SARS (Severe Acute Respiratory Syndrome): reflective practice of a nurse manager

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Aims and objectives. This paper describes the reflective practice of a nurse manager in Hong Kong in supporting frontline nurses to overcome the crisis of SARS.

Background. SARS infection was a crisis for everyone in endemic areas because of its threat to physical and emotional health. Hong Kong was the second leading endemic area in the world. Inadequate supplies of protective devices and the death of a nurse infected with SARS triggered nurses’ negative emotions.

Methods. A model of structured reflection was adopted to examine one’s practice. A problem-solving model for crisis intervention was integrated into the reflective stage of structured reflection.

Results. Promotion of nurses’ safety and emotional stability were the major goals in handling the crisis. Strategies were employed including self-awareness, empowerment and team building, information sharing, provision of personal protective equipment and emotional support for frontline nurses.

Conclusions. SARS infection threatens the physical and emotional health of nurses. From a positive perspective, such a crisis created an opportunity to learn and grow in terms of ethical, personal and aesthetic arenas.

Relevance to clinical practice. SARS epidemic raised worldwide attention and challenged the Hong Kong’s health care system. Reflective practice is useful to guide and examine nurses’ professional action during the crisis, and to put the experience into a learning perspective.

Key words: crisis intervention, Hong Kong, nurse manager, reflective practice, SARS, structured reflection

Introduction

Severe Acute Respiratory Syndrome (SARS) is a newly emerged infectious disease that is highly contagious and is associated with significant morbidity and mortality (Ho 2003). On March 12, 2003, the WHO issued a worldwide alert for SARS (Seto et al. 2003). Within 4 months, 8436 infected cases and 812 deaths were reported in 32 countries (WHO 2003). Indeed, Hong Kong was the second leading endemic area in the world. By July 2003, there were 1755 infected cases and 299 deaths of SARS in Hong Kong (WHO 2003). SARS was also a tragedy for health care professionals. A total of 341 Hong Kong health care workers were infected and six of them died (Hospital Authority 2003).

SARS is a viral illness caused by a coronavirus. There is evidence that some Asian animals carry viruses similar to the virus that causes SARS (Torpy 2003). These animals may have been the origin of the SARS virus that affects humans.
Symptoms of SARS include fever, shortness of breath, cough, muscle aches and malaise. In some individuals these symptoms may progress quickly to extreme shortness of breath and respiratory failure. This may require oxygen treatment with a mechanical ventilator and high-dose steroids. Unlike influenza or some other viral illnesses, there currently are no vaccinations or immunizations available to prevent SARS.

The SARS endemic upset the order and normal functioning of the whole of Hong Kong society (Thompson 2003). Worldwide travel advisories and alerts were in force to identify individuals at risk of developing SARS. Quarantines were imposed as a public health measure to stop the spread of SARS. Schools were closed; hospitals needed to be evacuated; visitors were prohibited in hospitals; and mask wearing became a public practice. Many lives were lost and hundreds of children became orphans.

More than 22% of SARS cases in Hong Kong were among health workers. The public hospital system carried enormous strain as a result of shortage of staff and increased patient load (Parry 2003). Many nurses were deployed to different settings and worked extra hours (Thompson 2003). In the earlier stage of the outbreak, frontline nurses were not supplied with adequate protective clothing (Parry 2003). As a result, a local newspaper launched a campaign to raise fund of HK$3.43 million from the public, enough for only 17 days supply of protective clothing (Parry 2003).

Because of the life threatening nature of SARS and the increasing workload, frontline health workers were at risk of occupational stress (Chan & Chan 2003, Thompson et al. 2004). Nurses in my ward started to grumble in the midst of the SARS outbreak. Negative emotions of fear, worry and guilt emerged and a real threat to physical safety existed. Some nurses practiced self-quarantine for the fear of spreading the disease to family members, and this caused frustration and feeling of isolation. As a nurse manager working at the middle management level, I sensed the tension and urgency to handle the staff’s stress reactions, as Shilling and Brackbill (1987) reported that exposure to occupational stress contributes to employee burnout, acute and chronic health conditions, poor staff morale and reduced job performance. Without proper management of their stress, nurses might give up their role in the so-called ‘historical battle of SARS’ (Chan & Chan 2003).

