisée par l'absence d'inégalités ou de violences fondées sur le sexe. Cependant, dans un rapport du HCR, la situation des femmes albanaises après la guerre est perçue comme s'être détériorée et, en outre, certaines jeunes femmes appartenant à des groupes socio-économiques défavorisés sont devenues victimes de la traite d'êtres humains (Baker & Hilde, 2002).

Certaines histoires n'ont peut-être pas encore été racontées ou peuvent être ensevelies sous un lourd mur de silence. Depuis mon enfance, j'ai continué à écouter de telles histoires, maintenant plus pour aider les victimes à trouver le courage nécessaire pour exprimer ce qu'elles ressentent au plus profond d'elles-mêmes. Dans beaucoup de cas, ce sont leurs silences qui sont les plus éloquents. Pour elles, revisiter les maux que la guerre et les conflits à créer peuvent entraîner l'ouverture la boîte de Pandore des temps modernes. Cependant, les femmes réfugiées du Kosovo victimes de violences sexuelles doivent être en mesure de trouver l'aide dont elles ont tellement besoin pour avoir l'espoir de reconstruire une meilleure vie. En albanais, ils l'appellent cela « Shpresë » et les petites filles sont parfois appelées « Shpresa », celle qui a de l'espoir.

Remarques de l'auteur

1. Une communication claire et une empreinte de compassion sont essentielles pour optimiser les soins infirmiers et médicaux.
2. Les infirmières peuvent aider les victimes de traumatismes en leur donnant le contrôle du processus médical, créant ainsi un sentiment de prévisibilité et en prévenant la perte de sécurité.
3. Renforcer le pouvoir des survivantes en leur faisant savoir à quel point elles peuvent être fières d'être venues chercher de l'aide
4. Nous devons être attentifs et éviter de juger ou de décider s'il y a eu ou non violence sexuelle.
5. L'écoute est un élément essentiel d'interaction avec les victimes.

Au sujet d'auteure

À titre de présidente de l'Alliance des femmes de la francophonie canadienne, Lily Crist travaille fort pour représenter les femmes francophones au Canada dans les neuf provinces et les trois territoires, où elles font partie d'une minorité linguistique. Elle est impliquée dans le mouvement des femmes depuis 22 ans. Mme Crist a étudié en tant qu'éducatrice pour adultes, conseillère et en sciences médico-légales, ce qui la conduit à être une partisane expérimentée et bien informée des victimes de violences sexuelles. Mme Crist a aidé à élaborer un projet pilote d'éducation qui apporte de l'information sur les relations saines, le genre et la diversité aux écoles secondaires francophones. En travaillant avec La Boussole, Mme Crist fait partie du seul organisme francophone à lutter contre l'itinérance et à offrir des services aux personnes vivant dans la pauvreté par le biais d'une banque alimentaire, de cours communautaires, d'appuis à des initiatives en santé mentale et par la création d'espaces francophones sécuritaires et ouverts à Vancouver. En outre, Mme Crist a contribué à la mise en place d'une ligne d'assistance francophone pour les crises, Inform'elles, qui offre un soutien aux femmes francophones vivant dans les régions anglophones. Depuis septembre 2018, elle poursuit des études en sciences infirmières au V.C.C. à Vancouver.

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The accuracy of medication volume delivered using prefilled "Code Cart" epinephrine syringes: A simulation study

By Domhnall O'Dochartaigh

Introduction

Epinephrine is a common resuscitation medication (US National Library of Medicine, 2017). Doses of intravenous epinephrine are given every day to pediatric patients in cardiac arrest across North America (de Caen et al., 2015). Prefilled syringes of epinephrine are popular because they can decrease medication administration delay. While supported by the manufacturer (Hansen, Eriksson, Mah, Meckler, & Guise, 2017), the accuracy of delivering small doses of epinephrine from 10 mL prefilled syringes has been questioned (Hansen, Eriksson, Mah, Meckler & Guise, 2017). We therefore performed a simulation study to assess the actual versus assumed volume of prefilled epinephrine syringes when the goal was to deliver volumes of 0.5 to 3 millilitres (mL), namely 50 ug to 300 ug.

Methods

We examined 10-millilitre prefilled epinephrine syringes containing 100 ug/mL or 1mg in 10 mL [Lifeshield Glass Abbojet, Hospira; Illinois, USA]. Our goal was to determine the actual volume expelled when the plunger was depressed to target doses/volumes: 50 ug/0.5 mL, 100 ug/1 mL, 150 ug/1.5 mL, 200 ug/2 mL, and 300 ug/3 mL. In order to measure the expelled volume, we attached a syringe-to-syringe transfer device [Braun, Bethlehem, Pennsylvania, USA]. Next, excess fluid and air was expelled from the prefilled syringe, and the fluid was levelled to the 0 mark. We repeated this experiment using 1 mL and 3 mL syringes.

The participant (one of two critical care nurse researchers) was blinded to the volume expelled. After measurement in the transfer device, the remaining volume in the preload syringe was expelled, measured, and recorded separately. Syringe volume readings were independently verified by two nurse researchers (DOD & MJD). The first ten readings were made with new-in-package epinephrine syringes. Subsequently, following a standardized procedure syringes were refilled to the total mean volume found in the syringes to match the manufacturer's original volume. For each trial the participant performed a syringe priming technique that mirrors everyday clinical practice. Namely, the participant held the prefilled syringe tip to eye level and expelled any excess fluid and air. A Research Ethics Community Consensus Initiative Screening Tool was utilized to determine this study did not involve human subjects and was of minimal risk (http://www.aihealthsolutions.ca/arecci/screening).

Results

The mean total volume of 10 prefilled syringes was 10.8 mL (95% CI 10.66–10.94). We conducted 193 separate tests with the preload syringe and 152 separate tests with the 1 mL and 3 mL syringes. See Table 1 for results.

