Despite the statistics and surveys that tell us most patients would prefer to die at home as they did in the 1930s, many patients are now dying in hospitals and extended care facilities. Death, in effect, has become very distant from the home and shared experience with loved ones and family. In the acute care environment, it is challenging at best to personalize the experience for the dying and their loved ones, especially in an environment that tends to make death more of an “exercise in technology.” In fact, the view of Western medicine is to consider death as a “failure” of the very technology we possess to keep patients alive. A significant challenge for the medical-surgical nurse is to master support and care for the dying, even though this may not be an area of comfort or expertise. As health care professionals, we are bound to respect the individual differences of culture, race, and spirituality, along with each individual’s values and goals of care.

Though the aforementioned information is quite important in the care of our patients, there is one common thread of paramount importance. Each of us has our own set of beliefs about and experiences with dying and death that we bring to every situation. As it is for each of our patients, the source of these beliefs and values can be the result of positive and negative experiences, cultural influences, and spiritual beliefs. Nurses must be aware of how these factors may influence our own approach and attitude for the dying and their families.

The Culture of Dying

Culture is a main component of life. It is shaped by ethnic heritage only in part; however, this can be a significant influence on views of death and how to care for the dying. This is once again an area where our personal beliefs can be influential in our actions in caring for patients. It is unreasonable to expect all nurses to know every aspect of every culture, and similarly, all patients’ views of death and the afterlife. From a practical perspective, it is important to be familiar with cultures that may be separate from our own and that exist...
We’ve Come a Long Way!

The Academy of Medical-Surgical Nurses is 15 years old! Those of you who attended the convention this year know that we celebrated the birthday in style. At the convention, some of you learned about the history of AMSN, but since some of you could not attend, I wanted to share some of that history with you.

A Steering Committee comprised of Sally Brozenec, Cecelia Gatson Grindel, Annette Levitt, Beverly Ann McGuffin, Peggy Miller, and Alice Poyss met in Philadelphia in 1991 to form AMSN. They signed an agreement with Anthony J. Jannetti, Inc. for association management services. Medical-surgical nurses across the country were very excited to have a nursing organization that recognized the specialty of medical-surgical nursing. Under the leadership of AMSN’s first president, Alice Poyss, more than 2,000 nurses joined AMSN the first year. Many of those nurses attended the first annual convention, which was held in Chicago in 1992. During the same year, MEDSURG Nursing: The Journal of Adult Health was launched and became AMSN’s official journal, with Marilyn Fetter serving as its first editor.

Under the leadership of Cecelia Gatson Grindel, AMSN’s second president from 1993-1994, membership grew to nearly 3,000 nurses. Wanting to recognize excellence in medical-surgical nursing, the first annual Clinical Practice Award was presented at the convention in Washington, D.C.

Under Sally Russell’s leadership from 1994-1995, the Core Curriculum for Medical-Surgical Nursing was published, which provided a comprehensive resource for professional nursing practice. In addition to the presentation of the Clinical Practice Award, the first annual Clinical Leadership Award was presented at the annual convention in Anaheim, CA.

Annette Levitt, president from 1995-1996, discussed the importance of active involvement in professional nursing organizations. She also stressed the need to collaborate with the media and provide public education to improve the image of nurses as patient advocates, educators, and caregivers.

I remember the AMSN president from 1996-1997, Karen Spann, quite well. She presided over the annual convention in San Antonio, my hometown. Karen discussed health care reform and focused on the nurse being the link between the patient and a changing health care environment. Karen liked to have fun, too, and she asked us to dance during opening ceremonies. I remember much laughter during that time. Karen passed away on January 7, 2006. She was a wonderful nurse and leader who will be greatly missed.

continued on page 9
What Is Myelodysplastic Syndrome?

Kathy Lattavo, MSN, APN, BC, CMSRN, RN, C

Abstract

Myelodysplastic Syndrome (MDS) is a group of rare hematological disorders characterized by hyperproliferation and ineffective hematopoiesis. This disorder results in peripheral blood cytopenias of one or more blood cell lineages. This article utilizes a case study to discuss the pathophysiology and care of a patient with MDS.

Have you ever cared for a patient with myelodysplastic syndrome (MDS) and tried to remember just exactly what that meant? MDS is a group of rare hematologic disorders. Characteristics include hyperproliferation and ineffective hematopoiesis resulting in peripheral blood cytopenias of one or more cell lineages. This causes an increased risk of transformation into acute myeloblastic leukemia. Patients are at increased risk for infection, bleeding, and hypoxia due to functional abnormalities (Kurtin, 2006).

MDS occurs primarily as a new onset. Between 15,000 and 20,000 new cases are diagnosed yearly. The number of cases is expected to increase as the population ages. Currently, the median age of patients is 70 (Memorial Sloan-Kettering Cancer Center, 2006). It is apparent that Ms. Smith has several risk factors for MDS, most notably previous treatment with chemotherapy and radiation.

Pathophysiology

How does MDS develop? The exact cause is unknown, but agents that damage deoxyribonucleic acid (DNA) or impair DNA repair increase the risk of developing MDS (Rothstein, 2003). All blood cell lines are derived from the same basic stem cell, which is able to self-replicate and is responsible for the replication and differentiation of all cell lines. With MDS, there is a malignant transformation at or close to the point of stem cell differentiation resulting in cell lines arising from an altered clone. This abnormal clone leads to dysmaturation of cell lines and pancytopenia.

MDS has been considered a geriatric syndrome because it is so closely associated with aging (Rothstein, 2003). The blood system of a healthy elder, who is not subjected to stress such as blood loss or infection, is very similar to that of a younger adult (Rothstein, 2003). It has been demonstrated that blood cells of older humans are not replaced as quickly as those of younger people during periods of stress. It is also believed that DNA repair is not as effective in the elderly. The elderly may also display more subtle manifestations of common toxicities and illnesses because aging can cause functional deficits in multiple organ systems (Kurtin, 2006). Treatment can be delayed and more complex due to these differences.

Patient Scenario

Sue Smith, a 60-year-old female, is admitted to the hospital for a tooth extraction prior to a bone marrow transplant. She was diagnosed with MDS approximately 6 months earlier. She has been dependent upon red cell and platelet transfusions since that time. Her past history includes breast cancer that was treated with a mastectomy, high dose chemotherapy, radiation, and stem cell transplant. She is admitted as an inpatient for extraction of an abscessed tooth and to stabilize her anemia, thrombocytopenia, and leukopenia.