This paper describes the authors’ use of reflective practice in supporting frontline nurses to fighting against SARS. Reflection is usually initiated when uncomfortable feelings and thoughts are sensed in a unique situation (Hancock 1999). The word ‘reflection’ originates from the Latin verb reflectere that means ‘bend’ or ‘turn backwards’ (Hancock 1999). Boyd and Fales (1983) defines reflection as a process of internally examining an issue of concern triggered by an experience, and creating and identifying personal meaning of the experience. The concept of reflective practice has been developed in nursing practice as a vehicle to enable nurses to articulate and learn from their work experience (Hancock 1999). As Schon (1987) argued, professionals are less likely to solve problems by making reference to academic knowledge but are more likely to refer to their own ‘theories in use’ that are gained from working experience.

The process of reflection was guided by one model of structured reflection suggested by Johns (1992, 1994a) that consisted of a series of highly structured questions. For examples, what is the ‘here and now’ experience? What was I trying to achieve? What were the consequences of my action? Johns (1994a) suggests that reflection can be a painful experience and a difficult task without expert guidance and support. Through the structured guidance provided by John’s model, the practitioner’s sense of awareness, reflectiveness, and commitment can be nurtured. This model aims to tune the practitioner’s experience into a structured and meaningful one, therefore enabling the reflective practitioner to make sense of and subsequently learn from their experience (Johns 1994a).

This paper reported my first-hand reflective experiences during the SARS outbreak including both reflection-in-action (thinking as practice occurs) and reflection-on-action (retrospective thinking about the experience). The paper begins with the description of the key stages of the structured reflection process: description of an experience, reflection, and learning (Johns 1994a). Within the stage of reflection, strategies adopted to handle the crisis were guided by Aguilera’s (1990) problem-solving model for crisis intervention. Finally, learning from reflection is discussed in terms of ethical, personal and aesthetic arenas (Carper 1978, Johns 1994b).

Description of the experience
Reflection always begins with the ‘here and now’ description of an experience (Johns 1994a). The significant background and factors that contributed to the experience are identified. In the early days of SARS outbreak, the tragedy was limited to one epicenter, the Prince of Wales Hospital. Nurses in my ward felt sorry for those sick colleagues but none of us were adversely affected by the disease. The outbreak only served as a hot topic for nurses’ gossip at that time.

With SARS infection quickly spreading out to the community and hospital levels, the sudden closures of schools and hospitals upset many nurses’ personal, family, social and career lives. Nurses were experiencing many challenges. These included the absence of proven treatment and reliable diagnostic technology of SARS, the risk of personal safety,
the shortage of personal protective equipment (PPE) and the psychological trauma resulted from the death of the first infected nurse who lost his life on duty. A series of emotional responses were elicited among nurses. Stress, anxiety, anger, agitation and frustration were manifested in their conversations.

Reflection

The reflection stage of the structured reflection model examines what a practitioner was trying to achieve, the rationale for and the evaluation of one’s action (Johns 1994a). Equally important to the cognitive element of reflection is the emotional aspect concerned with the recognition of the practitioner’s feeling about the experience when it was happening (Johns 1994a). Due to knowledge deficit and uncertainties about SARS infection, as a nurse manager, I was anxious and I felt further stressed in facing my colleagues’ negative emotions. I was tempted to escape from the role of leader. Conflict arose when I felt shameful for the thought of escaping and at the same time felt angry regarding my innocence and helplessness. On reflection, I rekindled my sense of courage and responsibility to tackle this great challenge, but I was still overwhelmed by a lack of confidence. I was confronted by an imbalance between the difficulty of a problem and my available repertoire of coping skills; a crisis was then precipitated (Aguilera 1990).

The awareness and identification of a crisis motivated me to plan my steps ahead. I used the general problem-solving model of crisis intervention to handle this crisis (Aguilera 1990). Aguilera’s model highlights the processes of filtering (attention aroused and self-awareness); cognition (problem sensed and structured); production (answer generated); and evaluation. The model guided me to delineate what I was trying to achieve, and provided a rationale to support my actions and outcomes for evaluation.