Table 1: Measured Volume of Epinephrine Expelled from three Syringe Sizes in Millilitres (mL)

Intended Delivery Volume in ml from 10 mL prefilled syringe	Number of tests	Mean Expelled mL (SD)	Min – Max mL	95% CI mL
0.5	65	0.51 (0.04)	0.46–0.62	0.50–0.51
1	65	1.00 (0.05)	0.90–1.13	0.99–1.01
2	35	2.05 (0.06)	1.90–2.20	2.03–2.07
3	16	3.04 (0.04)	2.98–3.10	3.02–3.06
Intended Delivery Volume in ml from 3 mL syringe				
0.5	26	0.51 (0.01)	0.49–0.53	0.51
1	25	1.01 (0.03)	0.98–1.1	1.01
2	25	2.00 (0.01)	1.99–2.03	2.00
3	25	3.01 (0.02)	2.98–3.04	3.01
Intended Delivery Volume in ml from 1 mL syringe				
0.5	26	0.51 (0.01)	0.5–0.53	0.51
1	25	1.01 (0.01)	0.98–1.03	1.01

Discussion

Reassuringly, our data confirm that with delivery of larger doses/volumes there is a smaller percentage of inaccuracy. In contrast, when small volumes are delivered the percentage inaccuracy increases. While perhaps intuitive, these findings address the concerns raised by Hansen et al. (2017). It is not known if, in previous studies that called micro-dosages of epinephrine into question, the preload syringe fluid was first depressed to zero. Regardless, they were zeroed in our study. Of note, extra fluid is provided in the syringes to prime the preload as well as purge any air. Our study is a useful reminder to undertake this important step.

Our results found that for all 193 preload tests the mean volume delivered was within 2% of the target and 95% were within 3% percent. Outlying minimum and maximum tests deviated greatest for the 0.5 mL and 1 mL target volumes (up to 24% and 13% respectively). Our work confirms what again may seem intuitive, namely that a smaller syringe may be more accurate when delivering less than 3-mL. We found lower percentage variation in the dose/volume delivered with the 1 mL and 3 mL syringe. This has been shown before (Erstad et al., 2006; Thobani & Steward, 1992), that the smallest possible syringe size should be selected. However, the use of smaller non-prefilled syringes should be balanced against the delay caused by drug preparation, namely transferring medications from vials to syringes for intravenous push administration. For example, delays commonly exceed one minute when using the drug decanting method, namely the process of drawing up a volume of drug followed by diluent (Moreira, Hernandez, Stevens, Jones, Sande, Blumen, et al., 2015). Clinicians should weigh the risk/benefit of using a preload syringe that is quicker against a smaller syringe which is more accurate at low dose. Similarly, manufacturers might consider creating smaller prefilled syringes.

Conclusion

To increase dosing accuracy, the volume of a prefilled syringe should be zeroed prior to administration. To further increase dosing accuracy when administering smaller volumes—especially volumes less than one mL—a smaller syringe should be considered.

Author's take-away:

1. Using prefilled syringes to administer epinephrine is common.
2. The accuracy of volume delivery has been questioned, especially when delivering lower volumes (0.5 to 3 millilitres) from a 10 mL syringe.
3. This study has found that administrating medications from pre-filled syringes is reassuringly accurate.
4. To increase dosing accuracy, the volume of a prefilled syringe should be zeroed prior to administration.
5. To further increase dosing accuracy when administering smaller volumes—especially volumes less than one mL—a smaller syringe should be considered.

About the author

Domhnall O'Dochartaigh is the Clinical Nurse Specialist for the Edmonton, Alberta, Zone Emergency Departments. His graduate education is in Trauma Sciences. He is also an Air Medical Crew (flight nurse) with the Shock Trauma Air Rescue Service. Domhnall has acted as section editor and trauma care subject matter expert for CJEN. His research interests include prehospital ultrasound, hemorrhage control, critical care and emergency nursing.

Note: *To avoid a conflict of interest, this submission was not processed by the authors. It underwent blinded peer and editorial review by persons uninvolved in this submission under the oversight of Assistant Editor Christopher Picard.*

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L'exactitude du volume de médicament administré à l'aide de seringues préremplies d'épinéphrine : Une étude de simulation

Introduction

L'épinéphrine est un médicament de réanimation courant (U.S. National Library of Medicine, 2017). Des doses d'épinéphrine par voie intraveineuse sont administrées chaque jour aux patients pédiatriques en arrêt cardiaque en Amérique du Nord (de Caen et al., 2015). Les seringues préremplies d'épinéphrine sont populaires car elles peuvent réduire les délais d'administration des médicaments. Bien que soutenu par le fabricant (Hansen, Eriksson, Mah, Meckler et Guise, 2017), la précision de l'administration de petites doses d'épinéphrine de 10 ml de seringues préremplies a été mise en doute (Hansen, Eriksson, Mah, Mecklaer et Guise, 2017). Nous avons donc réalisé une étude de simulation pour évaluer le volume réel et supposé de seringues préremplies d'épinéphrine quand l'objectif était de fournir des volumes de 0,5 à 3 millilitres (ml), à savoir de 50 à 300 µg.

Méthodes

Nous avons examiné des seringues préremplies d'épinéphrine de 10 millilitres contenant 100 ug / ml ou 1 mg dans 10 ml [Lifeshield Glass Abbojet, Hospira; Illinois, États-Unis]. Notre objectif était de déterminer le volume réel expulsé quand le piston était enfoncé aux doses / volumes cibles: 50 ug / 0,5 ml, 100 ug / 1 ml, 150 ug / 1,5 ml, 200 ug / 2 ml et 300 ug / 3 ml. Afin de mesurer le volume expulsé, nous avons installé un dispositif de transfert de seringue à seringue [Braun, Bethlehem, Pennsylvanie, États-Unis]. Ensuite, l'excès de liquide et d'air a été expulsé de la seringue préremplie et le liquide a été nivelé à la marque 0. Nous avons répété cette expérience en utilisant des seringues de 1 ml et 3 ml.

La participante (une des deux infirmières chercheuses en soins critiques) était aveuglée par le volume expulsé. Après la mesure dans le dispositif de transfert, le volume restant dans la seringue préremplie a été expulsé, mesuré et enregistré séparément. Les lectures du volume des seringues ont été vérifiées indépendamment par deux infirmières chercheuses (DOD et MJD). Les dix premières lectures ont été effectuées avec de nouvelles seringues d'épinéphrine. Ensuite, à la suite d'une procédure normalisée, les seringues ont été remplies jusqu'au volume moyen total trouvé dans les seringues pour correspondre au volume initial du fabricant. Pour chaque essai, la participante a utilisé une technique d'amorçage à la seringue reflétant la pratique clinique quotidienne. Plus particulièrement, la participante a tenu l'extrémité de la seringue préremplie à hauteur des yeux et a chassé tout excès de liquide et d'air. Un outil de dépistage du Research Ethics Community Consensus Initiative a été utilisé pour déterminer que cette étude ne concernait pas de sujets humains et qu'elle présentait un risque minimal (http://www.aihealthsolutions.ca/arecci/screening).