**Risk Factors**

Several risk factors are associated with MDS. These factors include age greater than 60 years, occupational exposure to benzene, previous chemotherapy and radiation therapy, and HIV (Kurtin, 2006; Rothstein, 2003). It is important to remember that about 10% to 20% of cases are related to treatments such as chemotherapy or radiation. Medical-surgical nurses can be expected to care for more patients with MDS because of the aging population, improved diagnostic capabilities, and current treatment protocols (Kurtin, 2006).

**Pathophysiology**

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**Figure 1. Calculation of Absolute Neutrophil Count**

\[
\text{ANC} = \text{Total White Blood Cell (WBC) count} \times \% \text{ neutrophils (segs)} \\
+ \% \text{ bands}
\]

(This information can be obtained from a CBC with a differential.)

OR

\[
\text{ANC} = \text{Total WBC count} \times \% \text{ neutrophils}
\]

(This information can be obtained from a CBC without a differential.)

Example: Mrs. Smith’s admitting labs were WBC = 1600, neutrophils = 1%, bands = 3%

\[
1600 \times (1\% + 3\%) = 1600 \times 4\% = 1600 \times 0.04 = 64
\]
The basic function of white blood cells (WBCs) is to fight infection. Five types of WBCs exist: neutrophils, lymphocytes, monocytes, eosinophils, and basophils. Each type represents a percentage of the total count (100%). The type most important in MDS is the neutrophil, the first line of defense against infection. Neutrophils digest bacterial organisms and debris. Bands or “stabs” are immature forms of neutrophils. An increase in “bands” is called a shift to the left and occurs with acute infections (Marrs, 2006).

### Signs and Symptoms

MDS cannot be definitively diagnosed except with a bone marrow sample (Memorial Sloan-Kettering Cancer Center, 2006). Signs and symptoms of MDS include 1) anemia, 2) thrombocytopenia, and 3) neutropenia. Anemia is the usual symptom and requires a referral to a specialist for a patient with MDS (Kurtin, 2006). Anemia can cause fatigue, malaise, weakness, shortness of breath, pallor, chest pain, tachycardia, dizziness, and fainting. A hemoglobin less than 10 g/dL is generally indicative of anemia. Ms. Smith’s admitting hemoglobin was 7.6 g/dL.

Ms. Smith was admitted to the emergency department a week before this inpatient admission with a platelet count of 70,000/mm³ and bleeding gums. Thrombocytopenia can be evidenced by a platelet count less than 100,000/mm³, increased bruising, petechiae, nose bleeds, bleeding gums, bloody stools, or hemorrhage from wounds. Approximately 25% to 45% of patients with MDS experience thrombocytopenia (Kurtin, 2006).

An absolute neutrophil count (ANC) represents the number of mature WBCs in circulation (Marrs, 2006). An ANC less than 1,000/mm³, fever, and bacterial infections are indicative of neutropenia. Neutropenia occurs in more than 35% of patients with MDS (Kurtin, 2006). Ms. Smith’s admitting ANC was 64/mm³ (see Figure 1). She also had a positive culture for cytomegalovirus.

### Table 1. Precautions for Cytopenias

<table>
<thead>
<tr>
<th>Anemia</th>
<th>Thrombocytopenia</th>
<th>Neutropenia</th>
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<tbody>
<tr>
<td>Cluster activities</td>
<td>Avoid/assess alterations in skin or mucus integrity</td>
<td>Neutropenic diet (no raw fruit, salads, vegetables, fish or shellfish)</td>
</tr>
<tr>
<td>Allow frequent rest periods</td>
<td>Apply pressure to injection or phlebotomy site for at least 5 minutes</td>
<td>Hand washing for everyone having contact with patient</td>
</tr>
<tr>
<td>Limit stimulation/activities as needed</td>
<td>Provide a well-balanced soft diet</td>
<td>No visitors/health care providers with infections, colds, or flu</td>
</tr>
<tr>
<td>Assess for signs and symptoms of hypoxia</td>
<td>Teach patient/family how to check for signs and symptoms of bleeding</td>
<td>Teach patient/family about signs and symptoms of infection</td>
</tr>
<tr>
<td>Small, frequent meals</td>
<td>Clarify any medication orders, such as aspirin or NSAIDs</td>
<td>Avoid invasive procedures, if possible</td>
</tr>
<tr>
<td>Provide foods high in protein and iron</td>
<td>No IM injections</td>
<td>No IM injections</td>
</tr>
<tr>
<td></td>
<td>No enemas, rectal suppositories, or rectal temperatures</td>
<td>No enemas, rectal suppositories, or rectal temperatures</td>
</tr>
<tr>
<td></td>
<td>Assess bowel function; avoid constipation</td>
<td>Assess bowel function; avoid constipation</td>
</tr>
<tr>
<td></td>
<td>Discourage use of razors or firm toothbrushes</td>
<td>No live plants, flowers, or potted plants</td>
</tr>
<tr>
<td></td>
<td>Communicate thrombocytopenia precautions to others</td>
<td>Communicate neutropenia precautions to others</td>
</tr>
<tr>
<td></td>
<td>Patient should wear mask when out of room</td>
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</table>
Although all of Ms. Smith’s assessment parameters were within normal limits at the time of admission, it is imperative that the medical-surgical nurse recognizes abnormal assessment findings associated with MDS. Assess the skin and mucous membranes for pallor, cyanosis, bruising, inflammation, exudates, erythema, and bleeding. Note the rate and character of respirations. Inquire about shortness of breath, dyspnea, cough, and sputum production. Auscultate all lung fields for adventitious breath sounds. Ask about activities of daily living. Watch trends in vital signs for indications of infection, fever, hypoxia, or anemia (Leon & Pase, 2004). Monitor lab values for decreased hemoglobin, increased mean corpuscular volume (MCV), decreased reticulocyte count, differential white blood cell counts, and platelet counts (see Table 1).

**Treatment**

Treatment for MDS is generally supportive. Goals of treatment include 1) improved quality of life, 2) minimized toxicities, 3) increased blood counts, and 4) prolonged life (Kurtin, 2006). Supportive treatment can consist of the following: antibiotics, transfusions of packed red blood cells (PRBC) and platelets, hematopoietic growth factors, interferon, hormone therapy, chemotherapy and differentiation-inducing agents. Aminocaproic acid (Amicar®) or other antifibrinolytic agents may be indicated for refractory bleeding (Kurtin, 2006). Newer agents are being developed specifically for the treatment of MDS. Azacitidine (Vidaza®) was approved in May 2004 as the first active agent for treatment of MDS (Kurtin, 2006). Lenalidomide (Revlimid®) is approved for the treatment of transfusion-dependent anemia (Kurtin, 2006). Clinical practice guidelines, developed by the National Comprehensive Cancer Network (NCCN), were published in July 2004 (Kurtin, 2006). An allogeneic bone marrow transplant is the only known curative treatment.