Referring to the process of filtering (Aguilera 1990), I commenced with assisting nurses to have a better understanding of the situation through talking about their feelings and concerns (Aguilera 1990, Rowe 1999). Group chatting during tea breaks and meal times on the issues related to the outbreak of SARS was encouraged. I took an initiative to share my own feelings of fear, anger, stress and helplessness in facing the threats of SARS. Nurses then appeared to feel safe and comfortable in expressing their thoughts and feelings. Individual’s emotions and concerns were being acknowledged. Such an interactive self-awareness approach helped us to minimize the pain and shock when our inner-self was disclosed (Rowe 1999).

The self-awareness process enabled us to identify and structure common problems. On top of our own health risks, most nurses felt anxious and guilty for being a potential SARS carrier that might expose their families and friends to the life threatening disease. We soon reached the cognitive stage of the Aguilera’s model and agreed that staff safety and protection against SARS was the first priority that deserved immediate action. The need to address emotional distress was also highlighted. With clear visions and goals, nurses’ attitudes appeared more positive and hopeful towards the challenge of SARS, as they knew that they could participate in decision-making and the implementation of strategies.

After the process of filtering and cognition, we seemed to be able to generate answers for enhancing physical safety and emotional support. We discussed and agreed to implement the following strategies: empowerment of nurses and team building; enhancement of personal protection; sharing of information; and emotional support.

Empowerment of nurses and team building

I realized that empowerment of nurses and team building was an essential first step as this was not a crisis that I could handle alone. Empowerment is a process of giving and accepting power in order to liberate people from their oppressive circumstances (Taylor 2000). All nurses, including senior and junior ones, were encouraged to participate in decision-making, such as the design of the infection control setting; and the selection and purchase of PPE. Nurses were empowered by delegations of responsibility to implement infection control measures in the ward. In all management decisions about infection control, nurses’ feedback and comments were welcomed and addressed.

To make best use of individual resources, I acted as a coordinator among the team to promote communication, reduce duplication of effort and generate synergistic effect by combining efforts from each team members. Nurses, regardless of their differences in seniority and academic preparation, were motivated to contribute their up-to-date knowledge, expertise and precious practical experience to control the spread of the disease. Nurses shared the agreed tasks willingly and learnt to accommodate individual differences in practice without compromising the standard of care. Some nurses used their own time after work to set up the infection control setting. Several nurses cancelled their preapproved annual leave to let the pregnant nurses to take a special paid leave during the SARS outbreak. All these voluntary acts demonstrated group cohesiveness and good team spirit among nurses.
Enhancement of personal protection

Practical measure to secure staffs’ protection against SARS was a primary concern. A case–control study in five Hong Kong hospitals revealed that participants wearing PPE (masks, goggles, gloves, gowns) and practicing hand-washing were less likely to develop SARS than those who did not use PPE (Seto et al. 2003). Efforts were made to secure different models and sizes of PPE to meet nurses’ safety needs. Unfortunately, the progress was delayed due to financial and administrative obstacles. Initially, goggles were not supplied for nurses due to material shortage. After several negotiations, the expenditures for goggles were finally met by cash rewards from a Hospital Continuous Quality Improvement Programs.

In the first batch of isolation gown supply, we found a serious problem of water infiltration. Due to the public media’s influence and collective efforts by nurses from other hospitals reporting similar water infiltration problem of the isolation gown, the management eventually provided new water-resistant gowns for nurses. Besides, we successfully arranged bathing facilities in the ward, because the nursing team suggested that bathing after each duty within the hospital could minimize the possible transmission of SARS viruses from hospital to family and to the community. All these requests might be viewed as demanding by resource-holders, but I believed that the frontline nurses deserved adequate protection and, most importantly, a workplace in which they could feel safe.