Résultats

Le volume total moyen de 10 seringues préremplies était de 10,8 ml (IC à 95 % de 10,66 à 10,94). Nous avons effectué 193 essais distincts avec une seringue préremplie et 152 essais séparés avec des seringues de 1 ml et 3 ml (voir le tableau 1 pour les résultats).

Table 1: Measured Volume of Epinephrine Expelled from three Syringe Sizes in Milliliters (mL)

Intended Delivery Volume in ml from 10mL prefilled syringe	Number of tests	Mean Expelled mL (SD)	Min – Max mL	95% CI mL
0.5	65	0.51 (0.04)	0.46–0.62	0.50–0.51
1	65	1.00 (0.05)	0.90–1.13	0.99–1.01
2	35	2.05 (0.06)	1.90–2.20	2.03–2.07
3	16	3.04 (0.04)	2.98–3.10	3.02–3.06
Intended Delivery Volume in ml from 3mL syringe				
0.5	26	0.51 (0.01)	0.49–0.53	0.51
1	25	1.01 (0.03)	0.98–1.1	1.01
2	25	2.00 (0.01)	1.99–2.03	2.00
3	25	3.01 (0.02)	2.98–3.04	3.01
Intended Delivery Volume in ml from 1mL syringe				
0.5	26	0.51 (0.01)	0.5–0.53	0.51
1	25	1.01 (0.01)	0.98–1.03	1.01

Discussion

Il est toutefois rassurant de voir que nos données confirment qu'avec la distribution de doses / volumes plus importants, le pourcentage d'inexactitude est moins grand. En revanche, lorsque de petits volumes sont administrés, le pourcentage d'inexactitude augmente. Bien qu'ils soient peut-être intuitifs, ces résultats répondent aux préoccupations de Hansen et al. (2017). On ne sait pas si, lors d'études précédentes ayant mis en cause les microdosages d'épinéphrine, le liquide de la seringue préremplie avait d'abord été réduit à zéro. Quoi qu'il en soit, ils ont été mis à zéro dans notre étude. Il est à noter que les seringues contiennent un excès de liquide qui permet d'amorcer la précharge et de purger tout air. Notre étude est un rappel utile pour entreprendre cette importante étape.

Nos résultats ont montré que pour les 193 essais de précharge, le volume moyen administré se situait à moins de 2 % de la cible et 95 % à moins de 3%. Les essais minimum et maximum les plus éloignés ont dévié au maximum pour les volumes cibles de 0,5 ml et 1 ml (jusqu'à 24 % et 13 % respectivement). Notre travail confirme ce qui, encore une fois, peut sembler intuitif : une seringue plus petite peut être plus précise lorsqu'elle contient moins de 3 ml. Nous avons constaté une variation en pourcentage plus faible de la dose / du volume administré avec les seringues de 1 ml et 3 ml. Il a déjà été démontré (Erstad, 2006; Thobani et Steward, 1992) que la taille de seringue la plus petite possible devrait être choisie. Cependant, l'utilisation de seringues non préremplies plus petites doit prendre en compte le retard causé par la préparation du médicament, à savoir le transfert des médicaments des flacons aux seringues pour une administration intraveineuse. Par exemple, les retards dépassent généralement une minute lors de l'utilisation de la méthode de décantation de médicament, à savoir le processus d'élaboration d'un volume de médicament suivi d'un diluant (Moreira, Hernandez, Stevens, Jones, Sande, Blumen et autres, 2015). Les cliniciens doivent évaluer les risques / avantages de l'utilisation plus rapide d'une seringue préremplie par rapport à une seringue plus petite mais plus précise à faible dose. De même, les fabricants pourraient envisager de créer des seringues préremplies plus petites.

Conclusion

Pour augmenter la précision de dosage, le volume d'une seringue préremplie doit être remis à zéro avant l'administration. Pour augmenter encore la précision du dosage lors de l'administration de volumes plus petits, surtout des volumes inférieurs à un ml, une seringue plus petite doit être envisagée.

Remarques de l'auteur :

1. Il est courant d'utiliser des seringues préremplies pour administrer de l'épinéphrine.
2. La précision de la distribution en volume a été mise en doute, en particulier lors de la distribution de volumes inférieurs (0,5 à 3 millilitres) par une seringue de 10 ml.
3. Cette étude a montré que l'administration de médicaments à partir de seringues préremplies est précise et rassurante.
4. Pour augmenter la précision de dosage, le volume d'une seringue préremplie doit être remis à zéro avant l'administration.
5. Une seringue plus petite doit être envisagée pour augmenter encore plus la précision du dosage lors de l'administration de volumes plus petits, surtout des volumes inférieurs à un ml.

Au sujet d'auteur

Domhnall O'Dochartaigh est un infirmier clinicien spécialisé pour les services d'urgence de la région d'Edmonton (Alberta). Ses études supérieures sont en sciences de la traumatologie. Il est également membre de l'équipe médicale aérienne (infirmier navigant) du service Shock Trauma Air Rescue. Domhnall a été rédacteur de section et expert en matière de soins de traumatologie pour le JCIU. Ses recherches portent sur les ultrasons préhospitaliers, le contrôle des hémorragies, les soins critiques et les soins infirmiers d'urgence.

Remarque : *Afin d'éviter un conflit d'intérêts, cette soumission n'a pas été traitée par les auteurs. Elle a été soumise à un examen aveugle des pairs et à une révision de la rédaction par des personnes non impliquées dans cette soumission, sous la supervision du rédacteur en chef adjoint Christopher Picard.*

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What broke me: A personal look at ED crowding and moral distress

By Laura MacKinnon, RN, BSN, ENC(c), CEN, CPEN

I sat in front of my computer on February 28 this year (2018) and started to write what I, ultimately, believed would be my resignation letter. Not just my resignation from my current job, by my resignation from nursing, in general. I had yet to complete my College of Registered Nurses of British Columbia (CRNBC) licence renewal and after my shift the day before, I was pretty sure I wasn't going back. I sat down with tears in my eyes and wrote what I felt, and I felt broken.