Ms. Smith received one unit of platelets and two units of irradiated cytomegalovirus negative leukocyte-depleted blood products on her third post-op day. She was transfused with 2 units of PRBCs and an additional 2 units of platelets on an outpatient basis 9 days after her first transfusions. Clindamycin 600 mg IV was administered every 8 hours during her hospital stay. She was discharged from the hospital on the fourth post-op day. At this time, her lab values were as follows: hemoglobin – 9.1 g/dL, hematocrit – 26.2%, WBC – 1,800/mm³ (ANC = 180/mm³), and platelets – 75,000/mm³.

**Summary**

The medical-surgical nurse can anticipate caring for more patients with MDS for a number of reasons, most notably an aging population. It is important to monitor lab values and signs and symptoms associated with MDS. Assessment and care are essential in prevention, identification, and education for our patients and families.
Certification demonstrates that you have taken the extra step to validate your knowledge and skills. To become certified, you have several options. The purpose of this article is to describe the differences in the three certification exams offered in medical-surgical nursing by two different organizations, MSNCB and ANCC.

The Medical-Surgical Nursing Certification Board (MSNCB) is a partner organization with the Academy of Medical-Surgical Nurses (AMSN) and is the credentialing board for CMSRN certification. The CMSRN exam is the only medical-surgical nursing exam developed exclusively by medical-surgical experts and endorsed by AMSN, the specialty nursing organization for medical-surgical nurses. RNs who successfully complete the examination are awarded the CMSRN (Certified Medical-Surgical Registered Nurse) credential. This credential clearly identifies your specialty as medical-surgical. RNs with bachelors and associate degrees, as well as diplomas, may earn the CMSRN credential; there is no differentiation in your level of education.

MSNCB and the CMSRN credential are relatively new. In 1999, AMSN members loudly voiced their need for AMSN to provide a medical-surgical certification exam. The CMSRN exam blueprint was written by a task force comprised of staff nurses, nurse managers, clinical nurse specialists, and a faculty advisor. The pilot exam was offered during the AMSN Annual Convention in 2002. The first official exam was given in May 2003. As of October 2006, just a little over three years since the initial exam, we are proud to announce that there are over 5,000 CMSRNs.

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association (ANA) and is the credentialing body for ANA. ANCC currently offers two exams for medical-surgical nurses with passers receiving the credentials RN, BC; or RN, C. The BC stands for board certified and can be earned by an RN with a bachelor's degree or higher. The C stands for certified and is awarded to an RN with an associate degree or diploma in nursing (ANCC, 2003). The credentials RN, BC and RN, C are also used for other specialty designations through ANCC, such as geriatrics, vascular, and ambulatory care nursing. Beginning in January 2007, several changes will occur. ANCC, after conducting a job analysis survey, has determined that the role of the medical-surgical nurse does not differ at the bedside based on education. Therefore, there will only be one exam and one credential, BC. The “C” credential will no longer be used. Anyone successfully passing the ANCC medical-surgical exam will earn the BC credential. Another change will be computerization of the exam.

Both MSNCB and ANCC are among the 40 boards/centers that offer certification examinations in various nursing specialties. All of these boards offer nationally standardized examinations that are prepared using accepted testing standards (Standards for Educational and Psychological Testing, 1999), published jointly by the American Educational Research Association, American Psychological Association, and the National Council on Measurement in Education.

A large number of nurses are certified by boards other than ANCC. Examples of these certifications include CCRN for critical care nursing, BCEN for emergency nursing, and OCN for oncology nursing. Some certification bodies offer exams in the same specialty. Both ANCC and the National Certification Board for office-based Nurse Practitioners (ONMC) now offer a single exam that results in the ANCC Board Certified (BC) credential.

<table>
<thead>
<tr>
<th>Table 1. Eligibility Requirements for Certification</th>
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<tr>
<td><strong>MSNCB</strong></td>
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<tr>
<td>RN with a current license in the U.S. or any of its territories</td>
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<tr>
<td>Have practiced two (2) calendar years as an RN in an adult medical-surgical clinical setting</td>
</tr>
<tr>
<td>BSN, AD, or Diploma earn CMSRN</td>
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</table>
| Have accrued a minimum of 3,000 hours within the past 3 years of practice in an adult medical-surgical clinical setting as a staff nurse, clinical nurse specialist, clinical educator, faculty, manager, or supervisor | Have a minimum of 2,000 hours clinical practice within last 3 years **
** Faculty: 500 hours of faculty teaching or clinical supervision may be used toward practice requirement
** Students may use up to 500 hours of time spent in academic program of nursing study toward clinical practice requirement |
| No contact hour requirement for certification | 30 contact hours within the last 3 years |
Corporation (NCC) offer exams in neonatal care. ANCC and NCBP (National Certification Board of Pediatric Nurse Practitioners and Nurses) each offer an exam in pediatric nursing. Exams in medical-surgical nursing are offered by both ANCC and MSNCB.

Many of the certification boards are members of the American Board of Nursing Specialties (ABNS), the “board of boards” (similar to the National Board of Medical Examiners). ABNS also accredits nursing certification boards. Both MSNCB and ANNC each produce quality exams that are psychometrically and legally sound. While ANCC has completed the process to have its medical-surgical nursing certification exams accredited through ABNS, MSNCB is still in the application process, which will be completed in 2007. Accreditation is a voluntary process that endorses the examination and the certification board, just as earning certification in your specialty is a voluntary process that validates your knowledge in the specialty.

MSNCB contracts with the Center for Nursing Education and Testing (C-NET) to administer its testing function. C-NET coordinates the development, maintenance, and administration of the CMSRN exam. ANCC employs its own testing experts to create its certification exams.

Table 1 shows the eligibility requirements to take the MSNCB and ANCC exams. Table 2 compares the exam and recertification fees for the medical-surgical nursing certification exams offered by MSNCB and ANCC. Individuals who take the MSNCB exam receive a discount if they are members of AMSN. Those who take the ANCC exams receive a discount if they are members of ANA. The membership discounts also apply to recertification. Table 2 also compares the exam and recertification fees along with the respective membership dues. All certifications are valid for 5 years.

Rewards of Certification

Top 5 rewards of certification:
• Validate your advanced clinical knowledge in medical-surgical nursing.
• Feel pride in your professional accomplishment.
• Increase your earning power and job satisfaction.
• Receive peer and collegial respect.
• Protect the public through expert patient care.

Why Should I Choose to Become CMSRN Certified?