Sharing of information

At the early stage of the outbreak, guidelines and policies on the management of SARS infection were limited (Ku 2003, Thompson et al. 2004). Ku (2003) reported that nurses had received hourly change of instructions on the use of PPE and this created confusion and frustration. We were very concerned in obtaining accurate and updated information, such as development of possible treatment alternatives, infection control policy and personal protective measures. Relevant information was announced daily to all nurses and the information notes were updated and compiled for easy and quick reference. Nurses were nominated to attend relevant training sessions on the proper use of PPE, infection control policy, cleansing and disinfecting procedures. Some nurses were even arranged to attend intensive care unit (ICU) training as the growing population of SARS patients heightened the demands for ICU nurses. In attending open forums on the SARS epidemic, nurses could share the experience in caring for and treating SARS infected patients in different hospitals in Hong Kong and overseas. Our nurses reported that they found themselves more knowledgeable and confident in the management of SARS infection after they had attended these training courses and discussion forums.

Emotional support

Handling nurses’ emotions was a big challenge for me. Besides the expected response of stress, spikes of anxiety occurred when infected colleagues were intubated for mechanical ventilation. One nurse said to me:

I met him (an infected colleague) in the lobby a few days ago, but now he is lying in an ICU bed with severe dyspnoea. I never think of death since I am still young, but suddenly death seems to be so near to me.

Both of us were silent. I nodded my head to acknowledge her feelings and patted her on her shoulder. Listening offered a good way of supporting staff in this situation.

Soft and relaxing background music was played in the ward because music, as an aesthetic and symbolic medium, has the ability to alleviate fear and anxiety (Stevens 1990). Steven’s study further demonstrated the usefulness of music to act as a distracter and to increase the patients’ thresholds of pain. I felt that music could be beneficial to both patients and nurses.

Informal group discussions of feelings and concerns among nurses were encouraged to prevent emotional isolation and to increase self-acceptance (Eads et al. 2000). Nurses felt more relaxed and relieved after they expressed their ultimate fear and concerns. Besides, I shared with them the information that in Canada, nurses caring for SARS patients also exhibited reactions of uncertainty, anxiety, anger and frustration (Maunder et al. 2003). This helped nurses to normalize their feelings and reactions, as normalizing specific fear might help us to minimize emotional discomfort (Eads et al. 2000).

To announce to nurses the death of the first nurse victim with SARS infection in Hong Kong and in our hospital, was the toughest time I had ever experienced. Nurses burst into tears. One nurse hid in a treatment room and cried. I offered nurses time and space to stay alone and grieve, or encouraged them to attend the prayer meeting if they were religious. Duty re-arrangement was made as one nurse expressed her wish to help the bereaved family to prepare for the funeral. Nurses in my ward collected donations for the bereaved family. Although it was a small sum of money, we all felt better with an opportunity to show respect to the deceased.

Evaluation of strategies

Eventually, Hong Kong reported zero infection on June 12, 2003. We then entered the final process of evaluation of crisis
management. All the proposed strategies of new infection control setting; provision of special uniforms; bathing facilities and good quality protective wears were finally approved for implementation by the Hospital Infection Control Audit Team. We all felt excited and felt that this approval and recognition was rewarding. Due to financial and administrative constraints, some measures were not implemented timeously; for example, the late supply of goggles and water-resistant gowns. Furthermore, due to environmental constraints, the location of bathing facilities was inconvenient for nurses. Nevertheless, the ultimate result of controlling the infection was regarded as successful as no colleague in our ward was infected with SARS.

Nurses expressed their appreciation to each other in managing the SARS epidemic. Nurses celebrated the outcome of crisis management as their collective achievement. Team spirit was evidenced by nurses’ greater flexibility, cooperation and commitment to their nursing roles. Nurses, including myself, felt more confident and motivated, as we were not alone in the management of the highly infectious and life threatening disease.

Learning from reflection
The final stage of structured reflection is to put the experience into a learning perspective (Johns 1994a). This stage enables the practitioner to look back and link the experience with the past, and to project to one’s future practice. The crisis of SARS outbreak provided good opportunities to observe the occurrence of unpredictable challenges in our health care system. On reflection, the traditional requirements of a nurse leader, such as technical skills, knowledge, expertise and specialization (Tahan 2000) were no longer adequate especially in times of a worldwide crisis. As a nurse manager, my learning from this reflective practice can be examined in terms of ethical, personal and aesthetical arenas (Carper 1978, Johns 1994b).