The events from my shift the day before still loomed over me; I hadn't slept well, I was emotional and hurting and the thought of going back to work was overwhelming. I didn't really want to quit, I love being a nurse, and I love my job in the ED, but I couldn't imagine having another experience similar to what happened on my last shift. In my mind, the events of the day before were worse than anything that I had ever experienced in my previous 11 years of nursing experience.

The thing is, the events of my previous shift weren't much different from any other day in our ED. We were busy, in the peak of another never-ending flu season and still seemingly recovering from the disaster that is Christmas time. Our department was seeing above average daily visits, baseline staffing levels were only being met 50% of the time, length of stays for admitted patients were gradually increasing with more patients being cared for in the hallways. The hospital was consistently over-capacity, with many days over 110%. With nowhere for the patients to go, they stayed in the ED. They stayed in ED for hours, sometimes 24 or more. At times, they stayed in the ED because they weren't deemed "hallway appropriate" on the medical/surgical floor they were intended to go to, yet here they were, in the hallway of the ED: no curtains, no privacy, no confidentiality, no dignity and nowhere to go. It was ultimately a simple interaction with one of these hallway patients who only needed to use the bathroom and couldn't that caused me to reconsider the path I had chosen.

Negative effects of ED crowding

Hallway nursing isn't new in this country, or emergency nursing in general, but it is the current reality even though the negative effects of ED crowding on patients are detailed and compelling. ED crowding negatively affects both admitted patients and the ED itself by "consum[ing] substantial amounts of resources and labor... prevent[ing] staff from treating the next patient, or bringing in a new patient from the waiting room" (Bernstein et al. 2006, p. 3). A 30% relative increase in the mortality rates of patients admitted through the ED is shown when ED crowding is present and hospital occupancy was greater than 90% (Spivulis, Da Silva, Jacobs, Frazer & Jelinek, 2006). The increased mortality rates were "independent of patient age, season, diagnosis or urgency" (Spivulis, Da Silva, Jacobs, Frazer & Jelinek, 2006, p. 211).

Crowding also results in delays in the administration of antibiotics, pain medication, as well as thrombolytic and percutaneous therapy in patients with AMI (Johnson & Winkleman, 2011). Along with delays in treatment, ED patients who are not admitted to hospital can also expect to spend longer in the ED when crowding occurs. White el al. (2013) report that during peak times of 1100–2300 hours, patients can expect to spend up to 23% longer in the ED before discharge. Derlet and Richards (2000) believe that public safety is at risk due to ED crowding. Crowding results in patients not getting proper assessments or reassessments by nurses and physicians, which lead to delays in diagnosis and treatment (Derlet & Richards). As ED crowding worsens and care areas fill up, patients are often treated in unconventional areas such as storage rooms and hallways (Stoklosa et al., 2018). When patients are in the hall receiving care and treatment, 78% of physicians reported deviating from their standard history taking while 90% altered their physical exam (Stoklosa et al.).

Patient satisfaction also suffers with overcrowding: patients have a higher rate of left without being seen (LWBS) and are more likely to wait longer and therefore return sicker the next time they require care (Pines et al. 2008). Not only do patient satisfaction scores drop with ED crowding, nurse satisfaction with "quality-related outcomes from nursing care" is compromised as is quality care (Johnson & Winkelman, 2011, p. 51).

Quality care underlies nursing professional standard and regardless of which province a nurse works in, they must practise to a set of standards set out by their college or regulatory body. According to the CRNBC, professional standards "provide an overall framework for the practice of nursing in BC. They set out minimum levels of performance that nurses are required to achieve" (2018, p.3). Moreover, as ED crowding worsens, patients are cared for in inappropriate areas and medications and treatments are delayed, nurses may be forced to care for patients in a manner well below the minimum standards that are demanded by their respective colleges. Patients are put into the hall because there is nowhere else to go. The hospital is full and yet sick and dying people are still coming into the ED. When patients are in the hall we can no longer meet our standards. Patients are stripped of dignity, confidentiality and respect. We take away safety measures and instead impose a new vulnerability onto the already compromised patient. Our ethics are compromised along with our standard of care.

Moral distress in the ED

Moral distress is defined by Jameton (1984) as "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Wolf et al. (2016) suggest that moral distress "arises when a nurse's internal values and perceived responsibilities are incompatible with the predominant views of the work environment

I am broken

On February 27, 2018, I worked what I would consider to be the worst shift ever in the Emergency Room. I am a nurse and I love my job. I think I'm a pretty good nurse, certainly not the best, but rest assured, if you are my patient, I've got your back. I take pride in my credentials and abilities. I have tried to better myself by taking as many courses as I can. I try to stay up to date on things, I try to meet the standards that I am sure I have set way too high. I have been an RN for more than 11 years, and an LPN for two years before that and never have I witnessed anything as heartbreaking as I did during this particular shift. To give that perspective, I have seen countless people die, of natural causes, old age, heart attacks and strokes. I have seen trauma. I have seen unspeakable things. Things most people cringe to hear about. I have asked for the organs, tissues and eyes of the dying and recently deceased before the bodies are even cold. I have watched parents collapse, as they learn that we will be stopping CPR and resuscitation efforts of their child. I have placed the bodies of dead infants back into their mothers' arms for the last time. I have handed stillborn babies to their mothers for the first and only time. I have seen bodies ripped apart, missing limbs, crushed and broken. I have seen abuse in all forms. I have carried the body of an infant in my arms to the morgue after she had her head crushed by a caregiver who threw her into a wall. I have seen what drugs and alcohol do, not just to the person who did it one time, but also to the person who is dying from a lifetime of addiction. I have been part of many conversations where patients learn they will never be going home. I have explained diseases and disease processes to patients, so they understand that their time on this earth is now limited. I have held the hands of those same patients and their families while the priest blesses them with Last Rights. I have been assaulted, by patients and their families, verbally and physically so many times I have lost count. I have found concealed weapons on patients who had intent to harm anyone in their way in order to escape police custody. I have done these things day after day, year after year, because it's been my job. I am a nurse and this is what I do, it is who I am. I have managed to separate the emotional baggage of these things from my life. They are horrible and unspeakable, but they happen… and when they do, I will be there with as much compassion and knowledge and experience as I can muster. Until last night… now I am unsure.