Here are 8 reasons:
1. The CMSRN credential clearly identifies the certification as medical-surgical nursing.
2. This program recognizes all RNs, regardless of education preparation.
3. It is the ONLY medical-surgical certification program endorsed by the Academy of Medical-Surgical Nurses, the specialty nursing organization dedicated exclusively to medical-surgical nursing.
4. It is the least costly certification in medical-surgical nursing for both certification and recertification.
5. Contact hours are not required for initial certification.
6. In addition to staff nurses, certification is offered to clinical educators, faculty, managers, clinical nurse specialists, and supervisors.
7. The exam questions are 100% clinically based.
8. The exam is written and reviewed by practicing medical-surgical nurses.

For more information about becoming certified through MSNCB, visit AMSN’s Web site (www.medsurgnurse.org) and click on “Certification.”
Too often, nurse executives and nurse faculty talk and operate in separate silos. It is critical – both for the future of nursing education and patient care – that they begin partnering and talking with each other. With the dawn of the nursing shortage upon us, it’s time to break the old paradigms, build new ones, and create and sustain meaningful dialogue and partnerships between service and academia.

Nursing Economic$: The Journal for Health Care Leaders has been a valuable resource for nurse executives and faculty, publishing a wide variety of articles that aim to advance nursing leadership in health care by providing information on current and emerging best practices. With its target audience of nurse executives, nurse managers, nursing educators, and other health care administrators, the editor, contributors, and publisher of Nursing Economic$ have taken two initiatives for conquering the divide between nursing executives and faculty.

Nursing Economic$ Summit: March 1-2, 2007

“Bridging and Partnering: Nurse Executive/Nurse Faculty Divide” is the theme of the First Nursing Economic$ Summit, an innovative and interactive two-day seminar, being held March 1-2, 2007, at the Hyatt Crystal City, Crystal City, Virginia. This Summit will bring together influential nurse decision-makers from hospitals (VPs, CNOs, DONs) and schools of nursing (Deans and Faculty) of all sizes, as well as community-based agencies and curriculums.

The goals of the Summit are to:
- Strategize immediate and long-range nurse executive and nurse faculty partnerships.
- Identify best practices in financing, goals, relationships, and skill sets.
- Develop skills to partner and re-establish relationships in a competitive marketplace for individuals and institutions.

You and your strategic teammates are invited to attend and participate in this meaningful and important endeavor.

CNOs and COOs: Bring your dean and clinical director teams. Deans: Bring your faculty and clinical and community partners.

A dynamic faculty, including Connie Curran (Editor, Nursing Economic$), Karlene Kerfoot, Pat Starck, Linda Cronenwett, Karen Drenkard, and other nursing leaders will present on the following topics (to name a few):
- Building Strategic Partnerships.
- Financing Cost of Nursing Education per Student.
- Quality and Safety Education for Nurses.
- Evidence-Based Leadership in Services and Academia.
- Benefits of Partnerships.

Quality exhibit time has been integrated into the Summit for attendees to interact with the leaders in the clinical and academic marketplace to further enhance new networks, skills, and ideas. An Opening Reception, Continental Breakfast, Coffee and Refreshment Breaks, and a Luncheon are provided in the Summit package.

What to Bring to the Summit
- One best practice that your team has built together
- Business cards
- A willingness to build partnerships

What You’ll Gain from Attending
- Knowledge about accessibility to access
- Best practices that you can steal shamelessly
- Web-based integrative resources
- Strategies for developing and maintaining critical partnerships and networks
- New networking opportunities
- Information resources

The Summit is hosted by Nursing Economic$: The Journal for Health Care Leaders, whose multidisciplinary Editorial Board is dedicated to bridging the gap and building partnerships between nurse executives and nurse faculty.

For more information or to request a registration brochure, contact us at 856-256-2429 or nejrnl@ajj.com, or visit www.nursingeconomics.net
President’s Message  
continued from page 2

Continued competence of the medical-surgical nurse was emphasized by Cindy Ludwig, AMSN president from 1997-1998. Cindy wrote about the nursing shortage and encouraged a proactive approach to maintaining appropriate staffing levels and high-quality care. Cindy continues to remain active on AMSN committees and was the most recent recipient of AMSN’s President’s Award for her continued commitment to AMSN.

AMSN’s Web site (www.medsurgnurse.org) was developed during Randy Whitney’s term as president from 1998-1999. In addition to the development of the Web site, The Cookbook for Chapter Success was published. From a clinical perspective, Randy helped remind us to always focus on the patient and family.

During Sharon Gothberg’s term as president from 1999-2000, the Online Services Committee was created because the AMSN Board of Directors recognized the growing technology trend, and therefore, the importance of the Web site. Sharon spotlighted the issue of safe staffing – an issue of major concern today. Under Sharon’s leadership, student and associate membership categories were added to encourage more participation within the organization. Medical-surgical nurses were very excited to celebrate Medical-Surgical Nurses Day for the first time on November 1, 2000.

I had the privilege of serving on the Board of Directors with the remaining presidents. With Marlene Roman, the bylaws were amended to change the term of office for the president from 1 year to 2 years. Marlene was the first president to serve a 2-year term from 2000-2002. The Nurses Nurturing Nurses (N3) Mentoring Program was introduced. I was honored to serve as the N3 Program Coordinator until 2005. “Nurses Nurturing Nurses” was adopted as AMSN’s tagline and was incorporated into the official logo. In February 2002, the Board of Directors approved moving forward with the development of a medical-surgical nursing certification exam. A certification task force was formed, and a blueprint was designed. In addition, AMSN News was renamed MedSurg Matters.

Doris Greggs-McQuilkin served as president from 2002-2004. Under Doris’s leadership, the first Certified Medical-Surgical Registered Nurse (CMSRN) exam was administered in May 2003, with 702 nurses passing the exam. Doris had a dream to establish a foundation that would assist nurses in their endeavors to support professional development and leadership skills. During Doris’ term, the AMSN Research and Scholarship Fund of the Nursing Economic$ Foundation was established. The Board of Directors also changed its structure from a regional model to a knowledge and strategic-based model. With this model, more individuals, especially committee chairs and members, are more involved in the work of the organization.

I have been privileged to be mentored by Cecelia Gatson Grindel, president from 2004-2006. Cece, as we fondly call her, is the only AMSN president to be elected to a second term. With Cece’s guidance, the Board of Directors implemented the new strategic plan. AMSN’s 14th Annual Convention was rescheduled from September 22-25 in New Orleans to October 27-30 in Las Vegas because of the devastating effects of Hurricane Katrina. AMSN had a record attendance of 696 attendees at the 14th Annual Convention. Nurses affected by the hurricanes were recognized at the convention. During Cece’s 2-year term, membership grew from 3,800 to an all-time high of just over 6,000! The Scope and Standards of Medical-Surgical Clinical Nurse Specialist Practice was developed and published. The Nurses Nurturing Nurses Online Mentoring Program was introduced. Most recently, the AMSN Foundation kicked-off fund-raising activities to match a $10,000 gift from Cece and her husband.