Ethics
Ethics are the beliefs and values about people and society that served as conscious guidelines for action (Brammer 1988). I encountered ethical dilemmas in the decision of overcoming or escaping from the fear of SARS, and in handling the water infiltration problem of isolation gowns. I have learnt the importance of duty-based reasoning and rights-based reasoning in decision-making (Marquis & Huston 1996). Through the duty-based reasoning, some decisions are made because we have a duty to do something or to refrain from doing something (Marquis & Huston 1996). I learnt that a leader has a duty to master fear and challenge (Weiland 1998). And through rights-based reasoning (Marquis & Huston 1996), I learnt that all nurses have the rights to work in a safe environment. Failure to report the problem of water infiltration to top management would have deprived nurses from their rights for safety needs. Although I worried about the breakdown of my relationship with top management, I was assured that I had made the right decision in reporting the problem of water infiltration and advocating for new water-resistant gowns. This experience reinforces my commitment to follow ethical principles in future practice.

Personal
The SARS crisis created an opportunity for me to enhance knowing of self in guiding my practice. I know that I am a person with a reasoning mind and a strong sense of responsibility. The belief of justice and righteousness is the core value that guided my decision-making and subsequent acts.

Emotionally, I tended to conceal my feelings so I did not allow myself to cry and be saddened for the death of the colleague. Accumulation of blocked emotions created further tension and accelerated the rapid development of a sense of failure. Therefore I was tempted to withdraw much earlier than other colleagues. I learned that a successful leader needs a strong sense of self-awareness and self-esteem in order to take risks, to learn, and to be truthful to self (Sofarelli & Brown 1998). I could have dealt with the situation better if I had better awareness of my emotions and provided myself with proper means to express my grief.

My loss of confidence was also an obstacle for being a good leader. Indeed, when I was tempted to give up my role as leader in the early stage, nurses in my ward encouraged me not to give up. I appreciated their support and care and experienced the return of my confidence through supportive teamwork. Nurturing a supportive team and building of personal confidence have become my goals in my career life.

Aesthetics
Nurses’ aesthetic qualities are sometimes referred to as the art of nursing (Ganner 1996). Sensitivity, intuition, honesty, caring, trust, empathy and teamwork are needed to use aesthetics in practice. A strong sense of courage and responsibility is also essential as nurses are always accountable to our clients and our colleagues (Kerfoot 1999).

My nursing sensitivity and intuition heightened my uncomfortable feelings towards the SARS outbreak and my
issues in clinical nursing

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Colleagues’ reactions to the crisis. Honesty was demonstrated by nurses’ disclosure of their personal thoughts and feelings. Abstract notions of caring, trust and empathy were exercised through the empowerment of nurses and emotional support to each other. Caring was put into practice by the provision of updated information, provision of PPE and infection control device. The use of silence, touch and the provision of time and space to grieve fostered the establishment of empathy and mutual respect in a nursing team. Furthermore, I gained first-hand experience of the importance of empowerment and team spirit in nursing management. They serve as the most powerful strategies in dealing with the disease, financial constraints, environmental limitations, and emotional distress. Before the SARS outbreak, the art of nursing was just some abstract ideas to me but now it has become my own ‘theories in use’.

Conclusion

The SARS epidemic in 2003 has ended. It is unclear whether SARS will return in the near future. The use of reflective practice facilitates myself to analyse the difficult circumstances, and to make meaning out of the experience. In Chinese characters, the term crisis is formed by ‘danger’ on one side and ‘opportunity’ on the other side (Weiland 1998). From the dangerous aspects of the SARS outbreak, SARS infection threatens our physical and emotional health. We suffered from emotional distress with fear of infection and death. We lost one nurse infected with SARS and subsequently another five health care professionals died. From a positive perspective, such a crisis created an opportunity for me to learn and grow. We got the opportunity for better understanding of our values, responsibilities, and personal strengths and weaknesses. Through the process of reflective practice, I acquired practical experiences of the essential qualities and duties of a nurse leader – courage, empowerment, and team building. Team spirit, mutual support, and empathy among nurses are precious experiences for the whole team. These are the most treasured harvests that can go beyond the fear of SARS infection.

Contributions

Study design: PYL, CWHC; data analysis: PYL, CWHC; manuscript preparation: PYL, CWHC.

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