Our hospital is in crisis. I cannot see how anyone can dispute this. We run at or above capacity most days. With the rising population and lack of primary care for so many, this will not end anytime soon. This causes a backlog of patients waiting in the ER. It causes patients to receive care in hallways and other inappropriate care areas throughout our hospital. This is simply undignified. Lack of safety aside, imagine feeling sick and miserable lying on a hospital stretcher, in a hospital gown, in the middle of the hallway. You are on display for everyone. Everything you do is seen and heard. Every question that is asked of you is heard. Every time you vomit, everyone sees it. Every time you go to the bathroom, every one will know. There is rarely even the semblance of privacy. There are no half curtains or rolling screens in the ER, there are only open halls.

Last night, as is typical of most nights lately in the ER, the hallway was lined with patients. As I walked up the hall, I passed a man who looked like he was struggling. His IV was stretched to the limit, he was half out of the bed, he appeared somewhat agitated and confused, he had a urinal bottle in one hand and a family member on each side of him. I quickly jumped in and rescued and secured his IV site and then asked about his obvious need to use the bathroom. His family were sure that given his current state he would not be able to walk the 20 feet down the hall to the bathroom, but he was desperate to go. The patient stood in the hall next to his stretcher while his family created a curtain around him with a flannel sheet. The patient then attempted to use the urinal. I am sure that due to his level of unwellness, coupled with the awkwardness of the makeshift curtain, he was unable to use the urinal successfully. He urinated all over the floor, himself and my shoes. I lied and told him he was doing a great job, and looked to his daughter to see tears overflowing in her eyes. All she could say was "this is so wrong, no one should have to do this". I can only imagine how humiliated and embarrassed she felt for herself and her father. I cannot imagine how angry I would have been if that had been my father. All I could think about was that this level of care is substandard. This is the level of care provided in third world countries. This should not be accepted in Canada, Island Health, the Victoria General Hospital or the ER. Of all the horrible things I have witnessed, this is it, this is what has broken me.

I was reviewing our Standards of Practice when doing my license renewal.
1-4. Takes action to promote the provision of safe, appropriate and ethical care to clients.
4-2. Provides care in a manner that preserves and protects client dignity.

Every time we put a patient in the hallway we fail on these standards. The patient is stripped of their dignity, confidentiality, safety and they are left exposed and vulnerable. Not one single staff member would be satisfied to have a member of their own family treated in this manner. Why have we become so complacent as to continually accept it when it is someone else's family? I challenge you to explain why this is allowed to continue on a daily basis.

I do not know where to go from here. I do know that there needs to be a change. Soon. No more patients deserve to be treated like this. No more patients should be treated like we are in the third world. I have spent the last 24 hours questioning if I want to go back to work. I certainly don't want to, but I feel like I need to. I need to be part of the change, part of the solution. I don't have the answers, but I want to find them.

Until we all acknowledge the problem, report the problem and demand a change, there will be no change. This will become the status quo and complacency will rule. To my colleagues, I ask that you push back and report the unsafe patient care. Report that you are not able to meet your standards. Force the change. To the management, I ask that you listen and act to support your staff and the patients. Would anyone of you really be happy to be treated this way?

Laura MacKinnon, RN, BSN, ENC(c), CEN, CPEN
Staff Nurse, Victoria General Hospital Emergency

and culture" (p. 39). Episodes of moral distress were reported by ED nurses when they felt they were providing "futile care" or if care was perceived to be provided by a less than competent provider. (Fernandez-Parsons, Rodriguez & Goyal, 2013).

A small study done by Kilcoyne and Dowling (2007) showed that nurses who were forced to pull admitted patients in the ED to hallways showed moral conflict and moral distress due to being unable to carry out their role, patients being vulnerable, lacking privacy, dignity and respect and being unable to meet basic human needs. ED overcrowding and hallway nursing is typically a gradual and adaptive modification to allow daily functioning in the ED and as such staff are able to adapt slowly to this change. The normalization of these conditions may be a factor in the levels of anxiety, stress, fear, frustration a poor sense of safety and security that providers view as barriers to the nursing role (Kilcoyne & Dowling, 2007).

Lamiani, Borghi and Argentero (2017) looked at studies exploring moral distress and the work environment and found "moral distress to be associated with poor ethical climate" (p. 63). They further determined that organizational factors were consistently linked to causes of moral distress. Several of the studies reviewed by Lamiani, Borghi and Argentero reported that "as a consequence of moral distress, clinicians might experience anger, frustration, guilt... and intention to resign from a job" (p. 63).

While the feeling of powerlessness is common when discussing moral distress, Rodney (2017) suggests that this is because providers have "internalized constraints [and] they view themselves as "victims" of moral distress rather than as individuals with moral agency capable of responding positively to ethically challenging situations" (p. S8). The term moral resilience has emerged in the literature and is seen as "the capacity of an individual to sustain or restore [her or his] integrity in response to moral complexity, confusion, distress, or setbacks" (Rushton, as cited in Rodney, p. S9). If nurses are able to develop moral resiliency they may feel less powerless and victim to the situations causing moral distress. Rodney states that "with proper support—including the opportunity for self-reflection and for true collaboration with other clinicians and with colleagues in management—nurses can create a climate that promotes safe, competent, and ethical care" (p. S9).

Building resiliency

Repeated events of moral distress may result in "moral residue". Moral residue is described as "that which each of us carries with us from those times in our lives when in the face of moral distress, we have seriously compromised ourselves or allowed ourselves to be compromised" (Webster & Bayliss as cited in Wolf et al, 2016, p. 44). Epstein and Hamric (2009) describe moral residue as having a crescendo effect. Repeated, unaddressed episodes of moral distress over time cause moral residue essentially altering the threshold for new exposures to morally distressing events. After 10 years of working in the ED and experiencing these events, it took a relatively small event to evoke a massive and disproportionate response. No one died, there was no severe dismemberments or any lifelong harm. Despite that, I was affected more than any of the other things I have done in my career. I can only assume that is due to repeated events of moral distress that I now carry that with me, more so than I thought, in the form of moral residue.