Multiple energetic, visionary, and tireless leaders have contributed to the success and growth of AMSN as the professional nursing specialty organization dedicated to adult health/medical-surgical nurses. Issues addressed by previous AMSN presidents, such as health care reform, safe staffing, and the nursing shortage, are once again prominent in today’s medical-surgical practice. With an excellent, hard-working, and dynamic Board of Directors, we will continue to move forward with AMSN’s strategic long-range plan and address issues affecting medical-surgical nursing practice. We look forward to working with you throughout 2007. Happy Holidays to you and your family!

Kathleen A. Reeves, MSN, RN, CNS, CMSRN  
President

MedSurg Matters welcomes news from AMSN members. If you have a news item or article that you would like published, send it along with your name, address, phone number, and other comments/suggestions to: Carol Ford, Managing Editor; East Holly Avenue/Box 56, Pitman, NJ 08071-0056 Fax: 856-589-7463, Email: fordcc@ajj.com

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<tr>
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**Crucial Conversations: Tools for Talking When Stakes Are High**

Crucial Conversations: Tools for Talking When Stakes Are High was written by Kerry Patterson, Joseph Grenny, Al Switzler, and Ron McMillan (2002). These four authors have an extensive background in teaching and consulting on leadership topics. They also co-authored Crucial Confrontations: Tools for Resolving Broken Promises, Violated Expectations, and Bad Behavior (McGraw-Hill 2004). Crucial Conversations: Tools for Talking When Stakes Are High is an excellent book and a must-read for nurses.

Many nurses are not comfortable addressing situations that require crucial conversations. Many nurses assume management will eventually take care of the problem, or else if ignored, it will just go away. This book teaches the reader how to hold crucial conversations. What is a crucial conversation? The answer to this is simple. Crucial conversations are those day-to-day conversations that can affect one’s life.

When a delicate subject comes up, there are three ways of handling the conversation: avoid the subject completely; face the issue (but handle the conversation poorly); or face the issue and do it well. Sometimes, the conversation can go very well, and crucial issues can be addressed. Most of the time, though, emotions get in the way. The sympathetic nervous system activates – so as blood is flowing to one’s arms and legs, it is not flowing to the critical thinking areas of the brain (because the brain is busy gearing up for a fight or flight). The conversation is not completely thought-out, and the participants may yell, resort to sarcasm, or say things that might be regretted later. Sometimes a simple conversation can turn crucial, and if participants are not prepared, it can turn ugly. The authors list a number of situations that can become crucial conversations, including ending a relationship, discussions about money, discussions about behaviors, discussing issues related to or with “ex-es,” giving criticism to a colleague or a supervisor, and getting or giving unfavorable feedback.

When one masters the skills of crucial conversations, a choice does not need to be made between being honest and being effective. This skill allows both. The authors state that the ability to hold a crucial conversation will allow dealing with controversial or risky issues in a way that does not compromise honesty or our effectiveness.

The idea behind crucial conversations is to allow people to address pressing issues in a way that solves the problem without creating new problems. When issues happen, members of the group are comfortable stepping up to address them, and the recipients of feedback do not feel threatened or challenged by it. The way a situation is addressed makes the difference between creating a relationship of resentment and anger, or a relationship built on mutual trust.

Patterson et al. (2002) tell us that there is one thing people need to know to become skilled at crucial conversations.

“When it comes to risky, controversial and emotional conversations, skilled people find a way to get all relevant information (from themselves and others) out into the open” (p. 20). That is the key to holding crucial conversations – getting important information out into the open.

This book provides clear steps to learning how to initiate and complete a crucial conversation. Many relevant examples are given to help the reader understand the concepts presented. If these skills are practiced regularly, the reader might find that it can be life-changing. Practice, practice, and more practice can help these skills become habits, and the reader can learn to become an expert at holding crucial conversations.

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**Reference**


**Additional Reading**


**Research Corner**

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presented at the annual San Antonio Breast Conference. Additionally, the results of this trial are so persuasive that currently, every oncology surgeon in the United Kingdom is being trained in SNB. Within the United States, an evidence-based guideline from the American Society of Clinical Oncology (Lyman et al., 2005) recommends sentinel lymph node biopsy as an appropriate alternative to axillary dissection for women with early stage breast cancer and clinically negative axillary nodes. These guidelines also emphasize that the clinical significance of isolated cancer cells detected by detailed pathological examination of sentinel nodes is unknown.

**Jane E. Lacovara, RN-BC, CMSRN, MSN, CNS**
**MEDSURG Nursing Editorial Board Member**
**AMSN Research Committee Member**

**References:**


**Additional Reading**

Moments that Matter

During the 15th Annual Convention in Philadelphia, we asked you to share your favorite med-surg nursing stories via the AMSN Web site. Here are a few that have been submitted. To submit your story, visit www.medsurgnurse.org

Turning Points

One memory stands out among all others as a life and career-changing moment. I was a young manager and was called upon to discharge an employee for excessive absenteeism. I followed the hospital's policy to the letter when I called her into my office. I then proceeded to tell the employee bluntly that she was discharged effective immediately, giving her no time to explain about her absences or discuss her personal issues leading up to “her problem.”

After the then-former employee left my office, I called Human Resources to report how the meeting had gone. My office window overlooked a river and a busy bridge spanning both sides of the banks of the river. I can remember vividly watching traffic cross the bridge and smugly commenting to HR that “everything went perfectly” when I suddenly stopped in mid-sentence and screamed, “Oh no! She's jumping!” The employee that I had just terminated so coldly had climbed to rail of the bridge and jumped into the deep and dangerous swirling water of the river below.

As a new manager, I stood on the bank of the river and watched as rescue workers reached the woman, pulled her to safety, and revived her. All the time, though in shock, I couldn't help replay the meeting over and over again in my mind, asking myself what I could have done differently that might have avoided this former employee’s desperate action. Later, I visited the employee in her hospital room and asked her what drove her to jump from that bridge. Tearfully the woman explained about the personal issues that were going on in her life stating, “My getting fired showed me that my life was hopeless.” I spent several hours with this woman talking about her problems. I was sickened at my cold and callous actions. I realized that if I had taken the time to talk and really listen to the employee when she first started getting into to attendance problems, her life and job performance might have turned out totally different. By early intervention, active listening skills, and problem-solving, I, as a manager, could have made a real and positive difference in this woman’s life.