When I sat to write out my resignation letter that day, I felt the frustration, guilt and powerlessness, but mostly I was angry. I angry that after 10 years seeing the lowest lows you can imagine working in an ED, that a hallway patient needing desperately to go to bathroom and unable to do so was the thing that made me want to quit. In my writing, I became angrier, more hurt and even worse, I felt let down by a system that I believed should have done better to prevent this. When I had finished my letter, I read it over and over. If I quit, I would never help another person, I would never get a chance to prevent this from happening again and I would be wasting an amazing gift. Instead of resigning, I finished my letter by challenging my organization to change. I challenged them to consider that they could do things better and finally, after long conversation with my much-more rational husband I decided that I would send my letter throughout the department I worked in and beyond to upper levels of administration. Then, with just an hour to spare, I completed my licence renewal. I would return to work, determined to do better, determined that change will happen.

My letter was surprisingly well received and I received a significant amount of positive feedback based on what I did and it shows me that I am not alone in my distress. Since sending it, I have been actively working on creating solutions and working toward change within the organization I work for. It is slow, but it's happening. It hurts me, but it is also healing. So, I did go back to work in the ED, I still love my job... most days. I still get excited to hear the sirens, to go to the trauma room, to get the IV into the three-day-old baby and pull life back from the brink of death. Speaking out in the way I did may have been dramatic to some, but for me it was my way of reclaiming moral agency and challenging institutional practices. But every time I walk up our hallway and see patients lying in our hallway, I feel the ache and I remember what broke me.

Author's take-aways

1. You are probably not alone if you experiencing moral distress, connect with those you work with about what you are experiencing and feeling.
2. Frontline staff and ED leaders need to work together, along with patient representatives, to improve the provision of care under challenging circumstances such as crowding.
3. ED nurses' proximity to patients, both physically and emotionally, leave us feeling our patients' distress.
4. Improving the quality of our workplace can improve the quality of care provided.

About the author

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Laura is an emergency nurse in Victoria BC. She has worked in EDs in four provinces and teaches TNCC and CTAS. She is a wife to the "much-more rational" Fraser, a fellow ED nurse and the mom of twin three-year-old boys. Laura is currently enrolled the Masters of Nursing program at Athabasca University.

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Healthcare workers teaching pilots: A satirical guide to breaking bad news

By Peter Brindley and Martin Beed

Commercial aviation has long been held up as the exemplar of safety and reliability. Accordingly, healthcare organizations and clinicians have enthusiastically absorbed lessons from the airline industry: whether in simulation, human factors, or crisis management. Nurses and doctors have undoubtedly benefitted greatly from the ideas of pilots and flight crews. If so, then we owe it to our less earth-bound friends to share whatever applicable lessons we have in return. We offer the following reflection on breaking bad news from our high-stakes healthcare industry back to their high-stakes aviation industry, though with tongue planted firmly in cheek.

Satire is the use of humour, irony, exaggeration, or ridicule to make a more serious point. Our goal is to caution against the appealing but specious idea that the reality of one profession can be easily translated to another. Ultimately, while healthcare should always be eager to learn from others, perhaps the best analogy for healthcare is *healthcare*. If so then the best comparator for a poorly functioning hospital might also be a high-functioning hospital not an airline. Similarly, the best healthcare insights might be gained from looking at especially patient-focused wards, and the best hospitals in which to work may be those with high staff retention. In other words, while we should always look to other industries we should also celebrate and admonish the successes and failures in our own.

Those of us engaged in education and patient safety could also use an analogy that is closer-to-home, namely medical research. Trialists create studies where the intervention group and control group are closely matched. This is because they want conclusions that are generalizable, attributable, and free of bias. If educators and administrators do not use robust analogies then we create room for excuses and inaction. Comparing aviation and medicine is a useful conversation starter but comes with insoluble differences. For example, planes do not take off during inclement weather, or until the crew is familiar. Healthcare workers do not always have the luxury of time or choice when a patient is dying in front of them.

We shall focus on a skill that is increasingly important in emergency departments, namely how to break bad news. What follows is the invitation of an apocryphal airline Captain to attend our simulation centre for a four-part course in crisis communication. Even if we accept that many verbal evaluations are not worth the paper they are written on, we offer the following potential transcript:

Session One: Structured debrief

INSTRUCTOR: So, how do you feel that went?
CAPTAIN: Rather well, I thought. I quickly got one of the nurses take the family in to the relative's room. I then clearly explained that the patient was going to die.
INST: Yes, about that. It's certainly a good idea to take the family to a quiet room before breaking bad news, and it is prudent to take a nurse along. However, we don't usually ask the nurses to double check that the door to the room is locked.
CAPT: Really? How strange!
INST: Yes, and moreover, we traditionally go into the room with the relatives, rather than talking to them through the door.
CAPT: Really…you mean you talk to the relatives face-to-face?
INST: That's correct.
CAPT: Only those from first class though. Surely you wouldn't…
INST: We don't really separate our patients by class. I suppose you could say that we consider all of our patients to be "first class".
CAPT: Really. Goodness. Well I never.
Transcript ends

Session Two: Structured debrief

CAPTAIN: Well, I for one thought that went much better.
INST: Yes, you certainly took on the suggestions from the last session.
CAPT: Indeed, I did.
INST: I have a few comments, if you're uhm ready for take-off.
CAPT: Absolutely, "chocks away" as we say.
INST: Well, if you remember, we discussed the need to give the relatives some sort of gentle opening statement. A few words that allow them to mentally prepare.
CAPT: Yes, indeed.
INST: Well I'm not sure I would go with "Brace! Brace! Brace!" I recommend going with something a little less alarming. Maybe a more soothing "I'm sorry, but I've got some bad news."
CAPT: Anything else?
INST: Well, now you mention it, having a checklist of points balanced on your knee doesn't go over well. Did you notice how they all looked a bit shocked when you ticked off the "is going to die" section?
CAPT: Well actually I don't look up when doing the checklist.
INST: And I should point out that we don't normally offer the relatives a cup of coffee until after the conversation is over. It doesn't typically help having a resuscitation team member walk in halfway with a fully loaded drinks trolley, even if it does contain, as you pointed out, complementary wine and beer plus modestly priced sandwiches for those with a valid credit card.
Transcript ends

Session Three: Structured debrief

CAPT: I must say, this breaking bad news malarkey is harder than it looks.
INST: Well, you did much better that time around.
CAPT: Well, the alterations to the scenario helped. I'm not really very good at all of the one-on-one stuff. It became much easier when I could pretend to talk to 250 passengers, all of who were

going to die within minutes.
INST: Yes, and how did you find the idea of providing time for reflection?
CAPT: I felt the fact that I then said nothing more for ten minutes gave them more than enough time to contemplate the true meaning of death.
INST: Anything else?
CAPT: Well, I felt I demonstrated empathy and compassion. After all, I was also going to die.
Transcript ends

Session Four: Structured debrief

INST: Well, we thought we'd end on a tough scenario. Would you agree?
CAPT: Yes, I never considered that one might need the passengers' agreement before initiating a flight plan.
INST: Oh yes, autonomy is very important in modern healthcare decision-making.
CAPT: But, do the passengers know anything about planes or flying … I mean nursing and medicine?
INST: I'm sorry but I'll have to stop you there. That sort of "pilot knows best" has no place in modern communication skills training.
CAPT: But there are so many passengers … I mean patients.
INST: Well, perhaps you could have asked the "passengers" to elect a spokesperson.
CAPT: But that's not what is expected in aviation law.
INST: Well yes, you see, you actually don't just need the passenger's agreement. I would also suggest you should have contacted their families.
CAPT: But it has nothing to do with them, they're not in the plane.
INST: Yes, but imagine the scenario – a passenger becomes unconscious during a flight. How would you know where they wanted to fly to? Who better than their family back home to tell you exactly where the plane needs to go?
CAPT: Uhm, yes, this communication is complicated stuff isn't it. I'd much rather just fly the plane.
Transcript ends

Perhaps in future sessions we could invite a group of clinicians to handwrite flight-plans for major airlines and then see exactly where the planes end up. We might then involve judges and lawyers in routine healthcare decision-making: what is the worst that could happen?

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- Indicate the primary person to contact and address for correspondence
- Provide five key words for indexing

2. A brief abstract is required for original research, systematic reviews and meta-analyses, of the article on a separate page of 150–250 words. The abstract should provide the context or background for the study and should state the study's purpose, basic procedures (selection of study participants, settings, measurements, analytical methods), main findings (giving specific effect sizes and their statistical and clinical significance, if possible), and principal conclusions. It should emphasize new and important aspects of the study or observations, note important limitations, and not over interpret findings. Clinical trial abstracts should include items that the CONSORT group has identified as essential. Funding sources should be listed separately after the Abstract to facilitate proper display and indexing for search retrieval by MEDLINE.

3. Acknowledgements

- Other contributing individuals and sources of research funding should appear in an acknowledgment section.

4. Body of manuscript (approximate maximum):

- Length, including tables, figures, and references:
  - new clinical practices = 8 pages, 2 tables or figures
  - research papers = 20 pages, 6 tables or figures
  - practice improvement papers = 12 pages, 4 tables or figures
  - scholarly projects = 12 pages, 2 tables or figures
  - reviews = 16 pages, 2 tables or figures
  - arts-informed scholarship = 8 pages, 2 tables or figures
  - letters to the editor = 4 pages, 1 table or figure
  - clinical case studies = 8 pages including tables and figures

Additional specific guidelines for Clinical Case Studies. Case Studies should be written in a similar format to include the following:

- Initial patient presentation
- Relevant history
- Relevant physical exam findings
- Relevant diagnostics
- Case progression
- Final case outcome
- Discussion/Teaching points
- References.

Graphics that will enhance the case study are encouraged (e.g. photos, diagrams, diagnostics).

Authors must receive, and submit, the appropriate permission from the source(s) to use such images in the final publication. Information or graphics that uniquely identify the patient may only be included if written permission is received from the patient for publication in CJEN.

Case studies usually document the management of one patient, with an emphasis on presentations that include care given in an emergency/urgent care/pre-hospital setting and involving emergency nurses and/or nurse practitioners and /or emergency pre-hospital providers. Other features that will be of interest to the reader include cases:

- that are unusual, rare or where there was an unexpected response to treatment
- where new diagnostic tools were used
- that inform readers of new treatment and management options, including relevance to emergency care practice.

5. Implications for nurses
- Provide a separate page with three to five important points or clinical/research implications relevant to the paper. These will also be published with the paper and possibly in NENA social media (e.g., newsletters, Facebook, Twitter).

6. Copyright
- Manuscripts submitted and published in the CJEN become the property of NENA.

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- Submit manuscripts electronically as a Word document to the editorial office and NENA national office (editor@nena.ca).
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Canadian Journal of Emergency Nursing Preferred Style

- Format: double spaced, 2.5 cm margins on all sides. Pages should be numbered sequentially including tables, and figures. Line numbering should be used as well.
- Prepare the manuscript in the style as outlined in the American Psychological Association's (APA) Publication Manual 6th Edition. An exception from APA is the spelling (should be current "Canadian" use where applicable).
- Use only generic names for products, devices and drugs.
- Suggested format for research papers is background, methods, findings/results, discussion, and conclusion.
- The CJEN supports the SAGER guidelines and encourages authors to report data systematically by sex or gender when feasible.
- Tables, figures, illustrations and photographs must be submitted each on a separate page after the references. Illustrations should be computer-generated or professionally drawn. Images should be in electronic form and high resolution. The CJEN is only printed in black and white copy. If you want to publish a photograph of people you must include a consent from them. CJEN will not reimburse the author for any costs incurred for permission to use a graphic for publication.

References

American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.