This incident was a major turning point in my focus as a manager. I began looking at my employees as co-workers and individuals with individual strengths and weaknesses. Good communication and problem-solving skills became important tools to my being an effective manager. Over the years, I found that there are very few employee work performance problems that cannot be improved or changed just by active listening and problem-solving with the employee. After all, being an effective manager is all about treating individuals as you would want to be treated.

– Rebecca A. Zimmerman

Defining Moments

My first knowledge that I had to be a nurse was 30 years ago, when I was a nurse assistant. I stood at the bedside of a dying old lady, and when I held her hand, I squeezed her hand to give emotional support. Even though she could not speak or see, she squeezed my hand back. It was a very defining moment for me. I knew from that moment on, I needed to be at the bedside of the patient.

– Diane R. Rodriguez

Lifting Spirits

I was a care coordinator primarily working with inpatients who were diagnosed with cancer and HIV. I loved working on the Oncology Unit. We were a tightly knit, multi-disciplinary team. My job was coordinating a smooth transition to home, wherever that may be. We had a male patient with leukemia, and the staff knew him well as he had multiple admissions, and most of his stays were quite lengthy. He was in protective isolation, and we wanted to lift his spirits. He worked at a Harley Davidson dealership and missed his buddies and the sounds of the “hawgs.” I called his friends at work, and we made a plan for a group of guys from his work as well as a Harley Club to do a “DRIVE BY.” I informed Administration and Security that a group of Harley Davidson riders would be coming through the hospital campus and sitting outside the room where our patient was staying. We coordinated that he would be looking outside the window with one of the nurses when the group of riders arrived. They revved up those motorcycles and waved. It was the best feeling to be outside the hospital and see our patient looking out the window to witness all these great guys. They did a little salute, revved their engines, and rode off. It has been a few years since that happened, and this patient has lost his courageous fight with leukemia. I will never forget him or his friends.

– Trish A. Weaver

Becoming an Expert Nurse

There are two memories that really stand out for me in my career, one from the beginning and one from the middle. As a new graduate nurse, I realized that I had made the transition to being a “real” nurse when the instructor came to me for advice on how to handle a patient situation one of her students was dealing with on my unit. As a unit-based educator, I was orienting a new nurse to medication administration. Someone called out from one of the rooms asking for help. When I walked into the room, I took one look at the patient and said, “Call the doctor, she is having a PE.” When the orientee asked me how I had known (I was right about the PE), I realized that I couldn’t give her anything specific, it was just a gut feeling. I realized then what they mean when they say expert nurses
The Joy of Nursing

I have worked in a 135-bed community hospital for nearly 22 years. For 15 years, I worked as a staff nurse. For the past 6 years, I have worked as the Assistant Director of the 28-bed Surgical Unit. During this time period, I have met many wonderful people and their families. One of the individuals with whom I worked will always maintain a special place in my heart and will forever influence the type of care that I provide.

Andy was a special man with a loving, devoted, and caring family. At the time of admission, he was 69 years old, had been feeling fatigued, was experiencing shortness of breath, and had developed some slurred speech and mild facial drooping. He came to our floor in April 2001 after developing a pneumothorax sustained during a diagnostic lung biopsy for a pleural mass. At the conclusion of the procedure, he was taken to the emergency room, and a chest tube was placed to resolve the pneumothorax. He was then brought to our unit for nursing care and observation.

Andy was understandably anxious, in a great deal of pain, and somewhat angry that the pneumothorax had occurred after what he viewed to be as a simple procedure. He was also frustrated because the radiologist who performed the initial biopsy had advised him that only a small sampling of tissue had been obtained prior to the lung collapse. He now accurately surmised that not only had his lung collapsed, but that the procedure would probably need to be repeated to obtain a more adequate specimen for pathologic review, staging, and treatment purposes. His wife and two children were with him, and everyone had a lot of questions to ask and concerns to voice. They asked the staff nurse to talk to someone “in charge.” I, being the Assistant Director of the unit, arrived to the room, armed with only the basic information that was available at the time of admission. Upon entering the room, I felt tension emanating from everyone present. What concerned me most was the tremendous pain and fear that I read on Andy’s face. I saw a man, curled onto his side, splinting his chest with his hands, and taking shallow painful slow breaths. When I asked him about his pain level, I was met with a firm stare. I assured Andy and his family that I would return shortly to discuss their concerns, but wanted to mediate him to alleviate his discomfort. They agreed and appeared relieved to see me return promptly with the promised pain medication. After administering the medication, I spoke quietly with Andy and his family, orienting him to his room, the unit, and to care routines. I completed my assessment of his physical status, positioned him for comfort, brought him something to drink, and asked them how I might help them to understand his plan of care and ongoing treatment options. As Andy and his family were relieved by my efforts to make him more comfortable, they began to ask questions. Over the course of the next two hours, the beginning of a special relationship formed between Andy, his family, and me. I found a man and his family who were desperately afraid and seeking information. I certainly didn’t have all of the answers that they were seeking. I did answer their questions, provide reassurance, offer comfort measures, and listen to their fears. During the next 11 days, Andy had a multitude of diagnostic tests and became prepared for the battle that he would face over the next 30 months. An MRI of the brain revealed a parietal mass. A bronchoscopy yielded an adequate lung tissue sampling and provided the final diagnosis. Andy had inoperable lung cancer that would only be relieved with chemotherapy and radiation for palliative purposes. The cancer had already metastasized to his brain. I purposely made rounds with the specialists who saw him daily. I wanted to ensure that I had every piece of information available to me to help update his family as well as to understand the ramifications of every test result. I supported Andy and his family as they struggled to understand as well as agree to more testing. I explained tests and procedures, often using the same words that the doctors had used, but which they seemed to understand better from me. I never did try to influence their decisions but only to ensure that they had all of the information available to make their own informed decisions.

I saw Andy and his family several times over the next 30 months. He stopped by the unit when he was in for chemotherapy treatments or needed blood specimens drawn. He always had a smile for me, even during the bad times. Andy was readmitted to our hospital’s medical unit with uncontrollable seizures in January 2004. I stopped by every day to check on him. He didn’t know me then, but his family remembered me. Andy’s wife and I talked about Hospice and that was the first time I heard her say, “He’s not going to make it.” He died later that week. I attended the visitation at the funeral home. His wife said, “You were always there for Andy, helping us work through the bad days. We were able to cherish the time that we had left together and do some of the important things that truly counted.” Andy and his family reinforced my theory that effective communication is one of the most essential aspects of nursing care that I can provide. Even though what I told them wasn’t always what they wanted to hear, I provided them with information that enabled them to make the best decisions they could during a difficult, trying time. I also found that with all of the busy administrative tasks that I complete, my heart and soul remained at the bedside caring for patients and their families. Andy reaffirmed my joy in nursing. I will always treasure the moments that I spent with him.

– Mary K. Barlett

Congratulations!

Tammy Richardson, BSN, CMSRN, Treasurer of the AMSN Metro Carolina Chapter #225, was honored earlier this fall as one of the “Great 100 Nurses” of North Carolina. This is a tremendous accomplishment, and we congratulate Tammy for this recognition of her dedication to nursing!
From MSNCB: Understanding Exam Exemption

Certification demonstrates that you have taken that extra step to validate your knowledge and skills. The Academy of Medical-Surgical Nurses (AMSN) and the Medical-Surgical Nursing Certification Board (MSNCB) encourage you to continue to show your commitment to excellence in your medical-surgical practice. Are you currently certified through another certification board? And is it time for you to renew that certification? I have some exciting news! You may be eligible for recertification by Exam Exemption as a medical-surgical nurse through MSNCB without retaking a certification exam. All you would need to do is to meet four criteria.

To begin, you must submit a copy of your current certification in medical-surgical nursing from another certifying body prior to your current certification expiration date, or up to six months after this date (there is a late fee attached).

The second criteria is that you hold a current and unrestricted license to practice as a registered nurse (RN) in the United States or any of its territories. You would also qualify if you hold a current, full, and unrestricted license to practice as a first-level, general nurse in the country in which your general nursing education was completed, and meet the eligibility criteria for licensure as an RN in the United States in accordance with the requirements of the Commission on Graduates of Foreign Nursing Schools.

Third, there is a minimum of 3,000 hours of practice experience as a staff nurse, clinical nurse specialist, clinical educator/faculty, case manager, manager, or supervisor. These hours must be obtained over the previous five-year certification period. The hours average approximately 600 hours of practice per year. Two of the last five years need to be in a medical-surgical setting.

The final criteria would be to have 90 approved contact hours (CH) of continuing education over the past five years. Seventy-five percent, or 68 contact hours, must be in the medical-surgical nursing specialty. Contact hours may be obtained by completing an approved educational offering, by authoring or co-authoring a book or chapter in a book, or by being a preceptor. It’s very important to keep a detailed record of your continuing education activities. Requirements for continuing education for the next certification cycle begin at the time of your recertification date.

Once you have submitted your packet, the decision for recertification by exam exemption is based solely on the materials you have submitted. Certification will then be good for a five-year period and will expire at the end of the month in which you were originally certified. Random audits of applications are conducted to ensure candidates are eligible for recertification, and you may be required to submit additional materials verifying experience or contact hours. When you have been approved, you will receive a pin, certificate, and a wallet card showing that you proudly earned the title of Certified Medical Surgical Registered Nurse (CMSRN).

Mary Behr, CMSRN
Secretary, MSNCB

EXAM DATES and LOCATIONS

May 5, 2007 • October 13, 2007

Scottsdale, AZ  Rochester, NY
Los Angeles, CA  Charlotte, NC
San Diego, CA  Cincinnati, OH
San Francisco, CA  Cleveland, OH
Denver, CO  Portland, OR
Hartford, CT  Philadelphia, PA
Deerfield Beach, FL  Pittsburgh, PA
Orlando, FL  Columbia, SC
Atlanta, GA  Memphis, TN
Honolulu, HI  Nashville, TN
Chicago, IL  Dallas, TX
Indianapolis, IN  Houston, TX
Boston, MA  San Antonio, TX
Lansing, MI  Alexandria, VA
Kansas City, MO  Charlottesville, VA
St. Louis, MO  Richmond, VA
Omaha, NE  Virginia Beach, VA
Freehold, NJ  Seattle, WA
Albuquerque, NM  Spokane, WA
St. Paul, MN  Tacoma, WA
Stony Brook, NY  (given the following Sunday)
New York, NY  Milwaukee, WI

Certified Medical-Surgical Registered Nurse (CMSRN) is the earned credential recognizing that the highest standards of medical-surgical nursing practice have been achieved. You can become certified by successfully completing the MSNCB examination.

Exams are offered at the above locations. Additional sites may be added for 10 or more candidates. Local sites are subject to cancellation for insufficient registration. Contact C-NET for information, 800-463-0786.

For more information and submission deadlines, contact:

MSNCB Certification
c/o C-NET; 601 Pavonia Avenue, Suite 201; Jersey City, NJ 07306; Phone: 800-463-0786 • Fax: 201-217-9785
E-mail: garbin@cnetnurse.com
Assisting Patients

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among the patient population for whom we are providing care. Perhaps the best approach in all situations is to take the time to ask. Once the question has been asked, it is important to take the time to listen. Though this may seem fundamental, there is no better way to be sure the care we provide is respectful and appropriate for each patient.

Despite what cultural differences may exist, more often than not, there is a common belief about the next phase of the journey or the afterlife. Learning what is acceptable or perhaps unacceptable in the care of the dead can be essential in ensuring the proper care of the patient as well as the family and loved ones.

Planning for Death

For many of us, the understanding of the term advanced care planning is limited to asking the question, “Do you have an advanced directive?” then filling in the “yes” or “no” box on the mandatory form. Advanced care planning can be in written or verbal form, and it can be detailed or abstract in nature. As caregivers, it is vital that we are aware of any details that are outlined in the advanced directive about treatment goals and specifics of care that the patient may request during the dying process. Karen Ann Quinlan and her case surrounding the “right to choose” led the way to the Patient Self Determination Act of 1990. This law requires us to ask for the existence of an advanced directive; this is the “letter” of the law, and it is our obligation to then move toward the “spirit of the law” and respect the detailed wishes of our patients regardless of our own beliefs.

Stages of Death

There are three distinct phases of the dying process as defined by the activity of the brain. In the neocortical stage, which occurs early, the part of the brain that can feel pain and pleasure, and experience emotion is no longer active. When the upper brain no longer functions, the patient is no longer aware of surroundings or sensation; some say this is the “coma” before death. The cerebral portion of the brain now takes over with the activity of the brain stem. Breathing becomes erratic and the heart rhythm is irregular. Finally, there is lack of activity in the whole brain, and death occurs.