Heidan, S., Babor, T.F., De Castro, P., Tort, S., & Curno, M. (2016). Sex and gender equity in research: Rationale for SAGER guidelines and recommended use. *Research Integrity and Peer Review, 1*(2). http://dx.doi.org/10.1186/s41073-016-0007-6

Note

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PENTHROX™ (methoxyflurane) is indicated for short-term relief of moderate to severe acute pain, associated with trauma or interventional medical procedures, in conscious adult patients.[1]

Inhaled PENTHROX™ provides RAPID onset of analgesic activity

Expected median onset of pain relief is 5 minutes[1]

Demonstrated EFFECTIVE reduction in pain intensity score vs. placebo in adults with acute pain associated with trauma

PENTHROX™ significantly reduced mean change in VAS pain intensity score overall from baseline vs. placebo

The estimated mean change overall in VAS pain from baseline was greater with PENTHROX™ -29 mm (n=102) vs. placebo -11.6 mm (n=101) (estimated treatment effect: -17.4 mm; 95% confidence interval [CI]: -22.3 to -12.5 mm; p<0.0001).[1,2]*

Demonstrated EFFECTIVE lower worst pain overall during bone marrow biopsy vs. placebo in adults

Mean worst pain overall (the highest of two patient-rated pain scores (NRS) at two time points: pain during aspiration and pain during core biopsy) during bone marrow biopsy procedure was significantly lower for PENTHROX™ vs. placebo (4.9 vs. 6.0; p=0.011)[1,3]†

Mean worst pain score during:[1,3]

- Aspiration was significantly lower with PENTHROX™ than placebo (3.3 vs. 5.0; p<0.001)
- Core biopsy was not statistically significantly different for PENTHROX™ vs. placebo (4.5 vs. 5.4; p=0.073)

SELF-ADMINISTERED under supervision‡

PENTHROX™ should be self-administered under the supervision of a healthcare practitioner, trained in its administration, using the hand-held PENTHROX™ Inhaler.

Patients can assess their own level of pain and titrate the amount of PENTHROX™ inhaled for adequate pain control. Continuous inhalation provides analgesic relief for up to 25–30 minutes, or approximately 1 hour when administered intermittently[1]

Patients should be instructed to inhale intermittently and to take the lowest possible dose to achieve pain relief.[1]

* A randomized, double-blind, multi-centre, placebo-controlled study in the treatment of acute pain in patients with minor trauma presenting to an emergency department. A total of 300 patients (203 adults, 95 adolescents; PENTHROX™ is not indicated in adolescents) were recruited (149 received PENTHROX™ and 149 received placebo). Patients with a pain score of ≥4 to ≤7 on the NRS were eligible for the study. One to two PENTHROX™ Inhalers containing 3 mL of methoxyflurane or 5 mL of placebo was administered. The duration of the study was 16 days.[1,2]

† A phase IV, randomized, double-blind, single-centre, placebo-controlled study to evaluate the efficacy and safety of PENTHROX™ for the treatment of incident pain in adult patients requiring analgesia associated with a planned bone marrow biopsy (BMB) procedure. Forty-nine patients were randomized to PENTHROX™ and 48 patients to placebo.[1,3]

‡ Please refer to Product Monograph for complete dosing and administration information.

CI=confidence interval; NRS=numeric rating scale; VAS=visual analog score.

Clinical Use:

Due to dose limitations of a treatment course of PENTHROX™ and the duration of associated pain relief, PENTHROX™ is not appropriate for providing relief of break-through pain in chronic pain conditions. PENTHROX™ is also not appropriate for relief of repetitive pain. PENTHROX™ is not indicated for use during pregnancy or the peripartum period, including labour.

Contraindications:

- Altered level of consciousness due to any cause including head injury, drugs, or alcohol
- Clinically significant renal impairment
- History of liver dysfunction after previous methoxyflurane use or other halogenated anesthetics
- Hypersensitivity to methoxyflurane or any other halogenated anesthetics
- Known or genetically susceptible to malignant hyperthermia or a history of severe adverse reactions in either patient or relatives
- Clinically evident hemodynamic instability
- Clinically evident respiratory impairment
- Use as an anesthetic agent

Most Serious Warnings and Precautions:

- **Nephrotoxicity:** Supratherapeutic doses of methoxyflurane inhalation have been shown to lead to serious, irreversible nephrotoxicity in a dose-related manner. Dosing limitations should be followed meticulously to prevent or limit risk of nephrotoxicity. Consecutive day use of PENTHROX™ is not recommended because of nephrotoxic potential. The lowest effective dose should be administered, especially in the elderly or in patients with other known risk factors of renal disease.
- **Hepatotoxicity:** Very rare cases of hepatotoxicity have been reported with methoxyflurane inhalation when used for analgesic purposes. Use with care in patients with underlying hepatic conditions or having risk factors for hepatic dysfunction. PENTHROX™ must not be used in patients who have a history of showing signs of liver damage after previous methoxyflurane use or halogenated hydrocarbon anesthesia.

Other Relevant Warnings and Precautions:

- Potential CNS effects
- Administer with caution in elderly patients with hypotension and bradycardia due to possible reduction in blood pressure
- Drug dependence
- May influence the ability to drive and operate machinery
- Do not administer concomitantly with alcohol ingestion
- To reduce occupational exposure to methoxyflurane, the PENTHROX™ Inhaler should always be used with the activated carbon chamber to adsorb exhaled methoxyflurane
- Local skin reactions or irritation to the eyes and mucous membranes
- Exercise caution if administering to a nursing mother

For More Information:

Please consult the Product Monograph at http://purdue.ca/en/products/Penthrox-PM for important information relating to adverse reactions, drug interactions, patient counselling, and dosing/disposal information (regarding the total maximum dose for a single administration or over the first day of treatment, in a single 48-hour period and entire treatment course) which have not been discussed in this piece.

The Product Monograph is also available by calling us at 1-800-387-4501.

References:

1. PENTHROX™ Product Monograph. Purdue Pharma. April 6, 2018.
2. Coffey F, et al. Methoxyflurane analgesia in adult patients in the emergency department: A subgroup analysis of a randomized, double-blind, placebo-controlled study (STOP!). *Adv Ther*. 2016;33(11):2012-2031.
3. Spruyt O, et al. A randomised, double-blind, placebo-controlled study to assess the safety and efficacy of methoxyflurane for procedural pain of a bone marrow biopsy. *BMJ Support Palliat Care*. 2014;4(4):342-348.

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