The timing of the phases of the dying process can be very difficult for loved ones; however, much comfort and encouragement can be brought to those who are present. It is an opportunity to reassure the family that their loved one is not suffering once the upper brain is no longer functioning and physical awareness is absent. Nurses must be sensitive and aware that those close to the dying person are also in need of care. Thus, if the family expresses distress with the patient’s condition during the dying process, nurses must be ready to support them with reassurance and interventions to ease the discomfort for all, not just the patient. The death experience affects not only the patient but also the family. The influences of nurses, as strong as they may be, cannot interfere with the experience. As caregivers, nurses must be respectful of what is required for all of those involved.

Grieving

Once death has occurred, grieving becomes the next step in the process. As mentioned previously, culture can play a significant role in death, so it is for the process of grief. Many are familiar with the work of Dr. Kubler-Ross and the stages of grief. A different perspective on the grieving process is provided by Worden (1991) with the described four tasks of mourning:

- Accepting the reality.
- Working through the pain.
- Adjusting to the environment.
- Emotionally relocating the deceased.

However, as the mourner proceeds through the evolution of grief, it is significant to remember that each person is an individual, and therefore, each process unique. Often, we are challenged by the desire to choose just the right words, when in truth there are no “perfect” words or phrases. We are cautioned to avoid phrases such as, “It was God’s will,” or “You should be happy she is out of her misery.” The best approach is once again to actively listen and keep our expressions of sympathy simple and heartfelt. There are occasions where words are not necessary, a touch of the hand or gentle hug say more than words ever could.

It is also important for nurses to remember that as caregivers, we can be a part of the grieving process for those entrusted to our care. We cannot exclude our emotions in the care of the dying. It is not only acceptable, but it is comforting to share tears with those who mourn for their lost loved one. This is “being present” in the moment. Those “firsts” (such as holidays, birthdays, and anniversaries) during the first year after the death has occurred can have significance for those closest to the patient as well as nurses and caregivers.

There are many situations that will result in complicated grief. Some examples of this include deaths as the result of violence, accidents, or suicide. Death as the result of AIDS can also be viewed as a source of complicated grief as it is often unexpected, traumatic, and devastating to loved ones. It is important to note that grief can be very different for different cultures. For example, in many Asian cultures, it is important for families to be present during the dying process in order to show respect and honor the deceased.

It is also important for nurses to remember that as caregivers, we can be a part of the grieving process for those entrusted to our care. We cannot exclude our emotions in the care of the dying. It is not only acceptable, but it is comforting to share tears with those who mourn for their lost loved one. This is “being present” in the moment. Those “firsts” (such as holidays, birthdays, and anniversaries) during the first year after the death has occurred can have significance for those closest to the patient as well as nurses and caregivers.

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Members of the AMSN Research Committee regularly read research articles and select areas of interest to the medical-surgical nurse. Jane Lacovara recently read an important study regarding sentinel lymph node biopsy and this column highlights that research paper.

Did You Know...?

Did you know... that a sentinel lymph node biopsy (SNB) has changed the way axillary lymph nodes have been evaluated for the last 100 years? With the advent of sentinel node biopsy, the incidence of lymphedema in the breast cancer population is decreasing. Sentinel lymph node removal is better than complete axillary dissection with regard to lymphedema, range of motion, quality of life, and sensory loss for node negative patients as demonstrated by the Axillary Lymphatic Mapping Against Nodal Axillary Clearance (ALMANAC) trial in the United Kingdom (Fleissig et al., 2006).

Sample and Procedure

A prospective study of 1,033 patients were randomized to the SNB group or the standard axillary treatment group, and were followed over 18 months with repeated quality-of-life measurements at the 1, 3, 6, 12, and 18-month periods after surgery, as well as one baseline measurement prior to surgery. The participating patients completed the Functional Assessment of Cancer Therapy for the breast and the Spielberger State/Trait Anxiety Inventory tools to compare their perceived outcomes and their quality of life. The patients were less than 80 years of age and were clinically node negative with invasive breast cancer.

Results

Patients in the SNB group did better in terms of functional well being than the patients in the standard treatment group, which showed a greater decline in function and a longer recovery period. In addition, the patients undergoing SNB did not show greater anxiety levels than the patients randomized to the standard axillary treatment. At the post-surgery 18-month measurement, approximately twice as many patients in the standard group (14%) versus the SNB group (7%) reported lymphedema or numbness on the affected side.

Conclusion

There have been many studies where SNB has been compared with axillary dissection where objective physical characteristics of the arm have been measured, such as circumference, but the patient’s arm morbidity and quality of life were not measured. Many patients who experience lymphedema report an annoying sensation or numbness that may not be evident in an objective physical measurement of the arm. This multi-center trial was so important that it was pre-

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they sought but were so often unable to find. Many adults also search for this same honesty and look to us as health care professionals to be truthful, gentle, caring, and present with them as they grieve.

Denise Verosky, MS, CMSRN, is Director, Nursing Education and Research, University of Pittsburgh Medical Center, Pittsburgh, PA.

Note: The information included in this article is taken from the content of the presentation by Nancy Bordine, BSN, RN, at the 2006 AMSN Annual Convention in Philadelphia. We thank her for her significant contribution to building our knowledge of caring for the dying and the grieving.

References


Additional Readings


Med-Surg Matters is indexed in the Cumulative Index to Nursing & Allied Health Literature

16th Annual Convention

Academy of Medical-Surgical Nurses

October 24-29, 2007
Las Vegas Hilton
Las Vegas, NV

We hope you will join us for AMSN’s 16th Annual Convention in Las Vegas, NV, October 24-29, 2007, being held at the Las Vegas Hilton.

New members and new convention registrants are invited to attend an orientation session on Thursday, October 25, 3:00 p.m. Pre-convention workshops will include the Medical-Surgical Overview/Certification Review Course (2 days) and a Leadership Workshop (1 day). The convention officially kicks off with the Opening Ceremonies at 4:15 p.m. on Thursday, October 25, and will conclude on Sunday, October 28, at approximately 12:00 noon. The Certified Medical-Surgical Registered Nurse certification examination will be held on Monday, October 29. A separate fee and registration are required to sit for the examination.

A preliminary schedule of events is posted on the AMSN Web site (www.medsurgnurse.org), and the convention registration brochure will be available in April 2007.

Viva Las Vegas!

Las Vegas is known as the premier entertainment destination of the world. The city conjures up visions of exciting casinos, dazzling entertainment, and lavish pampering. Recognized all over the world, the Strip offers tourists an opportunity to enjoy a walk in the warm desert evening or take a stroll downtown along the brilliantly lit streets. For all the latest attractions, events, shopping, restaurants, and city information, visit any one of the following:

www.lasvegasnevada.gov;
www.lasvegas24hours.com; www.lvchamber.com
www.vegas.com;
www.lasvegas.com

For more information about the convention or to request a registration brochure, visit www.medsurgnurse.org

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